

AUDIT COMMISSION UPDATE

JUNE 2002

fully equipped
2002
assisting independence

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Contents

	Preface	3			
1	Background	4			
	What <i>Fully Equipped</i> said	4			
	The immediate reaction to <i>Fully Equipped</i>	4			
	Government action since publication	5			
	The purpose of this report	11			
2	Continuing problems in equipment services	13			
	Structural arrangements	13			
	Processes	22			
	Outcomes	31			
3	Reports by users' groups	35			
	Reviews of services for people who need communication aids	35			
	Reviews of services for deaf or hard-of-hearing people	36			
	Reviews of services for blind or partially sighted people	38			
	Summary	40			
4	Good practice in equipment services	41			
	Orthotics services	41			
	Prosthetics services	41			
	Wheelchair and specialist posture services	44			
	Community equipment services	45			
	Audiology	47			
5	Conclusions, next steps and recommendations	48			
	Conclusions	48			
	Next steps	50			
	Additional recommendations of this report	51			
	Appendix 1	52			
	The implementation of <i>Fully Equipped's</i> recommendations	52			
	References	58			

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Preface

The Audit Commission has been responsible for the external audit of local authorities in England and Wales since 1983, and in 1990 it assumed responsibility for the audit of the NHS. As well as reviewing the financial accounts of all councils and health service bodies, the Commission's auditors have a statutory duty to examine the economy, efficiency and effectiveness of the use of resources. The Commission's aim is to help those who manage and work in local authorities and the NHS to deliver the best possible services within the money available so that public expenditure makes the maximum contribution to society.

In March 2000, the Audit Commission published *Fully Equipped*, a report on the provision of some forms of equipment to older or disabled people by the NHS or social services in England and Wales (Ref. 1). It examined five services from the user's perspective: orthotics; prosthetics; wheelchairs and specialist seating; community equipment; and audiology.

Since then, many NHS trusts and social services authorities have received local reports from their external auditors, or best value reviews about the performance of equipment services. This report summarises the findings of these local audits as well as reflecting on developments and other research since the publication of the original report. It goes on to identify continuing problem areas and sets out a programme of further work to help to improve services.

This report was prepared by Michael Yeats and Nick Mapstone with direction from David Browning. Particular thanks are due to the local auditors whose reports provided the foundation for this report, as well as to local service managers who in turn assisted in supporting the reviews. However, as with all its work, the responsibility for the findings and recommendations of this report rests with the Commission alone.

1

Background

What *Fully Equipped* said

1. In March 2000, the Audit Commission published *Fully Equipped*, a report on the provision of some forms of equipment to older or disabled people by the NHS or social services in England and Wales. It examined five services: orthotics; prosthetics; wheelchairs and specialist seating; community equipment; and audiology (Ref. 1).
2. Equipment services provide the gateway to the independence, dignity and self-esteem of some 4 million older or disabled people and for 1.7 million informal carers. But the report found that the current level of services was unsatisfactory in many respects:
 - there were unexplained variations in all aspects of service provision, bearing little relation to underlying levels of need;
 - the quality of services owed more to custom and practice, rather than to a considered view of the contribution that equipment services could make to the overall needs of the population; and
 - eligibility criteria were often unclear to users, carers, voluntary organisations and staff, and they were often applied inconsistently.
3. *Fully Equipped* showed that the organisation of equipment services was a recipe for confusion, inequality and inefficiency. It found that many equipment services were small and fragmented, characterised by a lack of clinical leadership and senior management involvement, and that they were failing to meet the demands of clinical governance. Users did not always get equipment of a reasonable quality meaning that some of the money spent was wasted. Poor clinical outcomes were found to combine with a waste of public money when services did not meet users' needs first time.
4. The Commission called for urgent action to improve standards, provide a fairer service and make equipment services an important component of strategies designed to promote independence.

The immediate reaction to *Fully Equipped*

5. The report was not universally welcomed. Some user groups were disappointed that it did not examine their area of particular interest. For example, it omitted important services like the provision of services to blind or partially sighted people; and it said little about communication aids or environmental controls. Others felt that it paid insufficient attention to services for disabled children.

...the services examined in the report have continued to struggle to attract the attention of senior policy makers and managers.

6. The Commission was accused of doing more harm than good by sapping already low staff morale and eroding patients' confidence in the quality of the services which they received. For example, the National Wheelchair Managers' Forum said: 'The report presented the wheelchair services in a rather negative way and, while we acknowledge there is a lot of work to be done, there are many excellent services and hundreds of committed, competent staff (Ref. 2).'

7. The Commission was further criticised by users' groups for perpetuating the use of outdated terminology. Not a few users regard the term 'disability equipment' as pejorative, and some see the associated negative connotations as a barrier to more people using such equipment. Users prefer the expression 'assistive technology' or 'equipment for independence'. However, other commentators welcomed the report [BOX A, overleaf].

8. The Government's immediate response to *Fully Equipped* was positive and expressed strong support for the report's main recommendations [BOX B, overleaf].

9. There was also strong support from the Welsh Assembly Government. All health authorities, trusts and social services departments in Wales were asked to 'Review the management of their equipment services to ensure that they are directed by clinicians where appropriate; supported by managers of an adequate calibre who are directly accountable for service performance and risk management; adequately funded to provide for the integration of these services into an overall strategy for risk management, infection control, and adverse incident reporting; adequately funded to meet legislation on lifting and handling and CE marking; incorporate the procurement of equipment into their overall supplies strategies, ensuring that the latest guidance from the National Assembly is met (Ref. 3). In developing local supplies strategies, trusts were asked to consult Welsh Health Supplies to appraise themselves of any current national initiatives. They were also asked to consider improving arrangements for product selection, process redesign, IT investment and whole-life product costing, and to consider establishing joint equipment services straddling health and social services.

Government action since publication

10. *Fully Equipped* was published at a time of very great change in the NHS in terms of new commissioning structures, a very large number of organisational mergers, and the imperative of delivering the NHS Plan and the associated National Service Frameworks (Ref. 4). Not surprisingly, the services examined in the report have continued to struggle to attract the attention of senior policy makers and managers. Plans for the improvement of equipment services rest more on hope than expectation in the face of stiff competition from other priorities.

BOX A

The reaction to *Fully Equipped*

Lord Ashley of Stoke (in introducing a debate on the report in the House of Lords on 12th April 2000):

“The Audit Commission’s report on equipment services for old and disabled people is a truly shocking indictment. It vividly demonstrates indifference, neglect and incompetence which have lasted for decades. I agree with the Audit Commission. The value of good equipment services is undeniable. But so, too, are the consequences of bad equipment services. What kind of life is it if a person is lost in a fog of misunderstanding because of a poor hearing aid; or cannot walk without pain and discomfort because orthopaedic shoes are faulty; or cannot cope with a heavy, unsuitable wheelchair; or, when confined to bed, develops painful bed sores because a special mattress is not available? It is an absolute disgrace that this equipment, which is so obviously needed, has not been routinely available to a universal high standard. The record is deplorable and disabled people are suffering as a result. ”

“In view of the enormous number of inadequacies it is no surprise to read not only of disabled people receiving poor equipment, but, as a result, of much financial waste with faulty equipment left unused. If people are forced into institutional care because of inadequate services, the cost escalates. Everyone loses – disabled people, the Treasury and society as a whole.”

Baroness Greengross (speaking in the House of Lords on 12th April 2000):

“The Audit Commission has produced an excellent report. It highlights particular services which are of great importance to many people. It will ensure that they are given a higher priority than they have been in the past.”

Rabbi Julia Neuberger (speaking at the Audit Commission launch conference for *Fully Equipped*):

“I think we know ineffective equipment and delays in provision create unnecessary ill-health and inability. We know they lead to extra hospital stays and residential care admissions and we need to do a financial calculation on that. But there are also moral costs because what we are doing by not getting our act together here is excluding people from fully participating in society. They could perfectly well do at relatively low-cost, compared with what we spend generally on health services. Quite apart from the economic calculation there is a moral calculation here: I don’t think we can afford the cost that there is to society of excluding people by simply providing them with poor equipment.”

James Strachan (speaking at the Audit Commission launch conference for *Fully Equipped*):

“The NHS is the world’s largest purchaser of hearing-aids and yet it uses technology from the 1970s – almost a modern form of an ear trumpet that just takes all the frequencies and blasts them to high heaven. No wonder people don’t use them.”

BOX B

The Government's immediate response to *Fully Equipped*

The Prime Minister (quoted in *The Daily Mail*, 30th March 2000)

'We cannot have a situation where older and disabled people are let down in the way this report suggests.'

Alan Milburn, Secretary of State for Health (quoted in *The Financial Times*, 30th March 2000)

'It (the report) paints a very stark picture of frankly a second-rate service in some parts of the country. What we have to do now is ensure that the Audit Commission's recommendations are actioned in every part of the health service.'

Lord Hunt, Health Minister (speaking in the House of Lords on 12th April 2000)

'The report makes several recommendations as to how standards can be improved and a fairer service provided. For example – it is an important recommendation – it proposes the development of a 'hub and spoke' arrangement across regions with specialist services at the centre supporting local services. There are proposals for joint health and social service arrangements for community equipment stores; the raising of the profile of those services and engaging the attention of senior managers, which I suggest is crucially important; and the better tracking of equipment to improve quality and save money by increased recycling.'

John Hutton, Health Minister (DH press release, 27th March 2001)

'One of the fundamental visions of the NHS Plan is to make the NHS more focused on the needs of the people who use it. Alongside this, we want to make sure that people are able to live independently and safely in their own homes for as long as possible. To help make this more of a reality for many thousands of older and disabled people and their carers, we shall be allocating additional funds to the NHS over the next three years to modernise community equipment services. The local government finance settlement will also include sufficient funding to allow local councils to play their part in this initiative.'

11. Nevertheless, some important developments affecting equipment services can be reported:

- the NHS Plan and community equipment services;
- the National Service Framework for Older People;
- hearing screening programme for new-born babies; and
- digital hearing aids.

The NHS Plan and community equipment services

12. The NHS Plan included the Government's intention to achieve a single, integrated community equipment service by 2004 (Ref. 4). Specific guidance on the integration of community equipment services was issued to the NHS and local councils in March 2001 (Ref. 5). It set ambitious targets to increase by 50 per cent the number of people benefiting from these services and to improve the quality of the equipment issued.

13. The Department of Health (DH) also established a national implementation team to help trusts and social services implement the guidance by the target date of April 2004. The additional funding for community equipment services announced was:

2001/02	£12 million
2002/03	£28 million
2003/04	£65 million
Total	£105 million (including £4 million for silicon cosmeses for artificial limbs, spread over the three years)

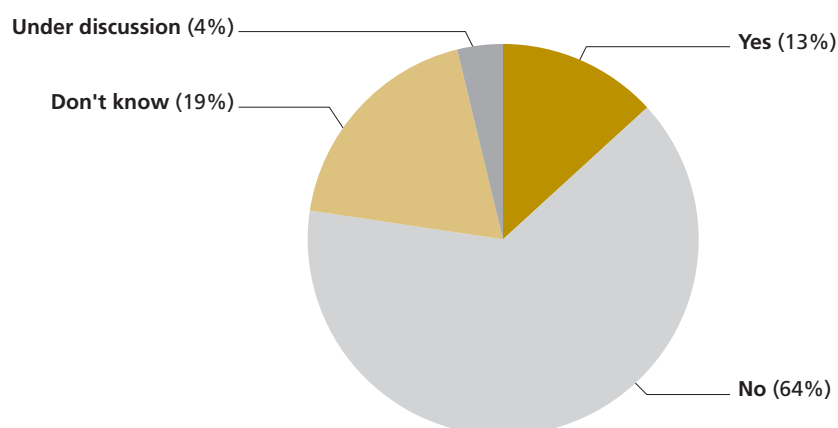
14. Extra Government grant was also promised to local authorities in their Personal Social Services settlement for 2001/02 to 2003/04 so that they too could support government policy. The Health Minister said that in total 'over £200 million' across the NHS and local government had been provided.

