



LEGAL FRAMEWORK FOR EQUIPMENT PROVISION

GUIDELINES

These guidelines cover the law in England. They do not cover home adaptations, although the Care Act 2014 applies to minor adaptations much as it does to equipment

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Note. The guidelines are not comprehensive, in the sense that to include every detail would have meant a large, less accessible document. The guidelines are not a substitute for taking formal legal advice in individual cases. The time of writing is February 2016. Future legal case law and ombudsman decisions will need to be taken into account of when considering the guidelines. As well as any changes to the legislation itself.

The guidelines have been compiled by Michael Mandelstam on behalf of the London Borough Occupational Therapists Management Group (LBOTMG). Acknowledgements are also made to members the LBOT group who have contributed to the production of these guidelines.

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1 CARE ACT 2014

1.1. BACKGROUND

Most of the Care Act 2014 came into force in England in April 2015, replacing a great deal of adult social care legislation in England – including the NHS and Community Care Act 1990 and the Chronically Sick and Disabled Persons Act 1970 (although the latter continues to apply to children).

To understand the effect of the Care Act on equipment, it is necessary to consider what the Act states and how it relates to other legislation, including health and education.

The Care Act 2014 applies to adult social care in England, arranged by local authorities with social services functions, as listed in schedule 1 of the Local Authority Social Services Act 1970.

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

1.2. WELL-BEING: THE PRINCIPLE RUNNING THROUGH THE CARE ACT

S.1 of the Care Act states that whatever social services do under the Act, in respect of an individual person, it has a general duty to promote the well-being of that individual.

Well-being is defined to include nine components. One is personal dignity; another is physical and mental health, together with emotional well-being. A third is control over day-to-day life. And a fourth is the suitability of a person's living accommodation. Clearly, equipment will sometimes be highly relevant to such aspects of a person's life. The nine components of the definition are:

- a) personal dignity
- b) physical and mental health and emotional well-being
- c) protection from abuse and neglect
- d) control by the individual over day-to-day life (including over the care and support provided to the adult and the way in which it is provided)
- e) participation in work, education, training or recreation
- f) social and economic well-being
- g) domestic, family and personal relationships
- h) suitability of living accommodation
- i) the adult's contribution to society.

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

Local authorities still, legally, have the last word as to what they are going to do for the well-being of any particular individual. But clearly, when they take decisions, authorities will have to show that they have taken significant account of the issues set out in s. 1.

For occupational therapists, the well-being definition, and emphasis on engaging properly with the person, should be welcome. Occupational therapists have long since prided themselves on taking a holistic approach to the people they work with.

Well-being comes into sharper focus still, when decisions are taken about people's legal eligibility for help. This is covered below.

1.3. PREVENTION, DELAY AND REDUCTION OF NEED: SECTION 2 OF THE CARE ACT

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

The strength of this legal duty is that it gives local authorities great scope as to how they implement it. And provision under s.2 does not depend on a person having eligible needs.

Its weakness, legally, is that for any particular type of provision for a particular individual, s.2 is almost discretionary. This is because the duty is expressed in vague terms. To enforce provision of a service for any one individual would be virtually impossible, because the duty is not to any one person, but rather to the local population in general.

Nonetheless, equipment provision is likely to feature reasonably prominently amongst the preventative services arranged by local authorities.

The s.2 duty is not confined to the local authority itself arranging preventative services. It includes identification and involvement of other services provided from other sources. Hence the importance also of s.4 of the Care Act: placing a duty on the local authority to establish and maintain an information and advice service.

1.4. PREVENTATIVE SERVICES: EXAMPLES INCLUDING EQUIPMENT

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

Local authorities must provide or arrange services, resources or facilities that maximise independence for those already with such needs, for example, interventions such as rehabilitation/reablement services, e.g. community equipment services and adaptations.¹

The guidance is what is called statutory. It is not legislation, but has legal strength. When it states that a local authority “must” do something then, in the absence of a very good reason, the local authority must do it. Or else risk losing a judicial review legal case or a finding of maladministration by the local government ombudsman. The “must” in the above quoted paragraph is directed toward the local population in need, not toward any particular individual: hence the difficulty in any individual enforcing provision.

Statutory guidance suggests that the majority of intermediate care and reablement will be provided as a preventative service:

Where local authorities provide intermediate care or reablement to those who require it, this must be provided free of charge for a period of up to six weeks. This is for all adults, irrespective of whether they have eligible needs for ongoing care and support. Although such types of support will usually be provided as a preventative measure under section 2 of the Act, they

¹ Department of Health. Care and Support Statutory Guidance: issued under the Care Act 2014, para 2.9.

may also be provided as part of a package of care and support to meet eligible needs.²

In some circumstances, the provision of equipment will be necessary to support that reablement, as illustrated in case studies set out in the statutory guidance.

1.5. PAUSING AN ASSESSMENT AND PROVIDING EQUIPMENT

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

Statutory guidance suggests that in some circumstances, the local authority could pause the assessment to allow for equipment to be provided, before the assessment is concluded and an eligibility decision made:

Local authorities should not, however, remove people from the process too early. Early or targeted interventions such as universal services, a period of reablement and providing equipment or minor household adaptations can delay an adult's needs from progressing. The first contact with the authority, which triggers the requirement to assess, may lead to a pause in the assessment process to allow such interventions to take place and for any benefit to the adult to be determined.³

² Department of Health. *Care and Support Statutory Guidance: issued under the Care Act 2014*, para 2.60.

³ Department of Health. *Care and Support Statutory Guidance: issued under the Care Act 2014*, para 6.25

1.6. PREVENTION, EQUIPMENT AND FINANCIAL CHARGING

Regulations state that, when provided by a local authority as preventative services under section of the Act, all equipment must be free of charge. So too must any minor adaptation costing £1,000 or less, likewise reablement for up to six weeks.⁴

People buying equipment. Less clear is the legal position when the local authority points people toward preventative services, in terms of independent retailers of equipment. Suggesting that it might be quick and easy for them to purchase their own equipment.

