Manual Handling, Single-Handed Care, Occupational Therapy And The Law: 2020 And Beyond: A Discussion Paper

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(Michael Mandelstam, August 2020)

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1. Introduction and summary

I have been asked by Matthew Box at *Inclusion.Me* to write a discussion paper about the legal aspects of manual handling, focusing in particular on what is commonly referred to as single-handed care – as it stands in 2020 and beyond in England.

I am very conscious of the significant success reported of single-handed care projects, including by *Inclusion.Me* itself. And of the benefits that can accrue all round – including improved outcomes of those being handled, as well as better use of everybody's resources, in terms of both money and staff time.

Bringing a legal perspective to the table furnishes an underpinning to single-handed care policy and practice, in order to support and consolidate such favourable outcomes. As well as to indicate the legal pitfalls to be avoided by local authorities, the NHS and other providers – and by practitioners in terms of their own professional practice and standards. Such pitfalls tend to expand in size and gape ever larger, in proportion to pressures within the health and social care system.

The paper considers what is meant by single-handed care, and the wider term, "reduced-carer handling". It adopts mainly the latter term, as being more useful to analyse the wider trend of reducing the number of care workers needed to care for and handle a person.

The paper sets reduced-carer handling in the context of relevant law, including health and safety at work legislation, welfare legislation such as the NHS Act and Care Act 2014, the Human Rights Act 1998 and the Mental Capacity Act 2005.

It notes that the term, "balanced decision-making", has been used to understand and reconcile such varied legislation. The term was used in one of the most influential of manual handling cases, known as the *East Sussex* case of 2003. In the context of reduced-carer handling and the tensions that may arise, this approach can assist resolve them. For example, the dilemma of safer (or cheaper) hoisting - against assistive handling which would be more consistent with a person's assessed needs. Or, as one judge memorably put it, remembering that in health care one is dealing with a person, not a sack of cement.

The paper goes on to pick out and summarise some of the relevant legal cases about such, and related, matters. Along the way, it refers to the increased focus on remote assessment in the context of a viral pandemic. And looks ahead to the future, to see where the trend of reduced-care worker handling may be leading. Including the question of increased "mechanisation" of care, the use of new technology and robots.

Lastly, it considers single-handed care from a slightly different angle; that of informal carers who often perform such manual handling. And the

complications that arise when both a lack of mental capacity and safeguarding concerns supervene.

2. Single-handed care or reduced-carer handling

The term, single-handed care is commonly used, but is probably not the optimum term to use. Better, as pointed out to the author by Frances Kent, would be “reduced-carer handling”.

This is for the simple reason that the trend we see is not just about reducing two care workers to one. It might be moving from three carer workers to two, or from one or two carer workers to none – i.e. not double-handed, not single-handed but “no-handed” care. In case of the last possibility, care workers are replaced wholly by equipment. Which could be simple equipment, electrical or otherwise, such as incontinence pads or a profiling bed replacing night-time-carers – as occurred in the *McDonald* and *Lewisham* legal cases, outlined below. Further along the spectrum come robotics, if the government’s vision for the future, of more or less autonomous robots in social and health care, comes to pass.

Reduced carer handling might be achieved through more careful assessment of a person’s needs and how to meet them; training and deployment of improved manual handling skills; use of different and more appropriate equipment – and basing decisions on individual assessment rather than blanket policies about how many care workers will be needed to handle people and with what equipment.

Assessment will typically include consideration of the person’s needs, the environment, equipment, skills, and competencies required by care workers in that individual situation.

Careful assessment and competent delivery of care depend crucially commissioning and contracts departments. If expert occupational therapy assessments are identifying manual handling solutions, single-handed or otherwise, they will be deliverable only if contracted care providers have staff who are suitably competent, supervised and trained. It is surely incumbent on

local authorities to work with care providers in a constructive manner, but at the same time to specify contractual requirements covering these matters.

Highly relevant to achieving reduced carer handling and good quality care, is section 5 of the Care Act 2014. It states that

- "*a local authority must promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring … a variety of high quality services to choose from … a local authority must have regard to … the importance of fostering a [care provider] workforce whose members are able to ensure the delivery of high-quality services (because, for example, they have relevant skills and appropriate working conditions)*".

Additionally, local authorities to recognise the importance of adequately supporting occupational therapists to assess and identify manual handling solutions. For example, by facilitating ready access to appropriate equipment, a crucial element of a move toward reduced carer handling. And ensuring adequate occupational therapist numbers (e.g. to avoid waiting lists), access to professional and clinical support, ongoing training, etc.

Immediately below are some of the benefits and disadvantages frequently cited for reduced-carer handling. The overall question for this discussion paper is how these pan out in law.

3. Reduced-carer handling: benefits

Reported benefits of reduced-carer handling sometimes seem overwhelmingly positive. They include good outcomes for those being handled, such as feelings of well-being, improved health, greater dignity, establishing a better relationship with one care worker (rather than two), greater flexibility in the timing of visits etc.

In addition, those doing the handling may feel more confident and gain new skills. If individual situations are being assessed more carefully, then the

handling might be carried out in improved manner. So too might the person's needs be better met, if those needs have been better considered. [1]

In other words, it would seem to follow that a greater focus on competencies, skills and use of appropriate equipment can benefit both care workers and service users – the latter if this focus leads to improved assessments and reviews of needs. This will lead also to an emphasis on reducing carer handling by greater use of handling equipment and more skilled handling. As well as on looking harder at the scope for reablement, rehabilitation and indeed equipment which can help the person help themselves with transfers. For instance, very simply, on this last point, a riser recliner chair may obviate the need for a carer to help somebody out of a chair.

For instance, hoists may indicate dependence and passivity. However, other equipment may positively aid the maintenance or even restoration of functioning and mobility – including riser recliner chairs, adjustable height beds, stand aids and so on.

For care agencies or other organisations supplying the handlers, their workforce will stretch further if individual situations call for fewer carers. Given the pressures on the health and social care workforce, this is a not insignificant consideration. For commissioners of care, such as local authorities and the NHS, it is of course cheaper to pay for one care worker rather than two. Likewise, if individuals themselves are paying for their own care.

