LEGAL FRAMEWORK FOR EQUIPMENT AND HOME ADAPTATIONS PROVISION

2ND EDITION

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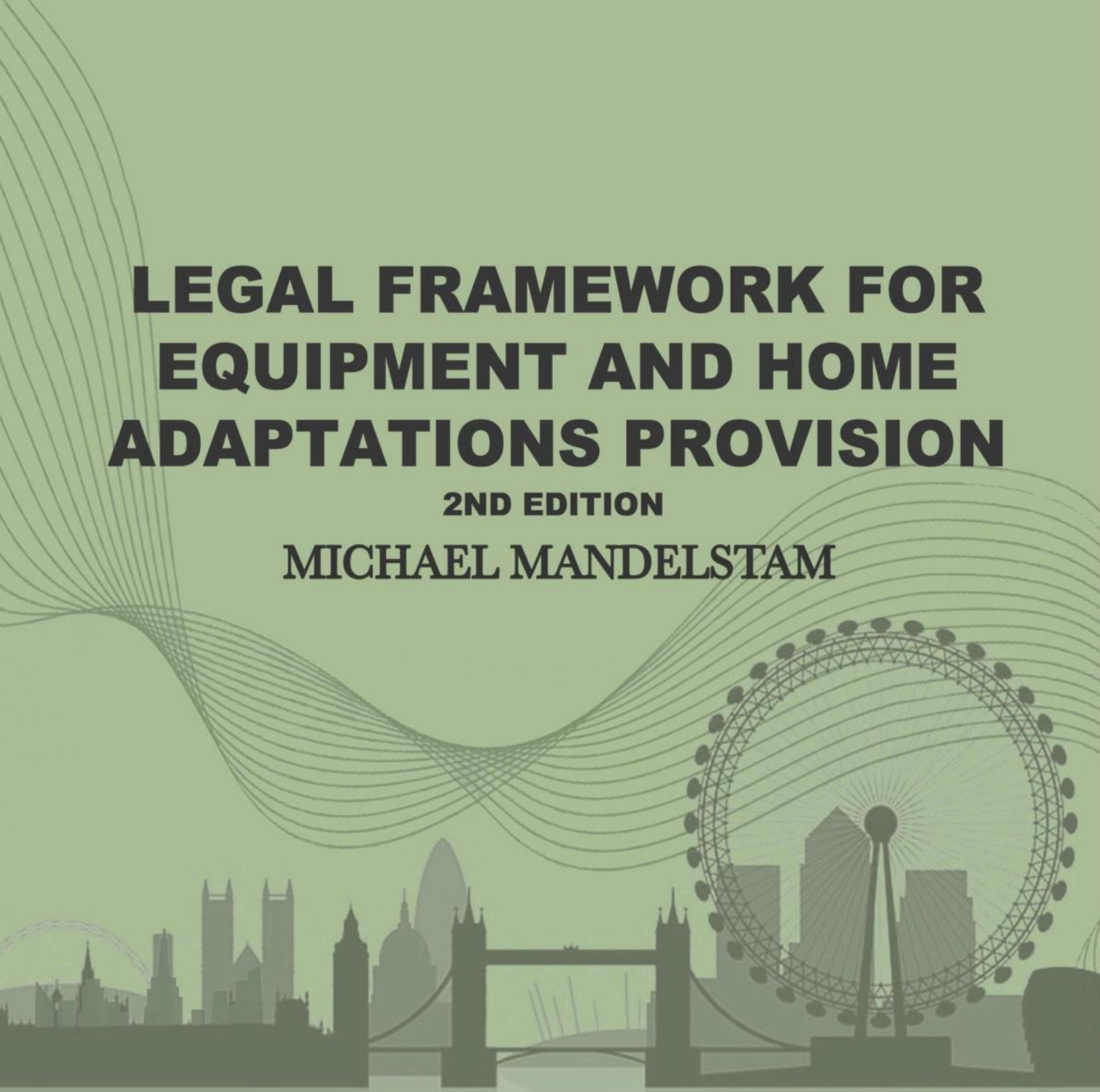

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Author's note. The author has worked, in one form or another, with occupational therapists for over 40 years, provides independent legal training and has written a number of books on social care and health care law.

He would like to thank the London Principal Occupational Therapists Group Network for asking him to update these Guidelines – and for all their help, comments and suggestions. Any views or mistakes are those of the author.

Using the Guidelines. These Guidelines set out a framework based on legislation, guidance, legal cases and ombudsman investigations. These are drawn on selectively, based on the many queries put regularly to the author by occupational therapists, both practitioners and managers.

The contents list allows the reader to go straight to a particular issue, without having to read the whole document. If the Guidelines are used electronically, then clicking on a contents-list heading will take you straight to the relevant paragraph(s). This enables a bite-sized approach to using the document.

The time of writing is March 2024. Future changes in legislation, guidance and legal case law will need to be considered. The Guidelines apply to England only.

Disclaimer. The Guidelines are no substitute for the taking of formal legal advice in individual cases or when local policies and operational procedures are developed. The Guidelines are just that: guidelines. They do not seek to stipulate what local authorities should or shouldn't be doing; that is for each local authority to decide. They provide pointers only.

CONTENTS

1 DECISION-MAKING: GENERAL

In principle, local authority policies about equipment and home adaptations should result in individual decisions which accord with law and good administration. This first section of the Guidelines is concerned, in the main, with how the courts (in judicial review cases) and the local ombudsman scrutinise local authority decision-making.

1.1 Pressure on local authorities

Pressures on local authorities are considerable. Arguably few authorities in practice can comply perfectly with all legal requirements all of the time. This is of course nothing new. Duties contained in some of the legislation, and the aspirations underlying them, have far outstripped available resources in relation to demand.

Twenty five years ago, in a major social care legal case, it was held that the Chronically Sick and Disabled Persons Act 1970 created an absolute duty to meet need, irrespective of resources, once it had been assessed that it was necessary to meet a person's needs. The case was originally about laundry and cleaning. One judge stated: *Having willed the end, Parliament must be asked to provide the means*.[1]

Parliament never has of course, which is why local authorities, occupational therapists, equipment services etc. find themselves so pushed. For children this is still under the 1970 Act. For adults (since April 2015) it is under the Care Act 2014, which also creates an absolute duty once eligibility has been established.

1.1.1 Controlling expenditure

Rising demand and limited resources lead therefore, almost inevitably, to compromises or shortcuts. Some are lawful, some unlawful - and some indeterminate but sailing close to the wind. This may be the reality but at least awareness of the law reduces the risk of a local authority running too far off the legal rails.

Nonetheless, some of the legal rules do give local authorities tools with which to control expenditure. For instance, using eligibility criteria to limit the number of people to whom a duty is owed. Or, once a person is assessed as eligible, seeking cost-effective options for meeting a person's needs.

Similarly, some health and safety at work duties involve what is reasonably practicable. This can allow for a principle of proportionality to be applied when weighing up degree of risk and therefore what level of resource allocation is reasonably required.

[1] *R v Gloucestershire County Council, ex p Barry* [1997] 2 All ER 1, House of Lords.

1.1.2 Law and good practice

Outlining the potentially wide extent of what can be provided under legislation is not with the purpose of heaping further, impossible pressure on local authorities. But merely to point out how such legislation can be used creatively to find reasonable solutions to individuals' needs – and how to apply it in a person-centred way.

The reality may be that local authority practitioners and managers feel they are unable to "fight every battle" they might wish to, because of the inevitable gate-keeping function they fulfil. But this does not mean that they won't wish to go the extra mile in some cases. Informed and creative use of law can only support good professional decision-making by occupational therapists. First, in order, as their professional code states, to:

provide a high-quality, evidence-informed and inclusive service; provide a person-centred or personalised service.

Second, as the same code notes:

Where service resources are limited, any priorities that are identified and choices made are compliant with legal requirements, and national and/or local policy. [2]

1.2 Decision-making process

In judicial review legal cases, when decisions made by public bodies are challenged, the courts are in general interested in the decision-making process, not the final outcome of the decision. They are looking for evidence of compliance with the relevant legislation, and that a decision has been made fairly and lawfully.

For instance, that relevant factors were considered, that the decision made does not appear to have been made irrationally (such that no reasonable public body, on the evidence, could possibly have made it) – and that the public body did not fetter its discretion by applying a blanket policy allowing of no exceptions.

The ombudsmen (social care or health), though not a court of law, take a similar approach when they investigate potential maladministration or failure in service.

[2] *Professional standards for occupational therapy practice, conduct and ethics*, Royal College of Occupational Therapists, 2021, paras 2.1.3 and 4.10.1.4.

1.2.1 Professional judgement

The law courts (in judicial review cases) and the Local Government and Social Care Ombudsman (LGSCO) are reluctant to interfere with professional judgement.[3] As the local ombudsman put it one case:

Professional judgement: bathroom recommendations. An occupational therapist recommended conversion of an existing bathroom to a wet room and use of an existing ground floor reception room as a bedroom. Mr X wanted instead a new build bedroom and new wet room for his mother. Four occupational therapists and three different managers reviewed the assessment and agreed with the original recommendation.

The ombudsman could see no sign of fault in the way the authority completed and decided the assessment. It had considered relevant information and reviewed the information several times over before reaching a final decision.

The ombudsman was not an appeal body and would not question the merits of a decision where there was no sign of fault in the way the decision was reached. This was essentially a matter of professional judgment for suitably qualified council officers to make.[4]

They are mostly interested in *how a decision is reached* – not what the *outcome* of the decision is.

Process not outcome: reducing care package with equipment. A local authority replaced double-handed moving and handling with single-handed – and a night-time carer with a profiling bed.

The judge noted evidence gathered from practitioners, how this had been applied against Care Act eligibility outcomes and the definition of well-being. But was not directly interested in whether her care package should have been changed in this way and reduced from 104 hours a week to 40 hours. It was not for the courts to subject Care Act assessments to "over-zealous textual analysis".[5]

In a different category of legal case – for example a negligence case where a person has directly suffered harm – the courts will examine professional judgement directly and call on expert evidence.

However, even in such negligence cases, the court is still very much concerned with the decision-making process. Rather than just the fact of an accident and harm caused, which alone does not determine whether there is fault and liability. And is not looking to see whether the professional involved made the best possible decision, but whether it was a decision made to at least a reasonable standard.

[3] *R(Ireneschild) v London Borough of Lambeth* [2007] EWCA Civ 234, Court of Appeal.
[4] LGSCO, *Buckinghamshire County Council* (23 000 590), May 2023.
[5] *R(VI) v London Borough of Lewisham* [2018] EWHC 2180 (Admin), High Court.

1.3 Adherence to legislation

Decisions need to be made consistently with the relevant legislation.

Looking at the right legislation: DFG legislation or Care Act? A local authority's mistaken decision about a disabled facilities grant (DFG) was partly explained with reference to a "holistic" (Care Act) assessment and needs. The judge pointed out that DFG decisions are made ultimately under the Housing Grants, Construction and Regeneration Act 1996 (HGCRA) – not the Care Act.[6]

For instance, the Care Act refers to personal hygiene only in relation to washing/bathing.[7] Whereas the HGCRA goes very much further by referring to a disabled occupant having access to a bath or shower or both.[8] So, in supporting a professional view that a person needs access to a bath or shower, a practitioner would derive more explicit help from the HGCRA than the Care Act.

The ombudsman, too, has picked up on this. As in the following case, when the Chronically Sick and Disabled Persons Act still applied to adults, before Care Act implementation:

Collapsing two Acts into one: fault. The local ombudsman found maladministration because a local authority had impermissibly collapsed, into one procedure, its dealing with applications for adaptations. The two Acts involved were the Housing Grants, Construction and Regeneration Act 1996 and the Chronically Sick and Disabled Persons Act 1970. The situation was exacerbated by the inadequacy of the self-assessment questionnaire that was used to make a judgement about a person's priority under both Acts.[9]

1.3.1 Duties and budgets

In social care and health care legislation, there are specific (strong) duties, general (weaker) duties and powers. Of these three categories it is the first which bites most significantly. Once triggered, such a duty must be performed; lack of resources is no defence.

Examples of such specific duties include the duty under s.9 of the Care Act to assess a person who appears to maybe have care and support needs; the duty to meet eligible needs under s.18 of the Care Act 2014; and the duty to meet a disabled child's needs under s.2 of the Chronically Sick and Disabled Persons Act 1970.

The courts understand that in one sense resources cannot be conjured up out of thin air. But have also recognised that financial cuts must stop somewhere if specific legal duties are not to become meaningless. If there is an absolute statutory duty, the local authority must find

[6] *R(McKeown) v London Borough of Islington* [2020] EWHC 779 (Admin), High Court paras 24, 53.
[7] *Care and Support (Eligibility Criteria) Regulations 2015.*
[8] *Housing Grants, Construction and Regeneration Act 1996*, s.23.
[9] Local Government Ombudsman, *Neath Port Talbot County Borough Council* (99/0149/N/142), 1999).

the resources, even if it means diverting resources from other budgets. Otherwise, statutory duties would in effect be downgraded to discretionary powers.[10]

1.3.1.1 Duties placed on local authority as a whole not individual services

Individual teams and budget holders in local authorities may sometimes feel they are put in an impossible position; for instance, if hit with the requirement of large expenditure on equipment, adaptations and a large care package. With insufficient money in the budget. The legal answer to this conundrum is that any such duty is imposed not on a particular team or budget but on the local authority as a whole.

A legal or ombudsman case would lie against the local authority as a whole. As mentioned above, resources will sometimes need to be diverted from other budgets in other parts of the local authority to ensure that "inescapable" duties are performed.

At its simplest, this means that a waiting list for assessing older people with equipment-related needs should not be viewed as an occupational therapy waiting list but a local authority waiting list. For instance, problems on the ground should therefore be reported "upwards" to councillors and the social services committee, so they are aware at local authority level. And any continuing wider failure in service delivery, including a lack of monitoring and inadequate records of waiting lists, is then squarely at the committee's, and the local authority's, door. Where it belongs.[11]

A further, but slightly different, example of the virtue of taking a global view came in the following ombudsman case. This was when saving a certain amount of money from one budget meant the necessity of even greater expenditure in another:

Unacceptable fettering of discretion not to top up a home adaptation was also not best value. The consequence of a blanket policy of not exercising the discretion to top up disabled facilities grants (DFGs) meant delay in funding the adaptations was a fettering of discretion.

Absurdly, the consequence of the rigid policy and delay in eventually agreeing the adaptations was to cost the local authority £735 per week. This was to pay for residential care until the adaptations were completed and the man could return home; he had muscular dystrophy, a benign brain tumour and used a wheelchair. Yet no consideration had been given as to whether it would have been better use of resources to get on with the adaptations instead. The evidence suggested it would have been better value for money to fund the adaptations at the outset. All this was maladministration.[12]

[10] *R v East Sussex County Council, ex parte Tandy / In re T (A Minor)* [1998] 2 WLR 884, House of Lords. Also: *R v Gloucestershire County Council, ex p Barry* [1997] 2 All ER 1, House of Lords.
[11] Local Government Ombudsman, *London Borough of Redbridge* (92/A/1173), 1993; and *London Borough of Redbridge* (92/A/4108), 1993.
[12] Local Government Ombudsman, *Walsall Metropolitan Borough Council* (07/B/07346), 2008.

1.3.2 Joint working and integration

Integrated care, and joint working more generally between local authorities and the NHS, is nothing new. A renewed emphasis came with the Health and Care Act 2022, and the formation of both integrated care boards (ICBs) and integrated care partnerships (ICPs).[13] More loosely, other legislation anyway permits (and promotes) closer working together:

- Section 3 of the Care Act promotes (but does not demand) integration with the NHS.
- Education, health and care (EHC) plans are designed to bring together into one place, the needs of a child with special educational and related needs (Children and Families Act 2014).
- Section 27 of the Children Act contains a general duty of cooperation between different statutory services.

Section 75 of the NHS Act 2006 provides for joint working in various forms including joint budgets, payments from a local authority to the NHS and vice versa. As well as the carrying out of NHS functions by a local authority, or of local authority functions by the NHS.

Integrated working would seem, intuitively to have advantages. For example, for the patient, less fragmentation and duplication. For practitioners, being able to work across the health and social care divide, pooling expertise and achieving better outcomes. For everybody, fewer disputes between NHS and social care and so greater certainty. And, for commissioners, perhaps cost saving.

Even so, on this last point, the National Audit Office has noted in the past that there is no compelling evidence to show that integration leads to sustainable financial savings or reduced hospital activity.[14]

1.3.3 Integration, equipment

In relation to equipment or any other provision, it is fundamental that underlying legislation does not change in the context of integrated working. Take the following examples:

- **Joint equipment service**. Joint equipment stores do not alter the underpinning of Care Act or NHS Act duties. Thus, equipment provided for a person with NHS continuing healthcare (CHC) needs may be issued from a joint store.[15] But ultimately the responsibility remains under NHS legislation; namely that the NHS, solely, must arrange and fund provision to meet CHC needs.[16] Including people's needs for equipment, health or social care related.[17]

[13] *Health and Care Act 2022*, s.26.
[14] *Health and Social Care Integration*, National Audit Office, 2017.
[15] *National Framework for NHS Continuing Healthcare*, 2022, para 325.
[16] *National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012*, r.32A.
[17] *National Framework for NHS Continuing Healthcare,* Department of Health and Social Care, 2023, para 315.

- **Local authority therapists meeting CHC needs?** Sometimes, local authority occupational therapists are asked to get significantly involved with patients who have already been assessed as having CHC needs. They may carry out in-depth assessments, formulate care/manual handling plans, provide equipment, demonstrate to carers, coordinate care and keep such cases under review.

  In doing so, they are arguably meeting the person's needs under s.18 of the Care Act and in the associated care and support planning. If so, s.22 of the Care Act would bite. This prohibits local authorities, *under the Care Act*, from meeting CHC needs.

  A joint working agreement could circumvent this obstacle. It could allow the local authority to meet the needs on behalf of the NHS, and therefore to be doing so under the NHS Act 2006. Of course, as already noted, the NHS would retain ultimate responsibility, including for funding.

- **Integrated hospital discharge**. Another example could be an integrated hospital discharge service, within which NHS ward staff are asked to carry out Care Act assessments (and related Mental Capacity Act assessments) on behalf of the local authority. If so, the rules of the Care Act (and the Mental Capacity Act) apply to those assessments (including for equipment). They are not disapplied in any way simply because NHS ward staff are doing them, may be pressed for time and subject to acute pressure from hospital bed managers.

In other words, integrated arrangements can sometimes pose a legal risk to local authorities if some caution is not exercised. For instance, this appears to have happened in the context of mental health. A significant number of integrated mental health teams has been disbanded over recent years. This has been, generally, because of fears that Care Act duties were being obscured or eclipsed by NHS priorities, practical or political.

In which case, for the local authority, both legally and financially, the integration may fail.[18] It is the local authority that remains overall responsible for Care Act functions.[19]

For example, in one mental health case, the local authority delegated both social care assessment and eligibility decisions to the NHS. The latter did not follow the rules, and the ombudsman held the local authority responsible. The local authority was surprised by this and refused to accept it was responsible. The ombudsman was concerned:

We are concerned that the Council refuses to accept it is responsible for Mr Y's social care needs, irrespective of any agreement it may have entered into with the [NHS] CCG. Adult social care is a

[18] E.g. *Mental health social work services in Suffolk*. Accessed 19/2/2024 at: https://www.suffolk.gov.uk/care-and-support-for-adults/how-social-care-can-help/mental-health-social-work-services-in-suffolk. Also: Withdrawing social workers from NHS will 'boost Care Act compliance', claims council. *Community Care*, accessed 19/2/24 at: https://www.communitycare.co.uk/2016/01/08/withdrawing-social-workers-nhs-will-boost-care-act-compliance-claims-council/

[19] *Care Act 2014*, s.79.

council function, yet the Council has been unable to explain how it ensures the social care needs of service users with Asperger Syndrome are met.[20]

1.3.4 Hospital discharge

Hospital discharge frequently involves joint input from the NHS and local authorities. It serves as an example of the need to be clear about who is doing what and under which legislation.

In July 2022, certain duties and safeguards relating to discharge from acute hospital beds were removed from schedule 3 of the Care Act. Since then, the overall legal picture of hospital discharge responsibilities has become further obscured than it already was.

Some issues remain clearer than others, but Department of Health guidance refers to the importance of local protocols to set out each organisation's role and responsibilities. Which means that the picture, across different local authority areas, may vary considerably:

- **Involving the patient and informal carer**. First, when beginning to make plans for discharge, the hospital must, as soon as is feasible, take appropriate steps to involve the patient and any informal carer. This is under s.74 of the Care Act 2014.

- **Awaiting NHS continuing healthcare assessment**. Second, if a person is discharged but is still awaiting an NHS continuing healthcare (CHC) assessment, guidance seems to state that the NHS should fund the interim services, until that assessment takes place. Unless the person already had a package of care before discharge, and their needs on discharge can safely and appropriately be met without any change to that pre-existing package.[21]

- **Person already has CHC status**. Third, if a person has already been given CHC status, then responsibility for meeting their needs lies with the NHS (integrated care board).

- **Discharge to assess**. Fourth, and more generally, guidance states that "discharge to assess", involving three key discharge pathways, could (but does not have to be) adopted by way of local policy and practice for discharges.

- **Local policies and protocols: variation**. Fifth, the following paragraph in guidance strongly indicates that local practices may vary: *NHS bodies and local authorities should adopt discharge processes that best meet the needs of the local population ... This could include the 'discharge to assess, home first' approach ... Where local areas agree to fund a period of care (pending a long-term needs assessment being carried out), agreements should be in place to ensure no one is left without care or – if needed – an assessment of long-term needs prior to the end of this period … NHS bodies, local authorities and other relevant partners should develop local protocols … set out each organisation's role and how responsibilities should be exercised.*

[20] Local Government Ombudsman, *Somerset County Council* (13 019 566) 2015, paras 3, 35.
[21] *National Framework for NHS Continuing Healthcare*, 2022, para 107.

- **Mental capacity**. Sixth, guidance states that if there is a reason to believe a person may lack the mental capacity - to make relevant decisions about their discharge arrangements at the time the decisions need to be made - a capacity assessment should be carried out as part of the discharge planning process.[22]

1.3.4.1 Equipment on discharge

So, what might all this mean when weighing up responsibilities about a person's care and equipment needs on discharge? The following three ombudsman cases are illustrative.

They underline the need for clarity - as far as this is possible in the often-chaotic context of hospital discharge from acute hospital beds. So that, locally, practitioners and management know who is doing what and where ultimate responsibility lies.

In the first case immediately below, the local authority was held to be at fault for, amongst other things, the hospital's failure to provide adequate equipment. Even though, there was an arrangement that it was the hospital that would make equipment recommendations.

The local authority felt it was unjust that it should be faulted. Yet it was the local authority that, under the Care Act, held the responsibility for the care package. Shortcomings on the part of the hospital, acting in effect (it seemed) on the local authority's behalf, did not alleviate that responsibility:

The Council's misconception that it was not responsible for the assessment and care provision, is cause for concern … The local process expects health colleagues to order suitable equipment and make referrals to the continence service and similar. However, the Council is responsible for the care that Ms Y received once discharged from hospital.

The details of this case were as follows:

Local authority responsible for equipment and care needs on discharge. A woman with brain damage was due for discharge. The care was to be provided by the local authority under the Care Act.

It assessed, together with health professionals, her needs in hospital. A physiotherapist stated that single handed care, following discharge, would be sufficient, if a family member acted as second carer/handler. However, the local authority reached no agreement with the family about this, and recorded that for safety reasons, family members would anyway not be asked to do this.

She was then discharged, with four calls a day involving a single care worker. The hospital had not assessed her need for a hospital bed, continence service referral and continence aids. Consequently, care workers raised a safeguarding alert about the level of support and need for equipment.

[22] *Hospital discharge and community support guidance*, Department of Health and Social Care, 2022, pp.6, 12.

The ombudsman found fault with the local authority about the level of support and lack of equipment when she was discharged. The authority denied it was responsible and said she should complain to the hospital. The ombudsman found that the local authority was at fault.[23]

In a second case, the failure to assess a person's capacity, and therefore adequately to judge the risk she was at - in terms of weight bearing and use of equipment - was down to the local authority:

Local authority responsibility for discharge: issues around care, equipment, mental capacity (and hospital occupational therapists). A woman had a stroke. Two months later, when hospital discharge was being considered, there were different strands of evidence suggesting strongly she did, or might, lack mental capacity to take decisions about where she lived and her care.

The hospital occupational therapists had recorded consistently her lack of insight into her needs and their implications. She didn't understand about her lack of weight bearing ability and the need for a hoist. They did not convert this "lack of insight" into a formal mental capacity assessment.

But the complaint did not lie against the hospital staff, including the therapists (always supposing there would have been any grounds for this). It lay against the local authority which, in this instance, was responsible for the hospital discharge arrangements. The social worker failed to carry out a mental capacity assessment, which was needed in relation to the discharge. The consequence was that the risk she was at, on discharge, was not fully articulated. On the first night home, she fell and was immediately readmitted to hospital. The ombudsman found fault with the local authority.[24]

In the next case, the ombudsman found fault both with the hospital and the local authority. The hospital's direct role in the discharge was severely criticised; but it was still the local authority which had then taken responsibility for placing the person in an arguably entirely inappropriate care home.

Inappropriate discharge: joint responsibility of local authority and the NHS. A woman had suffered a fall. Admitted to hospital she was now confused and unsteady on her feet. One day, health staff told the family she would be transferred to a community bed that afternoon, ostensibly for rehabilitation.

Instead, the NHS discharged her to a care home at 8.45pm that evening. She was discharged there without a mental capacity assessment, without consent, without her clothes, without any information about her care and medication needs – and without informing the family. The care home rang the family at 11pm that evening to get information about her care and medication.

The care home specialised in care of people with advanced dementia. It was known by the local authority to be providing poor care. She was traumatised and terrified. The family visited and found it difficult to find a seat not wet with urine.

The ombudsman found fault with both the hospital and the local authority.[25]

[23] LGSCO, *Kirklees Metropolitan Borough Council* (21 014 338), January 2023.
[24] LGSCO, *Calderdale Metropolitan Borough Council* (19 006 915), November 2020.
[25] LGSCO, *Worcestershire County Council* (17 014 175), May 2019.

1.4 Evidence, rationale

The court or ombudsman will want, generally, to see a record of the evidence and how it was weighed that, the decision-making rationale and conclusion.

Replacing night-time care and equipment: evidence. Night-time care was withdrawn in favour of a profiling bed and special mattress, the court took note that district nurses and the GP had been consulted about the proposed changes. There was a trial period. The court did not interfere with the local authority's decision.[26]

In a different case, a local authority removed a night-time carer, replacing her with a pressure relieving mattress, the ombudsman looked at the process and judged that the local authority had taken insufficient account of evidence from the GP and district nurse.[27]

In the following legal case, failure to explain the rationale for the decision, when the independent report of an occupational therapist was disregarded, meant the decision could not stand:

Irrational decision-making, lack of reasoning and explanation: not taking account of occupational therapy report. A local authority offered two hours a day of support to woman with complex needs living with her parents.

It failed to explain how its conclusion about her needs was so at variance with the reports of an independent occupational therapist and a specialist behaviour service. Both of who had done detailed assessments and pointed out the considerable extent of her needs.

The local authority countered by referring to the assessment of its own occupational therapist. But it emerged that this therapist had taken a "very cursory look" only at the independent OT report – and had not seen the woman for over a year. She conceded therefore that she could not be sure of the accuracy or otherwise of the expert report (which had been based on first-hand observation).

The local authority's decision was at such variance with the expert reports, that the judge could only conclude that it was irrational, in a legal sense, and thus unlawful.[28]

1.5 Relevant factors

The courts or ombudsman are not keen on interfering with professional judgement but will check that such judgement has been exercised, with relevant factors considered.

[26] *R(VI) v London Borough of Lewisham* [2018] EWHC 2180 (Admin), High Court.
[27] LGSCO, *London Borough of Croydon* (22 000 071), November 2022.
[28] *R(JG) v London Borough of Southwark* [2020] EWHC 1989 (Admin), High Court.

If satisfied about this, they will be less likely to interfere with how much weight was given to these relevant factors, and therefore less likely to interfere with the decision. However, in the following case, for obvious reasons, the court was not satisfied:

Manual handling and osteoporosis: failure in the decision-making process. A local authority decided that a woman should be hoisted when attending a day centre. The decision was challenged in the courts. The assessment was held to be unlawful because there was no recorded evidence that her severe osteoporosis – an obviously highly relevant factor - had been considered before the decision about hoisting was reached.

The judge held that the local authority would have to re-take the decision, this time evidencing that it had taken account of, and explained, all the pertinent issues.[29]

In the following case a decision was made about commode use downstairs, without the local authority having recorded whether, or how, it had considered privacy and dignity:

Commode use: failure to weigh up and record questions of dignity. A woman wanted a downstairs toilet/bathroom because she could not always get up the stairs unaided. The local authority concluded that on those occasions she could not, she could use a commode downstairs. There were five people living in the dwelling. The ombudsman faulted the decision, because the obvious issue of privacy had not been explained and recorded, before the decision was reached.[30]

1.6 Blanket policies

The courts and ombudsman tend to react badly to decisions which appear to have been reached not on the merits of the individual case – but in a pre-determined manner, driven by a restrictive or blanket policy.

Such policies may be tempting for local authorities because they are perceived to make life easier for both practitioners and public – by clearly spelling out what is or isn't on offer. They also tend to be adopted with a view to avoiding "floodgates opening" and saving money.

Nonetheless, they are, in principle at least, ill-advised for a number of reasons:

- **Undermining legislation**. They tend not to be consistent with the wording of legislation such as the Care Act 2014, which is about assessing individual need in terms of outcomes and well-being – and precisely not in terms of types of what services or equipment are available.

- **Not person centred**. Blanket policies are potentially anathema to the person-centred approach which so many local authorities advocate.

- **Undermining professional judgement**. In addition, blanket policies tend to undermine professional judgement and discretion, because they can result in pre-determined decisions.

[29] *R(SC) v Salford City Council [2007] EWHC 3276 Admin*, High Court.
[30] LGSCO, *Blackburn with Darwen Council* (21 015 502), Sept 2022.

Not necessarily cost-effective. Designed to save money, such policies can also be counter-productive. They sometimes preclude the most cost-effective option for meeting a person's need. For example, excluding in principle, a riser recliner chair - in a situation where it would result both in less dependence, and in more care having to be commissioned at greater overall cost to the local authority.

- **Unlawful fettering of discretion**. In addition to all of this, blanket or restrictive policies risk "fettering the discretion" of a local authority. This is unlawful. The term describes a common law legal principle, applied by the courts in judicial review cases and by the ombudsman.

Examples of the courts or ombudsmen faulting a restrictive, blanket policy include:

- Never helping with cleaning or shopping.[31]
- Not considering ramps for powered scooters.[32]
- Never helping people with holidays.[33]
- Never providing small aids.[34]
- Never considering garage conversions for a disabled facilities grant.[35]
- Never considering 24-hour care in a person's home.[36]
- Never considering night sits.[37]
- Never using discretion to top up a disabled facilities grant[38]
- Applying local wheelchair criteria rigidly, when refusing an indoor/outdoor powered wheelchair for a young man who did not fall within those criteria – this was a failure to consider whether his was an exceptional case.[39]

1.7 Human rights

[31] LGSCO, *Kingston upon Hull City* Council (17 010 857), 2018
[32] LGSCO, *Luton Borough Council* (16 008 034), 2017
[33] *R(BG) v Suffolk County* Council [2022] EWCA Civ 1047, July 2022, Court of Appeal.
[34] LGSCO, *Blackburn with Darwen Council* (21 015 502), Sept 2022
[35] LGSCO, *London Borough of Ealing* (20 011 145), November 2021
[36] LGSCO, *London Borough of Croydon* (22 000 071), November 2022
[37] LGSCO, *Sefton Metropolitan Borough Council* (21 013 989), May 2022
[38] Local Government Ombudsman, *Walsall Metropolitan Borough Council* (07/B/07346), 2008.
[39] Health Service Ombudsman, *Epsom and St Helier NHS Trust* (E.559/99–00), 2001.

In deciding about a child's needs for equipment or adaptations, public bodies must take care not to breach people's human rights.

The Human Rights Act 1998 means that decisions taken under other domestic legislation – such as the Care Act 2014, NHS Act 2006, Children Act 1989 etc. - must be taken consistently with the European Convention on Human Rights (ECHR).

Equipment and adaptations provision could, in some circumstances, engage human rights:

- **Article 2: right to life.**
- **Article 3: right not to be subjected to inhuman or degrading treatment.**
- **Article 5**: **right not to be deprived of liberty**, except through lawfully prescribed procedures (a qualified right, therefore).
- **Article 8**: **right to respect private life, family life, home** and correspondence – interference justified if according to law, necessary/proportionate in a democratic society for a prescribed purpose, which include protection of health, economic well-being of the country etc.

For instance:

Hoists, manual handling and human rights. A and B were sisters, 26 and 22 years old, with profound physical and learning disabilities. They were greatly impaired in their mobility and lived at home with their parents. Extensive manual handling was required by paid carers.

The local authority decided the two sisters would have to be hoisted extensively. The parents were opposed to this, favouring assistive handling short of hoisting. The local authority had a seemingly stringent manual handling policy. The judge noted that some manual handling issues could engage human rights:

Life. What if lifting was required because of the dwelling catching fire or they slipped under the water in the bath and could be saved only by being lifted out? (article 2)

Inhuman or degrading treatment. What if a failure to lift A or B manually might result in them remaining sitting in bodily waste or on the lavatory for hours, unable to be moved? (article 3)

Right to respect for private life. What if some lifting were required to enable them to participate in life in the community and to have access to an appropriate range of recreational/cultural activities? (article 8).[40]

1.7.1 Using human rights

The rules and cases below illustrate human rights in the context of health and social care. Understanding what may engage human rights gives practitioners and managers additional grounds on which to argue for a particular solution to a case. Even if it involves significant

[40] *R(A&B) v East Sussex County Council* [2003] EWHC 167 (Admin), para 129, High Court.

expenditure of resources. For instance, although resources can, up to a point, be raised to defend a potential breach of article 8 of the Convention, that is not the case with article 3 (inhuman or degrading treatment). See, further, below.

In the following case, the ombudsman praised as "exemplary" a trainee social worker who had persisted in highlighting the dire consequences of failing to provide suitably adapted accommodation for two disabled children. In such or similar circumstances, a practitioner can bolster their argument, for a solution to a person's needs, by referring to human rights. Which, in this sort of case, would be potentially articles 8 and 3.

Failure to meet needs of disabled children over 8-year period: human rights? A woman had five children, two with a genetic muscle wasting disease. They had no mobility, were doubly incontinent and needed 24-hour care and assistance with feeding, dressing, bathing and toileting. The younger of the two was also blind and had severe learning disabilities.