15. Unfortunately, the way that Government grant to local authorities is assembled is not transparent and councils have been unable to identify exactly how much extra money was allocated specifically for community equipment. Moreover, there is considerable uncertainty in the NHS as to whether there actually were new monies made available, or whether the sums included in the Guidance were already part of existing allocations. Either way, there is a consistent view that little of the first-year 'new' money has reached frontline services [EXHIBIT 1]. The 'additional money' was not ring-fenced or put into the hypothecated Modernisation Fund, and it appears to have been spent on higher priorities. This is a source of considerable despondency for operational managers. Some members of the public too have seen the announcement of new funds and are disconsolate that their needs remain unmet.

EXHIBIT 1

'Additional money' provided to community equipment services in 2000/2001

Very few equipment services have received additional money.



Source: Audit Commission survey, N=65

There... needs to be full consideration of whether children's needs would be better served in designated specialist services.

16. NHS Wales encountered similar problems in terms of implementing the recommendations of *Fully Equipped*. The main complaint is the lack of dedicated funding aimed at improving community equipment and, in some areas, the history of poor relationships between the local social services departments and trusts. There is also evidence of differing agendas between the trusts and social services departments.

17. Similar problems have occurred in the case of the additional funding made available for silicon prostheses. A recent survey found that less than £10,000 of the £1.3 million additional first year money had been spent on its intended purpose (Ref. 6). The DH wrote to health authorities on 12th December 2001 reminding them that additional funding for silicon cosmeses had been provided, but there is little evidence that any additional provision has been made to increase budgets for 2002/03.

National Service Frameworks

18. The National Service Framework for Older People (Ref. 7) makes some important references to community equipment, as recommended in *Fully Equipped*. Standard 2 of the NSF requires that:

NHS and social care services treat older people as individuals and enable them to make choices about their care. This is achieved through a single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

19. Unfortunately, the NSF for Older People fails specifically to mention orthotics, prosthetics and audiology services, even though there are three million users of these services and most of them are over the age of 65. This omission means that these services are likely to remain a low priority.

20. In view of these concerns, it is important that the forthcoming NSF for Children's Services makes adequate mention of children's needs for equipment. There also needs to be full consideration of whether children's needs would be better served in designated specialist services: for the most part, their needs are currently met in a service that is principally designed to meet the needs of older people.

Hearing screening programme for new-born babies

21. In June 2000, the Government announced the introduction of a hearing screening programme for new-born babies with initial pilot programmes at 20 hospitals (Ref. 8). This is an important policy initiative. There is strong evidence that neonatal hearing screening is more effective and cost effective than health visitors using infant distraction tests at six to nine months of age. Distraction tests fail to detect significant numbers of hearing problems sufficiently early (Ref. 9). They rarely identify hearing problems in children below the age of twelve months, and children with hearing problems are not identified until they are two years of age or more (Ref. 10).

22. Early identification and appropriate management lessen the impact of deafness on children, on their families, and on society (Ref. 11). Research in the USA has found that severe to profound hearing loss is expected to cost society \$297,000 over the lifetime of an individual. Most of these costs (67 per cent) are due to reduced work productivity, although the use of special education resources among children contributes an additional 21 per cent. The lifetime costs for those with prelingual onset exceed \$1 million, so interventions aimed at children, such as earlier identification and/or aggressive medical intervention, have a potential substantial payback (Ref. 12).

23. Children with hearing loss will be identified at an earlier stage by the introduction of better screening. Commissioners must ensure that adequate funding and support services are in place to meet this need, whether it is for appropriate digital hearing aids, speech and language therapy, cochlear implants or instruction in sign language. It is essential that this support is available quickly after diagnosis and that its provision is co-ordinated with all relevant public services.

Digital hearing aids

24. The National Institute of Clinical Excellence (NICE) produced guidance on hearing aid technology in July 2000 (Ref. 13). It concluded that:

- more time should be spent with patients to ensure that proper fittings are achieved at the patient's first visit;
- binaural hearing aids should be provided; and
- better technology aids should be used.

25. The review stopped short of recommending universal adoption of digital hearing aids, as recommended in *Fully Equipped*. However, it recognised that the NHS has been very conservative in its prescribing, typically offering the most basic linear aid. NICE concluded that the full range of analogue aids should be fully used while further evaluation of digital aids is undertaken.

While little of the new money for community equipment services has reached frontline services, most of the new funding allocated to audiology services in England is being spent as intended.

26. As part of the overall evaluation, it is important that wider economic arguments are considered. *Fully Equipped* referred to the wide range of NHS analogue hearing aids currently provided, which fragments NHS purchasing power. With the introduction of some digital aids, that range will continue to grow and purchasing power will be further diluted. Universal introduction of digital aids would reduce the number of models provided to three. The current approach of using some digital and some analogue hearing aids results in lost opportunities to aggregate demand.

27. Moreover, in the medium term, the current evaluation of digital versus analogue is likely to be superseded by the fact that manufacturers will simply stop making analogue hearing aids. Indeed, the Modernising NHS Hearing Aid Services project is anticipating the widespread introduction of digital hearing aids across the NHS. In May 2000, the Government announced the first wave of modernisation at 20 trusts, with central funding of £11 million for extra staff, equipment, IT and training. In December 2001, a further £20 million was announced to create a second wave of 30 trusts in 2002/03.

28. Similar encouraging progress is found in Wales: £2.25 million was spent in 2001/02 on improving the infrastructure and ensuring that each audiology services department is in a position to offer the new technology hearing aids (including digital aids) by the end of 2002. A further £1.7 million has been allocated to health authorities this year, primarily for them to purchase new technology hearing aids for next year. £1.8 million has been earmarked, and this funding has now been incorporated into the Assembly's baseline funding mechanism.

29. While little of the new money for community equipment services has reached frontline services, most of the new funding allocated to audiology services in England is being spent as intended. This is because it is allocated directly to trusts by a project manager at the Royal National Institute for Deaf People (RNID). The lessons of the success of the modernising audiology project would seem to be that it is:

- targeted at named trusts;
- concentrated on single agencies, in contrast to multi-agency commissioning and delivery in the case of community equipment; and
- supported by highly effective user groups, such as the RNID and the National Deaf Children's Society.

The purpose of this report

30. A stocktake of the current position reveals that progress in improving equipment services is patchy [BOX C, overleaf]. The progress made in audiology services and in community equipment services has not been matched by progress in mobility services, where major problems persist. Concerted action at both national and local level is needed in order to make a difference to the lives of service users.

BOX C

Summary of the current position of equipment services

	Audiology	Community equipment	Mobility
Strategy	<ul style="list-style-type: none"> ✓ Introduction of hearing screening for newborn babies. ✓ Modernising Hearing Aid Services Project. 	<ul style="list-style-type: none"> ✓ Clear Government support. ✓ Establishment of implementation team. 	<ul style="list-style-type: none"> ✗ Commissioning structures not in place. ✗ The Artificial Limb and Appliance Services in Wales is affected by a re-assessment currently taking place – in consequence little progress has been made in respect of wheelchair and prosthetics services.
Operational delivery	<ul style="list-style-type: none"> • Roll-out of digital hearing aids across the NHS required. ✗ Evidence of long waiting times. ✗ Some problems with local delivery. 	<ul style="list-style-type: none"> ✗ Little of the first-year funding has reached front-line services. ✗ Concerns regarding effectiveness of risk management. 	<ul style="list-style-type: none"> ✗ Limited local improvement.
Future challenges	<ul style="list-style-type: none"> • Upgrading of premises. • Reduction in waiting times. 	<ul style="list-style-type: none"> • The DH should require that new money is spent in accordance with Ministers' wishes. 	<ul style="list-style-type: none"> • Commissioning needs to support hub-and-spoke arrangements.

Source: Audit Commission

31. The purpose of this report is to help to maintain the impetus that was generated by *Fully Equipped*. The continuing problems that equipment services face are exemplified by the findings of the Commission's appointed auditors, which is described in Chapter 2, and by recent research carried out by users' groups, some of which are reported in Chapter 3. But there has been some progress; Chapter 4 goes on to describe examples of encouraging practice and Chapter 5 summarises the action that still needs to be taken to deliver the agenda that was set out in *Fully Equipped*.

2

Continuing problems in equipment services

32. The production of the national report, *Fully Equipped*, was a small part of a much wider project. During 2000 and 2001, the Commission's auditors and inspectors undertook reviews in about one-half of all the NHS bodies and local authorities providing equipment services. In total, 330 audits were undertaken. The first part of this chapter presents the main findings of the auditors' work using the model that they adopted to report their findings: structural arrangements; processes; and outcomes [EXHIBIT 2]. The second part goes on to describe the findings of other significant research that has been undertaken since the publication of *Fully Equipped*.

Structural arrangements

Commissioning equipment services

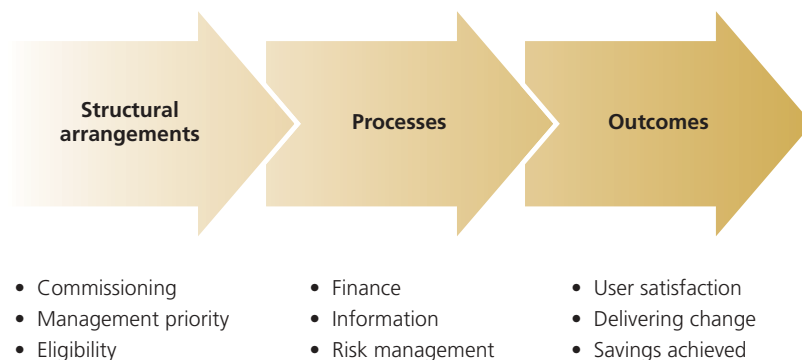
33. Auditors found that the standard of commissioning of equipment services to be exceptionally weak. Several common problems were identified:

- lack of knowledge about the underlying level of demand;
- absence of 'joined-up' commissioning;
- short-term thinking on commissioning;
- inappropriate commissioning currencies; and
- failure to use direct payment schemes.

EXHIBIT 2

Presentation of auditors' findings

Auditors' findings can be discussed under three headings.



Source: Audit Commission

...auditors found few examples of equipment services being explicitly linked to other health care objectives.

Understanding the underlying level of demand

34. A critical first problem is that service commissioners and providers generally have no idea of the underlying level of demand for equipment services. Unmet need is a serious problem as without equipment, people can face social exclusion. Data on the numbers of people who need help are not readily available. This hinders service planning and the ability to monitor changes in patterns of need and demand over time. By no stretch of the imagination can equipment services be described as ‘needs-led’. And, of course, the failure to assemble such vital information could be said to be discriminatory – no such dearth of information exists in services for people with coronary heart disease or cancer.

Absence of ‘joined-up’ commissioning

35. Auditors found some encouraging joint commissioning of community equipment services between the NHS and social services – as did the Social Services Inspectorate (Ref. 14). However, such arrangements were generally the exception to the rule. For the most part, services were being commissioned separately by health and social services with little recognition that each benefits from spending by the other.

36. In the case of community equipment services in particular, social services departments were finding themselves under increasing pressure to cope with the demands of people being discharged earlier from acute hospitals. The policy to support the immediate needs of the NHS was putting pressure on other parts of social services home-care budgets, and driving up eligibility criteria for those who needed less intensive support to help them to stay at home – risking unnecessary hospital admissions and increasing demands on the NHS.

37. Equipment services were seldom viewed in the context of wider health strategies to promote independence and prevent accidents. They therefore appeared to be less likely to receive funding from commissioners, and were perceived as less relevant in overall performance management terms.

38. On a similar theme, auditors found few examples of equipment services being explicitly linked to other health care objectives. For example, increases in the prevalence of diabetes will put significant demands on orthotics and prosthetic services in future years, but auditors found no evidence of commissioners considering how strategies to invest in therapy or equipment could reduce the long-term incidence of surgery.