This in itself might not be objectionable, legally. Because the prohibition on a local authority charging for equipment is just that. It presupposes the local authority is providing the equipment in the first place. However, the individual should still be informed that he or she is entitled to an assessment – assuming there is a possible need for care and support. And that if he or she were assessed as having an eligible need, any equipment required to meet that need would be provided free of charge.

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

Local authorities should be innovative and develop an approach to prevention that meets the needs of their local population. A preventative approach requires a broad range of interventions, as one size will not fit all.

⁴ *Care and Support (Preventing Needs for Care and Support) Regulations 2014.*

(...)The person concerned must agree to the provision of any service or other step proposed by the local authority. Where the person refuses, but continues to appear to have needs for care and support (or for support, in the case of a carer), then the local authority must proceed to offer the individual an assessment.⁵

As pointed out above, the assessment offered, should be proportionate and is not necessarily required to be in the person's home.

1.7. NATURE OF ASSESSMENT: IMPLICATIONS FOR EQUIPMENT

Statutory assessment under the Act comes under a number of different sections, for example, s.8 (of adults in need) and s.10 (informal carers). This is separate from whatever is done under s.2 of the Act, by way of prevention.

Regulations state that assessment must be appropriate and proportionate. Guidance states that simpler needs might be amenable to assessment on the telephone.⁶

In addition, the regulations state that local authorities must ensure that assessors are skilled, knowledgeable, competent and appropriately trained.⁷

The implications of this duty are not that qualified professionals are required to do every assessment. But instead, as guidance points out for example, the more complex an

assessment, the more likely it is that a social worker or occupational therapist will need to be involved. Or, for instance, there needs to be such professional support for staff taking calls and referrals at "first contact" points or centres.⁸

The regulations make clear also that people should be offered the opportunity of "supported self-assessment", if they have the relevant mental capacity and want it.⁹

1.8. WELL-BEING, LEGAL ELIGIBILITY AND EQUIPMENT

The Care Act replaced the scheme of eligibility in England known as Fair Access to Care Services (FACS). The new rules are in regulations made under the Act.¹⁰ To be eligible under the Act, three key questions have to be answered.

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

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

⁵ Department of Health. *Care and Support Statutory Guidance: issued under the Care Act 2014*. London: DH, 2014, paras 2.42, 2.46

⁶ Department of Health. *Care and Support Statutory Guidance: issued under the Care Act 2014*, para 2.9.

⁷ SI 2014/2827. *Care and Support (Assessment) Regulations 2014*.

⁸ Department of Health. *Care and Support Statutory Guidance: issued under the Care Act 2014*, paras 6.7, 6.27.

⁹ SI 2014/2827. *Care and Support (Assessment) Regulations 2014*.

¹⁰ *Care and Support (Eligibility Criteria) Regulations 2014*.

Inability to achieve at least two outcomes.

Second, is the adult unable to achieve at least two outcomes?

The outcomes are as follows. They would seem to represent the sort of holistic approach that occupational therapists would see themselves as taking – and equipment could clearly be highly relevant to such outcomes. They are:

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

There must be at least two outcomes not being achieved, for a person to be eligible. However, the regulations explain further what it means to be unable to achieve an outcome.

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

Only one of these, a) to d), is required. Thus, an adult might be managing to achieve certain outcomes but suffer pain doing so, or be at risk, or take a long time to do so. For instance, he or she might be achieving hygiene (getting into the bath) and toileting (using the toilet) outcomes, but only in pain and with significant risk. In which case, it could be that bathing equipment and raised

toilet seat and rails might ensure that the outcomes are achieved, reducing the risk and the pain.

Significant impact on well-being. Third, as a consequence, is there, or is there likely to be, a significant impact on the adult's well-being? This final question takes one back to s.1 of the Care Act, and the definition of well-being, as considered above. Clearly, as already noted, equipment might be highly relevant to components of well-being.

1.9. DUTY TO MEET ELIGIBLE NEED

If all three of the above questions are answered in the affirmative, the adult will have eligible needs. And the local authority will have a duty, under s.18 of the Act, to meet those needs by way of care and support – unless there is an informal carer able and willing to meet them. The duty to meet the need is subject to some provisos.

Ordinary residence. The person must be ordinarily resident in the area of the local authority – or of no settled residence but physically present in the area.

(It should be noted that the ordinary residence rules to determine the responsible local authority do not apply to the NHS. Instead, the responsible NHS clinical commissioning group (CCG) would normally be identified in terms of the GP with whom a person is registered).¹¹

Charging rules and people meeting their own needs? Under s.18 of the Care Act, if a person has resources over a certain

¹¹ NHS England. Who Pays? *Determining responsibility for payments to providers*, August 2013, p.7.

threshold, currently £23,250, and there is a charge for a care and support service, then the local authority will not have a duty to meet the need.

Unless (in the case of a non-residential service), the person asks the authority to do so. In which case the local authority would arrange the service but conduct a means-test to determine what the person would have to pay the local authority for the service.

However, this whole rule cannot apply in the case of equipment - because regulations state that equipment must be free of charge, along with any minor adaptation costing £1000 or less, and reablement for up to six weeks.¹²

Informal carer meeting eligible need. As already noted, if an informal carer is able and willing to meet the need, then although there is still legally an eligible need, there is no requirement that the local authority meet the need by providing care and support.

Alternative statutory route. Likewise, if there is another statutory route whereby a need could be met. For example, if a disabled facilities grant is available under the Housing Grants, Construction and Regeneration Act 1996, or the NHS is going to meet the need: in fact s.22 of the Care Act anyway prohibits social services from doing anything the NHS is required to do under the NHS Act 2006.

Cost-effectiveness. Even then, the duty of the local authority to meet a need is subject to the general principle that it is required to offer only the most cost-effective option for meeting the need - consistent with human

rights and having regard to the person's well-being.¹³

Power to meet need. Although a duty arises to meet an eligible need only, the Care Act makes clear that even if a person does not have an eligible need, the local authority can still choose to meet it.¹⁴

This may be important if the person is unable to achieve only one outcome (see above, para 1.8) – and therefore is not eligible. But the local authority believes that there is nevertheless a significant risk or impact on the person's well-being.

