POSTURE &
MOBILITY
GROUP

POSTURE & MOBILITY

Volume 21

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We know that for some children, a wheelchair is vital if they are to develop fully and live their lives to the full.

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Editorial

After a rocky year for the newsletter sub-group, the re-formed group have come together with renewed enthusiam, a variety of interests and representing a variety areas. The sub-group are now also supported by excellent administrative support, which will both make the sub-group member's lives easier and also ensure deadlines are met and 'best value' for the publication is obtained.

The newsletter will now follow the theme of the annual meeting and articles in line with the theme are both welcomed from readers and will also be commissioned by the sub-group. This edition loosely follows the theme of the International meting which was held earlier this year. The plans for the new 'Equipment Review' section has been circulated widely and initial reactions and responses to this have been favourable. Informing the members of recent publications and 'good reads' and also letters raising current issues (ie AfC) are always welcomed.

Move to a Journal

Discussions are ongoing about the move for the Group to produce a journal. 'Evidence based practice' is on all our lips but are we spending enough time or have enough opportunities to carry out searches, read material and write up any of our work/observations? Do we all have the skills to do this? Are we given the training or the time? Some of these are professional issues and some managerial but all are personal/individual issues which we must all address to remain competent to practice. Article in this and recent newsletters, are referenced and often original work. Do the membership wish to read such articles and do they find them useful for practice or not? Some members of the sub-group say 'Yes', some say 'No'. *What do you think?* If you all feel moving towards a 'news bulletin' of some form and a peer review referenced journal is the way forward (as the Occupational therapists and physiotherapists are already used to) or you disagree, let us know.

Election of Members

It is again time to put members forward for the committee as members who have served their terms leave the committee. Is there someone near to you who has some energy and would be a good hard working team member for the committee? If so, propose them NOW!

We hope you enjoy this edition and always welcome your comments and contributions.

Ros Ham, November 2005

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Letter from the Chair

It has come up remarkably quickly but I will come to the end of my three year term as chair of PMG at the AGM to be held in February. It has been a pleasure and a huge learning curve all at once. I have been privileged to work alongside some excellent people, some very experienced, some newer to the field, but all helping keep up the momentum of the group and taking it forward, sometimes in great strides. During my time in office the committee has securing paid administrative support for the group. This has provided a number of advantages in terms of having the resource available to take forward the activities of the group, and also in terms of taking some of the burden from voluntary committee members who were having to handle a workload which had become unrealistic for any person working in this capacity.

You should by now have received the provisional programme for the conference in February. Martin Moore and his team have put a lot of effort into this and I hope you will find the programme relevant to your particular field of work. As more names are confirmed they will appear on the website so keep an eye out. Martin has been working on a venue for 2007 for many months now and it would be fair to say that it is turning out to be extremely difficult to find somewhere meeting all our requirements. We have in many cases outgrown venues used in the past. To give you a flavour, we need somewhere that: 1. is wheelchair accessible, 2. has an auditorium that is sufficiently large, but not so large that we rattle, 3. has sufficient break out rooms for smaller sessions and workshops, 4. has sufficient exhibition space, 5. has suitable and sufficient catering arrangements, 6. has cheap, on-site or close by accommodation, and 7. has low costs overall. This is a tall order and we have found many venues that would in principle be suitable but have costs that would make conference fees unrealistic for many prospective delegates. If you have any suggestions then please contact me at the address below. We hope that we have covered the ground fairly well but with 850 members there should be a wealth of knowledge out there!

I am particularly pleased to see progress in the research sub-committee which has finally got its wheels rolling under the leadership of David Porter. Those of you present at the AGM earlier this year will have heard more of the detail and others will have seen the recent mail out which described the current activities of the sub-committee. I hope that this proves to be a useful resource. More detail is available on the website.

This brings me onto another subject. Dave Calder has been the website guru for PMG since its inception. As with other aspects of the functioning of the group this has become unmanageable for a volunteer given our increased reliance on this resource. As many of you will already know, Ben Lumley has been working on turning the website into a more central function for the group. Conference bookings are being handled on line as will membership applications in due course. Olwen will be making further use of the website and will shortly be able to update pages herself. This is a key part of the group now and I hope that it will become more central to your work.

The Scottish Seating and Wheelchair Group (SSWG) has undergone an internal review and is now known as the Scottish Posture and Mobility Network (SPMN) to reflect the change in emphasis on service provision to the 24 hour remit of postural management. SPMN and PMG continue to share minutes of meetings to ensure that the link between the groups is maintained.

There will be four vacancies on the committee at the AGM in February. Charlie Nyein served one year but had to stand down for personal reasons. Ros Ham, Jacqui Romer and Russ Jewell are all due to stand down having served their full terms. I should like to thank them all for their significant contributions to the group. Please consider whether you are able to stand for committee yourself. I believe it is healthy for the committee to have a mixture of experienced and not so experienced members, so be encouraged to stand if you are able to commit the time needed and have a passion for the activities of the group. Please read the Terms of Reference on the website for further details.

I would like to thank Olwen for being a dedicated soldier with quite remarkable flexibility; it has been a pleasure working with her. She also has an ease with people which has ultimately led to Patricia Marks coming on board to help out with the 2006 conference as Olwen herself takes some rest from the frantic few months organising the Exeter conference. I am sure you will agree that she has brought many good things to the group. Finally I would like to express my thanks to the committees of the past three years in terms of their support to myself and commitment to the group as a whole.

If you have any questions or comments please feel free to contact me at dave.long@noc.anglox.nhs.uk.

Dave Long, PMG Chair, November 2005

Do wheelchair services have a future?

Dave Long

The wheelchair collaborative focussed on improving efficiency within wheelchair services. Unfortunately it did not reach every service but of those it did, significant improvements were made. We all wanted to know whether the project would be extended to the remaining services and it is now clear that it will not, at least in the same format.

In June of this year the follow on to the wheelchair services collaborative was announced in the form of the CSIP (Care Services Improvement Partnership, Change Agent Team, Department of Health (DH)) wheelchair project which is scheduled to run until March 2006. Bernadette Simpson is the project lead and she is an Occupational Therapist with significant experience in social services. A steering group for the project was formed with representatives as follows, in no particular order:

- Audit Commission (David Bird)
- DH (Kay East and Helen Tomkys)
- National Wheelchair Managers Forum (Peter Gage)
- emPOWER (Sam Gallop)
- National Forum of Wheelchair User Groups (Peter and Elizabeth Kemp)
- NHS Purchasing and Supplies Agency (Andy Gudgeon, Paddy Howlin and Neil Griffiths)
- Commission for Social Care Inspection (Jan Clark)
- Healthcare Commission (Amanda Hutchinson)
- Whizz Kidz (Ruth Owen)
- British Society of Rehabilitation Medicine (Linda Marks)
- Warrington Disability Partnership (David Thompson)
- PMG (yours truly).

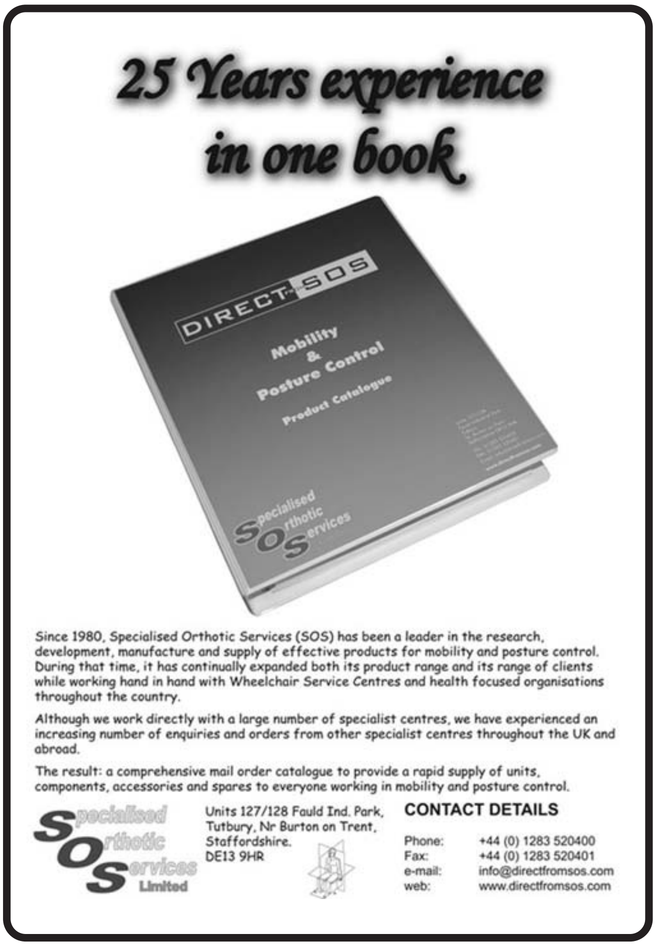
The project aims are to improve service delivery of wheelchairs through implementation of learning from the wheelchair services collaborative and to provide better co-ordination with related services. So far as I can tell there will not be the hands on support provided under the collaborative project but proposals will be put to government. Through consultation the problem areas we all know well have been identified:

- Commissioning (lack of, eligibility criteria, short term users, control of expenditure)
- Finance (levels of funding, vouchers, monitoring)
- Service provision (assessment, recruitment and retention, skill mix, health vs social need, reviews, repairs and maintenance, IT systems)
- Partnership working (difficulties with split budgets, complex care pathways, compartmentalised working)
- Rationale for provision (social inclusion, Disability Discrimination Act, improving life chances, independence, health economics, how do wheelchairs fit into the wider agenda and how can they reduce overall healthcare costs)

Right at this moment it is difficult to see what the outcome of the project will be. In Scotland a review of wheelchair services is currently being undertaken and this seems to have come about due to service users and their families lobbying the Scottish Executive. The recommendations from the project are likely to have teeth as the Executive are in the position to make policy decision centrally. It would appear, however, that we are unlikely to see the same gains in this country due to the big push from a political perspective to devolve decisions to a local level – we have tried and unfortunately failed to get the DH to rubber stamp a set of national standards for the provision of wheelchair services. It strikes me that while local decision making can be helpful in certain respects, the pendulum has swung too far in that direction. My personal belief is that there must be some national direction otherwise we will never see a dent in the postcode lottery that exists at present.

The other problem is that there has been no talk of increased funding. There is a lot of talk about improving efficiency which we know through the collaborative project will provide some improvements, but without substantially increased and sustained investment are we not just re-arranging the furniture? Finally, just when you were thinking that things could only get better… The current wheelchair services project is linked to the ICES (Integrated Community Equipment Services) project. A few people have now voiced their concern as to the level of the potential inclusion of wheelchair provision within community equipment services. It would seem that the complexity of wheelchair provision and the skills and experience this requires is at risk of being overlooked. There are no certainties but we as a group, *both* locally and nationally, must fight our corner and ensure that the expertise we have is recognised.

The CSIP wheelchair project steering group meets again in January and immediately after that much wider consultation with service users will take place. I am interested to see what happens and will aim to keep you posted with further developments.



Assistive Technology (AT) Forum News Bulletin

This is provided as a resource for AT Forum members and to highlight issues affaecting AT provision for a wider audience. FAST is the sectretariat for the AT Forum. If you wish to find out more about the work of the AT Forum please fo to the FAST website www.fastuk.org and please let FAST know if you would like to receiv the bulletin. E-mail atforum@fastuk.org

University of Greenwich Wheelchair Courses

If anyone is interested in attending these modules in 2006, please could they contact Ros Ham on email: rosalind.ham@talk21.com for more details.

Integrated care for people with complex needs SSWG

The Scottish Posture and Mobility Network (formerly SSWG) are holding their annual meeting on November 17th entitled 'Intergrated Care of people with complex needs' in Kirkaldy. Reports of the meeting will follow in the next newsletter.

Ros Ham

BHTA Conference

A high spot in the BHTA calendar, the conference will be held for the first time at Portcullis House, the impressive bronze and stone building next door to the House of Commons. Speakers already agreed include Andrew Lansley CBE, Conservative MP for Cambridgeshire South and Shadow Secretary of State for Health and Mark Oaten, Liberal Democrat MP for Winchester and the Meon Valley and Shadow Home Secretary.

For more information please contact the BHTA in their new City of London home at Suite 4.06, New Loom House, Back Church Lane, E1, Telephone 020 7702 2141, email bhta@bhta or see www.bhta.com

Angela Rippon to Compere BHTA 2005 ILD Awards

Well-known broadcaster Angela Rippon OBE is to compere the Independent Living Design Awards (ILD Awards) at the House of Commons on 10 November. The awards follow the British Healthcare Trades Association's (BHTA) annual conference at Portcullis House.

Angela Rippon, who was named European Woman of Achievement 2002 and awarded an OBE in June 2004 for services to broadcasting, the arts and charity, will be presenting trophies to the winning companies who have entered their products for the awards. Now in their 11th year, the awards recognise innovative design that makes a real difference to users. The nominated charity Phab will receive any funds raised as a result of the event.

The products which have been entered are being assessed by the judges, who are pre-eminent in their field of healthcare and assistive technology, and the winners will be announced by Angela Rippon.

Conference Report:
Manual Wheelchair Selection and Transfer Techniques

Presenter: R A Cooper, Director Human Engineering Research Laboratories
7180 Highland Dr.151R-1, Pittsburgh, PA 15206, USA

This plenary session, wheelchair specification, focused on the factors associated with manual wheelchairs especially the secondary complications that occur as direct consequence to manual propulsion and inappropriate wheelchair set up. Transfer techniques and their affects on upper limbs are additionally discussed. The author relates these topics to recent research.

Upper limb injury is a secondary complication that occurs due to manual wheelchair propulsion. Cooper highlighted the shoulder and wrist are most at risk with rotator cuff pathology, joint degeneration and carpal tunnel syndrome all are present in wheelchair users.

Sabick et al (2004) in a study of demand on upper limb during manual propulsion found injury to the wrist often involve median nerve dysfunction such as carpal tunnel syndrome. Pressure in the carpal tunnel is dependant on wrist kinestics (posture), and load on tendons in the carpal tunnel (joint movement). This study found propulsion places a large muscular demand on the upper limb. This is in line with Cooper who discussed the biomechanical factors associated with injury such as high frequency of the upper limb use, the force required to complete tasks and the extreme position of the upper limbs during propulsion. He highlighted the extreme posture of the wrist, shoulder in internal rotation and abduction.

Boninger et al (1999) studied pushrim kinetics and they found a higher risk of median nerve injury and thus carpal tunnel syndrome (CTS). The study of 34 subjects of independent wheelchair users with spinal cord injury found the rapid loading of the pushrim had greater risk of CTS development. Cooper proposed it is possible to reduce this risk through training of wheelchair propulsion of smooth low impact strokes. This supported by research conducted by Boninger et al (2004) These findings highlight the importance of wheelchair skills training for individuals to become more efficient and effective wheelchair users and thus reduce the incidence of shoulder pain.

Cooper additionally discussed the set up of a wheelchair can add additional stress on the upper limb as the axle position is linked to shoulder pain. Boninger et al (2000) highlights the angle of the axle can exacerbate shoulder pain. Patients farther back in their wheelchairs reduce the frequency of the propulsion, force of propulsion and push angle are increased. Cooper discussed the vertical axle position lowers the seat height and improves access to push rims and thus decreasing the stroke frequency and increases the propulsion efficiency. Van der Woode (1989) studied seat height and gross mechanical efficiency and found the optimal seat height to be position where the elbow is flexed at 100 to 120 degrees.

Wheelchair users perform between 8 to 40 transfers each day. Bayley et al (1987) in a study of 94 independent wheelchair users found 30% incidence of chronic shoulder pain during transfers. The most common cause of shoulder pain was chronic rotator cuff impingement syndrome. Cooper states the importance of level transfers and avoid placing hands on level surfaces and vary the method of transfer and leading arm to reduce shoulder impingement. The use of transfer equipment to reduce the amount stress the upper limbs are under was also discussed.

The learning points I have gained from this presentation is to think of the long term affects of being a full time wheelchair user and the benefit of wheelchair skills training, the importance of transfer methods and wheelchair / environment set up. As an OT it is routine to teach new wheelchair users how to transfer and when they are able to achieve one type of transfer I rarely practice different methods and discuss the benefits of alternating the methods and lead side. This session emphasised the importance of teaching wheelchair skills. If a patient can mobilise independently from the ward to department the goal is achieved however the efficiency is not tested and complex skills are not taught. I now feel it is valuable to teach these skills to reduce the likelihood of future secondary complication. The use of wheelchair skills test, Kirby et al (2004) could be used as an outcome measure to identify the effectiveness of the training and the patients progression and performance.