Short-term thinking in commissioning

39. The 1999 Health Act (Ref. 15) sought to encourage longer-term planning and service agreements between commissioners and the providers of services. The Government's comprehensive spending review provides a three-year planning cycle to support this aim. However, auditors found that commissioning decisions made through the annual Service and Financial Frameworks did not reflect the longer-term Health Improvement and Modernisation Programme (HimP) objectives. As a result, the long-term health and cost implications of providing less than optimal solutions were not properly considered. For example, a wheelchair that doesn't fit the user's posture can lead to significant musculo-skeletal deformities and increased expenditure in later years. But an abbreviated logic is applied and such long-term considerations are invariably overridden by the need to produce a balanced annual budget.

40. Higher priority is afforded to the NHS's explicit priorities of increasing capacity and reducing waiting times in acute specialties. However, auditors found little evidence that authorities and trusts had made the connection between these top priorities and the contribution that effective equipment services can make to strategies to deliver them [BOX D]. Many acute services are struggling with the need to reduce waiting times and increase capacity. Yet they face increasing pressure from admissions and have, on average, around 6 per cent of their beds occupied by patients who could be discharged if community services were organised. Equipment services could, therefore, play a vital part in strategies to optimise capacity, prevent unnecessary admission to hospital and facilitate prompt discharge of patients. However, a real leap of faith is needed to spend hard cash now in anticipation of these future benefits.

BOX D

Linking equipment services to higher priorities

An audit at one trust found a ten week waiting list for pressure-relieving equipment and a three-week waiting list for pressure-relieving equipment for terminally ill patients. The service had no purchasing or replacement plans to tackle the backlog, relying instead on the hope of extra funds from one-off winter pressures money.

The auditor calculated that it would take £100,000 to buy enough equipment to remove the backlog, but concluded that this money was very likely to be recouped as, in the previous year, 456 bed-days had been lost because beds were blocked by patients on the pressure equipment waiting list. The additional cost of hospitalisation because of pressure sores (to say nothing of the human costs) therefore did not even need to be brought into the calculation to justify the proposed investment.

Source: Local Audits

...community equipment provides good outcomes at reduced cost. If a medicine was discovered with a similar cost-profile, it would be hailed as the wonder-drug of the age.

Commissioning currencies

41. Auditors found that some commissioning arrangements contained perverse incentives – one commissioner was willing to fund the historical number of repairs to artificial limbs, thus providing no incentive in cash terms for the provider to reduce the number of repairs. Service specifications need to be expressed in terms of patients and their needs, not in numbers of pieces of equipment and the number of repairs. Commissioning currencies need to reflect the full long-term costs (including a reasonable allocation of overheads) of treating different categories of patient. They also need to create the necessary incentives for equipment suppliers to improve quality, minimise repairs and maximise recycling.

Failure to use direct payment schemes

42. Local authorities have the power to make payments to certain groups of people in order to enable them to buy their own community equipment services (Ref. 16). But auditors found few examples of councils using these powers, despite the fact that they have the potential to improve user choice, enabling people to make their own decisions about simple equipment and adaptations. A study found that most people with modest needs (some 80 per cent) were able to satisfy their needs for themselves. They gained little from interventions by nurses, occupational therapists or social workers. Many required only minimal help to continue to live independently. But speed was of the essence to sustain self-confidence and a sense of independence. Effective outcomes resulted from good advice and the opportunity to try out equipment (Ref. 17).

43. In this context, it is worth repeating one of the most compelling passages of *Fully Equipped*, which said: ‘community equipment provides good outcomes at reduced cost [BOX E]. If a medicine was discovered with a similar cost-profile, it would be hailed as the wonder-drug of the age.’

The low priority afforded to equipment services by providers

44. The lack of engagement by commissioners in equipment services results in them also being afforded a low priority by many providers. Auditors’ identified four main problems:

- failure to acknowledge the clinical contribution of equipment services;
- unexplained variations in policy and practice;
- unclear roles and responsibilities; and
- inadequate staffing levels.

BOX E**Does community equipment work?**

Humble devices like walking sticks, zimmer frames, bath benches, and simple home adaptations preserve the independence of older people and improve their quality of life. They can also cut healthcare costs in half, according to a randomised trial.

Participants who had unlimited access to the equipment of their choice – on average 14 devices each – cost \$14,000 per person in total healthcare costs over the next 18 months. On the other hand, users given ‘standard care’, which amounted to only two devices each, cost over \$30,000 in total healthcare costs per person during the same period.

Source: (Ref. 18)

Failure to acknowledge the clinical contribution of equipment services

45. Auditors noted that there was a tendency for senior managers who were not directly involved in equipment services to regard them primarily as a supplies function, rather than as a clinical service for which appropriate assessment, prescribing and review are fundamental to providing a high-quality service that has a significant impact on many other clinical services. To some degree, this tendency is perpetuated by the absence of any formal clinical audit programmes, particularly in the orthotics, wheelchair and community equipment services. Lack of resources was usually cited as the reason for this absence but it may be the very reason that audit is needed.

Unexplained variations in policy and practice

46. Lack of senior management involvement perpetuates variations in policy and practice. Auditors found that policies on service delivery ranged from in-house service provision to almost complete outsourcing of services. However, there was rarely any tangible basis for the chosen mode of operation, which usually owed more to history and convenience than to evidence that the chosen model delivered the best service to users. Social services inspectors came to similar conclusions about the delivery of community equipment services [BOX F, overleaf].

47. Auditors found significant differences in policy and practice between services. For example, there is little professional consensus in wheelchair services about the value of assessing users at home rather than in clinics [EXHIBIT 3, overleaf]. Again, these observed variations are the product of local custom and practice, with little evidence of clinical audit and professional consensus about the best approach.

BOX F

Conclusion of social services inspection of community equipment services

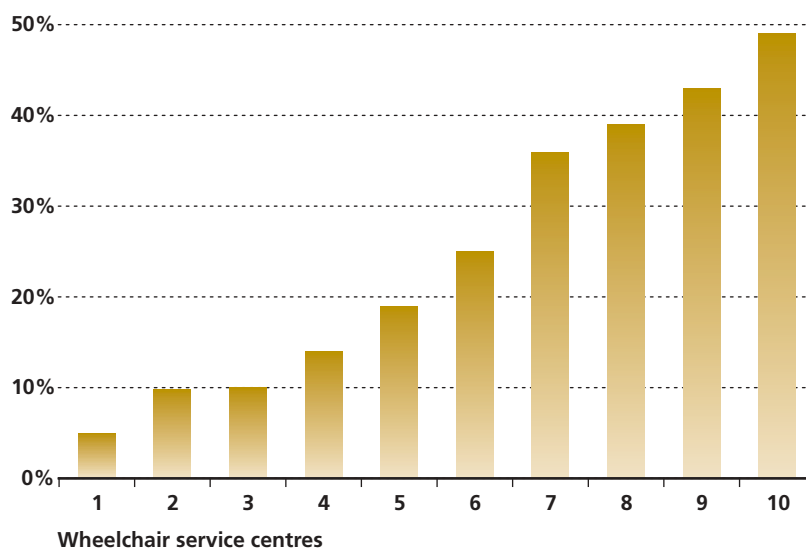
'The single factor that most inhibited improvement of older people's social care was when strategic thinking and prioritising was over-influenced by a council seeing itself as a social services provider. This caused some councils to give a higher priority to the sustainability and development of the council's own social care provision than to responding to the needs of local older people and their carers.'

Source: (Ref. 14)

EXHIBIT 3

Proportion of wheelchair service users who receive a home assessment

There is little professional consensus in wheelchair services about the value of assessing users at home.

Percentage of service users receiving a home assessment

Source: Audit findings

48. An auditor's analysis of community equipment loan provision by community and acute trusts and social services departments within one county identified that, even under broad headings, there was variation in provision between identical types of organisation [BOX G]. The variation in provision across the county was due to the lack of a unified agreement on which organisation would provide what equipment. However, the impact for users of the service was that the type of equipment that they received to enable them to live independently in the community depended on their postcode.

BOX G

Community loan provision in one county

	Community Trust 1	Community Trust 2	Acute Trust 1	Acute Trust 2	County SSD	Unitary SSD
Equipment provided						
Beds	Y	Y				
Bed equipment	Y	Y	Y		Y	Y
Kitchen equipment	Y		Y		Y	Y
Medical	Y	Y				
Mobility	Y	Y	Y	Y	Y	
Moving and handling	Y	Y			Y	
Personal equipment	Y	Y	Y		Y	Y
Personal hygiene	Y	Y	Y		Y	
Pressure relief	Y	Y				
Seating	Y	Y	Y		Y	Y
Toileting equipment	Y	Y	Y		Y	Y

Source: Audit Commission

49. Policies covering the provision of equipment to residential and nursing homes also varied significantly. This is a grey area. Some nursing and residential homes provide equipment as part and parcel of the package of care that they provide, some rely on the NHS to provide the equipment and others require residents or their relatives to pay for it. As the policy of continuing care develops, residential and nursing homes will become responsible for residents who are more dependent. This will increasingly force the issue, and many commissioners will need to clarify their policies for providing more expensive specialised equipment, such as pressure-relieving mattresses or hoists.

Unclear roles and responsibilities

50. Auditors found some examples of poor communication between different professionals, often because their roles and responsibilities were unclear. For example, in the prosthetics service they found examples of confusion between prosthetists and rehabilitation consultants, leading to duplication of effort. They also found a lack of clarity between the role of orthotists on the one hand and podiatrists/chiropractors on the other. There were also concerns about centre managers overruling the clinical judgement of professional staff on the grounds of cost.

Users sometimes perceive that staff invest enormous energy in putting up obstacles, rather than thinking creatively about how to meet their needs...

51. Similar problems were found when it came to demonstrating community equipment to users. It was sometimes unclear whether providing information about how to use the equipment was the responsibility of clinical professionals – for example, occupational therapists (OTs) and district nurses – or the staff from the equipment store.

Staffing levels

52. Previous work by the Audit Commission, among others, has emphasised the effectiveness of structured rehabilitation (Refs 19, 20) However, auditors were concerned that the staffing levels of some equipment services prevented proper investment in rehabilitation and community care. In particular, the shortage of OTs was identified as being a major problem. Community OTs spent, on average, a small proportion of their time on rehabilitative advice and continuing care management, and were having to concentrate instead on their role as equipment providers.

Eligibility criteria

53. The provision of equipment services is subject to people meeting locally-defined eligibility criteria. Once a public authority is satisfied that it is necessary to make arrangements to meet an individual's needs, then there is a duty in law to make provision under the Chronically Sick and Disabled Person's Act 1970 and the NHS and Community Care Act 1990 (Ref. 21). However, auditors found that some authorities were imposing strict eligibility criteria on community equipment services, or that they were avoiding making the assessment in order to contain costs.