For example, a piece of equipment might address the outcome of using the home safely, even though the assessment did not identify a second outcome not being achieved.

Blanket policies in the meeting of eligible needs. It is difficult to see how blanket policies, on not providing certain types of equipment, fit easily if at all into the legal framework.

First, any such blanket policies risk fettering the local authority's discretion. This is a legal principle that the courts and the local ombudsmen apply: they don't like to see a local authority or NHS body put itself in the chains, so to speak, of its own inflexible policy.

¹³ For the question of duty to meet need, but also cost-effectiveness principle, see older cases: *R v Gloucestershire County Council, ex p Barry* [1997] 2 All ER 1, House of Lords. And more recently: *R (McDonald) v Royal Borough of Kensington and Chelsea* [2011] UKSC 33 (Supreme Court). Also European Court of Human Rights: *McDonald v United Kingdom* (Application no. 4241/12), May 2014.

¹⁴ Care Act 2014, s.19.

¹² *Care and Support (Charging and Assessment of Resources) Regulations 2014.*

It is one thing to have a guideline which decision makers should take account of, but are able to depart from; it is another to be bound in every case, without that discretion to depart from the guideline.

Second, from the financial point of view, if the duty is to meet an eligible need in the most cost-effective way, it would make no sense to rule out in advance the most cost-effective solution. For instance, if a riser recliner chair meant that paid carers would be much less needed, then the chair – over time – might represent a significant cost saving to the local authority.

Equally, a refusal, as a matter of blanket policy, to assist somebody with eligible needs - but who only needed low cost, small items of equipment – would also be questionable. This very point was made by the now defunct fair access care services (FACS) guidance: sometimes small items of equipment could meet significant, eligible need. Local authorities should not therefore have been ruling out the provision of such low cost items as a means of meeting eligible need.¹⁵

Third, the whole approach of the Care Act is based on well-being, outcomes and a more person-centred approach. Personal budgets and direct payments should make it easier for different types of equipment to be provided, whether or not they are stock items held in the local joint equipment store.

Fourth, a blanket policy could be justified however, if provision of that type of equipment was exclusively and undeniably a matter for the NHS. Because s.22 of the Care

Act prohibits the local authority from doing anything that the NHS is required to do.

However, even this rule is not quite so clear, because there may be health and social care aspects to the same item of equipment. For example, wheelchairs are often associated with the NHS. But NHS wheelchair services may not provide wheelchairs for short-term use. Furthermore, there may be some instances in which a wheelchair may anyway be more about social care need than health need. As pointed out in a Department of Health publication from 2006:

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

Social services' assessment shows that replacement of his ramp with a larger one of lower gradient would be expensive, and might not be practical anyway. Furthermore, even if the ramp were replaced, it would not overcome the difficulties he is having getting around the neighbourhood. Having been assessed according to FACS guidance, he was provided with a powered wheelchair, it being the most cost-effective way of meeting his wider needs.¹⁶

1.10 WHAT DOES THE CARE ACT SAY ABOUT EQUIPMENT?

The Care Act itself says little about how a person's care and support needs might be met.

¹⁵ Department of Health. *Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care Guidance on Eligibility Criteria for Adult Social Care*, 2010, para 62.

¹⁶ Community Services Improvement Partnership, Department of Health. *Out and about Wheelchairs as part of a whole-systems approach to independence*, 2006, page 15.

S.8 of the Act, about meeting eligible care and support needs, gives no definition of exactly what care and support is. But it does list a few examples, including “goods and facilities” which could cover equipment. This list is, in any case, not exhaustive, merely illustrative.

The following are examples of what may be provided to meet needs under sections 18 to 20 —

- (a) accommodation in a care home or in premises of some other type;*
- (b) care and support at home or in the community;*
- (c) counselling and other types of social work;*
- (d) goods and facilities;*
- (e) information, advice and advocacy.*

However, as already noted above, the regulations about charging for meeting people’s eligible needs, or meeting needs more generally and preventatively, refer specifically to equipment. And the statutory guidance, too, refers to equipment.

1.11. DIRECT PAYMENTS AND EQUIPMENT

Broadly, s.31 of the Act states that once a personal budget has been agreed, a person will be entitled to a direct payment, subject to a number of conditions (including ability to manage it). This could clearly apply to equipment.

Personal budget. A personal budget is defined in s.26 as the amount it would cost the local authority to meet the need. In the case of equipment, this could give rise to the direct payment, equating to the personal budget amount, being insufficient to buy the piece of equipment required. Without the person, or family, topping up from their own

resources. This could occur, if the equipment in question is a stock item bought in bulk, at a price to reflect this, by the local authority/equipment service.

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

However, a request for needs to be met via a direct payment does not mean that there is no limit on the amount attributed to the personal budget. There may be cases where it is more appropriate to meet needs via directly-provided care and support, rather than by making a direct payment. For example, this may be where there is no local market for a particular kind of care and support that the person wishes to use the direct payment for, except for services provided by the local authority. It may also be the case where the costs of an alternate provider arranged via a direct payment would be more than the local authority would be able to arrange the same support for, whilst achieving the same outcomes for the individual.¹⁷

Ownership, maintenance. When a local authority makes a direct payment for more major items of equipment, questions of ownership, maintenance and care may arise. Previous Department of Health guidance, no longer extant but still useful, emphasised the importance of clarifying these matters:

Where a council makes a direct payment for equipment, it needs to clarify with the individual at the outset where ownership lies as well as who has responsibility for ongoing care and maintenance (just as it should where it arranges for the provision of equipment itself). A council will need to consider what conditions, if any, should be attached to the direct payment when it is used to purchase equipment, for example concerning what will happen to the equipment if it is no longer required by the individual. Equipment can also be purchased as part of making a package

¹⁷ Department of Health. *Care and Support Statutory Guidance: issued under the Care Act 2014*, para 11.26

cost-effective, for example supplying pagers or mobile phones to personal assistants.¹⁸

1.12. TAKING EQUIPMENT FROM ONE LOCAL AUTHORITY TO ANOTHER

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

Many people with care and support needs will also have equipment installed and adaptations made to their home. Where the first authority has provided equipment, it should move with the person to the second authority where this is the person’s preference and it is still required and doing so is the most cost-effective solution. This should apply whatever the original cost of the item. In deciding whether the equipment should move with the person, the local authorities should discuss this with the individual and consider whether they still want it and whether it is suitable for their new home. Consideration will also have to be given to the contract for maintenance of the equipment and whether the equipment is due to be replaced.¹⁹

However, it is worth noting that the word “should”, though a strong encouragement, is not as strong a word in the guidance, as the word “must”. Second, it is made subject to a number of provisos, such as cost-effectiveness, the equipment being suitable in their new home, and the person’s consent.