Louise Reid
Senior 1 Occupational Therapist, OT Dept
Charing Cross Hospital, London

References

Bayley JC, Cochran TP, Sledge CB (1989) *The weight-bearing shoulder. The impingement syndrome 69* 679-678

Boninger ML, Cooper RA, Baldwin MA, Shimada SD, Kroontz AM (1999) *Wheelchair pushrim kinetics: Body weight and median nerve function.* Arch Phys Med Rehabil 80 910-915

Boninger ML, Baldwin MA, Cooper RA, Kroontz AM Chan L(2000) *Manual wheelchair pushrim biomechanics and axle position.* Arch Phys Med Rehabil 81 608-613

Boninger ML, Impink BG, Cooper RA, Kroontz AM (2004) *Relation between median and ulnar nerve function and wrist kinematics during wheelchair propulsion.* Arch Phys Med Rehabil 85 1141-1145

Sabick MB, Kotajarvi BR, An KN (2004) *A new method to quantify demand on the upper extremity during manual wheelchair propulsion.* Arch Phys Med Rehabil 85 1151-1159

Van De Woude LHV, Veeger DJ, Rozendal RH, Sargeant TJ (1989) *Seat Height in handrim wheelchair propulsion.* J Rehabil Res Dev 26 31-50

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Financial barriers to Re-entering the Job Market

Presenter: Patricia Thornton, Social Policy Research Unit, University of York.

Ms Thornton started her session by confirming that in the UK we are indeed as indicated by other speakers striving to reduce poverty and social exclusion of groups of society, there is a target to reduce the employment gap between disabled and non-disabled people and there is a focus on recipients of Incapacity Benefits. The Organisation for Economic Cooperation and Development (OECD) have stated that developed countries should aim to reduce unemployment as it leads to inactivity, subsequently we can assume that inactivity costs rather than generates money.

However, there are many financial barriers that have been found by people who have attempted to return to work:

People who have been on benefits will have had marked **reduced incomes**, generally they will have depleted any savings they may have had, they will have found that benefits had not been sufficient to meet the average cost of living (essentials can cost between £389-£1528) and they will possibly have debts with high interest rates.

They may also be aware of **systematic barriers**, the prospect of returning to work involves a complex system with interacting and changing rules, there are unhelpful administration requirements and the problems of national guidelines being open to local discretionary decision-making leads to uncertainty. It remains hard to calculate the prospective financial situation for individuals considering return to work and there are shortages of professionals to advise.

There are without doubt for many people **financial disincentives**. People will often be no better off in work than when on benefits, wages are often lower than the benefits and there are problems with take up of in-work benefits, people also loose the right to other benefits such as free eye tests and prescriptions. A transitional return to work may indicate a marked reduced income and low hours may indeed not be viable. There is also the worry that if there is a need to return to claiming benefits if a job is lost/doesn't work out the rate may be reduced.

There are also **fears** for the individual that engaging in training, education programmes or voluntary work may trigger a review of their eligibility for claiming and it may become impossible to return to the previous level of benefit.

The OECD have highlighted some solutions to the barriers highlighted above. They feel that a person should have benefits to meet the extra costs of disability. There should also be transitional measures in place to support the process of return to work such as, initial continuation of benefits, support for graduated or transitional return to work, return to work incentives (additional credits if wages low), permanent wage supplements and advice available at one stop centres where traditional Job Centres and Benefits Agency are in collaboration. Additionally it would be beneficial to have improved support in the work place. Currently employment support costs are met by the employers themselves or through a grant process applied for by the employer or employee. Current programmes of support are rarely comprehensive, the UK scheme, Access to Work being unusual.

Access to Work includes an assessment of a person's need, considers environmental adaptations that may be required, human support (often known as Personal Assistants) and the cost of getting to/from place of work. Most costs are reimbursed through the scheme and it is applied for and used mostly to support people already in jobs and not those thinking of returning after a period of absence. This route of financial assistance needs to be promoted and highlighted to people who are thinking of returning to employment. Ms Thornton reported that there would not be the type of people in jobs currently if Access to Work Scheme was not available.

As an Occupational Therapist I was aware of the complexities faced by disabled people when considering returning to a work role, naturally we would want to encourage, enable and act as an advocate for individuals facing this challenge. But as this session highlighted and confirmed the massive barriers evident within today's society we could question if encouraging return to work is the right clinical stance to take? The culture is however changing in this country towards empowerment of individuals with disabilities and although we do have a long way to go it would be interesting to see if in 5 years time people report facing the same barriers and challenges as reported above?

Hannah Snowsill,
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Stroke Rehabilitation Services

Models of Service Delivery

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One of the features of this year's International Conference in Exeter was to offer "streams" of learning, and to have several different speakers present within one plenary or parallel session. The Models of Service Delivery stream maximised on the conference's international theme this year, with presentations from the USA, UK, Australia, and Norway.

Of all the topics under hot debate at this Conference I chose to report on this one because I felt the issues discussed have real relevance to my life as an NHS Wheelchair Therapist.

The feedback I offer below reviews three presentations which I particularly enjoyed.

Medicaid and Social Participation

Jean Minkel is an enthralling speaker – a pocket-sized New Yorker who presents with refreshing clarity and enthusiasm.

She described her work with the Independent Care Systems (ICS) scheme, a non-profit organisation in Brooklyn and The Bronx assisting people with disabilities to live independently. In contrast with "managed care", which frequently equates to cost containment by medical insurance providers, ICS collaborates with people with disabilities in building a specialised system of care to enable **full participation** in life.

Emphasis of care is shifted from medical necessity to functional need, for the purpose of community participation. This can include, for example, the consultation of therapists when purchasing new equipment, or the provision of a member-directed wheelchair maintenance programme, offering the room, tools and technical support to enable users to fix their own chairs.

It was heartening to hear "At ICS common sense is valued".

The Development of Barnet Wheelchair Services

Fiona Jackson from Barnet Wheelchair Service was equally clear and thoughtful. She gave a presentation which she stressed covered a collaboration between the staff and users of this Service, representing all views. She told us how their Wheelchair Service had undergone a period of change and development, with User engagement at the very heart.

Fiona explained that both the Service and the Users had acknowledged the risks and rewards of pioneering change. Both the Service and the Users cited the other as having a "lack of understanding". Clearly, there was a long process ahead!

To begin the process, the Service did an initial mail-shot to all 4000 users and had a 10% response. (Of the resulting User Group, there is a core membership of about 10 people, and the future structure and management of this is under review.) Two workshops were then held in conjunction with wheelchair users, utilising the S.W.O.T. (Strengths, Weaknesses. Opportunities, Threats) model and process mapping to stimulate ideas and a way forward. Facilitators involved in this process included the local DaB network.

Initially, the Service recognised that one of its primary problems was the waiting list. Innovative strategies were implemented to address this, including new referral assessments on evenings and weekends across the locality in venues such as scout huts and schools. Through co-ordination with their approved repairers, they were able to provide standard wheelchairs there and then, dramatically reducing the waiting list.

Once the waiting list was back under control, such a diverse approach was no longer required, and the Service is now able to have 65% of clients come into clinic, be assessed, and provided with a wheelchair on the same day.

Other positive changes which have developed include:
- Monitoring of the approved repairers
- Discussion regarding Service changes
- Support with designing patient information leaflets
- Training of staff and students.

Barnet Wheelchair Service clearly feels that User involvement and partnership working has benefited the Service, and now considers itself to be far more client focussed. There are no plans to return to the old systems!

Filling the Gaps in Funding

Peter Gage of North Essex Wheelchair Service then presented a heavily metaphoric vision of bridging the gaps in funding between providers and Users expectations. After first highlighting that the gap in funding will never be filled (because the more money that is poured in, the more it moves apart), the reasons for gaps were explored.

Four key reasons were suggested:

- Eligibility criteria is unrealistic
- Budgets actually are too small
- Services are poorly commissioned and poorly monitored
- Neglected services (e.g. no User group / a distant manager etc).

Perhaps slightly biased because of my own Newcastle roots, I enjoyed his analysis of the bridges over the river Tyne, and their economic equivalents. Peter advocated sourcing additional funding from any and every variety of means:

- the emergency bridge (unplanned resources e.g. family or fund raising)
- the diagnostic specific bridge (e.g. MND society)
- the education bridge (working with education providers towards a holistic approach to children's needs)
- the voucher scheme bridge
- the individual funding request bridge (a specific justifiable case put to the PCTs).

Peter concluded his talk succinctly – Why do we all do the jobs we do? – Is it to provide the best Service we can? Or to "protect" the budget?

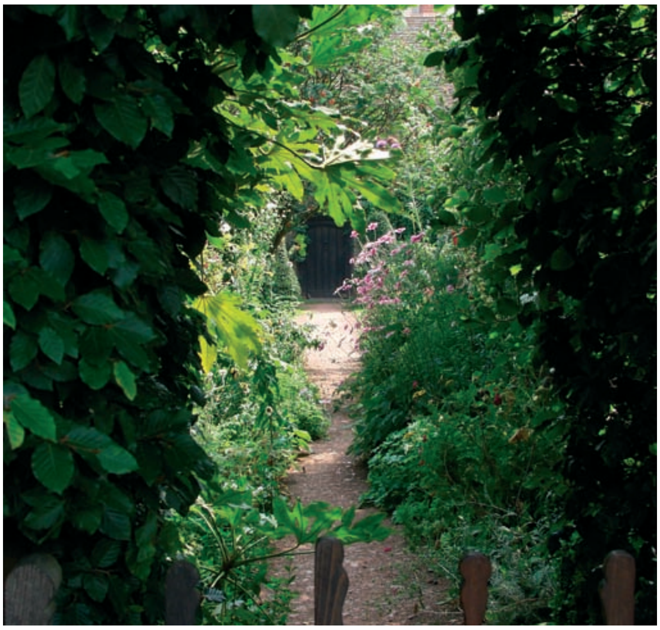
Thoughts and Conclusions

Following this parallel session, I reflected on what had been discussed.

I first considered the fundamental philosophy of the NHS – a service for all, free at the point of delivery – and how this differs from models of healthcare in the USA. It seems that Jean and ICS have their work cut out for them. They use clear social objectives with sound clinical reasoning to work as an opponent to the "cheapest is best" mentality, and offer functional outcomes. Sound familiar?

Meanwhile, the changes made at Barnet Wheelchair Services filled me with both excitement and dread. It is clear that partnership is, rightly so, the only real way forward. But the prospect of such upheaval in the way we work is daunting. In the NHS, Culture is the hardest thing to change. What I learnt from Fiona is that risks and reservations will occur, and transition will neither be easy nor a finite process. But the rewards will make it worth it.

Finally, the one for the money! We all know there isn't enough of it, and a huge, unjustified, disparity of Wheelchair Service funding across the UK. What this presentation explained was how to make the best use of our existing resources and then tap into others. Following Peter's Newcastle theme: "shy bairns get nowt!"



Picture from Eden Project vist after Exeter Conference 2005.

Pathways to Work

Presenter: Dr Niven-Jenkins, Medical Policy Advisor with Department for Work and Pensions

Dr Niven-Jenkins opened his session with some unbelievable facts:

In the UK 1 million people report sick each week, 3000 of these are still off work at 6 months, 2400 of these people will not work again in the next 5 years.

There are 2.7 million people of working age claiming Incapacity Benefit costing a total of £125 million a week. This sum is greater than the NHS bill for medicines every week, putting the vast financial implications of worklessness in the UK into perspective. The amount of people with mental health problems claiming incapacity benefit is rising and is the most reported reason for this benefit claim, musculoskeletal and cardiac problems follow with other smaller groups of health conditions/disability competing the spectrum.

It was reported that work is important for a number of reasons, it provides, financial status and security, regular occupation and activity, sense of identity and purpose and social interaction. On the opposite side Worklessness can cause change in health related behaviour (increasing morbidity and mortality), isolation and social exclusion, disruption to future work carer (if planning/hoping to return to employment) and a loss of motivation and confidence. Therefore in summary promotion of work opportunities to people who are not in employment should be for 3 reasons, health, social and economic.

Traditional processes of facilitating people in returning to work have largely proven to be unsuccessful, as people have indicated their obstacles to be due to mental health/psychiatric reasons rather than due to a certain pathology or impairment.

The Pathways to Work pilot schemes have been developed as a holistic approach to guide a person through a programme to enable recovery and facilitate return to work. The schemes have been set up in collaboration of Jobcentre Plus and the NHS with an aim to increase take up of work opportunities by people who have been claiming Incapacity benefit. The 7 pilot schemes consist of:

- Structured/comprehensive package of help, advice and support,
- Work focussed programme provision
- New health "Condition Management Programmes" delivered by the NHS but funded by the Department of Work and Pensions.

People choose which components they wish to attend, with no parts being obligatory. The scheme is only short term (4-13 weeks) and consists off, an initial assessment (goal setting), information about their condition, addressing person's concerns / beliefs, physical / psychological interventions (physical exercise, relaxation, stress management, Cognitive Behavioural Therapy) and vocational advice and support.

The results so far have been very promising, 10,700 people have returned to work with over 2000 of these people having been on benefits for more than 2 years. 20-25% of the people who have attended the work focussed interviews take up some sort of back to work help and about a third of people attending take up the Condition Management Programmes. Within the pilot areas twice as many people have entered jobs from claiming Incapacity Benefits compared to the rest of the country.

It is also important in my opinion to be aware of the changes in NHS/Government initiatives. There is a move towards making health service models more predictive and less reactive. The recent NSF for Long Term Conditions is an example of this, it is aiming towards working with people who have illnesses/disabilities to empower and educate them in the management of their condition. Also there is The Expert Patients Programme which is a self-management course giving people the confidence, skills and knowledge to manage their condition better and be more in control of their lives, this could be similar to the Condition Management Programmes mentioned above. The Commision for Patient and Public Involvement in Health has a role to make sure the public is involved in decision making about health and health services in England. This global change in delivery of NHS services may impact in the future on the uptake of return to work initiatives that are available.

Hopefully this summary will increase professional's knowledge of this particular scheme, we can encourage and support people we may meet in our working lives who are claiming Incapacity Benefits or who plan to following a change in their circumstances to contact their local Disabled Employment Advisor at their local Job Centre.

Hannah Snowsill,
Occupational Therapist,
Devizes and North Wiltshire Area
Stroke Rehabilitation Services

The Occupational Status of the Spinal Cord Injured Population

Presenter: Miss L Hills, Occupational Therapist, The Spinal Cord Injury Centre at Stanmore

This presentation was based on the research carried out by the Occupational Therapists at the Spinal Cord Injury Centre at Stanmore. Due to most Spinal cord injuries occurring in a working age population (usually under 30 years old) the team were keen to find out the incidence of return to work within the population of patients discharged from Stanmore.

The research was based around 3 questions:
1. What is the incidence of return to work?
2. What influences peoples choices?
3. Do they wish to discuss work during their inpatient rehabilitation?

A total of 242 questionnaires were sent out to patients with acute and traumatic SCI who had been admitted to the unit between 1998-2003. Participants were all over 16 years old and had sustained a complete or incomplete spinal cord injury. Of the 242 questionnaires 31% were returned of which 19 were excluded as they were inappropriate which left 57 questionnaires for analysis.

The results were interesting. Of the 57 respondents, 42% had returned to paid employment at one time but only 26% of these had returned and remained in paid employment. On investigating the reasons why such a high percentage had stopped employment it was found to be mainly due to health problems.

58% of the group who had returned to work had done so within a year of injury which is also surprising considering many people can be an inpatient in a SCI unit for an extended period of time.

25% of the respondents reported they were off work on long term sick leave with a higher incidence of these being cervical injuries.

The factors that influenced individuals' choice and/or reasons for returning to work were timing and level of injury (paraplegics were more likely to return to work that tetraplegics, but tetraplegics were the largest group to move towards the student role). There was no difference with return to work of people with incomplete versus complete lesions. Offered support of employer and family were important and people who had used structured support schemes had found them beneficial. Generally previous heavy workers prior to injury took up light/moderate work roles. Majority of people went back to the same employer, although possibly in different roles.

Although this research was very interesting the research methodology needed to be clearer on presentation. There was no comment on the study being approved by an Ethics Committee, one presumes cautiously it must have been approved to allow the patients to be contacted. There was also no comment on costs/budgets for the research, was it from an ethical source? Did the respondents have pre paid envelopes to return their questionnaires? The use of a pilot questionnaire/study was not reported so one has to assume that the study was completed without prior investigations. It wasn't clear whether the questionnaire was anonymous, or if it had been sent to both inpatients and those who had been discharged from the unit? Both factors could put the researcher in a position of power, forcing the respondent into certain answers or indeed dissuading them from completing the questionnaire. The exclusion criteria was not discussed so it was unclear whether this was set prior to sending out the questionnaires or completed as a reaction to the "inappropriate" responses. The type of questionnaire was not discussed, whether it was structured or unstructured and the pros and cons for statistical analysis of each method was not mentioned. There was unfortunately no comment on the reliability and validity of the research method, questionnaire and summary of the results.