54. Auditors found that eligibility criteria were generally set by provider organisations with a view to their meeting the available annual budget: thus 'need' is equated with 'money available', not with long-term healthcare and social needs. This creates significant tension between staff and service users and it is demoralising for both. There is a general view that eligibility criteria are used to exclude people, rather than include them, from receiving equipment services. Users sometimes perceive that staff invest enormous energy in putting up obstacles, rather than thinking creatively about how to meet their needs; while many practitioners complain of spending their time 'managing rationing' rather than providing direct care.¹

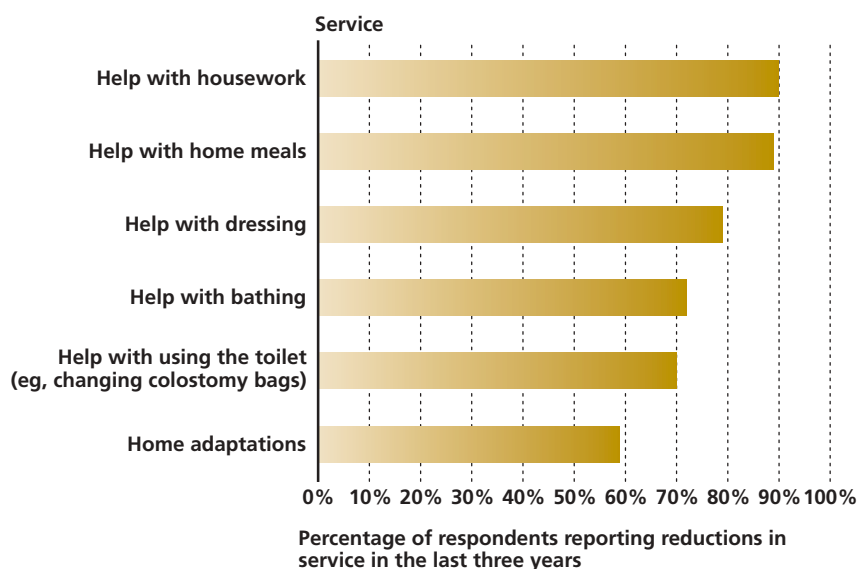
¹ The Department of Health is shortly to issue guidance on Fair Access to Care Services.

55. Auditors' findings confirmed the Government's own view that 'eligibility criteria are getting even tighter and are excluding more and more people who would benefit from help but who do not come into the most dependent categories'. (Ref. 22) Recent reports have suggested that social services nationally are overspent by £200 million, and are spending £900 million more than is indicated under the Government's standard spending assessment. (Ref. 23) At the sharp-end of service delivery, there is also evidence that many people have experienced reductions or face long waits for equipment and supporting services at a time when there is an expectation that services supporting independence need to be expanded to meet stated Government objectives [EXHIBIT 4 and BOX H, overleaf]. Such short-term thinking in cutting prevention strategies is likely to lead to far higher costs elsewhere: 70 per cent of those surveyed reported reductions in help provided with bathing and toileting and, apart from the role it plays in maintaining basic human dignity, hygiene is vital to controlling the risk of infection and pressure sores.

EXHIBIT 4

Percentage of service users reporting recent reductions in support from social services

Many services report reductions in funding.



Source: Ref. 24, N=1,514

BOX H**Users' experiences of equipment provision and associated services**

- “My husband and I, both in our 80s, are taken to an old people’s home twice a year for a bath. We asked the council to put in a bath in our house but were told there is no money.”
- “All care was withdrawn over the Christmas and New Year period. I went without food as there was no one to cook it for me. All baths stopped and my home help’s hours were cut by two-thirds without letting me know.”
- A 73 year-old man was paralysed in an accident at the age of 28. He worked for all of his adult life until retiring a few years ago. He lives independently on industrial injuries benefit and the basic state pension and requires help in his home for up to 14 hours a week. He was charged £12 a week for this help. Now his local authority has put up the charge to £112 a week.
- The children’s charity Whizz-Kidz, which supports the movement of non-mobile children, has provided the Audit Commission with many examples of children placed on waiting lists of three years for powered wheelchairs.

Source: Ref. 25 and Audit Commission

Processes**Finance**

56. Auditors noted that several consistent problems were being experienced by providers of equipment services in the area of finance. These included:

- budgetary systems;
- funding not ‘joined-up’;
- establishing partnerships;
- purchasing;
- economies of scale; and
- internal financial controls.

Budgetary systems

57. In many organisations, auditors found rigid budgetary systems with tasks and responsibilities fragmented – for example, responsibility for investment and operating budgets held separately. Operating budgets were found to be over-compartmentalised in some organisations, with money being strictly allocated to very specific tasks and very rigidly assigned to pay and non-pay budgets. This reduced budgetary flexibility, initiative and incentives for service providers. Conversely, auditors found in other organisations that budgets were not devolved to those making the referral to the services. In particular, some orthotic services were treated as a ‘free good’ by the wider orthopaedics service.

Lack of ‘joined-up’ funding

58. The fragmentation of funding and service responsibilities can fail to take account of users’ overall needs. The result can be poor value for money. At one trust, the surgery directorate spent £30,000 on performing a complicated operation to straighten a patient’s spine, but the wheelchair service could not then afford the £500 needed to adapt the patient’s wheelchair to accommodate his new posture. A major challenge for all equipment and rehabilitation services is to create the incentives and financial structures that can deliver best value right the way across public expenditure. Quite plainly, the need and costings for the provision of associated equipment must be aligned in commissioning, protocols and care pathways for all clinical services. Only if this is done can so-called ‘Cinderella’ equipment services meet the demands of clinical and medical developments in related specialties.

59. Auditors also found several cases where patients were measured for orthoses, artificial limbs or wheelchairs, but the provision of the equipment deferred until the start of the next financial year. From a user’s perspective, it is obviously desirable to get both prompt assessment and prompt provision of equipment. There is also a purely financial dimension: delay often means increased overall costs. Deferring the provision of equipment can mean that the patient’s needs change in the intervening period, so that when the equipment does arrive it no longer fits or meets clinical need. Also, extra care may be needed in the mean time, funded from another budget.

Establishing partnerships

60. Auditors found that there has been some progress in developing partnerships at a strategic level. Examples included multi-disciplinary community mental health teams, based in community mental health centres; and joint investment plans for older people.

...partners were often unable to agree the resources each would contribute in ways that provided stability and the ability to plan for the medium term.

61. However, auditors found less progress at an operational level. In particular, partners were often unable to agree the resources each would contribute in ways that provided stability and the ability to plan for the medium term. Progress in establishing partnerships was greatest in organisations with a long history of co-operation between health and social services, and especially where the partnership was supplemented with additional external funding, such as urban regeneration or European Union funding that was contingent upon joint working.

62. The NSF for Older People requires that a single assessment process be introduced for health and social care by April 2004 – delayed because of limited progress up to April 2002. Auditors found that in many organisations progress towards an integrated equipment service had been placed on hold while these wider integration initiatives were pursued. Progress was generally slow because of the practical difficulties of combining budgets. Many finance directors were cautious about transferring funds under the Health Act 1999 flexibilities, as smaller budgets would leave them with less overall flexibility.

63. Auditors also found some examples where partnership arrangements confused service users. NHS services are free at the point of delivery, but local authorities are required to charge for certain services, such as the provision of residential care, and have discretion to charge for other services, such as transport and non-residential social care. In establishing partnerships, agencies have to consider how best to clarify the difference between services with a charge and services that are free at the point of delivery. Auditors found that the following scenarios create particular confusion:

- when a joint assessment takes place, as it can blur the distinction between charged for and non-charged services. If one member of staff undertakes an assessment on behalf of health and social care, it may be more difficult for the user to understand the distinction; and
- where a service is provided through an integrated provider, as this may also blur the distinction for the user.

64. Where partnerships had been established, auditors found that problems with accounting arrangements persisted. For instance, it is still necessary to know, for accounting purposes, how much money is allocated to health and how much is allocated to social services as VAT still has to be accounted for separately at the year-end. Different VAT arrangements were identified as being a problem in several organisations. Clear guidance has now been issued by the DH and HM Customs and Excise (Ref. 25), but weaknesses in systems still make it difficult to allocate equipment to the different VAT treatments.

65. Auditors also raised concerns with some local authorities about the economics of their charging policies – the cost of collecting debt was sometimes either equal to, or exceeded the revenue collected.

Purchasing

66. One of the problems identified in establishing joint equipment services was the lack of agreement between different professionals on the range and type of equipment needed as part of the move to an integrated service.

67. Auditors also reported a difficult tension between the desire, on the one hand, to reduce costs by aggregating demand across a standardised equipment range; and, on the other hand, to meet users' demands for greater choice and variety of equipment. This tension is not clearly expressed or adequately resolved in many organisations.

Economies of scale

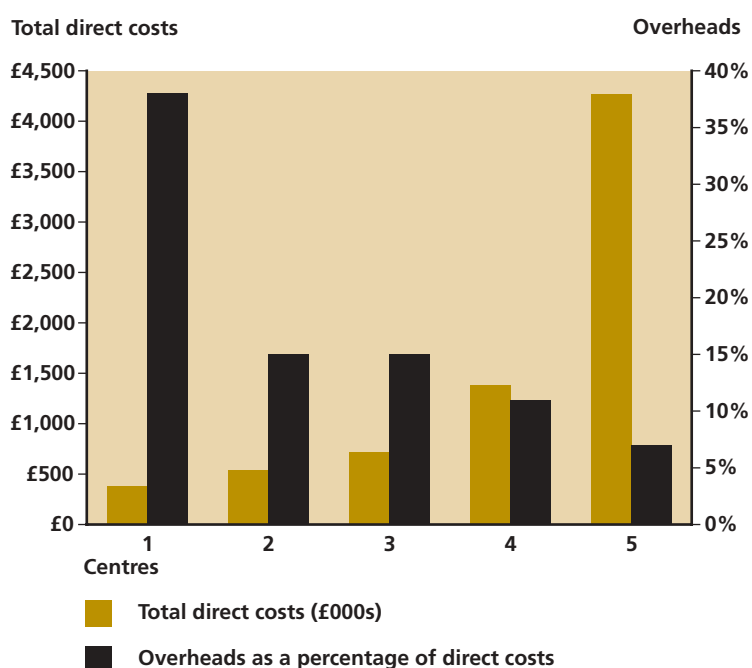
68. Auditors found that small-scale equipment and wheelchair services were comparatively expensive because of the allocation of high unit overhead costs [EXHIBIT 5].

69. The high overheads associated with small-scale operations is one argument that supports the development of larger-scale, integrated rehabilitation services in which it would be possible to spread fixed overhead costs over a greater volume of activity.

EXHIBIT 5

Overheads allocated to wheelchair service centres

There are high overheads associated with small-scale operations.



Source: Audit findings at five wheelchair services

Internal financial controls

70. The small scale of operation of many orthotics services was found to result in breaches of accepted practice in separation of financial responsibilities. In several orthotics services, auditors found that orders were raised and signed off by the same individual. While auditors found no evidence of any fraud, such inadequate controls pose a risk to probity.

Information

71. The quality of information was found by auditors to be poor, creating problems for:

- users;
- commissioners; and
- service professionals.

Users

72. The quality of information given to users was criticised in many audits. Advice was given based on what the local service could afford, not on the optimum solution for an individual's needs.

73. One auditor reported that: 'The poverty of information and absence of standards means that patients are not assessed in accordance with the health authority's wishes. The staff do not receive updates on new products and training opportunities, and users do not know how to register complaints or provide useful feedback on the services provided.' This finding is endorsed by user-feedback to the Audit Commission [BOX I].

BOX I

User views

Users report that information is a central and fundamental issue for them, together with the establishment of national standards in limb fitment, provision and repair along the lines of:

- Fitment:** Comfortable, 'right first time' limb fitted within eight weeks of first appointment. (Further standards need to be defined to avoid 'not right after 15th attempt and two years later as occurs far too frequently).
- Provision:** Access to information and choice of product. Flexible and user-focused appointment systems.
- Repair:** Speedy access (within 24 hours) and defined repair times.

Source: User correspondence

Urgent improvements to record keeping and the introduction of better information systems is essential if adequate management of resources and the introduction of clinical audit is to be achieved across all services.

Commissioners

74. The quality of management information available to most commissioners and providers of equipment services was found by auditors to be generally weak, making it very difficult to manage services proactively. In one cross-cutting review of community equipment services, the auditor commented: ‘The four health authorities all reported that they had received little or no information over the last 12 months, and that the information that had been provided was of little use.’ Even where performance information was available, commissioners seldom asked to receive performance reports.

Service professionals

75. All equipment services need IT systems that enable equipment in use in the community to be tracked, so that patients’ needs can be followed up and the effectiveness of their equipment reviewed. In the case of wheelchair and community equipment services, these systems also need to be able to track equipment for the purposes of recycling. A typical community equipment service has an annual turnover of £400,000; a typical system that enables tracking costs £20,000. So recycling only has to be increased by just 5 per cent of the annual turnover to save the cost of the system. The audits found that introducing IT systems increased recycling rates from around 20 or 30 per cent to 60 or 70 per cent at least.