So, in summary, to comply with the guidance, a local authority would want positively to look at each individual case, and not apply an

¹⁸ Department of Health. *Guidance on direct payments for community care, services for carers and children’s services*, 2009, para 110.

¹⁹ Department of Health. *Care and Support Statutory Guidance: issued under the Care Act 2014*. London: DH, 2014, para 20.36

unduly negative approach. Equally, in the presence of good reasons, a local authority could justify not letting the equipment go.

1.13. EQUIPMENT IN CARE HOMES

Uncertainty sometimes arises as to who is responsible for meeting the equipment needs of residents of registered care homes. On the one hand the care home or – on the other – social services or the NHS.

A starting point to summarise the legal position would be to refer to guidance issued by the Department of Health on NHS continuing healthcare, quoted more fully further on in this document. Although issued in that context, the principles set out apply more widely, including to social services.

First it states that a certain level of equipment should be provided by the care home under both regulatory and contractual requirements.

Second, it states that residents would have the same entitlement to standard equipment services as anybody else (not in a care home). The implication must be, of course, that this second entitlement applies only to the extent that the need is not already met by the equipment provided as standard in the care home.

Third, to the extent that a person has individual needs for equipment (whether or not they require bespoke equipment), over and above the first two avenues of provision, the NHS should provide that equipment.²⁰

²⁰ Department of Health, *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*, 2012, para 172, page 47.

If the need were for equipment to meet social care needs, rather than health care need, the same approach is arguably applicable.

Regulatory requirements. First, under regulations enforced by the Care Quality Commission, care homes must ensure that equipment is safe, is used safely and provided in sufficient quantity to ensure safety and the meeting of residents' needs. Equipment must also be clean, secure, and suitable for purpose, properly used and maintained, and appropriately located.²¹

Guidance on these regulations states (emphasis added):

- *Providers must make sure that equipment is suitable for its purpose, properly maintained and used correctly and safely. This includes making sure that staff using the equipment have the training, competency and skills needed.*
- *Sufficient equipment and/or medical devices that are necessary to meet people's needs should be available at all times.*
- *The premises and equipment used to deliver care and treatment must meet people's needs and, where possible, their preferences.*
- *Reasonable adjustments must be made when providing equipment to meet the needs of people with disabilities, in line with requirements of the Equality Act 2010.*
- *Equipment must be accessible at all times to meet the needs of people using the service. This means it must be available when needed, or obtained in a reasonable time so as not to pose a risk to the person using the service. Equipment includes chairs, beds, clinical*

equipment, and moving and handling equipment.²²

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

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

But it seems unlikely that the regulations and guidance envisage care homes not providing at least a basic range of the equipment typically required by residents of that type of care home – and instead envisage care homes relying wholly on statutory input from the NHS or social services.

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

In Scotland, the Convention of Scottish Local Authorities has published a detailed national protocol, as a guideline to defining the various responsibilities of care homes and statutory services.²³

Making sure needs are met. If a care home were arguably in breach of regulations or contract, then the breach would need to be

²¹ *Health and Social Care (Regulated Activity) Regulations 2014, rr.12, 15*

²² Care Quality Commission, *Guidance for providers on meeting the regulations*, March 2015, see pages 42, 57, 58.

²³ Convention of Scottish Local Authorities. *Protocol for the Provision of Equipment in Care Homes* (undated).

dealt with separately. Either via the Care Quality Commission, or through contractual negotiation.

In the meantime, however, it would be important to ensure that the person's needs were being met – by means of the NHS or social services providing the equipment required on a “without prejudice” basis. Because if a local authority or NHS body has placed a person in a care home, it has undertaken in law to meet that person's needs. The fact that the care home is in breach of a regulatory or contractual requirement does not diminish the duty.

1.14. INFORMAL CARERS: EQUIPMENT

The Care Act 2014 represents a significant change of approach toward informal carers.

First, they enjoy an extended right to assessment of possible need for support. The right to an assessment, under s.10 of the Care Act, is no longer dependent on the carer providing substantial care on a regular basis, as required previously under the Carers and Disabled Children Act 2000.

Second, the duty under s.2 to provide or arrange preventative services applies to informal carers as well as to adults in need.

Third, for the first time, informal carers will be assessed against eligibility criteria. If a carer meets the criteria, the local authority has a duty to meet that carer's need for support.

Fourth, a carer's needs can be met under the Care Act in two different ways. Either by arranging provision for the carer, or by arranging provision for the adult.

Fifth, s.20 of the Care Act states that it is legally possible under the Act for an informal

carer to be eligible but the adult cared for not to be eligible.

Sixth, whether as a preventative service or as an eligible-need service, equipment might meet the need of a carer for support. Whether it is equipment used directly by the carer (for example, a washing machine) - or by the adult in need, but in order to assist the carer (for example, a battery attached to an attendant/carers propelled wheelchair).

1.15. CARE ACT, PRISONS AND EQUIPMENT

The Care Act applies, in the main, to prisons (and to bail and probation hostels) - including the duties of prevention, assessment and the meeting of eligible needs.²⁴ This may involve assessment for, and provision of, equipment.

Care Act guidance states that equipment would be the responsibility of the local authority, whilst adaptations would normally be for the prison to provide (emphasis added):

For those assessed as being in need of equipment or adaptations to their living accommodation to meet their needs, local authorities should discuss with their partners in prisons, approved premises and health care services where responsibility lies. Where this relates to fixtures and fittings (for instance a grab rail or a ramp), it will usually be for the prison to deliver this. But for specialised and moveable items such as beds and hoists, then it may be the local authority that is responsible.