However the research may have assisted The South of England Review when they set standards and recommended pathways for patients with spinal cord injury during their rehabilitation. This Review includes all aspects of rehabilitation but perhaps as a result of this research includes standards for community reintegration. 49% of patients in this study agreed they would have been ready to explore return to work during their inpatient rehabilitation. The Review recommends that all individuals in rehabilitation will be provided with information and assistance regarding opportunities for education, training and employment. This standard should be transferred into other appropriate rehabilitation settings with other clinical groups if we are going to support individuals with returning to a working role.

Hannah Snowsill, Occupational Therapist,
Devizes and North Wiltshire Area Stroke
Rehabilitation Services

Integrated solutions for effective living

Ian Salt, Health and Social Care Change Agent Team

ICES (Integrating Community Equipment Services) was a Department of Health funded initiative across health and social care to develop community equipment services in England, removing unnecessary barriers for users, and modernising services. The ICES team completed their task in March of this year, extended by one year to support those services that were still experiencing difficulties and barriers to integration, and now, working with the Change Agent Team, the drive and enthusiasm to deliver integrated provision will continue.

Community equipment services help disabled people of all types and ages, including children and young people, to develop their full potential and to maintain their health and independence. Until now, health and social services have largely responded to their differing statutory obligations by developing equipment services that run in parallel. Organisational barriers and pressures on funding have worked against the interests of equipment users leading to frustration and delays. But now there is an opportunity for NHS organisations and local councils to use the Health Act 1999 to remove the barriers by pooling budgets and integrating services and there are some exciting times ahead.

Building telecare in England

On 19 July 2005, The Health Minister, Liam Byrne, announced the launch of the Preventative Technology Grant at the Investing in Telecare conference in London. £80 million will be made available to local authorities through the Preventative Technologies Grant in the two years from April 2006.

Telecare is a way of supporting people at home using simple monitors generally linked with the familiar community alarm systems (handsets and pendants connected through the telephone line to a control centre). Telecare monitors include flood and smoke detectors as well as more sophisticated devices that can detect if a user has fallen or not arisen from their bed by a particular time. For relatively small investments, telecare can support home care packages and offer a viable alternative to residential care. In most organisations, the infrastructure for telecare is already in place. In this country, we have the most developed community alarm system in the world. The price and reliability of monitors is now good. New suppliers are entering the market with mobile technology. There are many well-documented examples of telecare being used in conjunction with intermediate care, independent living and housing projects (e.g. sheltered and extra care housing, ‘smart’ homes).

Many organisations are looking at mainstreaming telecare as part of a range of community care and housing services for users. Particular users that could benefit include people who are discharged from hospital or are being supported by admission avoidance programmes within intermediate care. In some more sophisticated examples, telemedicine can monitor vital signs under clinical supervision and can support people at home with COPD and other chronic diseases. Some organisations are developing services for people with dementia (e.g. using mobile phones and GPS to locate someone who may have wandered). Telecare is set to play a key role in maintaining people at home through building their confidence and independence as part of a community care package. This is good news for older people particularly. It is also good news for carers.

There may be considerable gains in using telecare as a community care service to support a safe discharge in reimbursement protocols often alongside existing provision. The first few days in leaving hospital are critical and services that provide support and increase confidence can prevent re-admissions.

For more information about telecare, there is a helpful topic sheet on the ICES web site. www.icesdoh.org

Moving wheelchair services forward

The theme of this programme is to improve service delivery of wheelchairs through greater implementation of learning from the Wheelchair Services Collaborative experience and better coordination with related services. The aim of the programme is to improve outcomes for wheelchair users, maximising their independence and contributing to improving opportunity, choice, and quality of life.

This one-year project will help develop a base for the development of wheelchair services in future years. It will:

- Explore the interface and coordination of wheelchairs with community equipment, adaptation services and independent living centres.

- Examine the benefits in terms of efficiency, effectiveness of procurement, service responsiveness and outcomes for users.

- Make recommendations for future development and investment

- Review, clarify and update existing DH and national guidance.

For more information about this initiative you are invited to email the project lead, Bernadette Simpson – Bernadette@icesdoh.org

Supporting the implementation of the National Service Framework for Long Term Conditions.

The National Service Framework is mainly for people with long-term Neurological conditions. However, many aspects of the Quality Requirements in the NSF apply to people with other long-term conditions .The Health and Social Services in your local area will be expected to deliver each of the Quality Requirements over the next ten years, although how quickly they do this will depend upon local priorities.

The Health and Social Care Change Agent Team, part of the Care Services Improvement Partnership, have developed service improvement methodologies whilst working with health, social services, education, housing, industry, the voluntary and the private sector to develop their strategies in line with the national agenda, and have acknowledged the local determinants in such things as protocols and service models to achieve this. To enable service implementation of this NSF we are planning a number of events around the country. The aim of these events will be to improve awareness of the Long Term Conditions agenda and identify opportunities for service managers and commissioners to develop further their local partnership arrangements. We will engage with people to challenge their thinking and help test out their plans to implement this NSF. There will be an added focus on user involvement, the outcome of which will be to maximise their independence and to contribute to improving their quality of life. The combined skills, knowledge and experience of the Integrated Community Equipment Service (ICES) and the Change Agent Team will be harnessed to provide the most efficient use of our resources.

Approximately 10 million people across the UK have a neurological condition. They account for 20% of acute hospital admissions and are the third most common reason for seeing a GP. This NSF aims to make sure that services for people with long-term neurological conditions and their families and carers are faster and easier to use and better coordinated. It is about making sure that services are provided by people with knowledge and experience of specific conditions and are planned around the views of people with long-term neurological conditions and their carers;

This NSF was developed in consultation with people with long-term neurological conditions in order to raise standards of treatment, care and support across health and social care services.

For more information about this implementation programme you are invited to email Sharon Lloyd – Sharon@icesdoh.org or Nick Marcangelo – nick.marcangelo@dh.gsi.gov.uk

Ian Salt, Specialist areas:
Long Term Conditions/Telecare

A career spanning thirty years within a local authority setting, Ian was a team manager with Manchester Equipment and Adaptations Service. He has held responsibility for domiciliary care, residential care, physical disability service, sensory services, and community equipment services, before moving to the Department of Health in 2001 as the Director for the National Implementation Team for integrating community equipment services (ICES). For the past four years Ian has been working in areas of integration to support a 'whole system's approach' across the NHS and Local Government interface supporting various programmes associated with care service improvement and he is now a member of the Change Agent Team.

Holistic Integrated Seating: When Life is Living while Sitting…

Bart van der Heyden, Physical Therapist Consultant, Director for Training & Education Europe,
The ROHO Group

When you're reading this article, you're probably sitting in a chair behind a desk. Perhaps your cervical spine is in flexion so your head has a better position for reading, your thoracic spine has more kyphosis than usual, and your pelvis is tilted backwards. You probably sit sliding forwards in your chair, and perhaps your knees are slightly extended and crossed. It all makes perfect sense because at this instant this seems to be the most appropriate posture for reading in a relaxed way.

Favorite position for relaxing for our 3 year old…

Is this a normal posture? Nobody would think this isn't normal, since we all tend to adopt similar postures. But when a person in a wheelchair comes in for a wheelchair assessment, sitting in the same way as you are, all of a sudden the very same posture would be considered inappropriate! The situation would become even more interesting if you are still in the same posture when this person asks you what you're reading. Chances are he wouldn't believe you, especially when you answer him with your head bent over the article "Holistic Integrated Seating…"

A posture makes most sense if it's adapted to what we're trying to accomplish at that specific time (in our case the reading). The very same posture is less appropriate for other activities (e.g. attentive listening to the person who comes in for the wheelchair assessment). An optimal posture is selected because we have **a need, a motivation or a 'driver' to interact with the environment or to perform a (functional) task.** Most of the time this is an involuntary process, but the motivation or 'driver' depends on the individual's likes, needs and wishes at the time. When the driver or motivation changes there's a need to **move** to a more appropriate posture that can help to respond to the new 'driver'. This 'movement' or tonic activity can be very obvious (as in our example), or can be very subtle (e.g. a slight change in head position). Functional activities and the social environment will have an indirect influence on your 'driver' and motivation and consequently, postural movements and adopted posture. If in our case, the person you're assessing complains that you're reading and not looking up when he talks to you, you probably will change this habit in the future.

From my practical experience this 'holistic model' is also applicable for most people who sit in a wheelchair. And it helps me to find an appropriate seating solution for the individual (and interpreting pressure mapping data as well, but that's for another time).

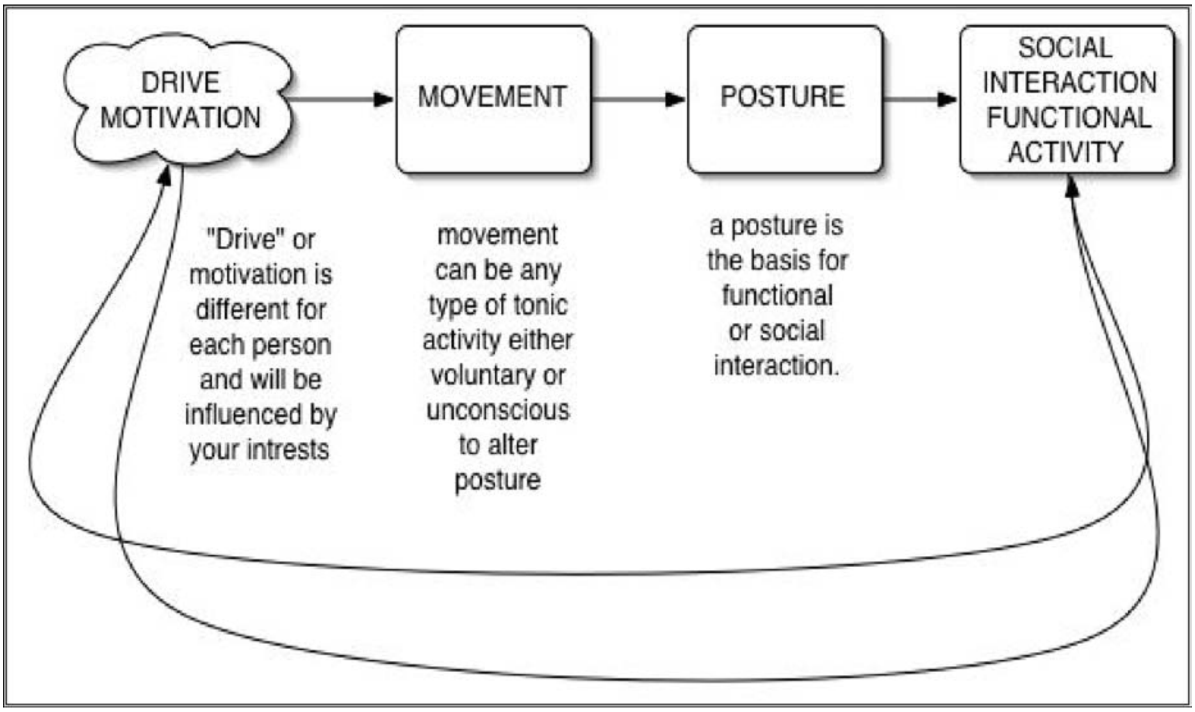
The start of a seating intervention is the seating assessment. It helps to find an answer to the following questions:

What is the individual's motivation or 'drive'?

It helps if we have an understanding of the individual's world: Who is this person? What are his/her experiences sitting in a wheelchair? How does the person handle sitting in a wheelchair? Who's in his / her social circle? Who are his caregivers? What's his/her relationship with them? What is the individual's character? What are the person's interests, likes, and dislikes?

The better you know the individual, the better you'll understand the person's 'driver' and how the seating equipment can fulfill these needs.

What kind of movements is the individual doing when he's sitting? What sets of postures are possible for the individual? What is the social interaction & functional outcome?



My 'holistic' view

1. OBSERVATION:

Are movements voluntary or involuntary? When is the person moving? What movements are possible? When is the person compensating? How frequent are these compensatory movements? What kind of posture does the person have? When is he/she changing posture? What kind of activities is he/she doing when he/she sits?

You'll get most out of an observation when the person is performing his daily routine. When someone is made aware they're being observed, he/she is likely to sit or act differently. (If your colleagues were to be watching you when you're reading, the chances are that you might sit in a less relaxed posture as compared with your posture while reading alone).

Here's an example:

Observation:

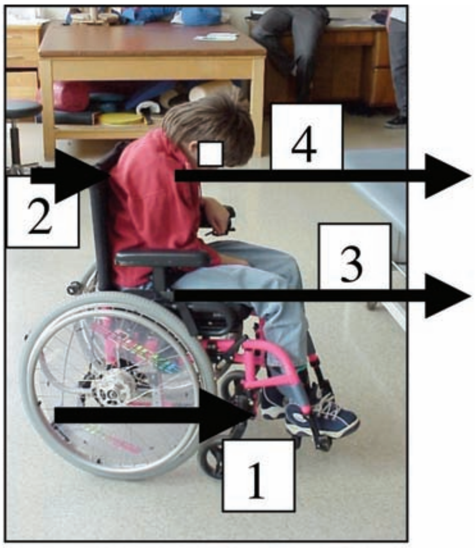
- This person leans forward on his chair, pressing with his left forearm and elbow into his arm support. This causes his trunk to lean towards the left side, resulting in a scoliosis, and a pelvic rotation. This person has a good head position, which allows him to interact with his environment.

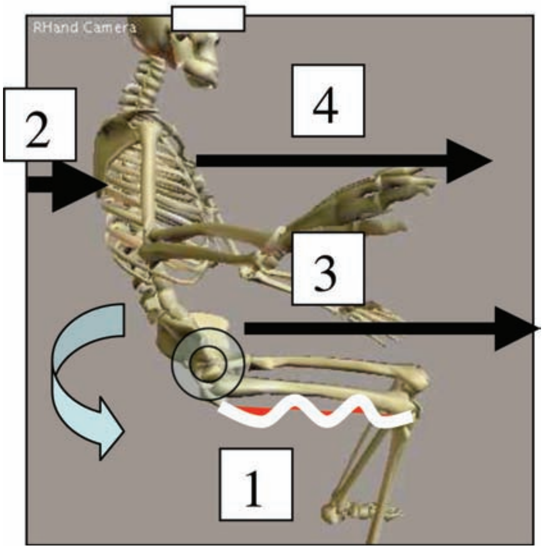
- Key questions: why is this person flexed forward, leaning on his arm support? Does he have enough thoracic freedom? Does he have short hamstrings and is there pressure on the calf support because of this? Is the pelvic rotation caused by tight hamstrings making the calf press against the calf support? Is he pressing with his left forearm on the arm support to get thoracic extension and a better head position? Is the scoliosis caused by the need of the person to seek support by leaning on his left forearm? Does he do the same with his right arm? What is he trying to do when he sits? What is his driver? How does he tend to sit during the day? How long can he sit before getting fatigued? What postures will he adopt when he's fatigued?

2. UNDERSTANDING WHY:

Here it's important to link the examination of the physical skills (in sitting and on the mat) with the findings from the observation.

Here's an example:





Understanding why:

- Physical examination showed contraction of both hamstrings. The calf support does not allow enough knee flexion causing the posterior pelvic tilt (PPT) (1).

- The person's position is passive and the backrest is too high, leaving no room for the thoracic kyphosis (2).

- This leave the person with 2 options:

    - Slide forwards with the pelvis to decrease the flexion tendency of the spine (the center of gravity (COG) is too forward). This is not really an option for this person since the pelvis is strapped in with a pelvic belt (3). (When the COG is too forward the postural muscles need to work hard to remain in an upright position. With time this will increase fatigue of the postural muscles)

    - Flexion of the thoracic spine. This is not really an option for this person either because he wants to see, and interact with his environment. He compensates for this flexion tendency by pushing and leaning with his arms on the seat and the arm supports (4).

How does all this information lead to a seating solution?

Posture will change with time therefore the person needs to move. Exactly how much movement is needed for each individual will depend on the individual's possibilities and needs. Ideally all the information from the assessment needs to be reflected in the seating solution. We need to create a unique three-dimensional shape, which allows changes of position over time. On top of that, each movement of one segment will have an influence on the other segments.

