Coronavirus: legal and practical implications for occupational therapists working in social care in Scotland, Wales and Northern Ireland

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1. Introduction and summary

I was delighted to be asked by Jill Pritchard and Gill Owen-John from the Royal College of Occupational Therapists Specialist Section – Housing, to write this briefing paper. Particularly to be given the opportunity to consider the law elsewhere in the United Kingdom, other than in England; bringing back to me those days of long train, and sometimes boat, journeys, to deliver training to occupational therapists in Scotland, Wales and Northern Ireland, where I was always made so welcome.

This briefing paper accordingly provides a legal perspective on the work of occupational therapists within social care in Scotland, Wales and Northern Ireland – and within both adult and children's services – in the context specifically of the coronavirus (COVID-19) pandemic. Although section 2 sets out the legal chapter and verse distinctive to each of these three parts of the United Kingdom, the subsequent chapters pick out issues and themes common to all.

Because we are in uncertain times, and the future course of the pandemic (and the Coronavirus Act 2020) is therefore somewhat unclear, I have tried to include matters within the paper which are of wider and more enduring relevance for the future. A glance at the contents list illustrates this; even section 3, particularly focusing on the Coronavirus Act 2020, draws on wider considerations. All of this, if nothing else, to give this briefing paper a longer, useful shelf life.

Section 2 highlights the fact that social care legislation is not the same across the United Kingdom; different legislation is involved. Some of it reads the same, some similar and some is unlike. The paper notes this, accordingly, when covering particular points. England is not covered. Nonetheless, some legal or ombudsman investigations from England are mentioned, where they are broadly helpful and relevant.

Section 3 covers, in particular, the effect of the coronavirus (COVID-19), its implications and the extent to which some of these feed into patterns of work and issues already facing occupational therapists and the local authorities for which they work. These include matters, for example, of referral, prioritisation, remote assessment, waiting times for both assessment and provision, and interim provision.

So that for however long the pandemic remains with us, this paper highlights such themes and patterns of work involving occupational therapists which are common to both present and the past and will undoubtedly be so in the future. This is considered specifically in sections 4 and 5.

In Section 5, in particular, the paper also refers to what can be termed 'balanced decision-making', weighing up sometimes 'competing' pieces of legislation. Typically, welfare legislation, under which people's needs are identified and met; human rights legislation; and health and safety at work legislation – tougher with the impact of limited resources. Such balanced decision-making has been required during the coronavirus pandemic; but it is a species of decision-making with which occupational therapists have long been familiar. The term was used by the courts as long ago as 2003, in a landmark case involving manual handling.

Finally, but not least, the paper draws attention to the crucial requirement that local authorities and their officers, such as occupational therapists, explain themselves in terms of recording evidence and clinical/professional reasoning – at any time, whether during a pandemic or otherwise. Something which, in any case and in 'normal' times, occupational therapists should be doing anyway in order to comply with their professional registration.[1]

The time of writing is September 2020.

Disclaimer
Nothing in this paper constitutes formal legal advice. For this, occupational therapists in social care should consult their own local authority's legal department.

Terminology
For convenience and brevity, in those parts of this paper referring to Scotland, Wales and Northern Ireland collectively, the paper uses the term local authority; but it must be noted that in Northern Ireland, social care is delivered by health and social care trusts not by local authorities, and in Scotland within the integration agenda many (previously local authority) occupational therapists are employed by the local Health and Social Care Partnership.

Legal and ombudsman cases
As noted above, this briefing paper illustrates legal points not just with the relevant legislation but with legal and ombudsman cases - drawn from Scotland, Wales and Northern Ireland where possible. As noted above, however, I have also included English cases of relevance and significance.

[1] Health and Care Professions Council (2016) *Standards of conduct, performance and ethics*. Standard 10. London: HCPC.

2. Legal framework for occupational therapists in social care in Scotland, Wales and Northern Ireland

The legal framework currently relevant to social care in Scotland, Wales and Northern Ireland includes the following. (For purposes of comparison only, the English equivalents are included):

- **Coronavirus Act 2020**

- **Welfare: social care** (local authority duties to assess and to meet the social care needs of adults and children)

  - **Scotland:**
  - *Social Work (Scotland) Act 1968*
  - *Chronically Sick and Disabled Person (Scotland) Act 1972*
  - *Social Care (Self-directed Support) (Scotland) Act 2013*
  - *Carers (Scotland) Act 2016*
  - *Children (Scotland) Act 1995*
  - *Public Bodies (Joint Working) (Scotland) Act 2014*

  - **Wales:**
  - *Social Services and Well-Being (Wales) Act 2014*

  - **Northern Ireland:**
  - *Health and Personal Social Services (Northern Ireland) Order 1972*
  - *Carers and Direct Payments (Northern Ireland) Act 2002*
  - *Chronically Sick and Disabled Persons (Northern Ireland) Act 1978*
  - *Children (Northern Ireland) Order 1995*

  - **England:**
  - *Care Act 2014*
  - *Children Act 1989; Chronically Sick and Disabled Persons Act 1970*
  - *Children and Families Act 2014*

- **Welfare: healthcare** (NHS duty to provide health care)
  - *National Health Service (Scotland) 1978*
  - *National Health Services (Wales) 2006*
  - *Health and Personal Social Services (Northern Ireland) Order 1972*
  - *National Health Service Act 2006 (England)*

- **Welfare: housing** (home adaptations)
  - *Housing (Scotland) Act 1987 (improvement grants)*
  - *Housing (Scotland) Act 2006*
  - *Housing Grants, Construction and Regeneration Act 1996 (disabled facilities grants, Wales and England))*
  - *Housing (Northern Ireland) Order 2003 (disabled facilities grants)*

- **Welfare: education** (special educational needs)
  - *Education Act 1996* (Wales: including statements of special educational needs)
  - *Education (Additional Support for Learning) (Scotland) Act 2004* (including coordinated support plans)
  - *Education (Northern Ireland) Order 1996:* including statements of special educational needs
  - *Children and Families Act 2014* (England: including education, health and care plans)

- **Mental capacity**
  - *Adults with Incapacity (Scotland) Act 2000*
  - *Mental Capacity 2005 (Wales and England)*
  - *Mental Capacity (Northern Ireland) Act 2016* (not yet fully in force)

- **General rights**
  - *Human Rights Act 1998 (United Kingdom-wide)*
  - *European Convention on Human Rights (United Kingdom-wide)*
  - *Equality Act 2010: protection against discrimination* (England, Scotland, Wales)
  - *Disability Discrimination Act 1995* (still applies in Northern Ireland)

- **Regulation of health and care providers**

  - **Scotland:**
  - *Public Services Reform (Scotland) Act 2010, Public Services Reform (Social Services Inspections) (Scotland) Regulations 2011* (Care Inspectorate)
  - *NHS (Scotland) Act 1978* (Healthcare Improvement)

  - **Wales:**
  - *Regulation and Inspection of Social Care (Wales) Act 2016* (Care and Social Services inspectorate).

  - *NHS (Wales) Act 2006* (Healthcare Inspectorate Wales)

  - **Northern Ireland:**
  - *Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003* (Regulation and Quality Improvement Authority)

  - **England:**
  - *Health and Social Care Act 2008 and Health and Social Care Act (Regulated Activities) Regulations 2014* (Care Quality Commission)

- **Health and safety at work**
  - **Scotland, Wales, England:**
  - *Health and Safety at Work Act 1974*
  - *Management of Health and Safety at Work Regulations 1999*
  - *Provision and Use of Work Equipment Regulations 1998*
  - *Lifting Operations and Lifting Equipment Regulations 1998*

- **Northern Ireland:**
- *Health and Safety at Work (Northern Ireland) Order 1978*
- *Management of Health and Safety at Work Regulations (Northern Ireland) 2000*
- *Manual Handling Operations Regulations (Northern Ireland) 1992*
- *Lifting Operations and Lifting Equipment Regulations (Northern Ireland) 1999*
- *Provision and Use of Work Equipment Regulations (Northern Ireland) 1999*

- **Regulation of health and care professionals** (including occupational therapists)
  - *Health and Social Work Professions Order 2002* (Health and Care Professions Council)

- **Law of torts (Wales, Northern Ireland, England), law of delict (Scotland): civil liability, common law**
  - *Common law of negligence*
  - *Trespass to the person*

It will be seen from the above that the social care legislation, under which occupational therapists work, differs across Scotland, Wales and Northern Ireland. (In Northern Ireland, social care occupational therapists work within health and social services trusts). So, too, for example, the housing legislation under which grants for home adaptations are provided. Broadly, one can say that the welfare legislation across the United Kingdom is roughly equivalent, but it does vary, at times considerably, in the detail.

2.1 Social care: Scotland

In Scotland, adult social care legislation remains fragmented (compared with Wales, for instance). The bedrock being still the Social Work (Scotland) Act 1968, which contains a general duty to promote social welfare by making available advice, guidance and assistance under section 12 of the Act.

More specifically is a duty to assess people's needs under section 12A; and linked to section 12A are eligibility criteria, to be published locally by local authorities but consistent with a national framework. If a person is assessed as having a certain level of need, there is then a duty to meet it.[2] This general legal position was referred to, in passing, in two recent Scottish cases involving Glasgow City Council.[3]

The strength of the section 12A duty and decision, linked to section 12 provision, was demonstrated in the case of *Robertson v Fife Council*, in which the House of Lords held that s.12A created the duty to decide whether there was a duty to meet need – not whether a person could pay for it.[4] The *MacGregor v South Lanarkshire* case noted that once a s.12A had identified a need that was required to be met, the local authority had to get on with it; a 7-8 month delay was not acceptable.[5]

[2] Scottish Government (2009) *National standard eligibility criteria and waiting times for the personal and nursing care of older people – guidance*. Edinburgh: SG, p10.

[3] *McCue's Guardian v Glasgow City Council* [2020] CSIH 51, 2020, para 1. And: *Q v Glasgow City Council* [2018] CSIH 5, paras 25, 29.

[4] *Robertson v Fife Council* [2002] UKHL 35, para 53.

[5] *MacGregor v South Lanarkshire Council* 2001 S.C. 502.

In addition, the Chronically Sick and Disabled Persons (Scotland) Act 1972 applies the Chronically Sick and Disabled Persons Act 1970 (CSDPA) to Scotland: see section 29 of the 1970 Act. That is, to both adults and children who are chronically sick or disabled or are suffering from a mental disorder – where the Scottish local authority has functions under respectively section 12 of the 1968 Act, or Children (Scotland) Act 1995.

Section 12A demands that, without even a request, local authorities consider a disabled person's needs under section 2 of the CSDPA – via s.4 of the Disabled Persons (Services, Consultation and Representation) Act 1986.

The CSDPA has the effect of sharpening up the duty to meet needs, in the case of disabled people. Case law has long since established that once a decision has been made under the 1970 Act that it is necessary to meet a disabled person's needs, then the local authority has an absolute duty to do so.[6] Furthermore, the CSDPA specifically mentions additional facilities, which could be taken to apply to equipment, as well as assistance with home adaptations. In fact, many of the other services referred to section 2 of the CSDPA could have implications for equipment provision.

Social care legislation was added to in the form of the Social Care (Self-directed Support) (Scotland) Act 2013, and the Carers (Scotland) Act 2016. The Children (Scotland) Act 1995 contains a general duty to safeguard and promote the welfare of children in need, including disabled children.