Many years of unmet need. By 1998, the local authority knew the family needed a ground floor bathroom and bedroom. The older child was too heavy to be carried upstairs. In 2002, the family was moved to a 4-bedroom house – the local authority intended to build a ground floor extension. But it had not checked first as to whether this was feasible and would receive planning permission; even though an architect had warned that it would not. And it did not. Suitable accommodation was not found until 2006.

Hosing child down in garden. By 2004, one of the children had a rash from not being bathed regularly; and painful feet from being dragged when moved. The mother had insufficient room to wash him when faeces spread across his body; she had no option but to hose him down in the garden regularly. By then, the other, older child would end up in faeces to his neck. He was petrified of using the stair climber because he had fallen from it three times and needed three people to lift him into it. The bathroom was anyway too small for him to be moved and handled within it.

Local authority's refusal to provide interim adaptations. A trainee social worker had persistently raised concerns about the gravity of the situation, including communicating with the director of social services. During all this time, the local authority had refused to provide interim adaptations other than a stair climber and hoist in the dining room. The local authority referred to the abusive actions of the mother in hosing down one of her sons in the garden. And to potential human rights issues.

Institutional indifference. The ombudsman was highly critical and laid the blame at the door of institutionalised indifference on the part of local authority managers. The local authority's reference to the mother's actions as abusive was "breathtaking insensitivity".[41]

[41] Local Government Ombudsman, *Bury Metropolitan Borough Council* (07C03887), October 2009.

1.7.2 Inhuman, degrading treatment

For article 3 to be breached, there must be a minimum level of severity and actual bodily injury or intense physical or mental suffering.[42] This legal test forms a high threshold. What might this mean? For example:

Severe restrictions on child at school: breach of article 3. Severe physical restrictions were actively put in place for a child at school, with no up-to-date care plan, risk assessment, and consideration of less restriction. The court identified a breach of human rights. The severely autistic child had been confined for long periods in a padded room, known as the blue room - with an absence of all such mitigating measures. The local authority was in breach of both articles 5 (unlawful deprivation of liberty) and article 3.[43]

In an adult case, a breach of article 3 was found based on inadequate care setting and equipment for a disabled prisoner:

Depriving a disabled woman of essential equipment and care. A thalidomide victim - lacking four limbs, with numerous health problems including defective kidneys - was committed to prison for contempt of court during civil proceedings. Her wheelchair battery was running low, but she was told by a court officer that she could not take the charger with her, since it was a luxury item.

In the police cell she was unable to use the bed and had to sleep in her wheelchair where she became cold. Emergency buttons and light switches were out of reach. She had become dangerously cold, and a doctor had to come and wrap her in a space blanket.

When she reached the prison hospital, she could not use the toilet herself, the female duty officer could not manage to move her alone, and so male prison officers had to assist. She was at risk of developing pressure sores because of the hardness of the bed. Lack of fluid intake and problems getting to the toilet led to her being catheterised.[44]

Nevertheless, its high threshold means that a breach of article 3 is not readily recognised by the courts, as in the following case which involved, amongst others, occupational therapists:

Degrading living conditions following a stroke; no breach of article 3. A local authority's social care and housing failed departments failed, for 20 months, to meet the needs of a woman who had suffered a stroke and was immobilised, doubly incontinent, in her living room, through which her large family constantly passed.

There was a breach of article 8 (see immediately below) but not article 3. It was a finely balanced decision, but the judge concluded that there was no intention to humiliate or debase her.

[42] *Pretty v United Kingdom* [2002] 2 FCR 97, European Court of Human Rights
[43] *C v A Local Authority* [2011] EWHC 1539 (Admin), High Court.
[44] *Price v United Kingdom*, (2001) 34 EHRR 1285, European Court of Human Rights.

The living conditions had not been deliberately inflicted on her; it was merely a failure by the local authority to act. The severity threshold for article 3 had not been crossed, notwithstanding the degrading circumstances.[45]

By contrast, the line was crossed in the following 2024 case, when a court did find a breach of article 3. It was about the accommodation and related equipment needs of an active, very disabled asylum seeker.

This is a notable and unusual case, since breach of article 3 is rarely found in relation to local authorities. Although it is an asylum case, it could have wider application, when local authorities judge more generally how significant and pressing a person's needs are – and how long they are left unmet. In this case, the court noted that lack of resources is not generally a defence under article 3:

Man with multiple sclerosis left by local authority in conditions causing severe physical and mental suffering amounting to degrading treatment: breach of article 3. A 50-year-old active asylum seeker had progressive multiple sclerosis (MS), paraesthesia with severe and varied pain. He lived in an ensuite bedroom with his wife and 2 children (girl aged 4, boy aged 10). The dimensions of the room were 5 x 3.5 metres. This was in a Home Office-provided asylum hostel.

Care conditions in room: no space for hoist or wheelchair, undermining of dignity. In the room were a hospital bed, single bed and bunk bed. There was no room for a hoist or wheelchair. He could not really move around and was largely bedbound. He urinated in a bottle, defecated on a pad in bed or on a commode. He could not hold the urine bottle, his wife had to. He could not access the bathroom or shower. The catheter bag had to be removed, emptied and flushed out in the bedroom – an intimate procedure with the family present. There was poor ventilation, the windows barely opened. The great heat in the summer made the MS worse. He was totally reliant on his wife for everything. He minimised hydration so as not to urinate when the children were awake or disturb them when they slept.

Eligible needs but local authority refusing to alleviate. The local authority assessed and found him unable to achieve any of the Care Act eligibility outcomes. The local authority refused to fund alternative accommodation, claiming the needs were not accommodation-related and did not fall under the Care Act – and that it was a Home Office responsibility. He had rejected alternative accommodation because this would have meant living alone without his wife who was his main carer; the local authority said he was therefore the author of his own misfortune. The judge disagreed; it was not unreasonable for him to reject it, given his circumstances and reliance on his wife.

Serious physical and mental suffering. The judge found the physical and mental suffering threshold had been crossed.

[45] *R(Bernard) v London Borough of Enfield* [2002] EWHC 2282 Admin, High Court.

Intent of the local authority. For it to be a breach of article 3, some sort of intent was required on the part of the local authority. The judge noted that the local authority might not have wanted him to be living so, but it made an intentional choice to leave him in those conditions for many months.

Furthermore, the local authority had probably been advised by its own lawyers that its position was unlawful, or at least that its legal case would be unlikely to succeed – because of previous case law on this sort of issue (division of responsibility between Home Office and local authority in the case of people with care and support needs).

Lack of resources not a defence in article 3 cases. The local authority argued lack of resources and finding accommodation at reasonable cost: but previous case law stated that best efforts, within affordability constraints, is not enough to avoid a breach of article 3. There was a breach also of article 8.[46]

1.7.3 Private life, family life, home

Similarly, when might article 8 be engaged – and any interference with that right be justified, or not justified?

Cost-effectiveness: incontinence pads instead of assistive handling at night: no breach of article 8. The European Court of Human Rights held that replacing a night-time carer with incontinence pads was an interference with the person's private life but was justified for the economic well-being of the country.[47] (At least it was in this individual case, based on the assessment of the person's needs).

In another case, the failure to provide a robotic wheelchair arm for a man with Duchenne's Muscular Dystrophy was held by the European Court, for broadly similar reasons, not to be a breach of article 8.[48]

In a further case, involving questions of equipment, adaptations and housing suitability, the High Court found no breach of article 3 but there was a breach of article 8. The situation had been brought about by failing to follow the relevant adult social care legislation:

Lack of suitable housing, equipment, adaptations for 20 months: breach of article 8. A woman was seriously disabled having suffered a stroke. For 20 months, the local authority either failed to move the family or provide suitable equipment or adaptations. She was stuck in the living room which served as her bedroom, doubly incontinent, unable to mobilise, with a husband and six children around her. It was depressing, demeaning, humiliating; the judge identified "corporate neglect" and a breach of article 8, in terms of her dignity and integrity (physical and psychological).[49]

[46] *R(TMX) v London Borough of Croydon* [2024] EWHC 129 (Admin), High Court, January 2024.
[47] *McDonald v United Kingdom*, Application (2014) 4241/12, European Court of Human Rights.
[48] *Sentges v Netherlands,* Application 27677/02, 2003, European Court of Human Rights.
[49] *R(Bernard) v London Borough of Enfield* [2002] EWHC 2282 Admin, High Court.

In contrast, there was no breach of article 8 in the following case, because unlike the case immediately above, the local authority had followed the requirements of both the Care Act and the Housing Act:

Highly unsuitable flat for disabled man for 20 months, but local authority behaving lawfully in relation to care, equipment, housing: no human rights breach. When a medical emergency left a man in his sixties paralysed below the waist in an 8th floor council flat with his family, it was 20 months before a suitable 3-bedroom house could be allocated to him. The doorways in the flat were too narrow for a wheelchair.

The local authority did what it could to meet his needs under the Care Act (providing care so many times a day and a hoist) and applied the Housing Act 1996 appropriately. There was no breach of article 8; the local authority had acted in accordance both Acts.[50]

1.8 Restriction, deprivation of liberty

Occupational therapists sometimes assess situations that require a degree of restriction or restraint of the person – or, sometimes even, deprivation of liberty (DOL) – involving equipment and adaptations. The following paragraphs summarise briefly some of the key points in what can be a complex area of law and practice.

Restriction of liberty is in law less than a deprivation. Deprivation of liberty itself brings into play article 5 of the European Convention on Human Rights and, with it, the requirement of additional legal safeguards.

1.8.1 Proportionality, least restriction

Across more than one piece of legislation, there is a general principle that restriction, restraint or deprivation of liberty requires justification in terms of proportionality involving the least, or less restrictive, option. For example:

- **Mental capacity: less restriction**. For those aged 16 or over lacking the relevant capacity, section 1 of the Mental Capacity Act (MCA) states that if an act is done in a person's best interests, consideration must be given to less restrictive options.

- **Mental capacity: restraint**. Under ss.5 and 6 of the MCA, restraint is permissible if it is to protect the person lacking capacity from harm and is proportionate to the risk (in terms of the likelihood of harm occurring, and its potential seriousness if it does occur).

- **Human rights: right to respect for private life, family life, home.** Article 8 of the ECHR states that any interference with this right must, amongst other things, be necessary in a democratic society – the word proportionality is sometimes used by the courts inter-changeably with the word necessary.

[50] *R(Idolo) v London Borough of Bromley* [2020] 860 (Admin), High Court.

- **Care Act 2014: minimum restriction.** Section 1 of the Care Act refers to the duty of a local authority to have regard to the need to ensure that restriction on the individual's rights or freedom of action is kept to the minimum necessary for achieving the purpose in question.

In the following case, the restrictions imposed by two separate families, on their disabled daughters (respectively 8 and 23 years old), were justified.

Locked doors, less restriction and human rights: disabled child and disabled adult. When the parents of an eight-year-old locked their daughter in her bedroom every night, there was no breach of human rights or indeed any other legislation. The local authority had carried out a careful and thorough assessment, and all concerned agreed that – in the circumstances - this was a carefully assessed, less restrictive and practicable way of keeping the child safe.

In the same legal case, a second family was doing much the same for their 23-year-old daughter who lacked the relevant mental capacity. The court came to the same view. Less restrictive options had been considered and rejected as unworkable or ineffective.[51]

Broadly, such a case illustrates the type of decision-making required. That is, identifying the overall purpose of maintaining family life, the safety required to maintain it, the risks to that safety, options to manage those risks, options that will be effective - and finally, of those, a less or least restrictive option.

The case is not about what type of restriction is or isn't permissible in general. Instead, this is down to individual circumstances. For instance, in the case of the 8-year-old, a safe space bed was considered but thought to be more restrictive than just the locked bedroom. But this was not the same as saying safe spaces should therefore never be used. Indeed, the judge did not rule out, for the future, the trial of such a bed for this child.

1.8.2 Educational and other settings

For educational settings for children and young people, the government has produced guidance (including reference to equipment). It emphasises key elements that will either avoid restriction altogether or keep it to a minimum.[52] These elements include, in summary:

- behaviour support plans,
- involvement and agreement of children/young people/parents,
- multi-disciplinary planning,
- avoiding restrictions,

[51] *Local Authority v A* [2010] EWHC 978 (Fam), High Court.
[52] *Reducing the need for restraint and restrictive intervention*, HM Government 2019, paras 1.10, 5.10.

- de-escalation,
- careful assessment,
- exploration of less restrictive options,
- prevention of serious harm (to child/young person, other children/young people, other people),
- proportionality (level/duration of restriction),
- frequent reviews,
- recording, monitoring, staff training.

The guidance goes on to consider the use of mechanical restraint:

(Mechanical restraint: use of equipment in limited circumstances*).* *Enforced use of mechanical aids such as belts, cuffs and restraints forcibly to control a child or young person's individual's movement.*

Mechanical restraint involves use of a device to prevent, restrict, or subdue movement of a person's body with the aim of controlling their behaviour.

Mechanical restraint may be used to manage extreme aggressive behaviour directed towards others or to limit self-injurious behaviour of extremely high frequency and intensity.

This contingency is most notably encountered with small numbers of children and young people who have severe cognitive impairments, where devices such as arm splints or cushioned helmets may be required to safeguard them from the consequences of their behaviour.

Any such devices should only be put in place by people with relevant training, qualifications, skill and experience. Wherever mechanical restraint is used as a planned contingency, it should be identified.[53]

An example of how a court will scrutinise restraining equipment came in the following case. It involved a school and an occupational therapy service and resulted in compensation awarded of £80,000, after the claimants brought a case under the Human Rights Act.

It underlines the importance of local authorities and occupational therapists keeping track of equipment – and how it is used, after it has been recommended and supplied in a school or other institutional setting. Also, how the purpose of the equipment is explained:

Occupational therapy-prescribed chairs in school: regular restriction/restraint not justified. Twin brothers, with autism, were placed in Hardrock chairs at a school concert. Their parents were told

[53] *Reducing the need for restraint and restrictive intervention*, HM Government, 2019, paras 1.10, 5.10.

this was a one-off so they could participate in attending the concert. Within a year, the chairs were being used for the brothers more routinely at school.

The local authority conceded that the straps and trays on the specialist chairs could restrict movement and amount to mechanical restraint. Their use had not been agreed with the parents and put in a care plan. The parents had therefore not consented, and this was a breach of the school's own policy and of national guidance.

There was no plan to reduce use of the restraints and explore less restrictive options. The school had not recorded, reported or monitored the use of the chairs with straps.

The school stated that the occupational therapy service had prescribed the chairs for therapeutic purposes, together with safety accessories including lap/shoulder belts, lap trays. The school said the chairs were intended for therapeutic purposes – and not to control the brothers' behaviour.[54]

1.8.3 DOL: equipment

If equipment is being used in a restrictive way, a decision may be needed about whether its prescription and use, considered in isolation, is so significant that it amounts to a deprivation of liberty (DOL) in the legal sense (see below). And not just to restriction.[55] As the courts have put it, "restraint might go beyond the parameters set out in sections 5 and 6 of the 2005 Act" and reach a point where it amounts to a deprivation of a person's liberty.[56]

Equipment usage might or might not, in its own right, amount to DOL. On the one hand, restraining equipment may be merely part of wider restrictions which, in sum, amount to a deprivation of liberty. Even though in isolation, the equipment use might not amount to DOL. For example:

Limited or extensive use of a lap belt. If a person is restricted by a belt for 10 minutes a day in order safely to shower, then the belt may be restriction but, *in itself,* is unlikely to be viewed as DOL.

However, there may be a DOL when one looks at the wider, restrictive care arrangements that the person is subject to. Such as the person anyway being confined in a care home and subject to continuous supervision and control, or likewise in their own home or in supported living.

In which case the limited use of the lap belt may be just one of several restrictions which together amount to an objective confinement.

On the other hand, were a lap belt to be in place for a person most of the day, to keep them in their chair, it could be that use of the belt – of itself - is regarded as sufficient to amount to a DOL.

[54] *CHH v Kent County Council* (Twins forced into mechanical restraint chairs, *Local Government Lawyer*, April 2022)
[55] E.g. *A Hospital NHS Foundation Trust v KL* [2023] EWCOP 59, Court of Protection.
[56] *Practice Guidance (Court of Protection: Serious Medical Treatment)* [2020] EWCOP 2, Court of Protection.

Consider a parallel: in one case, mobile phone restrictions placed on a young person *by themselves* did not amount to a DOL - in terms of the person being subject to continuous supervision and control and not being free to leave. But, in tandem with other restrictions, they could be an ingredient of the overall DOL.[57] In an ombudsman case, consideration was given to just this issue:

Lap belt: minimal or extensive use in a care home? Uncertainty surrounded how frequently a lap belt was being used in the care home for a particular resident (was it one hour a day as the care home claimed, or most of the time as a social worker had found).

There was anyway no DOL authorisation in place. But there should have been because, with or without the lap belt, the person was in law being deprived of their liberty within the overall care setting. There was a secure keypad to the exits, and she needed close and constant supervision.

The ombudsman found fault – the DOL issue should have been assessed properly and the role of the lap belt clarified.[58]

The local authority had, in this case, delayed doing a DOLS assessment for some three years. Once it had done so, it identified that the person needed more one-to-one care – up to an additional 21 hours a week. Once this was in place, the lap belt was no longer needed. This illustrates the importance of the DOLS rules being adhered to. Not least to ensure that less restrictive care options are identified and implemented.

To summarise. Whether, in a particular situation, equipment amounts to mere restriction or to a deprivation of liberty in its own right - its use anyway needs to be justified in terms of best interests, less restriction, proportionality, necessity etc, as outlined above.

For occupational therapists prescribing the equipment, they need firstly to look to justify its use at all – in terms of best interests and less restriction. Before considering whether to bring it to the attention of the local authority (the DOL team) in terms of possible DOL, exceeding mere restriction.

1.8.4 Deprivation of liberty (DOL)

Deprivation of liberty (DOL) engages article 5 of the European Convention on Human Rights (ECHR, summarised above). It has three key ingredients.

- **Objective** confinement for a non-negligible period of time: this means the person is under continuous supervision and control and is not free to leave.
- **Subjective**: lack of valid consent (which a person, lacking mental capacity, of course cannot give).

[57] *Manchester City Council v CP* [2023] EWHC 133 (Fam), High Court.
[58] LGSCO. *Surrey County Council* (21 009 849), October 2023.

- **Imputable** to the State: involvement or knowledge of the situation by a public body.

1.8.4.1 DOL: adults

If restriction of liberty or restraint is of such a nature and degree that it fits within the definition of deprivation of liberty, then additional legal safeguards come into play.

For adults (18 or over) in a care home or hospital), the local authority must authorise the DOL according to certain procedural rules in the Mental Capacity Act. This is unless the case is difficult or contentious, in which case, it must go to the Court of Protection for a decision.

These procedural rules, known as Deprivation of Liberty Safeguards (DOLS) are referring to the safeguards required to ensure that people are not wrongly confined. One of these safeguards is the appointment of a best interests assessor (BIA) to ensure that any arrangements are in the person's best interests. Occupational therapists sometimes act as best interests assessors.

If the person is in any other setting – for example, supported living, or in their own home – then the case must in any event go to the Court of Protection.

If the person is 16 or 17 years old, the case must also, in any event, go to court. Either to the Court of Protection or, perhaps more usually, to the High Court (Family Division) for exercise of the court's inherent jurisdiction.

1.8.4.2 DOL: children

For children who are under 16 years of age, the rules are different.

Up to age 16, parents can in principle provide a valid consent (the subjective element) for the objective confinement of their child. In which case article 5 of the ECHR is not engaged, all other things being equal, and application to court unnecessary.

Parental consent to DOL for a 15-year. When a 15-year-old was objectively confined in a psychiatric unit, it was agreed that it was the right thing, and the parents could give a valid consent. Arguably, the case need not have been taken to court. However, the zone of parental consent/authority for deprivation of liberty "runs out" on a child's 16th birthday. So, the judge noted that the case would have to return to court at that time.[59]

However, if the deprivation of liberty is drastic (even if ultimately justifiable and in the child's best interests), it may in some circumstances still need a court's scrutiny. This is so, even if the child is under 16 years old.

[59] *NHS Trust A v X* [2015] EWHC 922 (Fam), High Court.

For instance, the restraint envisaged, for transport arrangements for a 14-year-old to be taken to a residential school, required the court's scrutiny. They were agreed by the court to be the right thing, but their draconian nature meant they were beyond that which parents could validly consent to, within the zone of parental responsibility.[60]

As a rule of thumb, in terms of the objective (the confinement) part of the DOL test, the court is less likely to find confinement for children up to at least the age of ten. This is because, clearly, all younger children are generally more likely anyway to be subject to continuous supervision and control, and not be free to leave.

Once the child has reached twelve, the court may much more readily identify that the child is being objectively confined.[61]

1.9 Equality Act 2010

The Equality Act contains rights and protections for certain groups of people with a "protected characteristic" (including disability and age) – in contexts which include provision of social and health care services, schools, housing.

Based on their age alone, children are excluded from protection; however, a child would be protected, based on other characteristics, such as disability, for example.

The Act essentially protects from discrimination, as well as requiring reasonable steps to be taken and reasonable adjustments (including auxiliary aids) to be made to policies and practices.

In addition, public bodies – such as local authorities and NHS – have a public sector equality duty (PSED). This means they must subject their policies to scrutiny to ensure that they do not have a discriminatory effect (intended or otherwise).

For example, Care Act guidance states that assessors must be knowledgeable, competent, skilled and trained. And that the local authority must ensure the person is able to participate in the assessment. In one case, the ombudsman, referring to the Equality Act, found fault with the assessment, of a man with autism, by a practitioner with no knowledge or experience of autism.[62] In another case:

Home adaptations procedures: level playing field for children with challenging behaviour/sensory needs – and children with physical disabilities? The ombudsman scrutinised whether the policy - of

[60] *Re Z (A child: deprivation of liberty: transition plan)* [2020] EWHC 3038 (Fam), High Court.
[61] *Re AF (Children)* [2018] EWHC 138 (Fam), High Court.
[62] LGSCO, *City of Bradford Metropolitan District Council* (21 001 973), October 2022.

demanding supporting professional information – was operating equally as between children with challenging behaviour and/or sensory needs, compared to children with physical disabilities.

The child's mother had complained that the policy and practice were more onerous in relation to children with challenging behaviour/sensory needs.

Referring to the Equality Act, the ombudsman concluded that the local authority should clarify its local policy, to demonstrate consistency in its approach to adaptations for children with differing types of disability.[63]

[63] LGSCO, *Staffordshire County Council* (21 006 478), June 2022

2 CARE ACT 2014

The Care Act 2014 applies to adult social care in England. The powers and duties within it fall on local authorities with social services functions, as listed in schedule 1 of the Local Authority Social Services Act 1970.

It does not apply to children, other than transitional provisions (when a child is approaching the age of 18 years). Nor, in the main, does it apply to the NHS.

Note. References in this section to Care and Support Statutory Guidance are shorthand for: Care and Support Statutory Guidance, Department of Health and Social Care, 2023. This guidance is regularly reviewed and modified.

2.1 Well-being

Section 1 of the Care Act states that whatever a local authority does under the Act, in respect of an individual person, it has a general duty to promote the well-being of that individual. Well-being is defined to include nine elements. Equipment and adaptations could, depending on the circumstances, clearly be highly relevant to these elements:

a) personal dignity

b) physical and mental health and emotional well- being

c) protection from abuse and neglect

d) control by the individual over day-to-day life (including over the care and support provided to the adult and the way in which it is provided)

e) participation in work, education, training or recreation

f) social and economic well-being

g) domestic, family and personal relationships

h) suitability of living accommodation

i) the adult's contribution to society.

Section 1 of the Act states also that local authorities must have regard to the importance of beginning with the assumption that the individual is best placed to judge their own well-being. And that the individual's views, wishes and feelings must be taken into consideration. Further, any restriction on the person's rights or freedom of action must be kept to the minimum necessary.

The legal starting (although not necessarily finishing) point is that the person is best placed to judge their own well-being; and, as the guidance states, well-being is highly personal:

circumstances which create a significant impact on the wellbeing of one individual may not have the same effect on another.[64]

For instance, a person may have a strong preference for an unconventional type of sling and manual handling. Their personal dignity, physical/mental and emotional well-being, and control over day-to-day life would all need to be considered. Along with individually assessed risk, and comparative costs of options which could reasonably meet the person's needs.

That said, local authorities still, legally, have the last word as to how they judge, and are going to respond to, the well-being of any individual. But when they take decisions, they will have to show at least that they have taken significant account of the issues set out in s.1.

Taking account of, and deciding about, well-being without necessarily agreeing with the person. A local authority replaced a night-time carer with a profiling bed and pressure relieving mattress. The woman legally challenged the local authority, including on the well-being ground. The challenge was unsuccessful because the local authority could show that it had given holistic consideration to her well-being. It had evidence from both social care and NHS practitioners that the bed represented a reasonable of way of meeting her needs under the Care Act – and was not significantly undermining her well-being.[65]

2.2 Prevention of need

Section 2 of the Care Act places a general duty on local authorities to provide, arrange - or otherwise identify - services, facilities and resources to prevent, delay or reduce the needs of adults for care and support in the local area. And, likewise, in respect of the needs of informal carers for support.

The strength of the generality of this legal duty is that it gives local authorities great scope as to how they implement it. Provision does not depend on a person having eligible needs. Therefore, if a local authority chose to invest considerably in an equipment provision service – based purely on occupational therapy clinical assessment not requiring eligibility - it would be free to do so.

Its weakness is that the duty is expressed in vague terms. To enforce provision of a service for any one individual would be in principle difficult, because the duty is not to any one person, but rather to the local population in general.

[64] *Care and Support Statutory Guidance*, para 6.110.
[65] *R (VI) v London Borough of Lewisham* [2018] EWHC 2180 (Admin).

2.2.1 Equipment, adaptations

The Act itself is silent about what preventative services might look like. However, statutory guidance gives examples of what local authorities could do - and equipment features, along with reablement and minor adaptations. The guidance states (emphasis added):

Local authorities must provide or arrange services, resources or facilities that maximise independence for those already with such needs, for example, interventions such as rehabilitation/reablement services, e.g. community equipment services and adaptations.[66]

2.2.2 Charging for equipment

Regulations state that any equipment provided under s.2 of the Act must be free of charge.

And that any minor adaptation likewise must be free of charge. A minor adaptation is defined as one costing £1000.00 or less.[67] (The rule is the same in the case of eligible need under ss.13 and 18 of the Care Act[68]).

Importantly, these regulations do not state that more expensive adaptations cannot be provided under the Care Act. Merely that if they were, there would be a power to charge. Guidance confirms that, under the Care Act, assistance with major adaptations can be given.[69]

Note. Charging is anyway a discretion only; there is no duty under the Care Act to charge for anything at all, whether home care, day care/services or residential care. In practice, of course, most local authorities do charge for what they can.

2.2.3 Pausing assessment: equipment

Provision under s.2 of the Act, including reablement and equipment, is often a prelude to doing and concluding a s.9 assessment (see below). Statutory guidance suggests that in some circumstances, the local authority could pause or defer a s.9 assessment to allow for equipment to be provided, before the assessment is concluded and an eligibility decision made (emphasis added):

(Pausing assessment: reablement, equipment provision etc.) *Local authorities should not, however, remove people from the process too early. Early or targeted interventions such as universal services, a period of reablement and providing equipment or minor household adaptations can delay an adult's needs from progressing.*

[66] *Care and Support Statutory Guidance*, para 2.9.
[67] *Care and Support (Preventing Needs for Care and Support) Regulations 2014*.
[68] *Care and Support (Charging and Assessment of Resources) Regulations 2014*.
[69] Department for Levelling Up, Housing and Communities. *Disabled Facilities Grant (DFG) delivery*, 2022, paras 2.24-2.26. See also: *Care and Support Statutory Guidance*, para 15.52.

The first contact with the authority, which triggers the requirement to assess, may lead to a pause in the assessment process to allow such interventions to take place and for any benefit to the adult to be determined.[70]

2.2.4 Signposting to retailers

Slightly unclear, perhaps, is the legal position when a local authority seeks to point people, at this stage, toward preventative services, but in the form of independent retailers of equipment. And suggesting to people that it might be quick and easy for them to purchase their own equipment.

In one sense, this does not contradict the Care Act rule that equipment must be free of charge. This is because, the rule presupposes the local authority is providing the equipment in the first place.

However, the individual should still be informed that he or she is entitled to a s.9 assessment – assuming there is a possible need for care and support. And that if he or she were to be assessed as having an eligible need, any equipment required to meet that need would be provided free of charge. Albeit that the same choice of equipment might not be available compared to private purchase.

If an individual wants an assessment, it should be carried out and completed. The statutory guidance makes a key point. Namely, that if a person refuses (or, one would add, is likely to be unable) to avail themselves of suggested preventative services (including, therefore, equipment), the local authority must carry out an assessment and make an eligibility decision:

The person concerned must agree to the provision of any service or other step proposed by the local authority. Where the person refuses but continues to appear to have needs for care and support (or for support, in the case of a carer), then the local authority must proceed to offer the individual an assessment.[71]

2.3 Section 9 assessment

The legal threshold for an assessment, under s.9 of the Care Act, is low. The duty is triggered if it appears to a local authority that an adult may have needs for care and support. The duty is irrespective of the level of the adult's needs or of his or her finances.

Meaning that, even if it is highly unlikely that the person's needs will be eligible needs, the person would still be entitled to an assessment.

[70] *Care and Support Statutory Guidance, para 6.25.*
[71] *Care and Support Statutory Guidance,* paras 2.42, 2.46.

There are no rules about where the referral must come from or about why there is an appearance of need. It could be through the person themselves, family, other professionals.

An example might be a referral from a private hospital, which may not have provided all the equipment the person needs. If there were an appearance of possible need, there would be no ostensible grounds for refusing to do an assessment.

2.3.1 Appropriate assessment

An assessment must be appropriate and proportionate and enable the person to participate in it as effectively as possible.

The local authority must ensure that the assessor is skilled, knowledgeable, competent and appropriately trained in relation to the assessment they are carrying out.[72]

The implications of this duty are not that qualified professionals are required to do every assessment. But instead, as guidance points out, the more complex an assessment, the more likely it is that a social worker or occupational therapist will need to be involved. Or, for instance, there needs to be professional support for non-qualified staff taking calls and referrals at first contact points or centres.[73]

In line with this approach, some local authorities entrust equipment assessment and provision to different staff – including trusted assessors - depending on their expertise and the complexity of the case.

2.3.2 Personal outcomes

Section 9 of the Care Act states that, during assessment, the local authority must assess the outcomes the adult wishes to achieve in day-to-day life – and how these might be achieved, with or without the provision of care and support.

These are effectively "personal" outcomes - to be contrasted with "eligibility" outcomes (see below). There is not necessarily a duty to meet personal outcomes, but there is a duty at least to assess and consider them. Not to do so would be unlawful.[74]

For instance, a failure to record the goal of a woman, in a care home, to attend her local place of worship, and to consider how that goal/personal outcome could be met, was fault.[75]

However, occupational therapists will find that sometimes a personal outcome will "translate" into one or more eligibility outcomes. In which case, there would be a potential duty to meet the needs. For example:

[72] *Care Act 2014, s.9. And: Care and Support (Assessment) Regulations 2014.*
[73] *Care and Support Statutory Guidance,* paras 6.7, 6.27.
[74] *R(Davey) v Oxfordshire County Council* [2017] EWHC 354 (Admin), Court of Appeal, para 21.
[75] LGSCO, *Wiltshire County Council* (22 009 086), March 2023

Personal outcome of maintaining mobility: with manual handling implications. A woman wished to maintain walking ability, by retaining the assisting walking element of her care and support plan. This *personal outcome* was related, through the assessment process and care and support plan, to the *eligibility outcome* of safety.[76]

Similarly, in the example mentioned above, about attending a local place of worship, that personal outcome might be converted into two eligibility outcomes: getting into the community and maintaining personal relationships. This would be a way, for occupational therapists, of moving from a mere preference the person may have – to a need, which there is then a duty to meet. Fitting in with occupational therapists' code of conduct, ethics and professional standards:

As far as possible, you enable individuals to make their own choices. Where their ability to give informed consent is restricted or absent, you try to ascertain and respect the individual's preferences and wishes, at all times seeking to act in their best interests.[77]

2.3.3 Seeking expert input

The Care Act states that the local authority must consult a person with expertise. This would be in relation to the condition or other circumstances of the person being assessed, if the person's needs require this.[78]

This happens all the time, of course. Occupational therapists regularly consult other practitioners. In explaining a final decision, a local authority needs to be able to explain how it has responded to any advice received.

If the local authority is not going to follow that advice, then a court or ombudsman may want to see and understand why. Failure to consult an expert in the first place may be challenged, also.

Disregarding the views of a manual handling assessor about hoisting. An occupational therapist failed to explain why she continued to disregard the expert view of a manual handling assessor. This was in the context of a dispute with a family about whether hoisting or other assistive handling was needed. The ombudsman found a degree of fault in the failure to explain the variance of view.[79]

In another case:

Failing to explain why occupational therapy advice would not be followed. An independent occupational therapist produced a detailed report about the very complex needs of a woman living at home with her parents. The local authority's offer to the family, of two hours' daily support, was at

[76] LGSCO, *West Sussex County Council* (22 014 693), June 2023
[77] *Professional standards for occupational therapy practice, conduct and ethics*, Royal College of Occupational Therapists, 2021, para 3.5.3.4.
[78] *Care and Support (Assessment) Regulations 2014.*
[79] LGSCO, *East Sussex County Council* (16 017 727), Dec 2018.

huge variance with what the report had outlined by way of her needs. The judge found the failure to explain and rationalise such a divergence of view amounted to legal irrationality and therefore an unlawful assessment decision by the local authority.[80]

And again:

Preferring the view of one expert over another: night- time carer or specialist mattress. When a local authority sought to remove night-time care, and substitute for this a pressure relieving, specialist mattress, it sought advice from the district nursing service, an occupational therapist and general practitioner (GP). The views were not all the same, but one way of justifying a response can involve preferring the view of one expert over another, if there are competing views. The ombudsman declined to interfere with the decision.[81]

This issue – the requirement to take account of and weigh up expert evidence - was summed by a judge in the following case:

Nonsensical dismissal of expert views: severe epilepsy and the support required. In question was the night-time care required by a person with severe epilepsy. He suffered life-threatening fits at night once or twice a month.

A social worker made the final decision about what he needed, contrary to the advice of a specialist epilepsy nurse and consultant neurologist. The judge found fault. The decision: *simply does not make sense and does not address the needs identified in the reports from the medical and other professionals*.