76. Clinical note-taking and patient activity information systems in most equipment services were generally poor and not conducive to meaningful clinical audit. Urgent improvements to record keeping and the introduction of better information systems is essential if adequate management of resources and the introduction of clinical audit is to be achieved across all services. Clear notes are not optional in good professional practice. This is recognised by many clinicians and will be supported by the introduction of new professional standards. However, making effective notes takes time and costs money, and requires supporting administrative services and technology.

77. Auditors found that equipment services lack accurate information about their workload, impeding proper management. Few had an accurate picture of the:

- numbers of active patients (equipment services need regular review to ensure that records reflect real patients with real needs);
- numbers on waiting lists;
- cross-boundary flows;
- use of smaller items of equipment – for example, cushions/seating components; and
- allocation of costs and overheads to each component part of the service.

78. A further criticism of performance management systems in community equipment and wheelchair services is that they are inclined to be partial, measuring selected stages of the process, when what matters is the length of the entire process from start to finish [EXHIBIT 6].

79. Auditors raised concerns about the absence of performance measures which could be used to judge the quality of service. One auditor commented that: ‘managers are judged by balancing the budget and keeping the noise down, not on the quality of the service offered.’ However, it is difficult to obtain robust performance measures that get to the essence of equipment services: performance measures are often dependent on surveys or case-note reviews. Such measures are hard to standardise and compare across organisations. Many organisations do not have standards in place against which to judge success.

EXHIBIT 6

Steps involved in the provision of equipment

The process of equipment provision has several steps with different people involved.



Source: Audit Commission

Performance measurement... has historically emphasised the delivery of measurable, tangible services.

80. The poor quality and availability of information also makes it difficult to monitor contractors' performance under a contract. For example, most prosthetics services use the model service specification from the NHS Purchasing and Supply Agency (PASA). This specification includes some useful indicators against which to monitor contractors' performance, for example:

- the service shall be based on the provision of a minimum of one prosthetist per case load of 250 lower limb amputation sites and one per 500 upper limb amputation sites;
- the staffing structure will include a maximum ratio of three senior prosthetists to two new graduates to ensure continuous availability of senior support;
- a norm of five routine attendances will be appointed per prosthetist per day (or an average of 24 per week) for those prosthetists who do not have management responsibilities. In the case of a new graduate, a smaller caseload (average 18 per week) will be acceptable; and
- the contractor should achieve a target of 90 per cent of sockets produced, to be right first time (that is, they do not have to be repeated).

81. These are sensible indicators, but auditors found that most centres did not have the information to monitor whether they were being achieved. Auditors were especially critical of wheelchair services in this respect. One trust explained: 'Our main suppliers are rather old fashioned and have not been particularly receptive to new ideas... Lead-times are rarely met and both ourselves and the NHS Purchasing and Supply Agency appear toothless to enforce them.' One shortcoming is that contracts rarely include variation clauses to cover under-performance or over-performance.

82. There is a fundamental problem underlying these concerns. Performance measurement in the NHS and local authorities has historically emphasised the delivery of measurable, tangible services. This has perpetuated the tendency to wait for a problem to become a crisis before offering services. This in turn results in public services treating symptoms, rather than devising preventative strategies. Measuring the maintenance of independence or the prevention of accidents is, however, very difficult as it seeks to measure something that never happened. In the case of community equipment services, the national implementation team are seeking to tackle some of these difficult issues.

Risk management

83. Auditors found shortcomings in trusts' and authorities' compliance with manual handling regulations and with the Health and Safety at Work Act (HASAWA). These require that all equipment, including that in people's homes, must be checked regularly. But auditors found that hardly any trusts or councils had made any provision for the significant costs involved in terms of staff time and vehicles, in implementing such procedures.

84. Auditors also found that equipment services commonly failed to apply the DH's Controls Assurance Standards for Medical Devices to their equipment. DH guidance states that 'the term *medical device* covers a broad range of products, including those used every day for the treatment, or alleviation of an injury or handicap.' Equipment services are clearly included in this definition.

85. In addition, all NHS organisations are subject to legal and statutory requirements relating to 'the duty of care' that requires employers to provide competent and safe fellow employees, safe equipment and place of work, and a safe system of work. However, auditors noted the irony that carers undertake lifting and handling tasks that would be proscribed for an NHS or local authority employee: 51 per cent of carers have suffered a physical injury, such as a strained back, since becoming a carer (Ref. 26). (However, this problem may partly be the result of professional advice being ignored by carers.)

86. Auditors found a general absence of device management procedures that included policies for the purchase, acceptance, decontamination, maintenance, repair, monitoring and replacement of devices, and for the training of users and staff. Equipment purchasers and providers need to develop and implement suitable device management procedures to ensure that whenever equipment is used, it should be:

- suitable for its intended purpose;
- properly understood by the professional user; and
- maintained in a safe and reliable condition.

87. In addition to these concerns, auditors noted:

- few examples of planned preventative maintenance that followed manufacturer's guidance – there were also doubts about whether properly trained technicians checked that devices were safe and reliable;
- several examples of inadequate washing and decontamination facilities – where appropriate, all medical devices should be cleaned, disinfected and/or sterilised in accordance with the latest decontamination guidance; and
- poor facilities and cramped working conditions, especially in the orthotics and audiology services.

Outcomes

User and carer satisfaction

Users

88. A criticism that has been levelled at equipment services is that insufficient attention is paid to the opinions and needs of users. In the view of the DH: ‘it is often the authorities that offer a ‘one-size fits all’ service, based around what suits the provider rather than the user, that are the least cost-effective services’ (Ref. 27). Auditors found that relatively few organisations (about one in five) conducted regular user and stakeholder satisfaction surveys of the various equipment services that they provided. Auditors therefore conducted their own surveys in many organisations as part of their investigations.

89. Across all five services, a common theme emerged: as a group, users were significantly more satisfied than healthcare professionals with the quality of the service provided. One possible conclusion is that many users have low expectations [BOX J].

90. Local clinicians and managers reported that the level of complaints they received was strongly associated with the age of the service user: the younger and more active the user, the greater the number of concerns that would be raised.

91. The time spent waiting for services is seen as one of the main indicators of the quality of services provided. Long waits can have a very significant impact on the success of care and rehabilitation, and on the ability of users to live independently in the community. The audits found very large differences in average waiting times and in the numbers of people waiting between trusts or authorities.

BOX J

Findings of user surveys

- 22 per cent of patients reported that their orthoses were uncomfortable; average waiting times exceeded ten weeks from measurement to the supply of the orthosis; and 50 per cent of patients received no information about the use, care and repair of their orthosis. Nevertheless, 90 per cent of users reported that they were satisfied;^I
- 82 per cent of wheelchair users in surveys at six centres felt that the average six-weeks wait for a conventional wheelchair was reasonable;^{II}
- surveys across five prosthetics services found that, on average, 20 per cent of users did not use their artificial limbs, but only 10 per cent reported that they were dissatisfied.^{III}

I Local audits N=249 Five-point satisfaction scales used.

II Local audits N=193 Five-point satisfaction scales used.

III Local audits N=237 Five-point satisfaction scales used.

92. Auditors also found large variations in waiting times within the same organisation. Services are often unpredictable: two individuals with the same needs served by the same provider are likely to wait for very different amounts of time [EXHIBIT 7].

Carers

93. The formal care system cannot begin to deliver the range, volume, flexibility of care and support for users of equipment that is provided by unpaid carers. Relatives and friends are the major deliverers of care and act as partners with service providers, while also monitoring the quality of services. The philosophy of support behind the NSF for Older People is equally relevant to those unpaid carers, who are increasingly becoming old themselves (Ref. 27).

94. However, in many organisations, auditors found that there is still a difficulty turning recognition of the pivotal role that unpaid carers play into practical forms of support. Significant progress is needed to deliver the vision that is set out in the National Strategy for Carers (Ref. 28).

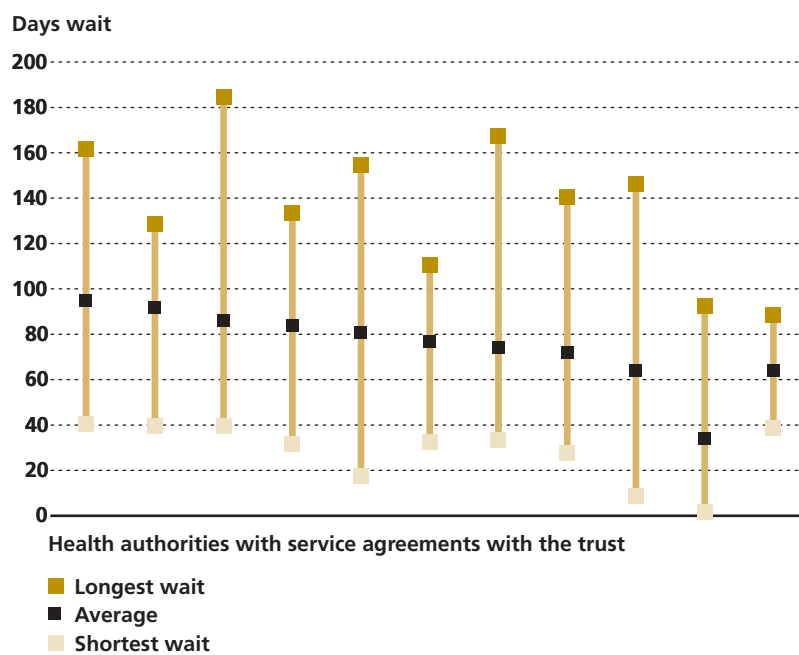
Delivering change

95. In the case of community equipment services, there is a tight timescale to deliver the integrated services expected by the Government, and several obstacles to be overcome [EXHIBIT 8]. Despite this, all community equipment services surveyed were confident that they will achieve full integration by April 2004. On the other hand, there is no timetable for delivering hub-and-spoke arrangements for mobility services, and there has been virtually no progress in this area at all.

EXHIBIT 7

Waiting times for made-to-measure orthoses supplied by one service provider

There are wide differences in users' experiences of waiting times within the same organisation.



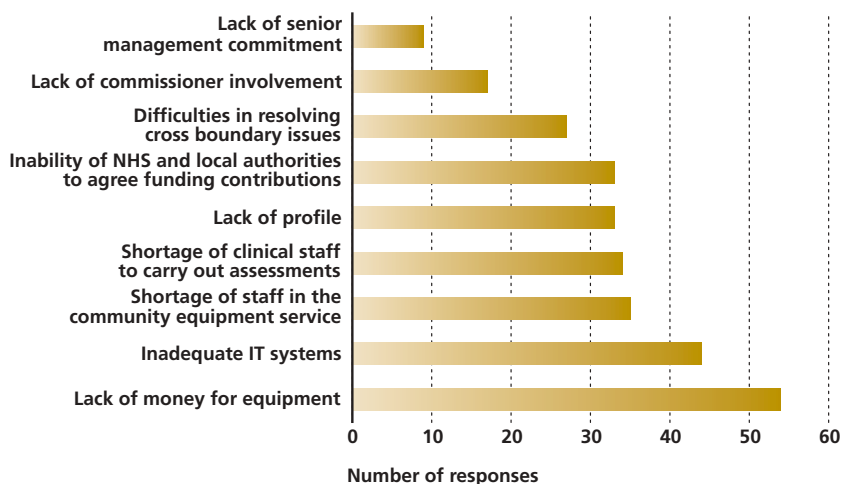
Note: Health authority contracts specified the same waiting time.

Source: Audit Commission analysis of services provided by 1 trust to 11 health authorities

EXHIBIT 8

Perceived obstacles to achieving the government's target for integrating equipment stores

Several obstacles have to be overcome in order to meet the Government's target.