It should be noted, however, that particularly (but not only) in relation to disabled children, the CSDPA takes on added significance. Not only because of the list of specific services that must be considered, and which repays scrutiny by occupational therapists when considering what is needed by a disabled child, but also because the duty under section 2 of the CSDPA is stronger than the general duty to be found within the Children (Scotland) Act 1995. Section 22 of this Act creates a general duty to safeguard and promote the welfare of children in need, which is not amenable to the same degree of enforcement as section 2 of the CSDPA.[7]

Safeguarding activity by local authorities is governed largely by the Adult Support and Protection (Scotland) Act 2007, which imposed duties on a range of local authorities.

2.2 Social care: Wales

Social care legislation has largely been consolidated, for both children and adults, in Wales, in the form of the Social Services and Well-Being (Wales) Act 2014. The Act is effectively a large and consolidated statute containing duties of assessment and provision for both adults and children, including eligibility criteria.[8] It also contains safeguarding provisions for adults and children at risk. The Act makes specific mention in section 34 of aids, adaptations and occupational therapy, as ways of meeting people's needs.

[6] R v *Gloucestershire County Council*, ex p Barry [1997] 2 All ER 1, House of Lords. R(KM) v *Cambridgeshire County Council* [2012] UKSC 23, And for a children's case: R(JL) v *London Borough of Islington* [2009] EWHC 458 (Admin).

[7] R(G) v *Barnet London Borough Council* [2003] UKHL 57, House of Lords. And: R v *Bexley London Borough Council*, ex p B [1995] CL 3225, High Court: involving a disabled child and comparison between the CSDPA dutiy and Children Act duty. Also: R(JL) v *London Borough of Islington* [2009] EWHC 458 (Admin).

[8] Care and Support (Eligibility) (Wales) Regulations 2015.

Once eligibility has been established, against the legally prescribed eligibility criteria, a Welsh local authority has a clear, specific duty to meet those eligible needs.[9]

2.3 Social care: Northern Ireland

Northern Ireland social care for adults is to be found primarily within the Health and Personal Social Services (Northern Ireland) Order 1972. It contains a general duty under article 15 to provide assistance, advice, guidance and social care.

A 'single assessment tool', aimed at older people, sets out an assessment legal framework, and refers to resulting eligibility and its legal implications but appears not to explain what the criteria for eligibility are.[10] (A 2015 report by the Older People's Commissioner commented on the need for clarification about eligibility for social care in Northern Ireland).[11]

Children's social care, including that of disabled children, is located more generally in article 18 of the Children (Northern Ireland) Order 1995.

More specifically, the Chronically Sick and Disabled Persons (Northern Ireland) Act 1978 imposes a strong duty to meet the needs of disabled adults and children. The effect of CSDPA provision has been explained above in relation to the equivalent provision in Scotland. Its strength has been illustrated in Northern Ireland, for instance, in the *Judge* case (home adaptations)[12], the *Withnell v Down Lisburn* case (home adaptations)[13], and the case of *LW* (domiciliary care, Belfast Health and Social Care Trust).[14] In the case of *PH v Western Health and Social Care Trust* (respite care) the greater strength of the CSDPA duty – compared with the more general duty under article 15 of the 1972 Order – was alluded to.[15]

2.4 Home adaptations and social care legislation

It is beyond the scope of this paper to consider in detail the rules about housing grants for standard amenities and for other purposes in Scotland, under the Housing (Scotland) Act 1987, as well as disabled facilities grants, under both the Housing Grants Construction and Regeneration Act 1996 (Wales), and the Housing (Northern Ireland) Order 2003. This is because such grants fall under housing, rather than social care, legislation.

Nonetheless, it is clear that legally such grants often fulfil the function of meeting social care needs – but just by a route other than the social care legislation. Therefore if, for whatever reason, the housing grant does not meet all or any of those needs – and they are deemed legally to be eligible social care needs, i.e. needs that must be met under that social care legislation – then social services must consider whether to assist. Not just with minor, but also potentially major, adaptations.

[9] Social Services and Well-Being (Wales) Act 2014, s.32; and Care and Support (Eligibility) (Wales) Regulations 2015, rr.3 and 4.

[10] Health and Social Care Board (2017) *Northern Ireland Single Assessment Tool: procedural guidance, version 4*. Belfast: HSCB, p55.

[11] Commissioner for Older People in Northern Ireland (2015) *Prepared to care? Modernising adult social care in Northern Ireland*. Belfast: COPNI.

[12] *Re Teresa Judge* [2001] NIQB 14, High Court (Northern Ireland).

[13] *Withnell v Down Lisburn Health and Social Services Trust* (2004) High Court (Northern Ireland).

[14] *LW's Application for Judicial Review* [2010] NIQB 62.

[15] *PH v Western Health and Social Care Trust* [2014] NIQB 60, para 55.

This has been made clear, in terms of applying the Chronically Sick and Disabled Persons Act, for example, in Scottish guidance[16] and drawn attention to in a Scottish ombudsman case of 2009 involving *Dumfries and* Galloway;[17] seemingly in Welsh Assembly guidance as well.[18] (English case law has noted the scope for assistance with major adaptations under the Children Act 1989, over and above disabled facilities grants.)[19]

The same principles would apply to Wales. The *Isle of Anglesey* case involved the court identifying a duty under the Children Act (in relation to a looked after, fostered, child) to assist with major adaptations – over and above what had already been done by way of a disabled facilities grant. This was in order to resolve manual handling issues in a shared care situation[20] In addition, it is worth noting that the reference in section 34 of the Social Services and Well-Being (Wales) Act 2014 – to 'adaptations' – is reference to just that; it is not qualified by the word 'minor'.

And in Northern Ireland case law, the courts assumed that adaptations in the form of a heating system could come under section 2 of the 1978 Act.[21] Another case brought in Northern Ireland concerned the provision of heating for a disabled person. The court held that it was quite acceptable for the health and social services trust to pass the matter on to the housing authority (the Northern Ireland Housing Executive). However, if the Executive could not satisfactorily deal with the problem, then the trust would retain 'overall statutory responsibility' for 'ensuring that the necessary requirements' of the person were met under the CSDPA.[22]

As noted above already, in addition, the English Court of Appeal noted that the duty to safeguard and promote the welfare of children in need under section 17 of the Children Act 1989 was capable of covering assistance with major adaptations.[23] (The equivalent being in Scotland, s.22 of the Children (Scotland) Act 1995; and in Northern Ireland, a.18 of the Children's (Northern Ireland) Order 1995).

[16] Scottish Government. *Implementing the Housing (Scotland) Act 2006, Parts 1 and 2. Statutory Guidance for Local Authorities. Volume 6. Work to Meet the Needs of Disabled People*, 2009, paras 14-16. And see: Wane, K. SPICe Briefing: Housing Adaptations (Major). Edinburgh: Scottish Parliament, 2016, p.7.

[17] Scottish Public Services Ombudsman. *Dumfries and Galloway Council* (200602104), 2009.

[18] National Assembly for Wales. *Housing renewal guidance*. NAFWC 20/02. Cardiff: NAW, 2002, para 26.

[19] *R(Spink) v London Borough of Wandsworth* [2005] EWCA Civ 302, para 45.

[20] *CD v Isle of Anglesey* 2004] EWHC 1635 (Admin).

[21] *Re Teresa Judge* [2001] NIQB 14, High Court (Northern Ireland).

[22] *Withnell v Down Lisburn Health and Social Services Trust* (2004) High Court (Northern Ireland).

[23] *R(Spink) v London Borough of Wandsworth* [2005] EWCA Civ 302, para 45.

3. Coronavirus Act 2020: effect on social care

The Coronavirus Act 2020 came into force at the end of March 2020. Section 89 of the Act states that it will expire in two years, subject to earlier review and expiry under section 90. The Act obviously has wide application in providing the legal basis for restrictions to be imposed within society in the United Kingdom. However, it also, specifically, has application to social care in Scotland, Wales and England; it does not refer to social care in Northern Ireland.

3.1 Coronavirus Act: Scotland

In Scotland, section 16 of the Coronavirus Act 2020 means that local authorities are relieved of duties to carry out assessments and to meet certain needs.[24] However, the provisions are qualified, and guidance issued by the Scottish government emphasises this. In summary, the position is as follows.

Adults, Scotland

Local authorities in Scotland do not have a duty to perform any of the following duties – if the local authority considers that it is not practical to comply with the duty, or that if it did it would cause unnecessary delay in providing community care services 'to any person'. The rationale for this is to avoid a duty during the pandemic toward those arguably in lower need, which would result in delay for those in more urgent need. In the case of adults in need:

- **Assessment of need:** under section 12A of the Social Work Scotland) Act 1968;
- **General social care principles:** application of the general principles of social care under section 1 of the Social Care (Self-directed Support) (Scotland) Act 2013.

In the case of informal carers, a local authority does not have a duty to perform any of the following duties if it considers that it is not practical to comply with the duty, or that if it did it do so, this would cause unnecessary delay in providing support to a carer under section 24 of the Carers (Scotland) Act 2016:

- **Carer support plan (adult carer):** preparation under s.6 of the 2016 Act;
- **Outcomes and needs (adult carer):** identifying adult carer's outcomes and needs under r.2(1) of the Carers (Scotland) Act 2016 (Adult Carers and Young Carers: Identification of Outcomes and Needs for Support) Regulations 2018;
- **Carer support plan (young carer):** preparation under s.12 of the 2016 Act;
- **Outcomes and needs (young carer):** identifying young carer's outcomes and needs under r.3(1) of the Carers (Scotland) Act 2016 (Adult Carers and Young Carers: Identification of Outcomes and Needs for Support) Regulations 2018;

[24] Section 16 of the Act was brought into force by the Coronavirus Act 2020 (Commencement (No. 1) (Scotland) Regulations 2020.

- **General social care principles:** application of the general principles of social care, under section 1 of the Social Care (Self-directed Support) (Scotland) Act 2013 – as applied to the Carers (Scotland) Act 2016;

- **Needs of a carer:** 'identified needs', under s.24 of the Carers (Scotland) Act 2016, are a person's needs for support in order to enable them to provide or continue to provide care for a cared-for person.

Children, Scotland

In the case of children, a local authority does not have a duty to perform any of the following duties if the local authority considers that it is not practical to comply with the duty or that if it did it would cause unnecessary delay in providing services under section 22(1) of the Children (Scotland) Act 1995 – safeguarding and promoting the welfare of children in need. (In the case of looked after children, the delay refers to delay in the provision of advice, guidance or assistance under s.29 of the 1995 Act):

- **Assessing a disabled child:** under s.23(3) of the 1995 Act;

- **General social care principles:** application of the general principles of social care under section 1 of the Social Care (Self-directed Support) (Scotland) Act 2013, as they relate to ss.22 or 23 of the Children (Scotland) Act 1995;

- **Assessing formerly looked after children:** under s.29(5) of the 1995 Act (relating (after care for person who was looked after by the authority).