The local authority had: *failed to give appropriate weight to obviously relevant material and relied excessively on the non-expert view of a social worker in a face of a wealth of evidence to the contrary from appropriately qualified and experienced experts*.[82]

It may not just be a failure to weigh expert advice, but an omission to seek it in the first place.

Occupational therapy assessment, stand-aid, hoist: delay in seeking advice from continence service. Occupational therapists were seeking to work with the daughter of an older woman who had been assessed to lack capacity in respect of her care.

The question was whether a stand aid should continue to be used or, instead, full hoisting. The woman's daughter was opposed to this. A secondary matter was whether – were hoisting to be adopted - clothing and incontinence pads should be adjusted on the bed before, or whilst, she was in the sling.

[80] *R(JG) v London Borough of Southwark* [2020] EWHC 1989 (Admin)
[81] LGSCO, *Worcestershire County Council* (21 007 523), December 2022.
[82] *R(Clarke) v London Borough of Sutton* [2015] EWHC 1081 (Admin), High Court.

The local authority said best practice was for this to be done on the bed first, before hoisting; but it accepted that this would have caused the mother distress because of the additional handling required. Eventually, a solution was found, using a "continence product", which was recommended by the continence service.

However, the local authority had delayed in seeking the advice of that service. This caused avoidable distress to both mother and daughter in terms of the additional handling on the bed that had continued, unnecessarily, for a period of time. The ombudsman found fault.[83]

2.3.4 Remote assessment

Statutory guidance has always stated that simpler needs might be amenable to assessment on the telephone.[84]

This guidance was written long before the COVID pandemic of early 2020. During the lockdowns, however, local authorities explored remote assessment more fully, using a range of technology.

There is no explicit rule one way or the other in the Care Act about remote assessment. But the same rules, as outlined above, apply - whether the assessment is face-to-face, remote or a hybrid of both. Namely, the legal requirement of appropriateness and proportionality, and enabling the person to participate.

Remote assessment of person with autism. The local authority assessed a person with autism on the phone and found he wasn't eligible.

He had previously explained that he struggled on the telephone for more than 20 minutes at a time. There was no record that the local authority had taken this into account; the assessment exceeded an hour. In addition, there was no evidence that it had followed its own policy of sending a list of questions in advance, so that the person could prepare for the assessment.

The ombudsman found a failure to make reasonable adjustments to the assessment process and fault in relation to its Equality Act obligations.[85]

Therefore, for remote assessment for equipment (or adaptations), it would be for the occupational therapist (and manager) to take a view about whether and when any such assessment would both be compliant with Care Act requirements – and be consistent with good professional practice.

In a case about a disabled facilities grant (DFG) – albeit under different legislation[86] – the judge pointed out that part of the decision-making process would require access to the applicant's home. For instance, for assessing needs, identifying necessary building works or

[83] LGSCO, *Knowsley Metropolitan Borough Council* (21 001 821), February 2022.
[84] *Care and Support Statutory Guidance,* para 2.9.
[85] LGSCO, *Lancashire County Council* (19 019 811), December 2020.
[86] *Housing Grants, Construction and Regeneration Act 1996*.

resolving a planning issue. But that apart from such necessary visits, other aspects of the DFG application could be managed remotely.[87] In effect a hybrid approach.

2.3.5 Waiting times for assessment

The Care Act contains no timescales for assessment. In their absence, the courts would say that the duty must be performed within a reasonable period of time or without undue delay: *what is a reasonable period of time will depend upon all the circumstances of the case*.[88]

More generally, the ombudsman has stated that, from point of initial referral/request, an assessment should be carried out within 4-6 weeks.[89] Over the years, in various cases involving occupational therapy services, the ombudsman has identified mitigating steps that a local authority should take. For example:

Approach to waiting times. First, there should be well-defined criteria for assessing priorities. Second, the criteria should be applied after proper consideration and reassessed promptly in the light of any relevant new information. Third, people in need and their advisers should be informed of the criteria, timescales, of their allocated priority, of council services and of reputable alternative suppliers.[90]

A system of prioritisation should be effective:

Ineffective system of priorities. A local authority had a waiting list of 392 people waiting for occupational therapy assessments. It operated three priority groups; 360 of those waiting fell into priority group 2. The ombudsman found this to be maladministration because it meant the system of prioritisation was ineffective.[91]

There should be a reasonable degree of consistency within a local authority. In another finding of maladministration, one of the 'serious failures' was that a person had waited four years and eight months for an assessment. But might have waited only five months had she lived a few hundred yards away in the same authority.[92]

Without adequate referral information, a system of priorities will not work:

Improperly determined priority for a person suddenly blind. A woman suffered a sudden and complete loss of sight. She was referred to the sensory disability team. She was considered not to

[87] *R(McKeown) v London Borough of Islington* [2020] EWHC 779 (Admin), High Court, para 55.
[88] *R(D) v Brent Council* [2015] EWHC 3224 (Admin), High Court, para 19.
[89] *Complaints about councils that conduct community care assessments. Fact Sheet 14*. Local Government Ombudsman, 2013.
[90] Local Government Ombudsman, *Wakefield Metropolitan District Council* (02/C/14023), 2004.
[91] Local Government Ombudsman, *Halton Borough Council* (01/C/09625), 2002.
[92] Local Government Ombudsman, *London Borough of Hackney* (91/A/0482), 1992.

have a high priority but still should have been contacted within six weeks; however, in practice a rigid three-month waiting time was being operated.

Her priority had anyway been improperly determined, since she had been at risk from burning and scalding and suffered injuries, which her doctor had seen. This incorrect determination had occurred because of the inadequacy of the original referral (based on a sparse report). And also the failure of the sensory disability team to follow up subsequently with the woman what the issues and risks really were.[93]

With a risk of priority-making being hit and miss:

Screening and allocating priorities for assessment: hit and miss. a disabled housing association tenant applied for disabled facilities grant. She needed to be assessed by social services in order that the recommendation could be made. She was placed on a waiting list of 549 people, of whom 111 were deemed to be a priority. The average wait was one year. The social services assessment officer conceded that identifying priority assessments was 'hit and miss' because application

forms contained inadequate information on which to base the decision about priority. This was maladministration.[94]

2.4 Eligibility

Section 9 assessment leads to a decision about eligibility. It is a finding of eligibility that triggers a duty to meet need. This makes section 9 assessment the all-important gateway to decision making about a person's needs; and eligibility as the all-important vehicle for the meeting those needs.

Regulations set out the detail.[95] Eligibility hinges on three questions. If all three are answered in the affirmative, the adult will have eligible needs. The local authority will then have a duty, under s.18 of the Act, to meet those needs by way of care and support – including equipment and adaptations - unless there is an informal carer able and willing to meet the needs.

Pleading lack of financial resources is not a legal defence to non-performance of the duty to meet eligible needs; however, resources are a relevant consideration in how those needs are met and local authorities can accordingly seek a cost-effective option.

[93] Local Government Ombudsman, *Stockport Metropolitan Borough Council* (02/C/03831), 2003.
[94] Local Government Ombudsman, *Bolton Metropolitan Borough Council* (92/C/0670), 1992.
[95] *Care and Support (Eligibility Criteria) Regulations 2015.*

2.4.1 Impairment or illness?

First, does the adult have care and support needs arising from, or related to, a physical or mental impairment or illness?[96]

Note. There is no requirement that the impairment be substantial and permanent (as was previously the case for adults under s.2 of the Chronically Sick and Disabled Act 1970, through the operation of the definition formerly set out in s.29 of the National Assistance Act 1948).

Guidance states that if there is no current, formal diagnosis, then it is for the assessor to decide. Namely, whether it is more likely than not that the person's needs are due to some sort of impairment or illness, rather than due to "other circumstantial factors".[97]

An example of a failure to take such an approach – albeit under previous legislation – was as follows:

Diagnosis, request for wash and dry toilet, occupational therapy assessment. A person was born with physical problems. He suffered difficulty in defecating and micturition, causing him great unhappiness, embarrassment and loss of confidence because of difficulty in keeping himself clean. He became socially withdrawn.

When he was 17, his mother requested from social services an automatic washing/drying toilet.

Over an extended period, he was referred between the social services learning disability and physical disability teams – and between a consultant neurosurgeon, consultant psychiatrist and gastro-enterologist. No diagnosis was forthcoming.

Social services continued to refuse to provide the toilet without a causal diagnosis. There was also uncertainty, in any case, about which team would be responsible for any provision. Finally, five years later, the toilet was provided, with definite medical advice still not having been provided (eventually a voluntary body diagnosed cerebral palsy).

The ombudsman was critical of the delay in provision, even in the absence of a precise diagnosis.[98]

This first eligibility question makes clear that the Care Act is as much about mental impairment or illness as it is about physical:

Reablement, physical, mental disability undermining daily living: failure to assess. A woman had a knee replacement, followed by successful physical reablement. She was now physically functional in terms of daily living activities. However, she had bi-polar disorder, and the consequent depression meant she struggled with those activities.

The local authority refused to do a Care Act assessment at all (let alone come to an eligibility decision), saying her mental health was the concern of her GP, not social services. The ombudsman found fault in the failure to carry out a s.9 assessment.[99]

[96] *Care and Support (Eligibility Criteria) Regulations 2015*.
[97] *Care and Support Statutory Guidance*, para 6.104.
[98] Local Government Ombudsman, *Northumberland County Council* (99/C/1276), 2000.
[99] LGSCO, *London Borough of Haringey* (17 006 783), August 2018.

2.4.2 Not achieving two outcomes

The second main eligibility question is about outcomes. It is whether, as a result of the person's needs, there are at least two outcomes the person is unable to achieve.[100]

The outcomes are as follows and would seem to dovetail with the holistic approach that occupational therapists would see themselves as taking:

- managing and maintaining nutrition.
- maintaining personal hygiene.
- managing toilet needs.
- being appropriately clothed
- being able to make use of the adult's home safely.
- maintaining a habitable home environment.
- developing and maintaining family or other personal relationships.
- accessing and engaging in work, training, education or volunteering.
- making use of necessary facilities or services in the local community including public transport, and recreational facilities or services.
- carrying out any caring responsibilities the adult has for a child.

2.4.2.1 Not achieving an outcome

There must be at least two outcomes which the person is unable to achieve, for a person to be eligible. The regulations explain further what it means – legally - to be unable to achieve an outcome. This is:

- if the person is unable to achieve it alone,
- can do so but only at the cost of significant pain, distress or anxiety,
- can do so but only with health and safety risks to themselves or others, OR
- can do so but it takes significantly longer than normal.

[100] Care and Support (Eligibility Criteria) Regulations 2015.

For example, an adult might be managing to achieve certain outcomes but suffer pain in doing so, or be at risk, or take a long time to do so:

Crawling up the stairs to the bathroom: pain, risk, time. A person might be maintaining personal hygiene (getting into the bath) and toileting (using the toilet) - but only with the pain and significant risk (as well as time) involved in crawling up and down the stairs. With an obvious and significant impact on her well-being. In which case, it could be that equipment or adaptations are required, to reduce that risk and pain – so that the outcomes would then be achieved in law (as well as in reality, so to speak).

In the following case, the ombudsman noted that the woman was achieving a habitable home environment in reality - but not in law:

Visual impairment and additional time taken. A visually impaired woman, with other physical needs as well, was achieving the outcome of maintaining a habitable home environment, but it took her a long time. The assessor was at fault in finding that she was achieving this outcome.[101]

2.4.3 Impact on well-being

The third main eligibility question is about well-being. This is, whether, as a consequence of being unable to achieve at least two outcomes, there is, or is likely to be, a significant impact on the adult's well- being.[102] This final question takes one back to s.1 of the Care Act, and the definition of well- being, as considered above.

2.4.4 Needs-led, not service-led

Depending on circumstances, equipment might be required for any one or more of the outcomes. As already noted, eligibility is dependent on a judgement being made about a person's needs, ability to achieve outcomes and impact on well-being.

Eligibility is clearly not, therefore in law, dependent on the type of service – or equipment – that a person requires.

This is why s.8 of the Act gives a few general and illustrative examples only, of what can be provided under the Care Act to meet care and support needs. The examples include reference to "goods and facilities", words which can clearly apply to equipment and adaptations.

[101] LGSCO, *Kingston upon Hull City Council* (17 010 857), February 2018
[102] *Care and Support (Eligibility Criteria) Regulations 2015*.

2.4.4.1 Avoiding blanket policies

As already noted above in these Guidelines (see section 1), blanket policies not to provide certain services risk unlawfully undermining the meaning and application of the legislation – as well as of unlawfully fettering the discretion of the local authority.

A common view seems to be that blanket policies, excluding certain types of provision, are essential in order to contain expenditure. Arguably this is not the case. Because, to reiterate, the duty to provide something only arises if there is an assessed, eligible need – and if the "something" is a cost-effective way of meeting that need. If it is not, then there is no duty to provide it. If it is cost-effective, then it will be a way of actually saving money; in the sense that any other provision would be more expensive. So the logic goes.

In addition, blanket policies are clearly not in line with the "person-centred" approach which so many local authorities claim to follow. Nor, presumably, with what many occupational therapists would regard as good professional practice. For instance:

Not providing small items of equipment. A woman had fibromyalgia, arthritis, irritable bowel syndrome, dizzy spells, blackouts. She struggled to use the stairs alone. She also had difficulty gripping objects in kitchen. Consequently, she had suffered several burns, when dropping things. In response, the local authority stated that it no longer provided small aids of "nominal value".

The occupational therapist's report contained no detail of what kinds of small aids or minor adaptations the woman had requested, what might have been suitable and whether anything could be provided. The ombudsman found fault.[103]

Policy not to consider ramps for scooters. A woman asked a local authority to provide a wet room and a ramp to access her house because she regularly used a mobility scooter. She could, at present, only leave her property with the help of her friend/informal carer. On whom she was totally reliant both to leave and to return to her property. An occupational therapist advised that it was against the authority's policy to provide a ramp for scooters.

The ombudsman found that there was an over reliance on the stated council policy and insufficient assessment of the person's health conditions and the impact on her carer. There was no proper consideration of how her ability to access the community was affected.[104]

Such cases illustrate how mobility issues can feed into the eligibility outcomes in the Care Act – in these examples, getting into the community and safety in the dwelling respectively. In an older case and albeit under previous legislation, the local authority refused even to assess a woman who had requested a shelter for her privately purchased wheelchair.

Refusal to assess for shelter for a privately purchased wheelchair. A woman lived in a council house and received income support and mobility allowance. She was in poor health, had difficulty in walking and was entirely reliant on a neighbour to go shopping or to other facilities such as the local library.

[103] LGSCO, *Blackburn with Darwen Council* (21 015 502), September 2022.
[104] LGSCO, *Luton Borough Council* (16 008 034), 2017.

To alleviate these problems, she had bought an electric wheelchair but now required a shelter for it for protection against the weather and vandals. She had identified a prefabricated store costing £1000. A charity had given her £600 towards the cost. She hoped to enter into an agreement with the supplier to pay the rest by instalment but was concerned that this financial commitment was beyond her means.

The local authority said it had no budgetary provision for wheelchair storage. Therefore, it would not even assess because she did not meet its criteria for a service. The ombudsman found fault with the failure to assess and the restrictive eligibility rule.[105]

Linking mobility vehicles, and related needs to social care is in line with a 2010 Department of Health document. This pointed out how a powered wheelchair could meet social care needs – and, if not required to be provided through the NHS, could be provided under social care legislation.[106] More recently, the ombudsman considered the issue of mobility and Care Act outcomes:

Helping people with mobility in social care: restrictive approach by local authority not justified. A local authority had identified walking assistance, including an element of exercise, as part of a care and support plan. This was part of achieving the eligibility outcome safety of safety. Presumably on the grounds that, in her case, maintaining weight bearing ability would contribute to safety when carers were not present.

When the local authority withdrew this walking assistance, without proper review, it claimed that mobility could only be a health need and was something that the local authority could not help with in principle. The ombudsman did not agree and found fault.[107]

2.5 Power to meet need

Although the duty under s.18 is to meet an eligible need, s.19 of the Care Act makes clear that even if a person does not have an eligible need, the local authority can still choose to meet it.

This may be important if the person is unable to achieve only one eligibility outcome, and therefore is not eligible – but the local authority believes that there is nevertheless a significant risk or impact on the person's well-being. For example, a piece of equipment might address the outcome of using the home safely, even though the assessment did not identify a second outcome not being achieved.

Similarly in case of urgency, where assessment and therefore eligibility have not yet been established, provision can be made in the interim to meet that person's needs. This, too, could involve equipment.

[105] Local Government Ombudsman, *Sheffield City Council* (93/C/1609), 1995.
[106] *Out and about: wheelchairs as part of a whole-systems approach to independence*, Department of Health, 2006, p.15.
[107] LGSCO, *West Sussex County Council* (22 014 693), June 2023.

Although s.19 contains a power only, rather than a duty, local authorities must consider using it in individual cases, rather than simply deciding never to exercise a "mere" power:

Urgent, interim provision of care and equipment, occupational therapy report. A woman provided night-time care for her two adult sons. Both had multiple, severe physical and learning disabilities. Care was commissioned during the day. During the night, the mother would turn and reposition them, changing pads (double incontinence) regularly. She was now struggling and asked for additional help, during the night.

She had hypertension, swollen feet, pain due to arthritis and slipped or dislocated discs affecting her back. She had delayed having surgery, in order to continue to look after her sons. She had been expected to cover 12 hours of daily care including 10 hours of night-time care by herself.

She now sought urgent adjustment to the care and support plan, to provide night-time carers and appropriate equipment. An expert occupational therapy assessment, obtained independently by the mother, supported this request. However, the local authority stated that until it completed a reassessment, it had no duty to change the care and support - or to provide equipment. The reassessment remained pending, so nothing happened.

The judge held, on grounds of urgency, that the local authority should have made interim provision under s.19 of the Care Act. It was: *a statutory discretionary power which was relevant and applicable in the present case … the defendant could not justify as reasonable its refusal to act* in the light of the expert occupational therapy report. [108]

2.6 Cost effectiveness: equipment

At the care and support planning stage – when working out and agreeing how to meet a person's needs - a local authority must take all reasonable steps to reach agreement with the person. This, found in s.25 of the Care Act, means just what it says. It does not, as a matter of course, mean that the local authority must reach agreement in every case.

The courts have long since accepted that in performing a duty to meet a need, a local authority can seek to provide the most cost-effective option. In doing so, however, the local authority must have evidence that this option can meet the need. [109]

The courts do not tend to interfere, directly at least, with professional judgement (see section 1 of these Guidelines). For instance, in the individual circumstances of one case, it was not unlawful to replace a night-time carer (who provided assistive handling) with incontinence pads, even though the woman concerned was not clinically incontinent.[110]

[108] *R(Raja) v London Borough of Redbridge* [2020] EWHC 1456 (Admin), High Court, para 65.
[109] See e.g. an important "test" case under the Care Act: *R(Davey) v Oxfordshire County Council* [2017] EWHC 354 (Admin) and [2017] EWCA Civ 1308. High Court and Court of Appeal. Also: *R(VI) v London Borough of Lewisham* [2018] EWHC 2180 (Admin), High Court, para 59. And an older, important case on this issue: *R v Gloucestershire County Council, ex p Barry* [1997] 2 All ER 1, House of Lords.
[110] *R(McDonald) v Royal Borough of Kensington and Chelsea* [2011] UKSC 33 (Supreme Court). Also European Court of Human Rights: *McDonald v United Kingdom* (Application no. 4241/12), May 2014.

2.6.1 Reduced carer handling

Significant sums of money may hinge on how needs are met. In one case, replacement of a night-time carer and change to single-handed, rather than double-handed, hoisting during the day, reduced the number of care worker hours from 104 per week to 40. The local authority successfully resisted a legal challenge.[111]

This case was about changing from double-handed to single-handed care in the day – and "no-handed" care at night. The night-time carer had been repositioning the woman through the night for both pain (she had a progressive muscular dystrophy) and skin management; she was replaced by a profiling bed.

It needs to be borne in mind, however, that decisions must be made on an individual, rather than a pre-determined, basis – and so be evidenced and reasoned. This was missing in the following case:

Pre-determined and therefore flawed decision to replace night-time care with assistive technology. The ombudsman found that a pre-determined decision - to introduce assistive technology in place of a night-time carer, for a woman with autism, mental health needs and high levels of anxiety – was flawed.

This was because of the lack of evidence that assistive technology would be a reasonable way of meeting her needs. It appeared also that a decision had been made by the manager and social worker involved, 22 days before the assessment had been completed.[112]

Thus, although it is now realised that single-handed, rather than double-handed, care is possible and desirable (for various reasons) in some situations, this does not mean it should be regarded as the default position. Any more than double-handed care should ever have been seen as a default position. There may be various reasons (physical, mental, situational etc.) why, in a particular situation, single-handed care will not do.

In other words, the position should be – and always should have been – that manual handling decisions are made on a case-by-case basis. In a major manual handling legal case involving human rights, the judge noted: *Just as context is everything, so the individual assessment is all*.[113]

2.6.2 Cost-effectiveness and panels

Occupational therapists sometimes need to defend, in front of panels, decisions about equipment, adaptations and related care provision.

[111] *R (VI) v London Borough of Lewisham* [2018] EWHC 2180 (Admin), High Court.
[112] LGSCO, *Norfolk County Council* (18 013 498), June 2019.
[113] *R(A&B) v East Sussex County Council* [2003] EWHC 167 (Admin), High Court, para 128.

Panels, understandably and explicitly or otherwise, tend to seek to control expenditure, whilst still ensuring that people's needs are met. However, they – just like practitioners or individual managers who are taking decisions – must justify their decisions. More so, if a panel chooses to override a decision which is sound and well-reasoned.

In other words, if an occupational therapist believes that a particular piece of equipment is needed – albeit not cheap – it is for that practitioner to defend and explain. If a panel overrules the practitioner, it in turn needs must justify this:

Hospital discharge of 95-year-old woman: panel overruling professionals unlawfully. A panel overruled a thorough, 40-page assessment, compiled by a social work team manager. It concerned a 95-year woman, recovering in hospital from a fall. The panel kept no detailed record of its discussion and decision and documented no reasoning. The Court of Appeal was highly critical, finding a breach of both social care legislation and human rights.[114]

More recently and similarly:

Panel decision: no minutes, reasons. A detailed assessment of a woman with physical and mental health needs was overruled by a panel. Reasons were not provided. The family and adult in need were not told about the fact of the decision let alone the reasons. The decision appeared to have been made at a meeting of the funding panel, at which no minutes were taken. The judge held the decision to be unlawful.[115]

2.7 Ordinary residence

Under s.18 of the Care Act, the duty to meet need depends not just on eligibility but also on the person being, in law, ordinarily resident within the local authority. Or, alternatively, of no ordinary residence anywhere but physically present within the local authority and thus of no settled residence.

This can lead to uncertainty about which local authority is responsible for providing equipment to meet a person's needs. The legal definition of ordinary residence is a person's abode in a

particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of long or short duration.[116]

2.7.1 Ordinary residence, equipment

There is a "deeming" rule in s.39 of the Care Act.

[114] *R(Goldsmith) v London Borough of Wandsworth* [2004] EWCA Civ 1170, Court of Appeal.
[115] *R(P) v London Borough of Croydon* [2022] EWHC 2886 (Admin), November 2022, High Court.
[116] *R(Shah) v London Borough of Barnet* (1983) 2 AC 309, House of Lords.

This is to the effect that if Council A places a person out of area (in Council B) – in a *care home, supported living or shared lives placement* - the person nonetheless remains ordinarily resident in Council A. For however long they remain in the placement.

Which would mean that Council A would remain responsible for ensuring their needs, *including for equipment*, are met in that placement – even though it is out of area.

2.7.2 Placed out of area by housing

A person may be placed out of area by Council A in Council B, under duties within the Housing Act 1996. The question of ordinary residence under the Care Act can then arise.

Rules about which local authority is responsible are not the same under the Care Act as they are under the Housing Act.

Applying the Care Act definition of ordinary residence (above), it is possible in some circumstances for a person to remain the housing responsibility of Council A - but to become the Care Act responsibility of Council B, for as long as they remain placed there by Council A. For instance:

Housing placement out of area of woman with severe sight impairment – and Care Act responsibility? A woman, with severe sight impairment and a young child, was given temporary accommodation under the Housing Act by Council A in the area of Council B. The housing team was seeking to move her back to Council A but could provide no timescale for this. The ombudsman found it was Council B which had Care Act responsibilities towards her, even though housing responsibilities remained with Council A.[117]

Note. In relation to disabled facilities grants (see section 7 of these Guidelines) in such a case, it would be the out of borough local authority (Council B) that has potential responsibility under the HGCRA – subject to all the usual conditions and rules about DFGs.

2.7.3 Changing ordinary residence

A person may move area in the community (not a placement, for which see above) from Council A to Council B.

Their intention and the wider evidence may point to the move being for the foreseeable future and that their abode will now be in Council B. This could then mean they would become ordinarily resident in Council B from day one.

Permanent or temporary move in the community from Council A to Council B: responsibilities for equipment? An elderly woman living in Council A may decide to live with her daughter in Council B. She has terminated or is terminating her tenancy in Council A and the evidence is clearly that there is no intention of returning to Council A. She arguably becomes ordinarily resident in Council B, on arrival. In which care, the meeting of need and provision of equipment would fall to Council B.

[117] LGSCO, *London Borough of Wandsworth* (18 004 354), April 2019.

Alternatively, she may decide to stay a few weeks only with her daughter, by way of a break, but with every – or probable – intention of returning to her flat in Council A. Or at least leaving the possibility of return open during those few weeks.

In which case, during her stay with her daughter, she remains ordinarily resident in Council A. If eligible needs for equipment arise during her stay, Council A would, overall, have a duty to meet them under s.18 of the Care Act.

Council B, on the other hand, would nonetheless have a power to provide the equipment for a person ordinarily resident within Council A. Section 19 of the Care Act provides for this, irrespective of ordinary residence, if the need is urgent – or if the person has an eligible need, is ordinarily resident in Council A, and Council B notifies Council A what it is going to do.

2.7.4 Using equipment out of area

If a local authority is meeting eligible needs, for a person ordinarily resident within its area – nevertheless some of those needs may need to be met occasionally or regularly out of area.

This could involve activities, breaks, holidays, recreational facilities[118] – or, for instance, shared care involving an out-of-area relative. Equipment may be assessed as integral to enabling such needs to be met. If so, an equipment service could scarcely prohibit, as a matter of policy, to allow equipment to be used out of area. To do so might effectively preclude an assessed, eligible need from being met.

2.7.5 NHS accommodation

Ordinary residence rules to determine the responsible local authority do not apply to the NHS. Instead, the responsible NHS integrated care board (ICB) would normally – there are exceptions - be identified in terms of the GP with whom a person is registered.[119]

A person might be registered with a GP out of borough, "over the border" so to speak. In which case the responsible ICB might not be co-terminous with the local authority. Effectively cross border issues then arise; social care equipment being provided by Council A but health care equipment by an ICB with which the GP, in the area of Council B, is associated.

In addition, the Care Act states that in determining ordinary residence under the Care Act, any period of NHS-provided accommodation must be ignored in determining a local authority's responsibility. For instance:

[118] *R(BG) v Suffolk County Council* [2022] EWCA Civ 1047, July 2022, Court of Appeal.
[119] *Who Pays? Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers*. Department of Health 2022, s.10.2.

Ignoring period of NHS-provided accommodation. A person ordinarily resident in Council A is placed by the NHS in a care home in the area of Council B, by way of meeting their NHS continuing healthcare needs. Equipment needs would fall to the NHS to meet.

Six months later, following a review, the NHS steps back and a local authority must take over the care home placement. In determining whether Council A or Council B now has responsibility for the placement (including equipment), the period of the NHS placement must be ignored.

The question therefore is where the person was ordinarily resident immediately before the NHS made the placement. In this example, it was Council A.

2.7.6 Students and equipment

Local authorities sometimes are asked to assess for and provide equipment in relation to students in higher education, who are studying out of area. This can lead to uncertainty about where the student is, in law, ordinarily resident. The answer is not always immediately obvious, but Department of Health guidance previously stated that the following approach should be taken.

Note. The paragraphs referred to immediately below are no longer (possibly inadvertently) in the most recently updated guidance but remain useful as to the probable legal position.

The guidance suggests that sometimes, the person will arguably become ordinarily resident in the area of the university:

(not returning to original local authority) *where a young person is intending to move areas to go to university, the starting point would be that they are ordinarily resident in the same place as they were ordinarily resident under the [Children Act] 1989 Act.*

Again, this may not always be the case. If the young person moves to the area in which the university is located for settled purposes and has no intention to return to his authority of ordinary residence under the 1989 Act, then the facts of his case may lead to the conclusion that he or she has acquired an ordinary residence in the area of the University.

Or, sometimes and alternatively, the person may remain ordinarily resident in the original local authority:

(Returning regularly to base authority). *Alternatively, if the young person has a base with his or her parents (or those with parental responsibility for him or her) in the local authority where he or she was ordinarily resident under the 1989 Act, and he or she intends to return to this base during the university holidays (including the long summer holiday) then the facts of his case may lead to the conclusion that he or she remains ordinarily resident in the "base" local authority. (…) this local authority would be responsible for meeting eligible needs under the 2014 Act, both during term time at university and during holidays.*[120]

[120] *Care and Support Statutory Guidance* (2015 version) , Annex H8, paras 46-48.

2.7.7 Moving areas with equipment

Department of Health guidance states that people "should" be able to take with them the equipment, provided by one local authority, when they move to live in the area of another. The guidance reads:

(Taking equipment from one local authority to another). *Many people with care and support needs will also have equipment installed and adaptations made to their home.*

Where the first authority has provided equipment, it should move with the person to the second authority where this is the person's preference, and it is still required and doing so is the most cost-effective solution. This should apply whatever the original cost of the item.

In deciding whether the equipment should move with the person, the local authorities should discuss this with the individual and consider whether they still want it and whether it is suitable for their new home. Consideration will also have to be given to the contract for maintenance of the equipment and whether the equipment is due to be replaced.[121]

The word "should", though a strong encouragement in statutory guidance, is not as strong a word as the word "must". The guidance anyway contains provisos, such as cost-effectiveness, the equipment being suitable in person's new home, and the person's consent.

In summary, to comply with the guidance, a local authority would want positively to look at each individual case, and not apply an unduly restrictive or negative approach. Equally, in the presence of good reasons, a local authority might justify not letting the equipment go.

It would seem to be open to local authorities to consider such "portability" of equipment on a *quid pro quo* basis in terms of finance – swings and roundabouts, so to speak. Alternatively, they could explore reimbursement from one local authority to another.

2.8 No charging for equipment

Local authorities have a discretion to means-test for most services which they provide under the Care Act. However, in exercising a duty or a power to meet eligible need, there are some things that cannot be charged for. These include equipment and any minor adaptation costing £1000 or less (see section 2 of these Guidelines).[122]

2.9 Universally available equipment

[121] *Care and Support Statutory Guidance*, paras 20.35-20.36.
[122] *Care and Support (Charging and Assessment of Resources) Regulations 2014.*

The Care Act is clear; if a person has eligible needs, the local authority has a duty to meet them. For most things, authorities can financially means-test – but not for equipment (see immediately above).

Nevertheless, local authorities sometimes deny people certain types of equipment, even if they do have eligible needs. This might be on grounds that the equipment is low cost; or that it is equipment which is generally available to the public at large. Either ground is, in principle at least, questionable.

Practice seems to vary between local authorities, and ultimately it is for each local authority to steer a course between the legal points set out below, and pragmatism.

2.9.1 Low-cost equipment

Equipment is sometimes denied to people on grounds that it is low cost.

However, s.9 of Care Act 2014 makes clear that entitlement to assessment (and therefore an eligibility decision) is irrespective of a person's financial resources.

Section 18 states that eligible needs must be met. And regulations state that any equipment provided must be free of charge. Therefore, in case of eligible need, to deny people the equipment they require on grounds that they can afford to buy it, does not seem consistent with the scheme of the Care Act.

There is, after all, no point having a rule that equipment must be provided free of charge, if local authorities simply refuse, potentially arbitrarily, to provide the equipment in the first place. Even in the face of eligible need.

Furthermore, any such policy or practice anyway pre-supposes that the person can afford the equipment – and has the physical and mental ability to obtain it. Even one or more small items, which for one person may be relatively low cost, may not be for another.

2.9.2 Small aids meeting needs

Small (and low cost) such items may be, but this does not mean that they might not meet significant, eligible needs.

This very point was made by previous Fair Access To Care Services (FACS) guidance issued by the Department of Health under previous legislation: sometimes small items of equipment might meet significant, eligible social care needs.

The guidance stated that local authorities should therefore not rule out such low-cost items as a means of meeting such needs.[123] Defunct the guidance may now be, but the logic and legal principle it expressed arguably applies to the Care Act.

[123] *Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care Guidance on Eligibility Criteria for Adult Social Care*, Department of Health, 2010, para 62.

As the ombudsman found in one case, the small items or minor adaptations a woman needed in the kitchen were to reduce the risk of her suffering burns. Safety in the kitchen, in turn is clearly relevant to the eligibility outcome under the Care Act of using the home safely.[124]

2.9.3 Universal equipment

Equipment is sometimes denied to people on grounds that it is universally available to, and used by, the public at large. And that therefore the Care Act does not apply. Yet, such a policy and practice does not straightforwardly add up, legally. For example, local authorities have put forward this type of argument unsuccessfully in several cases. From these, a parallel could be drawn with equipment.

2.9.3.1 Not meeting "universal costs"

Local authorities sometimes argue that there are certain costs everybody has to pay.

In one case, a local authority refused, as a matter of blanket policy, to meet needs for holiday travel and accommodation, admission costs for attractions, leisure activities, hobbies/interests (including supplies or special equipment) etc. And argued that, under the Care Act, the function of a local authority is not to relieve poverty.

The courts have disagreed with this approach, pointing out that local authorities have a duty to meet assessed need; and that restrictive policies ruling out, in all cases, help with such things are unlawful.[125]

Similarly, local authorities have argued in some ombudsman cases that cleaning and shopping are everyday needs, and so nothing to do with the Care Act. The ombudsman has consistently disagreed and found fault.[126]

2.9.3.2 Everyday needs and disability

The courts have also pointed out that an everyday item or activity for a disabled person does not fulfil the same function as for a non-disabled person:

Everyday activity has different significance for a disabled person. A judge agreed with the local authority that bowling was an activity that non-disabled people take part in at their own expense. However, the activity, for the disabled person (in this case, autistic and non-verbal) would be designed and structured in such a way that would not be necessary for non- disabled people. In other the words, the significance for the former is different than for the latter.[127]

[124] LGSCO, *Blackburn with Darwen Council* (21 015 502, September 2022.
[125] R*(BG) v Suffolk County Council* [2022] EWCA Civ 1047, Court of Appeal, July 2022.
[126] E.g. LGSCO *North Yorkshire County Council* (19 013 234), March 2020
[127] *Rw v Royal Borough of Windsor and Maidenhead* [2023] EWHC 1449 (Admin), High Court, June 2023.