Aids for individuals, as defined in the Care and Support (Preventing Needs for Care and Support) Regulations 2014, are the responsibility of the local

²⁴ Care Act 2014, s.76.

authority, whilst more significant adaptations would be the responsibility of the custodial establishment.²⁵

The National Offender Management Service (NOMS) guidance repeats the gist of the Department of Health guidance, in relation to equipment but is drafted incorrectly. It states that:

*Local authorities are required by regulations supported by guidance to provide at their cost equipment (e.g. hoists) and personal aids (e.g. to assist mobility) up to the value of £1,000.*²⁶

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

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

*In general, the responsibility for minor adaptations and fixings rests with the prisons. In cases of very severe needs it may be necessary to undertake larger scale building work, or to relocate prisoners to adapted or specialist cells.*²⁷

1.16. EQUIPMENT AND STUDENTS AWAY FROM HOME

Local authorities sometimes are asked to assess for and provide equipment in relation

²⁵ Department of Health. *Care and Support Statutory Guidance: issued under the Care Act 2014*, para 17.42

²⁶ National Offender Management Service. PSI 15/2015. *Adult social care*. London: NOMS, 2014, para 12.3

²⁷ National Offender Management Service. PSI 15/2015. *Adult social care*. London: NOMS, 2014, para 12.4

to students in higher education, who are studying out of area. This can lead to uncertainty about where the student is “ordinarily resident”. But it is ordinary residence that determines whether a duty arises to meet a person’s eligible need (see para 1.9 above).

The answer is not always immediately obvious, but Department of Health states that the following approach should be taken. Either, sometimes, becoming ordinarily resident in the area of the university (emphasis added):

where a young person is intending to move areas to go to university, the starting point would be that they are ordinarily resident in the same place as they were ordinarily resident under the [Children Act] 1989 Act. Again, this may not always be the case. If the young person moves to the area in which the university is located for settled purposes and has no intention to return to his authority of ordinary residence under the 1989 Act, then the facts of his case may lead to the conclusion that he or she has acquired an ordinary residence in the area of the University.

Or, sometimes, remaining ordinarily resident in the original local authority:

*Alternatively, if the young person has a base with his or her parents (or those with parental responsibility for him or her) in the local authority where he or she was ordinarily resident under the 1989 Act, and he or she intends to return to this base during the university holidays (including the long summer holiday) then the facts of his case may lead to the conclusion that he or she remains ordinarily resident in the “base” local authority. (...) this local authority would be responsible for meeting eligible needs under the 2014 Act, both during term time at university and during holidays.*²⁸

²⁸ Department of Health. *Care and Support Statutory Guidance: issued under the Care Act 2014*, Annex H8, paras 46-48.

2 CHILDREN AND EQUIPMENT

2.1 CHILDREN ACT 1989

S.17 contains a general duty to safeguard and promote the welfare of children in need. A child in need is defined to include not just a disabled child, but also a child whose health or development is at risk.

The duty is very broad. It could cover the provision of major adaptations, as held by the Court of Appeal.²⁹ So it could clearly cover equipment as well.

However, the duty under s.17 of the Children Act might be broad, but it is relatively weak. Legally enforcing provision of equipment, or indeed anything else, under s.17, for an individual child would be extremely difficult. This is because the duty is a general one toward children in need in the area generally, not toward an individual child.³⁰

2.2 CHRONICALLY SICK AND DISABLED PERSONS ACT 1970 (CSDPA)

S.2 of the CSDPA is legally an extension of Part 3 of the Children Act 1989. It continues to apply to children, although the Care Act has disappplied it in relation to adults. Its significance is at least twofold.

First, in contrast to s.17 of the Children Act, it constitutes a duty toward each individual child, and is therefore amenable to enforcement. This duty is triggered once a

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

Second, s.2 of the CSDPA contains a list of specific services. It is worth spelling out these services below, since most, perhaps all, could be related in some circumstances to equipment. That said, paragraph (e), with the reference to "additional facilities" could be understood as applying to equipment in the home:

(a) the provision of practical assistance for the child in the child's home;

(b) the provision of wireless, television, library or similar recreational facilities for the child, or assistance to the child in obtaining them;

(c) the provision for the child of lectures, games, outings or other recreational facilities outside the home or assistance to the child in taking advantage of available educational facilities;

(d) the provision for the child of facilities for, or assistance in, travelling to and from home for the purpose of participating in any services provided under arrangements made by the authority under Part 3 of the Children Act 1989 or, with the approval of the authority, in any services, provided otherwise than under arrangements under that Part, which are similar to services which could be provided under such arrangements;

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

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

(g) the provision of meals for the child whether at home or elsewhere;

(h) the provision of a telephone for the child, or of special equipment necessary for the child to use one,

²⁹ *The Queen on the Application of Spink (By His Litigation Friend Henrietta Spink) v The London Borough of Wandsworth* [2005] EWCA Civ 302

³⁰ *R(G) v Barnet London Borough Council* [2003] UKHL 57, House of Lords.

or assistance to the child in obtaining any of those things.

2.3 CHILDREN AND FAMILIES ACT 2014

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

2.3.1. EDUCATION, HEALTH AND CARE PLANS

In summary, children with higher levels of special educational needs, which cannot be met by the school from its own resources, will no longer have statements of special educational needs (SENs). Instead, they will have education, health and care (EHC) plans. These contain, as the name suggests, three key elements of needs and provision: educational, health and social care.

As far as equipment is concerned, questions may still arise as to whether the primary need for it relates to education, health or social care. However, once this has been decided, there are clear duties to provide it.

Under s.37 of the Act, an EHC must contain the following (emphasis added):

(a) *the child's or young person's special educational needs*

(b) *the outcomes sought for him or her*

(c) *the special educational provision required by him or her*

(d) *any health care provision reasonably required by the learning difficulties and disabilities which result in him or her having special educational needs*

(e) *in the case of a child or a young person aged under 18, any social care provision which must be made for him or her by the local authority as a result of section 2 of the Chronically Sick and Disabled Persons Act 1970*

(f) *any social care provision reasonably required by the learning difficulties and disabilities which result in the child or young person having special educational needs, to the extent that the provision is not already specified in the plan under paragraph (e).*

It should be noted that any provision made by the local authority (including, therefore, equipment) under the CSDPA, must be included within the EHC.