(The Chronically Sick and Disabled Persons Act 1970 is not mentioned in the Coronavirus Act. However, its operation in Scotland is referred to in section 29 of the 1970 Act as hinging on functions under the Social Work (Scotland) Act 1968 and the Children (Scotland) Act 1995. There may therefore be some uncertainty as to whether the duties on Scottish local authorities under section 2 of the 1970 Act are affected or not by the Coronavirus Act 2020).[25]

The Coronavirus Act 2020 provides some protection for a Scottish local authority if there has been a delay in assessing people's needs and in deciding whether to meet them – even after those duties have been reinstated. A court would need to take account of the length of time those duties had been suspended as it were; and the number of assessments a local authority then had to carry out following that period of time.[26] In other words, getting to grips with a backlog when things return to 'normal'; something that could clearly affect occupational therapists in terms of having to make continuing priorities and waiting lists.

Statutory guidance, issued under section 17 of the Coronavirus Act, elaborates. It uses the word 'easing' to refer to the relaxation of duties. It emphasises that duties under the Adult Support and Protection Act 2007 are unaffected and that isolation may create

[25] For example, s.12A provides for a separate duty to assess a person's needs under the CSDPA, via the Disabled Persons (Services, Consultation and Representation) Act 1986.

[26] Coronavirus Act 2020, s.17(11).

additional risks under the 2007 Act. Also, that the easing of the section 12A duty to assess people under the 1968 Act applies to people who may lack capacity but have not yet been assessed.

The guidance notes that partial assessments are just that and would need to be converted to full assessments when opportunity allows. It refers to social workers delegating more to other professionals, including occupational therapists, physiotherapists, and nurses.[27] Also to the *Ethical Framework* guidance published in England, as an aid to decision-making when making priorities. Overall, the relaxation of duties should be applied as a last resort only.[28]

3.2 Coronavirus Act: Wales

In Wales, section 15 and schedule 12 of the Coronavirus Act 2020 broadly mean that local authorities do not have to comply with duties to carry out certain assessments and to meet certain needs.[29] However, the provisions are to a degree qualified, and guidance issued by the Welsh Assembly emphasises this. In summary only, the duties of which local authorities are in principle relieved include:

- **Assessment of adult in need:** under s.19 of the Social Services and Well-Being (Wales) Act 2014, and under the Care and Support (Assessment) (Wales) Regulations 2015;
- **Assessment of carer (of an adult):** under s.24 of the 2014 Act, and under the Care and Support (Assessment) (Wales) Regulations 2015;
- **Deciding about eligibility (adults in need and carers):** under s.32 of the 2014 Act and under the Care and Support (Eligibility) (Wales) Regulations 2015 (although there is nothing to stop a local authority deciding whether to meet the needs of an adult in need or carer under ss.35 and 40 of the Act);
- **Duty to meet eligible need of adult in need:** under s.35 of the 2014 Act (but the duty to meet need, in order to protect an adult from abuse or neglect, or the risk of these, is unaffected);
- **Duty to meet eligible need of carer:** under s.40 of the 2014 Act. This duty is replaced by a duty that the local authority considers it necessary to perform in order to protect the carer from abuse or neglect or risk of it;
- **Care and support plans (adults in need and carers):** under s.54 of the 2014 Act and Care and Support (Care Planning) (Wales) Regulations 2015;
- **Portability of care (adults):** under s.56 of the 2014 Act.

(Duties to meet the needs of children, including disabled children, are unaffected by the

[27] Scottish Government *(2020) Coronavirus (COVID 19): changes to social care assessments: statutory guidance for local authorities on sections 16 and 17 of the Coronavirus Act 2020.* Edinburgh: SG.

[28] Department of Health and Social Care (2020) *Responding to COVID-19: the ethical framework for adult social care*. London: DHSC.

[29] Section 15 and schedule 12 of the Act were brought into force by the Coronavirus Act 2020 (Commencement (No. 1) (Wales) Regulations 2020.

Coronavirus Act 2020. The Welsh Assembly has however issued operational guidance in relation to vulnerable and at risk children.)[30]

The Coronavirus Act 2020 provides some protection for a Welsh local authority if there has been a delay in assessing people's needs and in deciding whether to meet them – even after those duties have been reinstated. A court would need to take account of the length of time those duties had been suspended as it were, and the number of assessments a local authority then had to carry out following that period of time.[31] In other words, getting to grips with a backlog when things return to 'normal'; something that could clearly affect occupational therapists in terms of having to make continuing priorities and waiting lists.

Statutory guidance issued by the Welsh Assembly elaborates on the Act. It states that the modifications to the duties, afforded by the legislation, should be *used as a last resort only*. That local authorities should not block, restrict or withdraw whole services, but merely make temporary, person-centred decisions about care and support during the pandemic.

Even with the relaxation of duties, local authorities should still respond as soon as possible to requests for help – and still consider needs and wishes and assess what may need to be provided – responding in a proportionate manner. Safeguarding duties to adults and children under the 2014 Act are unaffected by any relaxation of duties. A decision about adopting such relaxation must be formally taken and recorded.[32] Like the Scottish guidance, it refers to the *Ethical Framework* published in England, as an aid to decision-making when making priorities.[33]

3.3 Coronavirus: Northern Ireland

The Coronavirus Act 2020 does not introduce, for Northern Ireland, the easements and relaxation of duties that it does for Scotland, Wales and England. Apparently, because of its 'distinct legislative context, Northern Ireland has taken the view that they can achieve the necessary flexibility without legislation.'

(However, temporary modifications to duties in relation to looked after children were introduced in regulations. Comparable modifications were introduced in England.)[36]

[30] National Assembly for Wales (2020) *Children's social services during the COVID-19 pandemic: guidance*. Cardiff: NAW.

[31] Social Services and Well-Being (Wales) Act 2014, schedule 12, para 24.

[32] National Assembly for Wales (2020) *Adult social services during the COVID-19 pandemic: guidance: how local authorities support adults and adult carers during COVID-19*. Cardiff: NAW.

[33] Department of Health and Social Care (2020) *Responding to COVID-19: the ethical framework for adult social car*e. London: DHSC.

[34] Department of Health and Social Care (2020) *Adult Social Care Covid-19 Forum – weekly teleconferences 08/04/2020, 13:00-14:00: 'Care Act Easements'*. London: DHSC, para 13.

[35] Children's Social Care (Coronavirus) (Temporary Modification of Children's Social Care) Regulations (Northern Ireland) 2020.

[36] Adoption and Children (Coronavirus) (Amendment) Regulations 2020.

4. Pressures on social care and occupational therapists: how to manage them lawfully

At times, the effect of the coronavirus pandemic has been to place extreme pressure on both social care and healthcare services, including occupational therapists. Certain strategies have been recommended and explored in dealing with such pressure.

The 'easement' or relaxation of duties introduced by the Coronavirus Act 2020 and associated guidance, outlined above, entails the question of dealing with pressures – whether those easements are adopted, or whether a local authority attempts to continue to comply with all those normal duties, with which it is no longer obliged to comply.

The Welsh guidance, for example, says that the easements should be adopted as a last resort only.[37] Meaning that local authorities should try to find a way of managing pressures, whilst at the same time complying with their duties as normal. Which then begs the question as to how far those existing duties can be performed, and complied with, flexibly and in perhaps a different manner to normal.

Similarly, in Scotland, the guidance explains more globally that the relaxation of duties will be 'be brought into operation for the shortest time possible and only when absolutely necessary to protect people'. And, more specifically, that local authorities 'will only have this option to disregard duties to the extent that it is not practical to comply with them or would cause unnecessary delay in the provision of support'.[38]

Equally, if a local authority does take advantage of the relaxation in duties, it is therefore clear that the authority must still respond to people's needs as best it can. And to make priorities rationally and ethically, on an individual basis, rather than arbitrarily and in sweeping fashion.

Therefore, either way, whether a local authority formally embraces the easements or shies away from them, occupational therapists may find themselves having to think ever harder about how to manage pressures. The following headings represent at least some of the questions that may typically arise.

It will be immediately obvious to occupational therapists that such pressures are, in principle, nothing new. They have been grappling, as a profession in social care within the United Kingdom, with such matters for years – given the relevance, to occupational therapy, of so many of the referrals to adult social care.

4.1 Referral information and triaging

If face-to-face contacts have been at a premium, and to be avoided whenever necessary and possible on health and safety grounds, much will hinge on referral and 'triaging'. The

[37] National Assembly for Wales (2020) *Adult social services during the COVID-19 pandemic: guidance: how local authorities support adults and adult carers during COVID-19.* Cardiff: NAW, p2.

[38] Scottish Government (2020) *Coronavirus (COVID 19): changes to social care assessments: statutory guidance for local authorities on sections 16 and 17 of the Coronavirus Act 2020.* Edinburgh: SG, paras 1.6 and 2.2.1.

guidance on coronavirus, referred to above, stresses the need for careful decision-making and thus the avoidance of arbitrariness.

This has been a theme in the past as well. In a Welsh case involving Dinefwr council, the ombudsman criticised the application by the local authority of a policy about priority without being able to produce a record of the formal adoption of that policy.[39]

Similarly, the ombudsman, over the years, has made the obvious point in occupational-therapy related cases that if decisions are to be made at the referral stage about priority and urgency, then those decisions must be grounded in sufficient referral information. Particularly when significant waiting times may attach to any decision being made. For example:

Screening and allocating priorities for assessment: poor referral information
A disabled housing association tenant applied for a disabled facilities grant for a home adaptation. 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 a 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. This was maladministration.[40]

In a Welsh ombudsman case, decisions about priority were being made entirely on the basis of a self-assessment questionnaire. If a person fell beneath a certain threshold, the request was closed. Furthermore, the questionnaires were scrutinised, and decisions made, by an administrative assistant. This was all fault on the part of the local authority.[41]

4.2 Prioritisation and waiting times

The result of any referral and triaging process will typically be to give any particular case a level of priority and also indication as to how, sooner or later, the case should be dealt with. The Scottish, Welsh and Northern Irish guidance refers to Ethical Framework guidance issued in England about social care and the coronavirus. This considers the making of priorities and sets out eight key values and principles:

1. Respect
2. Reasonableness
3. Minimising harm
4. Inclusiveness
5. Accountability
6. Flexibility
7. Proportionality
8. Community.

[39] Local Government Ombudsman. *Dinefwr Borough Council* (94/0772), 1995.

[40] Local Government Ombudsman. *Bolton Metropolitan Borough Council* (92/C/0670), 1992.

[41] Local Government Ombudsman. *Neath Port Talbot County Borough Council* (99/0149/N/142), 1999.

A key point made within the guidance is that these values and principles will be particularly important in the case of prioritisation, rationing and, effectively, denial of care and assistance:

> *Recognising increasing pressures and expected demand, it might become necessary to make challenging decisions on how to redirect resources where they are most needed and to prioritise individual care needs. This framework intends to serve as a guide for these types of decisions and reinforce that consideration of any potential harm that might be suffered, and the needs of all individuals, are always central to decision-making.*[42]

More concretely, Scottish guidance refers to key considerations: risk to life; risk to a person's immediate health through not being able to wash, eat and look after themselves independently; child and adult protection; ability of carers to continue to provide care; and existing complex care arrangements, including where a person lacks capacity.[43]

Welsh Assembly guidance spells out the stark sort of choice that may need to be made: 'an example might be where a local authority is faced with a decision about reducing personal care for one person so that another gets the help they need to eat'.[44]

Over the years, ombudsman investigations into occupational therapy waiting lists have sought to identify how priorities were made and whether they were applied fairly and in a reasonably sophisticated manner. For instance:

Over-simple system of priorities
A disabled child had to wait 15 months on an occupational therapy waiting list 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 over-simple system meant that the child's needs were not met promptly and was maladministration.[45]

Not having a priority system at all for housing grants and handling referrals in date order will clearly not do.[46] In an older Welsh ombudsman case, handling referrals in date order, as well as confusion about the distinction between enquiry forms and full application

[42] Department of Health and Social Care (2020) *Responding to COVID-19: the ethical framework for adult social care*. London: DHSC, p3.