SINGLE-HANDED CARE PROJECTS: CONSIDERING THE OUTCOMES FOR SERVICE USERS.
Reviewing the above positives, one cautionary note may nevertheless be as follows. The benefits of reduced-carer handling are sometimes reported as the result of "projects".[2]

That is, a concerted effort, over a period of time and typically by a local authority, to promote and increase such handling. During any such project, there may well be a closer (than usual) assessment and review of people's needs. This could then be expected, irrespective of the aim of reduced-carer

[1] See generally: Harrison, D. (2017 and 2018) Single-handed care: it is a vision or a reality. Parts 1 and 2. *Column*, Volume 29, Issue 4, 2017. And Volume 30, Issue 1, 2018. Also: Inclusion.Me. *A Social Return on Investment Analysis and Report on the Double-handed Package of Care Review project for Thurrock Social Services*. June 2019.

[2] For example, referring to various projects: Phillips, J; Mellson, J; Richardson, N. *It takes two? Exploring the manual handling myth*. University of Salford, 2014.

handling and of saving money, arguably to lead to better outcomes for the service user. In which case it may be that it is the closer attention to a person's needs, and not just reduced-carer handling, which at least partly contributes to those seemingly improved outcomes.

4. Reduced-carer handling: disadvantages?

In order to weigh up the legal and practical implications of reduced-carer handling, one needs to consider its possible disadvantages as well.

These can, in some situations, be various. Whilst some service users may welcome a reduced number of carer workers, others may be opposed for a variety of reasons, related to physical, emotional, psychological and cognitive needs (and wishes).

Whilst single-handed care projects may have gone the extra mile to consider individual needs, if single-handed care then becomes a default position, risks may be attached if care is not taken. For instance, people may end up being hoisted (by one care worker) rather than assistively handled by two – even though the latter may be essential to maintain or restore a degree of mobility.

Nor is it just about the positives of people retaining some mobility, but also the negatives in the form of a range of counter-indications attaching to immobility. As considered, for instance, in an ombudsman case, involving the obvious, positive benefits of the person retaining mobility - but also the counter-indications of more bed care and turning that would be required (problematic because of reflux problems) and of hoisting (PEG feed having to be disconnected).[3]

Likewise, in a protracted manual handling case the author was involved with, in which the GP had identified a significantly increased risk of aspiration pneumonia – should the patient lose her mobility, through a refusal by the local authority to countenance assistive handling.

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

It may simply be a matter of safety: in the following case, though the care plan did call for double-handed handling, single-handed was provided, resulting in death:

Single-handed care contrary to care plan: fall, fracture, hospital admission and death. An 86-year old resident was supported by two members of staff as she took a bath using a bath chair. At the end of the bath, she was handled by a single member of staff only. This was contrary to the care plan which specified a minimum of two handlers. Consequently, she slipped out of the bath chair, falling to the ground, hurting her knee.

The following day, she complained of pain. The GP suspected a fractured and advised urgent referral to hospital and an X-ray. The care home did not follow this advice, giving pain relief instead; nor did it explain to the family details of the accident and severity of the fall. Five days later, realising she was in significant pain, the family took her to hospital. A fracture was diagnosed, necessitating an operation, during which she suffered a heart attack and die. The care home was found guilty and fined £12,000.[4]

Reduced-carer handling may also put greater pressure on a single care worker to be sufficiently confident and competent – given that there is nobody else immediately to hand with whom to share any concerns or difficulties. Which may be no bad thing, if that care worker has the necessary skills and confidence; something which, however, may by no means always be the case (through no fault of the care worker).

Thus, for commissioners and care providers, it becomes even more important to ensure such confidence and competence in the handlers.

THE RISK OF DEFAULT APPROACHES. A default position generally carries wider legal and practical risks. Calling something a "default" implies that it may be departed from. Nonetheless, once established in a climate of pressure on commissioners and providers, it can easily become a blanket policy. In which case, it ceases to take account of individual needs and of handler competence. Further, if commissioners of care become aware of how much money can be saved through reduced care handling, they may overtly or covertly start to put pressure on those key professionals who carry out assessments.

[4] Sarsby, S. *Liverpool care home fined over £12,000 for "failings" in care and treatment*. AT Today, 25th March 2019. Accessed on 7th August at: **http://attoday.co.uk/liverpool-care-home-fined-over-12000-for-failings-in-care-and-treatment/**

For instance, occupational therapy managers have from time to time related to the author just such pressure which they sometimes find difficult to resist – in terms of signing off packages of care contrary to their professional judgement.

If an occasional therapy team is lauded in an organisation by commissioners for saving money, the pressure may be on the team to continue to find savings. Indeed, there is nothing wrong with that – as long as professional judgements and the meeting of people's needs are not jeopardised. (In fairness, other occupational therapists report that whilst single-handed care is in principle regarded as default position, they can depart from it freely on the basis of professional judgement, evidence and reasoning in any one case).

THE FINE LINE: SAVING MONEY, FOLLOWING POLICY AND STAYING TRUE TO CORE PRINCIPLES. A recent document published by the Royal College of Occupational is called, *Relieving the pressure on social care: the value of occupational therapy*. On its second page, it states that "occupational therapy services are not only cost effective but can make a considerable difference to people's quality of life". On the third, its first example is of how a single-handed care project saved a local authority £475,000 per annum. [5] The wording surely illustrates the fine and sometimes difficult line that may need to be trodden, between a profession arguing its usefulness in saving money, but being clear that it remains true to its core principles.

By way of a further example, manual handing guidelines published by the Chartered Society of Physiotherapy fully recognise the need for safety, and the importance of equipment in manual handling. But they make a clear statement also that the profession is not about to turn tail and abandon its core skills and its aim of rehabilitating patients.[6]

5. Coronavirus (Covid-19), manual handling and reduced-carer handling

[5] Royal College of Occupational Therapists. Relieving the pressure on social care: the value of occupational therapy. London: RCOT, undated, pp.1-3.
[6] Chartered Society of Physiotherapists. *Guidance on manual handling in physiotherapy*. 4th edition. London: CSP, 2014, p.12.

The request to write this discussion paper has been made at a time when we have all, in everyday life, been hugely affected by the coronavirus, Covid-19. When, in health and social care, the Coronavirus Act 2020 has been in force, legally depleting, temporarily, certain duties in the Care Act and NHS Act 2006. Not to mention the practical difficulties for health and care providers generally of discharging functions under these two Acts, and under the Health and Social Care Act (Regulated Activities) Regulations 2014 (governing minimum standards of care in health and social care, enforced by the Care Quality Commission).