2.3.2. STRENGTH OF DUTIES UNDER EHC PLANS

The duty to meet these three sets of needs is strong. Under the CSDPA, needs must anyway be met, as already discussed above. And s.42 of the 2014 Act is clear that the local authority must secure the specified special educational provision for the child.

Likewise, the NHS clinical commissioning group must arrange any specified health care provision which could of course include equipment. This last duty on the NHS is significant, because under the old system of statements of special educational needs, the NHS did not have a concrete duty to make provision.³¹

2.3.3. EHC PLANS AFTER AN 18TH BIRTHDAY

Education health and care plans can, in some cases, continue until a person reaches 25.

At the age of 18, the needs of the child – now an adult – will be assessed under the Care Act 2014. So that normally the care part of

³¹ *R v Brent and Harrow Health Authority, ex parte London Borough Of Harrow*, Queen's Bench Division, 1996.

the EHC will cease to be determined by the Children Act and the CSDPA – and instead be determined by an assessment and eligibility decision under the Care Act.³² However, local authorities are given a discretion to continue with provision under the Children Act and the CSDPA – so long as the EHC plan continues - after a person's 18th birthday.³³

³² Care Act 2014, s.58.

³³ Children Act 1989, s.17ZG

3 NATIONAL HEALTH SERVICE ACT 2006

3.1. GENERAL DUTY TO PROVIDE

Health care equipment, for both adults and children, is provided under the NHS Act 2006. Compared to the detailed duties in social care legislation, the Act is vague. It sets out duties in broad terms only.

The vagueness of these general duties under the NHS Act mean that the legal basis for provision of equipment by the NHS differs significantly from the basis for provision by local authorities. Whereas local authorities function in relation to eligibility criteria, which create legally enforceable duties, this is not how the NHS works. In theory, NHS provision of equipment is down to individual clinical judgement. In practice it may be in fact subject to local priorities and rationing, which legally are generally difficult to challenge.³⁴

3.2. COMMUNITY EQUIPMENT

Community equipment is probably covered by s.3 of the Act. It states that clinical commissioning groups must arrange for the provision of various things – “to such extent as it considers necessary to meet the reasonable requirements” of the local population it is responsible for.

Included in the list of what must be provided are “such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the group considers are appropriate as part of the health service”.

³⁴ *R v Cambridge Health Authority, ex p B* [1995] 6 MLR 250, Court of Appeal.

3.3. WHEELCHAIRS

Wheelchairs are specifically mentioned in schedule 1, paragraph 9 of the 2006 Act. Clinical commissioning groups are given a specific power, though not a duty, to make arrangements for the provision of vehicles (including wheelchairs) for people who appear to the CCG to have a “physical impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities”.

3.4. NHS CONTINUING HEALTHCARE (CHC)

NHS continuing healthcare for adults is defined in regulations as meaning “a package of care arranged and funded solely by the health service in England for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness.”.³⁵

Sole responsibility of NHS. The word “solely” denotes that legal responsibility lies with the NHS. By the same token, s.22 of the Care Act 2014 forbids a local authority, under the Care Act, to meet needs by providing a facility or service that the NHS is required to provide.

Community equipment and CHC. Putting these two legal provisions together, once NHS continuing healthcare status is established, then it is the NHS that has responsibility for providing community equipment to people in their own homes. Guidance highlights this point:

³⁵ *National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, r.32A.*

Where someone is assessed as eligible for NHS continuing healthcare but chooses to live in their own home in order to enjoy a greater level of independence, the expectation in the Framework is that the CCG would remain financially responsible for all health and personal care services and associated social care services to support assessed health and social care needs and identified outcomes for that person, e.g. equipment provision ..., routine and incontinence laundry, daily domestic tasks such as food preparation, shopping, washing up, bed-making, support to access community facilities, etc. (including additional support needs for the individual whilst the carer has a break).³⁶

The same guidance gives further help to explain responsibilities for equipment provision (emphasis added):

Where individuals in receipt of NHS continuing healthcare require equipment to meet their care needs, there are several routes by which this may be provided:

- a) *If the individual is, or will be, supported in a care-home setting, the care home may be required to provide certain equipment as part of regulatory standards or as part of its contract with the CCG...*
- b) *In accordance with the principles set out in paragraphs 113 - 117, individuals who are entitled to NHS continuing healthcare have an entitlement – on the same basis as other patients – to joint equipment services. CCGs should ensure that the availability to those in receipt of NHS continuing healthcare is taken into account in the planning, commissioning and funding arrangements for these services.*
- c) *Some individuals will require bespoke equipment (or other non-bespoke equipment that is not available through routes (a) and (b) above) to meet specific assessed needs identified in their NHS continuing healthcare care plan. CCGs should make appropriate arrangements to meet these needs. CCGs should ensure that there is clarity about which*

*of the above arrangements is applicable in each individual case.*³⁷

These paragraphs can be explained simply. Paragraph (a) refers to the obligation on a care home to provide a certain level of equipment to a resident – within the fee paid to the care home for an NHS continuing healthcare patient.

Paragraph (b) is stating that a person with NHS continuing healthcare status is entitled to equipment – in a care home or their own home – just as they would be to any other service under the NHS continuing healthcare rules. If there is a joint equipment store locally, and standard equipment is required, it would be issued from that store. But it would still be, ultimately, the legal and financial responsibility of the NHS – against whom the equipment should be “chalked up”, as it were.

Paragraph (c) notes that – for a person in a care home or in their own home – any equipment required, but not available through either the care home or the joint equipment store, should be provided separately by the NHS.

Joint working and equipment provision.

None of the rules above prevent a local authority providing equipment for a person on behalf of the NHS, even when the NHS is responsible legally for provision. This could be founded on a joint working agreement under s.75 of the NHS Act 2006. This would then mean that the equipment was being provided by the local authority not under the Care Act 2014, but under the NHS Act 2006.