[43] Scottish Government (2020) *Coronavirus (COVID 19): changes to social care assessments: statutory guidance for local authorities on sections 16 and 17 of the Coronavirus Act 2020*. Edinburgh: SG, para 3.3.

[44] National Assembly for Wales (2020) *Adult social services during the COVID-19 pandemic: guidance: how local authorities support adults and adult carers during COVID-19.* Cardiff: NAW, p15.

[45] Local Government Ombudsman. *Rochdale Metropolitan Borough Council* (93/C/3660), 1995.

[46] Local Government Ombudsman. *Leicester City Council* (97/C/3498), 1998.

forms, contributed to maladministration.[47] In another case in Wales, priority decisions were likewise being clouded by the failure to distinguish consideration of need under housing grants legislation from need under the Chronically Sick and Disabled Persons Act 1970.[48]

And, in the following case, there was an all-round abnegation of responsibility to consider how urgent a referral might be:

Nobody taking responsibility for prioritising occupational therapy referrals
A housing authority, responsible for home adaptations, stated that it did not prioritise referrals from social services as it did not have the competent staff (i.e. occupational therapists) to do this. However, the social services authority making the referrals stated in its turn that it was not its task to prioritise on behalf of a housing authority. Unsurprisingly (given the unattractiveness of such abnegation of responsibilities), the ombudsman found the absence of a system of priorities to be maladministration on the part of both councils.[49]

The ombudsman in England has in the past stated that, in normal times at least, assessment in adult social care should in any event be carried out within four to six weeks, whilst recognising that complex assessments may take longer.[50]

So, in normal times – in a Northern Ireland ombudsman case involving the *Western Health and Social Care Trust* – a wait of 20 months for assessment of an informal carer was clearly fault.[51] In a Welsh ombudsman case in *Carmarthenshire*, a three-year wait for an occupational therapy assessment of adaptations required was clearly unacceptable, with the local authority seemingly unaware of its social care responsibilities and possible impact on the person's human rights.[52]

Nonetheless, in the light of a public health emergency, both the ombudsman and the courts are going to be sympathetic to unavoidable delays, as long as local authorities have shown and recorded that that they have made reasonable efforts in all the circumstances to behave rationally and fairly.

4.3 Human rights

In whatever way local authorities decide to make priorities, during the pandemic and in the future, there is in principle a further particular brake on the limits of what they can do – namely, to try to ensure they do not breach human rights. Even when formally applying the easement or relaxation of duties.

[47] Public Services Ombudsman for Wales. *Merthyr Tydfil County Borough Council* (2003/0648/MT/147), 2005.

[48] Local Government Ombudsman. *Neath Port Talbot County Borough Council* (99/0149/N/142), 1999.

[49] Local Government Ombudsman. *Castle Morpeth Borough Council and Northumberland County Council* (02/C/04897, 02/C/13783), 2003.

[50] Local Government Ombudsman. *Complaints about councils that conduct community care assessments*, September 2013.

[51] Northern Ireland Public Services Ombudsman. *Western Health and Social Care Trust* (16809), 2019, paras 24-26.

[52] Public Services Ombudsman for Wales (2011) *Carmarthenshire Council* (201001198), paras 69-72.

The Coronavirus Act 2020 itself spells this out explicitly for England[53]; for Scotland, Wales and Northern Ireland it is implied – since public bodies, in the exercise of their statutory functions, must in any case act consistently with the Human Rights Act 1998 and the European Convention on Human Rights. The Scottish guidance refers to the upholding and consideration of people's human rights.[54] Similarly, the Welsh guidance.[55]

There are at least four relevant articles of the European Convention on Human Rights to consider:

- the right to life (Article 2);
- the right not to be subjected, amongst other things, to inhuman or degrading treatment (Article 3);
- the right not to be deprived, unlawfully, of one's liberty when mentally incapacitated (Article 5);
- the right to respect for private life, family life, home and correspondence – but this can be interfered with if the interference is in accordance with law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others (Article 8).

These rights are incorporated into United Kingdom law by the Human Rights Act 1998. (They do not derive from the European Union, so are unaffected by Brexit.) That said, human rights may not be breached as easily as some may suppose.

Article 8, for example, allows interference with people's private life (including their physical and mental integrity) but only if there is a sound, proportionate reason. For instance, in an emergency situation, this might relate to public safety, health and the rights of other people – so long as such interference is proportionate (indicated by the word 'necessary'). Concerns raised recently by the Scottish Human Rights Commission, about the early months of the pandemic, were that evidence suggested that some people had suffered a rapid reduction or withdrawal of support without an assessment of proportionality.[56]

The following, occupational therapy-related, case – the *Bernard* case –highlights that the threshold for breaching Article 3 is high, and likely to be higher still if any alleged breach is associated with a public health emergency. It involved the local authority's social services and housing departments failing to meet, for nearly two years, the needs of a woman who had suffered a stroke. She lived during this time in dire circumstances. Article 3 was not breached, but Article 8 was:

[53] Coronavirus Act 2020, schedule 12, para 4.

[54] Scottish Government (2020) *Coronavirus (COVID 19): changes to social care assessments: statutory guidance for local authorities on sections 16 and 17 of the Coronavirus Act 2020*. Edinburgh: SG, paras 1.5 and 3.1.

[55] National Assembly for Wales (2020) *Adult social services during the COVID-19 pandemic: guidance: how local authorities support adults and adult carers during COVID-19*. Cardiff: NAW, pp4, 7, 17.

[56] Scottish Human Rights Commission (2020) *COVID-19, Social Care and Human Rights: Impact Monitoring Report*. Edinburgh: SHRC, p5.

Failure to provide equipment and adaptations or alternative accommodation: 'corporate neglect'
A local authority failed for some 20 months to meet the assessed community care needs of a woman, seriously disabled following a stroke.

Background: She had hemi-paralysis and almost no use of her right arm and leg. She had very limited mobility and was dependent on an electrically operated wheelchair, but the property was too small for this to be used. Likewise, too small for any substantial equipment or adaptations. She was doubly incontinent and had diabetes. She was cared for by her husband; he also looked after their six children, aged between 3 and 20.

Daily life: The husband's evidence was as follows. His wife was doubly incontinent and, with frequently less than one minute's warning of the need to use the toilet, commonly defecated or urinated before he could help her reach the toilet. He had to persistently clean the carpets, clothes and bedclothes. This happened several times each day. He had to go to the laundrette often twice a day, and buy incontinence pads, together with disposal pants and wipes. However, the family had only State benefits to live on, so the cost of all this, and floor cleaner and carpet cleaner in addition, meant they were impoverished. This left them in rent arrears, unable to bridge the gap between housing benefit and the rent owing.

His wife could not access the upper part of the house at all and it was a real struggle for her to leave her bedroom, which was in fact the family's living room accessed directly from the front door. With six children, there was no privacy. His wife found this situation depressing, demeaning and humiliating.[57]

Thus, as can be gleaned from this case, a breach of Article 3 is not easily made out even in 'normal' times, because the courts impose a high threshold to be surmounted before a breach is identified. Degrading treatment has been characterised by the courts as occurring if it '*humiliates or debases an individual showing a lack of respect for, or diminishing, his or her human dignity or arouses feelings of fear, anguish, or inferiority capable of breaking an individual's moral and physical resistance*'.[58]

In the *MB* case of 2020, in the context of the coronavirus, it was argued that the sudden discharge from hospital of a patient with serious mental health needs amounted to inhuman or degrading treatment. Her bed was needed in the light of a decision about clinical priority and limited public resources. The court rejected this argument:

Hospital discharge in the time of coronavirus; clinical priorities; risk of distress, self-harm, suicide: no breach of Article 3
A woman had been in hospital for about a year. She had a diagnosis of functional neurological disorder, manifesting as variable upper and lower limb weakness, variable and intermittent upper limb tremor and speech disturbance. She had chronic migraine,

57 *R(Bernard) v London Borough of Enfield* [2002] EWHC 2282 Admin.
58 *Pretty v United Kingdom* [2002] 2 FCR 97, European Court of Human Rights.

fatigue and generalised pain. She had long-standing, complex psychological conditions, including post-traumatic stress disorder, disrupted attachment, obsessive compulsive disorder, possible borderline personality disorder and Asperger's syndrome. She needed help with personal care, including washing, dressing and toileting.

In the light of the coronavirus outbreak, she was told she would have to leave the hospital forthwith. She refused, arguing that the result would be likely to precipitate extreme distress, and possibly self-harm or suicide. And that this would amount to a breach of Article 3 in terms of inhuman or degrading treatment.

The court disagreed. It stated that the primary duty on the State under Article 3 is not to inflict suffering. Whereas the duty to take positive steps to avoid suffering is more limited and is a duty to take reasonable steps only. And, if the hospital discharge decision is being taken in the light of scarce public resources and on the basis of clinical priority, such that one patient needs a bed more than another, the court would be highly unlikely to interfere and find a breach of Article 3.[59]

Although there was a breach of Article 8 in the *Bernard* case (above), this Article is not in general so easily contravened either. The courts may be reluctant to find a breach of adult social care legislation, if 'positive' obligations to provide welfare services are involved, unless the plight of the individual is severe – such, in fact, as to engage Article 3 as well.[60]

For instance, in a 2020 case in England, involving occupational therapists amongst others, the court found no breach of the Care Act 2014, the Housing Act 1996 or of human rights, even though the disabled person concerned remained confined to his bedroom for a long period of time, with a predictably severe impact on him:

Unable to leave bedroom, even to use bathroom, for 20 months: flat unsuitable for wheelchair: severe impact of delay, no breach of human rights
A man had been living with his wife and young daughter in an eighth-floor council flat when he suffered a medical emergency resulting in the sudden loss of the use of his legs. He spent an entire period of 20 months without being able to leave his bedroom. He could not use the bathroom and had to rely on others for all his most basic hygiene needs. He could not use a wheelchair because the doorways and corridors of the flat were too narrow. He challenged the delay.

The court found that the local authority had followed the rules under both the Housing Act 1996 and the Care Act 2014; delay did not necessarily mean unlawfulness in all the circumstances. As far as Article 8 of the Convention went, the court stated there was no breach even though it accepted that the effect on the man was severe. This was because there would be no compensatory breach of Article 8 on grounds of delay, unless the

[59] *University College London Hospitals NHS Foundation Trust v MB* [2020] EWHC 882 (QB).