In relation to manual handling generally, questions have arisen over face-to-face or remote assessment, demonstration, 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, of weighing up - using professional judgement – the environment, the person being handled, the handlers, needs, safety (including infection risks) and so on.

Such matters are not confined to reduced-carer handling or single-handed care, in particular. But they are of course relevant to a reduced risk of infection (the fewer care workers required in a person's home, arguably the fewer the risks of transmission). And if, during such a period, the care workforce is stretched more than usual, then again reduced-carer handling takes on additional significance in maximising its potential.

6. Beyond coronavirus

Whenever Covid-19 subsides, there may well be a legacy left behind which will affect manual handling. One such would presumably and inevitably be increased attention to infection control in general. Another would be consideration of what can be achieved remotely in health and social care on an ongoing basis – and not just during a period of pandemic crisis.

In this sense, the Covid-19 may be viewed as having simply accelerated trends already in evidence, or certainly in the pipeline. Under the Care Act 2014, probably most local authorities have long since been doing a form of remote assessment – by telephone – of those people whose needs they believe are

relatively straightforward. And who therefore do not need to be seen face to face. With other forms of technology now much commonly available, such as tablets and smart phones, the scope for remote assessment becomes that much greater.

Similarly, 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 relieving pressure on the GP service.[7] The benefits and risks of this have been consulted upon by the Royal General College of General Practitioners.[8] Hospitals have been conducting some outpatient appointments remotely.[9] At the end of July, the Secretary of State for Health announced that in future all *initial* GP consultations should be by telephone or online.[10]

There are of course limits to remote assessment. One legal case in March 2020 involved a mental capacity assessment of a care home resident. Given the infection risks at the time, the judge stated that a remote assessment was necessary in all the circumstances, but manifestly undesirable. Creativity would be required.[11] Because such assessments are not straightforward. The judicial comment suggested an acceptance that in normal times, one would not be looking for remote assessment to deliver judgements about mental capacity.

Where does this leave manual handling, related issues (including equipment use) and remote assessment? Legally, the answer lies in practitioners and organisations considering their responsibilities – as outlined below – and coming to reasoned professional judgements as to what is or is not achievable remotely. For instance, when complying with the Care Act 2014 duty to carry out an appropriate and proportionate assessment.[12] And, under health and

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[7] Marshall, M; Shah, R; Helen Stokes-Lampard, H. Online consulting in general practice: making the move from disruptive innovation to mainstream service. *British Medical Journal*, 26th March 2018.
[8] Royal College of General Practitioners*. Online consultations in general practice: the questions to ask*. July 2020.
[9] NHS England. *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.
[10] Cowburn, A. All initial GP consultations should now happen on phone or online, Matt Hancock announces. *The Independent*, 31st July 2020.
[11] *BP v Surrey County Council* [2020] EWCOP 17, 25th March 2020.
[12] Care and Support (Assessment) Regulations 2014.

safety at work legislation, when avoiding or reducing risk - either of infection or of manual handling - as far as is reasonably practicable.[13]

7. Reduced carer handling: past, present and future

This paper is trying to outline how single-handed care, the current focus in many local authorities, is part of a wider picture. Involving reduced carer handling. And that, in turn, reduced carer handling – together with increased use of more, and more appropriate, equipment - is not just a present phenomenon but also past and future. And furthermore that - considering this past, present and future - there have been, there are and there will be, similar legal considerations in play.

THE SPREAD OF HOISTS, BEDS AND CHAIRS. During the 1980s, there was a series of manual handling cases brought to court in the common law of negligence. Not uncommonly, one of the themes of these cases was the use of equipment. For instance, whether hoists were available and maintained – and whether nurses were trained and encouraged to use them. In order, primarily, to avoid unsafe assistive handling and lifting. Yet not, by the same token, to relegate the needs of patients to an irrelevance.

As the judge put it in one of these older cases, patients might not always like hoists, and nurses (then) might not have been accustomed to using them. But nonetheless a hoist might be required to save a nurse from injury, particularly when she was confronted with a "short, obese, great in girth and heavy" patient.[14]

Another simple illustration would be the increased use, in the recent and near past, of riser recliner chairs or adjustable height beds, which for those with some residual mobility may reduce or even remove the need for assistive handling. Likewise, equipment designed to raise a patient from the floor to chair or bed – and mobile lifts, enabling the person themselves to stand up and then walk, with support from the frame.

[13] Manual Handling Operations Regulations 1992.
[14] *Munrow v Plymouth Health Authority* (1991), High Court, unreported.

ROBOTICS. Looking to the future, research continues on the use of robotics in health and social care. Outside of manual handling, there are robotic surgeons in use and pet cats for older people.[15] Four-foot-high, £15,000 in cost, mobile robots have "patrolled" care homes, greeted residents and talked to them, inter-actively, in Southend, amongst other places.[16] Robots may allow others such as family members or practitioners, to communicate via a mobile robot's video screen with somebody confined to their own home or a care home.[17]

Closer to manual handling are robots being considered to assist with care tasks – including the bringing of food and drink to care home residents and ensuring that a person takes medication on time. Even robots to perform actual manual handling tasks, such as helping a person to their feet.[18] Or out of bed.[19] In terms of reduced carer handling, robotics may not yet be about "no-handed care":

Piloting robots engaged in manual handling in a care home: issues that arose. When robots were piloted in a care home in Japan, a care worker would need to supervise the robot when it was manually handling a resident. From the pilot questions arising included the meeting of people's needs, emotional reactions to the robot, safety, comfort, discomfort, expenditure of time setting up the robot. Although many of the care workers complained of bad backs, incurred by caring tasks in the past, they nonetheless did not necessarily embrace the new technology. Not, it seems, because of fear of losing their jobs, but because of the effect of the robots on the caring relationship between care worker and resident.[20]

Practical questions emerging from this pilot would all feed into the legal issues outlined in this paper – safety, cost-effectiveness, needs, human rights and balanced decision making (see below).