Source: Audit Commission survey of equipment services, N=65

Savings

96. Auditors found very few savings opportunities in the audits undertaken. In total, savings of less than £1 million were identified. Where they were identified, they related to:

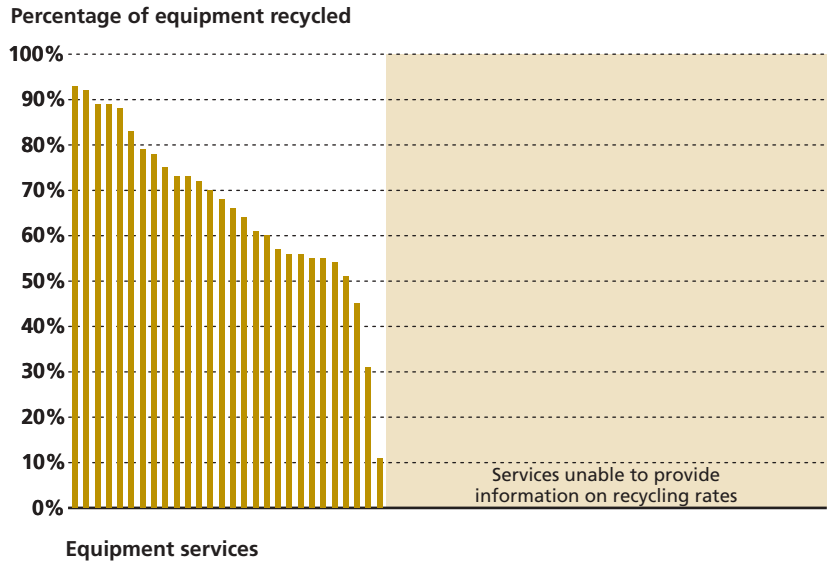
- opportunities to increase the proportion of ready-to-wear orthoses prescribed (typically around £10,000, although as high as £44,000 in one trust); and
- the scope to reduce the value of stock held in community equipment services (typically a one-off saving of around £10,000, but as high as £25,000 at one store).

97. The biggest single savings opportunity comes from increasing the amount of community equipment that is recycled. Auditors found big differences in performance between similar services in this area [EXHIBIT 9, overleaf]. They also found that low collection and recycling rates were strongly associated with higher than average expenditure on new equipment and with higher levels of stock. If all community equipment services could increase recycling to the levels of upper quartile performance (about 70 per cent), savings of a further £5 million would be achieved.

EXHIBIT 9

Percentage recycling rates achieved by community equipment stores

There are opportunities in some community equipment services to increase recycling rates.



Source: Audit Commission survey of equipment services, N=65

3

Reports by users' groups

98. In addition to the Commission's work, several user groups have reviewed equipment services recently. These reviews have covered:

- services for people who need communication aids;
- services for deaf and hard-of-hearing people; and
- services for blind and partially sighted people.

Reviews of services for people who need communication aids

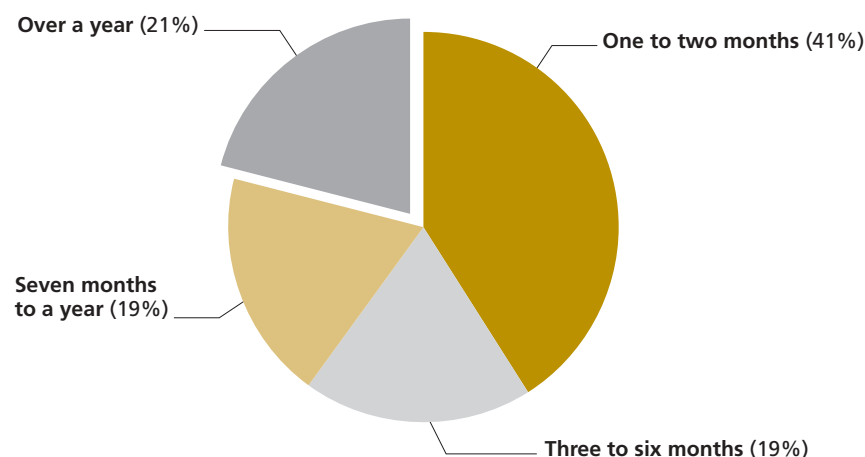
99. Scope has undertaken research into the current provision of communication aids for people with cerebral palsy (Ref. 29). Their report reiterated many of the messages of *Fully Equipped*:

- there is little understanding of the underlying level of need in the community for communication aids in the community;
- people have to wait a long time following their initial assessment before they receive the help that they need [EXHIBIT 10];
- funding levels are inadequate, with almost half of those surveyed relying on charities or private means to fund communication aids;
- one in three people surveyed said that they received inadequate training;
- equipment is of dubious quality – 70 per cent of users' equipment had broken down at least once; and
- some repairs take a long time [EXHIBIT 11, overleaf]

EXHIBIT 10

Time taken to receive a communication aid after assessment

One in five users have to wait for over a year.

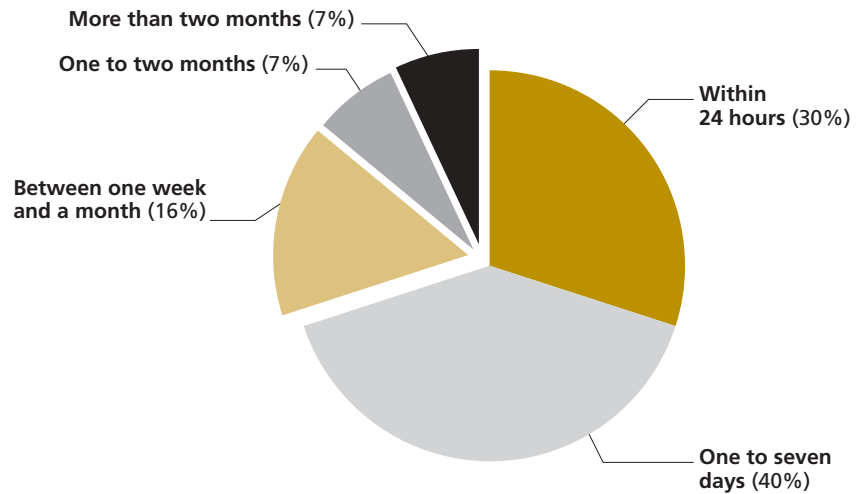


Source: Audit Commission analysis of data provided by Scope, N=226

EXHIBIT 11

Time taken to repair broken communication aids

30 per cent of users experience waits of over one week.



Source: Audit Commission analysis of data provided by Scope, N=185

Reviews of services for deaf or hard-of-hearing people

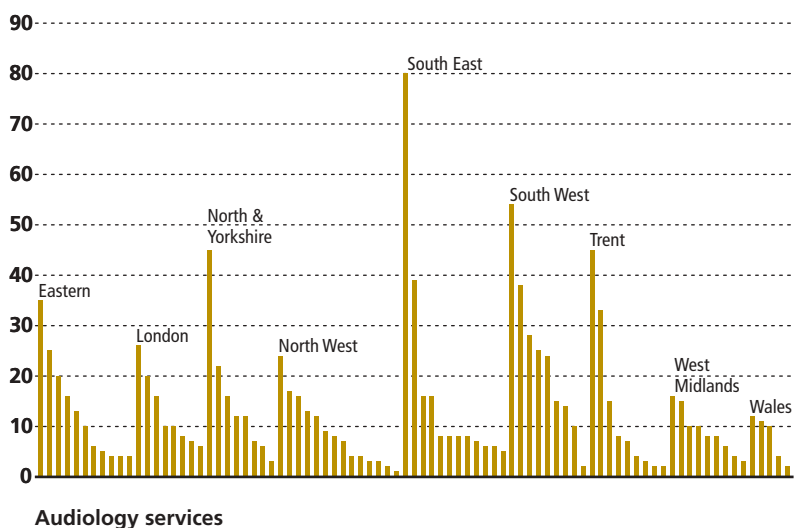
100. In March 2001, the RNID published *Audiology in Crisis – Still Waiting to Hear* (Ref. 30). It found long waiting times unacceptably wide variations in staffing in audiology services; and poor facilities and inadequate accommodation [EXHIBITS 12 and 13].

EXHIBIT 12

Waiting time for a hearing test

There are wide intra-region variations in the amount of time that people have to wait for a hearing test.

Weeks wait for a hearing test



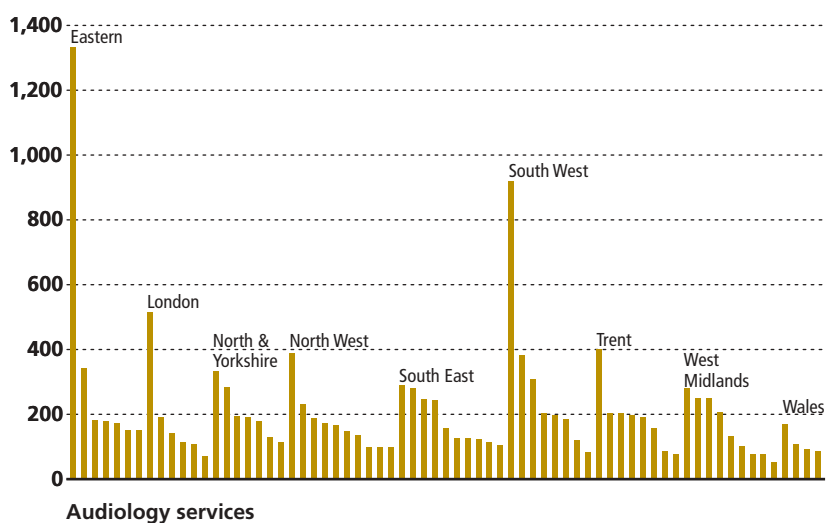
Source: Audit Commission analysis of data provided by RNID

EXHIBIT 13

Audiology service staffing levels

There are wide intra-region variations in staffing levels.

New referrals per WTE staff member in 2000/01



Source: Audit Commission analysis of data provided by RNID

101. The report concluded that:

- health authorities should increase investment in order to prevent an increase in waiting times;
- NHS trusts should review staffing levels so that they can meet the growing numbers being referred to the service and can allow adequate time for consultations with patients; and
- facilities and accommodation should be improved.



Reviews of services for blind or partially sighted people

102. Several reports have been produced recently that examine the provision of services for blind or partially sighted people (Refs 31, 32, 33, 34, 35, 36, 37). Taken together, they paint a deeply depressing picture of extensive and deep-seated poverty; significant care needs that are not being met; and widespread social isolation and exclusion. The key messages are that:

- an estimated 1.7 million people in the UK could be categorised as being blind or partially-sighted (Ref. 38);
- over 95 per cent of people with serious sight problems have some sight, but they face significant difficulties with everyday activities;
- 90 per cent of people with a serious sight problem are aged over 60, and are also more likely to live alone, suffer restrictions in everyday life accompanied by other age-related conditions, such as hearing loss, and physical limitations (Ref. 39);
- 75 per cent state that they need help with activities involved in daily living;
- most depend on informal carers – one-quarter have never received a visit from social services;
- lack of adequate transport means that many become housebound – 60 per cent never go out alone;
- 90 per cent blind or partially sighted people are on an income of less than one-half the national average (a widely-accepted definition of poverty);
- 10 per cent were aware that they could claim benefits but did not do so either because they found filling in the forms too difficult or because they did not have information about how to claim;
- 75 per cent are living with other health problems or disabilities;
- waiting times for referral to low-vision services range from three months to one year;
- services for people with low vision are unequally distributed throughout the country, and many people live a significant distance from their nearest service;
- low-vision services are provided by social services departments, voluntary organisations and the NHS and would benefit from greater co-ordination and coherence (Ref. 40);
- 88 per cent of people over 65 who have cataracts and 75 per cent who have glaucoma have no contact with eye specialists; and
- 30 per cent of people over the age of 65 are visually impaired – the condition is treatable in three-quarters of these cases but only one-quarter have contact with eye services (Ref. 41).