[60] *R(Anufrijeva) v London Borough of Southwark* [2003] EWCA Civ 1406.

local authority had both breached a legal duty – and an element of culpability and lack of respect could be demonstrated.[61]

Likewise, if it comes to limited resources and identifying cost-effective options to meet people's needs – in which occupational therapists are well versed – the courts may be very reluctant to interfere. In the *McDonald* case, in which incontinence pads replaced assistive handling at night for a woman who had suffered a stroke, the European Court of Human Rights held that there had in principle been a breach of her Article 8 right – but that it was justified for the economic wellbeing of the country.

Stroke, night-time carer, assistive handling, incontinence pads, dignity: no breach of human rights

A former ballet dancer suffered a stroke, aged 56, followed by a number of falls, leaving her with compromised mobility. She had a small and neurogenic bladder but was not clinically incontinent. She had a night-time carer to help her on to the commode several times a night; the need had been assessed as assistance on to the commode.

The local authority then told her she would have to use incontinence pads, instead of having the night-time carer. However, it had not initially carried out a formal review or reassessment to underpin this decision – so was at that stage in breach of its duty to meet the assessed need. Finally, after a year's delay, it formally reassessed her need more broadly as safe urination at night – thereby creating, legally, more options through which to meet the need.

The European Court held that during that period of a year, her private life had been interfered with in terms of dignity – and could not be justified because the interference was not in accordance with the law (clearly providing incontinence pads was not the same as helping her to the commode).

However, once her need had been reviewed and recalibrated, as it were, to safe urination at night, the provision of incontinence pads was now in line with the assessed need. And, at this point, the European Court held that the continuing interference with her private life/dignity had fallen into line, and been in accordance with, the law. The interference also pursued a legitimate aim, namely the economic wellbeing of the country and the interests of other service users. In terms of whether it was a necessary and proportionate decision, the Court held that her personal interests had been adequately balanced against the more general interest of the local authority in carrying out its social responsibility of provision of care to the community at large.[62]

Returning to the coronavirus, interference with the Article 8 right can also be justified on a ground other than the economic wellbeing of the country; for example, the protection of health, or the rights of other people:

[61] *R(Idolo) v London Borough of Bromley* [2020] EWHC 860 (Admin).

[62] *McDonald v United Kingdom* (2015) 60 E.H.R.R. 1.

Coronavirus: interference with Article 8 on health grounds and the rights of other people

A man was deprived of his liberty under the Mental Capacity Act 2005 in a care home; because of the coronavirus, a ban on family visits was put in place. The court found this undoubtedly interfered with his private life but was a proportionate measure for the protection of health, in the light of government guidance about care homes and the coronavirus. (The court even seemed to suggest that, even if there was a breach of Article 8, under Article 15 of the European Convention, 'derogation' from Article 8 in an 'emergency' is provided for – although such derogation would have to be implemented at central government level).[63]

In the *MB* case, already summarised above, the decision to discharge a woman with serious mental health problems, because her bed was needed by others at a time of public health emergency, was held to be an interference with the right to respect for private and family life. But was justified as necessary to protect the rights of other patients in need of inpatient treatment.[64]

4.4 Remote assessment

Inevitably, the question of remote assessment has arisen for occupational therapists in the context of coronavirus: can an adequate professional assessment be carried out, other than face to face, and in what circumstances? That is, not just in relation to basic occupational therapy skills and principles, but also against the procedural requirements of the relevant social care legislation.

The legislation, set out in section 2 of this paper, contains, in certain places, detailed requirements that must be satisfied for an assessment – under the normal rules without relaxation of duties – to be lawful. For example, under the Social Services and Well-Being (Wales) Act 2014, section 19 and the Care and Support (Assessment) (Wales) Regulations 2015. Likewise, under the Social Work (Scotland) Act 1968, section 12A and the Social Care (Self-directed Support) (Scotland) Act 2013.

Although such detailed requirements can, during the coronavirus period, be relaxed, nonetheless, the question of adequate remote assessment is likely to persist into the future, even when the pandemic has subsided, and the Coronavirus Act 2020 is wound up (see 5.4, discussion about the future).

Practically, for instance, questions have arisen during the pandemic and in the context of manual handling, about face-to-face or remote assessment, demonstration of equipment and techniques, training and delivery of care. Issues include the appropriateness and efficacy of such remote work, and the safety of both handled and handler. And the need, remotely, to weigh up – using professional judgement – the environment, the person being handled, the handlers, needs, safety (including infection risks) and so on.

[63] *BP v Surrey County Council* [2020] EWCOP 17.

[64] *University College London Hospitals NHS Foundation Trust v MB* [2020] EWHC 882 (QB).

4.5 Necessity of remote assessment in some circumstances

In the light of the coronavirus and social distancing, the courts will recognise that a remote assessment, normally not appropriate, might be so in this time of emergency. For instance, in relation to a mental capacity assessment, the Court of Protection in England stated in the *BP v Surrey* case:

Remote assessment: necessary but vigilant scrutiny required

'Over the last few weeks, I have had cause to issue a number of guidance documents to address a rapidly changing landscape. On 19th March 2020, I recognised the reality that capacity assessments would, of necessity, for the time being, be required to be undertaken remotely. There is simply no alternative to this, though its general undesirability is manifest. Assessments in these circumstances will require vigilant scrutiny'.[65]

This same case returned to court a few weeks later, when the question of remote assessment came up again. The care home had refused access to a doctor to carry out a capacity assessment (because of the risk to the residents, in a coronavirus-free care home, even though the doctor offered to wear protective clothing). Conversely, the doctor was not prepared to conduct such an assessment remotely.

The judge's view of all this was as follows, and surely helpful not just in relation to mental capacity assessment, but also to other types of assessment including those conducted by occupational therapists. If one professional would not conduct a remote assessment, then another would have to be found:

Remote assessments of mental capacity not desirable but necessary, creative use of other options required

The judge stated: 'In my Guidance, dated 19th March 2020, I addressed some of the concerns identified by the professions and observed the reality that for the time being many, perhaps most, capacity assessments would require to be undertaken remotely. I stated, "there is simply no alternative to this, though its general undesirability is manifest". I further emphasised that with "careful and sensitive expertise" it should be possible to provide sufficient information. I specifically contemplated that video conferencing platforms were likely to play a part in this process as they now do in so many other spheres of life and human interaction.

If BP had remained at the home, it would have been necessary to instruct a different assessor. I remain of the view that creative use of the limited options available can deliver the information required to determine questions of capacity. It may be that experienced carers well known to P and with whom P is comfortable can play a part in facilitating the assessment. Family members may also play a significant role in the process. I am aware that in many areas of the country innovative and productive approaches of this kind are proving to be extremely effective'.[66]

[65] *BP v Surrey County Council* [2020] EWCOP 17, 25th March 2020.
[66] *BP v Surrey County Council* [2020] EWCOP 22, 29th April 2020.

4.6 Creativity in remote assessment

In the BP v Surrey case, the judge referred to creativity in overcoming the limitations of remote working, including use of careful and sensitive expertise, and information from other sources, including family members. Likewise use of video technology.

Scottish guidance follows this approach, stating that 'the decision whether an assessment can be done in person or remotely will need to be individually risk assessed taking into account: the quality of information held on current systems which is available to help make temporary care decisions; information from family members, friends, unpaid carers and current care workers; urgency of the need for support; the vulnerability of the person; the risk of transmission of the virus to the person and to workers'. And refers to the use of telecare to review how things are going and how people are coping.[67] The same guidance notes the potential for using self-assessment more:

- **(Self-assessment):** 'to enable the initial triage in coming to better decisions more quickly about where priorities lie. This might also reduce the volume of calls and lengths of time spent on initial discussions at points of first contact and can provide a starting point for further discussion. This approach is in line with the principles and spirit of the [Social Care (Self-directed Support) (Scotland) Act 2013] and supports people to begin to think about their own strengths and the capacity of their families and communities'.[68]

Some occupational therapists have related to the author that the necessity of remote assessment has meant that they prepare considerably more thoroughly than they would have done previously – a silver lining to the pandemic crisis, perhaps?

4.7 Not hiding behind the Coronavirus

The overall gist of guidance in Wales and Scotland makes clear that decisions to restrict assessment and provision should not be made arbitrarily and need to be justified. One of the lessons to be learnt from the pandemic will be how to respond to such crises in future.

For instance, in the context of hospital-based healthcare, it has been suggested about decision-making – during the first wave of the pandemic in the first part of 2020 – that prioritisation, triaging and treatment was unnecessarily undermined by a lack of guidance, by political anxiety and by fear – and that what was required was *ordinary* (clinically sound) decision-making in an *extraordinary* time.[69]

Perhaps a simple example of trying to make rational and evidenced decisions arose in a case about home adaptations. The court made clear that the decision about what could and could not be done about the grant application, and how quickly, had to be considered in the individual circumstances. In this case, the local authority was proposing a delay, citing social

[67] Scottish Government (2020) *Coronavirus (COVID 19): changes to social care assessments: statutory guidance for local authorities on sections 16 and 17 of the Coronavirus Act 2020*. Edinburgh: SG, para 3.8.

[68] Scottish Government (2020) *Coronavirus (COVID 19): changes to social care assessments: statutory guidance for local authorities on sections 16 and 17 of the Coronavirus Act 2020*. Edinburgh: SG, para 3.8.

[69] Burman R, Cairns R, Canestrini S, Elias R, Melaxa V, Owen G...Sutherland E (2020) *Making ordinary decisions in extraordinary times. British Medical Journal*;370, m3268, pp m3268.

distancing restrictions necessitated by the coronavirus. But the judge pointed out that the outstanding aspects of the grant application did not in fact require access to the woman's home – and therefore should be resolved in six weeks, not the six months proposed by the local authority:

Processing a home adaptation grant application at the time of the coronavirus
Following a leg amputation, a woman had become wheelchair dependent. She was a council tenant. She required an external platform lift, so she could access the street from her front garden, without calling on her sons to carry her up the steps.

The court found overall that a disabled facilities grant (DFG) application had been rejected on the basis of what the court considered to be a fundamental misunderstanding of several of the DFG rules. The local authority therefore needed to reconsider its decision and the judge considered how quickly this should be done. It referred to doing this within six months.

However, the woman could not exit her home, and her need was urgent. The judge acknowledged that the coronavirus and associated restrictions complicated matters – 'but there is a significant difference between carrying out a reassessment of … general care needs which in my judgment is not required for a DFG (given that there is already a Care Act Assessment) but would have required access to the Claimant's home – and any assessment of the necessary building works or resolving a planning issue which, it is not suggested would require access to the Claimant's home'.

The judge noted that the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 permitted movement for the purposes of work. And it was not being suggested that 'most aspects of consideration of grant applications other than necessary visits are not capable of being carried out remotely'. In normal circumstances, six weeks would have been more than adequate; the judge accepted it might be a little longer due to present circumstances. But not the six months urged by the local authority.[70]

The court went on, for good measure, to note how the relatively recent coronavirus-related restrictions on the general population contrasted with the much greater restriction to which the woman had been subject for the past year, because of her inability to leave her home for want of adapted access, which the local authority had been obstructing, unlawfully:

Not imposing unnecessary restrictions
The judge stated: 'The real lesson of the movement restrictions for coronavirus for this case is in my judgment to place in stark relief the degree of deprivation of freedom for the Claimant which is involved in continued delay over the lawful consideration of a DFG. The UK population has been prevented from leaving their homes subject to a significant list of reasonable excuses for just over one week at the time of this judgment.