Like the bowling or other activity, equipment takes on extra significance for a disabled person. A luxury for some people, the equipment might be essential for others. And not be cheap.

For instance, it seems that some local authorities will not consider provision of riser recliner chairs, on the grounds that they are widely available for general use by disabled or non-disabled people alike. Even though a) the chair may be a cost-effective way of meeting an assessed, eligible need, b) the person may not be able to afford it, and c) it could make a huge difference to an already circumscribed daily life. This could be viewed as leading to potentially regressive policy and practice. In other words, of those who need a riser recliner chair, only those who can afford it would benefit.

2.9.4 Voluntary organisations

A voluntary organisation may be able to meet eligible needs for equipment - promptly, reliably and to the standard the local authority would have been obliged to apply (i.e. type of equipment needed and free of charge).

Clearly, and depending on all the circumstances, this may not be objectionable. However, the needs would still be required to be recorded as eligible; and the reliability and ability of the voluntary organisation or other service would need to be established.[128]

Voluntary organisation: wrongly relying on a grant for equipment. A local authority recorded that a visually impaired woman did not have eligible needs because a local charity was helping her with administrative tasks and could make a grant for assistive technology to help her access the internet.

In addition, the local authority stated that Care Act outcomes on dressing did not require clothes to match or be clean. And that she could make more use of long-life foods, her freezer, and ready meals in relation to nutrition.

The ombudsman faulted the decision because the local authority did not know whether she would get a grant; failed to recognise the importance to her dignity of clean and presentable clothes; and failed to recognise the importance of fresh food.[129]

2.10 Health or social care equipment?

Uncertainty may attach to whether something is health or social care in nature (or both), and who should be providing it: the local authority or the NHS?

The following may suggest that certain types of provision (including equipment), traditionally associated with health care, might in fact sometimes fall under social care. This can lead to local authorities fearing floodgates opening.

[128] *R(Antoniak) v Westminster City Council* [2019] EWHC 3465 (Admin), High Court.
[129] *Local Government Ombudsman*. *London Borough of Hammersmith and Fulham* (15 011 661), July 2016.

However, it should be borne in mind that any duty to meet need is contained by the cost-effectiveness principle (see section 2.6 above). And that the paragraphs immediately following are not in principle heaping an ever greater burden on local authorities. But instead are indicating that, in certain circumstances, the legislation can be used creatively – and in line with good professional practice – to meet people's social care needs albeit still in a cost-effective manner.

2.10.1 Prohibitions on health care

Section 22 of the Care Act states that a local authority is not allowed to provide anything the NHS is required to provide – unless that thing is incidental or ancillary to whatever social services is anyway doing - *and* is of a nature that would be expected to fall within social care. In addition, the local authority is not allowed, under the Care Act, to provide registered nursing care.

How to make sense of these words? Incidental or ancillary refers to the *quantity* of health or nursing care required. Nature refers to the *quality or type* of health or nursing care required.[130] So, to determine whether something could be provided under the Care Act, and whether there is a duty to do so, would seem to boil down to the following types of question:

- Is there an assessed, eligible social care need?

- If so, is it something that the NHS is required to provide?
- If so, is the NHS going to provide it?
- If no, and social services were to provide it, is it just an "add on" (incidental or ancillary) to what social services is already providing?
- If so, is it also of a nature that would be expected to fall within social care?

- If it is not something the NHS is required to provide, then a duty to provide would be identified by falling back simply on whether it is a cost-effective way of meeting assessed, eligible need.

In the following case, the court held that the tracheostomy care required by a child was both, in quantity and type, beyond the remit of social care. It amounted, in law, to NHS continuing healthcare.

Tracheostomy care. During the day, the tube might need suctioning as regularly as every 15 minutes, although the period between suctioning was often longer. At the time of the case, suctioning was needed about three times a night.

[130] *R(Coughlan) v North and East Devon Health Authority* [1999] EWCA Civ 1871, Court of Appeal.

Suctioning required disposable catheters attached to a battery-operated suction machine. In addition, the tube itself required replacing regularly, about once a week, or when there was an emergency such as if the child pulled the tube out altogether.

If the child was not suctioned or if the tube came unstuck, the child would suffocate and die within minutes or suffer serious brain damage in a shorter time. The tapes which kept the tube in place also needed changing if they became loosened, wet, dirty or chafed.

The mother had turned to social services for extra assistance.

The court found that the nursing care required, including tube replacement and unblocking, was nursing care of a type beyond that which social services legally could provide. Likewise, the nursing care was more than incidental or ancillary, in terms of the quantity required, to anything that social services might otherwise do.[131]

More generally, outside of NHS continuing healthcare cases, what is the NHS actually required to do? This may not always be obvious (see section 5 of these Guidelines).

For example, NHS wheelchair services work to certain criteria which restrict the circumstances in which wheelchairs are provided. In the presence of such limitations, might the Care Act become relevant to meeting certain needs?

A Department of Health report pointed out that a person may have a social care need for a wheelchair, which is not going to be met by the NHS. Although an older document, the principle could clearly apply to the Care Act. The wheelchair in the following example would assist the person with eligibility outcomes such as getting into the community and maintaining personal relationships. The report gave an example:

Example of social services providing a wheelchair. *Alan has a manually propelled wheelchair from the NHS. He has increasing difficulty propelling it up a ramp to his home, and also up and down the inclines in his neighbourhood. This is beginning to affect his independence seriously.*

He has requested a powered outdoor wheelchair from the NHS but has been refused. Social services' assessment shows that replacement of his ramp with a larger one of lower gradient would be expensive and might not be practical anyway.

Furthermore, even were the ramp replaced, it would not overcome the difficulties he is having getting around the neighbourhood. Having been assessed, he was provided with a powered wheelchair by the local authority, this being the most cost-effective way of meeting his wider needs.[132]

The provision of wheelchairs is in any case, under the NHS Act 2006, a power only, not an explicit duty. Therefore, strictly speaking, it seems they NHS not required, in law, to be provided under the NHS Act 2006.[133]

[131] *R(T) v London Borough of Haringey* [2005] EWHC 2235 (Admin), High Court, paras 61, 62, 70.
[132] *Out and about Wheelchairs as part of a whole-systems approach to independence*, Department of Health, 2006, p.15.
[133] *NHS Act 2006,* schedule 1, paragraph 9.

Wheelchairs are but one example. More widely, for example, a renal dialysis machine would not be of a nature to be associated, in law, with social services. Similarly, tracheostomy care.[134]

On the other hand, a riser recliner chair might perform some health care, as well as social care, functions. One could ask whether the chair would be merely incidental or ancillary to what social services is providing (e.g. an add-on to a care package) and of a nature to be expected of social care?

The answer in at least some cases must surely be yes, and thus the local authority would not be prohibited from providing it under s.22 of the Care Act – even it if performs some health care functions. For instance, the ombudsman found fault in a case of delay in providing a riser recliner chair:

Riser recliner chair: health or social care? A local authority queried providing a riser recliner chair because part of its function was deemed to be health related. For a while at least, social services refused to provide it – even though it met social care needs as well. Instead, a high seat chair was provided, even though it had not been assessed as capable of meeting the person's need.

Eventually, the riser recliner was provided, but not before avoidable delay of a year. The occupational therapist had, at one point, recorded that the functional need to stand was social care, but the supporting of her legs was health care – and that therefore the riser recliner was "not part of her remit or funding pot".[135]

2.11 Direct payments, equipment

Broadly, s.31 of the Care Act states that once a personal budget has been agreed, a person will be entitled to a direct payment, subject to conditions (including mental capacity and ability to manage the payment).

2.11.1 Personal budget

A personal budget is defined in s.26 as the amount it would cost the local authority to meet the need. In the case of equipment, the personal budget can be made available by way of a direct payment.

[134] *R(T) v London Borough of Haringey, Haringey Teaching Primary Care Trust* [2005] EWHC 2235 (Admin), High Court.
[135] LGSCO, *Norfolk County Council* (18 015 338), August 2019.

2.11.2 Refusing a direct payment

Department of Health guidance suggests that, in some circumstances, a local authority might decline a request for a direct payment based on cost-effectiveness, a point that could apply in some circumstances to equipment provision:

(Cost-effectiveness principle applied to direct payments?). *However, a request for needs to be met via a direct payment does not mean that there is no limit on the amount attributed to the personal budget. There may be cases where it is more appropriate to meet needs via directly provided care and support, rather than by making a direct payment.*

For example, this may be where there is no local market for a particular kind of care and support that the person wishes to use the direct payment for, except for services provided by the local authority.

It may also be the case where the costs of an alternate provider arranged via a direct payment would be more than the local authority would be able to arrange the same support for, whilst achieving the same outcomes for the individual.[136]

Applying what the guidance states to equipment, it could be that a direct payment, equating to the personal budget amount, would be insufficient to buy the piece of equipment on the open market. Unless the person, or family, were able and prepared to top up the amount from their own resources. This could occur, for instance, if the equipment required is a stock item bought in bulk, at a price to reflect this, by the local authority/equipment service.

2.11.3 Equipment maintenance

When a local authority makes a direct payment for more major items of equipment, issues of ownership, maintenance and repair arise – and what happens when the equipment is no longer needed.

Various options exist, but whichever is adopted, there needs to be clarity in the direct payment agreement. Previous Department of Heath guidance, no longer extant (for adults) but still useful in principle, emphasised the importance of this:

(Clarifying maintenance and ownership). *Where a council makes a direct payment for equipment, it needs to clarify with the individual at the outset where ownership lies as well as who has responsibility for ongoing care and maintenance (just as it should where it arranges for the provision of equipment itself).*

A council will need to consider what conditions, if any, should be attached to the direct payment when it is used to purchase equipment, for example concerning what will happen to the equipment if it is no longer required by the individual. Equipment can also be purchased as part of making a package.[137]

[136] *Care and Support Statutory Guidance*, para 11.26.
[137] *Guidance on direct payments for community care, services for carers and children's services,* Department of Health, 2009, para 110.

2.11.4 Risk of liability

Previous guidance from the Department of Health, now superseded and not replicated under the Care Act, stated that direct payment recipients should be given information about health and safety, including the results of any risk assessment carried out. In addition, recipients should be encouraged to develop strategies on lifting/manual handling.

The guidance stated that, as a general principle, local authorities should avoid laying down health and safety policies for individual direct payment recipients. It noted that those recipients had a common law duty of care toward those they employed.[138]

2.11.5 Health and safety at work

Health and Safety Executive (HSE) guidance advice reminds local authorities of their duty under s.3 of the Health and Safety at Work Act 1974. This is a duty an employer has toward non-employees who are affected by its undertaking/activities.

Non-employees could include, therefore, personal assistants of a direct payment recipient. The advice goes on to state that, at the least, local authorities should:

- **Assess need**: adequately assess care needs and how safe care should be delivered.
- **Review**: make sure arrangements are in place to review assessments to help ensure safe delivery of care.
- **Share risk assessments**: share any relevant risk assessments, which form part of the care assessment, with direct payment recipients. This will help recipients to take health and safety into account when employing carers.
- **Communicate**: ensure that there is good ongoing communication between the person in receipt of payments and the local authority, so far as is reasonably practicable.
- **Advise**: consider what health and safety advice recipients might need.
- **Explain**: explain the safeguards needed in the employment of workers.
- **Review** the adequacy of payments: review the level of direct payments to help ensure the right services to provide a safe level of care are secured.

The HSE concedes it is difficult to judge how reasonably practicable it is for a local authority to maintain a grip on health and safety, given that the direct payment recipient is the employer. This of course means that the local authority's involvement is less than direct.

The HSE states that the main duties of care, both criminal and civil, will rest with the employer (the direct payment recipient). And that the degree of local authority

[138] *Guidance on Direct Payments for Community Care, Services for Carers and Children's Services*, Department of Health, 2009, paras 132–134. (This has been withdrawn for adults but may still be extant for children.)

responsibility might depend in part on the specifics of the agreement which the local authority has with the direct payment recipient.[139]

2.11.6 Recipient of payment: duties

The view of the HSE seems to be that the direct payment recipient does not in general have duties, as an employer, under health and safety at work legislation - towards his or her personal assistants, employed to provide basic personal care in the home.

This is because of the effect of s.51 of the Health and Safety at Work Act 1974, which excludes the employment of "domestic servants" as giving rise to duties under the 1974 Act. This would then preclude also the application of regulations such as the Manual Handling Operations Regulations 1992.

However, the HSE advice goes on seemingly to muddy the water by stating that an employee is not a domestic servant if complex health care activity is involved (e.g. operation of life support or palliative care equipment). The same applies, according to the advice, where (emphasis added):

the task(s) require specialist training including qualified trained healthcare professionals. Examples of specialist training may include, for example, training people in handling tasks or dealing with behavioural issues.[140]

This reads altogether vaguely. It doesn't seem plausible that basic manual handling tasks undertaken by PAs impose employer responsibilities on the direct payment recipients, under *health and safety at work legislation.* But, of course, the direct payment recipient will in any event have both *a contractual duty and common law of duty of care* towards their employees.

2.12 Equipment in care homes

Who is responsible for meeting the equipment needs of residents of registered care homes? On the one hand the care home or – on the other – social services or the NHS?

Guidance on funded nursing care (FNC) outlines when either social services or the NHS will be responsible for equipment. It states that if individuals in a care home require equipment to meet their care needs, there are several routes by which it may be provided:

- **(Care home responsibility: contract or regulatory standards).** *The care home may be required to provide certain equipment as part of regulatory standards or as part of its contract with the ICB.*

[139] *Local Authority Duties towards People in Receipt of Direct Payments*, Health and Safety Executive, undated. Accessed on 02/01/2023 at www.hse.gov.uk/healthservices/direct-payments.htm

[140] *Guidance on Domiciliary Care and Section 51 of the Health and Safety at Work etc Act*, Health and Safety Executive, 2011. Accessed on 03/01/2024 at www.hse.gov.uk/foi/internalops/sims/pub_serv/071105.htm.

- **(NHS and local authority responsibility)** *Individuals who are entitled to NHS-funded Nursing Care have an entitlement – on the same basis as other people – to joint equipment services. ICBs and local authorities should ensure that the availability to those in receipt of NHS-funded Nursing Care is taken into account in the planning, commissioning and funding arrangements for these services*.

- **(Bespoke or other equipment for the individual not otherwise available**). *Some individuals will require bespoke equipment (or non-bespoke equipment that is not available through routes (a) and (b) above) to meet specific assessed needs identified in their care plan. ICBs and (where relevant) local authorities should make appropriate arrangements to meet these needs*.[141]

If a person has NHS Continuing Healthcare needs, then the NHS is responsible for their health and social care equipment needs.[142] However, the same issue will arise: in which circumstances the care home would be providing the equipment as basic, and in which the NHS should provide the equipment additionally.

2.12.1 Regulatory requirements

Under regulations enforced by the Care Quality Commission, care homes must ensure that equipment is safe, is used safely and provided in sufficient quantity to ensure safety and the meeting of residents' needs. Equipment must also be clean, secure, and suitable for purpose, properly used and maintained, and appropriately located.[143]

Guidance on these regulations states (emphasis added):

- **(Suitability, maintenance, training etc.).** *Providers must make sure that equipment is suitable for its purpose, properly maintained and used correctly and safely. This includes making sure that staff using the equipment have the training, competency and skills needed*.

- **(Availability).** *Sufficient equipment and/or medical devices that are necessary to meet people's needs should be available at all times*.

- **(Needs, preferences, equality).** *The premises and equipment used to deliver care and treatment must meet people's needs and, where possible, their preferences. Reasonable adjustments must be made when providing equipment to meet the needs of people with disabilities, in line with requirements of the Equality Act 2010.*

- **(Obtaining equipment in reasonable time).** Equipment must be accessible at all times to meet the needs of people using the service. This means it must be available when needed, or obtained in a reasonable time so as not to pose a risk to the person using the service.

[141] *NHS-funded Nursing Care Practice Guidance*, Department of Health and Social Care. 2022, para 75.
[142] *National Framework for NHS Continuing Healthcare*, 2022, para 172.
[143] *Health and Social Care (Regulated Activities) Regulations 2014*, rr.12, 15

- **(Equipment examples).** *Equipment includes chairs, beds, clinical equipment, and moving and handling equipment*.[144]

The implication would be that a care home should be providing a basic range of equipment to meet the needs of its residents, including chairs, beds, lifting equipment etc.

A care home could no doubt, in some circumstances, claim to be meeting this requirement for a particular individual, by relying on equipment provided individually and additionally by the NHS or social services.

But it seems unlikely that the regulations and guidance envisage care homes not themselves providing at least a basic range of the equipment typically required by residents of that type of care home. Otherwise, what are care home fees for?

2.12.2 Contractual requirements

In addition to the regulatory requirements, immediately above, it is open to local authorities, NHS bodies and care homes to set out more detail about who is expected to provide what, by way of equipment. By means of the contract.

For instance, in Scotland, the Convention of Scottish Local Authorities published in 2012, a detailed national protocol. This was for inclusion in the Scottish National Care Homes Contract. The protocol defines, in detail, the various responsibilities of care homes and statutory services.[145]

There is nothing equivalent, nationally, in England, but there is nothing to stop a local authority, working with local care homes, from developing such a local protocol for inclusion in local contracts.

2.12.3 Making sure needs are met

If a care home were arguably in breach of regulations or contract, then the breach would need to be dealt with. Either via the Care Quality Commission, or through contractual enforcement or negotiation, or both.

In the meantime, however, it would be important to ensure that the person's needs were being met – by means of the NHS or social services providing the equipment required.

This is because if a local authority or NHS body has placed a person in a care home, it has undertaken in law to meet that person's needs. The fact that the care home is in breach of a regulatory or contractual requirements does not diminish the duty.

[144] *Guidance for providers on meeting the regulations*, Care Quality Commission, March 2015, pp. 42, 57, 58.
[145] *Protocol for the Provision of Equipment in Care Homes*, Convention of Scottish Local Authorities, 2012.

The local ombudsman will generally hold a local authority responsible for a care home's failure to meet a person's needs – whether or not, in a "moral" sense, the local authority is to blame.

Were a care home not providing (the right) equipment, using it wrongly (e.g. with manual handling) and the resident suffered adverse consequences, the ombudsman is likely to hold the local authority responsible for the failure.

Care home, and therefore local authority, at fault for pressure sores caused by lack of suitable equipment. A care home failed to provide suitable care and equipment (air mattress) for a resident placed by the local authority, the ombudsman held the latter responsible for the failure. The woman developed severe pressure sores and the ombudsman noted that social services had commissioned the care, so the local authority was at fault.[146]

The lesson of this is that local authorities need to consider how they check and review both individual placements in care homes, as well as more generally monitor providers for continuing suitability.

2.13 Informal carers: equipment

The Care Act 2014 strengthened and supplemented duties to informal carers.

- **Assessment.** First, carers have, under s.10 of the Act, a right to assessment of possible need for support.
- **Prevention**. Second, the duty under s.2 to provide or arrange preventative services applies to informal carers as well as to adults in need.
- **Eligibility.** Third, for the first time, informal carers must be assessed against eligibility criteria. If a carer meets the criteria, the local authority has a duty to meet that carer's need for support.
- **Meeting need**. Fourth, a carer's needs can be met under the Care Act in two different ways. Either by arranging provision for the carer, or by arranging provision for the adult.
- **Adult cared for: doesn't need to be eligible**. Fifth, s.20 of the Care Act states that it is legally possible under the Act for an informal carer to be eligible but for the adult cared for not to be eligible.

Either as a preventative service or as an eligible-need service, equipment might meet the need of a carer for support. The equipment might be used directly by the carer - for example, a washing machine. Or by the adult in need – but with help from the carer; in

[146] LGSCO, *Somerset County Council* (17 008 893), August 2018.

which case the choice of equipment may be governed by both the adult's needs and the carer's.

Provision for adult but with impact on informal carer. When a local authority refused, out of hand, a ramp for a person with privately purchased scooter, the ombudsman found fault. For applying a restrictive policy about such a type of provision; but also, for failing to consider the impact on the informal carer. Without whose help the woman could neither leave nor return to her property.[147]

2.14 Safeguarding under Care Act

Under s.42 of the Care Act, there is a duty placed on a local authority to make enquiries if it has reasonable cause to suspect three things:

- that the person may have care and support needs, and
- that there is a risk, or experience of, abuse or neglect, and
- because of their needs, they are unable to protect themselves.

Sometimes compliance with recommendations about how to use equipment – by adults in need and their informal carers - surfaces in adult safeguarding and involves occupational therapists. In responding to such concerns, relevant factors to bear in mind include the following.

Section 42 does not refer simply to risk of harm, but more specifically to abuse or neglect. That is potentially a major distinction, since occupational therapists work often with people who may be at risk of harm - but only a small subsection of these would be at risk of abuse or neglect.

Note. Contrast s.47 of the Children Act 1989, which casts its net wider by referring to reasonable cause to suspect "significant harm".

Proportionality of response is required, to avoid unjustified draconian reactions. In the following case, the judge found flaws in how a local authority had responded to the risk around hoisting:

Hoisting by informal carer, safeguarding: unjustified threat to deprive woman of her liberty. The court disagreed with a local authority's attempt to deprive a woman of her liberty in a nursing home and to separate her from her husband. It declared that this was not in her best interests. The local authority had earmarked it as an adult protection issue.

[147] LGSCO, *Luton Borough Council* (16 008 034), 2017.

She lacked capacity to decide about her care and residence. Manual handling formed a key, although not the only, part of the local authority's evidence. This element related to him single-handedly hoisting his wife and leaving her in a sling for periods of time.

Not always following professional opinion. The judge rejected the local authority's case. He pointed out that it is not necessarily in a person's best interests that professional opinion always be followed.

Husband's expertise. Furthermore, the husband's acts in hoisting his wife were based on his intimate knowledge of her likes and dislikes and on weighing up the benefits to her against the risks. The evidence was that he did her more good than harm.

Flawed risk assessment. In addition, the occupational therapist's risk assessment appeared to be a year out of date; had not taken account of the fact that he had been successfully handling his wife in this way for two years; and had not emphasised that the primary risk was to the husband (who had capacity to accept the risk) rather than to the wife.[148]

In this same case, a consultant from the older people's team had recently assessed and stated as follows. This suggests just how finely balanced safeguarding interventions sometimes need to be, before being used to break up longstanding relationships:

She enjoys the company of her husband. She enjoys watching television at home and is able to concentrate. She can laugh. Her mood is fine. She feels safe at home. No one is troubling her or treating her badly. Her husband helps her with her personal care. She is comfortable with him doing it. He is able to do it well despite having problems with his legs. She had home carers but did not like the service. She said her husband is very good to her and treats her well. She did not want to go into a care home, saying "it is not my way."[149]

In a contrasting case, the approach seemed, overall to involve working together rather than threat:

Stand-aid or hoist? The occupational therapists did not see eye to with the daughter of a woman who lacked the relevant mental capacity. The issue was whether the mother should continue to use a stand aid or change to full hoisting.

In coming to a best interests decision, therapists worked with the daughter, carrying out various assessments and trying different equipment and slings, sometimes more than once.

The therapists were slow in involving the continence service – to deal with an issue about clothing, hoisting and toileting. And this caused some friction and delay. But otherwise, they seemed to have gone the extra mile in attempting to find an acceptable solution: there was no mention of safeguarding.[150]

[148] *A London Local Authority v JH* [2011] EWHC 2420, High Court.
[149] *A London Local Authority v JH* [2011] EWHC 2420, High Court, p.42.
[150] LGSCO, *Knowsley Metropolitan Borough* Council (21 001 821), February 2022.

2.15 Care Act, prisons, equipment

Under s.76, the Care Act applies, in the main, to prisons and approved premises (bail and probation hostels). This includes the duties of prevention, assessment and the meeting of eligible needs, including therefore those relating to equipment.

Guidance states that equipment needed in prison would be the responsibility of the local authority, whilst adaptations would normally be for the prison to provide:

For those assessed as being in need of equipment or adaptations to their living accommodation to meet their needs, local authorities should discuss with their partners in prisons, approved premises and health care services where responsibility lies.

Where this relates to fixtures and fittings (for instance a grab rail or a ramp), it will usually be for the prison to deliver this. But for specialised and moveable items such as beds and hoists, then it may be the local authority that is responsible.

Aids for individuals, as defined in the Care and Support (Preventing Needs for Care and Support) Regulations 2014, are the responsibility of the local authority, whilst more significant adaptations would be the responsibility of the custodial establishment.[151]

The National Offender Management Service (NOMS) guidance repeats the gist of the Department of Health guidance, in relation to equipment. However, it seems to have been drafted incorrectly. It states that local authorities are required by regulations, supported by guidance, to provide at their cost equipment (e.g. hoists) and personal aids (e.g. to assist mobility) up to the value of £1,000.[152] This reads misleadingly.

In fact, the legal position – already outlined above in section 2 of these Guidelines - is that the £1,000 limit under the Care Act applies to minor adaptations only - and is in any case not about what can be provided. It is only about what can be charged for, assuming it is provided in the first place. And this rule does not in any event apply to equipment.

The NOMS guidance goes on to state that it would be for the prison to provide minor adaptations, including fixings:

In general, the responsibility for minor adaptations and fixings rests with the prisons. In cases of very severe needs ,it may be necessary to undertake larger scale building work, or to relocate prisoners to adapted or specialist cells.[153]

Likewise for major adaptations:

Where significant scale or high-cost work is indicated by a social care assessment, prisons should share the relevant recommendations with MoJ Estates Directorate and seek specialist advice from MoJ Estates and the local authority. Costs of works may be met from NOMS or prison budgets, or by MoJ Estates in line with current arrangements.[154]

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[151] *Care and Support Statutory Guidance*, para 17.35.
[152] *Adult social care*. National Offender Management Service, PSI 15/2015, para 12.3.
[153] *Adult social care*. National Offender Management Service, PSI 15/2015, para 12.4.
[154] *Adult social care*. National Offender Management Service, PSI 15/2015, para 12.3

Equipment provision in prisons may not be straightforward because of risk of misuse, and the guidance refers to risk assessment:

Where specific equipment is offered it may be necessary for this to be risk assessed for security and safety prior to deployment in a prison, and it may be necessary to request alternatives where there are concerns or if equipment is misused.

Local authorities may wish to consider sharing with Security and Safer Custody departments the details of those types of equipment which the establishment's population might most commonly require-in order to speed the process of risk assessing equipment which it proposes to issue to named prisoners.[155]

2.16 Delegating responsibilities

The Care Act, s.79, allows for most functions to be delegated by a local authority to other agencies. This covers not only the obvious – in terms of actual provision of services and equipment by independent providers– but could also extend, for example, to core statutory functions such as assessment, care and support planning and review. Including for equipment.

However, a local authority would need to be sure that the contractor was following the Care Act rules. This is because s.79 makes clear that the local authority retains ultimate legal responsibility for any Care Act functions so delegated.

For instance, sometimes a local authority contracts out elements of equipment provision to an independent provider. The authority would need to ensure that the provider did not start to impose rules, inconsistently with the Care Act, about how equipment, and what equipment, would be provided. To allow this to happen could risk the "tail wagging the dog", the authority losing control over Care Act functions, those functions being undermined - but the authority nonetheless being ultimately responsible.

[155] *Adult social care*. National Offender Management Service, PSI 15/2015, para 12.3

3 CHILDREN AND EQUIPMENT

Provision of equipment for children, in social care, is governed by the Children Act 1989 and more specifically by the Chronically Sick and Disabled Persons Act 1970.

3.1 Section 17, Children Act

Section 17 of the Children Act contains a general duty to safeguard and promote the welfare of children in need. Key points include:

- **Child in need**. A child in need is defined to include not just a disabled child, but also a child whose health or development is at risk.

- **Disabled child.** A disabled child is defined as: *blind, deaf or dumb or suffers from mental disorder of any kind or is substantially and permanently handicapped by illness, injury or congenital deformity*.

- **Wide application of duty including to equipment**. The duty is very broad. It could cover the provision of major adaptations, as pointed out by the Court of Appeal.[156] So, it could clearly cover equipment as well.

- **Provision for family members**. Section 17 also allows for provision to any member of the family, as well as the child in need themselves.

- **Parent carer assessments: provision of equipment**. Following a parent-carer (of a disabled child) assessment under s.17, equipment for a parent in their own right could also be provided. For example, a washing machine to assist a parent manage the laundry implications of severe double incontinence.

- **Direct payments**. Direct payments are available, under certain conditions, for parents to manage the direct payment for a child. Including for equipment. In some circumstances, the direct payment could be.[157] (For more about direct payments generally, see section 2 of these Guidelines).

- **Weakness of duty**. The duty under s.17 of the Children Act might be broad, but it is relatively weak. Legally enforcing provision of equipment, or indeed anything else, under s.17, for an individual child could be difficult. This is because the duty is a general one toward children in need in the area generally, not toward an individual child.[158]

[156] *R (Spink) v The London Borough of Wandsworth* [2005] EWCA Civ 302, Court of Appeal.
[157] Children Act, s.17A. And see: *Guidance on direct payments: for community care, services for carers and children's services*, Department of Health 2009, para 157ff.
[158] *R(G) v Barnet London Borough Council* [2003] UKHL 57, House of Lords.

The last point, the relative weakness of the s.17 duty, makes consideration of s.2 of the Chronically Sick and Disabled Person Act 1970 all the more important for disabled children needing equipment and adaptations.

3.2 Chronically Sick and Disabled Persons Act

Section 2 of the Chronically Sick and Disabled Persons Act 1970 (CSDPA) is legally an extension of Part 3 of the Children Act 1989.

It continues to apply to disabled children, although the Care Act, from April 2015, disapplied it for adults. The definition of disability under s.17 of the Children Act (see above) applies as well to s.2 of the CSDPA.

It seems that there remains a duty, under an older 1986 Act, to assess on request a disabled child's needs under the CSDPA on request, for example, by the parent or the disabled child. But, in any case, the courts have separately held that there is a duty to assess children in need (and therefore disabled children).[159]

First, in contrast to s.17 of the Children Act, there is a specific duty owed toward each individual, disabled child – not just children in need generally. It is therefore more readily amenable to enforcement.

This duty is triggered once a local authority has accepted that it is necessary to meet a disabled child's needs by providing any of the services listed in s.2. Assuming also that the child is ordinarily resident within the area of the local authority.

Second, s.2 of the CSDPA contains a list of specific services. They are worth spelling out since most, perhaps all, could involve matters such as equipment and manual handling, for example. That said, paragraph (e), with reference to "additional facilities" could be understood as applying explicitly to equipment in the home:

- **(practical assistance)** the provision of practical assistance for the child in the child's home.
- **(recreation etc.)** the provision of wireless, television, library or similar recreational facilities for the child, or assistance to the child in obtaining them.
- **(outings etc.)** the provision for the child of lectures, games, outings or other recreational facilities outside the home or assistance to the child in taking advantage of available educational facilities.
- **(travel)** the provision for the child of facilities for, or assistance in, travelling to and from home for the purpose of participating in any services provided under arrangements made by the authority under Part 3 of the Children Act 1989 or, with the approval of the authority, in

[159] *R(G) v Barnet London Borough Council* [2003] UKHL 57, House of Lords, para 32.

any services, provided otherwise than under arrangements under that Part, which are similar to services which could be provided under such arrangements.

- **(adaptations, additional facilities)** the provision of assistance for the child in arranging for the carrying out of any works of adaptation in the child's home or the provision of any additional facilities designed to secure greater safety, comfort or convenience for the child.

- **(holidays)** facilitating the taking of holidays by the child, whether at holiday homes or otherwise and whether provided under arrangements made by the authority or otherwise.

- **(meals)** the provision of meals for the child whether at home or elsewhere.

- **(telephone)** the provision of a telephone for the child, or of special equipment necessary for the child to use one, or assistance to the child in obtaining any of those things.

The words may be useful when arguing a case. Paragraph (e) covers provision not just for safety but for "comfort" and "convenience". This clearly extends the scope of how occupational therapists can put forward justification for their equipment recommendations.

Paying attention to the words. A local authority rejected an application for a shelter for a powered wheelchair on grounds that there was no evidence of "serious inconvenience" or "personal danger." The ombudsman criticised this decision because it had been reached without assessment, and on the grounds of making no budgetary provision for such things.[160]

Comment. In reference to adaptations/additional facilities referred to in s.2 of the CSDPA, this rationale added an arguably impermissible gloss of "serious" to the term "greater convenience". Greater does not have the same meaning as serious. It also ignored the word "comfort" in the same paragraph. And made no mention of other potentially relevant paragraphs relating to outings, recreational facilities and travel – which may have been relevant to use of the person's powered wheelchair.

3.2.1 Necessity to meet a need

The CSDPA creates a strong, enforceable duty to meet a child's need, once the local authority has decided that it is necessary to meet it. The question therefore is how it reaches this point of it being necessary to do so.

For adults under the Care Act, the position is clearer in legislation, because Care Act regulations stipulate explicit and detailed criteria for eligibility and therefore a duty to meet need. For children, there is no such parallel.

[160] Local Government Ombudsman, *Sheffield City Council* (93/C/1609), 1995.

3.2.2 Distinguishing legislation

It is for local authorities to decide locally how the decision about what is "necessary" is made. In doing so, the courts have stated that the local authority must distinguish any local criteria being used under s.17 of the Children Act, from any local criteria being used in relation to section 2 of the CSDPA.[161] This is because of the different nature of the s. 17 and the s.2 duties.

3.2.3 Rights of a disabled child

In practice, however, it appears that a distinction is sometimes not made between criteria used under the Children Act from criteria used under the CSDPA. And further, that practitioners are sometimes unaware of under which Act they are taking a decision.[162]

If an occupational therapist wishes to make a strong argument for meeting a disabled child's needs, the CSDPA therefore needs to be highlighted. That is, in its own terms, and not just under the vague cover of s.17 of the Children Act. Referring only to the latter is, from a legal point of view, tantamount to downplaying legal entitlement of a disabled child, as the courts have pointed out.[163]

All this points to a need for clear, local eligibility criteria to be formulated and applied by the local authority for the CSDPA. This was referred to in 1999 by the courts:

Importance of clear eligibility criteria for disabled children. The judge stated: *depending upon a local authority's financial position, so the eligibility criteria, setting out the degree of disability which must exist before help will be provided with laundry or cleaning or whatever, may properly be more or less stringent.*[164]

Since then, the courts have reiterated this need for clear, local criteria.[165]

Once a decision is taken (under whatever local criteria there are) that – under the CSDPA - it is necessary to meet need, then the need must be met, irrespective of resources.[166] Once that decision is taken, it may not be open to the local authority immediately to back track.[167]

[161] *R(JL) v London Borough of Islington* [2009] EWHC 458 (Admin), para 111, High Court.
[162] Repeated, anecdotal evidence from many practitioners in children's services.
[163] *R(B) v London Borough of Bexley* (2000) 3 C.C.L. Rep. 15, High Court. And: : *R(JL) v London Borough of Islington* [2009] EWHC 458 (Admin), High Court.
[164] *R v Gloucestershire County Council, ex p Barry* [1997] 2 All ER 1, House of Lords.
[165] *R(JL) v London Borough of Islington* [2009] EWHC 458 (Admin), para 111, High Court.
[166] *R v Gloucestershire County Council, ex p Barry* [1997] 2 All ER 1, House of Lords.
[167] *R v Wigan Metropolitan Borough Council, ex p Tammadge* [1998] 1 CCLR 581, High Court.