Sight loss is one of the most significant risk factors in terms of an older person's ability to undertake everyday activities.

103. On a more positive note, these facts emphasise the vital contribution that services for blind or partially sighted people could make to strategies to promote independence [BOX K]. Sight loss is one of the most significant risk factors in terms of an older person's ability to undertake everyday activities. It is therefore a highly predictive factor leading to disability and loss of independence (Ref. 42). Inadequate low-vision services mean more residential care and attendance costs for local authorities, and very likely increased costs for the NHS. However, two out of five local authorities do not offer any low-vision service at all, equipment stores rarely stock low vision aids, and access to low-vision services in the NHS is variable.

BOX K

Evidence that visual impairment increases the risk of injury

- The likelihood of a fall related injury to those with reduced visual acuity is between 1.3 to 3.0 times more likely than to non-visually impaired populations (Ref. 43).
- The chances of a hip fracture are between 1.5 and 2.4 times greater for those with reduced visual acuity (Ref. 44).
- The chances of a hip fracture for those with poor depth perception or self-reported poor vision are 6.0 and 1.4 greater respectively (Ref. 44).
- The chances of a child with visual impairment suffering a pedestrian injury is 4.0 greater than for normally sighted children (Ref. 45).

104. The cost of shortcomings in these services is felt in other parts of the NHS. In 1999, there were 190,000 A&E attendances resulting from falls by people with a visual impairment. The associated cost to hospitals of these falls was £270 million. Of these falls, 89 per cent and the majority of the costs occurred in those aged 75 years or more. Nearly one-half of the falls (90,000) happened as a direct result of visual impairment, at a cost of £130 million (Ref. 46). Therefore, targeting the three-quarters of the visually impaired population whose condition is treatable needs to form a key element in commissioners' strategies to achieve the targets for reducing falls, as set out in the NSF for Older People.

Summary

105. Taken together, the work undertaken by various user groups since the publication of *Fully Equipped* illustrates serious shortcomings in many aspects of equipment services. Further evidence of problems comes from a dossier of users' complaints and concerns compiled by the Audit Commission since publication of the report. Aside from a clear sense of deep-seated anger about their personal experience of the quality of the service that they received, three common themes run through the letters. In a sense they summarise the future challenges for equipment services:

- users want to be much more closely involved in decision-making about the services that they receive, and they want to be provided with more choice;
- public agencies need to be willing to work in partnership with users, with charities and with private sector suppliers (for example, there is evidence that some NHS services are not willing to work with charities); and
- the cost of inadequate equipment services falls on other parts of the public services at much higher cost because of falls, failed rehabilitation, and loss of independence.

4

Good practice in equipment services

106. Relatively little in the way of good practice was identified in the local audits. This is not surprising, since auditors usually concentrate their efforts on services where there are perceived risks. However, some organisations have responded positively to the publication of *Fully Equipped* in the following service areas:

- orthotics;
- prosthetics;
- wheelchairs and specialist posture services;
- community equipment; and
- audiology.

Orthotics services

107. A project at the Royal National Orthopaedic Hospital is seeking to modernise orthotics services with the introduction of computer-aided design and manufacturing (CAD/CAM) [BOX 1].

108. A further example of innovative practice is found at East Lancashire NHS Trust, where the trust has included two users on the panel that is responsible for re-specifying and tendering the orthotics service in Blackburn and Burnley. The procurement manager believes that they have brought a unique perspective to specifying the new service and the tendering process.

Prosthetics services

109. North Bristol NHS Trust has signed a ten-year contract to provide a fully integrated prosthetic and orthotic service with the clinical hub at Southmead Hospital, with clinics running in premises owned by local PCTs. This arrangement is to be underpinned by:

- deployment of dual-qualified orthotists/prosthetists (at a junior level);
- an IT system that provides:
 - a single patient file that can be used by all service providers with online access from satellite clinics;
 - tracking of hardware that has been issued; and
 - an appointments system that can be accessed by the patient transport service.
- continual professional development for all orthotists/prosthetists, supported by the employer – each prosthetist/orthotist has one day per month allocated for activities to achieve individual training objectives (agreed jointly between the trust and the contractor).

BOX L

Using CAD/CAM in orthotics services

Fully Equipped described the current practice in the measurement and manufacture of made-to-measure orthotic shoes: an orthotist measures the patient's foot; the measurements are sent to a manufacturer who interprets the orthotist's instructions to make a laste for the shoe; a sole and uppers are made; the shoe is sent to the orthotist, who tests the shoe on the patient for fitting; the shoe is invariably returned to the manufacturer for adjustments to be made, and so on.

This antiquated process represents high cost and poor quality. It has several shortcomings: several appointments have to be made for the patient; research at the Royal National Orthopaedic Hospital has found that orthotists' accuracy in measuring the patient's foot is often wrong by +/- 4mm; there are long delays while the shoes are sent between various parties; and overall the process is far too long (this is particularly a problem for children whose feet are still growing, or for people with degenerative conditions).

The process can be radically improved. The patient can be seen by the orthotist, who marks on the foot where support is needed; an accurate measurement of the foot is taken using digital cameras; CAM systems make the laste to form the base of the shoe, while the patient chooses a pattern and colour of shoe. Leather is cut using the dimensions taken by the cameras. The shoe is then assembled. The whole process takes ten hours, rather than ten weeks.

The time spent on the production of the shoe is halved; more importantly the shoe could, in most cases, be produced on the same day for outpatients instead of over ten weeks.

The first obstacle to introducing such technology is that the business case for capital investment (about £200,000) looks weak when matched against the number of people who benefit (about 24 pairs of orthopaedic shoes are made per month, but the benefit would be considerable if demand could be aggregated). In order to fund the project, the trust proposes to obtain money from the DTI, and use the equipment to make bespoke shoes for the general public in partnership with a commercial supplier.

There is also the possibility of using the technology for prosthetic and wheelchair services so that as much as possible is gained from the technology.

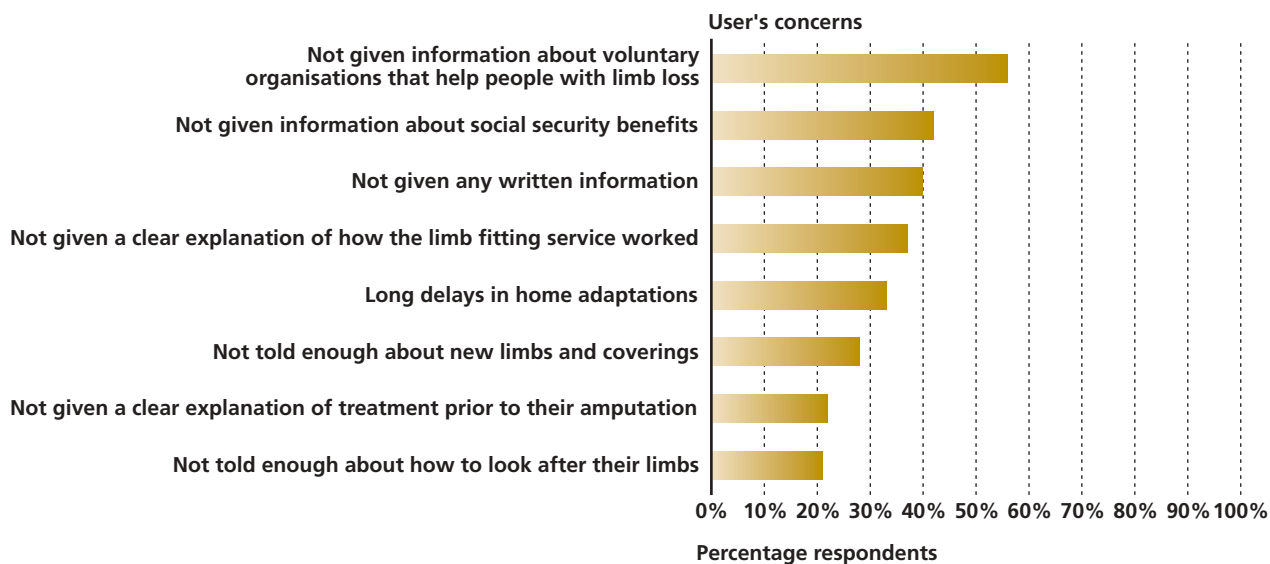
Source: Audit Commission

110. *Fully Equipped* reported on a survey of 2,300 users of the prosthetics service. After comfort and cosmetic appearance, the two most common concerns raised by users were firstly, that they were not given information about voluntary organisations that help limbless people; and secondly, the fact that they were not given information about social security benefits [EXHIBIT 14, overleaf]. Some may feel that these are not services that the NHS should provide. However, not only is this a major issue in terms of social exclusion, but access to benefits can also be the key to managing and enhancing independence and therefore reducing healthcare costs. North Bristol NHS Trust, for example, employs a Welfare Rights Officer to tackle these concerns.

EXHIBIT 14

User satisfaction with the prosthetics service

Users would welcome better information on a variety of their needs.



Note: Response rate = 64 per cent.

Source: *Quality Health surveys, February 1999, N=2,300*

111. The Prosthetic Strategic Supply Group, facilitated by PASA, has undertaken further important work. The group has issued commissioning guidance in the form of an integrated clinical pathway for amputees from initial consideration of amputation through to continuing care and review in the community. The document identifies the elements of each stage of the process; the parties involved; the key objectives for clinical audit purposes, and finally the pertinent questions to ask of the service at each stage.¹

112. The DH has also issued guidelines to commissioners covering the Assessment and Provision of Equipment for People with Complex Physical Disabilities. This definition is one of the first 23 specialised services to be covered by the National Specialised Services Definition Set, published in December 2001. More than 500 people (clinicians, hospital managers, finance and information staff, and commissioners) were directly involved in working group meetings, and many more provided comments during the consultation stages over the year. Many of the definitions have been endorsed by the relevant national organisations.

¹ Further information is available at www.pasa.doh.gov.uk/rehabilitation/

113. The definitions identify the activity that should be regarded as specialised and therefore subject to any arrangements that are in place for the commissioning of specialised services. The definitions provide a helpful basis for service reviews and strategic planning, and enable commissioners to establish a broad baseline position and make initial comparisons on activity and expenditure.¹

Wheelchair and specialist posture services

114. Auditors identified several examples of good practice [BOX M].

¹ Further information is available at www.doh.gov.uk/specialisedservicesdefinitions/5disequip.htm

BOX M

Good practice in wheelchair and specialist posture services

Greenwich Primary Care Trust and the London Borough of Greenwich operate a joint seating assessment service to provide a holistic assessment of seating/posture and positioning for children with complex disabilities. The assessment process covers the child's 24-hour seating and postural needs – both mobile and static. The approach involves collaborative working, not only interdisciplinary but also interagency, and includes the child/young adult, their family and carers in all decisions. Timely and cost-effective provision focusing on evidence-based practice and the latest up-to-date equipment are paramount to the aims of the clinic.

The Centre for Disability Research and Innovation (CDRI), which is a University College, London academic department based at the Royal National Orthopaedic Hospital NHS Trust (RNOH), has reviewed the current provision of specialist wheelchair services.

A project compared what can be provided in a needs-led, client-driven programme with what is actually provided by the current NHS system within current resource constraints for 50 people with complex disabilities. There was concern that clinical judgements and the information provided to users in NHS wheelchair services were mitigated by financial constraints, and that individual service users were not given all of the information available about technologies that could help them to achieve their mobility, seating and positioning goals.

With funding from the National Lottery Charities Board, research has been conducted into the gap between public provision in specialist wheelchair services and the solutions acceptable to each individual. Details of the cases were posted on a secure access internet site and comments invited from an international multi-disciplinary group of experts in the field about the proposed seating and mobility solutions for each individual. The project found the average cost of current service provision to be three times less than the optimum.