Understanding the relationship of these segments with one another helps define how each simple segment adjustment will influence the entire posture. It also helps to have an idea of the compromise you're willing to accept. Most of the time, only a limited set of postures and movements are possible, so we have to compromise between what is possible with the seating solution and which movements and postures are needed most for the individual. This is a difficult task indeed!

Fortunately there's always the possibility to simulate a

So what was changed?

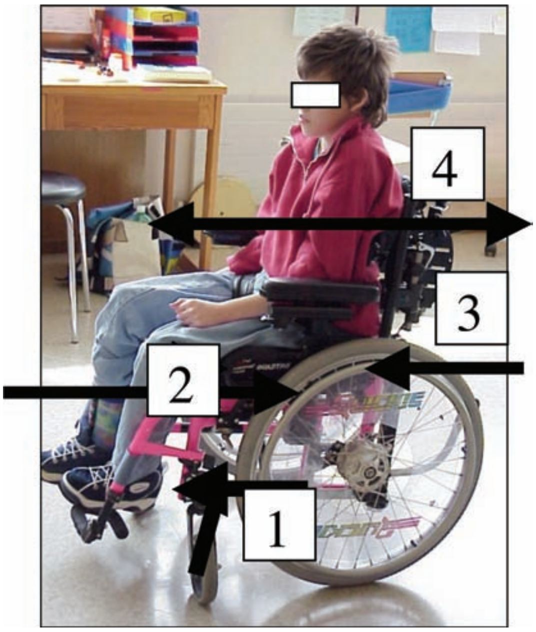
- The calf support was removed as it did not allow enough knee flexion before, and did not help much in keeping the feet on the foot support. This adjustment alone caused less PPT (1).

- Better support of the pelvis in the frontal and sagittal plane improved stability (2).

- The next step was to readjust the pelvic and lumbar support based upon the individual's ROM (range of motion) in a seated position (3). The ROM was evaluated during the physical assessment.

- Key to this intervention was the thoracic support. After trial and error I found the optimal position of the thoracic spine (4). This was the best compromise between enough room for the thoracic spine and optimal head COG. This posture allowed for the most functional and comfortable long-term positioning of this person.

Results & outcomes: there's less need to lean on the arm support and the time the person can spend in a functional head position has increased significantly.



seating solution through trial and evaluation. Sometimes these are the most important tools we've got…

Let me know what you think.

Bart Van der Heyden
bvanderheyden@attglobal.net

Wheelchair Services PLC – are you thinking what I'm thinking? Thoughts about 'Commissioning a patient-led NHS' (28 July 2005)

Peter Gage, Chair, National Wheelchair Managers Forum
CSM. North Essex Wheelchair Services

The requirements set out by Sir Nigel Crisp in the above document are, to be concise, 'far reaching and fast moving'. The environment within which we all currently operate has the potential to become changed beyond recognition as GPs take up the role of commissioning our services. We, the providers of these services, must engage in the process, form views with our service users based on facts and evidence, and then ensure that together we lobby for the best outcomes. Do not ignore the title of this document or its predecessor 'Creating a patient led NHS' (17 March 2005). It is all about patient involvement and providing the services that reflect patient choices.

As I understand the paper, these are the key points:

1. Strategic Health Authorities (SHAs) will be reduced in number, increased in geographical size, become coterminous with Government Office boundaries, and deliver significant savings in management and administration costs.
2. Primary Care Trusts (PCTs), currently the main providers of Posture/Mobility/ Wheelchair Services, will relinquish the provider role and focus on the role of ensuring the delivery of the Government's commitments to health. They will also place and manage the contracts that have been commissioned by the GPs under Practice Based Commissioning (PBC), probably having coterminousity with County Councils and Local Authorities They will also reduce in numbers, increase in geographical size, and deliver significant savings in management and administration costs.
3. GP practices, probably formed into 'clusters', will become responsible for Commissioning services (PBC) that meet the health needs of their local population. They are also responsible to manage their budget effectively, delegated from the PCT, over acute, community, and emergency care.
4. The manifesto promise of £250million of overhead costs savings is realised.
5. The timescale is very short;
   Full Consultation process is completed by March 2006
   First wave of enhanced PBC implemented by March 2006
   PCT reconfigurations undertaken by October 2006
   SHA reconfigurations completed by April 2007
   PCT changes in service provision complete by December 2008

So what could happen to Wheelchair Services as we currently know them? Predictably, what is best for patients is likely to vary across the country, which means that we could continue to see different solutions in different places.

Who would be the provider of wheelchair services?

Foundation Trusts? Possibly, or rather probably, but at present these are Acute Trusts and community services do not sit very easily within them. However, this is clearly envisaged in Sir Nigel's paper. There is a real danger that wheelchair services would remain low priority within an Acute Trust. But, of course, some Wheelchair Services are already a part of an Acute Trust and where this relationship is already established it may well continue to thrive. There may be good local reasons for this arrangement to be favoured but it is not the most natural of liaisons.

GP practices, or groups of practices, may wish to run wheelchair services. Probably not a very likely or viable proposition.

These services would likely be fairly small in size and economies of scale would not be realised. However, several small services, working loosely as consortia, may achieve some of the benefits. The clear advantages in this proposal is the ability of these services to react to local peoples' needs and reflect their choices, supported financially by their funders - the GP practices.

An external, 'not for profit' organisation of therapies? In this possibility, therapies (including wheelchair services) could come together to form an organisation, outside of the NHS, and sell the services back to the commissioning practices. The organisation would need to be very robust on its basis of provision, financial management, marketing, and contract management. The terms of provision and eligibility criteria, would need to be tightly adhered to so that the organisation could stay afloat. Staff would need to pay particular attention to terms of employment, working conditions, pension arrangements, and security of employment. This would be a high-risk option for both the organisation, the staff employed in it, and patients it serves. It is difficult to see how this would enhance choice for patients over current provision unless GPs purchase a higher level of service than is currently commissioned, i.e. there is a greater investment as a result of PBC. A possibility may be that this option is able to link up with an existing Charity organisation, local or national. The question here is: if it is outside of the NHS why should it remain a 'not for profit' organisation? This leads us to another option.

The external private provider of wheelchair services. (This organisation may or may not include other therapies such as Occupational Therapy and Physiotherapy services.)

Already, much of what most wheelchair services do is provided by external contracts e.g. manufacture, maintenance, storage, modifications, deliveries, and collections (logistics functions). What is provided in house is the clinical assessment and administrative functions. The reason this is currently so is that each part, looking to its skills base, does what it is best at. So why should not the private providers also employ the people providing the clinical and administrative skills? Some services have taken their logistics functions in house. Surely, its as easy to do the reverse and take the clinical and administrative functions out of house? If, simultaneously, the voucher scheme were to be expanded to cover all provision, rather like the Direct Payments for carers, greater choice and responsibility would be placed into the hands of the patients. (Isn't that the name of the game)

Discussion

The privatised wheelchair service will need to make a profit otherwise it will not happen and where, in the services currently provided, is the potential to take a profit?

Take a look at Private Finance Initiatives (PFI) and Local Improvements for Trusts (LIFT). Who would have expected, a few years ago, that private companies could run NHS hospitals or premises and make a profit whilst also providing improved services to patients ?

Take a look at Community Equipment Services (CES). They struggled with providing a reasonable service until the advent of ICES. A step change has been achieved through integration of Health and Social provision, supported by increased investment of financial resources. Result; some Community Equipment Services are now being run by private companies providing improved services to patients.

The same step change could be achieved with Wheelchair Services. Lets face it, big change is upon us already. It is not an option to remain status quo. How well we all survive the changes will relate directly to how fully we embrace the opportunities, think flexibly and innovatively, and act promptly. One size will not fit all and we must expect some areas to be more radical in their solutions than others. There could be challenges to employment terms and conditions, depending on the options, and all involved need to be aware.

I write this article on 19th August 2005, but by the time it is published in the Autumn issue changes and other options may be available. The decisions to be taken ahead are big ones and we will make mistakes, but that is part of the learning process and we must believe that it will lead us to providing increased choice, happier patients, and greater job satisfaction. It is difficult to imagine how we can achieve this without financial investment, but it could come in ways we have not expected. Patient Choice is here to stay and we all welcome it in principle. Let's get on with this consultation, explore all of the options - these and any others - and then, together with our service users, build our business plans.

Wheelchair Services: Pivot of Community Rehabilitation?

Dr Andrew Frank, Consultant in Rehabilitation Medicine, Stanmore Specialist Wheelchair Service,
Disablement Services Centre, HA7 4LP

Introduction

The International Conference on Posture and Wheeled Mobility held in Exeter in April 2005 brought together experts from 19 countries to review the 'state of the art' for wheelchair provision. It was organised jointly by the Posture & Mobility Group (PMG), the British Society of Rehabilitation Medicine (BSRM), and the Scottish Seating &Wheelchair Group(SSWG). It was soon clear that wheelchair services cannot exist in isolation – they inter-relate with many other services needed by those with physical disabilities. What may have been a surprise to some delegates, however, was the extent of these inter-relationships – embracing, in varying proportions, medical, surgical, physical, environmental, and psychosocial services (British Society of Rehabilitation Medicine 2004a).

Meeting the needs of wheelchair users

Another mistake made in understanding the needs of those with disabilities is to assume that 'one service fits all'. Those with acquired disabilities may have conditions that are going to improve (e.g. stroke), deteriorate (e.g. motor neurone disease) or have an unpredictable course (e.g. rheumatoid arthritis or multiple sclerosis) (Turner-Stokes & Frank 1990). Whilst the former usually need hospital services and the latter two groups community-based services, wheelchair services are needed by all groups!

One common error is to consider independence in a restricted manner. The recent government green paper is an example of limited consideration around the term 'independence' (Department of Health 2005a). In its response to the green paper (Chamberlain et al. 2005), the BSRM suggested 3 differing interpretations of the term 'independence:

- Personal independence – ability to look after oneself in terms of personal care
- Societal independence – ability to participate in society – family or work roles
- Autonomy – ability to make decisions for oneself.

It is the 2nd and 3rd interpretations of the term that are of particular interest to wheelchair services although understanding how personal independence is maintained is essential if the wheelchair is to facilitate basic activities e.g. safe transfers (British Society of Rehabilitation Medicine 2004b) and transportation (Belcher & Frank 2004)

Participation in Society

The relationships with the world of employment were explored at the conference, with some criticisms of the Access to Work (Jobcentre 2002; Miller 2000; Tyerman & Meehan 2004) provision of wheelchairs. The government is keen to expand the workforce from the current 75% employment rate to 80% (recognising that many currently on incapacity benefits could work if given adequate support) (Department for Work & Pensions 2005). This explains, in part, the current moves to encourage those with disabilities back into the world of work (Department for Work and Pensions 2004; Department of Health 2004; Department of Health 2005b; Prime Minister's Strategy Unit 2005). Paradoxically, long waiting times remain in many parts of the country for electric powered indoor/outdoor chairs (EPIOCs) which could facilitate increased employment.

Children and adolescents in education may also face prolonged waits for powered chairs, even though many need carers to push them (while sat in manual chairs) from one classroom to another. This incurs unnecessary expense and is also demeaning for these young people - whom we should be encouraging towards an independent life. The example of Duchenne Muscular Dystrophy was cited at the conference, where the combination of appropriate EPIOC and environmental control units can safely facilitate the development of independence that will be needed when the individuals wish to leave home to go to college or university. The need for wheelchair users (hereafter referred to as 'users') to harness assistive technology is inhibited by the lack of integration of assistive technology services. Thus in some parts of the UK, environmental control units are provided from different centres than powered electric chairs, even when these services are provided from regional centres!

The need to relieve strain on informal carers is now well recognised (Department of Health 2005b), as is the enormous relief that can be provided to carers of users when provided, for example, with an EPIOC (Frank et al. 2000). Thus, a quarter of those provided with

EPIOCs volunteered that freedom from 'pushing' loved ones was a major bonus to carers (Frank, Ward, Orwell, McCullagh & Belcher2000). Although the government is committed to providing equipment speedily and efficiently, it is notable that wheelchair services were not discussed to any serious degree within the National Service Framework for Long-term Conditions in the section on equipment (Department of Health2005b). Nor has there been any urgency to follow-up the Wheelchair Services Collaborative, in spite of the publication of the Good Practice Guide (Department of Health and the NHS Modernisation Agency 2005) and considerable encouragement to do so from wheelchair users and rehabilitation professionals alike (Frank, Gage & Kemp 2004).

Finally, powered wheelchairs increase users' autonomy. Even though many choose to go shopping with their informal carers, once in the shops they can go their different ways e.g to buy presents for birthdays.

Why are wheelchair services poorly supported?

If wheelchair services are so pivotal for England's 1.2 million users (Department of Health and the NHS Modernisation Agency 2005), why are they so relatively neglected in England (Empower 2004)? The conference did not discuss whether all countries consider their wheelchair services to be neglected compared with other areas of health care, although for some countries such provision may not be part of state-provided services. Bardsley suggested that a poor knowledge base, probably reflecting inadequate research, was a major factor. Others felt that there were too few 'one stop shops' where people with severe disabilities could go for a holistic assessment of their needs. **Thus in the UK there has been no coherent planning of services for those with physical disabilities,** with services dealing with the BODY developing differently from those dealing with the ENVIRONMENT, and those dealing with the MIND. Thus the description of England's rehabilitation services by Martin Ferguson-Pell was hardly recognisable to clinicians predominantly working in hospital-based clinical services.

Such problems were contrasted with the clear planning described by ∞ke Norsten from Norway, where there are clearly defined services at local, regional and national levels, dealing with all aspects of disability. These services are integrated with co-location of all services needed for the holistic assessment of those with physical disabilities. Thus, therapists attempting to overcome physical deconditioning, work together with those offering assistive technology, psychological support, or vocational rehabilitation (rehabilitation into work). Those with complex requirements that could not be met locally are referred to an appropriate centre. Such centres, when linked to educational establishments, can also provide training for disabled people to become rehabilitation professionals, as a valuable part of the rehabilitation team, as was described from Norway.

Inadequate political support may also be a factor. There is little doubt that widespread political support for the coalition of user groups and rehabilitation professionals which developed informally after the publication of the Audit Commission reports (Audit Commission. 2000; Yeats, Mapstone N & Browning 2002), facilitated the setting up of the Wheelchair Collaborative in 2002. It may be that continued pressure from such coalitions and repeated letters to Members of Parliament (MPs) will be needed to persuade the Department of Health to treat wheelchair services on a par with other health provision. If all those who have to wait more than 18 weeks for chairs were to complain to their MPs that other patients with relatively trivial complaints had to be seen within 18 weeks and they had to wait much longer (in spite of severely disabling conditions), more action might be forthcoming!

Finally, it may be that we have not developed the professional alliances that are so necessary in health care. It was noted how few managers were present at the conference and perhaps we should have invited more civil servants to participate. Rehabilitation professionals need allies within commissioning and management circles as well as within the Department of Health.

Clinical issues

Much of the conference revolved around clinical and technical issues: far too many to discuss in detail. However, some memories stand out particularly. Whilst most are aware of the myriad of methods of supporting people within their wheelchair, the use of a standard corset is not usually considered – perhaps because most wheelchair services work geographically distant from orthotic departments. Jeannie Minkel, however, has found them useful on occasions and some users like their invisibility.

Wolf commented on the influence of vibration on wheelchair users' pain. Some wheelchair users attending the conference did not use the roads to move from one session to another because the 'sleeping policemen' in the road were so uncomfortable. Several speakers commented on wheelchair users' pain, an area of increasing importance as more users sit in powered wheelchairs for longer periods; and as an increasing variety of disorders can result in wheelchair use, including painful musculoskeletal disorders (Boninger et al. 2003; Crane et al. 2004; Gibson & Frank 2005).

There was a major focus on skin integrity, with participants being reminded that both direct pressure and shearing forces, within and without wheelchairs, may influence skin breakdown. Another fascinating presentation by Rabey discussed the importance of communication, skills of which may not come easily to all rehabilitation professionals. The value of approaching sensitive topics with an indirect question was usefully stressed.

Concepts of professionalism

Professionalism not only embraces the responsibility of the individual professional to keep up to date, but also the responsibility to run an efficient service. This would include monitoring waiting times for assessment and/or delivery; the need for good information services; and for informed choice covering both the advantages and the disadvantages of either positive or negative courses of action e.g. in choosing a supportive 'posture' or allowing 'mobility' within the chair.