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[15] Robotic pets spark joy in care homes. *Engineering and Technology*, May 2019. Accessed at: https://eandt.theiet.org/content/articles/2019/05/robotic-pets-spark-joy-in-care-homes/

[16] Levy, A; Witherow T. Coming to a care home near you... the robot companions for the elderly: £15,000 machine called Pepper seeks out residents to talk to and could also monitor their health. *Daily Mail*, 24th October 2017.

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

[18] Department for Business, Energy & Industrial Strategy. Press release: *Care robots could revolutionise UK care system and provide staff extra support*. Her Majesty's Government, 26th October 2019.

[19] Dredge, S. Robear: the bear-shaped nursing robot who'll look after you when you get old
This article is more than 5 years old
Japanese robot can lift patients from beds into wheelchairs or help them to stand up, promising 'powerful yet gentle care' for the elderly. *The Guardian*, 27th February 2015.

[20] Wright, J. Tactile care, mechanical Hugs: Japanese caregivers and robotic lifting devices. *Asian Anthropology*, 4th January 2018.

These issues are likely to become more pronounced in the future. The Department for Business has made clear that with increasing numbers of older people and strains on the adult social care workforce, robotics is the great hope. Including, even, the helping of people with mobility, with getting up from chairs or from the floor and with physiotherapy.[21]

The pilot referred to above was in the context of Japan trying to make up for a shortfall in the care workforce, in relation to a proliferating elderly population.[22] In similar vein, the current strains, already considerable, in the United Kingdom on social care are likely to be exacerbated, at least in the short term, by new immigration policies linked to Brexit.[23] Thus, it is clear why the UK government is so interested in robotics and the increased mechanisation of social care. And why a press release about social care, from the Department of Business, Energy and Industrial Strategy, attached importance to the question of "autonomy": that is, the autonomous functioning of a robot.[24]

A short briefing paper on social care by the Parliamentary Office of Science and Technology puts it this way: "a key question is whether robots and robotic technology can integrate into existing social care environments, and with current technology, or replace them altogether". It goes on to consider the scope for robots:

Development of robots in for social care. "Robots providing physical assistance have been developed to perform tasks such as lifting and carrying. Robots have also been developed to assist with tasks like feeding, washing, and walking, and are being developed to support physiotherapy. Prototypes of robotic toilets have also been developed that can raise, tilt, recognise the user, and adjust its settings. A 2018 review identified few studies that reported on the effectiveness of physically assistive robots in social care. One study looking at the results of an EC funded pilot project found that physically assistive robots (such as semi-autonomous wheelchairs) helped to promote mobility and assisted with users' personal care". [25]

[21] Department for Business, Energy & Industrial Strategy. Press release: *Care robots could revolutionise UK care system and provide staff extra support*. Her Majesty's Government, 26th October 2019.
[22] Lewis, L. Can robots make up for Japan's care home shortfall? Financial Times, 18th October 2017.
[23] Walker, P; Booth, R; O'Carroll, L; Elgot, J. Brexit: UK's new fast-track immigration system to exclude care workers Minimum salary thresholds to also remain in place, presenting additional barrier. *The Guardian*, 13th July 2020
[24] Department for Business, Energy & Industrial Strategy. Press release: *Care robots could revolutionise UK care system and provide staff extra support*. Her Majesty's Government, 26th October 2019.
[25] Parliamentary Office of Science and Technology. *Robotics in social care*. Postnote 591, December 2018.

There is a parallel with agriculture; in anticipation of a limited workforce in the future, at least partly related to Brexit immigration policies, farmers have been mechanising further, anticipating a reduction in the size of the workforce.[26]

8. Health and safety at work legislation and reduced-carer handling

In many quarters and for many years, double-handed care was a given.[27] An assumption was made that manual handling, in particular hoisting, required two people. Cited as the basis for this approach were the Manual Handling Operations Regulations 1992 (MHOR). In fact, those regulations state no such thing. Instead they demand that risk must either be avoided or reduced (following suitable and sufficient risk assessment), in either case as far as is reasonably practicable.

So, the correct answer, from the point of view of health and safety at work legislation, is that the number of care workers required always depended, and depends, on a risk assessment of the individual situation. There has never been a specific rule about this. Which means that manual handling decisions should continue to be based on assessment of the individual person's needs, the environment, equipment available, competencies of those doing the handling etc.

In this, legal sense at least, so called single-handed care is nothing to write home about. Single-handed, double-handed, triple-handed or no-handed – it is all the same. Namely, about individual circumstances and assessment. Which is hardly consistent with a strictly prescribed rule – or even with a default position if the latter in practice begins to bring about a presupposition of the outcome.

REASONABLE PRACTICABILITY IN REDUCING RISK. What is reasonably practicable in terms of avoiding or reducing risk in health and social care has always legally been given meaning by the individual context. In health and social care this

[26] Beattie, A. Brexit and agriculture: British farmers to plough new course. *Financial Times*, 14th January 2018.
[27] See e.g. Phillips, J; Mellson, J; Richardson, N. *It takes two? Exploring the manual handling myth*. University of Salford, 2014, p.7.

inevitably includes the needs of the person being handled – for instance, disabled children in an NHS unit needing to have their beds against the wall (with the consequent manual handling implications in terms of bedmaking).[28]

Consider, similarly, an urgent callout to paramedics, meaning they had to negotiate, with the patient in a carry chair, a steep and narrow staircase of a Sussex cottage. The court pointed out that a furniture removal firm could have walked away; the context of the ambulance service was different. However, that did not mean exposing its employees to unacceptable risk; it meant taking reasonable steps in managing the risk and balancing it against public utility.[29]

In both of these cases, the claimant employee, alleging injury, lost their claim, partly because of the context which required a balancing of people's needs with employee safety.

For organisations to adopt a default position of single-handed care would therefore risk inconsistency with legislation. This is because default positions can inadvertently become entrenched as custom and practice. With the potential consequence that the MHOR 1992 will not be adhered to, thereby giving rise to health and safety risks. For example, a default position, gone to the bad, may sign off single-handed care which would be safe for a competent handler – but not safe in relation to the actual handler being asked to do the job, because he or she lacks the requisite competence and confidence.