³⁶ Department of Health. *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*, 2012, para 85.1, page 108.

³⁷ Department of Health, *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*, 2012, para 172, page 47

3.5. NHS CONTINUING CARE FOR CHILDREN

The position for children is not quite the same as for adults.

The relevant regulations do not define continuing care for children the same as they do for adults. For the latter, NHS CHC is defined as a package of care arranged and funded solely by the NHS (see above). Whereas for children, the regulations state that:

*Continuing Care for Children means that part of a package of care which is arranged and funded by a relevant body for a person aged 17 or under to meet needs which have arisen as a result of disability, accident or illness.*³⁸

Multi-agency approach. Department of Health guidance emphasises the multi-agency approach to children. It maintains that continuing care for children works differently to continuing healthcare for adults:

*There are significant differences between children and young people's continuing care and NHS Continuing Healthcare for adults. Although a child or young person may be in receipt of a package of continuing care, they may not be eligible for NHS Continuing Healthcare or NHS-funded Nursing Care once they turn 18. Further information on how to support transition is given below.*³⁹

The new guidance emphasises the link with education, health and care (EHC) plans (see above) – with continuing care arranged by the NHS equating to the health part of the EHC plan.

³⁸ National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, r.32A.

³⁹ Department of Health. *National Framework for Children and Young People's Continuing Care*, 2016, p.5.

NHS responsible for health care, but not solely responsible for meeting all needs.

As already noted, sole responsibility for meeting health and social care needs is placed on the NHS in the case of continuing healthcare for adults. But this is not so for children. Even so, the NHS still retains specific legal responsibility for some things.

For example, in the *Haringey* legal case involving a child, the judge held that some of the principles governing CHC for adults would apply also to children. The case involved tracheostomy care for a child at home. He held such care could not, as a matter of law, be provided under children's social care legislation.⁴⁰ He arrived at this view, by citing the leading adult case, the *Coughlan* case, on NHS continuing healthcare.⁴¹ Department of Health guidance states:

*In line with the Haringey judgement (...) there are clear limits to what care should be funded by the local authority, which should not be a substitute for additional NHS care for children. In this case, the High Court determined that the duty under section 17 of the Children Act 1989 did not extend to meeting essential medical needs.*⁴²

Decision support tool. Department of Health guidance for children includes a “decision support tool” (DST), to assist in identifying continuing care needs – that is, needs to be funded by the NHS. The DST looks at levels of need across different “domains” of the person's needs.

⁴⁰ *R (on the application of D and another) v Haringey London Borough Council* [2005] All ER (D) 256.

⁴¹ *R v North and East Devon Health Authority, ex parte Coughlan* [1999] B.L.G.R. 703).

⁴² Department of Health. *National Framework for Children and Young People's Continuing Care*, 2016, p.8.

(For adults, the DST is used to assist in deciding whether a person's needs are NHS continuing healthcare – and fall solely to be met by the NHS.⁴³ For children the DST is used to identify just “continuing care” – that part of a care package to be provided by the NHS).⁴⁴

3.6. PERSONAL BUDGETS AND DIRECT PAYMENTS

The NHS has a power to make direct payments to patients, under s.12A of the NHS Act 2006. In principle, this power applies to the provision of equipment, as well as services.

If an adult has NHS continuing healthcare status, or continuing care status as a child, then the clinical commissioning group (CCG) must ensure that it is able to arrange provision by means of a personal budget. A direct payment is then one option for managing that budget.⁴⁵

⁴³ Department of Health. *Decision Support Tool for NHS Continuing Healthcare*, 2012.

⁴⁴ Department of Health. *National Framework for Children and Young People's Continuing Care*, 2016, p.31, para 148.

⁴⁵ SI 2012/2926. National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, rr.32A, 32B.

4 HEALTH AND SAFETY AT WORK ACT 1974 AND REGULATIONS

The Health and Safety at Work Act 1974, and regulations made under it, impose a number of duties. Most of these are imposed on employers in relation to employees. But some are directed also to the duty of employers towards non-employees.

In the context of equipment, this legislation is therefore relevant to equipment provision, storage, delivery, demonstration etc. And to the use of equipment, in the work setting, including people's own homes. But it applies also to the use of equipment, not in the work context, by disabled people themselves and their families. In this last case, it is the duties to non-employees that are relevant. For example, s.2 of the 1974 Act contains the duty towards employees, but s.3 the duty to non-employees.

Another example would be the Provision and Use of Equipment at Work Regulations 1998. These stipulate duties of inspection and maintenance of some equipment used at work. And so would cover the use of equipment in people's homes, when that equipment is being used by employees – for example, local authority or care agency employees. But, if the equipment were being loaned by the local authority and used by family members only, it might still need to be inspected and maintained. But this would then come under the duty to non-employees, under s.3 of the Act.

4.1. DUTY OF THE EMPLOYER TOWARD EMPLOYEES

Under s.2 of the 1974 Act, it is the duty of the employer to, so far as is reasonably

practicable, ensure and provide for the health, safety and welfare of all staff at work.

More specifically this includes, but is not limited to the following. The emphasis has been added to highlight the relevance to equipment (emphasis added):

(a) the provision and maintenance of plant and systems of work that are, so far as is reasonably practicable, safe and without risks to health;

(b) arrangements for ensuring, so far as is reasonably practicable, safety and absence of risks to health in connection with the use, handling, storage and transport of articles and substances;

(c) the provision of such information, instruction, training and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety at work of his employees;

(...)

(e) the provision and maintenance of a working environment for his employees that is, so far as is reasonably practicable, safe, without risks to health, and adequate as regards facilities and arrangements for their welfare at work.

4.2. DUTY TOWARD NON-EMPLOYEES

Under s.3 of the 1974 Act, the employer has a duty to conduct the undertaking to ensure, so far as is reasonably practicable, that people not employed by the employer – who may be affected - are not thereby exposed to risks to their health or safety.

So, in the context of equipment provision and loan by local authorities, this duty can clearly cover, amongst other things, people and their families using equipment in their own home.