[70] *R(McKeown) v London Borough of Islington* [2020] EWHC 779 (Admin).

In contrast the Claimant has been almost entirely prevented by her disability from leaving her home for at least one year. In those circumstances and on the basis of the facts as known to me today, in my judgment the reconsideration should not exceed a period of ten weeks'. [71]

4.8 Universal services

Scottish guidance suggests local authorities, during the pandemic, direct people to community groups and third sector organisations, in order to reduce referrals to local authorities for formal assessments.[72] Welsh guidance refers also to use of community support and networks.[73]

It is not entirely clear, of course, that such groups will necessarily be any better able to help than the local authority during a crisis period. (For example, due to the pandemic, Age UK home-help and related services have been closing – as has happened in the East of England.)[74]

However, if a local authority adopts the easements – the relaxation of duties – then, by and large, it does not matter legally if any such 'universal services' are unable to meet a person's needs. This is because there would no longer be a duty on the local authority to meet (what would normally have been) eligible needs.

Increasing reliance on universal services is not something new, however, that has come to the fore just in the pandemic. It is something that many local authorities have been exploring for some time and will continue to do.

For instance, it is explicit in regulations about eligibility in Wales: one of the eligibility conditions is that the person is unable meet their need themselves with the assistance of services in the community to which they have access.[75] Past Scottish guidance on eligibility in adult social care noted that a person's needs might be moderate or low and so not be eligible. One of the indicators pointing to these lower levels of need was that it could be met in other ways without the involvement of social services.[76] Northern Ireland single assessment guidance also refers to this principle.[77]

To sum up, when a local authority is applying duties of assessment and meeting eligible need as normal, referral to a universal service may be acceptable legally. But only if it is clear that the universal service will reliably and quickly meet the eligible need, in a

71 *R(McKeown) v London Borough of Islington* [2020] EWHC 779 (Admin).

72 Scottish Government (2020) Coronavirus *(COVID 19): changes to social care assessments: statutory guidance for local authorities on sections 16 and 17 of the Coronavirus Act 2020*. Edinburgh: SG, para 3.4.

73 National Assembly for Wales (2020) *Adult social services during the COVID-19 pandemic: guidance: how local authorities support adults and adult carers during COVID-19*. Cardiff: NAW, pp4, 12, 24.

74 Sullivan, O. Stark warning that more charities face closure in wake of Age UK Suffolk collapse. *East Anglian Daily Times*, 16th July 2020.

75 Care and Support (Eligibility) (Wales) Regulations 2015, rr.3 and 4.

76 Scottish Government (2009) *National standard eligibility criteria and waiting times for the personal and nursing care of older people – guidance*. Edinburgh: SG, p10.

77 Health and Social Care Board (2017) *Northern Ireland Single Assessment Tool: procedural guidance, version* 4. Belfast: HSCB, p43.

reasonable and comparable manner (including the financial basis on which this is achieved) to what direct social services provision would have achieved. If, however, the universal service is unable to do this, not least because the person is unable to access it suitably, then the local authority risks being in breach of its duty to meet the person's eligible needs.

This issue has been subject to investigation by the local ombudsman in England. For instance, in the following case, asking a woman to buy some small items of equipment, which were easily available and which she would be perfectly capable of buying, was held to be acceptable:

Asking a person to buy small items of equipment
A woman had polymyalgia rheumatoid arthritis affecting hands, shoulders, arms and knees. The local authority considered a number of outcomes including habitable home environment, toileting, personal hygiene, being appropriately clothed, and nutrition. On this last point, the local authority assessed that she could eat, drink and prepare independently but asked carers to chop vegetables. It suggested she buy an electric tin opener, lightweight baskets to cook vegetables, easy grip knives and a microwave/table-top oven. The ombudsman considered that this was acceptable; it had considered her strengths and capabilities.[78]

On the other hand, in the following case, the local authority purported to rely on a voluntary organisation for equipment to meet a person's eligible need, with no evidence that the organisation would actually do so:

Wishful thinking about a voluntary organisation grant for equipment in order to meet eligible need
A local authority declined to meet a visually impaired woman's eligible 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 if the grant was not forthcoming. This was maladministration.[79]

4.9 Interim provision

Guidance makes clear that if a full assessment is not possible because of the coronavirus then, when circumstances allow, a full assessment should be completed at a later date. However, with or without the easements and relaxation of duties, the question of interim provision may arise – if, for whatever reason, a full assessment has not yet been done.

It might not be just about the coronavirus; it could be an unrelated matter of urgency or other complications. Whatever the circumstances, interim provision is a matter which may require serious consideration. In normal times, legislation provides, one way or another, for interim, urgent provision; this power has not been suspended by the Coronavirus Act.

[78] Local Government and Social Care Ombudsman, *North Yorkshire County Council* (19 013 234).

[79] *LGO, London Borough of Hammersmith & Fulham*, 2016 (15 011 661), para 24.

Thus, in Scotland, section 12A of the Social Work (Scotland) Act 1968 states that in case of urgency, a local authority is free to provide community care services without having first carried out an assessment of need. Alternatively, provision could be made under section 12 (which is not suspended), freestanding from section 12A. In any event, Scottish guidance about the coronavirus envisages provision being made, without full assessment, and being regarded as merely temporary in nature.[80]

In Wales, section 36 of the Social Services and Well-Being (Wales) Act 2014 permits a local authority to provide care and support, even if an assessment has not yet been completed – and therefore eligibility has not been determined. Welsh guidance about the coronavirus refers to 'temporary' provision.[81]

In Northern Ireland, health and social services trusts have a very broad duty to provide help, which would not preclude assistance in case of urgency, short of a full assessment.[82] Likewise, under section 2 of the Chronically Sick and Disabled Persons (Northern Ireland) Act 1978, trusts have a duty to meet need if they believe it is necessary to do so. Again, therefore, on this basis, there is ostensibly nothing to preclude such necessity triggering provision in case of urgency.

Even when there is not an explicit duty to meet need, short of a full assessment and eligibility decision, nonetheless a local authority must be legally alert to exercising its powers, or least weaker duties, to meet need where this is clearly called for in the circumstances.

For instance, the following case was not about the coronavirus (although the court hearing was in fact, because of the pandemic, a remote hearing using Skype). But it did involve occupational therapists and the question of use of interim powers to meet need if, for whatever reason, a full assessment – or, in this case, reassessment – had not yet been completed. An informal carer was no longer able and willing to care for her two adult sons, but the local authority failed to adjust the care package and to fund double-handed, night-time care – at least in the interim. This was despite two occupational therapy assessments pointing to the need for it:

Informal carer caring for and manually handling her sons: occupational therapy assessment; local authority acting unlawfully in declining to provide overnight care/handling

A woman cared for her two sons, aged 25 and 32. Both had multiple, severe disabilities, including profound learning disability. During the night, she would turn and reposition them, as well as changing their pads (they were both doubly incontinent).

One son had cerebral palsy, epilepsy, Sjorgen Larsson syndrome, multiple profound learning disability and thoracolumbar kyphosis of the spine. The other had cerebral palsy,

[80] Scottish Government (2020) *Coronavirus (COVID 19): changes to social care assessments: statutory guidance for local authorities on sections 16 and 17 of the Coronavirus Act 2020*. Edinburgh: SG, para 3.5.1.

[81] National Assembly for Wales (2020) *Adult social services during the COVID-19 pandemic: guidance: how local authorities support adults and adult carers during COVID-19*. Cardiff: NAW, pp2, 18.

[82] Health and Personal Social Services (Northern Ireland) Order 1972, a 15.

multiple profound learning disability, Sjorgen Larsson syndrome, increased thoracic kyphosis, shoulder obliquity and pelvic obliquity.

The mother herself had hypertension, swollen feet, pain due to arthritis, slipped or dislocated discs affecting her back. She had postponed back surgery because of the need to look after her sons. However, she was now suffering from pain, discomfort and tiredness. She had been previously 'expected to cover 12 hours of daily care including 10 hours of night-time care by herself.'

She now sought an urgent adjustment to the care package during the night. An expert occupational therapy assessment, obtained independently by the mother, had identified that double-handed care was required. The local authority stated that under the Care Act rules, and on grounds of health and safety, it could not change the care package until it had completed a statutory review and reassessment. However, this had drifted and an impasse had been reached.

The court ruled that, pending the reassessment, interim care should be provided by the local authority during the night – using its power to provide assistance under s.19 of the Care Act, even if an assessment (or reassessment) had not yet been completed.[83]

[83] *R(Raja) v Redbridge* LBC [2020] EWHC 1456.

5. Coronavirus ramifications: past, present and future

The effect on social care of the coronavirus pandemic is very apparent at the time of writing this document. However, issues that have been thrown up, practically and legally, by the pandemic link to the past and future as well as the present. So, when people state that the pandemic crisis is unprecedented, one would not argue, but some of the ramifications run along familiar lines.

5.1 Infection control

It seems clear that greater attention will have to be paid to infection control in the future. And that, anyway, infection control in the past was sub-optimal. For instance, some of the scandals of the early 2000s involved a cavalier approach to *clostridium difficile* in English hospitals, leading to scores of avoidable deaths, even in one hospital alone.[84]

When, even with suitable protective equipment, risks of infection to service users, families, care workers or local authority staff remain significant in certain situations now and in the future, carefully weighed decisions will need to be made. It is one thing to defer a decision about a person's care or rehabilitation that can wait a bit; quite another when it is a matter of essential care, whether to do with food, hygiene, pain, wound care etc. But then again, missing a window of rehabilitation may ultimately have serious consequences including, in the end, an effect on basic and essential functioning.

5.2 Health and safety at work

Matters of infection control relate ultimately to health and safety at work legislation. For example, the safety of employees under section 2, and non-employees under section 3, of the Health and Safety at Work Act 1974 – or under the Health and Safety at Work (Northern Ireland) Order 1978.

More specifically, for example, weighing up the consequences of a remote manual handling assessment and whether it is at all acceptable might go to the safety of local authority staff; for instance, of those delivering the care, with the Manual Handling Operations Regulations 1992 in mind, but also, of non-employees, under section 3 of the 1974 Act. These could be the service user and family members but also care agency staff – who of course would be non-employees of the local authority.

In terms of personal protective equipment, when face-to-face assessment and, obviously, provision of care are required, then the Provision and Use of Work Equipment Regulations 1998 and Personal Protective Equipment (Enforcement) Regulations 2018 (referring to a European Regulation 2016/425) will be applicable. A range of relevant guidance about

[84] Healthcare Commission (2006) *Investigation into outbreaks of Clostridium difficile at Stoke Mandeville Hospital, Buckinghamshire Hospitals NHS Trust, July 2006*. London: HC.

And also: Healthcare Commission (2007) *Investigation into outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust, October 2007*. London: HC.

personal protective equipment for health and social care professionals is pointed to by Health Protection Scotland.[85] Likewise Public Health Wales.[86] And the Public Health Agency in Northern Ireland.[87]

5.3 Remote assessment: past and present

Remote assessment has already been discussed previously in this document. It is nothing new. Some local authorities have long since been exploring how far assessments, at least the simpler variety, can be conducted over the telephone. (Statutory guidance in England refers explicitly to this).[88] In each individual case, the local authority would legally need to reassure itself, on the evidence, that it has sufficient, reasonably reliable material on which to assess and take a decision remotely.