3.2.4 Blanket policies under CSDPA

Blanket policies (see section 1 of these Guidelines) under the CSDPA about what can and can't be provided for children are likely, legally, to be unwise. They would risk undermining the words of the Act and also risk unlawfully fettering the local authority's discretion.

In the past, local authorities have lost legal challenges, for example, when they placed blanket restrictions on whether, or how, they would assist people with holidays.

One, unsuccessful, argument was that the CSDPA was not about relieving poverty. The court disagreed, pointing out that the CSDPA was about meeting need; the local authority could not therefore rule out, as a matter of policy, assistance with holidays.[168] Notably, more recently, the courts have taken a similar approach to adult services under the Care Act, in a case about holidays and other recreational activities.[169]

The same might apply to equipment. To take but one example:

- **Car seats**. Many local authorities have struggled with the issue of car seats. Yet, it is probably arguable that if a car seat were necessary - in order to meet assessed, disability-related needs to get into the community under the CSDPA - then the local authority might have to consider assisting with it.

  Charitable funding may be a possible avenue for the discharge of the local authority's potential responsibility – but what happens if this is not available at all or reliably?

- **Specialist car seat**. The car seat may be specialist and be expensive compared to an ordinary child's car seat. Equally, the car seat might be required for a child at an age when a car seat would not normally be required. Either of these circumstances could point to a special, disability-related need.

- **Blanket policy**. It may be that a local policy probably should not exclude (by way of a blanket policy) assistance with even an "ordinary" car seat for a disabled child - if it is required to meet an assessed need under s.2 of the CSDPA.

  Expertise. The question as to whether occupational therapists have the expert knowledge to assess and make decisions about car seats is a separate and subsidiary question. If necessary, expert input can be sought – to feed into the decision which social services makes - about whether a car seat is required to be provided under the CSDPA. After all, occupational therapists frequently seek expert advice in relation to a whole range of needs of disabled children.

3.3 Shared care

Disabled children sometimes have needs across two households if there is a shared care arrangement.

[168] *R v North Yorkshire County Council, ex p Hargreaves (no.2)* [1997] 96 LGR 39 High Court.
[169] *R(BG) v Suffolk County Council* [2022] EWCA Civ 1047, July 2022, Court of Appeal.

It need not be only separated parents; it could be other relatives with whom the child spends regular time. It could for example be a split between a person's mother and foster carers (as in one case, when the mother was too ill to care for her daughter all week).[170]

The duty to provide in both settings, and the extent to which a second dwelling should be adapted and equipped, will depend on assessed need. There is no automatic right, for example, to have one dwelling mirror the other. The nature of the dwellings might differ, and therefore correspondingly the type of equipment or adaptation required.

It might depend on how much time the child spends in the second dwelling; relatively short, limited, periods of time might demand, for instance, less adaptation or equipment. Always supposing that spending time in the second dwelling is assessed in the first place as a need which must be met.

However, a policy of never providing equipment or adaptations in a second dwelling would scarcely be legally sustainable. It would mean that individual need was not being considered and risk also an unlawful fettering of discretion (blanket policy).

In terms of legal responsibility for the second dwelling the position could look roughly be as follows.

- **Shared care: ordinary residence and CSDPA**. First, in social care, the CSDPA requires that the child be legally "ordinarily resident" within the local authority. The definition of ordinary residence is a person's abode *in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration*.[171]

- **Shared care: CSDPA 1970**. Second, however, s.2 of the CSDPA arguably does not explicitly confine provision to one dwelling only. The gateway to provision is the child having ordinary residence within the local authority; if the needs call for it, there would appear to be nothing to stop the local authority assisting the child with equipment in two dwellings.

- **"Home" and the CSDPA**. The CSDPA uses the word "home" in two of its key paragraphs (concerning practical assistance – and also adaptations and additional facilities).

  It is clearly arguable that a child could effectively have two homes in a shared care arrangement. This could be the case, even if the second dwelling were in the area of a different local authority; the child would still be ordinarily resident in the first (and main) local authority. Thus, the latter local authority, dependent on assessed need, could arguably incur a duty in relation to both dwellings, even if the second of these were out of area.

[170] *CD v Isle of Anglesey* [2004] EWHC 1635 (Admin), High Court.
[171] *R v Barnet London Borough Council, ex p Shah* (1983) 2 AC 309, House of Lords.

- **Providing equipment for a home in another council area**. It is sometimes suggested that provision of equipment in a second home, which was out of area, would not be legally required - or permitted for the local authority of ordinary residence.

  However, it is not clear that this is correct. This is because the provision of services and potentially equipment outside of the main home is clearly contemplated in general by s.2 of the CSDPA. After all, it refers to outings, holidays, access to recreational facilities etc. Not only may these obviously be outside the main home but also outside of the area of the local authority. In the same vein, why not equipment provision in a second, shared care, home, albeit in a different local authority area?

- **Shared care: Children Act 1989**. Third, and in any case, s. 17 of the Children Act requires only that a child be in the local authority's area (which is more general than being ordinarily resident). The courts have held that a child can be in two areas at the same time.[172] In which case, s.17 responsibilities to provide equipment could apply to the second local authority in respect of the second home – in a shared care situation.

  Shared care: a looked after child. If a disabled child is a looked after child under the Children Act, then the local authority has a duty to ensure that accommodation, in which the child is placed, is suitable.[173] This could include consideration of adaptations – as the court pointed out in a case when a disabled teenage girl split her time each week between her mother (who had a long-term illness) and longstanding foster carers.[174]

  Shared care: disabled facilities grants (DFGs). As far as housing legislation is concerned and DFGs (see below, section 7 of these Guidelines), the Housing Grants, Construction and Regeneration Act 1996 refers to a dwelling being the disabled occupant's only or main residence. It is difficult to see how a child could, legally, have two only or main residences. Assuming this is correct, then a DFG would be available for one dwelling only.

  Nevertheless, under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002, there is a wide discretion to assist with housing, including with adaptations. So, this could in principle be used to assist with adaptations to a second dwelling.[175] For an out of area second dwelling, it would be the local housing authority in which the second dwelling was situated.

3.4 Looked after children: equipment

[172] *R(Stewart) v London Borough of Wandsworth* [2001] EWHC Admin 709, para 28, High Court.
[173] *Children Act 1989*, s.22.
[174] *CD v Isle of Anglesey* [2004] EWHC 1635 (Admin), High Court.
[175] *Disabled facilities grant (DFG) delivery: guidance*, 2022, para B12.

If a child is "looked after" under s.20 of the Children Act 1989 by a local authority, there are certain rules about local authority responsibilities, including when these go across local authority borders. In broad summary:

- **Responsible local authority**. Under s.20 of the Children Act a local authority is responsible for providing accommodation for any child in need in its area, where this appears to be required. Under s.22, the authority must promote and safeguard the welfare of that child. Provision of accommodation can include foster care.

- **Care plans**. The local authority must prepare a care plan. This must include how the child's needs are to be met. The care plan must be kept under review.[176] Such a care plan could cover equipment, manual handling and other physical care issues.

- **Suitable accommodation**. Under s.22C of the Children Act, local authorities must ensure that any accommodation provided is suitable for the child's particular needs. This could relate to equipment and adaptations.[177]

- **Foster care: equipment.** Additional regulations confer duties on fostering providers (local authority or fostering agency). They stipulate that the fostering provider must ensure that the child has access to such medical, dental, nursing, psychological and psychiatric advice, treatment and other services the child needs. In addition, it must ensure that the child is provided with such individual support, aids and equipment needed by the child because of health needs or disability.[178]

- **Ordinary residence: original local authority**. The child remains legally ordinarily resident within the local authority with the looked after responsibility, even if the child is placed out of area.[179] Thus, responsibility for equipment provision would remain with the original local authority. However, a second local authority may take over the provision of out of area accommodation – after being notified by the original local authority. This is a power not a duty. If it does so, the second local authority can recover expenses from the original local authority.[180] The primary, overall duty remains with the original local authority.[181]

- **Out of area placement and adulthood**. At the age of 18, a child may need a placement under the Care Act (when moving on from the Children Act). The courts have held that it is the original local authority (with the looked after responsibilities under the Children Act) which retains responsibility. For instance, if a foster placement were to be replaced by a shared lives/adult placement, it would be the local authority that made the foster placement which remains responsible under the Care Act.[182]

[176] *Care Planning, Placement and Case Review (England) Regulations 2010.*
[177] *CD (A Child) v Anglesey County Council* [2004] EWHC Admin 1635, High Court.
[178] *Fostering Services (England) Regulations 2011*, r.15.
[179] *Children Act 1989, s.105(6).*
[180] *Children Act 1989, s.20(2) and s.29(7).*
[181] *R(Cornwall Council) v Secretary of State for Health* [2015] UKSC 46, Supreme Court, para 6.
[182] *R(Cornwall Council) v Secretary of State for Health* [2015] UKSC 46, Supreme Court.

- **Home adaptations**. Home adaptations provided under the Children Act and/or Chronically Sick and Disabled Persons Act 1970 would fall generally under the above rules. For a disabled facilities grant under the Housing Grants, Construction and Regeneration Act 1996, it would fall to the local authority in whose area the dwelling is situated.[183] For example, with out of area fostering, it would be the responsibility of the housing authority in which the foster carers' home was situated.

- **NHS responsibilities for looked after children and other categories of children placed in residential accommodation out of area**. Responsibility for health care provision of equipment for children in general is normally established by ascertaining the GP registration of the child. And then identifying the integrated care board (ICB) with which the GP practice is associated. This is often referred to as the general rule.

  In the case of looked after children placed out of area, and some other categories of children placed out of area, the rule is not quite the same. There are exceptions. If these exceptions apply, then the original ICB remains responsible. These include:
  - any looked after child;
  - a relevant child under s.23A of the Children Act 1989 (16-17 years old, formerly looked after);
  - any child who qualifies for advice and assistance from the local authority pursuant to Section 24 of the 1989 Act (including 16-21 years old formerly looked after);
  - any child provided with accommodation at a school to which they were admitted in accordance with an Education Health and Care Plan; and
  - any child that requires accommodation in a care home, a children's home or an independent hospital in order to meet their continuing care needs, including under the Children and Young People's Continuing Care National Framework.

- Residential accommodation includes, but is not limited to, a care home, a children's home, an independent hospital or a residential school. A placement into foster care will also constitute residential accommodation. These rules, set out in dense regulations, are summarised in *Who Pays?* guidance.[184]

3.5 Charitable funding for equipment

If a local authority determines, under s.2 of the CSDPA, that it is necessary to meet a child's needs, then it must do so. As noted above, lack of resources is not a defence to non-performance of the duty.

Were a charity able to meet reliably the identified need and with reasonable speed, then there would appear to be little legal objection to a need being met in this manner. Nevertheless, were it to be unable or unwilling to meet the need, either wholly or partly –

[183] *Housing Grants, Construction and Regeneration Act 1996, s.101*. Which cross refers to s.2 of the Housing Act 1985 to establish the responsible housing authority.
[184] *Who Pays? Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers*. NHS England, 2022, section 15. The source regulations are now the: *National Health Service (Integrated Care Boards: Responsibilities) Regulations 2022, schedule 3.*

and within a legally reasonable period – then clearly the local authority could not claim to be discharging its duty.

For instance, when a blind woman was referred to a local charity for equipment and she complained to the ombudsman:

Voluntary organisation's grant for equipment was doubtful. A local authority declined to meet a visually impaired woman's needs under the Care Act on the grounds that a local voluntary organisation would give her a grant for technology to access the Internet. But the grant was discretionary, and the local authority did not consider how she would manage, were the grant not forthcoming. This was maladministration.[185]

The following case illustrated a requirement to avoid the availability of charitable assistance from clouding assessment of need – in this case, in relation to a six-year period covering the person's time as both a child and adult:

Charitable help obscuring the lack of a full assessment, when the charity withdrew. Over a period of six years, the local authority failed properly to assess the needs of the person, first as a girl and then as a woman. She had multiple and profound mental and physical disabilities.

It had now decided to provide weekend respite care at a care home. This was arranged with a charity. The charity was then forced to close the home on Sundays. The local authority stated that it could not be held responsible for this effective withdrawal of service.

The local authority did not respond with a formal reassessment. This would have had to conclude that either there was no longer a need, or that the authority was in breach of its duty to meet the need. Instead, it simply denied its commitment to the family. The local ombudsman found maladministration.[186]

In a further case, an occupational therapist, on behalf of the local authority, closed a case, before establishing whether the person concerned (with eligible needs) could obtain, from charitable sources, the various small items of equipment he needed.[187]

3.6 Speed of assessment

The CSDPA 1970 itself contains no timescales for assessment, nor does the Children Act 1989 in relation to the assessment of children in need.

However, statutory guidance does set out both principles and timescales. Although this guidance refers primarily to the Children Act, s.17 of this Act covers children in need; and

[185] Local Government Ombudsman, *London Borough of Hammersmith & Fulham* (15 011 661), 2016, para 24.
[186] Local Government Ombudsman. *North Yorkshire County Council* (01/C/03521), 2002.
[187] LGSCO, *Reading Borough Council* (21 009 005), November 2022.

that the definition of children in need includes disabled children. In addition, the CSDPA is anyway, in law, in effect an extension of the Children Act.

So, it is at least arguable that the following guidance applies to disabled children and, by extension, to assessment under the CSDPA 1970:

- **(timeliness)** *The timeliness of an assessment is a critical element of the quality of that assessment and the outcomes for the child.*

  The speed with which an assessment is carried out after a child's case has been referred into local authority children's social care should be determined by the needs of the individual child and the nature and level of any risk of harm they face.

  This will require judgments to be made by the social worker on each individual case.

- **(acknowledging receipt of referral in a day)** *Within one working day of a referral being received, a local authority social worker should acknowledge receipt to the referrer and make a decision about next steps and the type of response required.*

- **(45 days to conclude assessment)** *The maximum timeframe for the assessment to conclude, such that it is possible to reach a decision on next steps, should be no longer than 45 working days from the point of referral. If, in discussion with a child and their family and other practitioners, an assessment exceeds 45 working days, the social worker should record the reasons for exceeding the time limit.*

- **(interim provision)** *Whatever the timescale for assessment, where particular needs are identified at any stage of the assessment, social workers should not wait until the assessment reaches a conclusion before commissioning services to support the child and their family. In some cases, the needs of the child will mean that a quick assessment will be required.*[188]

Some local authorities may maintain that a screening process for a disabled child will constitute the assessment (and compliance with the guidance). This would then mean that later occupational therapy assessment and provision would constitute the next steps and be characterised as "service provision", rather than assessment. Even when, in substance, it is the occupational therapy input which represents the real assessment. The ombudsman may not always see it this way.

When is the real assessment? A local authority argued that it had completed the assessment, well within its target of 3 months. The reality, in the ombudsman's view was that the real assessment conducted by an occupational therapist, as opposed to the screening, did not take place for 18 months.[189]

[188] *Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children*, HM Government, 2018, paras 76-84.
[189] Local Government Ombudsman. *London Borough of Ealing* (97/A/4069) 1999.

The ombudsman will generally scrutinise what efforts are made to avoid or mitigate unreasonable delay. In the following case, as an example, the system of priorities was over simple and seemed to be less than rational, because if a case was classed as complex, it could not, also, be categorised as urgent:

15-month wait for reassessment and replacement seating for disabled child. A disabled child had to wait 15 months for new seating, including a 12-month wait for assessment. The assessment had been prioritised as complex, which meant that it was on a longer waiting list than existed for cases categorised as emergency or simple.

The ombudsman concluded that the system of priorities was over-simple, because within the category of complex cases there was no provision for relatively simple solutions to tide people over until a full assessment could be made.

Furthermore, there was no provision for treating some cases more urgently within the complex category, even though they were not emergency in nature. This overly simple system meant that the child's needs were not met promptly and was maladministration.[190]

In addition, in the same case, the ombudsman questioned whether the local authority had explored other mitigating steps for expediting on occupational therapy assessment. For instance, by drawing on NHS therapists, its own therapists working with adults or therapists working in private practice.

Delaying assessment, because of an uncertain change of circumstance that may or may not occur any time soon, may amount to breach of duty:

Failure to assess pending rehousing possibility. The local authority refused to carry out an assessment of need for an autistic child aged seven years old under s.17 of the Children Act 1989. And likewise failed to assess his mother's ability to care. The local authority's explanation was that the family might soon be rehoused; and it would be a waste of resources to assess now, given that circumstances might soon change.

The court held that, if the change of accommodation was going to occur within one or two months, a postponement might have been justifiable; but on the evidence, there was no indication as to when the accommodation would be found. The local authority was therefore obliged to carry out both assessments, and the s.17 assessment within 35 days.[191]

[190] Local Government Ombudsman. *Rochdale Metropolitan Borough Council* (93/C/3660), 1995.
[191] *R(J) v Newham London Borough Council* [2001] EWHC Admin 992, High Court.

4 EDUCATION, HEALTH AND CARE PLANS

The Children and Families Act 2014 governs the system of special education in England.

In summary, children with higher levels of special educational needs, which cannot be met by the school from its own resources, have education, health and care (EHC) plans. The legislation refers to special educational provision being educational or training provision that is additional to, or different to, that which would be made generally for others of the same age.[192]

There are three key elements to EHC plans: education, health care and social care. The idea is to bring together and unify a child's needs in the plan. This includes a child's needs for equipment. Responsibility is as follows:

- **Local education authorities** have a duty to pull together the plans.
- **Special educational provision** is the responsibility of the local education authority.
- **Health care provision** is the responsibility of the NHS, in particular the integrated care board (ICB).
- **Social care provision** is the responsibility of the local social services authority.

These three streams of provision are brought together under the 2014 Act, but legally they have different foundations. Equipment and therapy provision referred to in an EHC plan will fall under one or more of three options, but with different underpinning:

- **special educational provision** is truly the product of the 2014 Act.
- **health care provision** is effectively being made under the functions which the NHS has under the NHS Act 2006.
- **social care provision** is what the local authority is (anyway) providing under s.2 of the Chronically Sick and Disabled Persons Act 1970 (CSDPA) – and any other social care (effectively, the Children Act 1989) reasonably required by the learning difficulties or disabilities of the child.[193]

Note. References in this section to the *SEN Code of Practice* are shorthand for: *Special educational needs and disability code of practice: 0 to 25 years: statutory guidance for organisations who work with and support children and young people with special educational needs and disabilities*. Department of Education; Department of Health 2014.

[192] *Children and Families Act 2014*, s.21.
[193] *Children and Families Act 2014*, s.21.

4.1 Equipment in EHC plan

Is the primary need for equipment going to be characterized as education, health or social care?

The Code of Practice makes abundantly clear that provision set out in EHC plans must be specific. Including that: *equipment is required by, and will be provided for, the individual child, including specialist equipment, wheelchairs and continence supplies*.[194]

Equipment to meet an educational or training need should be in the educational part of the plan; to meet a health need (reasonably required by the learning difficulties/disabilities resulting in special educational needs) in the health part of the Plan - and to meet a social care need in the care part of the plan.

4.2 Duty to provide equipment

Once equipment is included in the educational provision part of an EHC plan, the local education authority has a duty to provide it.

Similarly, when equipment is included in the health provision part of the plan, the duty falls on the relevant NHS integrated care board (ICB). Although it is the local education authority pulling the plan together, the ICB must in law agree to what goes into the health provision part of a plan before it can be included and create a duty.[195]

And it is therefore important to realise that, although set out in the EHC plan under the 2014 Act, any health provision would in essence be made under functions of the NHS Act 2006.[196] Which, in general, gives ICBs considerable leeway in deciding what they will or will not provide under s.3 of that Act.[197]

As far as the care part of the EHC plan is concerned, the rules do not in principle add to what the child would anyway be assessed as needing under the Children Act and the CSDPA 1970, already outlined above.

This is because the 2014 Act states that, whatever (including therefore equipment) the child is being provided with under the CSDPA, it must be recorded in the care provision part of

[194] *SEN Code of Practice*, p.156.
[195] *Special Educational Needs and Disability Regulations 2014*, r.12.
[196] *Children and Families Act 2014*, s.21.
[197] *R v Brent and Harrow Health Authority, ex p London Borough of Harrow* [1997] E.L.R. 187. (An older special educational needs case involving therapy services, which the NHS refused to provide under NHS legislation).

the plan. And likewise, any provision being made under the Children Act 1989, s.17, insofar as the provision is relevant to the child's learning difficulties.

Nonetheless, if a child has an EHC plan, and the local authority has not yet assessed the needs of the child under the CSDPA and Children Act, the ombudsman may find fault if it does not then do so.[198]

4.3 Function of equipment

Section 21 of the Children and Families Act states that any health care provision or social care provision which educates or trains a child or young person is to be treated as special educational provision (instead of health care provision or social care provision). This would mean that ultimate responsibility for ensuring provision would switch away from the NHS (health care) or social services (social care) to the local education authority instead.

In the view of one judge, this means that health or social care equipment which enables a child merely to participate in education would, be in the health or social care sections of the EHC plan.

But, the judge went on, if the equipment itself in some way educated or trained a child, then it could fall under the educational part of the plan. This would then switch statutory responsibility for meeting the need. The question arose in a tribunal case about a wheelchair:

Is a wheelchair educational or health care related? This tribunal case revolved in part around whether a wheelchair merely gave the 20-year-old student access to education at a sixth form college, in which case it would come under health provision and be for the NHS to provide.

Did the wheelchair itself educate or train the student? On the other hand, were the wheelchair to also, in its own right, have the effect of educating or training the student, then it would fall within the education part of the plan – and therefore be for the local authority to provide instead. The wheelchair needed to be mounted with a Voca device, to allow mobility and communication via one switch.

Parents wanted the local authority, not the NHS, to provide the wheelchair. One of the reasons for the parents bringing the case was that they did not seem to trust the NHS wheelchair service to continue to provide what their son required. Therefore, it seems, they wished to argue that the wheelchair constituted educational provision, which would trigger arguably a stronger duty on the local authority to provide the wheelchair and to maintain it.[199]

[198] LGSCO, *Staffordshire County Council* (18 011 727) 2020.
[199] *East Sussex County Council v JC* (SEN) [2018] UKUT 81 (AAC), Upper Tribunal.

The judge concluded, in this particular case, that the wheelchair did not appear to educate or train the young person but appeared merely to give access to education or training. In which case it would remain as health provision. For it to be argued as special educational provision would have required explanation:

How could health or social care equipment directly educate or train a child? The judge asked whether there was: *adequate explanation as to how … use of the wheelchair actually educates or trains him. Is it because learning to use it, and developing and applying that learning, in itself amounts to education or training? If so, is this a one-off process that only takes a very short time, like learning to make a cup of tea?*

Analogy of learning computer skills*. Is it an ongoing, developing and cumulative process, like learning computer skills? Is there nothing to learn in this process but only from the facilities that the wheelchair enables [him]?*[200]

Taking this approach, the courts found another case that even if medical and nursing support is essential for the child to be educated, that is not sufficient to make it special educational provision. It remains clearly an NHS responsibility. Whereas, in the same case, it was clear that the speech and language therapy required was special educational in nature.[201]

All this may not be intuitively easy to understand. For instance, in a further case, the judge held that provision can be educational, even if it does not itself educate or train the child: *And that it is only necessary to decide whether provision of something educates or trains a child, if it is also, and would otherwise be, health or social care provision*.

The judge pointed out that a hearing aid constituted health provision but did not educate or train the child: the teacher/lesson content did.

Hearing aid, loop system: educational, even if not educating or training the child. *A provision may be educational without itself educating a child … The difference is easy to demonstrate. Suppose a teacher is giving a lesson to a class. One pupil in the class has impaired hearing and wears a hearing aid. The school has installed a loop system, and the teacher uses a microphone.*

With the hearing aid on the T setting, the pupil can hear the lesson. The microphone and the loop system are both educational provision. But they do not themselves educate the pupil. The hearing aid may be both an educational provision and a health care provision, but again it does not educate the pupil. The teacher and the contents of the lesson educate the pupil.

In this case, the correct term for the tribunal to use was 'educational provision'. It is only relevant to decide whether a provision 'educates a child' if it is also health or social care provision.

[200] *East Sussex County Council v JC* (SEN) [2018] UKUT 81 (AAC), Upper Tribunal.
[201] *East Sussex County Council v KS* [2017] UKUT 273 (AAC), Upper Tribunal.

On the other hand, the judge concluded that the need for a low level electro-magnetic environment amounted wholly to educational provision. This was because the NHS did not recognise the child's condition as medical; so, the wired connection she needed was not health provision in the first place. Therefore, although the wired connection did not of itself educate her, it but would nonetheless still be educational provision.[202]

On any view, this has the potential to be confusing. Applied to postural support seating, so a child can participate in classroom learning, such seating would appear to fall within health provision. It may facilitate access to that learning, but it will not of itself be educating or training a child. So would remain an NHS responsibility.

The niceties of the above may not really matter in practice if joint local working is effective and a child anyway gets the equipment he or she needs. When it becomes more important to work out just how these legal rules apply, is when problems occur, and children are at risk of going without.

4.4 Local offer, joint commissioning

The Children and Families Act 2014 imposes duties on local education authorities to publish a local offer and to commission services jointly - in relation to education, health and care provision for children with special educational needs and for disabled children.[203]

The Code of Practice goes on to make clear that both the local offer and joint commissioning should be detailed and specific. Covering, for example, specialist equipment, wheelchairs and continence supplies.[204]

These are both rather general duties, prone in practice to vagueness. Nonetheless they should in principle mean that there is greater certainty about what equipment may be available locally. Thus leading, hopefully, to less argument about which organisation is responsible for which type of equipment.

4.5 EHC plans to age 25

At the age of 18, the needs of the child – now an adult – will be assessed under the Care Act 2014. Normally, the care part of the EHC plan will cease to be determined by the Children Act and the CSDPA – and instead be determined by an assessment and eligibility decision under the Care Act. If there is delay in the Care Act assessment and decision about provision, the legislation allows for provision, in the interim, to continue under the

[202] *EAM v East Sussex County Council* [2022] UKUT 193.
[203] *Children and Families Act 2014*, ss.26 and 30.
[204] *SEN Code of Practice* paras 3.6, 4.40.

children's legislation.

However, local authorities are given a discretion to continue with provision under the Children Act and the CSDPA – so long as the EHC plan continues - after a person's 18th birthday.[205]

[205] *Children Act 1989*, s.17ZG.

5 NATIONAL HEALTH SERVICE ACT

Overall, health care provision in England is governed by the National Health Act 2006.

5.1 General duty to provide

Health care equipment, for both adults and children, is provided under the NHS Act 2006.

Compared to detailed duties in social care legislation - such as the Care Act for adults and the Chronically Sick and Disabled Act for children – the NHS Act is vague. It sets out duties to meet need and provides services in broad terms only.

The vagueness of these general duties means the legal basis for provision of equipment by the NHS differs significantly from that by local authorities. Whereas local authorities function in relation to eligibility criteria (particularly under the Care Act), which create legally enforceable duties for individuals, this is not how the NHS legislation tends to work.

In theory, NHS provision of equipment is down to individual clinical judgement. In practice it is subject to local priorities and rationing, which legally are not easy to challenge.

The courts have confirmed the difficulty of enforcing provision under the NHS Act 2006, if the issue is one of limited resources, competing priorities and the need to ration services. For instance, if life-saving treatment for a 10-year-old girl with leukaemia could not be enforced, how much more difficult to enforce provision of equipment?[206]

5.1.1 Local criteria: wheelchairs

Take wheelchairs, as an example of local criteria and policies. They are specifically mentioned in schedule 1, paragraph 9 of the NHS Act 2006.

Integrated care boards are given a specific power, though not a duty, to make arrangements for the provision of vehicles (including wheelchairs) for people who appear to have a: *physical impairment which has a substantial and long- term adverse effect on their ability to carry out normal day-to-day activities*.

In practice, wheelchairs are provided by the NHS, but local wheelchair services operate local criteria. A common example is that to qualify for a powered indoor/outdoor wheelchair, the person must – amongst other things - be a full-time wheelchair user, be unable to walk indoors and be unable to use a manual wheelchair indoors.[207]

[206] *R v Cambridge Health Authority, ex p B* [1995] 6 MLR 250, Court of Appeal.
[207] See e.g. *Eligibility criteria: wheelchair and specialist seating service*. Sussex Community NHS Foundation Trust, 2021.

These local criteria rule out a significant amount of powered wheelchair provision by the NHS. Not on grounds of there being no clinical need, but in effect by artificially restricting the meaning of clinical need in this context.

Legally, it is difficult to challenge the application of such criteria when they are formulated and applied because of limited resources. In the following case, the health service ombudsman refused to intervene:

Lightweight manual wheelchairs: excluded on grounds of cost. An NHS primary care trust operated eligibility criteria for the provision of lightweight manual wheelchairs.

A young woman with cerebral palsy was assessed by a charity as needing one, so that she could perform certain activities that she could not manage in her standard wheelchair. Her request to the NHS for this was refused. The ombudsman found nothing wrong with the application of such criteria – on grounds of cost - for lightweight wheelchairs, which were more expensive than the standard chairs.[208]

Nonetheless, the principle that public bodies must not fetter their discretion, by operating a blanket policy, does apply to the NHS as a public body. For example, in one case, the NHS wheelchair service had applied too rigid an approach to indoor-outdoor powered wheelchairs:

Powered wheelchair: national and local guidance applied too restrictively. A complaint was made by the parents of their disabled son, about provision for him of an electrically powered indoor/outdoor wheelchair.

The health service ombudsman found that the NHS trust had applied local and national guidance too restrictively and had not taken account of his previous experience of using such wheelchairs. It had failed to consider whether he had exceptional needs not coming under the terms of the guidance.[209]

5.1.2 Community equipment

Community equipment is in general covered by s.3 of the NHS Act 2006. It states that an NHS integrated care board (ICB) must arrange for the provision of various things – *to such extent as it considers necessary to meet the reasonable requirements* - of the local population it is responsible for. Included in the list of what must be provided are:

such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the group considers are appropriate as part of the health service.

[208] Health Service Ombudsman. *Plymouth NHS Primary Care Trust*, 2002
[209] Health Service Ombudsman, *Epsom and St Helier NHS Trust 2001* (E.559/99–00), 2001.

NHS continuing healthcare (see below) is one area of NHS provision which contains more specific duties – specified in additional regulations – than are found generally within the NHS Act itself.

5.2 NHS continuing healthcare

NHS continuing healthcare (CHC) for adults is defined in regulations as meaning:

(sole NHS responsibility) *a package of care arranged and funded solely by the health service in England for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness.*[210]

Unlike much NHS provision, made generally under the NHS Act, the additional, specific rules about CHC make it a stronger, more specific duty. Which probably accounts for why CHC decisions cause so much tension and difficulty between local authorities and NHS integrated care boards. CHC can often be associated with high-cost packages of care, represent a considerable financial drain and therefore be prime territory for dispute.[211]

5.2.1 Sole responsibility of NHS

The word "solely" in the regulations (quoted immediately above) denotes that legal responsibility lies wholly with the NHS. Including for equipment. By the same token, s.22 of the Care Act 2014 forbids a local authority, *under the Care Act*, to meet needs by providing a facility or service that the NHS is required to provide.

CHC status, in brief and loosely (it is not straightforward), can legally be achieved through two routes.

5.2.2 Decision Support Tool

First, through use of a screening tool called a Checklist. If a person scores sufficiently highly on this, then they are assessed in more depth using a Decision Support Tool (DST).

This is followed by a summary of their needs using the descriptive categories: nature, intensity, complexity or unpredictability of need.

Finally, a decision as to whether the person's health or nursing needs, taken as a whole, are more than incidental or ancillary to what social services would be, or is, providing (quantity of care test). Or whether, taken as a whole, those health or nursing needs are of a nature that would not be expected in social care (quality/type of care test).

[210] *National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012*, r.32A.
[211] *NHS Continuing Healthcare*, Mandelstam, M. Jessica Kingsley Publishers, 2020.

5.2.3 Fast Track Pathway Tool

Second, and alternatively, there is a so-called end of life route. This depends on a doctor or nurse, involved in the patient's care on behalf of the NHS, using a Fast Track Pathway Tool - and evidencing that the patient has a rapidly deteriorating health condition which may be entering a terminal phase.[212]

5.2.4 Community equipment and CHC

Once NHS continuing healthcare status is established, then it is the NHS that has responsibility for providing community equipment to people in their own homes (or in any other setting). That means equipment to meet not just their health care, but also their social care, needs. Guidance highlights this point (emphasis added):

(NHS/CHC responsibility for equipment to meet both health and social care needs). *Where an individual is eligible for NHS Continuing Healthcare and chooses to live in their own home, the ICB is financially responsible for meeting all assessed health and associated social care needs.*

This could include equipment provision … routine and incontinence laundry, daily domestic tasks such as food preparation, shopping, washing up, bed-making and support to access community facilities, etc. (including additional support needs for the individual whilst the carer has a break). However, the NHS is not responsible for funding rent, food and normal utility bills.[213]

The same guidance gives further help to explain responsibilities for equipment provision (emphasis added). It states that when individuals in receipt of NHS continuing healthcare require equipment to meet their care needs, the following possibilities apply:

- (**Regulatory and contractual responsibility):** *a) If the individual is, or will be, supported in a care-home setting, the care home may be required to provide certain equipment as part of regulatory standards or as part of its contract with the ICB*.

- **(Standard equipment to be funded by NHS)** *b) In accordance with the principles set out … individuals who are entitled to NHS continuing healthcare have an entitlement – on the same basis as other patients – to joint equipment services. ICBs s should ensure that the availability to those in receipt of NHS continuing healthcare is taken into account in the planning, commissioning and funding arrangements for these services*.

- **(Bespoke or otherwise needed by individual)** c*) Some individuals will require bespoke equipment (or other non-bespoke equipment that is not available through routes (a) and (b) above) to meet specific assessed needs identified in their NHS continuing healthcare care plan.*

[212] *National Framework for NHS Continuing Healthcare*, Department of Health and Social Care, 2022.
[213] *National Framework for NHS Continuing Healthcare,* 2022, Department of Health and Social Care, para 315.