Whether single-handed or double-handed care, an example of the importance of competency was illustrated in a case about assistive handling and resulting injury to one of the handlers, an occupational therapy assistant (OTA). What in the judge's view would have been safe for two physiotherapists, in terms of the patient's mobility plan, was not safe for one physiotherapist and one partially trained occupational therapy assistant.[30]

9. Needs, human rights, wishes and law

[28] *Koonjul v Thameslink NHS Health Care Services* [2000] PIQR P123, Court of Appeal.
[29] *King v Sussex Ambulance Service* [2002] EWCA Civ 953, Court of Appeal, paras 23, 36.
[30] *Stainton v Chorley and South Ribble NHS Trust* (1998), High Court, unreported.

We have seen, immediately above, that the context - of health and social care - affects the application of the term, reasonably practicable, within health and safety at work legislation. This all-important context obviously comprises the needs, wishes, views and human rights of the person being handled. Under legislation such as the Care Act 2014 and the NHS Act 2006. The relevance of this, to the question of reduced-carer handling, is self-evident. Not just in relation to the safety of the handler and the handled, but also to the meeting of a person's needs.

The advantages of single-handed care have already been alluded to above. For instance, service users may find that not only does it meet their needs, but dignity, health, flexibility of visits may all be improved. As well as being cheaper all round. Equally, caution is required. Single-handed care may indeed be a cheaper option. But in some circumstances, it cannot be considered legally or professionally to be an actual option, if it would not meet the needs.

For instance, as also discussed above, people may require assistive handling with two handlers, in order (positively) to maintain or to continue to improve, functioning – as well as (negatively) to avoid the detrimental consequences of immobility leading to people becoming wholly bed-bound and chair bound. Rather than single-handed hoisting which would be cheaper but would not, on any reasonable view, meet the person's needs.

A simple example of the careful assessment required, by an occupational therapist, about single-handed or double-handed care was as follows:

Single-handed care: careful occupational therapy assessment of the need for a correct chair and timing of medication for single-handed care. An occupational therapist (OT) assessed that a single care worker could manage transfers at lunch teatime. This depended, however, on the person being seated in the correct chair (which was about to be delivered). Also, on him being given his medication at the start of the visit. This was because time was required for the medication to take effect. Previously care workers had been transferring him immediately after the medication had been taken.

However, morning and evening visits would require two carer workers, because the handling transfer involved was more complex. The assessment by the therapist followed on from an assessment by a social worker, two months earlier, which had identified double-handed care for all four daily transfers. The ombudsman found no fault with the OT's recommendations.[31]

[31] LGSCO, *West Berkshire Council* (19 005 638), 2020.

The juxtaposition of a person's needs with the cost-effective meeting of those needs – in the context of reduced-carer handling- has surfaced in a number of legal and ombudsman cases, considered immediately below.

10. Cost-effectiveness, reduced-carer handling and the law

The following major human rights case, involving manual handling and the replacement of a care worker, made clear that interference with a person's dignity, can in some circumstances be justified in the name of limited resources.

Incontinence pads replacing assistive handling by a night-time carer for a woman not incontinent: interference with dignity but justifiable for the economic well-being of the country. A former ballerina suffered a stroke and several falls, leaving her with compromised mobility. She had a small, neurogenic bladder but was not clinically incontinent. She wanted to retain the night-time care worker she had been provided with, to assist her manually to transfer on to a commode two or three times a night. The local authority, ultimately, offered her incontinence pads instead. Central to her argument was dignity. The local authority's argument was that the pads would be a cheaper way of meeting her needs, although it did argue also that they would be safer than the nocturnal, assistive handling.

The case went to the High Court, Court of Appeal, Supreme Court and finally to the European Court of Human Rights. She lost in all four courts. The European court ruled that her dignity was being infringed by the local authority but was nonetheless justified for the economic wellbeing of the country.[32]

Likewise, the following *Lewisham* case is an example of reduced carer handling all round, on grounds of cost-effectiveness, held by the High Court to be lawful. First by introducing a hoist, in order to decrease the number of care workers required for transfers from two to one. Second by use of a profiling bed and pressure relieving mattress to reduce the one care worker at night (who would turn the woman in bed for pressure relief and for the management of pain) to no care worker at all.

[32] *McDonald v United Kingdom* (Application no. 4241/12), European Court of Human Rights 2014. And: *R(McDonald) v Royal Borough of Kensington and Chelsea* [2011] UKSC 33.

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 well-being. 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.[33]

This case seems almost a paradigm example of reduced-carer handling. From double- to single-handed care, and at night from single-handed care to no-handed care. It illustrates the legal requirement to meet a person's needs – but to do so much more cheaply. The number of care worker hours was reduced by over sixty each week. A simple calculation would lead to the conclusion that tens of thousands of pounds per year would be saved, just in this one case. Never mind the savings if a similar result is achieved for a significant number of people.

This case is also a reminder of course, that whilst single-handed projects have reported better outcomes for the person in need, not everybody will welcome the imposition of a different approach to caring. Part of the woman's argument in the *Lewisham* case centred on the social inter-action that would be lost during the night – as well as, she maintained, experiencing greater pain. The local authority argued that her social needs were covered in other parts of the care plan, and related to daytime activity, since she could leave the house in her wheelchair to get to the library, the Post Office, church etc. Whereas her nocturnal, assessed eligibility centred on meeting toileting and skin management, not emotional or social support.[34]

Nonetheless, the onus remains on the local authority, or NHS body - or indeed any other provider - to demonstrate that the cost-effective option will indeed meet the need.

[33] *R(VI) v London Borough of Lewisham* [2018] EWHC 2180 (Admin).
[34] *R(VI) v London Borough of Lewisham* [2018] EWHC 2180 (Admin), paras 82-83.

REDUCING CARE WORKERS: EXAMPLES OF PITFALLS TO AVOID. In the following, older case, a risk assessment had concluded that double-handed care was required for a woman with multiple sclerosis, and that one care worker would no longer suffice. However, the local authority was determined to pay no more for her care. All too neatly, it halved the care worker hours to ensure the cost remained the same, despite the two care workers now required. The flaw was that the local authority was unable to explain how her needs were going to be met in half the time, since her needs had not changed, either legally or in reality.

Manual handling risk assessment: doubling up carers but not meeting other needs. A local authority provided a care package for a woman with multiple sclerosis. She frequently shook uncontrollably, was registered blind, had deep vein thrombosis, had epilepsy with extended seizures, was incontinent and was physically unable to tolerate a catheter. She could not manage any personal task unaided (including, for example, getting into and out of bed, dressing or moving from her chair). She lived with her husband.