Review allows assessment of personal, clinical, and administrative aspects of the service. The vital role of wheelchair users in the development and operation of services, together with the value of techniques such as process mapping were emphasised (Department of Health and the NHS Modernisation Agency 2005). In contrast, Thornberry pointed out that carers & others involved in users' welfare were relatively neglected at conference, although attempts to show changes in the quality of life of carers of EPIOC users were described.

Conclusions

1. Many wheelchairs, particularly EPIOCs, enable users to participate more fully into society, including:
    - increasing family responsibilities
    - allowing young people to develop separate identities during adolescence
    - the world of work.

2. Individuals with complex physical disabilities need comprehensive services rather than isolated wheelchair assessments.

3. Services for those with severe physical disability in England lack any coherent structure. Rehabilitation professionals need to fight together for a national strategy for rehabilitation services

4. The PMG must become more politically active, working with service commissioners, service managers, other rehabilitation professional groups, the Department of Health, and wheelchair user groups in the fight to develop the comprehensive services needed.

This article is based on a conference overview given at its conclusion. The views expressed are those of the author and do not necessarily reflect those of the conference organisers or the PMG.

References

Audit Commission. 2000, *Fully Equipped: the provision of equipment to older or disabled people by the NHS and Social Services in England and Wales.* Audit Commission, London.

Belcher M, Frank AO. 2004, Survey of the use of transport by recipients of a Regional Electric Indoor/Outdoor Powered (EPIOC) wheelchair service. *Disabil Rehabil*, vol. 26, no. 10, pp. 563-575.

Boninger ML, Cooper R A, Fitzgerald SG, Lin J, Cooper R, Dicianno B, Liu B. 2003, Investigating neck pain in wheelchair users, *American Journal of Physical Medicine & Rehabilitation*, vol. 82, no. 3, pp. 197-202.

British Society of Rehabilitation Medicine 2004a, Musculoskeletal Rehabilitation. *Report of a working group (ed. Neumann V)*. British Society of Rehabilitation Medicine, London.

British Society of Rehabilitation Medicine 2004b, *Specialised wheelchair seating national clinical guidelines. Report of a multidisciplinary expert group (Chair: Marks, LJ)*. British Society of Rehabilitation Medicine, London.

Chamberlain MA, Frank AO, Neumann V, Ward CD. 2005, *Independence, Well-being and Choice: Response of the British Society of Rehabilitation Medicine (BSRM)*. British Society of Rehabilitation Medicine, London.

Crane BA, Holm MB, Hobson D, Cooper RA, Reed MP, Stadelmeier S. 2004. Development of a consumer-driven Wheelchair Seating Discomfort Assessment Tool (WcS-DAT). [Report], *International Journal of Rehabilitation Research March*, vol. 27, no. 1, pp. 85-90.

Department for Work & Pensions 2005, *Department for Work & Pensions Five Year Strategy: opportunity and security throughout life*, HMSO, London.

Department for Work and Pensions 2004, *Building Capacity for Work: a UK framework for vocational rehabilitation* ELCI 3, HMSO, London.

Department of Health 2004, *Choosing Health: making healthier choices easier (Public Health White Paper)*, Department of Health, London, CM 6374.

Department of Health. Independence, *Well-being and Choice: Our Vision for the Future of Social Care for Adults in England: Social Care Green Paper*. Cm 6499, 1-85. Department of Health, London

Department of Health 2005b, *The National Service Framework for Long-term Conditions*. Department of Health, London.

Department of Health and the NHS Modernisation Agency 2005, *Improving services for wheelchair users and carers: Good Practice Guide – learning from the Wheelchair Services Collaborative*. Department of Health and the NHS Modernisation Agency, London.

Empower 2004, *NHS Wheelchair and Seating Services Mapping Project: final report, January 2004*, Empower, London.

Frank AO, Gage P, Kemp P. 2004, *England's Wheelchair Services: a vision for their development Posture and Mobility Group* London.

Frank, AO., Ward, JH., Orwell, NJ., McCullagh, C., & Belcher, M. 2000, Introduction of the new NHS Electric Powered Indoor/outdoor Chair (EPIOC) service: benefits, risks and implications for prescribers, *Clin Rehabil*, vol. 14, no. December, pp. 665-673.

Gibson J, Frank, AO. 2005, Pain experienced by Electric Powered Chair (EPIOC) users: a pilot exploration using pain drawings, *Physiother Res Int*, vol. 10, no. 2, pp. 110-115.

Jobcentre. *Make it work: a guide to specialist services for disabled people*. 2002. Sheffield, Department for Work and Pensions.

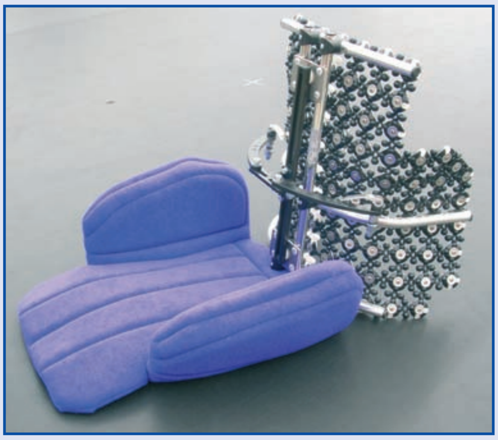
Miller, S. 2000, *Working with MS: a guide for employees and employers*, Multiple Sclerosis Society, London.

Prime Minister's Strategy Unit 2005, *Improving the life chances of disabled people: final report* London.

Turner-Stokes L, Frank AO. 1990, Emerging Specialities – Disability Medicine. *Br J Hosp Med*, vol. 44, pp. 190-193.

Tyerman, A. & Meehan, M. 2004, *Vocational assessment and rehabilitation after acquired brain injury: inter-agency guidelines*. British Society of Rehabilitation Medicine, Jobcentre Plus, Royal College of Physicians, London.

Yeats, M., Mapstone N, & Browning, D. 2002, *Fully Equipped 2002: Assisting Independence*. Audit Commission, London.



Moving Forward – Re-inventing the Wheelchair Service in Scotland

Linsay Stevenson, B.E.S. Rehab Ltd

In December 2004 a public petition was presented by wheelchair users and carers to Andy Kerr, the Scottish Minister for Health regarding provision for wheelchair users in Scotland. As a consequence a report was requested on the future of the Scottish wheelchair service to follow consultation with all interested parties and, in particular, wheelchair users, carers, and service providers. The first stage of this process was a series of public meetings held across Scotland earlier this summer at which major areas of concern were identified.

These major areas were: underfunding; the need for a client centred rather than resource driven service; the need for more local service provision both for convenience and to reduce delays in repair and maintenance. It was clear from the initial consultation that the majority of participating users and carers felt that nothing short of a complete overhaul of the existing provision was needed and several stressed the need to look beyond Scotland to identify good practice in countries with similar demographics and geography.

A one-day conference was held in Edinburgh on 12 September: the concerns raised in the early consultation process were reflected in the structure of this meeting. Sylvia Shearer from the Health Planning and Quality Division of the Scottish Executive set the context of the conference and was followed by two speakers representing carers and users speaking very honestly of their own experience of the existing paediatric and adult services. Terje Sund, from Norway, a Senior Government Advisor on rehabilitation at the National Insurance Administration in Oslo presented the Norwegian model. Norway is very similar to Scotland, both in its demographics and geography. The population of 4.5 million is scattered through a mountainous terrain with only 14.5 people to the square kilometer. Terje outlined the philosophy and structure of provision in Norway for wheelchair users.

The Norwegian model of assistive technology provision is based on the rehabilitation perspective: “Time limited planned processes with well-defined goals and means in which several players work together.” This approach is holistic and patient centred. Assistive technology is defined as any item which is “necessary and suitable” to allow a patient to achieve desired and agreed outcomes. Delivery of the service is divided between national level provision, the 19 counties, and the 340 individual municipalities (see diagram 1). Each county has an integrated disability service catering for all types of disability i.e. hearing and visual impairment, mental, and physical disability. This integration of services means that patients with multiple disabilities receive integrated support from a team of 18 to 20 professionals who work together under the one roof. Funding is also integrated, with central government providing £200,000,000 each year to cover all assistive technology provision, including wheelchair provision.

During parallel workshops delegates were able to discuss specific issues arising from the earlier public consultations. The outcomes of these workshops were then aired in a plenary session. In this session, chaired by Martin Ferguson –Pell (Professor of Disability and Technology, Centre for Disability Research and Innovation, Stanmore), the philosophy and aims of an effective wheelchair service were a dominant theme: “It’s about freedom.” said one young wheelchair user.

From the provider side, the need to identify and agree the criteria underpinning assessment were stressed in order to end the current situation where existing criteria are used to ration scarce resources rather than meet patient needs and aspirations.

The structure of the service also came under scrutiny and the need for local services was expressed. Issues touched on were accessibility to reduce travelling time, more devolved provision for the majority of less specialized needs requiring less specialised expertise, with major centres providing support for the small number of patients with complex needs. One suggestion was for mobile outreach units which would take the basic services to the patient rather than vice versa.

Funding was a major issue with the present grossly inadequate level of funding (£120.00 per patient per annum) recognised as a major stumbling block to development of the service. As well as governmental commitment to adequate levels of funding, it was suggested that funding from multiple sources should be pursued, recognising that many patients with multiple deficits require more than one type of assistive technological support. This could be more efficiently provided by a service based on the Norwegian model where all disabilities are supported within the one centre.

The possibility of a voucher system similar to that in use in parts of England was the subject of some heated debate, both in the workshop and in the plenary session, but Dr Geoff Bardsley from the TORT Centre in Dundee summed up the majority opinion when he said we should: "shoot for the best wheelchair service we can achieve and hold back the voucher system for individual choice when we have the best wheelchair service we can achieve."

Martin Ferguson-Pell held a straw poll of conference opinion and the conference agreed overwhelmingly that:

- There is a requirement for the political will to recognise the rights of wheelchair users and enshrine these rights in law.
- There is a need for a planned, co-ordinated, funded service based on patient and carer-centred needs which is needs led and not budget driven.

The conference as a whole also approved the statement drawn up by one group that:

"The service should be a basic human and civil right, accessible through self referral and should ensure individuals are given all appropriate aids necessary to fulfil the basic rights of every citizen to play an active part in society and their chosen daily life, regardless of physical or learning limitations or differences."

This statement will be enshrined in the final report of the consultation process to be presented to the Scottish Executive in early 2006.

The final speaker, Lewis Macdonald, Deputy Minister for Health and Community Care in the Scottish Executive, who had listened with interest to all the foregoing and commented particularly on the level of funding available in Norway, spoke of re-invigorating the joint futures programme to provide funding for a patient centred approach to patient care and provision. Mr Macdonald certainly heard what the users, carers and providers see as their vision of the Scottish wheelchair service of the future and how to achieve it. It remains to be seen whether political actions will match his words and the Scottish Executive are prepared to put their money where their mouths are to provide a wheelchair service fit for the 21st century that gives the level of service users and carers require and the resources that increasingly demoralised staff must have to meet those demands.

The draft document will be available for consultation on the NHS Quality Improvement website (www.nhshealthquality.org). Further information can be obtained from, or comment passed to, Rhona Hotchkiss of Frontline Consultants, (rhona.hotchkiss@frontlinemc.com)

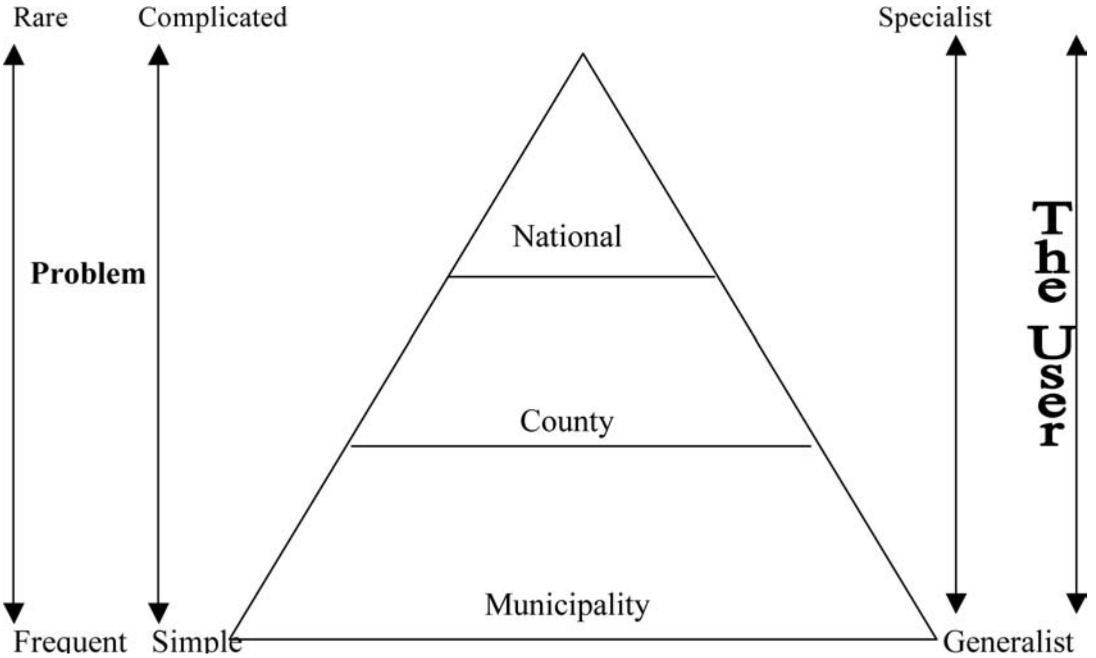


Figure 1: Responsibility for education; work; health; leisure; social aspects of life in Norway.

PMG Research & Development Sub Committee

At the 2005 AGM of the Posture & Mobility Group in Exeter, members voted to allocate £20,000 towards a scheme to fund several small research projects in the field of posture and wheeled mobility.

Since then a PMG sub-committee for Research & Development has been created with the initial aim of implementing and overseeing this scheme. The R&D sub-committee currently consists of seven people with a range of professional, user and carer perspectives. All have a common interest in research and have kindly offered to invest some of their time.

The scheme is open to members of PMG, and offers grants of up to £5,000 (mainly to pay replacement salary costs) for individuals undertaking small or pilot research studies which are likely to be of relevance and interest to the PMG membership.

The scheme was advertised in a mail shot to the membership in June with guidelines, flowchart and a timetable available on the PMG website. Outline proposals were invited for submission via the PMG website and by the closing date of 1st September 2005 a total of seven proposals had been received.

The PMG R&D sub committee is due to meet on the 8th September and will invite more detailed proposals from applicants where appropriate. Detailed applications are then required by 1st November and following independent peer review a final decision about funding will be made in early January 2006. Applicants will need to demonstrate that their studies fulfil all the requirements of the research governance frameworks for health and social care.

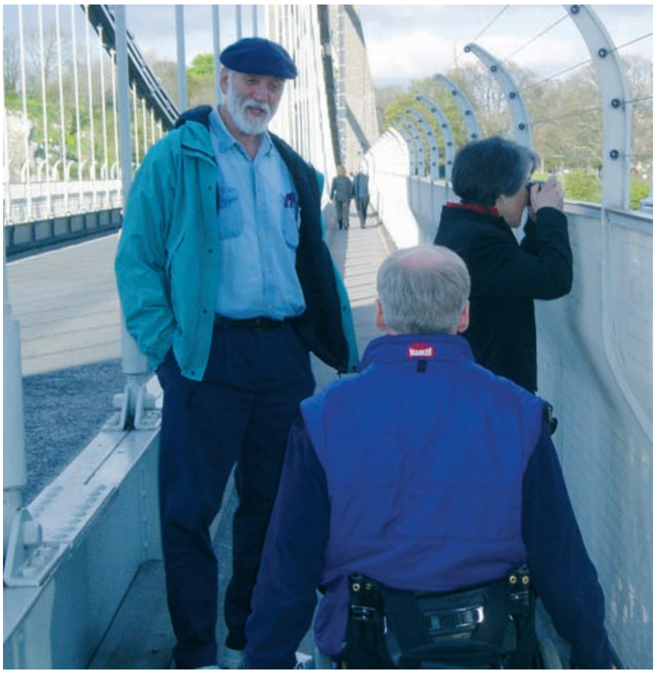
A list of the studies funded by PMG will be posted on the website and published in the PMG newsletter. Eventually the findings and recommendations from each study will be presented at the PMG conference and also published in the newsletter.

For further information please visit www.pmguk.co.uk and click on the Research tab, or go direct to http://research.pmguk.co.uk

If you have any questions or comments about the funding scheme, please contact the PMG office: olwen.ellis@pmguk.co.uk

David Porter

Education and Conference Planning Sub Committee



Planning is well under way for the National Conference in February 2006 to be held at the Dunes Conference Centre, Lytham St Annes.