ICBs should make appropriate arrangements to meet these needs. ICBs should ensure that there is clarity about which of the above arrangements is applicable in each individual case.[214]

These paragraphs can be explained simply. Paragraph (a) refers to the obligation on a care home to provide a certain level of equipment to a resident – within the fee paid to the care home, by the NHS, for an NHS continuing healthcare patient. And/or under regulatory standards, contained in the Health and Social Care Act (Regulated Activities) Regulations 2014.

Paragraph (b) is stating that a person with NHS continuing healthcare status is entitled to equipment – in a care home or in their own home – just as they would be to any other service under the NHS continuing healthcare rules.

If there is a joint equipment store locally, and standard equipment is required, it would be issued from that store. But it would still be, ultimately, the legal and financial responsibility of the NHS – against whom the equipment should be "chalked up", as it were. And it would remain the responsibility of the NHS in law to ensure the person's equipment needs are met.

Paragraph (c) notes that – for a person in a care home or in their own home – any equipment required, but not available through either the care home or the joint equipment store, should be provided separately by the NHS. Whether it is bespoke or not bespoke for that person.

5.2.5 Joint working, CHC, equipment

None of the CHC rules above prevent a local authority providing equipment for a person on behalf of the NHS, even when the NHS is responsible legally for provision. This could be founded on a joint working agreement under s.75 of the NHS Act 2006.

It would mean that the equipment was being provided by the local authority *not under the Care Act 2014, but under the NHS Act 2006*.

This would need to be spelt out because, to reiterate, sole responsibility for arranging and funding CHC is placed on the NHS; and, by definition, section 22 of the Care Act prohibits local authorities from meeting CHC needs – *under the Care Act*.

5.2.6 Home adaptations and CHC

Guidance notes that sometimes, in addition to a disabled facilities grant (DFG), a person with CHC status may need a financial top up to fund an adaptation. If so, the NHS should consider whether funding the adaptation is a cost-effective option for meeting the person's CHC needs – which of course the NHS has a duty to meet. Likewise, if an adaptation were

[214] *National Framework for NHS Continuing Healthcare*, 2022, Department of Health and Social Care, para 325.

required which simply does not fall within the DFG rules at all.[215] See further below, in section 7 of these Guidelines.

5.3 Continuing Care for children

The position for children is not quite the same as for adults, when it comes to continuing care.

The relevant regulations do not define continuing care for children in quite the same way as they do for adults. For the latter, NHS continuing healthcare CHC is defined as a package of care arranged and funded solely by the NHS (see above). Whereas for children, the regulations refer to continuing care for children as being "that part" of a package of care to be arranged and funded by the NHS as continuing care:

Continuing Care for Children means that part of a package of care which is arranged and funded by a relevant body for a person aged 17 or under to meet needs which have arisen as a result of disability, accident or illness.[216]

5.3.1 Multi-agency approach

Department of Health guidance emphasises the importance of a multi-agency approach to children. It maintains that continuing care for children works differently to continuing healthcare for adults:

There are significant differences between children and young people's continuing care and NHS Continuing Healthcare for adults. Although a child or young person may be in receipt of a package of continuing care, they may not be eligible for NHS Continuing Healthcare or NHS-funded Nursing Care once they turn 18.[217]

The guidance emphasises the link to education, health and care (EHC) plans (see above) – with continuing care, arranged by the NHS, equating to the health part of the EHC plan.

5.3.2 Split responsibilities?

As already noted, sole responsibility for meeting health and social care needs is placed on the NHS in the case of continuing healthcare for adults. But this seems not to be so for children, at least as the guidance explains it.

However, whatever the gist of the guidance is, or is meant to be, the NHS may still retain specific and sole legal responsibility. For example, in the *Haringey* legal case involving a child,

[215] *National Framework for NHS Continuing Healthcare*, Department of Health and Social Care 2022, para 56.4.
[216] *National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012*, r.32A.
[217] *National Framework for Children and Young People's Continuing Care*, Department of Health, 2016, p.5.

the court held that some of the principles governing CHC for adults would apply also to children.

The case involved tracheostomy care for a child at home. The judge stated that such care could not, as a matter of a law, be provided under children's social care legislation.[218] He arrived at this view, by citing the leading adult case, the *Coughlan* case, on NHS continuing healthcare.[219] Department of Health guidance picks up this point:

(limits to social care responsibilities) *In line with the Haringey judgement (…) there are clear limits to what care should be funded by the local authority, which should not be a substitute for additional NHS care for children. In this case, the High Court determined that the duty under section 17 of the Children Act 1989 did not extend to meeting essential medical needs.*[220]

The *Haringey* case clearly illustrates that if a child's health needs predominate, effectively the NHS might be meeting all the needs. Notwithstanding the steer of the guidance in terms of joint packages of care.

In the *Haringey* case, for example, the tracheostomy-related needs meant suctioning was required as often as every 15 minutes during the day, and three times at night. The risks were significant if the mother got too tired, and the potential consequences of getting it wrong were very serious.[221]

5.3.3 Decision Support Tool

Accordingly, the Department of Health guidance for children includes a "decision support tool" (DST), to assist in identifying continuing care needs – that is, needs to be funded by the NHS. The DST looks at levels of need across different "domains" of the person's needs.[222]

If a child scores sufficiently highly, such as a "priority" or "severe" in at least one domain, or three "high" needs in different domains, this is meant to indicate continuing care eligibility.

At the very least, it could be argued that if the equipment required by a child is in connection with the domains of need pointing to eligibility for NHS continuing care, then it is the NHS which would clearly have the responsibility for providing that equipment.

5.3.4 Normal offer for children

The guidance seems to characterise continuing eligibility for health care, as eligibility for input which is over and above what would normally be offered by the NHS. Guidance states that:

[218] *R(D) v Haringey London Borough Council* [2005] All ER (D) 256, High Court.
[219] *R v North and East Devon Health Authority, ex parte Coughlan* [1999] BLGR 703), Court of Appeal.
[220] *National Framework for Children and Young People's Continuing Care*, Department of Health, 2016, p.8.
[221] *R(D) v Haringey London Borough Council* [2005] All ER (D) 256, High Court.
[222] *National Framework for Children and Young People's Continuing Care,* Department of Health, 2016,para 148.

A continuing care package will be required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone.[223]

This is not particularly informative since what would "normally" be on offer can itself be a moveable feast. This is because of the leeway afforded by the NHS Act, the consequent vagueness about what must be provided and the variation in provision, from one area to another, which is therefore permissible.

The legal distinction is that the NHS has more leeway to restrict and ration what has been offered as "normal", as opposed to rather less leeway when it comes to "continuing care". The following case was about a child's respiratory needs and associated health needs. And whether, in the presence of a continuing care need, he would be entitled to more NHS care than would otherwise be normally offered:

Need for equipment and related continuing care. A boy was 7 years old. In September 2017, a malignant brain stem tumour was identified. Surgery removed most, but not all, of the tumour. He remained for several months in hospital, some in a vegetative state.

By May 2018, he was well enough to be discharged, but with a range of serious health issues, including respiratory needs. He had a tracheostomy and was supported by mechanical ventilation during the night.

The NHS clinical commissioning group (CCG) tried to reduce the child's care to the "normal" offer, by removing the child's continuing care status. This would significantly reduce the number of hours of care provided.

The decision was held to be unlawful; it turned out that the CCG had ignored the evidence of a specialist respiratory practitioner. And departed from both the guidance and its own local policy for ratifying continuing care decisions for children.[224]

5.4 Personal health budgets

The NHS has a power to make direct payments to patients, under s.12A of the NHS Act 2006. In principle, this power applies to the provision of equipment, as well as services.

If an adult has NHS continuing healthcare status, or continuing care status as a child, then the integrated care board (ICB) must ensure that it is able to arrange provision by means of a personal budget. A direct payment is then one option for managing that budget.[225]

[223] *National Framework for Children and Young People's Continuing Care*, Department of Health, 2016, p.5.
[224] *R(JP) v NHS Croydon Clinical Commissioning Group* [2020] EWHC 1470 (Admin), High Court.
[225] *National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations* 2012, rr.32A, 32B.

In addition, and separately, patients have the right to a personal health budget in relation to NHS wheelchair provision.[226] This right was introduced in December 2019 and also includes the option to manage the personal budget for the wheelchair as a direct payment.[227]

[226] *National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations* 2012, r.32A.
[227] *Guidance on the legal rights to have personal health budgets and personal wheelchair budgets*, NHS England, 2022.

6 MANAGING RISK

The management of risk falls under more than type of legislation/law. This includes health and safety at work legislation, care standards regulations and the common law of negligence. In addition are various bits of guidance, codes of practice and alerts and notices from the Medicines and Healthcare Regulatory Agency (MHRA).

6.1 Health and safety at work

The Health and Safety at Work Act 1974 (HSWA), and regulations made under it, contain various duties. Most of these are imposed on employers in relation to *employees*. But some are directed also to *non-employees*.

In the context of equipment, this legislation is relevant to provision, storage, delivery, demonstration etc. And to the use of equipment, in a work setting, including people's own homes. Regulations augment the Health and Safety at Work Act. For example:

- Management of Health and Safety at Work Regulations 1999,
- Manual Handling Operations Regulations 1992 (MHOR),
- Provision and Use of Equipment at Work Regulations 1998 (PUWER),
- Lifting Operation and Lifting Equipment Regulations 1998 (LOLER).

6.1.1 HSWA: duty to employees

Under s.2 of the 1974 Act, it is the duty of the employer to, so far as is reasonably practicable, ensure and provide for the health, safety and welfare of all staff at work.

More specifically this includes, but is not limited to, the following. The emphasis has been added to highlight the relevance to equipment:

- **(system of work)** the provision and maintenance of plant and systems of work that are, so far as is reasonably practicable, safe and without risks to health.
- **(handling, storage etc.)** arrangements for ensuring, so far as is reasonably practicable, safety and absence of risks to health in connection with the use, handling, storage and transport of articles and substances.
- **(information, training etc.)** the provision of such information, instruction, training and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety at work of his employees.

- **(working environment)** the provision and maintenance of a working environment for his employees that is, so far as is reasonably practicable, safe, without risks to health, and adequate as regards facilities and arrangements for their welfare at work.

6.1.2 HSWA: non-employees

Under s.3 of the 1974 Act, an employer has a duty to conduct its undertaking to ensure, so far as is reasonably practicable, that people not employed by it – but who may be affected by the undertaking - are not thereby exposed to health and safety risks.

In the context of equipment provision and loan by local authorities, this duty can clearly cover, amongst other things, people and their families who are using this equipment in their own homes. As well as employees of care agencies who might be using local authority equipment and/or are following a local authority care and support plan. They non-employees of the local authority but potentially affected by it.

Self-operated hoist, death in own home. A man, paralysed in a motorbike crash, choked to death. He had become tangled in the self-operated hoist at his home. The hoist was supplied by the local authority. The remote control was lying on the floor and the emergency lowering system had failed. He had no way of calling for help. The failure had been systemic. There was no alarm system fitted, and the hoist had not been inspected properly. The Health and Safety Executive prosecuted the local authority, which was held liable under s.3 of the HSWA 1974. It was fined £100,000 and £60,000 costs.[228]

6.1.3 Managing risk regulations

The Management of Health and Safety at Work Regulations 1999 (MHSWR) impose an explicit duty of risk assessment (including reviews) on employers. This applies to both employees and non-employees. The regulations also state that an employer must provide adequate health and safety training.

In the following case, the breach of legislation appeared (from reports of the case_) to be under s.3 of the Health and Safety at Work Act 1974, and maybe the 1999 regulations as well.

Patient impaled on hoist: failure in system of work and training. A patient died after suffering catastrophic internal injuries, impaled on a lifting hoist. No individual was held to blame, but the cause was a failure to train and supervise staff – who had removed a knee support from the equipment, which should have remained in place. The NHS Trust was fined £1 million.[229]

[228] *Newport council fined over Michael Powell's hoist death*, BBC News, 13th September 2011. Accessed 22/2/24 at: https://www.bbc.co.uk/news/uk-wales-south-east-wales-14907525.
[229] *Pilgrim Hospital impaled patient death: NHS fined £1m,* BBC News, 19th July 2017. Accessed 19/2/24 at: https://www.bbc.co.uk/news/uk-england-lincolnshire-40659280.

6.1.4 Lifting Operations regulations

The Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) apply to the use of lifting equipment at work. They impose duties on employers. In summary these include regular examination and ensuring that lifting equipment is safe, both as hardware and how it is used/operated.[230]

They also impose a duty on anybody else who has control to any extent of lifting equipment; control of a person at work who uses or supervises or manages the use of lifting equipment; or control of the way in which the lifting equipment is used, and to the extent of this control.

The implications of both the employer duty – and the duty on anybody else with some control over the equipment – is considered further below in relation to reviewing equipment in the community.

6.1.4.1 Lifting equipment at work?

Guidance states, therefore, that generally any lifting equipment used by an employee at work will be covered by LOLER.

By contrast, in health and social care, lifting equipment would not be work equipment if a user of care services purchased equipment primarily for their own use and/or use by family carers at home. The same is true if equipment has been loaned by an employer or community equipment provider to individuals to be used solely (or mainly) by themselves, family or unpaid carers.

However, even then, more general duties under the Health and Safety at Work Act 1974, s.3 (covering non-employees), could apply – to provide safe equipment and maintain it, so far as is reasonably practicable.[231] Guidance further elaborates (emphasis added):

- **(Work equipment or not?)** *If the service provider supplies equipment such as a stair lift, bath lift or toilet riser, primarily to reduce the risk of injury to care workers while attending to the client, then the equipment may be considered work equipment. In these circumstances, the Provision and Use of Work Equipment Regulations 1998 (PUWER) will [anyway] apply.*

- **(LOLER).** *Depending on the type of equipment, the Lifting Operation and Lifting Equipment Regulations 1998 (LOLER) may also apply. These regulations require the equipment provider to maintain and inspect the equipment.*

- **(Client's own use).** *If the equipment is mainly for the client's own use, then the PUWER/LOLER regulations will not apply.*

- **(Safe for non-employees, clients, family members, care workers of other agencies).** *However, the equipment provider has responsibility under the general provisions of the*

[230] *Lifting Operations and Lifting Equipment Regulations 1998*.
[231] *How the Lifting Operations and Lifting Equipment Regulations Apply to Health and Social Care*, Health and Safety Executive, 2012.

Health and Safety at Work Act 1974, to ensure that it is safe for the client and care workers to use.

- **(Maintaining equipment under one piece of legislation or another)**. *Though the PUWER/LOLER regulations may not apply, their provisions can be used as a guide to establish proper maintenance arrangements.*[232]

6.1.4.2 Equipment for lifting?

It is not always clear whether equipment should be regarded as lifting equipment and therefore fall under LOLER (as well as PUWER).

Guidance from the Health and Safety Executive refers to identifying the principal function of a piece of equipment to determine if LOLER apply. It is to the effect that much equipment in health and social care has an element of lifting as part of its normal operation (e.g. a height adjustable bed or dentist's chair).

However, the principal function of such an item is as a bed or chair and not as a device for lifting or lowering of loads. Height adjustability alone does not mean that LOLER apply to the equipment.

A bath lift would come under LOLER but not a height adjustable bath. If LOLER do not apply, the Provision and Use of Work Equipment Regulations 1998 (PUWER) would anyway still do so.[233]

6.1.4.3 Examining lifting equipment

There is a duty in LOLER to examine lifting equipment thoroughly every six months, Or, in accordance with an examination scheme specifying an alternative interval. Therefore, six months is the default, but not the only, option. This duty applies to lifting equipment which is exposed to conditions causing deterioration liable to result in dangerous situations.

Clearly, the use of hoists and slings, for example, in a person's home would easily come within this rule, as noted in a safety alert issued by the Medicines and Healthcare Regulatory Agency (MHRA) about people falling from hoists. It refers to LOLER and notes the following risks, for example:

- **sling straps incorrectly fitted** to the hoist and/or the person being lifted.
- **wrong size or type of sling** used.
- **unclear responsibility** for equipment maintenance.

[232] *How the Lifting Operations and Lifting Equipment Regulations Apply to Health and Social Care*, Health and Safety Executive, 2012.
[233] *How the Lifting Operations and Lifting Equipment Regulations Apply to Health and Social Care*, Health and Safety Executive, 2012.

- **ad hoc checks by frontline staff were not a substitute** for systematic local programmes providing routine maintenance checks and for the six-monthly thorough examination demanded by LOLER. This was not to preclude frontline staff from being trained to check the hoists for evidence that those maintenance checks were in date.[234]

Guidance from the Health and Safety Executive adverts to the same sort of issues for a range of moving and handling equipment.[235]

6.1.4.4 Who should examine?

In terms of who should carry out the thorough examination of lifting equipment, guidance states the following (emphasis added):

- **(LOLER: who should carry out thorough examination).** *In respect of thorough examination of accessories, such as slings, the person should have sufficient understanding and ability to identify any wear, deterioration or damage to such equipment.*

- **(Inhouse expertise).** *There may be sufficient in-house expertise to appoint a competent person. This is particularly likely with the simpler and lower-risk devices and accessories. An employee nominated to carry out this work should not generally be the same person who performs routine maintenance, as they would be responsible for assessing their own work.*

- **(Independent verification?)** *Competent persons should be able to act with impartiality and independence. The employer should consider independent verification of any 'in-house' competent person's work.*[236]

6.1.4.5 Hardware and how it is used

Duties under LOLER are – judged by the very name - not confined to ensuring lifting equipment is inherently safe as hardware, but to its operation as well.

For instance, one of the duties involves ensuring that a lifting operation is (a) properly planned by a competent person; (b) appropriately supervised; and (c) carried out in a safe manner.[237] The approved code of practice/guidance elaborates on this.[238]

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[234] *Risk of Death and Serious Harm by Falling from Hoists. Patient Safety Alert, Stage One Warning*. Medicines and Healthcare Regulatory Agency, 2015.
[235] *Moving and handling equipment*, Health and Safety Executive, undated, https://www.hse.gov.uk/healthservices/moving-handling-equipment.htm
[236] *How the Lifting Operations and Lifting Equipment Regulations Apply to Health and Social Care*, Health and Safety Executive, 2012.
[237] *Lifting Operations and Lifting Equipment Regulations 1998*, r.8.
[238] *Safe use of lifting equipment Lifting Operations and Lifting Equipment Regulations 1998: Approved Code of Practice and Guidance*. Health and Safety Executive, 2014, pp.46-47.

6.1.5 Work equipment regulations

The primary objective of the Provision and Use of Work Equipment Regulations 1998 (PUWER) is to ensure that equipment used at work is kept in safe working order. But also, that it suitable for the particular use to which it is put.

PUWER place responsibility on the employer to provide suitable work equipment for the task and ensure that information, written instructions and training are available to the people who use it.

They also apply to anybody else who has control to any extent of (a) work equipment; (b) a person at work who uses or supervises or manages the use of work equipment; or (c) the way in which work equipment is used at work.[239]

The implications of both the employer duty – and the duty on anybody else with some control over the equipment – is considered further below in relation to reviewing equipment in the community.

6.1.5.1 Maintaining work equipment

There is a duty to ensure that work equipment is maintained in an efficient state, in efficient working order and in good repair.

This is an absolute obligation. Reasonable efforts (due diligence) to maintain the equipment – even if the defect is neither foreseeable nor identifiable – may not be enough.

In one case, a postman was injured when using a bicycle for deliveries. The particular fault, which caused the accident, could not have been identified even with a reasonable system of examination and maintenance. The Post Office was nevertheless held liable.[240]

Note. Personal injury cases, brought directly under PUWER, are no longer possible by virtue of amendment to s.47 of the Health and Safety at Work Act 1974. This does not preclude negligence cases being brought.

In addition:

- **Deterioration**. There is also a duty to ensure that work equipment - exposed to conditions causing deterioration, which is liable to result in dangerous situations - is inspected at suitable intervals.

- **Exceptional circumstances occurring**. Assessment is required of whether exceptional circumstances have occurred, such as to jeopardise safety. This is to ensure that health and safety at work conditions are maintained, and that any deterioration can be detected and remedied in good time.

- **Inspections**. Employers must ensure that inspections are recorded and kept until the next inspection.

[239] *Provision and Use of Work Equipment Regulations 1998*.
[240] *Stark v Post Office* [2000] 3 WLUK 75, Court of Appeal.

Equipment used mainly or solely by people and their families will not come under PUWER. But may still need to be inspected and maintained: see the HSE advice, quoted in the LOLER section immediately above. This would be under s.3 of the Health and Safety at Work Act 1974.[241]

6.1.5.2 Safe use of equipment

The employer has a duty under PUWER to ensure that work equipment is suitable for the purpose for which it is used or provided. Suitable means how it foreseeably will affect the health and safety of any person (suggesting not just employees). Working conditions must be taken account of in premises where the equipment is being used at work (including e.g. a person's own home). And the equipment must be used only for the operations for which it is suitable.

Additional to this is the duty on the employer to provide information, instructions and training on use of work equipment.[242]

6.1.5.3 Equipment in care homes

A care home, as employer, will have a straightforward responsibility to maintain equipment used by its staff in the home, under both PUWER and, in the case of lifting equipment, LOLER. And to ensure that it is used safely.

A local authority might provide additional equipment for a particular resident in an independent care home. In which case, the employer (the care home) under PUWER still has the responsibility for ensuring that the equipment, day to day, is safe for its staff to use at work. The local authority on the other hand is clearly not the employer, but arguably may have a degree of control, if it has loaned the equipment and so retains ownership.

In considering responsibilities under PUWER, the courts have on the one hand emphasised the importance of ownership and provision – but also, separately, the degree of control an organisation has:

Collapse of wooden ramp: local authority staff using it but local authority had no control over ramp itself. When an NHS-supplied ramp, provided for a person's own home, collapsed – and a social services employee was injured - the local authority was not liable under PUWER. The authority had no control over the equipment; it did not own, did not possess it. It had no responsibility or even right to repair it.

The position would have been different if the accident had occurred on premises owned, managed or occupied by the local authority, or if the local authority had responsibility for the condition of the ramp. [243]

[241] *How the Lifting Operations and Lifting Equipment Regulations Apply to Health and Social Care*, Health and Safety Executive, 2012.
[242] *Provision and Use of Work Equipment Regulations 1998,* rr.4, 8, 9.
[243] *Smith v Northamptonshire County Council* [2009] UKHL 27, paras 67, 68, 76, House of Lords.

On the other hand, ownership and provision may not determine responsibility, because of the lack of control over the equipment/item:

Owner/provider of equipment not liable. When an organisation provided equipment (fencing) for an independent contractor to transport and erect, the provider was not liable for the injury which occurred: it had not maintained control over the fencing.[244]

How might these two cases be applied to equipment provided in care homes by local authorities?

The extent of local authority responsibility under PUWER would probably be determined by factors such as ownership (has the authority retained this) - and the degree of control. And what agreement, with the care home, was in place for examination and maintenance.

The care home responsibility would be in terms of it being the employer of the staff using the equipment – and obviously having day to day to control over the equipment.

Either way, it would be sensible for the local authority to be clear as possible with the care home about ownership and maintenance responsibilities. To minimise the risk of things going wrong.

6.1.6 Manual Handling regulations

The Manual Handling Operations Regulations 1992 (MHOR) are aimed at improving the safety of employees involved in manual handling. In brief, employers must:

(a) avoid, so far as is reasonably practicable, manual handling operations carrying a risk of injury; or, failing this,

(b) assess the relevant manual handling operations and take appropriate steps to reduce the risk of injury to the lowest level reasonably practicable.[245]

6.1.6.1 Managing risk

The implications of the MHOR are various. They include, of course, provision of appropriate equipment to avoid or minimise risk to staff.

However, in health and social care, it will not always be reasonably practicable to eliminate risk. This might be because of the nature of their needs and individual circumstances.

For instance, it could be about how to manage assisted transfers in appropriate circumstances to maintain function; rehabilitation; counter-indication to hoisting; urgent situations (when less than optimum handling might be required) etc.

[244] *Jennings v Forestry Commission* [2008] EWCA Civ 581, Court of Appeal, para 52.
[245] *Manual Handling Operations Regulations 1992*, r.4.

6.1.6.2 Balancing needs and risk

For obvious reasons, manual handling of people is in generally more complex than handling inanimate loads. Consequently, there is a range of practical guidelines available about manual handling, risk and the management of it. For instance, the *Handling of People* is now in its 7th edition.[246] Physiotherapy guidelines, too, contain many useful pointers.[247]

However, in addition to the professional and practical side of approaching manual handling, is the legal aspect. Not just the legislation but also legal or ombudsman cases. Some of these have considered the balance to be struck between risk and meeting people's needs in the context of manual handling.

Many have involved equipment. In all of them, the courts have recognised that the reasonable practicability duty must take account of context. The regulations talk about load, but the load – in health and social care – is a person and so must be "humanised". As a manual handling conference, in 2003, highlighted.[248] And the risks of handling need to be balanced with a person's needs:

Patient not a sack of cement when deciding about hoisting. In moving a confused hospital patient, the court noted it had to be remembered he was not a sack of cement – when choosing between assistive handling, hoisting or something in between using other equipment[249]

Urgency: use of carry chair on stairs. When responding to an urgent call, there was a degree of risk to paramedics in using a carry chair on the stairs of the patient's home. However, the urgency of the call had to be considered.[250]

Making beds for disabled children. Bed-making in an NHS unit for disabled children may have carried a degree of risk, because the beds were against the wall and had to be pulled out. However, they were against the wall for a reason relating to the disabled children[251]

Manual or powered wheelchair at school: child's independence and development. A learning support assistant claimed she had been injured whilst pushing manual wheelchairs at a school. Normally, a child would self-propel, but on a bad day the child might need pushing. It was argued the risk could have been avoided by providing all the children with powered wheelchairs.

The court disagreed, accepting evidence that the self-propulsion was important to encourage independence, mobility and rehabilitation. To force a student who normally used a manual wheelchair to use a powered wheelchair instead, would be contrary to the best interests of the student. It was therefore not reasonably practicable, in this context, to avoid the use of manual wheelchairs.

[246] *HOP7, Guide to the Handling of People: person-centred practice*. 7th edition. Backcare, 2023.
[247] *Guidance on Manual Handling in Physiotherapy, 4th edition*. Chartered Society of Physiotherapy, 2014.
[248] *Humanising the Load*: title of National Back Exchange annual conference, 2003.
[249] *Urquhart v Fife Primary Care Trust* [2007] SCLR 317, Court of Session Outer House.
[250] *King v Sussex Ambulance NHS Trust* [2002] EWCA Civ 935, Court of Appeal.
[251] *Koonjul v Thameslink Healthcare Services NHS Trust* [2000] PIQR P123, Court of Appeal.

The school's risk assessment and training had been adequate; there was anyway doubtful evidence that the assistant had suffered injury through the pushing of the wheelchairs.[252]

Hoisting or assistive handling? Hoisting two very disabled sisters at home, for the safety of staff, had to be weighed up against their needs and human rights, and a balance found.[253] This was a landmark case and is summarised in more detail in these Guidelines above (section 1.6).

Assistive handling: managing the risk and meeting person's needs. Following a risk assessment, it was agreed that a care agency could not do assistive handling for a woman in her own home, cared for by her mother. The risks were probably too great – for those care agency staff.

A manual handling assessor identified that assistive handling was still needed and sought to find a solution. Increased bed care was counter-indicated for several clinical reasons. She proposed finding more confident, knowledgeable, competent carers through use of a direct payment arrangement. So as to manage the risk but at the same time meet the woman's needs.[254]

6.2 Negligence

Very basically, the test for common law negligence comprises three main elements:

- **Duty of care**. was there a duty of care between the alleged perpetrator of the accident and the person suffering the accident?
- **Breach of duty**. Was that duty breached through carelessness or lack of reasonable competence? and
- **Harm**. Was the harm directly caused by that breach of duty?

6.2.1 Employer duty to employees

In the case of an employer, there is automatically a personal, non-delegable duty of care towards an employee. This duty has been long established and is:

Employer taking reasonable care. *…a duty on the employer to take reasonable care and to use reasonable skill, first, to provide and maintain proper machinery, plant, appliances, and works; secondly, to select properly skilled persons to manage and superintend the business; and thirdly, to provide a proper system of working.*[255]

For instance, if an employee were to be injured delivering community equipment because of a poor system of work – as in one case, a failure in training.[256]

[252] *Sloan v Rastrick High School Governors* [2014] EWCA Civ 1063, Court of Appeal.
[253] *R(A&B) v East Sussex County Council* [2003] EWHC 167 (Admin), High Court, para 129.
[254] LGSCO. *East Sussex County Council* (16 017 727), 2018.
[255] *Wilsons v Clyde Coal* [1938] A.C. 57, House of Lords, para 86,.
[256] For a comparable example: *Walsh v TNT UK Ltd* (2006) S.L.T. 1100, Outer House, Court of Session, Scotland.

Or, if manual handling injury were sustained through a failure to have in place information or training. For example, when no proportionate information about manual handling was given to a social worker who made home visits. These could foreseeably find the staff member confronted with emergency situations, including those involving a manual handling decision (in this case helping a 15 stone man back into bed).[257]

6.2.2 Duty to contractor's employees?

Less clear is if an organisation/employer (e.g. a local authority) were to use an independent contractor, and one of the contractor's employees were injured.

For example, if a contractor's employee were to be using community equipment belonging to the local authority and/or in following a manual handling plan. Would the local authority owe the same duty of care to the contractor's employees, as it would to its own employees? It is likely, broadly, to depend on the extent of the control it has in relation to the activity in question.[258]

A comparable example, albeit a prosecution under health and safety at work legislation, was as follows. It involved refuse collection, but the parallel potentially with contracted out care services, involving manual handling (with equipment use), is obvious:

Local authority liable for manual handling injury to employees of independent contractor. A local authority contracted out a manual handling related task. It knew that the contract for its refuse collection service was potentially underfunded; it did not check the safety credentials of the contractor; and it failed to monitor the contract conditions. Bad practices flourished, unsafe working was endemic and two serious accidents to employees of the contractor occurred. The Health and Safety Executive successfully prosecuted the local authority.[259]

6.2.3 Vicarious or direct liability

Local authorities, as employers, will in general be *vicariously liable* for actions or omissions carried out by employees in the course of their work. For example, actions or omissions in relation to equipment which result in injury to somebody else – perhaps a fellow employee, an agency care worker, service user or family member.

Local authorities could in principle also be *directly liable* in their own right for systemic failings. For instance, organisational failings around prescription, provision, maintenance of equipment etc. As opposed to the individual actions or omissions of an employee.

[257] *Colclough v Staffordshire County Council* [1994] CL 94/2283, County Court. And (1997) High Court, unreported, on damages: see Zindani, G. *Manual Handling: Law and Litigation*. London: CLT Professional Publishing, 1998, p.189.
[258] Bennett, D. *Munkman on Employer's Liability, 17th edition*. Edinburgh, LexisNexis, 2019, para 4.77ff.
[259] *Health and Safety Executive v Barnet London Borough Council* (1997), unreported.

A simple illustration of the distinction between vicarious liability and direct liability of an organisation came in the following manual handling case:

Vicarious and direct liability of organisation for injury to nurse. A nurse succeeded in her negligence case against her employer, who was held liable both directly and vicariously.

It was vicarious liability because the porters had failed to lift when they should have done so, the increased weight she had to bear resulting in an injury to the nurse's lower back. The health authority was vicariously liable for the lack of reasonable care applied by the porters.

There was also *direct liability* because there had been a wider failure at senior level to consider risks and alternatives to such lifting, a failure in the system of work.[260]

In the following negligence case, a care home settled (i.e. agreed compensation) out of court. This was after a resident died from a fall from a hoist. The actions of the carers would make the employer vicariously liable. The failure of the home to provide induction training and consider the competence of its carers would tend toward direct liability:

Liability for fall from hoist. A resident died after fracturing his pelvis, falling from a hoist in a care home. The carers had not correctly fastened up the leg straps on the hoist. The loops on the hoist were not attached to the tracking hoist correctly. None of this had been checked immediately prior to the hoisting. One of the two carers present (an agency-employed carer) had not read the relevant care plan, had not been given an induction and had not used this specific type of hoist before.[261]

6.2.4 Independent contractors

What is less clear is when a local authority might be liable in negligence for the faults of an independent contractor resulting in injury to a third party (e.g. service user). *Even if the authority has taken reasonable care in choosing and monitoring the contractor*.

For instance, a contractor providing an equipment storage, delivery and maintenance service. Or one carrying out assessments on behalf of the local authority or providing care services. And injury is then caused, through carelessness, to the service user.

The courts have suggested that such negligence liability could arise because in certain circumstances, there might be a "non-delegable" duty of care. For example, in the case of children or vulnerable adults (emphasis added):

Enduring duty of care duty owed by local authority for actions of independent contractor, even if care was taken in choosing that contractor. The Supreme Court held that a non-delegable duty could be owed in some circumstances towards third parties.

[260] *McGowan v Harrow Health Authority* [1991] C.L.Y. 1403, High Court.
[261] *Negligence of Nottingham care home causes death of husband & father.* Nelson's Solicitors, 12th March 2021. Accessed 22/2/24 at: https://www.nelsonslaw.co.uk/negligence-claim-gregory-court-care/.

In this case it would be towards children at school. The case involved an accident in a swimming pool, with the swimming lesson being given by an independent contractor but as part of the school curriculum. A pupil drowned.

The Supreme Court held that, even in the absence of carelessness on the part of the local authority in awarding the contract, the local authority would be liable for the actions of the independent contractor (the swimming instructor).

The Supreme Court stated also that the principle of such a non-delegable duty could apply if: *the claimant is a patient or a child, or for some other reason is especially vulnerable or dependent on the protection of the defendant against the risk of injury. Other examples are likely to be prisoners and residents in care homes.*[262]

The safe bet for a local authority, therefore, is simply not to take an out of sight, out of mind approach to contracting out services - including equipment-related assessment, provision and care.

6.2.5 Reasonable care: practitioners

Practitioners involved in equipment provision – whether making decisions, formulating care plans, delegating, instructing, guiding, advising, training, demonstrating etc. – should be aware that the test of whether they have taken reasonable care hinges on whether they have made a reasonably careful decision.

This does not mean they must show that they possessed the 'highest expert skill' in their field of work, but merely that they acted reasonably competently.[263]

Therefore, it is not necessary even to decide which of two professional practices was the better practice. So long as what the professional did was in accordance with a practice accepted by at least some responsible professionals. This should, in principle, be a reassurance to practitioners; the decision does not in any sense have to be "the best".