She received 12 hours' continuous care from one carer. A manual handling risk assessment then identified the need for two carers, instead of one. The care plan was revised, and the carers doubled up, but the number of hours was halved to six.

However, the local authority could not explain to the court how all her other needs were going to be met in half the time, especially in relation to the risk of seizures and their consequences. In the absence of changed need, or at least another way of meeting need, the decision to reduce the hours was unlawful.[35]

In effect, the local authority was wedded to single-handed care and its lesser cost - but was not enthused about meeting the person's needs at greater cost. It is a good example of a pitfall to be avoided.

Similarly, in the following case. Although not about manual handling, it is on the same theme of replacing a care worker with equipment. It is a warning to local authorities not to pre-judge how a person's needs can be met – and not to impose a cheaper solution irrespective of the evidence about those needs. The case was about assistive technology and mental disorder:

Removing care workers, providing equipment – with no evidence that the equipment would meet the person's needs. A woman her fifties lived in her own home with three regular carers. She had Asperger's, mental health issues, severe/complex obsessive-compulsive disorder and anxiety. She was fearful of technology and strangers. Being

[35] *R v Birmingham City Council, ex p Killigrew* [2000] 3 CCLR 109.

frightened of technology, she would lock herself in her room in an emergency and not seek help. She had a night-time carer.

In July 2017, a social work assessment confirmed she continued to need this. In August, a manager allocated a different social worker; before the new assessment was even conducted, the social worker and manager had already focused on removing the night-time support. In fact, 22 days before the new assessment was completed, the new social worker indicated the night-time support would be reduced. The night-time support was removed, the woman because greatly distressed. The ombudsman's criticism centred on the fact that the decision made by the council was resource-led rather than needs-led. This was contrary to the requirements of the Care Act.[36]

The legal and practical risks of allowing a default position on manual handling to get out of hand, and to evolve into a fixed, blanket policy, has been discussed above. Night-time care, around which the ombudsman case immediately above, revolved is perhaps a comparable example. Many local authorities, it seems, have a starting point these days of not providing this type of care.

It is no accident that the *McDonald* and *Lewisham* cases covered above, were both about replacing night-time care - albeit they were cases which the local authorities succeeded in winning, because they could demonstrate that the person's needs would still be met adequately. More recently, in 2020, local authorities have lost two cases, both involving night-time care – one of which focused particularly on the manual handling of two severely disabled young adults.[37]

11. Balanced decision-making and reduced carer handling

Safety, people's needs and wishes, human rights and limited resources – all considered above – can form a heady and sometimes unstable cocktail. Both legally and practically. Mixing these up in the right proportion is the aim, giving rise to an expression, sometimes used in the context of manual handling, known as "balanced decision-making".

[36] Local Government and Social Care Ombudsman. *Norfolk County Council* (18 013 498), June 2019.
[37] *R(Raja) v London Borough of Redbridge* [2020] EWHC 1456. And: *R(JG) v London Borough of Southwark* [2020] EWHC 1989 (Admin).

Building on the cases already referred to above, involving the weighing of competing considerations, the following are examples of such decision-making. Its relevance to reduced carer handling is obvious; the potential cost-saving and convenience to commissioners and providers must be weighed up against people's needs and rights, as well as health and safety at work.

HUMAN RIGHTS. In the important *East Sussex* case of 2003, the needs of two severely disabled adult sisters living at home were pitched against the safety of care workers. The local authority wanted the sisters to be exclusively hoisted; the parents wanted assistive handling for their daughters. The judge referred to human rights (article 8 of the European Convention) in the context of achieving a balance:

Balanced decision-making: 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".[38]

The judge added that, on any view, blanket policies were unlikely to achieve this balance and were likely to be unlawful. This was because "individual assessment is all".[39] Individual assessment of need and blanket polices do not mix; they are anathema to one another.

STRIKING THE BALANCE WITH CHILDREN AT SCHOOL. In the following two school cases, the requirement for a balance to be struck was highlighted by the courts. In the first, the safety of staff predominated since the risks of manual handling, which was single-handed as proposed by the mother of a pupil, were too great:

Steps taken to protect staff, by them not lifting – single-handedly or otherwise - -a paraplegic and incontinent pupil, were not discriminatory but based on unavoidable duties under health and safety at work legislation. Following a road accident, a pupil had

[38] *R(A&B) v East Sussex County Council* [2003] EWHC 167 (Admin), para 129.
[39] *R(A&B) v East Sussex County Council* [2003] EWHC 167 (Admin), paras 128, 154.

been left paraplegic. Bowel accidents occurred at school with some frequency. A special needs coordinator allowed her "heart to rule her head" and performed heavy lifting, in order to change him at school. There was no room for a proper a changing facility and equipment (the school had asked, hitherto unsuccessfully) the education authority for resources to do something about this). The alternative was for him to go home to an uncle to be changed.

The coordinator suffered a serious injury. A health and safety consultant did a risk assessment and stated that the risks of manual lifting were too high. The school's head teacher prohibited staff from performing such handling; the mother argued her son was being discriminated against under the Disability Discrimination Act 1995. The Court of Appeal found in favour of the school, stating that it would have been irresponsible and unlawful to continue with such high-risk manual handling.[40]

The second case involved the needs of disabled children, in a mainstream school, using self-propelling, manually operated wheelchairs, which sometimes needed to be pushed - for example, if the pupil was having a bad day. In the context of this discussion paper, the case was about whether to opt for some single-handed care for some pupils (the pushing), or to adopt a prescriptive position of no-handed care (represented by the option of powered wheelchairs for all):

Pushing manual wheelchairs at school: children's independence and mobility. A learning support assistant brought a legal case, claiming she had been injured whilst pushing manual wheelchairs at a school. One of the arguments was that the risk could have been avoided by providing all the children with powered wheelchairs.

The judge accepted that "students were not provided with their wheelchairs by the school, but by the NHS or privately funded by their parents. Students therefore used their own wheelchairs at school, as well as out of school. The choice of wheelchair was not a matter for the school, but was specific to each student, based on medical and therapeutic considerations in the light of the best interests of the student".