The planning committee this year is Martin Moore, Barend ter Haar, Sue Pimentel, Lone Rose, Russ Jewell and Linda Marks.

One day training courses have been put on hold for the time being due to the workload that the committee has in trying to compile and arrange a quality 2 day conference programme.

We hope to look at the 1 day courses again very soon once the majority of the work has been done for the conference, we'll keep you posted.

Visit www.pmguk.co.uk for further information on the programme, bookings and abstracts.

Martin Moore

Posture & Mobility Group
Minutes of Annual General Meeting 2005

Newman Lecture Theatre, Exeter University, 14th April 2005

Chair: David Long
Vice-chair: Martin Moore
Treasurer: Barend ter Haar
Minutes: Olwen Ellis (PMG administrator)

1. **No apologies for absence received.**

2. **Minutes of AGM 2004**

   Mike Hare proposed that the minutes of last year's AGM held on 2nd April 2004 at East Midlands Conference Centre, Nottingham be accepted.

   Ros Ham seconded and the minutes were approved unanimously.

3. **Chair's report**

   i. The chair congratulated Martin Moore on being elected as vice-chair of the group.

   ii. Report on the success of the one-day training course run by Wendy Murphy in Liverpool in December. The course was heavily over-subscribed and the training sub-committee plan to put on more such courses.

   iii. The Research and Development sub-committee are proposing to set up a PMG research fund (see item 6).

   iv. The administration of Posture and Mobility Group still under scrutiny by the finance sub-committee: as PMG expands its work, it is likely that additional funds from revenue will need to be allocated to paid administration. Committee members cannot be expected to devote the hours necessary now the group has grown to the size it is and is undertaking the present levels of activity.

   Robin Luff proposed that the Chair's report be accepted.

   Tony Burdett seconded and the Chair's report was approved unanimously.

4. **Treasurer and Membership Secretary's report**

   Membership of PMG is at a record level, showing the health of the group going forward. The treasurer presented a brief financial report, and announced that a full set of accounts will be published in PMG Newsletter later in the year.

   Mike Edwards proposed that the Treasurer's report be accepted.

   Linda Marks seconded and the Treasurer's report was approved unanimously.

5. **Elections to PMG Committee**

   i. Martin Moore wished to thank Natalie Dean, Penny Martin and Gillian Wigham – retiring members of the committee – for all the work they had done as part of the Conference Planning and Education Sub-committee in their 3 years' service on PMG committee.

   ii. Dave Long announced that David Calder had agreed to be nominated for a further term; three other members were also nominated:

   Linda Marks, Joanne McConnell and Emma Stacey.

   No ballot had been necessary, and the meeting unanimously elected the 4 candidates to serve on the committee for 2005-2008.

6. **Research sub-committee proposal**

   David Porter presented the paper distributed at the meeting on Small Research Funds proposal in more detail, and requested that PMG members approve a sum of money to be spent by the sub-committee on funding small research projects in the field of posture & wheeled mobility. The meeting unanimously approved £20,000 to be made available to the Research Fund in 2005/6, with any surplus to be carried forward into the next year. The chair thanked David Porter for his considerable efforts in the formation of a research sub-committee for the group.

7. **Any other competent business**

   i. Regional committees/representation

   a. Andrew Frank reported that at a conference parallel session there had been discussion about a regional structure being created for PMG members to be able to meet more often. David Long pointed out that PMG does not have the resources at present to create such a structure and manage it. Voluntary regional groups are only as effective as the people who are involved in them and have in the past been shown to find maintaining themselves difficult. The chair suggested that this be re-visited in the future.

b. Nigel Shapcott raised the issue of having a dedicated representatives from Wales and other geographical regions on the PMG committee. David Long presented the current view that members are voted on to the committee because of what they can bring to it from a personal rather than a geographical perspective. Robin Luff suggested that members from Wales and all regions of England should be putting themselves forward for election to the committee and encouraging their colleagues to ensure their region is represented. General agreement that the committee requires a balance of the professions more than a regional mix, although it was also noted that the committee is heavily weighted with members from the south of England. The committee should look to co-opting where it is felt there are areas (geographical or practical) that need to be addressed to correct serious imbalances. It was acknowledged that a broad geographical spread is helpful in maintaining the national profile of the group

ii. **PMG Newsletter**
Andrew Frank raised some criticisms about the quality of the PMG newsletter.

The chair reminded the meeting that all the work on the newsletter is currently being done voluntarily and demands a huge amount of energy and time from the editor. If there are members who feel they can contribute towards the work of the newsletter, they can be co-opted to the editorial sub-committee and should make themselves known to the committee or administrator. Their assistance would be gratefully received.

iii. **ISPO**
Suggestion that PMG links in with ISPO for conferences, but the practical and financial issues need to be addressed before another large annual event can be organised by PMG administration and committee. The chair will raise the idea with PMG committee during the year and report back.

8. Date of next Annual General Meeting

The date of the next AGM is 8th February 2006 at Pontins Conference Complex in Lytham St Annes, Lancashire.

Spectra Blitz

Julia Cunningham, Mobility Therapist, Whizz-kidz

Key features of chair:

- Compact frame
- Angle adjustable back
- Adjustable seat size
- Swingaway multi adjustable legrests

Benefits:

- Seat width is adjustable from 25-39cm
- Seat height has 2cm of adjustment
- Alternative seating is easy to fit
- Optional tilt-in -space

Disadvantages:

- The footrests foul on the front castors unless the seat is either tilted back or the hangars are cut short leaving no growth.

Implications for practice:

Good basic chair for smaller children which has many of the advantages of the spectra plus but a much more compact frame. It does not have a kerb climber but this is not often required at this age. It is easy to use with a range of seating and different control options. The tilt-in–space option is a plus but there is no way of adding a seat riser which is often useful with primary age children.

THE POSTURE AND MOBILITY GROUP OF ENGLAND & WALES

STATEMENT OF FINANCIAL ACTIVITIES

YEAR ENDED 31 DECEMBER 2004

	Note	**Total Funds 2004 £**	Total Funds 2003 £
INCOMING RESOURCES			
Income from charitable trading activities:			
Subscriptions		**9,458**	8,842
Conference and exhibition		**131,744**	134,061
Investment income	**2**	**3,794**	2,615
Courses		**2,255**	–
Advertising in Bulletin		**–**	300
TOTAL INCOMING RESOURCES		**147,251**	145,818
RESOURCES EXPENDED			
Charitable expenditure:			
Direct charitable expenditure	**3**	**95,616**	96,861
Management and administration	**4**	**14,736**	16,389
TOTAL RESOURCES EXPENDED	**5**	**110,352**	113,250
NET INCOMING RESOURCES FOR THE YEAR	**6**	**36,899**	32,568
Balances brought forward		**103,570**	71,002
Balances carried forward		**140,469**	103,570

All movements are in Unrestricted Funds

THE POSTURE AND MOBILITY GROUP OF ENGLAND & WALES

DETAILED STATEMENT OF FINANCIAL ACTIVITIES

YEAR ENDED 31 DECEMBER 2004

		2004		2003
	£	**£**	£	£
INCOME				
Subscriptions		**9,458**		8,842
Bank interest		**3,794**		2,615
Courses		**2,255**		–
Conference and exhibition		**131,744**		134,061
Advertising in Bulletin		**–**		300
TOTAL INCOME		**147,251**		145,818
CHARITABLE EXPENDITURE:				
Conference and exhibition expenses	**88,777**		88,475	
Course expenses	**1,655**		30	
Books subsidy	**5,184**		8,356	
		95,616		96,861
MANAGEMENT AND ADMINISTRATION				
Administration	**3,838**		4,228	
ISO Standards	**–**		604	
Newsletter	**4,519**		5,858	
Accountancy fees	**1,000**		450	
Committee expenses	**3,655**		4,940	
Taxation	**–**		53	
Bank charges	**172**		–	
Depreciation of fixed assets	**1,552**		256	
		14,736		16,389
TOTAL EXPENDITURE		**110,352**		113,250
NET INCOMING RESOURCES FOR THE YEAR		**36,899**		32,568

The Bodypoint Hip Grip

Dave Harrison, West Midlands Rehabilitation Centre, Oak Tree Lane, Selly Oak, West Midlands

In 2004, the West Midlands Rehabilitation Centre was one of five centres asked to trial a new postural support product, by its distributors BES Rehab, and provide recommendations concerning its development. Here is a summary of the report that was submitted.

The Hip Grip is a dynamic pelvic stabilisation device that claims to provide a wheelchair user with stability and correct pelvic positioning whilst allowing them to rotate their pelvis forward, increasing the user's functional reach. Rubber strips act as springs to allow the user to return to a neutral position with the minimum of effort. The springs are available in three strengths to ensure the appropriate resistance is applied. The hip grip locates around the pelvis. It uses the PSIS (posterior superior iliac spine), iliac crest, and the ASIS to secure the user. The top of the sacral pad is set to the top of the sacrum, the wing pads surround the iliac crests on either side of the pelvis. The belt comes out from slightly below the iliac crests and secures over the ASIS. The belt must be tight to secure the pelvis correctly. The pivot is positioned when fitting so that the Hip Grip pivots around the ITs (ischial tuberosities) rather than the hip joint.

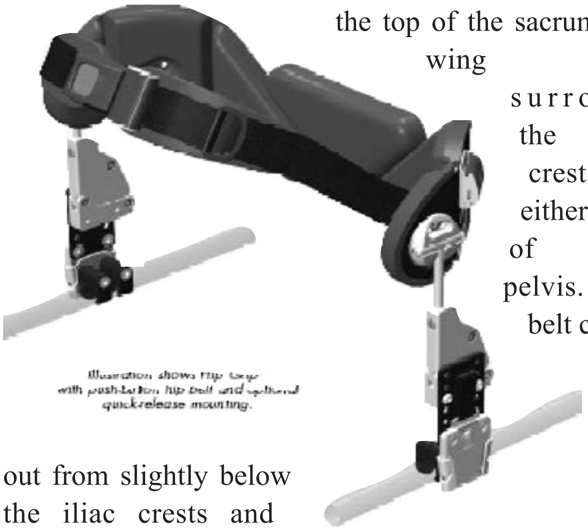


Illustration shows Hip Grip with push-button hip belt and optional quickrelease mounting.

Case Study 1

The first trial was with a 54-year-old male with progressive MS. The client was unable to maintain a stable posture in his wheelchair and had a flexible pelvic obliquity resulting in his using a range of methods to support himself. During assessment, measurements were taken to establish his functional reach to calculate the effect of the Hip Grip. Anatomical measurements were also taken and the Hip Grip adjusted accordingly before fitting to the client's wheelchair. The fitting process took a lot longer than expected as the mounting components and adapter plates provided did not fit the client's Newton Badger wheelchair. Therefore time-consuming modifications were necessary.

After four weeks the client stated that the Hip Grip was "brilliant and encouraging" and he described how the product guides his pelvis whilst performing tasks, gave him increased stability and security, and added that it reduced fatigue, enabling him to perform tasks for longer. Following five months of use it was concluded that the Hip Grip had improved the client's quality of daily activities and lifestyle. Again he stated that it improved his confidence and he felt "less disabled". His only negative opinion was that he couldn't fasten or adjust the lap belt or always achieve a neutral pelvic position independently. The Hip Grip didn't seem to hinder the client's functional reach either. Results of measurements showed (although not consistently) that his reach had generally improved, suggesting that the product did not restrict forward movement in the chair. This client was extremely satisfied with the Hip Grip product. Difficulties with fitting and donning the equipment are outweighed by the functional benefits. The improvement in posture was clearly visible.

Case Study 2

The second client to be trialled with the Hip Grip was a 53-year-old male with a spinal injury resulting in tetraplegia. This causes the client to slouch down in his chair with the pelvis tilting posteriorally and with a left obliquity. Once again, functional reach measurements were taken prior to the fitting of the product and anatomical measurements provided the data to fit the Hip Grip correctly. The change in posture immediately had a negative effect on the client's breathing as the tight fit (necessary to secure the pelvis) restricted his adapted method of diaphragmatic breathing. His functional reach was also compromised due to his limited muscular strength. However, it should be noted that the main goal was to prevent the pelvis sliding forward. After his first review it was clear that the client found a neutral pelvic position too uncomfortable for his breathing, and due to excess tissue around the pelvic area, the client was still able to tilt his pelvis posteriorally. The pelvic obliquity however seemed to be neutralised. It was decided that a moulded cast would be more beneficial and the product was removed.

Case Study 3

The third client to try the Hip Grip was a 13-year-old female with cerebral palsy. She had a tendency to lean forward and to the left, but was able to maintain a neutral position if encouraged. She was found to be hyperlordotic: therefore the main aim was to break the spasticity pattern by fixing her pelvis into the chair, consequently bringing the lordosis to a manageable level. Approximately three hours were spent modifying the fixing components to mount the Hip Grip to the chair successfully as, again, the original fixing components were unsuitable. Once fitted correctly, the client's posture was immediately more upright, securing a much greater support than her previous modular seating system. A major benefit was that she could return to a neutral pelvic position with ease and without using her arms as she did previously, which triggered an increase in muscle tone throughout her body. Although the Hip Grip was being used for a slightly different purpose for this user, it did appear to solve some of the user's postural problems.

Conclusions

The Hip Grip is a unique device with regards to the combination of postural support and freedom of movement it can offer. In the cases where it has been fitted successfully, it works very well. It holds and stabilises the pelvis very effectively, but it is an expensive product if it is used incorrectly performing as a lap belt. From a clinical point of view it could be justified with regards to preventing the progression of postural problems that result from fatigue and the functional improvements should be taken advantage of. The Hip Grip is well designed and well made although the fitting components are a problem.

Fitting the product is currently a time consuming task as the range of fitting components available are limited (and imperial), considering the number of wheelchairs that the product could be fitted to. The extra time and effort required to fit the product should be added into the cost when assessing a client. Hopefully this should improve in the future as the company receives feedback from the organisations that are trialling the Hip Grip; recommendations were welcomed which included adaptations for both round frames as well as square.

It is slightly disappointing to have only three Hip Grips in issue at this time. It could be argued that it is difficult to assess the product properly with so few Hip Grips actually in use. However, through the fittings that have worked and those that have failed, an appreciation of what makes a suitable candidate for the Hip Grip has been developed.

Of the three Hip Grips in use, one is working conventionally, providing postural support and increased functional reach, one is used to secure the pelvis, succeeding where all other options have failed, and the other was used by a SCI patient who did not really utilise the functional benefits and the product was subsequently withdrawn. Different factors have been identified to provide an indication as to when not to issue the Hip Grip: the Hip Grip should not be fitted to obese wheelchair users where a tight fit is difficult, or those with no control or power over the postural muscles of the trunk.

Recommendations for product updates include metric fittings, a ratchet belt to make tightening easier, possible concepts for fitting the Hip Grip to users who have too much adipose tissue around their midriff, and improved fitting components. The Hip Grip has the potential to improve the quality of life for a large number of wheelchair users if correctly prescribed. However, the question should be asked whether it meets their postural needs or is purely functional before issuing an expensive product. For those that need it and can benefit from its use, it is important that sufficient time and resources are allocated to fit and adjust the Hip Grip correctly.

(The Hip Grip was designed by Beneficial Designs Inc and has been licensed to Bodypoint Designs for manufacture. The UK distributor is BES Rehab Ltd).

Barend ter Haar of BES Rehab comments:

We appreciate this valuable and well-balanced report. The experiences of the West Midlands Rehabilitation Centre are reflected in the results from the other initial trial centres in the UK. The principle of these is that clients with excess adipose tissue are unsuitable candidates: it is necessary that the Hip Grip is a tight fit,

Continued overleaf…

Continued from page 35

so that the Hip Grip itself is moved by forward movement, rather than the adipose tissue being displaced.

The biggest engineering challenge is to find fixing points on the wheelchair which ensure the Hip Grip is mounted on the optimum position. Bodypoint has been developing a range of Adapter Plates to suit different makes of chairs, as new difficulties are encountered. Currently these include parts that fit 20 x 35 mm rectangle, 22 x 22 mm square, and 20 x 40 mm oval tubing, as well as a flat multi-hole adapter plate for the Quickie 2 chair (see illustration). The illustration also shows the new HW311 Quick Release Connector, a handy fixation device that can be ordered for use with other products.

Further modifications in the pipeline include an adapted belt with foam-filled pads which are positioned over the ASISs. Metric fittings are planned for the future. A smaller paediatric size is on the drawing-board. Bodypoint is also happy to work with prescribers to develop new adapter plates where current designs fail to meet fitters' needs.