For instance, the evidence of two experts (e.g. occupational therapists), differing to that of one expert therapist, would not necessarily be preferred by the court 'merely on the basis that two outnumbered one'.[264] Nevertheless, the court would need still to satisfy itself that any expert view put forward on behalf of a professional could be justified on an objective, logical basis.[265]

In the following case, it was not enough that a physiotherapist was following established guidelines. Common sense, perhaps, suggested that those guidelines were inadequate. The court accepted an alternative view of what was reasonably required in the circumstances:

[262] *Woodland v Essex County Council* [2013] UKSC 66, paras 16, 23, 34, Supreme Court.
[263] *Bolam v Friern Hospital* [1957] 2 All ER 118, High Court.
[264] *Hewes v West Hertfordshire Acute Hospitals NHS Trust* [2020] EWCA Civ 1523, para 55, Court of Appeal.
[265] *Bolitho v Hackney Health Authority* [1998] A.C. 232, House of Lords.

Failing to give sufficient warning about electrical therapy equipment. The case involved electrical treatment and a physiotherapist. She was found negligent in terms of instruction given to a patient - despite doing what she had been taught, and despite expert supporting evidence given by the chief examiner of the Chartered Society of Physiotherapy.[266]

Such a case is a reminder for practitioners not to take undue refuge in guidelines, but to keep their wits about them, so to speak.

6.2.6 Reasonable care: organisations

As already noted, organisations could be held negligent in their own right – i.e. direct liability. For instance, in relation to systems of work, instructions, training, supervision, procedures applying to equipment.

6.2.6.1 Protection from liability

Nevertheless, in some circumstances, local authorities and the NHS will be protected up to a point from liability in negligence - for harm suffered by a service user (i.e. not an employee).

This sometimes happens if the circumstances relate to organisational issues such as policy, resources or the performance of statutory duties rather than straightforward carelessness.

Respiratory arrest: no good evidence to explain non-arrival of ambulance. An ambulance failed to arrive in a reasonable time of 40 minutes, given the urgency of the call. The ambulance had been allocated; it simply didn't show up. As a result, a woman suffered avoidable respiratory arrest from asthma, with serious consequences. The delay was not down to lack of resources and pressing demand on those resources. Instead, no explanation was forthcoming, and there was evidence of falsification of the relevant records. The London Ambulance Service was held liable. Had the delay been explicable through lack of resources, the outcome of the case might have been otherwise.[267]

Simple carelessness or incompetence will not attract protection. The Court of Appeal noted that if a person was handled and dropped by carers, there would be no issue of policy, priorities etc. It would be a simple operational matter.[268]

On the other hand, in the following case, it was alleged that a woman had suffered an injury because of delay in providing bed rails which she had been prescribed – and that the local authority should be liable. The judge disagreed:

Delay in supply of bed rails: no negligence because delay was related to statutory functions and resources. There was delay in providing prescribed bed rails for a woman. She allegedly suffered injury as a result. The delay was two months. The judge held that the local authority would not be liable for the woman's injuries, even if the injury had been caused by the absence of the bed rails (which anyway was doubtful).

[266] *Clarke v Adams* (1950) 94 SJ 552, High Court.
[267] *Kent v Griffiths* [2001] QB 36, Court of Appeal.
[268] *Wyatt v London Borough of Hillingdon* [1978] 76 LGR 727, Court of Appeal.

This was because relevant factors included whether the cot sides were held in stock, where they were held, what resources were available to deliver them, what other calls upon those resources there may have been, delivery times from different suppliers, weighing up of cheaper price against longer delivery time, etc.

These were issues related to statutory functions and resources; and, therefore, could not give rise to a duty of care and to liability in negligence.[269]

6.3 Care Quality Commission (CQC)

The Care Quality Commission operates under the Health and Social Care Act 2008. The role of CQC is to register, review and inspect/investigate health (and social) care providers. Overall, it seeks to ensure fundamental standards in health and social care.

Amongst other things, it has the power to issue statutory warning notices; impose, vary or remove registration conditions; issue financial penalty notices; suspend or cancel registration; prosecute specified offences; and issue simple cautions.

6.3.1 CQC and HSE

In recent years, a 'memorandum of understanding' has been in place between the Health and Safety Executive (HSE) and the Care Quality Commission.

This is to the effect that prosecution for health and safety incidents involving service users (who are of course non-employees) will normally be taken by the Care Quality Commission rather than by the Health and Safety Executive. However, prosecution in relation to injured employees remains the responsibility of the Health and Safety Executive.

CQC would prosecute under its own legislation (Health and Social Care Act 2008 and associated regulations). If, however, it exhausts its legal enforcement powers, it might look to the HSE for support. Presumably for the latter to use the health and safety at work legislation.[270]

Formerly, a Health and Safety Executive prosecution in respect of risk or injury to service users or patients would normally have lain primarily under s.3 of the Health and Safety at Work Act 1974.

[269] *Sandford v London Borough of Waltham Forest* [2008] EWHC 1106 (QB), High Court.
[270] *Memorandum of Understanding (MoU) between the Care Quality Commission (CQC) and the Health and Safety Executive (HSE)*, HSE, CQC, 2017.

6.3.2 Fundamental standards

Under the Health and Social Care Act (Regulated Activities) Regulations 2014, CQC seeks to ensure and enforce fundamental standards. Standards relevant to equipment and associated care – some more explicit than others - include the following:

- **Person-centred care**: the care and treatment of service users must (a) be appropriate, (b) meet their needs, and (c) reflect their preferences (r.9).
- **Dignity and respect**: service users must be treated with dignity and respect, including privacy and supporting autonomy, independence and involvement in the community (r.10).
- **Consent**: care and treatment of service users must only be provided with the consent of the relevant person, subject to mental capacity considerations and rules under the Mental Capacity Act 2005 (r.11)
- **Safe treatment**: care and treatment must be provided in a safe way (r.12).
- **Safeguarding**: service users must be safeguarded from abuse and improper treatment (r.13).
- **Nutrition and hydration**: people's nutritional and hydration needs must be met (r.14).
- **Premises and equipment**: premises and equipment used by the service provider must be: (a) clean (including relevant standards of hygiene), (b) secure, (c) suitable for the purpose for which they are being used, (d) properly used, (e) properly maintained, and (f) appropriately located for the purpose for which they are being used (r.15).
- **Record-keeping**: this should be accurate, complete and contemporaneous (r.17)
- **Staffing**: there must be a sufficient number of suitably qualified, competent, skilled and experienced staff (r.18).
- **Fit and proper test, staff**: staff should be of good character, have relevant qualifications (and competence, skills, experience), be able, by way of health, to perform the required tasks, have a criminal record certificate, etc. (r.19).[271]

6.3.3 CQC and local authorities

In 2023, CQC began to inspect local authorities in relation to their functions under the Care Act 2014. This of course is wider than just looking at risk assessment and safety – but nonetheless these could also be a consideration. The four main themes CQC intends to follow are:

- **People**. How local authorities work with people.
- **Support**. How local authorities provide support.

[271] *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*.

- **Safety**. How local authorities ensure safety within the system.
- **Leadership**.

Under these headings, there are further quality statements. Under safety, are the following which could clearly relate to equipment provision in some circumstances:

- **(Safe systems, pathways and transitions).** *We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services*.

  (Safeguarding). *We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately*.[272]

6.3.4 Prosecutions by CQC

In terms of CQC enforcement procedures and potential prosecutions, the relevant regulations repeat the word "must" when it comes to maintaining standards. However, there is a statutory defence of due diligence within the regulations.[273] Guidance states:

(Due diligence). *It is a statutory defence for the Registered Person to prove on the balance of probability that it took all reasonable steps and exercised all due diligence to ensure that the relevant prosecutable fundamental standard(/s) was met*.[274]

Examples of prosecutions by CQC, in cases involving equipment, include the following:

Single-handed care contrary to care plan: fall, fracture, hospital admission and death. An 86-year-old resident was supported by two members of staff as she took a bath using a bath chair.

At the end of the bath, she was handled by a single member of staff only. This was contrary to the care plan which specified a minimum of two handlers. Consequently, she slipped out of the bath chair, falling to the ground, hurting her knee.

The following day, she complained of pain. The GP suspected a fracture and advised urgent referral to hospital and an X-ray. The care home did not follow this advice, giving pain relief instead; nor did it explain to the family details of the accident and the severity of the fall.

[272] *Interim guidance on our approach to local authority assessments*, Care Quality Commission, February 2023.
[273] *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*, r.22.
[274] *Memorandum of Understanding, Care Quality Commission, National Police Chiefs' Council*, undated, para 8.

Five days later, realising she was in significant pain, the family took her to hospital. A fracture was diagnosed, necessitating an operation, during which she suffered a heart attack and died. The care home was found guilty and fined £12,000.[275]

Absence of bed rails, falling out of bed and death. A 98-year-old man fell out of bed. This led to his death, because of failure to put in place bed rail extensions to keep residents from falling. The fine imposed on the care home, following conviction, was £163,000.[276]

Falling out of shower chair. A 62-year-old man was strapped loosely into a shower chair and fell forward; he died. The care home was fined £190,000.[277]

6.4 Medicines and Healthcare Regulatory Agency

The Medicines and Healthcare Regulatory Agency (MHRA) is the designated authority that administers and enforces the law on medical devices in the UK. It has a range of investigatory and enforcement powers to ensure the safety and quality of devices. It is primarily, but not only, concerned with manufacturers.

The MHRA's overall aim is to ensure that medical devices put on the market and then put into service comply with regulatory requirements.

The MHRA can exercise various enforcement powers under the Consumer Protection Act 1987, Medical Devices Regulations 2002 and General Product Safety Regulations 2005. Which, in the main, apply to manufacturers but elements can apply to suppliers and distributors as well.

The MHRA, in relation to this legislation can, for example, issue prohibition notices, notices to warn, recall notices – and prosecute for failure to comply. MHRA issues in addition what it calls field safety notices, national patient safety alerts and device safety information.

6.4.1 Bed rails

To take an example of a National Patient Safety Alert (NPSA). In August 2023, MHRA drew attention to the risk posed by certain equipment, including bed rails and bed grab handles.

Deaths, serious injuries: bed rails etc. MHRA noted that for a year three-year period ending 31st December 2022 there had been: *18 reports of deaths related to medical beds, bed rails, trolleys, bariatric beds, lateral turning devices and bed grab handles, and 54 reports of serious injuries. The majority of these were due to entrapment or falls.*

[275] '*Liverpool care home fined over £12,000 for "failings" in care and treatment*.' Sarsby, S,AT Today, 25 March 2019: http://attoday.co.uk/liverpool-care-home-fined-over-12000-for-failings-in-care-and-treatment
[276] *CQC Prosecute Owner of York Care Home*, CQC, 2017.
[277] *Care Provider Prosecuted by CQC after Fatal Accident at Nursing Home*, CQC, 2016

Various action points were included, some of which would need to be put in train by 1st March 2004, but which would come to full fruition over time. Some allowed for the making of priorities: For instance:

- **Training**: develop staff training,
- **Systems**: review medical device management systems,
- **Patient review**: review people deemed as a priority (e.g. atypical anatomy),
- **Risk assessment**: implement system to update risk assessment where the equipment or the person's clinical condition has changed.

With these, a local authority would have some leeway as to exactly how, and how quickly, they were implemented. However, a further action point was seen as particularly demanding, namely by 1st March 2024 (6 months from issue of the alert) to:

(Urgent review of all bed rails and bed grab handles): *review all patients who are currently provided with bed rails or bed grab handles to ensure there is a documented up-to-date risk assessment. Complete risk assessments for patients where this has not already been done and for each patient who is provided with bed rails or bed grab handles.*[278]

For all these points, but particularly the last, local authorities (and NHS Trusts) would have to consider how to respond to such a demanding task. In terms of how they saw the degree of risk, the resources proportionately required, competing priorities.

This MHRA alert stipulated a short compliance time of 6 months, which some local authorities and NHS Trusts viewed as unreasonable. However, it should be borne in mind that evidence of the risks posed by bed rails – and bed grab handles - is nothing new. In 2020, MHRA had issued a document to this effect, including the importance of risk assessment.[279]

But such warnings go back a long time, pointing to the ever presence of risk, which should therefore have remained prominent within an organisation's priorities. For instance, to 2007 and a "safer practice notice" issued by the National Patient Safety Agency.[280] Which was to be used alongside an MHRA device bulletin from 2006.[281] Not to mention "sector information" issued by the Health and Safety Executive in 2012.[282]

[278] *Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls*, National Patient Safety Alert, MHRA 2023, action point 6.
[279] *Bed rails: management and safe use*. MHRA, 2020 (updated subsequently, August 2023).
[280] *Using bed rails safely and effectively: Safer Practice Notice 17*. National Patient Safety Agency, 2007.
[281] *Safe use of bed rails*, Device Bulletin, MHRA 2006.
[282] *Bed rail risk management, Sector Information Minute (SIM07/2012/06)*, Health and Safety Executive, 2012.

In another words, it is strongly arguable that even without this latest 2023 NPSA, local authorities and NHS Trusts should anyway have long since taken steps to manage the risks of bed rails and bed grab handles.

6.4.2 Liability and a safety alert

In terms of consequent liability, if things go wrong, an accident occurs, what implications are there with reference to compliance – or non-compliance with an MHRA safety alert?

Generally, questions of liability would depend on how reasonably and proportionately an organisation responded to any such alert, weighing up the degree of risk and allocation of resources to deal with it.

It is not clear how the MHRA could take direct action – under its governing legislation - if a National Patient Safety Alert were not complied with. It is an alert – not, it seems, a directly enforceable stipulation. Potential liability for non-compliance is likely to link to other legislation.

6.4.2.1 Non-compliance with alerts

On any view, flat non-compliance is likely to increase both the risk of harm and also therefore the risk of consequent liability under various, other legislation.

The NPSA of 2023, about bed rail etc., itself carries a red, bannered warning to this effect: *Failure to take the actions required under this National Patient Safety Alert may lead to CQC taking regulatory action*.[283]

Even then, any regulatory action taken by CQC would not simply be on the basis that the NPSA had not been complied with. It would have to be argued, presumably, on the basis that failure to respond to the NPSA in turn constituted a breach of the fundamental standards which CQC enforces, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

And that a local authority or NHS Trust had consequently failed to show due diligence in upholding those standards. A due diligence test would also have to take account of the greater difficulty of managing risk of equipment in people's own homes – than, for example, in a care home or a hospital.

But there are other possible routes of legal liability, beyond the Care Quality Commission. For instance, under the Health and Safety at Work Act 1974 (ss.2, 3), and or Provision and Use of Work Equipment Regulations 1998. Also, common law negligence cases (brought by injured service users, family or staff), adverse findings at coroners' inquests or ombudsman investigations.

[283] *Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls*, National Patient Safety Alert, MHRA 2023

HSE prosecution: bed rails. A hospital was prosecuted under the Health and Safety at Work Act 1974, s.3 (duty to non-employees). A patient who was deaf, blind and quadriplegic died after getting his head caught in bed rails.

The Trust had no systems in place on each ward for assessing the risk to patients from bed rails. The practice was poor for obtaining, recording and disseminating information about his needs. Staff did not formally share knowledge of individual patients. There was no system in place to alert staff to his needs or habits. Instead, staff were relied upon to remember him from previous visits or to retrieve records to read through his past medical notes.

The Trust was fined £50,000 and paid £40,000 costs.[284]

More recent such cases have been prosecuted by CQC:

Bariatric hospital beds and bed rails. An NHS Trust was prosecuted in relation to the entrapment and death of two patients, in bariatric hospital beds. With liability of £1 million being imposed.[285]

Care home, bed rails, procedures not followed, risk not managed. A care home was prosecuted when a man died having fallen twice, avoidably. CQC flagged concerns about bed rail use in the case of 10% of residents in the home. Including a failure to follow correct procedures and manage risk. The housing trust, owner of the care home, was fined over £160,000.[286]

Care home, trapped between bed and rails. A woman died in a care home. She was trapped between bed and bed rails. The rails were not being maintained; staff were not competent in their roles; relevant safety policies were not in place. The woman died of a heart attack, but the CQC prosecuted in relation to the bed rails and other safety failings. The care provider was fined £24,000 and ordered to pay £14,000 costs.[287]

A coroner may make adverse findings:

Coroner's report: bed rails. Following entrapment of her leg, the resident of a care home had her leg entrapped in bed rails, leading to amputation, followed by death (albeit without direct causation). Nonetheless, the coroner made a Regulation 28, *Report to Prevent Future Deaths*, noting that the care home did not do a risk assessment.[288]

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[284] *Basildon fined for death of disabled patient,* Nursing Times, 10th June 2010.
[285] *Shrewsbury and Telford NHS Trust admits failures after two patients die*, BBC News, 18th May 2022, accessed 26/02/24 at: https://www.bbc.co.uk/news/uk-england-shropshire-61492208.
[286] CQC prosecute owner of York care home, Care Quality Commission, 11th April 2017. Accessed 19/2/2024 at: https://www.cqc.org.uk/news/releases/cqc-prosecute-owner-york-care-home.
[287] *Hartlepool nursing home provider prosecuted by CQC for failing to provide safe care, Care Quality Commission*, 28th May 2019. Accessed 19/2/2024 at: https://www.cqc.org.uk/news/releases/hartlepool-nursing-home-provider-prosecuted-cqc-failing-provide-safe-care.
[288] *Regulation 28 report to prevent future deaths*: Assistant Coroner South Wales Central, inquest on 11th July 2019 (Care Inn Ltd, Crossfield House Ltd).

Negligence cases may lie, for compensation, in relation to bed rails, whether the fault lies in assessment, risk management or simply failure to use the rails as intended:

Negligence: unmonitored patient left to fall out of bed. A 91-year-old, registered blind, woman was admitted to hospital, agitated and confused having contracted an infection. She was left unmonitored in a bed, on which the side guard rails had not been raised and locked in place. She fell out of bed and suffered a fractured shoulder and facial injury. Consequently, she could not return home and had to be admitted to a care home and was now separated from her husband after sixty years of marriage. The hospital admitted liability and settled the claim out of court.[289]

Or indeed the local ombudsman may find fault, who in a 2017 case, referred to a previous NPSA practice notice about the importance of assessments for bed rails:

Care home failing to carry out bed rails assessment. A care home failed to consider whether to carry out a bed rail assessment for a resident. The care home's policy was unclear about the circumstances in which such assessment was required. It stated the reason it had not done was because when she returned from hospital it had noted that that she had not previously fallen out of bed. The ombudsman found that her history was of course relevant, but the risks had now obviously increased. This was due to her progressive dementia, increasing anxieties, her sleeping on an air mattress, and recent operation.[290]

6.5 Community equipment: safety

Safe use of equipment in the community has always been challenging. The primary reason for this is, of course, that a local authority has in principle far less control of equipment being used in people's homes – than, for example, the NHS has of equipment being used in a hospital setting, or a care provider has of equipment being used in a care home.

It is one thing to ensure that wheelchair tyres are inflated in a hospital, and for liability to follow if they are not and lead to injury.[291] Quite another to monitor and inflate tyres in the community.

There is far less control over how people use equipment in their own homes. Overall, given that a full proof system is likely to be unattainable, the next best thing is to ensure policy and procedures based on identifiable priorities and proportionality.

[289] Unmonitored vulnerable woman fell from hospital bed, Leigh Day, 5th September 2021. Accessed on 1/3/24 at: https://www.leighday.co.uk/news/news/2012-news/unmonitored-vulnerable-woman-fell-from-hospital-bed/.
[290] LGSCO, *Norfolk County Council* (16 014 997), November 2017.
[291] *Commons v Queen's Medical Centre Nottingham University Hospital NHS Trust* (2001), County Court, unreported. For a short summary, see Meikle, J. 'Nurse wins £345,000 for back pain.' *The Guardian*, 6 June 2001.

At a most basic level, on a theme of proportionality, priorities and pragmatism, there is clearly going to be – for example - less risk attached to a reaching stick being supplied without instructions, and with no review, than a hoist.

6.5.1 Making priorities

Clearly, even with a very well-resourced and applied review system, there is no guarantee that things won't go wrong. It is about trying to tip probabilities against an accident, not implementing a water-tight solution. Inevitably, with scarcity of resources, this is likely to mean the adoption of a system of priorities.

6.5.2 Balance of risk and resources

Traditionally, in some health and safety work legislation, and in the law of negligence, the courts have effectively referred to the importance of proportionality.

Put simply, this means the higher the risk, the greater the allocation of resources required by the organisation. In terms of what is reasonable in relation to alleged negligence, the following case illustrated this. The risk was foreseeable and substantial, demanding resource allocation:

Abandoning equipment maintenance system because of cash shortage: foreseeability of risk and liability. A faulty castor system caused a bed to tip and partially collapse, injuring a nurse.

The judge noted that a previous system for maintaining hospital furniture, beds and equipment had been abandoned because of cash limits and the pressure on hospital beds. (This system had involved the wards being closed once a year, during which time the beds would be sent away for a general overhaul).

The system now was that if something went wrong with furniture or equipment, the engineers would be called, but this would of course be on a reactive basis only. The district engineer was unhappy with this, foreseeing that if checks were not made periodically then patients could be seriously hurt, since he knew that wheels did come off beds about twice a year. The judge held the health authority liable.[292]

On the other hand, the lower the risk, the less resource allocation is needed. Even so, if the low risk could be managed reasonably cost-effectively, there might still be liability if this is not done and injury results:

Pushing forks of a hoist under a bath; not a great risk but proportionate response should have been made. A nurse was injured attempting to steer the forks of a hoist underneath a bath.
The court held that there was a foreseeable risk of injury in this task, although not necessarily a great risk. The employer should therefore have done something about it: but what?

[292] *Denton v South West Thames Regional Health Authority* (1980), High Court, unreported.

The degree of risk did not justify obtaining a new hoist dedicated to this particular bath. However, shifting the plinths under the bath, so that they were visible, would have been a proportionate response to the risk. Likewise, marking the floor, indicating where the hoist should be lined up. The NHS Trust had done neither of these things but the cost of doing so would have been modest; therefore, breach of the MHOR was made out.[293]

6.5.3 Issuing community equipment

Safety of community equipment relates to both assessment and review of the person's needs, as well as ensuring the hardware itself is safe at the outset and continues to be so. For instance:

- **Competent assessment** of need in the first place.
- **Source**: has the equipment been sourced from a reputable supplier?
- **CE marking**: does it have appropriate CE marking on it?
- **Storage**: has it been stored in suitable conditions in the equipment store; possible damage or deterioration issues?
- **Checked on issue**: is it checked again immediately before issue?
- **Transport**: is it transported safely to the service user.
- **Delivery**: is it delivered safely into a person's home?

  Instructions: are instructions included, are they legible, can they be understood? if necessary, have the manufacturer's instructions been supplemented,
- **Additional instructions?** Are additional instructions included for the particular needs of the service user?
- **Installation** requirements.
- **Demonstration**: has the equipment been demonstrated where needed?
- **Decontamination** between loans etc.
- **Review systems**: both the hardware and the person's use of the equipment.

[293] *Egan v Central Manchester and Manchester Children's University Hospitals NHS Trust* [2008] EWCA Civ 1424, Court of Appeal.

- **Collecting equipment**: system for when no longer needed.[294]

In the following coroner case, the equipment was itself sound but the failure to demonstrate could, in principle at least, have contributed to the person's death.

Failure to demonstrate a triangular walker delivered to a person's home before fall and death. A 79-year-old woman was recommended a walking aid by the local authority. It was an "A Frame"; a triangular walking aid which needed to be folded out and fixed with a bolt.

The occupational therapy assessment took place on 14th February. It was delivered on 28th February. She first used it on 23rd March, when she fell in the kitchen. She used her pendant alarm and was taken to hospital. She had suffered a stroke. She developed pneumonia and died on 27th March. Her words had been, following the fall, that "the frame went and I followed it".

The coroner concluded she died of natural causes. However, the coroner also wrote to the director of social services. This was to the effect that it was not sufficient that such equipment, carrying with it obvious risk if used incorrectly, should simply be dropped off by a driver/handyman. It needed first to be properly demonstrated, so it could be checked whether the person understood how to use it and could actually do so safely.[295]

6.5.3.1 Risks and benefits

Provision of equipment - or non-provision of equipment in favour of an alternative such as rehabilitation or assistive walking for maintaining function - is not always about eliminating risk. Either because it is not possible to do so, or it is undesirable.

A balancing of risks and benefits for the person may conclude that there are risks – but that they are justified. If so, to demonstrate appropriate decision-making involving risk, clear recording and reasoning are required. The following case involved a staff member, but could equally well have involved the patient/service user:

Occupational therapy assistant injured: care plan not updated; balance of risk upset. An NHS Trust was held liable for an injury to an occupational therapy assistant. One of the reasons was that a physiotherapist had not updated a patient's care plan, even though the patient's condition had changed. This meant she now posed a greater risk than previously, when being assistively handled. So, the balance between risks and benefits to the patient of assistive handling - notwithstanding the importance of rehabilitation/maintenance of the patient's functioning - had been lost.[296]

[294] See generally: *Managing medical devices: guidance for health and social care organisations*. Medicines and Healthcare Regulatory Agency, 2021.
[295] HM Coroner for the Birmingham and Solihull Districts. *Letter to Director of Social Services, Warwickshire County Council*, 18th December 1995.
[296] *Stainton v Chorley and South Ribble NHS Trust* (1998), High Court, unreported.

6.5.4 Equipment review

As with initial provision, the two main aspects of review are about the safety of the hardware, but also about the ability of the person to continue to use the equipment safely (even if there is nothing wrong with the hardware itself). A person's needs and abilities may change over time and render the use of the equipment, that was safe 12 months ago, no longer so.

A local authority could consider a range of factors to determine a system of priorities proportionate and lawful review of equipment – both the hardware, and a person's abilities and need to use it.

6.5.4.1 Welfare duty: review

One legal aspect of review is in terms of health and safety legislation (immediately below). Another is welfare legislation. For instance, s.27 of the Care Act states that care and support plans must be kept generally under review. It does not state how frequent reviews should be.

Guidance suggests a minimum of 12-monthly reviews, with a light touch review 6-8 weeks after implementation of the care and support plan. However, if needs or circumstances change unexpectedly, an unplanned review may be needed sooner than scheduled.[297]

Also, s.27 states also that a review must take place whenever it is reasonably requested by an adult in need or informal carer.

6.5.4.2 Priorities: LOLER, PUWER

As already noted above, where equipment is being used at work, there are specific duties under LOLER (e.g. examination scheme, by default six-monthly) and a strict duty under PUWER to keep work equipment maintained in an efficient state, in efficient working order and in good repair. And to ensure that it is used suitably and safely.

Even where the equipment is provided by the local authority but is not being used by employees – only by service users and family - a comparable duty would still lie under s.3 of the Health and Safety at Work Act 1974 (see above).

6.5.4.3 Priorities: sector information

A local authority should remain up to date with relevant information about risk being provided in the sector.

For instance, as discussed above, the Medicines and Healthcare Regulatory Agency (MHRA) issued a National Patient Safety Alert (NPSA) in 2023. About the risks posed by bed rails and

[297] *Care and Support Statutory Guidance*, paras 10.42, 13.13.

bed handles. Both in terms of the hardware, but also people's continuing ability to use them – and whether there were up-to-date risk assessments.[298]

Similarly, some years ago, the MHRA issued an alert about patient hoists and slings – involving compatibility of slings and hoists, laundering of slings, and maintenance of hoists generally. This stated that manufacturer's instructions should be followed, hoists and slings be visually inspected before use, slings be laundered according to manufacturer instructions – and hoists and slings be inspected under LOLER.[299]

Clearly, taking these two examples, a local system of priorities and resource allocation needs to take account of such communications.

6.5.4.4 Priorities: individual risks

A local authority will hold information about individual service users and their situations. Some with a higher degree of risk due to the equipment itself, how it needs to be used – or due to changing or unstable needs or circumstances of the person. Others' needs and situations will be relatively stable, in lower risk and the person and/or family well able to communicate for themselves if issues arise.

For instance, the NPSA from August 2023 - about various equipment including bed rails, bed grab handles etc. - notes in its action point 7, the making of priorities where there are changes in the person's condition:

Changing condition of person. The Alert states*: Implement systems to update risk assessments where the equipment or the patient's clinical condition has changed (for example, reduction/improvement in weight or mobility), and also at regular intervals.*[300]

[298] *Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls*, National Patient Safety Alert, MHRA 2023.
[299] *Patient hoists and slings*, MHRA, 2014.
[300] *Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls*, National Patient Safety Alert, MHRA 2023.

7 HOME ADAPTATIONS

There are effectively three main legal ports of call for home adaptations. And, in some circumstances, a fourth comes into play.

- **Disabled facilities grants**: first, the Housing, Grants, Construction and Regeneration Act 1996 creates a clear and strong duty to approve disabled facilities grants (DFGs) if certain conditions are met. The responsibility is placed on local housing authorities which may or may not be part of the same local authority as social services and education. The Act applies to both adults and children.

- **Regulatory Reform Order (RRO) assistance**: second, still within housing legislation, the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 gives local housing authorities wide powers to assist with housing locally, including with home adaptations for disabled people.

  Social care: third is social care. Should a person's needs not be met through housing legislation, then the fall back, as it were, is to the social care legislation. Use of this legislation would be based on assessed, eligible need. And on assistance with the adaptation(s) being a cost-effective way of meeting the need. For adults this is the Care Act 2014, for children the Chronically Sick and Disabled Persons Act 1970 (CSDPA) and Children Act.[301]

  Guidance makes clear that such social care assistance should be considered where a need is established and a) a top up to DFG is required; b) the DFG applicant would have difficult paying their assessed financial contribution to DFG; or c) an adaptation is needed falling outside of DFG.[302]

- **NHS continuing healthcare**: fourth, if a person has NHS continuing healthcare needs, then statutory guidance for adults is clear that if the adaptations needs are not met through housing legislation, then the NHS (integrated care board) should consider assisting with the adaptation. If, this is a cost-effective way of meeting the person's continuing healthcare needs.

Sometimes the cost of an adaptation may be high, and careful consideration given to the options just described.

Before refusing to meet an adult or child's needs for a high-cost adaptation, a court or ombudsman may wish to scrutinise whether and how the local authority has in fact considered all this different legislation properly before taking its decision - rather than just dismissing the adaptation out of hand on ground of cost.[303]

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[301] *Disabled facilities grant (DFG) delivery: guidance, 2022,* paras 2.24-2.26. See also: *Care and Support Statutory Guidance*, para 15.52.
[302] *Disabled facilities grant (DFG) delivery: guidance, 2022,* paras 2.24–2.26.
[303] LGSCO, *City of Bradford Metropolitan District Council* (22 008 066), April 2023

Note. In this chapter, frequent reference is made to guidance: *Disabled facilities grant (DFG) delivery: guidance, 2022*. This is shorthand for: *Disabled facilities grant (DFG) delivery: guidance in for local authorities in England. Department for Levelling Up, Housing and Communities; Department of Health and Social Care*, March 2022.

References to the LGSCO are to the Local Government and Social Care Ombudsman.

7.1 Housing Grants Act 1996

Under the Housing Grants, Construction and Regeneration Act 1996 (HGCRA), several key conditions must be met, for a person to be entitled to a disabled facilities grant (DFG).

The courts have emphasised that the decision must consider each of these conditions, sequentially; and that to muddle them up, or run together two conditions that must be considered separately, can lead to unlawful decisions.

For example, first check whether the works being applied for come under one of the listed purposes in s.23 of the HGCRA. And only then go on to consider whether the works are necessary and appropriate under s.24 of the Act.[304]

7.1.1 Disabled occupant

Section 100 states that a person is disabled if (a) their sight, hearing or speech is substantially impaired, (b) they have a mental disorder or impairment of any kind, or (c) they are physically substantially disabled by illness, injury, impairment present since birth, or otherwise.

7.1.2 Intention to stay in dwelling

Under s.22 of the Act, there must be a tenant's or an occupier's certificate, certifying that the disabled occupant intends to live in the dwelling or flat as their only or main residence throughout the grant condition period. Or for a shorter period as permitted by their health and other relevant circumstances. The grant condition period is five years in the case of a tenant, and ten for an owner occupier.

It should therefore be noted that the intention to remain for the entire grant condition period is not an absolute condition; it could be a shorter period.

7.1.3 Purpose of works

The works being applied for must fall within at least one of the purposes listed in s.23 of the HGCRA. These are (emphasis added):

[304] *R(B) v Calderdale Metropolitan Borough Council* [2004] EWCA Civ 134, Court of Appeal.

- **Access**: to facilitate access by the disabled occupant to and from the dwelling, qualifying houseboat or caravan, or (ii) the building in which the dwelling or, as the case may be, flat is situated.

- **Safety**: making (i) the dwelling, qualifying houseboat or caravan, or (ii) the building, safe for the disabled occupant and other persons residing with him.

- **Family room**: facilitating access by the disabled occupant to a room used or usable as the principal family room.

- **Sleeping room**: facilitating access by the disabled occupant to, or providing for the disabled occupant, a room used or usable for sleeping.

- **Lavatory:** facilitating access by the disabled occupant to, or providing for the disabled occupant, a room in which there is a lavatory, or facilitating the use by the disabled occupant of such a facility.

- **Bath or shower or both**: facilitating access by the disabled occupant to, or providing for the disabled occupant, a room in which there is a bath or shower (or both), or facilitating the use by the disabled occupant of such a facility.

- **Wash-hand basin**: facilitating access by the disabled occupant to, or providing for the disabled occupant, a room in which there is a wash-hand basin, or facilitating the use by the disabled occupant of such a facility.

- **Cooking**: facilitating the preparation and cooking of food by the disabled occupant.

- **Heating system**: improving any heating system in the dwelling qualifying houseboat or to meet the needs of the disabled occupant or, if there is no existing heating system thereor any such system is unsuitable for use by the disabled occupant, providing a heating system suitable to meet his needs;

- **Using power, light, heat:** facilitating the use by the disabled occupant of a source of power, light or heat by altering the position of one or more means of access to or control of that source or by providing additional means of control;

- **Caring for a person:** facilitating access and movement by the disabled occupant around the dwelling, qualifying houseboat or caravan in order to enable him to care for a person who is normally resident there and is in need of such care;

- **Gardens**. such other purposes as may be specified by order of the Secretary of State. Gardens have been specified: making access to a garden safe for a disabled occupant, and also facilitating access to and from a garden by a disabled occupant.[305]

[305] *Disabled Facilities Grants (Maximum Amounts and Additional Purposes) (England) Order 2008.*

7.1.4 Necessary and appropriate

The local (housing) authority must be satisfied, under s.24 of the Act, that the proposed works are necessary and appropriate to meet the needs of the disabled occupant. Before being satisfied, it must consult social services. The final decision rests with the housing authority but the consultation must take place first, with social services (usually, but not necessarily, occupational therapists) making recommendations.

The needs of the disabled occupant, referred to in s.24, are the needs relating to one of the purposes for which DFG can be granted (see immediately above). For example, accessing and exiting the dwelling – in one particular case about involving an application for an external platform lift. The needs referred to are not general and broader in nature, for example wider needs that might be identified under the Care Act. In other words, necessity and appropriateness is about:

the works which are the subject of the application for the grant, and which are contended to be within one of the purposes specified in section 23.