"Some students with manual wheelchairs would propel themselves while others would require to be pushed. The evidence showed that it is important to encourage independence and mobility and that to require a student who normally uses a manual wheelchair, to use a powered wheelchair at school, would be contrary to the best interests of the student". It was therefore not reasonably practicable to avoid the use of manual wheelchairs at school.[41]

ASSISTIVE HANDLING BALANCED WITH SAFETY. In a more recent ombudsman case, the tension was between assistive handling to maintain mobility, and the greater convenience to the local authority and care agency of hoisting. Not

[40] *R(K) v Special Educational Needs and Disability Tribunal* [2007] EWCA Civ 165.
[41] *Sloan v Rastrick High School Governors* [2014] EWCA Civ 1063, Court of Appeal, paras 18-20.

least because there was some risk attendant on any assistive handling carried out:

Finding a solution to meet a person's needs, taking account of the risks of assistive handling. A manual handling adviser 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 adviser 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 of the need to disconnect her PEG feed for a significant period when hoisting was required.

The manual handling adviser 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.[42]

In summary, the recommendation of the manual handling assessor represented a balanced approach, compared to that of the occupational therapist. The ombudsman saw evidence that, when completing a risk assessment, the OT had at least considered the manual handling assessor's moving and handling plan which had suggested manual transfers to and from the toilet were possible.[43]

The ombudsman will not interfere ultimately with professional judgement but will look for evidence of a sound decision-making process, adequately recorded. This would include relevant considerations being taken account of (not necessarily followed) - in this instance, the manual handling adviser's assessment and plan.

PEOPLE NOT OBJECTS. In the case of an elderly, confused, heavy, hospital patient who had already fallen out of a hoist, the question arose about an acceptable manual handling technique for transfers. The options were three: hoisting, swivel transfer or cross-arm lift (using a medi-sling, with handles to be used by

[42] Local Government and Social Care Ombudsman, *East Sussex County Council* (16 017 727), December 2018.
[43] Local Government and Social Care Ombudsman, *East Sussex County Council* (16 017 727), December 2018, para 29.

a nurse on either side). In identifying which of these three would have been a suitable means of transfer, namely the swivel transfer, the judge noted:

A patient is a person not a "sack of cement". "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".[44]

In any event, it is essential that practitioners carefully document their evidence, reasoning and conclusions. For instance, in the *Lewisham* case, described above, the council won the case essentially because several relevant practitioners had given 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 decided contrary to her wishes.

OCCUPATIONAL THERAPISTS JUSTIFYING DECISIONS PROFESSIONALLY AND LEGALLY.
Occupational therapists making sometimes-difficult decisions may be reassured by what the courts confirm from time to time in judicial review cases. Namely, that social worker and occupational therapy assessments should not be subject to "over-zealous textual analysis".[45] And should be "construed [by the court] in a practical way against the factual background in which they are written and with the aim of seeking to discover the substance of their true meaning".[46]

Plenty of leeway is generally given. Always bearing in mind, as noted already, that neither the courts (in judicial review cases) nor local ombudsmen will challenge professional judgement. Counter-intuitively, they are interested in the process, not the final decision and outcome.

But to repeat, such leeway 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

[44] *Urquhart v Fife Primary Care Trust* [2007] SCLR. 317, Court of Session Outer House.
[45] *R (Ireneschild) v Lambeth Borough Council* [2007] EWCA Civ 234, paras 57, 71.
[46] *R* (*McDonald) v Kensington & Chelsea LBC* [2011] UKSC 33, para 53.

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.[47]

12. Informal carers, single-handed care, manual handling, safeguarding and occupational therapy assessments

Manual handling by informal carers, typically family members, introduces an added dimension to the notion of single-handed are. On the one hand, local authorities greatly welcome informal care. Legally, it relieves them of their duty, under section 18(7) of the Care Act 2014, to meet the cared for adult's needs. Financially they save money. From the informal carer's view point it is single-handed care; from that of the local authority it is in effect no-handed care because the authority is not paying for it.

The fly in the ointment is safeguarding. That is, when the local authority comes to believe – sometimes justifiably, sometimes not - that the handling may be abusive or neglectful and it decides to make safeguarding enquiries under section 42 of the Care Act.

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

Of the cases below, the first concerned a local authority keen that the informal carer should continue single-handed care, despite the fact that the carer was no longer able and willing to do so. The rest, involving more or less a safeguarding element, are suggestive of the sort of sometimes heavy-handedness in this type of case that needs to be avoided.

REFUSING TO ASSIST AN INFORMAL PERFORMING SINGLE-HANDED CARE. In the following case, the local authority was keen on the single-handed care of an informal carer to continue. The cost-saving to the local authority – which otherwise would have had night-time needs to meet and fund – would have been considerable. The woman concerned was providing ten hours of care during the night for her severely disabled sons. This included regular changing of pads (her sons were doubly incontinent) and frequent repositioning.

The mother had now stated that she was no longer able to provide the care. This is a requirement of the Care Act – that the informal carer be able and willing – for the local authority to be able to rely on the carer to meet the need, rather than having to do so itself. The High Court bridled at the local authority's inaction. A supportive and thorough occupational therapy assessment lay at the heart of the woman's successful judicial review application for interim care to be provided as a matter of urgency:

Local authority allowing an informal carer to continue with single-handed care and declining to help. A mother cared for her two severely disabled adult sons during the night. This included manual handling. She had managed this single-handed up to now. She had then said she could no longer manage this because of her own health problems, leading to pain, discomfort and tiredness. The local authority stated that it would not alter the care and support plan until it had completed a reassessment. Several months later, it had still not done this, although it did have an independent occupational therapy assessment which stated that double-handed care would be required. To be followed, subsequently, by its own expert report, to similar effect. The court ruled that, pending the full reassessment, interim care should be provided by the local authority during the night. [48]

SAFEGUARDING AND SINGLE-HANDED CARE BY INFORMAL CARERS: PITFALLS? Conversely, in different circumstances, and in a different type of court (the Court of Protection), the following example shows a local authority taking against an informal carer who was carrying out (successfully) single-handed transfers of his wife. The local authority sought a draconian solution to this

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

(and other issues), a solution which, on best interests grounds, the court rejected:

Single-handed care by a husband involving his wife lacking capacity – and reaction of local authority and occupational therapist. Relying on an occupational therapy assessment, a local authority insisted that double-handed hoisting, of a woman with dementia and lacking mental capacity, by care workers was required. And that the single-handed operation carried out by the husband, when care workers were not there, was not only unsafe but also potentially an adult protection issue. The local authority sought, on this ground and others, to have the wife deprived of her liberty (and therefore of her husband) in a nursing home. This was despite the husband's success at hoisting her single-handed, without incident, over the previous two-year period. He was well attuned to his wife's comforts, discomforts, likes, dislikes.