A final point: to excel in seating one has to be good at thinking and working in three dimensions. This is especially valuable when setting up and installing a Hip Grip.

FullRiver Batteries

Michael Hare

This is by no means a scientific survey just a collection of observations and comments.

I recent weeks I have had a number of incidents involving FullRiver batteries.

It is always the same, when one gets to see the same problem a few times in a short space of time, one begins to think the whole product is faulty. So to put this in prospective, I have spoken to the technical manager from a firm of large Wheelchair Repairers, who have had a lot of experience with batteries and have up to date test equipment. He tells me that they have bought 2500 FullRiver Batteries and have had 18 failures in the warranty period. However, this does not include those he terms as "dead on arrival" those that never worked from the start.

This type of battery seems to be increasingly bought by wheelchair Repairers and supplied as standard by some manufactures.

The problem I have experienced is one of durability with the heavy user. The case I have at the moment is typical. A long term user who with his previous batteries of another manufacture, was getting a full days use from them and they lasted approximately three years. His FullRiver batteries have lasted four months and after two months he found he had to come home at lunch time and put the chair on charge for the afternoon to have enough power through the evening to his bed time.

He is a very active user and likes to go out in the morning and spend the day out in his community.

The Technical Manager I spoke to, says he has found that in some cases where the batteries were fitted to an Indoor/outdoor Powered chair, they get better life and performance if they use a good 8 amp battery charger. In this case the charger used was the one supplied with the chair and it is 6 amp. This manufacture now supplies FullRiver batteries with that particular chair.

Does this mean we have a battery problem or incompatible chargers?

Not all the problems that have been experienced were with Indoor/out door chairs some were with Indoor chairs, but predominantly those used at places of education as well as home. Whilst other users with this type of battery in similar situations were not experiencing problems. There seems to be some inconsistency with the quality.

Speaking to other Rehabilitation Engineers, I am told there has been some confusion between the types of batteries on offer, a 35 amp AGM and a 33 amp Gel. Some people have opted for the 35 amp when they should have had the 33 amp.

I am also that told recent changes in codes for these batteries have in some instances resulted in the wrong battery being ordered.

Some Hospital Purchasing Departments Policies seem to favour direct contact with the supplier when a warranty claim is being made rather than an Adverse Incident report, so how much of this type of failure is going unreported?

This can also apply to Repair contractors that have a parts inclusive contract, they are keen to get the part replaced, rather than have it sitting on a shelf waiting for a MHRA investigation to be completed.

Is there any one else experiencing these problems and if they are what do they do about it?

Hippo from Moving people

Joanne McConnell, Mobility Therapist, Whizz-kidz

Key features of Chair:

- Front wheel drive
- Powered options available T.I.S, riser, recline and leg rests
- 4/6 mph
- Lights and indicators standard
- 12 miles radius
- Seating OSS (optimum/support system) as standard also can integrate other seating systems
- Crash tested with riser
- Ranges of controls available
- Flip over control within tray as cost option
- Choice of foot plate option, separate or one piece flip up
- Suspension

Benefits of chair:

- Good positioning of lights, less likely to damage
- Very supportive seating as standard
- Front wheel drive, good responsive chair to learn in
- Small seat size; 250mm – 380mm width depth 250mm – 400mm
- Good adjustment for growth
- Compact chair offering full range of powered features
- Many standard features (e.g. indicators)
- Good turning radius 1300mm

Disadvantages:

- Lap strap, poor adjustment, no padding
- Seat to floor height, quite high for young child
- Only two colour choices
- Exposed scissor riser mechanism, can be a risk for schools

Implications for practice:

This chair is a great addition to the paediatric range, it is a good competitor for Koala and much more is included as standard. It is not as low as Koala if needing a standing transfer or for a nursery classroom. It offers a lot more features than the Blitz.

It claims to be one of the only chairs crash tested with riser. The chair looks very cool and the seating offers good support from many children.

The chair is not as costly to maintain as the Permobil or Balder range and it is available through a good range of dealers nationwide.

The chair is both manoeuvrable indoors, and handles well outdoors over grass and gravel and on a camber.

The delivery time is very good compared to Permobil and Balder (considering all three manufacturers are importing the chairs) 4-6 weeks in most cases. The manufacturers are happy to consider a wide range of specials at competitive prices.

Wirral and West Cheshire Wheelchair Service
Mobility Product Evaluation

Date of Evaluation …../…./…..

Product Name ……………………………………………….. **Cost Range**
£…………………….

Manufacturer ………………………………….. **Rep Name** ………..……………………….

Product Type: -

Transit W/C ☐ **Notes** ……………………………………..……………..
S/P W/C ☐ ……………………………………………………….
Ergonomic S/P W/C ☐ ……………………………………………………….
Powered Wheelchair ☐ ………………………………………………………..
Buggy ☐ ………………………………………………………..

Seat Options: -

Standard ☐ **Notes** ……………………………………………………..
Tilt in Space ☐ ………………………………………………………..
Recline ☐ ………………………………………………………..
Tilt and Recline ☐ ………………………………………………………..

Supports Available: -

Headrests ☐ **Notes** ……………………………………………………..
Hip Supports ☐ ………………………………………………………..
Lateral Supports ☐ ………………………………………………………..
Pommel/Knee Blocks ☐ ………………………………………………………..
Elevating Leg Rests ☐ ………………………………………………………..
Adjustable Angle footrests ☐ ………………………………………………………..
Height Adjustable Armrests ☐ ………………………………………………………..

Width Adjustment ☐ **Range** ………………………..**To** …………………………..
Seat Depth Adjustable ☐ **Range** ……………………….. **To** …………………………..

Frame Type:

Folding/Fixed (delete) **Notes** ………………………………………..……..
Detachable Seat ☐ ………………………………………………………..
Total Weight of Item ………………………………………………………..
WT carrying capacity ………………………………………………………..

Suitable for (user type)

Permanet ☐ **Semi – Permanent** ☐ **Regular** ☐ **Occasional** ☐

**Ease of Use Scale 1-10 (10 – likely to be misused/breakdown,
1 easy to use – little to go wrong)** ☐

Comments

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Reverse E~Auctions

The BHTA Position Paper

Michael Hare, Senior RE, Leeds

Not everyone with a clinical involvement in the NHS is aware of the changes that have been taking place replacement within NHS procurement: this paper looks at some of the issues involved. The risk to the clinician is that what has been prescribed in the past is starting to be treated as a commodity: one wheelchair is likely to be considered the same as another, one cushion is assumed to perform the same as another. Clinical choice is being reduced or eliminated.

NHS Reverse E-Auctions for all suppliers were introduced by the Department of Health last year in order to save money in a number of product areas, and savings have been achieved. NHS PASA now procures all products (whether tins of baked beans, scanners and even locum doctors) on new contracts by this method – the lowest bid wins.

The majority of BHTA's member companies who produce critical medical products (assistive technology products) have had established contracts with NHS PASA over many years, i.e. long term relationships.

On the plus side for BHTA members is that they can bid as many times as they wish and they can see the competitor prices – there are no sealed bids. But their drawback is that they are driven purely by price. There is a recognition in setting specifications that service is a part of the product, but companies are expected to weight that service element in advance, and it is difficult to quantify.

What BHTA members think of reverse e~auctions

While recognising that reverse E-auctions are here to stay, BHTA members think that they eliminate trust and undermine the basis for a mutually supportive relationship between the supplier and NHS. Their view is that the tactics will ultimately have a detrimental effect on patient care and safety as service and training become less of a priority.

Industry works with critical suppliers to achieve mutually acceptable outcomes, and the purchaser can benefit from the skills and knowledge of the supplier. This requires trust, communication, sharing objectives, and a readiness to innovate.

Suppliers believe the use of e-auctions will:
- eliminate trust
- reduce their chances of a fair profit
- expose the process to a greater risk of unfair manipulation than previously
- eliminate the incentive for suppliers to share information so reducing innovation
- incur extra costs for the NHS (because there will inevitably be unforeseen costs as a result of working with new suppliers chosen on the basis of lowest cost)
- reduce the number of competitors on the market (companies driven out of business)
- which could ultimately result in higher prices

What Does BHTA propose?

- To enter into a dialogue with NHS on where and how an e-auction should take place. They would like to determine the NHS criteria for adding value and it must encompass NHS bodies in all UK (including Scotland, Wales, and Ireland).
- To determine the impact of new EU regulations on criteria to be set out in OJEU adverts. These criteria will indicate percentages for total of each elements – service, quality, experience, price. These criteria would then apply when deciding awards. When are these to be introduced?
- To ensure the pre-qualification process is rigorous, so the same standards are applied to companies inside and outside the UK (same quality guarantees e.g CE Mark)
- To include the following key elements in an e-auction negotiation:
    - o Guaranteed volumes or minimum percentage of estimated total
    - o Guaranteed duration, a formal contract not a framework agreement
    - o Post award monitoring of successful tender offers
    - o OFT involvement if predatory pricing becomes evident

Criminal Record Bureau (CRB) Checks

Michael Hare, Senior RE, Leeds

As someone employed as a Senior Rehabilitation Engineer within the NHS, what is written here is not intended to be a criticism of either the Public or the Private Sector. The detail applies just as much to both.

One of the NHS Trusts I work for is in the process of tendering for a new Wheelchair Maintenance and Refurbishment Contract, and in the process I discovered that the current Private Sector Contractor's staff have not had CRB checks. Although this seems not to be a requirement by law, one has to have a CRB check to do voluntary work (even if it is for only one hour every six weeks) and it will be re-checked every three years, even if the work done does not require the person to go into the peoples' homes, and they never see any one alone: because of the vulnerable nature of some of the people encountered, it was considered to be a requirement.

If you ask around, you will find only a few of the Private Sector sales/repair services near me have had their staff CRB checked, and very few of the Public Sector in-house repair services have done it, although some have had Police checks on their staff when originally employed, albeit often some time ago. This is surprising considering the emphasis some Trusts put on their Contractors' staff being checked. With a few exceptions, the companies that have done it, did it because it was a requirement of a Contract. Some that have more than one Contract have checked only those staff who were employed on the Contract that specifically required it. Having CRB checks is recommended by the BHTA, but it is not a specific part of the Code of Practice (although I understand this is being reviewed at the moment).

What are the Trusts with in-house repair teams doing? Is this too much of an important issue to be a voluntary action? Although it costs money and takes time for the Trusts and the companies that work for NHS and Social Services Clients to do these checks, is the present situation good enough? More Trusts are realizing that they have to put this requirement into their Contracts, but where does this leave in-house repair staff? It can be for their own protection as much as anyone else's. It is time for everyone to think carefully about this issue for their own protection and safety.

Trusts and companies are sending staff representing their Trust or business into the homes of vulnerable people, often alone, and into schools where, by the nature of the staffing situation, they can be left alone with a child. In doing an assessment they have to come into close proximity with the client, if not touch them. It is not unusual to be required to lift a child out of a chair to make adjustments and repairs. This is a closer contact than some professionals have with their clients/patients/customers and they are required to have CRB checks. Added to this some of our clients do not have the awareness that anything might be wrong or able to communicate it if they were.

Apart from the physical side, there is a question of honesty when dealing with these vulnerable clients. The potential for someone to take advantage of the situation and steal from these clients is significant; added to which there is also the potential for a false or mistaken accusation. How are you expected to believe a person who has been accused of doing something wrong, but denies it, when you discover after the event they have past criminal convictions for a similar offence?

A real or an unjustified accusation against a member of staff could have a serious affect on your Trust or business. A reputation for trust that took time to build could be wiped out overnight. Vehicles can be impounded, financial transactions frozen, staff suspended on full pay, paperwork and court cases: the disruption to your normal work or business could be substantial.

What if it does not happen to your Trust or company, but to another? Does this affect your business? Yes it does. Anything like this taints us all and if it is considered to be widespread, Government Agencies can take action against the whole industry. There are whole industries facing sanctions for the malpractice of a few, at the moment.

Regardless of the hands-on issues, any staff with access to records and data should be automatically and regularly checked. There is no room for complacency in this matter; it is our responsibility to see that it is right. Can we judge someone's character by what they seem? Some of the employers who have had criminals working for them, have said they were a model employee: their workmates and friends cannot believe the person was capable of such things. Do people change? Yes they do. People with an unblemished character can change. Circumstances in their lives can change and desperate people do desperate things. Some go undetected for years. This has been put as an argument for not doing the checks. “Someone may not have a conviction or have got one after the check”.

However it is good and common practice to check to see if employees have a driving licence, and to recheck it annually to see that they have not been banned in the preceding year. This is no different to rechecking the CRB credentials every so often, in most cases every three years. If the worst happened you can demonstrate you took all reasonable precautions. It is better than having to admit you did nothing at all.

Is it now the time to take the initiative and consider making it compulsory for all staff before it is forced upon us. This could be championed as a virtue. “All our staff are CRB checked – would you trust your nearest and dearest with any one else?” This would protect you and your.

Michael Hare

Picture from Eden Project vist after Exeter Conference 2005.

BHTA Tells You How To Increase Battery Life

The British Healthcare Trades Association (BHTA) has launched an advisory leaflet on battery care that will give consumers who use an electrically powered wheelchair or scooter a positive boost.

Called *Get Wise – get more from your battery*, the leaflet shows how the performance and lifespan of batteries for powered mobility equipment can be maximised. It’s been produced with the cooperation of leading mobility vehicle manufacturers and battery manufacturers.

Why did the BHTA develop the leaflet? Says director general Ray Hodgkinson: “Although the battery is one of the most important parts of a mobility vehicle – in effect it’s the fuel tank – battery care is usually not first and foremost on consumers’ minds, which can lead to poor or inefficient use.”

The leaflet is full of simple, useful tips to ensure people get the best out of their battery at all times, wherever they are – even abroad. It answers common questions such as;

- What is the best way to prepare mobility batteries to get the most out of them?
- What lifespan can be expected from batteries?
- What factors affect range on powered mobility equipment
- Can batteries be transported by air?

Sensible battery care tips are also included, such as never running batteries completely flat, right through to correct disposal.

Just one of the useful BHTA *Get Wise* range of consumer leaflets, *Get More from Your Battery* is available from BHTA, New Loom House, Suite 4.06, 101 Back Church Lane, London E1 1LU, by writing in and enclosing an A5 size sae.

BHTA
There are around 350 BHTA member companies with over 17,000 employees who manufacture and retail assistive technology products and services (including wheelchairs, hoists, walking sticks, stoma products and prosthetics) to help less able people and those with disabilities within the NHS, in the community and in their own homes.

Andrew Watt Sinclair Brown

1946 – 2005

I first met Andrew when he joined the, now, Rehabilitation Engineering Service (R.E.S.) at Chailey Heritage in 1975 as Research Engineer and the first Electronics Engineer. His first research projects included the measurement of limb movement of children with athetoid cerebral palsy and the development of electronic communication aids. The former project was to help us understand the nature of these movements and the effects of various interventions. It informed the design of various viscous damping aids, such as the now commercially available NeaterEater.

The latter project was initially to allow the use of the Bliss Symbol communication system by children who could not point to the symbols, a step forward from the simple mechanical pointing devices we were providing at the time. Andrew developed various switch operated scanning devices and produced the first (and only) Bliss Symbol printer. From 1981, as Deputy Director, he managed the electronic assistive technology (E.A.T.) service and some research programmes, including innovative switch systems for driving powered wheelchairs, operating computers, environmental control systems, etc.. He had a large clinical workload and was instrumental in bringing in the latest electronic technology developed elsewhere to benefit our client group. He worked in collaboration with many colleagues around the UK to advance E.A.T. including with the University of Sussex to develop a novel voice output communication aid which reached commercial availability with applications for people after a stroke.

Andrew was a member of various national committees promoting the development, standardisation and availability of E.A.T. and also the Snowden Awards committee providing E.A.T. to those for whom it was financially out of reach for employment etc. He also developed, implemented, and managed a fully computerised stock control and workflow management system for the R.E.S. at Chailey. This was no mean feat for such a complex service and it served us well for many years, being sufficiently flexible to cope with the seemingly annual changes to NHS Management processes and upon which the present commercially developed system was based.

In recent years Andrew worked nationally as an independent assessor and “expert witness” in the ever increasing cases of litigation taken out by disabled children and their families seeking redress for birth injuries. He specialised in interface technology in the fields of powered mobility, communication and education. This role increased, to put heavy demands on his time and he took early retirement from Chailey in 2000.

Andrew was a secretive type of person who would do anything for anybody, sometimes at the expense of the progress in his own work targets. He preferred to fade into the background at social gatherings and was reluctant to talk about himself.