This is an important distinction. A Care Act assessment might reveal shortcomings in other parts of the dwelling which, nevertheless, the person might choose to live with. The Care Act assessment should not undermine the application for a DFG for the external platform lift, in this example. Care had to be taken not to import, into the HGCRA, statutory schemes from other legislation.[306]

7.1.4.1 Suitability, all or nothing?

The test is therefore not about the overall suitability of the dwelling, following the adaptation, but about the necessity and appropriateness of the particular adaptation works applied for:

In all cases the assessment of whether relevant works are necessary and appropriate must be made against each applicable purpose individually. So, for example, if it is not possible to appropriately provide access to a room suitable for sleeping, that should not in itself prevent a grant being awarded to gain access to the home.[307]

Put another way, a DFG application does not necessarily have to be all or nothing. if a person wanted to get by in their kitchen and bathroom as they were, albeit with some difficulty, that was up to them; they could apply for an external platform lift without having to apply for works to the kitchen and bathroom as well.[308]

7.1.4.1 Trusted assessors

The implication of the duty to consult is that social services recommendations would be competently made. The legislation does however not state that an occupational therapist

[306] *R(McKeown) v London Borough of Islington* [2020] EWHC 779 (Admin), paras 14, 23, 29, 53, High Court.
[307] *Disabled facilities grant (DFG) delivery: guidance*, 2022, para B66.
[308] *R(McKeown) v London Borough of Islington* [2020] EWHC 779 (Admin), High Court, para 24.

must necessarily be involved. Guidance refers, for instance, to the use of trusted assessors in simple or simpler cases.[309]

Adaptations recommendation based on inadequate expertise. The ombudsman found fault when a recommendation for a downstairs/extension adaptation was made. The recommendation had been made without the use of qualified staff; social services subsequently disowned the recommendation. The ombudsman concluded that the local authority had not assessed the woman's needs properly, given her significant needs.[310]

7.1.5 Reasonable and practicable

In addition, also under s.24, the housing authority must decide if the works are reasonable and practicable. The age and condition of the dwelling are the only relevant factors underpinning this decision.

7.1.6 Timescales

Under s.34 of the HGCRA, a decision must be made as soon as reasonably practicable and, in any event, within six months of a completed application. And payment must be made, under s.36, within 12 months of the original date of application.[311]

Guidance sets out further detail with a view to a system of priorities and total days needed for completion of the works: urgent and simple (55 days), non-urgent and simple (130), urgent and complex (130), non-urgent and complex (180).[312]

The guidance does not constitute law, nor is it even statutory guidance, but nonetheless the Local Government and Social Care Ombudsman refers to it regularly.[313] In judging whether the legislation and guidance have been followed, the ombudsman might typically take account both of local authority's the clarity and effectiveness of its approach to the urgent/non-urgent distinction. And also break down the elements of delay for each stage of the adaptations process and consider whether they were justifiable.[314]

7.1.7 Financial means-testing

If a grant is approved, a statutory means-test, under s.30 of the Act, is applied to adults, but not to children. This may mean that a person must contribute toward some or, in some circumstances all, of the cost.

[309] *Disabled facilities grant (DFG) delivery: guidance*, 2022, para 4.35.
[310] Local Government Ombudsman*, Dyfed County Council* (95/0227) 1996.
[311] *HGCRA 1996*, ss.34, 36; *Disabled facilities grant (DFG) delivery: guidance*, 2022, para B115.
[312] *Disabled facilities grant (DFG) delivery: guidance*, 2022, para 4.16.
[313] E.g. LGSCO, *City of Bradford Metropolitan District Council* (19 017 147), February 2021.
[314] E.g. LGSCO, *London Borough of Hillingdon* (20 001 187), April 2021, paras 31-37.

Even if it is clear that a person will be assessed to contribute fully and so receive "nil grant", the person should still be encouraged to proceed with the application. This is because if, within the grant condition period (five years for tenants, ten for owners), the person applies for another DFG, the financial implications of contributing to the first DFG will be taken into account.[315]

7.1.7.1 Placing charge on property

In addition to the means-test, local housing authorities have a power to place a land charge if the DFG applicant owns the property. The charge can require repayment by the recipient of any amount of the grant in excess of £5000. The overall amount of the charge cannot exceed £10,000. Repayment can be demanded if the recipient disposes of the property.

The local authority must be satisfied it is reasonable to demand repayment, having considered:

- the extent to which the recipient of the grant would suffer financial hardship were he to be required to repay all or any of the grant.
- whether the disposal is to do with employment.
- whether the disposal is connected to physical, mental health, well-being of the grant recipient or of a disabled occupant of the dwelling.
- whether the disposal is to enable the recipient to move to live with or near a disabled or infirm person in need of care, with a view to caring for that person.[316]

7.1.8 Maximum grant payable

The maximum amount of DFG that can be awarded in England is £30,000. This maximum is reached before a person's contribution is calculated, not after; so, any contribution is deducted from this maximum amount.[317]

7.1.9 Tenure: council tenants

DFGs are available to people in all housing tenures, including private sector, housing association tenants and council tenants. Guidance reiterates the effect of the legislation:

(All housing tenures). *Disabled Facilities Grants are capital grants that are available to people of all ages and in all housing tenures (i.e. whether renting privately, from a social landlord or council, or owner-occupiers) to contribute to the cost of adaptations.*[318]

[315] *Disabled facilities grant (DFG) delivery: guidance*, 2022, para B112.
[316] *Housing Grants, Construction and Regeneration Act 1996: Disabled Facilities Grant (Conditions relating to approval or payment of Grant) General Consent 2008*.
[317] *Disabled facilities grant (DFG) delivery: guidance*, 2022, para B111.
[318] *Disabled facilities grant (DFG) delivery: guidance*, 2022, para 1.2.

The guidance further explains (emphasis added):

(Council tenants can apply the same as anybody else). *Government funding for the Disabled Facilities Grant is intended to fund adaptations for owner occupiers, private tenants, or tenants of private registered providers (housing associations). Eligible council tenants can apply for a DFG in the same way as any other applicant. However local housing authorities with a Housing Revenue Account (HRA) should self-fund home adaptations for council tenants through this account.*[319]

Some housing authorities misunderstand this legal rule, confusing funding source with legal duty:

Applying the law wrongly and misleading a family in council housing. A housing authority told a family, seeking adaptations for a child, that it was unfortunate they had misunderstood the DFG legislation which, it stated, did not apply to council tenants.

In fact, the position was the exact opposite. The social services OTs involved in the case challenged the housing authority, the family complained, and the ombudsman found fault with the housing authority.[320]

It is not just a question of a local authority allowing a council tenant to apply for a DFG, but also of applying the rules equitably:

Equitable treatment of council tenants when applying for a DFG. A woman applied for an external platform lift for her council dwelling. The local authority refused the application. The judge noted that an: *application for the DFG for a council tenant must be considered on the same basis as an application from an owner occupier and that what is being considered is the need to access the dwelling which the applicant occupies as his/her home, in my judgment it is not lawful to refuse a DFG on the ground that the Claimant must move her home*.[321]

The judge made an important point in this case that, had the person not been a council tenant, the local authority could not have refused the application and told her she must move. So, likewise, it should not have done so for a council tenant.

Telling council tenants to move. The judge stated: *Had the Claimant exercised her right to buy, it would not in my judgment be open to the Defendant to refuse the grant on the basis that she must sell up and move elsewhere. The structure of the Act, the legislative history and its purpose which relates, according to section 23, to "the dwelling", i.e. the person's home for the time being, exclude such an approach*.[322]

In practice, therefore, there seems to be striking variation. Some housing authorities routinely accepting DFG applications from council tenants, others apparently refusing and issuing misleading information in pursuit of misguided policies. The following, from a 2023

[319] *Disabled facilities grant (DFG) delivery: guidance*, 2022, para 2.8.
[320] LGSCO, *Runnymede Borough Council* (22 007 178), February 2023.
[321] *R(McKeown) v London Borough of Islington* [2020] EWHC 779 (Admin), para 49, High Court.
[322] *R(McKeown) v London Borough of Islington* [2020] EWHC 779 (Admin), para 19, High Court.

ombudsman case, sums it up and may be useful to occupational therapists when in dialogue with housing officers:

Barring council tenants from apply for DFGs. The ombudsman stated: *However, Mr X repeatedly asked whether the Council would consider extending his property. Mr X was entitled to apply for a DFG and the Council failed to suggest or refer Mr X to its DFG process. It has failed to consider his request for adaptations in line with the criteria for a DFG: is it necessary, appropriate, reasonable and practicable*. This was fault. The ombudsman went on:

In response to our enquiries the Council told us a council tenant cannot apply for DFG. This is incorrect. As set out in the Government Guidance, council tenants can apply for a DFG in the same way as any other applicant. If the statutory test is met for a DFG, the only difference is in the way this is funded; through the Council's own housing revenue account rather than through Government DFG grant funding.

Council tenants should not be treated less favourably than other applicants for a DFG purely on the basis of funding arrangements.[323]

7.1.10 Identifying right local authority

The responsible local housing authority for a DFG is the local authority in whose area the dwelling is situated.[324] For instance, if Council A places a child in foster care in Council B, it would be Council B responsible for any DFG decisions if adaptations were required. Similarly, a shared lives placement in the case of an adult.

7.1.11 Relevance of resources

When a decision is made about whether works are necessary and appropriate, the courts have held that resources should not be considered. It is a "technical question", a matter of professional judgement.[325]

As far as whether the works are reasonable and practicable, the only permissible consideration – this is explicit in s.24 of the Act - is the age and condition of the dwelling.

For instance, the general state of the budget would not be a ground for refusal, since it would have nothing to do with the state of the dwelling. However, financial resources could be relevant if, for example, the building were old and dilapidated and required excessive expenditure to make the adaptation possible.[326]

[323] LGSCO, *London Borough of Hounslow* (21 018 113), December 2022
[324] *Housing Grants, Construction and Regeneration Act 1996*, s.101. Which cross refers to s.2 of the *Housing Act 1985* to establish the responsible housing authority.
[325] *R v Birmingham City Council, ex p Taj Mohammed* [1998] 1 CCLR 441, High Court.
[326] *R v Birmingham City Council, ex p Taj Mohammed* [1998] 1 CCLR 441, High Court.

7.1.12 Private occupational therapists

The duty in the HGCRA is for housing to consult with social services before deciding whether the works are necessary and appropriate.

Sometimes people pay for their own occupational therapist to do an assessment and make a recommendation. If so, should the housing authority then bypass social services? The answer would appear to be no, since the duty to consult social services remains, as guidance confirms:

some applicants will be assessed by a private occupational therapist. A district council must still consult the social services authority in these cases.[327]

7.1.13 Long-term future needs

The courts have stated that looking into the *long-term* future, when deciding on whether works are necessary and appropriate, is not a relevant consideration. Particularly because the Act does not specify that present *and* future needs be taken account of.[328]

7.1.14 Age and condition of dwelling

As already noted above, the decision whether the works are reasonable and practicable can only take account of the age and condition of the dwelling.

Local authorities sometimes apply the term, reasonable and practicable, too casually and thus create legal problems. For example, stating that the works are not reasonable and practicable because the dwelling would not be suitable for a person's needs makes no legal sense. As the courts have pointed out, a person's needs are nothing to with the age and condition of the dwelling.[329] Similarly:

Reasonable and practicable: age and condition of the dwelling. A local authority seemed to argue that it was not reasonable and practicable to approve the works in question, because it had a policy of not funding "backup" adaptations if the primary adaptation fails (in this case the through-floor lift, the proposed backup being a stairlift). The judge held that this policy had nothing to do with the age and condition of the dwelling and was unlawful.[330]

7.1.15 Likely length of use

The fact that a person may not be able to remain in the dwelling – or to use the adaptation - for five years, for example, does not necessarily mean they will not be eligible for a DFG. It

[327] *Disabled facilities grant (DFG) delivery: guidance*, 2022, para 4.12.
[328] *R(McKeown) v London Borough of Islington* [2020] EWHC 779 (Admin), High Court, para 33.
[329] *R(McKeown) v London Borough of Islington* [2020] EWHC 779 (Admin), High Court, paras 34, 36,.
[330] *R(Gulrez) v London Borough of Redbridge* [2022] EWHC 2908 (Admin), High Court para 69.

may be that they are dying, that they deteriorate or have to move for other relevant reasons. The guidance explains:

(Deteriorating condition, less than five years' usage of the adaptation). *The grant condition period is usually 5 years. However, the intention required by an owner/ tenant/ occupier is for the disabled person to live in the dwelling as their only or main residence for that period or for "such shorter period as his health and other relevant circumstances permit … So, prognosis of a deteriorating condition or possible imminent death of the disabled person should not be a reason for withholding or delaying grant approval.*[331]

Guidance goes on to state:

Where the disabled person has a limited life expectancy then it may be appropriate to consider funding adaptations that can be more easily removed when they are no longer required if that is considered the right approach in the circumstances.[332]

7.1.16 Equipment or adaptations?

Adaptations under the HGCRA are referred to as "works", a word which is clearly not suggestive of free-standing items of equipment. Nonetheless, there is inevitably overlap. Guidance notes that joint working is required:

"where authorities agree to fund hoists through the DFG it would not be appropriate to order a sling separately unless the delivery and installation of both can be suitably arranged. The disabled person and their carers or family should experience a joined-up service".[333]

Nonetheless, because the works must amount to capital expenditure, guidance gives pointers as to what can or can't be included within a DFG. For instance, slings for hoists and shower seats could be part of the original DFG but could not be a freestanding provision (e.g. a replacement sling).[334]

7.1.17 Blanket policies

Blanket policies are legally ill advised (see section 1 of these Guidelines). This is because they tend to restrict the meaning of legislation, risk unlawfully fettering the discretion of the local authority – and stymy the ability of practitioners to recommend and deliver cost-effective, person-centred solutions. Examples of restrictive policies include never doing:

- garage conversions[335],
- topping up DFGs[336],

[331] *Disabled facilities grant (DFG) delivery: guidance,* 2022, para B34.
[332] *Disabled facilities grant (DFG) delivery: guidance*, 2022, para B67.
[333] *Disabled facilities grant (DFG) delivery: guidance*, 2022, para 2.31.
[334] *Disabled facilities grant (DFG) delivery: guidance*, 2022, Appendix A.
[335] LGSCO, *London Borough of Ealing* (20 011 145), November 2021
[336] Local Government Ombudsman, *Walsall Metropolitan Borough Council* (07/B/07346), 2008.

- ramps for privately purchased scooters,[337]
- hardstanding/shelter for privately purchased wheelchairs[338],
- windows.[339]

The following case involved a blanket policy on sensory rooms:

Wrongly excluding sensory rooms categorically. An occupational therapist stated that sensory rooms could not be provided by way of DFG. This appeared to be a restrictive statement/policy. Because although sensory rooms are not listed under s.23 of the HGCRA, they may – in some circumstances - perform the function of significantly improving safety in the dwelling for the disabled occupant and others living there. The ombudsman pointed out, therefore, that the statement represented inaccurate advice.[340]

This example illustrates well, how occupational therapists may need to be creative and think how the works required can legitimately be shown to come under the wording/purposes in the HGCRA.

7.1.18 Two disabled occupants

If there are two disabled occupants of the same dwelling, there is no reason why more than one DFG cannot be applied for. Guidance states:

Where more than one disabled person lives at the same address, the housing authority can consider multiple applications based on their individual needs. However, the authority would be best advised to use its wide discretionary powers to ensure integration of the necessary works, having regard to the impacts on the disabled persons.[341]

The guidance seems to be suggesting that if applying for two DFGs might pose problems, the local authority anyway has discretionary (RRO) powers which it can use to ensure the required adaptations are provided.

7.1.19 Behaviour

People with behaviours that challenge may need adaptations for a variety of reasons; very commonly the reason is to keep them safe.

First, the definition of disabled occupant clearly includes mental disorder.

Second, the safety purpose in the HGCRA is widely drawn and includes not just the safety of the disabled occupant but also that of other people living there.

[337] LGSCO, *Luton Borough Council* (16 008 034), 2017.
[338] Local Government Ombudsman, *Sheffield City Council* (93/C/1609), 1995.
[339] LGSCO, *London Borough of Havering* (22 010 192) March 2023.
[340] LGSCO, *Royal Borough of Windsor and Maidenhead Council* (22 007 357), September 2023.
[341] *Disabled facilities grant (DFG) delivery: guidance*, 2022, para B11.

Third, there should in consequence not be blanket policies denying DFGs to people with challenging behaviour.

Loft conversion for extra bedroom. An application was made for a loft conversion to keep separate, two brothers on safety grounds by creating an additional bedroom. The Court of Appeal made clear that this was a legitimate subject of a DFG application. The older brother, with Aspergers Syndrome, would attack his younger brother during the night. Approval would still depend of course on the works being judged to be necessary and appropriate.[342]

Were there other realistic, reasonable and imminent ways of meeting such needs, it may be that the local authority might judge the adaptation to be not necessary and appropriate. For instance, considering information and options from a nursing team, an NHS OT who had provided dyspraxia treatment and the child and family health team.[343]

Equally, a local authority should take care not to put greater obstacles in the way of children with challenging behaviour than those with physical disabilities. If it does, issues could arise under the Equality Act 2010.

Procedures for DFG applications for children with sensory and/or challenging behaviours. One local authority, for DFG applications for children with sensory/behaviour, stated that: *Referrals for children with sensory needs and/or challenging behaviour requesting a safe space or similar provision need to demonstrate active intervention from relevant services with evidence of sensory/behavioural strategies implemented alongside supporting letter from professionals involved advocating the need for provision*.

The local authority argued that a parallel approach was taken for physical disability: evidence of the child's engagement with physiotherapy and of having reached their maximum physical potential.

The mother of the child in question pointed out the family had already been involved with various professionals to manage behaviour – and that the waiting list to be seen by the children and adolescent mental health services (CAMHS) was so long that it was not fair to redirect people in need.

The ombudsman concluded that: *The Council's policy does appear to treat people differently. It is only those with sensory needs/challenging behaviour/mental impairment that must have a letter of support …*

The Council requests a supporting letter from professionals to then assess the DFG application. This adds an extra stage to the process and makes it more difficult for those with mental impairment to access support, therefore creating an obstacle to the process, which might be unnecessary …

The Council accepts the wording of the policy is open to misrepresentation and it needs to review it, which it will do with the involvement of its legal team.[344]

[342] *R(B) v Calderdale Metropolitan Borough Council* [2003] EWHC Admin 1832, High Court; [2004] EWCA Civ 134, Court of Appeal.
[343] *R(B) v Calderdale Metropolitan Borough Council* [2003] EWHC Admin 1832, High Court, para 30.
[344] LGSCO, *Staffordshire County Council* (21 006 478), June 2022.

7.1.20 Shared care

Shared care is commonly raised as a matter for children, although it could also arise for adults. It refers to a child (or adult) being cared for regularly in different dwellings. DFG is available only for a person's only or main dwelling, so that it is difficult to see legally how two DFGs could be awarded in such circumstances. Guidance therefore states that in addition to a DFG, discretionary powers (RRO) should be used.

(Shared care: adaptations in two dwellings). *Where a disabled child has parents who are separated and the child lives for part of the time with each parent, a statutory DFG is only available at the address which is the main residence of the disabled child, usually the home of the parent in receipt of child benefit. However, it will often be in the best interests of the child to provide adaptations at both locations.*

Authorities are encouraged to use their discretionary powers in considering applications to adapt the homes of disabled children in these situations to ensure that they can maintain normal living arrangements.[345]

However, if that approach fails to meet the need, consideration must then be given also to social care legislation - if adapting a second dwelling is considered to be a cost-effective way of meeting the disabled person's assessed, eligible needs.

The courts have taken seriously the duty to consider adaptations to two dwellings. In one case, extensive works had already been carried out in one dwelling (ostensibly through DFG funding). For the second dwelling and the adaptations required, the judge referred to s.2 of the Chronically Sick and Disabled Persons Act 1970, s.17 of the Children Act 1989 and s.23 (what is now s.22C) of the Children Act 1989 (duty to ensure that accommodation provided for a looked after, disabled child is suitable):

Refusing to adapt a second dwelling/home for a disabled child: a "demon" had infected the local authority's decision-making. A disabled teenager spent some of the week with her mother, some with longstanding foster carers. The local authority had in the past provided "elaborate" adaptations to the mother's home, including wheelchair facilities, a lift, a hoist and special washing/lavatory units.

It now went to considerable lengths to avoid doing adaptations – other than through DFG – to the second dwelling, the foster carers' house. Including unlawful deregistration of the foster carers, on spurious grounds to avoid having do further adaptations. Deregistration that had at a stroke eroded the child's life in her established second home with her foster carers, of whose family she considered herself a part and of whom she was very fond. The judge, noting the impact on the teenager, said a "demon" had "infected" the local authority's decision-making for a period of two years.[346]

[345] *Disabled facilities grant (DFG) delivery: guidance*, 2022, para B12.
[346] *CD (A Child) v Anglesey County Council* [2004] EWHC Admin 1635, High Court.

7.1.21 Foster carers

Guidance states that foster carers are eligible to apply for a DFG, the application being made to the housing authority within which the foster carers live. However, if a top up were required, the guidance points out that the relevant social services authority (which had arranged the placement) would be responsible.[347]

7.1.22 Bathing and strip washing

The HGCRA refers in s.23 to a disabled occupant having access to, and being able to use, a bath or shower or both – and, separately and in addition, a wash-hand basin. Guidance states that when considering what is "necessary and appropriate", strip washing is not acceptable as a solution, other than short-term and interim:

(Strip washing not acceptable). *Access to toilet, washing, bathing and showering facilities are listed separately to clarify that a disabled person should have access to a toilet wash hand basin and a shower or bath (or if more appropriate, both a shower and a bath). The provision of facilities for `strip washing` is not an acceptable alternative to an appropriate bathroom.*

(Strip washing: short-term or the person's wish). *It may be appropriate in some cases to resort to this as a short-term interim solution, and a disabled person may exercise the choice to strip wash rather than use an accessible bath or shower provision, but it is not considered a "necessary and appropriate" solution. For the most complex needs specialist equipment such as a wash/dry toilet, rise and fall bath or height adjustable basin may be required.*[348]

7.1.23 Garden

First, in 2008, access to the garden was added to the list of purposes for which DFG can be given in the HGCRA. The relevant order states that applications for adaptations to gardens must be about making the garden safe for the disabled occupant and also facilitating access to and from a garden.[349]

Second, and in addition, the safety purpose, within the purposes already listed in the HGCRA, refers to safety in the dwelling. And dwelling is defined to include garden in s.101 of the HGCRA.

Third, guidance points out that the general access to the dwelling purpose in the HGCRA could involve the garden:

overcome any obstacles which are preventing the disabled person from moving freely in and out of the property, including common parts, in and around the garden and any yard, outhouse.[350]

[347] *Disabled facilities grant (DFG) delivery: guidance*, 2022, paras B13 – B14.
[348] *Disabled facilities grant (DFG) delivery: guidance*, 2022, paras B74.
[349] *Disabled Facilities Grants (Maximum Amounts and Additional Purposes) (England) Order 2008.*
[350] *Disabled facilities grant (DFG) delivery: guidance*, 2022, paras B46.

The above would suggest, depending on the individual situation, three bites of the cherry, so to speak, in considering an application for garden-related adaptations: the regulations, the safety purpose in the HGCRA, and the access to the dwelling purpose in the HGCRA.

All subject, of course, to the decision about necessary and appropriate, and about reasonable and practicable. Guidance goes on to give examples of what activities might underpin a decision about necessary and appropriate:

access to the garden should allow the disabled person to access their home or garden for drying clothes, playing or supervising play and gardening.[351]

7.1.24 Dropped kerbs

Guidance states that in relation to the access to the dwelling purpose in the HGCRA,

access can also include works outside the normal curtilage of the dwelling, such as a dropped kerb pavement crossing.[352]

This is of note, because other types of works generally approved for DFG will be within the curtilage of the dwelling.

7.1.25 Overcrowding

Guidance effectively makes the point that the individual circumstances have to be carefully considered. Overcrowding:

(Distinguishing disability related need from overcrowding). Overcrowding: *in itself is not a valid reason to refuse a grant, but it would not normally be necessary and appropriate to provide a new room if other bedrooms are accessible but occupied. However, where an additional bedroom would make the premises safer for the disabled person or others living with them, then providing a new room could be considered under that purpose. For example, where two siblings currently share a room but one is a risk to the other due to behaviours that challenge.*[353]

This reflects a legal case:

Disability-related need for additional bedroom – not overcrowding. The needs, in relation sharing of a bedroom by two children (brothers), could be identified as disability related as opposed to simple overcrowding. The older brother, with Aspergers Syndrome would attack his younger brother during the night. Had it not been for this, there would not have been a problem; the parents would have put all three boys in one bedroom and their daughter in the other.[354]

[351] *Disabled facilities grant (DFG) delivery: guidance*, 2022, paras B69.
[352] *Disabled facilities grant (DFG) delivery: guidance*, 2022, paras B47.
[353] *Disabled facilities grant (DFG) delivery: guidance*, 2022, paras B73.
[354] *R(B) v Calderdale Metropolitan Borough Council* [2003] EWHC Admin 1832, High Court, para 19; [2004] EWCA Civ 134, Court of Appeal.

7.1.26 Successive applications

There are no explicit rules in the HGCRA about making more than one application for a DFG over time. Guidance envisages that, if a person's needs change significantly, then they could apply for a DFG:

(Successive applications). *For people with degenerative conditions, further adaptations may become necessary at a later date. There is no restriction on successive applications for DFG on the same property. In such cases, any previous contributions will be taken into account - in the last 5 years for tenants and 10 years for owners. Any new assessed contribution will be reduced by any previously assessed contribution if the applicant went ahead with the previous adaptations.*[355]

There seems little reason to believe that the legal effect of the *McKeow*n case[356] is that multiple, simultaneous applications could be made, one for each DFG purpose, so as artificially to circumvent the £30,000 limit on mandatory grant.

7.1.27 Landlord permission

An obstacle to home adaptations comes in the form of a refusal of landlord permission – even if all the conditions are met for DFG approval. Guidance states that landlords must not: *arbitrarily and unreasonably refuse this permission and must comply with the Equality Act.*

(Landlord permission). *Note that even where the tenant's application is entertained without an owner's certificate, a grant cannot normally be awarded without the landlord's permission to carry out the works.*

(Not refusing permission unreasonably). *However, a local authority can award a grant for works inside a disabled person's home in the absence of a landlords' permission, where such permission has been unreasonably withheld, or where the landlord has attached unreasonable conditions to the consent in breach of the Equality Act.*

(Equality Act). *Under the Equality Act 2010 a landlord cannot unreasonably withhold their consent to an adaptation or attach unreasonable conditions to any consent. Where consent is refused, or conditions attached, the burden is on the landlord to show that their consent has not been unreasonably withheld to make adaptations (and how easy it would be to undo them).*

(Other legislation). *These provisions do not apply to a protected tenancy under S1 of the Rent Act 1977 or a statutory tenancy under s.2 of that Act or a secure tenancy under the Housing Act 1985 [under this last Act, there are separate rules about reasonableness of landlord's consent/permission].*[357]

7.2 Regulatory Reform Order

[355] *Disabled facilities grant (DFG) delivery: guidance*, 2022, paras B112.
[356] *R(McKeown) v London Borough of Islington* [2020] EWHC 779 (Admin), High Court.
[357] *Disabled facilities grant (DFG) delivery: guidance*, 2022, paras B28 – B31.

The Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) gives local housing authorities a power to provide housing assistance to people. The assistance can include acquiring living accommodation but also adapting or improving it.

Assistance may be provided in any form; it may be unconditional or subject to conditions, including repayment of, or contribution to, the assistance. For example, grants or loans. The housing authority could take security, including a charge over the property. Housing authorities must, under the Order, have a local, published policy, explaining what assistance is on offer.

The scope for assistance is wide, depending on elements included within the local policy. This would suggest there would usefully be close working between housing and social services – including occupational therapists – when these policies are formulated. When the RRO was passed, guidance outlined this wide scope, stating that it could be used to assist with, for example:

- choice of means-tested mandatory disabled facilities grant (DFG) or the option of a non-means-tested loan
- relocation (if, for instance, the existing dwelling was in a severe state of disrepair making adaptation unsuitable).
- small-scale adaptations to avoid the complexity of a DFG.
- topping up a DFG where the disabled person cannot afford a contribution or some of the works needed are not within the mandatory DFG purposes.
- a "complete solution" for the disabled person's need.[358]

Local authorities have, then, wide discretion. However, guidance points out that blanket policies – precluding consideration in individual cases of certain types of assistance (even if not in the local policy) – would risk unlawfully fettering the local authority's discretion.[359]

In practice, there seems to be considerable variation as to how the RRO is used. Some local authorities use the RRO to bypass DFG for at least some adaptations, so as to speed the process up.

Others routinely add in up to £5,000, £10,000 or £15,000 in order to top up DFGs. And some, but not all, use the RRO to fund adaptations that could not come under DFG at all, because the works do not come within the purposes set out in the Act.

[358] *Private sector housing renewal: A consultation paper*, 2001, Department of Transport, Local Government and the Regions. para 9.7. Also: *Regulatory Reform (Housing Assistance) (England and Wales) Order 2002: Explanatory document*. Department of Transport, Local Government and the Regions. 2001, pp.11, 27–29.
[359] *Housing renewal*. ODPM 5/2003, Office of the Deputy Prime Minister, 2003, para 4.5.

7.3 Social care

It has already been noted that if a person's needs for adaptations are not met through a DFG, together with the RRO, then a fall back is the social care legislation. (For which see sections 2 and 3 of these Guidelines). On the basis, for both adults and children, that there are eligible needs, and that home adaptations would be a cost-effective way of meeting them.

This could mean, for instance, topping up a DFG with extra money. Alternatively, it could mean considering use of social care legislation for an adaptation that simply would not come under DFG. Or assisting where the person cannot afford, or would have difficulty affording, their assessed financial contribution to the DFG.[360]

For instance, the following legal cases about adaptations strayed outside of DFG. In the first, seemingly because the adaptations requested did not come within the list of DFG purposes. In the second, because DFG had already been received, but additional funding was needed. For example:

Conversion of outhouses, equipment storage: social care/CSDPA case. The dispute was about conversion of outhouses to store the equipment and medication that two children with cystic fibrosis required. The purpose being storage (apparently without an argument about safety), the case did not centre on the HGCRA and DFG, but on s.2 of the Chronically Sick and Disabled Persons Act 1970.[361]

Funding additional to DFG: social care. Similarly, when funding additional to DFG was being sought in a legal case about the needs of two disabled children, the court considered potential use of the Children Act 1989 (and the CSDPA 1970).[362]

7.3.1 Means-testing: social care

Under s.14 of the Care Act, a local authority could financially means-test the adult for assisting with an adaptation costing over £1000.

Under s.29 of the Children Act 1989, a local authority could means-test the resources of the parents up to a child's 16th birthday. For instance, in one case, having done so, a local authority offered an interest-bearing loan, repayable if the disabled occupant moved away or died within 20 years. A legal challenge to the imposition, and terms of the loan, failed.[363] Thereafter, at 16 or 17 years old, it would be the resources of the child to be tested.[364]

[360] *Disabled facilities grant (DFG) delivery: guidance, 2022,* paras 2.24-2.26.
[361] *R(L) v Leeds City Council* [2010] EWHC 3324 (Admin), High Court.
[362] *R (Spink) v The London Borough of Wandsworth* [2005] EWCA Civ 302, Court of Appeal.
[363] *R(BG) v Medway Council* [2005] EWHC 1932 (Admin), High Court.
[364] *R (Spink) v The London Borough of Wandsworth* [2005] EWCA Civ 302, Court of Appeal, para 36.

7.4 NHS Continuing Healthcare

As noted at the beginning of this section, a fourth port of call for adaptations may be the local NHS integrated care board (ICB) in some circumstances.

For example, an adult with NHS continuing healthcare (CHC) needs may require a top up for a DFG, or an adaptation which simply doesn't come under the DFG purposes. In which case, statutory guidance explains:

(NHS responsibility for adaptations). *The ICB retains responsibility for deciding with the individual how their needs will be met, including in situations where property adaptation is assessed as an appropriate option. DFGs are means tested and the individual might not be entitled to a grant or the grant might not cover the full cost of the adaptation. ICBs are reminded that in such circumstances they must give consideration to the option of funding the adaptation if this is a cost-effective solution.*[365]

The basis for this is that if a person has NHS continuing healthcare needs in law, then the NHS ICB must meet not just all a person's healthcare needs, but also their social care needs. This is why if a top up for a DFG is required, or a different adaptation altogether to what can be provided by way of DFG, it is to the NHS legislation, rather than social care legislation (Care Act 2014) that one needs to turn.

Some integrated boards recognise their potential duty - others seem not to, denying that adaptations could ever be their responsibility under the NHS Act 2006. To counter this, one can point to the above paragraph from the guidance. As well as the longstanding precedent for the NHS doing some home adaptations.

For instance, guidance issued in 1974 stated that home adaptations required for home renal dialysis should be funded by the NHS; it would be responsible for adaptation of people's homes to provide suitable accommodation for dialysis. This guidance was reaffirmed in 1993.[366]

7.4.1 Consulting social services

The guidance states that a DFG should still be applied for by a person with continuing healthcare needs.

The requirement that social services be consulted, before housing decides whether the works are necessary and appropriate, probably remains even in CHC cases. So, if consulted with for a person with NHS continuing healthcare needs, social services OTs may need to get information from their health colleagues more familiar with the patient.

[365] *National Framework for NHS Continuing Healthcare*, 2022, para 56.3.
[366] *Services for chronic renal failure*, HSC(IS)11, Department of Health and Social Security, 1974. And: *Home dialysis patients: costs of metered water for home dialysis*, : HSG(93)48, Department of Health, 1993.

In one case, the local housing authority seemed, initially at least, to consult only an NHS OT, because the person had CHC status – with social services not involved. This seemed to lead to confusion and disagreement about what was necessary and appropriate - culminating in a judicial review legal case.[367]

7.4.2 Continuing care for children

For children, the equivalent guidance about continuing care does not explicitly refer to home adaptations.[368] However, it is arguable that the same principle set out in the adult guidance could and should be applied.

This would be to the extent that a child's continuing care needs have been identified using the Decision Support Tool set out in the children's guidance – and that the adaptation would be about meeting those needs. See section 5 of these Guidelines.

[367] *R(Gulrez) v London Borough of Redbridge* [2022] EWHC 2908 (Admin), High Court.
[368] *National Framework for Children and Young People's Continuing Care*, 2016.