For the future, once the Coronavirus Act 2020 has expired or been withdrawn, and normal duties apply, there is certainly scope and discretion within the legislation for local authorities to consider how assessments should be conducted in the future.

For instance, section 19 of the Social Services and Well-Being (Wales) Act 2014 states that the 'nature of the needs assessment required by this section is one that the local authority considers proportionate in the circumstance'.

Past Scottish guidance referred to the notion of 'simple assessment' applying, 'where indicated needs or requests for services are straightforward and can be dealt with by low level response'. The word proportionality occurs in an example within guidance taken from one Scottish local authority, and the guidance noted of course that proportionality of assessment is not just about the vehicle of assessment but also, who does the assessment. Thus, simple assessments could be carried by unqualified staff.[89] This guidance is nearly 20 years old; the notion of proportionate, and varied approaches to social care assessments is not novel.

Ultimately, in terms of their own professional practice, it is up to occupational therapists to make judgements about when a remote assessment and other associated activity is legally adequate. In terms of defending a decision to assess remotely, in one way or another, the therapist would need to explain why she or he is satisfied that, in all the circumstances, the assessment was adequate and proportionate. In terms of their professionalism, but also, in terms of the detailed requirements for assessment imposed by legislation – particularly, for example, given the extensive detail in the Social Services and Well-Being (Wales) Act 2014 and in associated Welsh regulations.

5.4 Remote assessment: future?

Given that local authorities have anyway been exploring in the past notions of proportionate and adequate assessment, it would seem likely to come into increased

[85] Public Health Scotland (2020) Coronavirus (COVID-19). Available at: *https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/*

[86] Public Health Wales (2020) *Information for Health and Social Care professionals – Wales. Available at: https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/information-for-healthcare-workers-in-wales/*

[87] Public Health Agency (2020) Guidance for HSC staff on using PPE. Available at: *https://www.publichealth.hscni.net/covid-19-coronavirus/guidance-hsc-staff-healthcare-workers-and-care-providers/guidance-hsc-staff*

[88] Department of Health (2016) *Care and support statutory guidance.* London: DH. para 6.3.

[89] Scottish Executive (2001) *Guidance on single shared assessment of community care needs*. Edinburgh: SE, paras 19, 26.

focus for the future. First, because of the endless pressure on time and resources in social care. Secondly, because the pandemic has forced alternative ways of working on local authorities, who are likely to examine what may be of enduring use and value, even once the pandemic has subsided.

In 2018, for instance, the Scottish Health and Sport Committee published a paper on the use of technology in health and social care, including for remote clinical consultation. Referring, for example, to the benefits of telemedicine for people living in physically remote and rural Scottish communities.[90]

Similarly, a Welsh Parliamentary review about 'transforming' health and care in Wales covered telehealth, telecare, remote areas, virtual consultations etc.[91] Neither report anticipated of course that, within a short time, social distancing and the coronavirus would expand the relevance of 'remote' consultations to those in the heart of a city.

More recently still, a Northern Ireland Department of Health document reflected on the pandemic and on lessons learnt from technology:

- **(video consultations):** 'video consultations, which were previously only carried out in very low numbers, are now also widely embedded within the service. Where a face-to-face appointment is not necessary, video consultations provide a more efficient model of GP to patient contact and the widespread use of technology should be incorporated into the service going forward'.
- **(adult social care):** 'Many adult social care services have adopted new and innovative ways of working. For instance, care homes have made use of technology to connect residents with their families, through video-calls, and to enable 'virtual ward rounds' by GPs or other professionals with care homes residents. This has helped limit the physical footfall in and out of homes. The use of technology to monitor vital signs and residents' activities of daily living via a digital remote monitoring platform is being implemented by all trusts.[92]

The pandemic has of course highlighted that technology has moved on, way beyond reliance on the telephone to consult with and assess people. There are now other and increased options for use of technology, including tablets and other types of computer. Such video technology could even be embedded, for instance, in a mobile robot which could move around the environment where a person is confined in a care home or their own home – and enable others such as family or practitioners, to communicate via a video screen.[93]

Already we see that general practitioners have, during the coronavirus crisis, adopted remote consultations as a default starting point, before considering the need for face-to-face contact. This is something that has been under consideration for years, as a way of

[90] Health and Sport Committee (2018) *Technology and innovation in health and social care*. Edinburgh: Scottish Parliament.

[91] Parliamentary Review of Health and Social Care in Wales (2018) *Revolution from within: transforming health and care in Wales.* Cardiff: National Assembly for Wales.

[92] Department of Health (Northern Ireland) (2020). *Rebuilding health and social care services: strategic framework*. Belfast: DHNI, paras 4.9, 4.30.

[93] Di Nuovo A (2018) How robot carers could be the future for lonely elderly people. *The Independent*, 6 December 2018.

relieving pressure on the GP service.[94] The benefits and risks of this have been consulted upon by the Royal College of General Practitioners.[95] Hospitals have been conducting some outpatient appointments remotely.[96] At the end of July, the Secretary of State for Health in England announced that in future all initial GP consultations should be by telephone or online.[97]

Of course, there is obviously a cautionary note to be struck. It is one thing to use new technology and remote working to achieve roughly comparable outcomes; it is quite another to use them as convenient, but inadequate and potentially unlawful, shortcuts. For example, in August 2020, 'significant incidents' were reported, arising from general practitioners' excessive elimination of NHS appointments. NHS England issued corrective guidance.[98]

Clearly, the sort of thing obviously to avoid, as occurred in one ombudsman case, is assessment or review on the telephone of a person with learning disabilities who is also deaf.[99]

It would seem that occupational therapists will need to embrace and to make use of new opportunities and ways of working, whilst defending their core principles. This will come back, as mentioned above, to professional judgements and to what is acceptable and what is not. This may not always be straightforward. Many years ago, the author recalls speaking to two occupational therapy managers in the same week. One was operating a mail order bath board service and said, that with due care, it was both safe and beneficial; the other stated she would never find it professionally acceptable to adopt such a way of working. Each was exercising professional judgement, but with very different results.

5.5 Legally balanced decision-making

Weighing up the factors considered above in this section, it is clear that when making sometimes difficult decisions, local authorities and occupational therapists must weigh up a variety of potentially competing practical and legal considerations. This is what has been going on, of course, during the pandemic, weighing degree and urgency of need against health and safety and limited resources – in terms of both staffing and protective equipment.

Therefore, legal considerations include health and safety at work, not only about infection control but also the implications of remote working and assessment (e.g. safe manual handling); the meeting of people's needs under social care legislation; human rights; and

[94] Marshall M, Shah R, Stokes-Lampard H (2018) Online consulting in general practice: making the move from disruptive innovation to mainstream service. *British Medical Journal*, 26th March 2018.

[95] Royal College of General Practitioners (2020) *Online consultations in general practice: the questions to ask*. July 2020.

[96] NHS England (2020) *Clinical guide for the management of remote consultations and remote working in secondary care during the coronavirus pandemic*. March 2020. And see: Rapson, J. Covid sparks boom in digital hospital outpatient appointments. Health Service Journal, 11th May 2020.

[97] Cowburn A (2020) All initial GP consultations should now happen on phone or online, Matt Hancock announces. *The Independent*, 31 July 2020.

[98] Serle J (2020) GPs asked to keep doors open after 'significant incidents' warning. *Health Service Journal*, 4th August 2020.

[99] Local Government Ombudsman. *Birmingham City Council* (05/C/18474), 2008.

the eternal refrain of limited resources. Thus, to repeat, there are four factors which form a heady mixture and which need to be blended into a well-balanced mixture:

1. Health and safety.
2. Meeting needs.
3. Human rights.
4. Limited resources.

However, striking such a balance will be familiar anyway to occupational therapists. The *McDonald* case, already mentioned above, was one example of weighing up how to meet the claimant's needs against limited resources – and evidencing that incontinence pads were a legally acceptable substitute, in the particular case, for night-time, assistive manual handling.

The landmark manual handling case of 2003, the *East Sussex* case, called for just such balanced decision-making – this time weighing up of needs not against resources but against health and safety at work. It involved the needs of disabled adult sisters (and the wishes of the parents) and the safety of care workers doing the manual handling. Human rights applied, according to the judge, to the sisters but also to the care workers:

Balanced decision-making and proportionality: human rights of the person being handled and of the handlers

'When the assessment of the "impact" on both the carer and the disabled person of the range of alternatives has been made (assuming there is a range), the employer must balance the two impact assessments one against the other... Within the context of Article 8, the balance between conflicting or competing rights is to be resolved by inquiring of each claimant whether the interference with his right required if the other claimant's right is to be respected is such as to be "necessary in a democratic society for the protection of the rights and freedoms of" the other. And well–known Convention jurisprudence adopts the concept of proportionality".[100]

Not long after this came a striking judicial example, in a Scottish hospital manual handling case, of just such a balancing exercise. The judge noted that in considering need against the safety of nursing staff, it had to be recalled that the patient involved was not a sack of cement:

Manual handling in a Scottish hospital: patient was not a sack of cement, but nurse safety was still a requirement

A judge considered the three options there had been for the manual handling of a heavy, awkward hospital patient with dementia. Of these, the first was not good for the patient but safest for staff (hoist). The third was perhaps best for the patient but too unsafe for staff (cross-arm lift).

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

The middle way (swivel transfer) was a reasonable compromise between these extremes: 'The 1992 Regulations clearly apply to the manual handling of hospital patients, as they apply to sacks of cement. Nevertheless, different considerations are relevant in the case of a patient (or, indeed, any person), on the one hand, and to a sack of cement, on the other. The comfort and safety of the patient are of importance … a nurse's job requires the manual handling of patients. Here, use of a hoist offered [the patient] neither a comfortable nor a safe means of transfer to the commode whereas a swivel transfer was … reasonably safe for all concerned'.[101]

In a more recent *East Sussex* case, this time involving the local ombudsman, the manual handling assessor seemed to go the extra mile in finding a way of managing risk, whilst still meeting the person's needs:

Finding a solution to meet a person's needs, taking account of the risks of assistive handling

A manual handling assessor assessed the situation of a woman with learning and physical disabilities. She had epilepsy and experienced frequent seizures, as well as a tracheostomy and osteoporosis. The care agency involved stated that it wished to cease assistive handling.

The manual handling assessor recognised the limited competence and confidence of care agency handlers to provide assistive handling – but also identified that assistive transfers and walking had improved the woman's mobility. In addition, more bed care and hoisting – the alternative to the assistive handling – were counter-indicated because of severe reflux (triggered by turning her in bed) and the need to disconnect her PEG feed for a significant period when hoisting was required.

The manual handling assessor identified the need for knowledgeable and confident care workers, who might be found through using a direct payment rather than the care agency. This recommendation was at variance with an occupational therapist's recommendation, which had similarly identified the risk of the care agency continuing to assistively handle but appeared not to explore how the tension could be resolved – simply recommending instead the hoisting.[102]

[101] *Urquhart v Fife Primary Care Trust* [2007] SCLR. 317, Court of Session Outer House.

[102] Local Government and Social Care Ombudsman, *East Sussex County Council* (16 017 727), December 2018.