4.3 DUTY OF SELF-EMPLOYED PEOPLE TO THEMSELVES AND OTHERS

Under s.3 of the 1974 Act, self-employed people have duties, in some circumstances, to not expose themselves or other people to health and safety risks.

4.4. DUTY OF EVERY EMPLOYEE WHILE AT WORK

Under s.7 of the 1974 Act, employees have duties, too. Employees must take reasonable care of their own health and safety and that of other people affected by their actions or omissions.

4.5. MANUAL HANDLING OPERATIONS REGULATIONS 1992

Regulations augment the Health and Safety at Work Act 1974, which applies to all work activities and requires employers; to ensure, so far as is reasonably practicable, the health, safety and welfare of all their employees while at work.

These Regulations are aimed at improving the safety of employees involved in manual handling. In brief summary, employers must:

- *avoid, so far as is reasonably practicable, manual handling operations carrying a risk of injury; failing this,*
- *assess the relevant manual handling operations and take appropriate steps to reduce the risk of injury to the lowest level reasonably practicable.*

The implications of the Regulations are various. They include, of course, provision of appropriate equipment to avoid or minimise risk to staff.

However, in health and social care, it will not always be reasonably practicable to eliminate risk, because of the needs of service users. This might be because of the nature of their needs and environment, urgent situations, not to mention rehabilitation which sometimes involves at least a degree of risk to staff – etc.

Therefore, the regulations are also about training staff in manual handling techniques – notwithstanding the availability of equipment. For instance, about how to manage assisted transfers in appropriate circumstances (when the risk is manageable and the needs of the service user require assisted transfer).

4.6. LIFTING OPERATIONS AND LIFTING EQUIPMENT REGULATIONS 1998 (LOLER 1998)

These Regulations are made under the Health and Safety at Work Act 1974. They apply to the use of lifting equipment at work.

Where equipment for lifting people 'is exposed to conditions causing deterioration which is liable to result in dangerous situations,' it must be thoroughly examined either a) by default every six months or b) at some other interval specified in a competently drawn up alternative examination scheme. Defects must then be remedied. A report of a thorough examination must include, for example:

- *safe working load*
- *the examination scheme (e.g. default six-monthly, or alternative scheme)*
- *reference to defects, repairs, renewal, alterations required*
- *date of next examination*
- *name etc. of person carrying out examination*

- *date of the report.*⁴⁶

There has sometimes been doubt as to when LOLER apply – e.g., because of questions about the definition of ‘lifting equipment’, and whether equipment is being used ‘at work’ when it is loaned for the use of individuals and informal carers.

But, in any case, if LOLER does not apply because the equipment is not lifting equipment, PUWER (see below) would apply, assuming the equipment is being used at work.

And if equipment is not being used at work, then s.3 of the Health and Safety at Work Act 1974 is likely to apply. Thus, the message is that lifting equipment needs to be examined and maintained adequately, whichever bit of law applies.

This was spelt out in 2002 guidance from the Health and Safety Executive:

If the service provider supplies equipment such as a stair lift, bath lift or toilet riser, primarily to reduce the risk of injury to care workers while attending to the client, then the equipment may be considered work equipment. In these circumstances, the Provision and Use of Work Equipment Regulations 1998 (PUWER) will apply. Depending on the type of equipment, the Lifting Operation and Lifting Equipment Regulations 1998 (LOLER) may also apply. These regulations require the equipment provider to maintain and inspect the equipment.

If the equipment is mainly for the client’s own use, then the PUWER/LOLER regulations will not apply. However, the equipment provider has responsibility under the general provisions of the Health and Safety at Work etc Act 1974, to ensure that it is safe for the client and care workers to use. Though the PUWER/LOLER regulations may not apply, their

*provisions can be used as a guide to establish proper maintenance arrangements.*⁴⁷

4.7. PROVISION AND USE OF WORK EQUIPMENT REGULATIONS 1998 (PUWER 1998)

The primary objective of PUWER 98 is to ensure that use of equipment at work does not result in health and safety risks, regardless of its age, condition or origin.

The PUWER place responsibility on the employer to provide suitable work equipment for the task and ensure that information, written instructions and training is available to the people who use it.

Employers must ensure that work equipment is maintained in an efficient state, in efficient working order and in good repair.

Employers must also ensure that work equipment exposed to conditions causing deterioration, which is liable to result in dangerous situations is inspected (a) at suitable intervals. They must also assess if exceptional circumstances have occurred, such as to jeopardise safety. This is to ensure that health and safety conditions are maintained and that any deterioration can be detected remedied in good time.

Employers must ensure that inspections are recorded and kept until the next inspection.

Equipment used mainly or solely by people and their families will not come under PUWER. But may still need to be inspected and maintained: see HSE advice, quoted in the section immediately above in this document.

⁴⁶ Health and Safety Executive. *Lifting Operations and Lifting Equipment Regulations (LOLER) 1998: guidance.* (1999, reprinted 2008). Schedule 1

⁴⁷ Health and Safety Executive. *Handling home care,* 2002, para 53

5. CONSUMER PROTECTION ACT 1987

Liability is imposed on manufacturers of defective consumer products, which cause damage, and on suppliers, when requested cannot identify where they got the products from.

Department of Health guidance issued to the NHS in 1988, when the Act came into force, suggested that records of equipment should include the following type of detail; serial and batch number, date of issues of product for patient use, proof that instructions/warnings about use, maintenance, storage, expiry dates have been followed. However, it did also acknowledge that there would be practical limits to the amount of record keeping possible.

must keep up to date with MHRA warnings on specific equipment and take appropriate action when alerts are received.

6. MEDICAL DEVICES REGULATIONS 2002

Manufacturers have an obligation to place a CE mark on a device to show that it conforms to essential safety requirements. Although custom made devices need to conform to essential requirements, a CE mark is not placed on them. Regulation of medical devices is overseen by the Medicines, Healthcare products Regulatory Authority (MHRA).

Manufacturers must report, to the MHRA, malfunctioning of or deterioration in the performance of a device, inadequacy or instructions and technical or medical reasons for recall of a device.

Adverse incidents should be reported to the MHRA.

The MHRA issues device alerts and safety notices. Health and social care organisations