In addition, the local authority and therapist had objected to him leaving his wife in a sling for too long – though he had his own reasons for doing so. He wanted an alternative sling, kinder to the skin, but this had not been forthcoming even though the therapist was aware that there were problems with the current sling.

The judge was less than overwhelmed with the local authority's assessment and proposed solution - and held that her best interests lay in remaining at home.[49]

This case also highlights a point already made above; that there needs to be evidence of an adequate assessment:

Adequate assessment and reasoning about single- or double-handed hoisting by informal carer. The judge noted that the therapist involved had now acknowledged, when questioned in court, that she had not seen or assessed the woman for over a year, when she wrote the report now being relied on. Even then, she was not sufficiently concerned so as to take remedial action and had failed to follow up on a number of other issues over the preceding months.

Again, when questioned, the OT conceded that the husband had been performing the single-handed hoisting successfully for two years. And that the real risk was not so much to her, but more to him in terms of cumulative back strain. The judge noted however that, unlike his wife, he had the mental capacity to assume risks to his own health. The implication was that the local authority had, up to that point in the case, been insufficiently clear about who was predominantly at risk. The judge found the local authority's evidence unconvincing.[50]

In a recent ombudsman case, the mother of a disabled woman held out for assistive handling, rather than hoisting, for her daughter – against the

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

professional assessment and recommendation of a local authority occupational therapist. The mother said that if nobody else would, then she would, alone and single-handedly, assistively handle her daughter. The NHS clinical commissioning group's apparently kneejerk reaction to the mother's statement was to reach for the word "safeguarding". Yet, once a manual handling adviser had assessed, she came essentially to the very same view as the mother about her daughter's needs.[51]

This case seems to illustrate the sometimes-fine line between judging whether a situation is simply a matter calling for negotiation, compromise and creativity – as opposed to safeguarding, with its implication, under the Care Act, of abuse or neglect. (Section 42 of the Care Act, underpinning the making of enquiries, refers to abuse or neglect, not simply harm).

In another, older, ombudsman case, the local authority insisted that the "dedicated" parents, of a severely disabled young man, accept not just a hoist but also a hospital bed. So that they would not have to lift him in and out of a sofa bed in the living room. When the parents indicated acceptance of the hoist, but not the hospital bed, because of insufficient space (they were a large family living in a small house), an adult protection referral was made. This was then escalated by the local authority to the police and to the NHS, without even telling the parents. The ombudsman had this to say:

Manual handling: adult protection concern and referral to the police "beggars belief". "I turn now to the adult protection referral. One thing that has become clear from my investigation is the fact that [his] family are devoted to him. Quite apart from any procedural shortcomings, it beggars belief that the referral was made at all, and this was compounded by the fact that the family was informed far too late. I have no doubt that the family found the referral extremely hurtful, not least because it perceived itself as providing care for [their son] in the absence of any significant care provision by the Council. The adult protection referral and the delay in telling the family of it were maladministration by the Council, which caused the family distress and outrage when they found out".[52]

There is something slightly disturbing about these types of case. Which seem to show local authorities and the NHS happy to rely on informal carers to carry out sometimes highly complex and demanding caring tasks – single-handedly.

[51] Local Government and Social Care Ombudsman. *East Sussex County Council* (16 017 727), December 2018.
[52] Local Government Ombudsman, *Luton Borough Council* (07/B/07665), 2008.

But the moment these carers begin to struggle, or hold an alternative view to the local authority, a heavy-handed, sometimes draconian, response sometimes ensues either inappropriately or, at the very least, prematurely.

This can sometimes come perilously close to a controlling, coercive approach of the type "do this or else" - which the courts have condemned as often counter-productive, beyond the scope of welfare legislation and therefore of a local authority's legal powers.[53]

13. Concluding word

Reduced carer handling is nothing new. For instance, riser recliner chairs, hoists and stand aids have long contributed to it. But times are moving, both in terms of new technology and the financial pressures being placed upon the health and social care system.

With change comes a challenge to occupational therapists to consider new ways of working and of meeting people's needs. Likewise, to care providers to embrace reduced carer handling where it can be done safely and appropriately to meet people's needs. And sometimes to replace care workers altogether.

Undue resistance to change, whether reduced carer handling, remote assessment (where necessary, workable and adequate) – or who knows, an explosion in robotics (perhaps), is neither recommended nor generally productive. Equally a balance needs to be struck. Embracing change, managing pressures creatively and not allowing the best to be the enemy of the good are one thing; maintaining core values another.

A second point to make in the context of reduced carer handling is as follows. Despite all the pressures in health and social care, the prescribed eligibility criteria within social care and the more covert rationing within the NHS, nonetheless occupational therapists as professionals still wield a lot of power. And play a most influential role.

[53] *A Local Authority v A and B* [2010] EWHC 978 (Fam), para 53.

The cases on manual handling and reduced care (*McDonald* and *Lewisham* cases), summarised in this paper, could not have been argued and won by the local authorities concerned without OT assessments and recommendations Conversely, in the *Redbridge* case which the local authority lost, occupational therapy assessments (undertaken both independently and for the local authority) were central to identifying the scale of the caring tasks being undertaken by the mother single-handedly (literally) - and the manual handling implications. And, therefore, pivotal in relieving her of those tasks, in the form of double-handed, paid care.

Conversely, the *JH* case, also considered above, revealed significant shortcomings in the manual handling assessment of a man caring for his wife. It was not a straightforward case, and other factors were in play. Even so, the manual handling assessment was a central plank, though not the only one, of an attempt by the local authority to deprive a woman of her liberty. A draconian step on any view. How important, therefore, that any such manual handling assessment be subject to exceptionally rigorous professional scrutiny before being deployed to such ends.

So: triple-, double-, single- or no-handed care, whether paid carers or informal carers. Legally, which is right? It all depends, of course.

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