Born in Scotland of a South African Mother and a Scottish Father, Andrew went to live in South Africa with his Mother during his early years. There are stories that his Mother, a doctor, helped Nelson Mandela when he was injured and on the run during the apartheid years. Andrew would not talk about those years and hated the politics. After he gained his degree in Electrical Engineering in Johannesburg he came to England and gained an MSc in Physiology and was appointed as a Lecturer at Charing Cross Medical School before coming to Chailey. Andrew did much for disabled children and their families and those who worked with them, and had much more to offer. Sadly, his alcoholism took over and, after being a factor in his early retirement, finally, and prematurely, deprived us and his family of a talented man with his heart in the right place. Andrew’s wife, Jenny, would like it to be known that the Andrew at the end was not the Andrew she knew at the beginning and that nobody should be under the illusion that alcoholism is not a mental illness. Our thoughts are with Jenny and their adult children, Hannah, Jessica, and James.

Roy Nelham

Whizz-Kidz Mobility Centre

Julia Cunningham MCSP, Whizz-Kidz
Alexandra Strick, Project Manager for Mobility Centres, Whizz-Kidz

The Children's Mobility Centre in Newcastle upon Tyne was opened in December 2003 as part of a pilot scheme run by Whizz-Kidz in response to research showing that families and professionals lacked an independent resource to find out about mobility equipment for children and young people and issues surrounding it. Reasons for choosing Newcastle included its large population with good transport links locally and nationally, a large identified population of disabled children, and many interested local groups.

The centre was originally developed as part of a Whizz-Kidz pilot project, funded by a Department of Health (section 64) grant, and has since attracted a number of small grants and donations, but is seeking further support and sponsorship.

Prior to the opening, a local steering group was formed including representatives from dealers, the local wheelchair service, other professionals, and parents of disabled youngsters. This was instrumental at the planning stage and also helped to build local links.

The centre is situated within the Disability North building which is used by many other organisations and is almost opposite the Freeman Hospital and wheelchair service. It is accessed easily from Newcastle itself and further afield. People visit us from Teeside, Durham, Northumberland, and even Carlisle.

The centre is staffed by an administrator every day with therapist input two days a week on average. The centre holds a wide range of information about mobility products, but most of the equipment is not stored at the centre being instead brought in by dealers as required for appointments. This is done so that products demonstrated are up to date and to avoid storage difficulties.

The main aim of the centre is to offer people independent impartial advice so that they can make their own informed decisions. The centre is open to everyone. They do not have to apply for funding to Whizz-Kidz, indeed most families obtain funding elsewhere and we offer people a list of local and national sources of funding. Most families and professionals who contact us do so in the first instance by telephone and then they may come in for an appointment for assessment and to try equipment. Some people do "come in off the street" and again they are offered any advice and an appointment booked as necessary.

We continue with Whizz-Kidz' policy of working closely with other charitable and statutory organisations, sometimes suggesting to families that they contact their wheelchair service before making a private purchase: often people are simply not aware of what is on offer.

Research had shown strongly that a child friendly environment was needed, so we try hard to achieve that. The centre is bright and welcoming with a toy area and drinks available. The child is always central in the assessment process.

The other two main uses of the centre have been to host study days for professionals and exhibitions for families and professionals. Exhibitions have included trike days, manual chair days, and buggy days – usually one every two months. Study days have included powered mobility and seating. The events have been held on different days of the week including Saturdays to make them more family friendly and all have been well attended.

Wheelchair training is to be run from the centre in 2006 with a taster day planned for October.

Numbers using the centre have grown steadily as the Centre's activity and reputation have become increasingly well known and the centre is now a well established, widely-used and highly regarded local resource.

Figures have been collected over the two years to show the numbers of initial enquiries, visits for demonstrations, visits for advice, and numbers attending exhibitions and study days. These statistics show a steady increase in numbers with a total of 620 people having contact with the centre so far this year. These figures show an increase of approximately 33% over last year's figures.

The trailblazing success of this first centre has now led in turn to the development of a second Whizz-Kidz Children's Mobility Centre in the West Midlands. The new, Birmingham based centre is set to be opened towards the end of 2005 or early 2006, with three-year funding from the Vodafone UK Foundation.

With a second centre established, Whizz-Kidz hopes that a third centre in the South East may then also be considered.

If anyone would like more information please contact Whizz-Kidz on 020 7233 6600 or email a.strick@whizz-kidz.org.uk.

Action plan proposal: Website – Posture24.com

As part of my work on the Post Graduate Certificate Course on Posture Management for People with Complex Disabilities (Oxford Brookes University and Oxford Centre for Enablement) I am proposing to design, launch, and moderate a website on the theme of 24 hour Postural management.

The website is designed to fulfil two main roles:

First, it will be a resource and means of communication for the therapists who have completed the Posture Management Course, are members of the Posture Management (PM) Focus Group, and have signed up as **'members'** of the site. Members will have access to restricted areas of the site, and be able to interact with and contribute to the site. Members will form a **'panel of experts'** who can respond to enquiries directed to the site, and interact with each other by way of email, and forums.

Secondly, it will act as a resource for other people who require information about postural needs. Initially it will be aimed at professionals, such as physiotherapists, occupational therapists, and rehabilitation engineers. They will be able to view parts of the site as a **'guest'**, or sign-up as an **'associate'** to enjoy increased access, receive relevant electronic mailings and interact with the members of the PM Focus Group via the **enquiries forum** or by mailing the **enquiries email** address. Guests and associates will be able to view information posted by members of the PM Focus Group, make use of the links pages, and find information about relevant courses, new equipment, and events.

The site is in its early stages of development and ideas and support are currently being sought. Please see the flow diagram outlining the proposed structure of the website. The site aims to be user friendly and be navigable by people who have minimal IT skills.

Forums:

Reflective practice forum. A place for the members of the Network to discuss issues related to posture management to foster a culture of reflection upon best practice. Restricted to members only.

General discussion forum. A more general forum for discussion between site members, using a less formal format. Also restricted to members only.

Enquiries Forum. This forum allows people (guests and associates) who have enquiries regarding posture management to access expert opinion from the 'panel', and input from others who access the site, for the purposes of sharing information. This forum will need to be monitored more closely to ensure that it is not being misused. It will be in a 'text only' format, and will not allow attachments to submissions.

Reviews.

Literature review. Members of the site can review literature that they read pertaining to posture management or closely related topics. These will be quite short and may involve a simple rating system to indicate how applicable they are, and how useful the information is, etc. Only members can contribute directly to this: third parties can input via the moderator, though this will be restricted. The results of the reviews will be displayed in the general site for the consumption of guests and associates. The reviews can be discussed further on the forums.

Equipment review. Likewise, the equipment review assesses the various pieces of equipment available for postural assistance.

General review. For reviewing courses and miscellaneous reviewing. See literature review.

Communication.

Email directories. Members of the web site will have access to a database of email addresses for their fellow PM Focus Group members. This directory will be made up of the information collected when the members sign-up for the web site. The members directory will only be accessible to members, and only incorporate details that have been authorised by each member at sign-up. The contents of the associate directory is only visible to the website administrator and will only be passed to relevant authorities if required (misuse, etc). The directories will form the basis of the mailing lists.

Enquiries email. Enquiries can be directed to the website moderator. These can be dealt with and forwarded to the most appropriate location.

Information email. Outgoing only. This address is used for emailing to the people on the mailing lists. Replies to this email will be blocked and deleted.

Administrator email. To contact the website administrator to make suggestions or complaints and to report misuse of the website.

Submissions email. Submissions for display on the site will be passed to the moderator for screening prior to posting.

Business email. This is the point of contact for any businesses wishing to make use of the website to inform people of the launch of equipment, etc.

Information.

The information section of the site is accessible by all users, but submissions must be made via the moderator.

Background. Background information for the site will consist of basic information on… What is Posture Management?... Principals of 24 hour postural management… etc. A general overview of information valuable to those who wish to expand their knowledge of posture management.

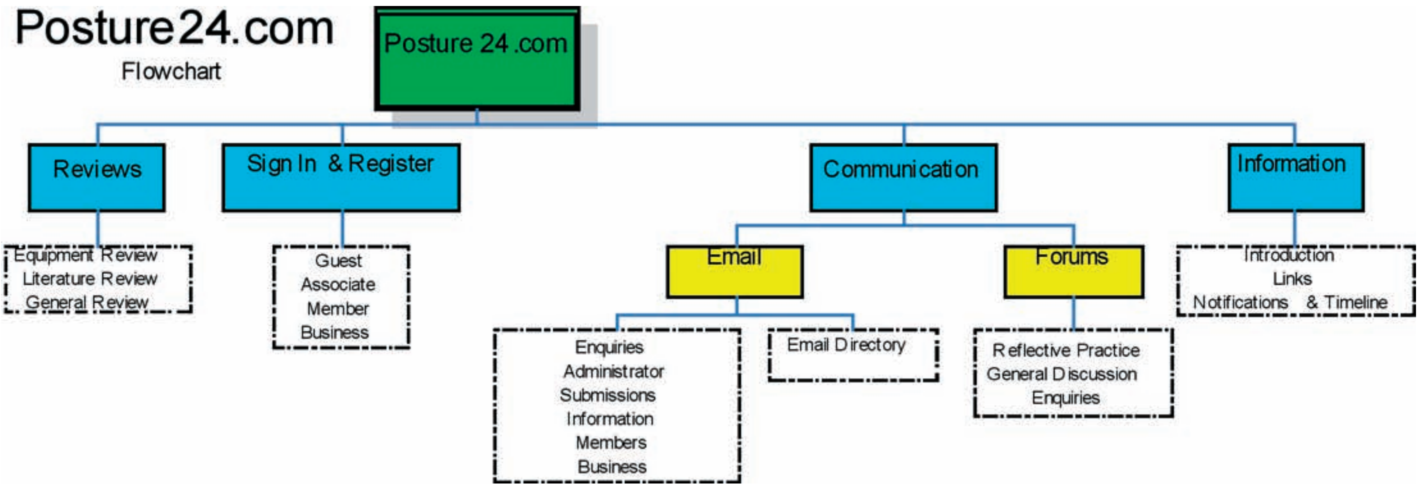
Links. The links pages will take you to external resources that are of use to people with interests in posture management. These will obviously need to be with the permission of the target sites. These may be companies with interests in postural management, organisations, and charities of interest to those who work in this field, educational and health institutions, and more general sites that can together form a directory for those wishing to access further information.

Notifications and Timeline. These should work together to inform people of up-to-date information about posture management. Companies with whom links have been formed can notify launches of new equipment, etc. (this will need to be done in an impartial manner). Other information may include dates of relevant courses, relevant governmental policies, and anything else of value to interested professionals. Submissions to the notifications section will be made via email to the moderator of the site, to be screened before display.

Security and Legal. Misuse of the system will result in withdrawal of access rights, and reporting to relevant authorities, if necessary. Any information that is posted on any of the forums will be the property of the contributor and not reflect the views of the website team, the PM focus group as a whole, nor any of the organisations involved in the site. Issues regarding Data Protection and other legal requirements will be investigated as part of the process of setting up this site and will be in place before the site is officially launched. Likewise, prevention of misuse of the system will be further investigated to ensure that the site is safe, informative, and useful to those who decide to sign up to it.

Note: Initially the pilot of the site will be hosted on an existing domain, but eventually it will require a domain name and web-space of its own. Please note that at the moment there is only a holding page at the URL address (Posture24/ffisio.com) until the site is launched. Initially, the site will be aimed at those who work within the UK, but there are plans to roll out the site to those who work in Eire and the EU. Obviously, there may be interest from a wider community as the internet is a world wide resource, so expansion of the site may be an area for future development.

Calvin Ruck, MCSP, SRP



POSTURE &
MOBILITY
GROUP

The PMG National Training Event 2006

The Dunes Conference Complex, Pontin's, Lytham St. Annes, Lancashire FY8 2SX.

"Maintaining the Momentum"

(Check www.pmguk.co.uk for regular updates)

Monday 6th February 2006

Time	*Event*	*Presenter(s)*
08:00	*Registration*	

Tuesday 7th February 2006

Time	*Event*	*Presenter(s)*
09:00	Opening Address by PMG Chair	David Long, PMG Chair
09:10	"Getting Cinderella to the Ball" – using change to our advantage	T.B.C.
10:10	*Coffee & Exhibition*	
11:10	**Free Papers/Case Studies**	
12:30	*Lunch & Exhibition*	
14:00	**Parallel Sessions**	
PS1	Alternative Service Models from around the UK	Carol Grills, Northern Ireland Derek James, PUPIS Wales Joyce McDonald, Fife Postural Management Service
PS2	Wheelchair Collaborative: net gains 2 years on.	Val Marshall, North Cumbria Peter Rowell, Worcestershire Krystyn Jarvis, Overview from National Wheelchair Managers Forum (NWMF)
PS3	Stroke Rehabilitation – latest treatments/research – case studies – symptom patterns – cognition and perception	Oxford Centre for Enablement (presenters T.B.C.)
PS4	"Let me inform you" – users' views	Kevin Fitzpatrick, Chair of ALAS Posture and Mobility Steering group
PS5	Assistive Technology (AT) Forum: alternative strategies for equipment provision	Philippa Palmer, AT Forum
15:30	*Tea & Exhibition*	
16:50	**Parallel Sessions (repeat)**	*as above*
17:45	*Reception & Exhibition*	
19:30	*Conference Dinner & Entertainment*	

Tuesday 7th February 2006		
Time	***Event***	***Presenter(s)***
08:00	*Registration*	
08:30 to 09:15	**Wake-up Sessions (parallel)**	
WS1	De-mystifying Audit & Research	Clare Smith, RD Direct
WS2	Continuing Professional Development (CPD) – The Learning Journey	Linda Marks, Disablement Services Centre, The Royal National Orthopaedic Hospital, Stanmore
WS3	Alternative funding opportunities	Ros Ham, St Mary's Hospital, Portsmouth Hospitals NHS Trust
WS4	"Driving, Communicating, Living"	Mike Loxley Penny Martin, Treloar Trust Coral Smith
WS5	Biomechanics of secondary supports	Barend ter Haar, B.E.S Rehab Ltd
WS6	Dynamic seating to reduce low back pain	B-Seated (Netherlands), Carmen Platvoet and Loek Dapper
09.30 to 10.45	**Plenary Session**	
09:30	Management of the Dysplastic Hip and Spinal Surgery	Fergal Monsell, United Bristol Healthcare Trust John Hutchinson, North Bristol NHS Trust
10:45	*Coffee & Exhibition*	
11:45	PMG AGM	
12:10	Aldersea Lecture	Pauline Pope
13:00	*Lunch & Exhibition*	
14:15	MS update	Alan Thompson, National Hospital for Neurology & Neurosurgery
14:45	Multiple Sclerosis Case Presentations	Teams from Kings College Hospital NHS Trust and The Royal National Orthopaedic Hospital, Stanmore
15:50	Prizes & close	Dave Long, PMG Chair
16:00	*Tea*	

The next issue of Posture & Mobility will be in **April 2006**. The deadline for this issue is the **1st March 2006**. The aim of Posture & Mobility is to keep members in touch with current events in the world of posture and mobility and to provide the opportunity to share ideas and learn of new initiatives. Articles should be between 500 and 2,000 words. Photos and/or cartoons are welcome as are jokes and mindbenders etc. Please send contributions, preferably by **email,** to **Patricia Marks** at **patricia.marks@pmguk.co.uk (send all pictures in their original format, not as part of a word document)**. Otherwise post a floppy disk, compact disc, or print in Times New Roman 12pt.

Emineo – The Stand Out Lightweight Comfort Chair From Gerald Simonds

The Emineo (Latin for ‘I Stand Out’) lightweight comfort wheelchair is revolutionary. It provides optimal comfort by focusing on sitting position, mobility and the ability to make individual adjustments quickly and easily. The result is a well balanced wheelchair which rolls extremely easily and encourages activity in even the most immobile user.

Emineo’s new SmartSit seating system gives better stability and maximum freedom of movement. Backrest, legrest and armrest adjustments can all be made easily, while the user is in the chair, so support and relief in all the right places can be given instantly.

A unique tilt system, which can be operated by the user, helps to keep Emineo’s balance point constant, independent of the tilt position. Pulling the tilt release lever allows an easy change from an active, mobile position to a comfortable resting position. It also means that the driving wheels can be placed further forward which, with a stable frame construction, gives Emineo fantastic rolling characteristics. It’s simple to fold the backrest down and, with many easily detachable parts, Emineo fits snugly in an ordinary family car.

The Emineo is only available in the UK and Ireland from Gerald Simonds Healthcare.
Ring 01296 380200 for more details.

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