6. Evidence, reasoning and recording

At the outset of the coronavirus pandemic, the local ombudsman in England issued the following short statement, to the effect that recording the rationale for decisions was still required:

Local authorities should still assess people's social care and support needs throughout this period and should make a written record of this assessment. Directors of Social Services should ensure that proportionate professional recording is maintained and may consider a single alternate document for local use.[103]

Likewise, Scottish guidance refers to the importance of keeping a record of decision-making during the period of easing of duties; including any decision to dispense with the duty to assess, decisions to conduct full or partial assessments and decisions about the provision of support.[104]

Welsh guidance emphasises that, in relaxation of duties, the Director of Social Services should authorise arrangements for recording: the reason the decision needs to be taken; the impact of the decision on the people who ordinarily use the service; the impact of the decision on families and carers of people who ordinarily use the service; and possible alternative sources of care and support and the likelihood of this being available.[105]

6.1 Decision-making process: judicial review legal cases

The courts, in judicial review cases, are looking primarily at the *decision-making process* of local authorities. These cases are about challenging, and trying to overturn, a decision (not about pursuing compensation for injury). They are not, therefore, somewhat counter-intuitively, about the final decision that the occupational therapist, on behalf of the local authority, takes but about how the decision was reached. This is because, by and large, the role of the courts (in judicial review cases) does not – at least generally speaking – include the questioning of professional judgement directly. But evidence of a rational and lawful decision-making process does need to be recorded, as a matter of process.

(Unlike in England, though, the public services ombudsmen in Scotland, Wales and Northern Ireland can investigate not just procedural failings in decisions but also the 'merits': i.e. they can investigate professional judgements made on behalf of the local authority in social care, by practitioners such as occupational therapists and social workers.)[106]

[103] National Assembly for Wales (20202) *Adult social services during the COVID-19 pandemic: guidance: how local authorities support adults and adult carers during COVID-19*. Cardiff: NAW, p18.

[104] Scottish Government (2020) *Coronavirus (COVID 19): changes to social care assessments: statutory guidance for local authorities on sections 16 and 17 of the Coronavirus Act 2020*. Edinburgh: SG, para 3.11.

[105] National Assembly for Wales (2020) *Adult social services during the COVID-19 pandemic: guidance: how local authorities support adults and adult carers during COVID-19*. Cardiff: NAW, p15.

[106] Scottish Public Services Ombudsman Act 2002, s.7. And: Public Services Ombudsman (Wales) Act 2019, s.15. And: Public Services Ombudsman (Northern Ireland) Act 2016, s.15.

6.2 Judicial review and ombudsman cases: examples

More generally – whether during the pandemic or not – the decisions of occupational therapists and local authorities need to be explained and recorded in terms of evidence, reasoning, and conclusion. It can be very simple, as the following examples from Northern Ireland and Scotland reveal:

Failure to record reasons about occupational therapist input

In Northern Ireland the ombudsman found fault with the Housing Executive when, in relation to house repairs for a disabled man, there was a failure to record reasons for decisions regarding whether an occupational therapist's input was required or not.[107]

No record of occupational therapist check on adaptations

In Scotland, for relatively straightforward reasons, the ombudsman found fault with the local authority when the adequacy was not checked of an adaptation that had been carried out. And when the occupational therapist involved did not record, or inform the private sector housing team whether or not the adaptation met the assessed needs. This meant in turn that the council could not fully demonstrate compliance with the adaptations process.[108]

Lack of evidence about suitability of shower chair

In another Scottish case, a woman requested a different type of shower chair for her adult son with complex needs. The council refused her request, stating that his current shower chair was meeting his clinical need. The ombudsman took advice from an independent occupational therapist. The ombudsman concluded that there had been insufficient evidence (recorded) for the council to state that the current shower chair was meeting the son's needs. Furthermore, when the request was declined, reasons were not given to the mother. This was fault on the part of the local authority.[109]

The good news is that courts – and ombudsmen – are generally conscious of the reality of everyday practice in social care, even in normal times. And whilst demanding evidence of a thorough, evidenced and reasoned approach – with some awareness demonstrated of the relevant legal framework – they shy away from what they have called 'over-zealous textual analysis':

Giving local authority staff some leeway

The court was clear that an expert occupational therapy report needed to be taken account of by the local authority; but if the authority then chose, *with reasons*, to depart from that report's recommendations, the court would not interfere. Over-zealous judicial analysis of the recording of an assessment was to be avoided: 'One must always bear in mind the context of an assessment of this kind. It is an assessment prepared by a social worker for his or her employers. It is not a final determination of a legal dispute by a lawyer which may be subjected to over-zealous textual analysis. Courts must be wary, in my view, of expecting so much of hard-pressed social workers that we risk taking them away, unnecessarily, from their front-line duties.' [110]

[107] Northern Ireland Public Services Ombudsman, *Housing Executive* (16797), 2018.

[108] Scottish Public Services Ombudsman, *Aberdeenshire Council* (201607082), 2017.

[109] Scottish Public Services Ombudsman, *South Lanarkshire Council* (201900785), 2020.

[110] *R(Ireneschild) v Lambeth LBC* [2007] EWCA Civ 234, paras 44-57, 71.

In the following case, the local authority succeeded essentially because several relevant practitioners had given and recorded their professional views. These practitioners included an occupational therapist, district nurses and the GP. In other words, the woman's needs and views had been carefully considered before the local authority made its decision, contrary to her wishes.

Reducing a care package with single-handed care and a pressure mattress
A woman's care package was lawfully reduced from 104 hours a week to 40 – against her wishes and, she argued, her wellbeing. She was 55-years old, suffered from incurable, degenerative, muscular dystrophy and was bed- and wheelchair-bound. The reduction was achieved first by introducing a hoist, which enabled a change from double-handed to single-handed care and second by removing a night-time carer who turned the woman in the night and substituting instead a pressure relieving mattress and incontinence pads.

The local authority was able to show that it had assessed thoroughly and professionally, considered the Care Act rules, and taken advice from district nurses and the GP – by way of showing that the single-handed hoisting and removal of the night-time carer were reasonable options in meeting her needs. The court declined to interfere with the decision.[111]

In an older case involving the Chronically Sick and Disabled Person Act 1970 and occupational therapy assessments, the court would not interfere with the local authority decision:

Court not interfering with decision about adaptations for disabled children
A local authority resisted a mother's strong wish for an outhouse to be converted to provide a treatment room and to store equipment and fridges (for antibiotics) for her two children with cystic fibrosis. The local authority could show that it had taken account of what the mother had stated, the expert advice she cited and a number of relevant factors – and that the disability team manager had come to a reasoned view. She disagreed with the mother's view that, psychologically, the trappings of the disability need to be separate from the rest of the home. (A treatment table was, anyway, not generally needed any more, compared with the past, since an acapella device was now being used.) The court would not interfere with the local authority's decision. [112]

And in the following Scottish ombudsman case, the ombudsman declined to intervene, despite the family seriously disagreeing with the occupational therapy assessment. This was because the local authority could show relevant factors had been considered and flexibility shown:

[111] *R(VI) v London Borough of Lewisham* [2018] EWHC 2180 (Admin).

[112] *R(L) v Leeds City Council* [2010] EWHC 3324 (Admin).

Evidenced assessment and flexible approach by occupational therapist and council
A local authority agreed to fund adaptations to the bathroom. The parents did not believe the local authority had taken account of their son's needs. But the ombudsman was 'satisfied that the council showed flexibility and discretion in their consideration of the bathroom adaptations, as these went beyond the minimum requirements of the legislation and guidance. We found that the council showed awareness of Mr and Mrs C's son's specific needs and that their proposed bathroom adaptations supported the assessment carried out by their occupational therapist'. [113]

If this is to give the impression of considerable leeway given by the courts and ombudsman, that will only go so far – since it does presuppose a plausible-looking assessment, with relevant evidence and reasoning, that has been recorded. Consider the following case, in which a decision was taken that a woman with severe osteoporosis was to be hoisted. The judge scrutinised the decision to ensure that it had been reached taking account of her individual needs – as opposed to the imposition of a blanket approach to manual handling. Evidence and reasoning were found to be sorely lacking:

Eight-line document about hoisting a woman with severe osteoporosis: no recorded consideration of the person's needs, evidence of a blanket policy about hoisting
The local authority argued that a physiotherapist had taken account of the woman's osteoporosis and that an assessment in relation to manual handling had been carried out. It produced a document in court consisting of eight lines, purporting to be an assessment.

`It was clear to the judge that these eight lines were no more than instructions as to how a hoist should be used. But there was no consideration of the particular needs of the woman; no consideration of the risks to her, no assessment of those risks and no consideration of the suitability of manual lifting as opposed to using hoists. There was some evidence that the local authority followed a general policy against lifting, instead requiring hoisting. The decision was held to be unlawful. The local authority would have to retake the decision.[114]

6.3 Other types of case: decision-making process

In other types of legal case, the recording of decision-making likewise will be pivotal. For instance, in a personal injury negligence case, a physiotherapist had failed to keep a patient's rehabilitation care plan up to date and fully documented. The woman had deteriorated and now posed a greater risk when being assisted to walk. An occupational therapy assistant was subsequently injured; the NHS Trust was held liable.[115]

[113] Scottish Public Services Ombudsman, *Midlothian Council* (201101679), 2012.

[114] *R(SC) v Salford City Council* [2007] EWHC 3276 Admin, paras 24, 25.

[115] *Stainton v Chorley and South Ribble NHS Trust* (1998), High Court, unreported.

In yet another type of legal case, involving questions of mental capacity and a person's best interests – or, in Scotland, benefit – a professional's recorded decision-making may be closely examined:

Flawed assessment about manual handling and best interests
In what had been labelled an adult protection case, an occupational therapist's assessment of a husband's manual handling of his wife (lacking capacity) was flawed in a number of ways. For instance, the assessment had not taken account of the positive aspects of what the husband had been doing, including two years of such handling without incident and his understanding of his wife's likes, dislikes, comfort and discomfort. Furthermore, the assessment had been written over a year since the therapist had last seen the wife. The assessment had referred to the risks, but not in general to the benefits, of what the husband was doing. On this basis, and on other weaknesses in the local authority's position, its attempt to deprive the wife of her liberty in a nursing home failed.[116]

[116] *A London Local Authority v JH* [2011] EWHC 2420 (COP), pp.47-48.

7. Concluding word

The coronavirus pandemic has put in the spotlight a range of law and practice in social care across the United Kingdom. Whilst there have obviously been some very specific challenges, these are in principle specific examples, and magnification, of issues anyway present in the work of occupational therapists. Namely, from a legal perspective, the taking of a balanced approach to essentially four key issues: health and safety, meeting people's needs, human rights and limited resources. Further, such decision making needs to be professionally evidenced, reasoned and recorded, all in the context of the relevant legislation.

The pandemic has arguably sharpened up trends, such as remote assessment, that were already present in social care. And, for the future, local authorities will almost certainly scrutinise what has been learnt during the time of coronavirus and what may endure and be useful in the future, even when the pandemic has subsided. Increased use of technology, for both assessment and the meeting of people's needs, is likely to be a significant focus.

If this whole period does herald significant change within social care, this would signify an opportunity for occupational therapists to embrace new ways of working, yet at the same time being careful not to abandon core principles for the sake of organisational expediency.

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