In some cases the gap has been filled by money from charities or from the individual or their family. A colloquium, 'The Way Forward – establishing principles for provision of seating and mobility' held at the RNOH in October 2001 set out agreed principles for the delivery of specialist seating services. These are useful building blocks for the development of good practice in commissioning improved services. The principles can be found at http://www.cdri.ucl.ac.uk/web_page/presentation_files/Presentations_cdri.htm

Source: Centre for Disability Research and Innovation

Community equipment services

115. Auditors identified several examples of good practice in community equipment services [BOX N].

BOX N

Good practice in community equipment services

Bradford Hospitals NHS Trust has established an equipment library, attached to the physiotherapy department, to provide people who are leaving hospital with simple aids to walking. Electronic tagging and bar-coding of equipment is used and helps to achieve a 90 per cent recycling rate.

Several authorities have established rapid response teams (or community rehabilitation teams) comprising OTs, physiotherapists, social workers, nurses and rehabilitation assistants. These services focus attention on 'fast-tracking' people out of acute hospitals, providing them with timely and high-quality discharges from hospital. Halton Borough Council, in partnership with the local health community, has established a rapid access rehabilitation service whose key role is active intervention to improve levels of independence; prevent inappropriate admissions to hospital, residential homes or nursing homes; and speed-up hospital discharge.

Northamptonshire social services, the NHS and the voluntary sector have developed the *Safe at Home* project to enable older people with dementia to live in their own homes for longer. The key drivers behind the project have been:

- maintaining the independence of older people with dementia who may not be receiving 'direct' social services but whose independence is important both to them and to their carers; and
- developing preventative services in response to the rising costs of residential care, nursing care or hospital admission.

The project aims to maintain independence by installing a range of technology such as alarms, detectors and fall monitors in older peoples' homes, as well as by building on to existing community alarm systems. Such equipment is low cost – on average £242 per person.

The project has produced a number of benefits:

- it supported and maintained the independence of the users in their own homes and avoided the additional confusion of moving house;
- it also reduced carers' concerns about the safety of the user in their own home; maintaining and supporting carers has become an increasingly important element of the project;
- analysis with a comparator group identified that initial care package costs were slightly higher for the *Safe at Home* group; however, over the subsequent 12 months costs increased by 59 per cent for the comparator group and by only 47 per cent for the *Safe at Home* group;
- based on the 18 people in the *Safe at Home* scheme, total savings of £68,000 over 12 months were possible, based on costs within the comparator group, through reduction in the demand for residential care, nursing care or hospital care.

The project is now being rolled out into other areas of Northamptonshire and will be extended by enabling a wider range of healthcare professionals to refer into the service. Although the work has focused on people with dementia, it could also be applied to any groups with cognitive impairment.

Source: Audit Commission

116. Auditors identified several lessons for success in community equipment services that need to be implemented at a local level [BOX 0].

BOX 0

Lessons for success

Local action	Why
Establish cross-agency consensus.	A process of consensus-building across agencies provides a unifying force and establishes a clear baseline position. Providers need to have an equal role in influencing investment.
Provide executive control and leadership.	Involving directors is key to both top-level buy-in and to implementation. It has an important legitimising effect on the development of partnership and on the promotion of cross-agency consensus.
Project manage the partnership process.	Identify a dedicated management agent for joint commissioning as a precursor to the future ability to pool budgets along the lines proposed in <i>Partnership in Action</i> .
Differentiate between strategic and operational roles.	Need to differentiate between a strategic decision-making body and an operational group that takes responsibility for day-to-day operations and the development of the joint service. The strategic group, comprising programme directors and executives from the funding agencies, work at the boundary between the client-based programme and the wider executive to ensure that strategic priorities are addressed.
Work within existing legislative frameworks.	Need to develop partnership approaches within recognised boundaries. Partnership arrangements should acknowledge and work within existing structures and the statutory duties of partner agencies.
Adopt flexible structures for client-based programmes.	Different models and degrees of joint commissioning are needed in order to meet the needs of different service users.
Promote the concept of integrated care.	Develop clear joint messages on the principles and priorities of partnership working – for example, a statement of principles signed by all parties.
Invest in communication arrangements.	Improve communication mechanisms between the central executive body and the various professions and staff to promote joint working.
Overcome entrenched cultural attitudes.	Identify champions within partner agencies, who are respected by their peers and are able to promote partnership working.
Develop partnership as 'core' business.	Effective partnership working is central to the delivery of organisational objectives – not an optional 'add-on'.
Seek to secure long-term funding and agree funding arrangements.	Need to be clear about the nature of mainstream or external funding. Partnership arrangements need to include: <ul style="list-style-type: none"> • how much each partner will contribute; • how much variation from year to year will be acceptable; • how much variation in year is acceptable; • how the partners plan to keep to the budget; how underspends or savings will be managed; • monitoring arrangements in terms of the nature, timing and recipients of service and financial management information; and • details of contracts that the partnership enters into for the delivery of services.
Support the process of change.	Identify problems with the existing skill mix in order to implement integrated care approaches and to develop staff training programmes to improve skill mix.

Source: Audit Commission

Audiology

117. Auditors identified several concrete examples of good practice in audiology services [BOX P].

BOX P

Good practice in audiology services

Barnsley's audiology services have three open sessions a week where patients can attend without an appointment. The trust is planning additional staff hours to prepare for the introduction of digital aids and for further improvements to the service.

East Kent has set up a Joint Policy and Planning Board of Physical and Sensory Disabilities to develop a framework, to implement Kent's *To Be Heard* strategy on services for people in Kent and Medway who are deaf or hard of hearing.

South Essex has a one-stop-shop, a dedicated hearing aid clinic, where patients can access a hearing test, medical assessment and, if required, referral for impression all at the same appointment. The trust is also developing direct referral and commissioning of digital hearing aids.

Source: Local audits

5

Conclusions, next steps and recommendations

Conclusions

118. The value of any study is not the publicity generated but the action that results. Judged by this criterion, it is plain that *Fully Equipped* has, so far, been of limited value to users of equipment services. Its recommendations have yet to be fully implemented (Appendix 1), leaving many equipment services unable to breakout of a vicious circle [EXHIBIT 15].

119. While there are some encouraging signs of progress in audiology and community equipment services, there has been little progress in improving mobility services. In particular, the hub-and-spoke model of service provision recommended by the British Society for Rehabilitation Medicine is not widely developed; and nor has there been much progress towards the integration of the orthotics and prosthetics service, recommended by the 1992 Bowker report (Ref. 47) and reiterated in *Fully Equipped*. All of the major prosthetic service companies now offer fully integrated prosthetic and orthotic services, so the constraint on progress is with commissioners, not with the industry.

EXHIBIT 15

The vicious circle of equipment services

Equipment services are locked in a vicious circle.



Source: Audit Commission

...the UK lacks a national focus on services that are designed to support independence...

120. It is hard systematically to compare and contrast the three mobility services examined in the performance audits (orthotics, prosthetics and wheelchair services). Nevertheless, the overall impression of the audits – and a view confirmed by the senior auditors responsible for co-ordinating reviews across several organisations – is that the prosthetics service probably emerged as the most effective of the three mobility services. In general terms, prosthetics services usually had the clearest sense of organisational direction, reasonable management information and the necessary scale of operation.

121. These impressions, however subjective, confirm the view expressed in *Fully Equipped* that prosthetics services that are shown to be delivering high-quality services should, wherever practically possible, be established as the hubs of a hub-and-spoke model. They should be commissioned to provide support to local orthotics and wheelchair services. These larger centres could become centres of excellence and could develop university affiliations with access to academic and technical facilities. The DH and commissioners should specify services that drive such a reorganisation forward, taking full advantage of the opportunities afforded by information technology, telecare opportunities, and clinical networks.

122. Users of the prosthetics service, however, sound a cautionary note to this proposal, warning that ‘the most likely outcome will be a levelling off achieved by levelling down prosthetics and levelling up the other services. Any deterioration would be impossible to audit. This would be extremely undesirable for existing and future prosthetics users’. There is also anecdotal evidence that smaller centres are often better at customer care.

123. A further general conclusion concerns scale: the least critical audit reports were made in the larger centres of operation, whether in mobility or in community equipment services. Community equipment services that served whole counties appear to have the necessary scale to provide the necessary leadership, management information and logistics capability. Larger rehabilitation centres were also found to result in increased efficiency and economies of scale.

124. It is also clear that the UK lacks a national focus on services that are designed to support independence, such as is available in Scandinavia and the USA. The DH should therefore consider sponsoring a national organisation to bring all stakeholders together to promote shared learning, improve standards and establish collaborative practice in services designed to promote independence. Such a body would contribute to establishing national standards and competencies, as well as examining important issues, such as the health economics arguments underpinning these services.

Next steps

125. The way that equipment services are organised remains fragmented, rather than being a modern integrated service fit for the 21st Century. But the current low priority given to equipment services will need to change because of simple demographics: between 1995 and 2025 the number of people over the age of 80 will increase by half, while the number of those living beyond 90 years of age will double (Ref. 7). New technologies and increasing demands from service users should also force the pace of change in the long term.

126. More immediately, the priorities and planning framework and health authority revenue resource limits for 2002/03 contain three inter-related priorities: improving emergency services, reducing waiting times and increasing capacity.¹ Equipment services have a major role to play in delivering all of these objectives both by preventing admissions to hospital and supporting prompt discharges. Research at one hospital by the Audit Commission found that of 100 emergency admissions to medical wards, 47 had been preceded by a fall at home, and delays to 14 per cent of hospital discharges were attributed to delays in providing community equipment services (Ref. 1).

127. Specific targets include reducing the number of acute beds blocked that are by delayed discharge by 20 per cent by March 2003, compared with April 2002. Social services received earmarked funding of £100m in 2001/02 (LAC 2001/34) and £200m in 2002/03 to reduce delayed discharges. Community equipment services in particular are a vital part of any strategy to achieve this target.

128. The audits confirmed that commissioning of services is a key weakness that needs to be tackled to break out of the vicious circle. The Audit Commission therefore proposes to carry out further work in this area and to provide guidance to social services, PCTs and strategic health authorities on the commissioning of equipment services. The work will examine how the commissioning of equipment services fits into wider healthcare and social policy objectives; and will emphasise the health economics case for investing in equipment services. The work will also explore options for developing alternative models of service delivery, including making more effective use of Public:Private Partnerships, direct payments and voucher schemes.

129. Tackling the problems of equipment services is about much more than getting better value from these services. It is also about tackling the isolation and social exclusion that many vulnerable people suffer. On average, people with disabilities are poorer than other people (Ref. 1), and patients from deprived backgrounds have less access to healthcare than people from more affluent areas (Refs 48, 49). Following discussions with service users about the Commission's future proposals for work in this area, one user summed up the change in approach and attitudes that is needed:

¹ Further information is available at www.doh.gov.uk/nhsplanimpprogramme.htm

“Ultimately, improved commissioning, based partly on health economics, is key to blowing apart the mindset that has ruined disabled people’s life chances for decades since the creation of the welfare state. Somehow disabled people are seen as parasites, even if deserving. But that’s got to change if the progress in education, employment and independence foreshadowed by the Disability Discrimination Act is to be realised – and the financial benefits with it.”

Additional recommendations of this report

130. In addition to the outstanding recommendations of *Fully Equipped*, further action is required. A major review of current policy, strategy and operational delivery is needed both centrally and locally in order to reinvigorate the wider independence agenda [EXHIBIT 16].

EXHIBIT 16

Recommendations of this report

A major review of current policy, strategy and operational delivery is needed to energise the wider independence agenda.



Source: Audit Commission

Appendix 1

The implementation of *Fully Equipped's* recommendations

This appendix reproduces the recommendations of *Fully Equipped* and comments on auditors' findings and current issues (paragraph numbers refer to paragraph numbers in the original report).

Specific recommendations for orthotics services

Recommendation	Current position / Progress reported by auditors
Managers need to ensure that their trust chooses a model of orthotics provision that is rationally based, and has sufficient throughput to ensure a high-quality service. Stand-alone orthotics services dealing with fewer than 150 patients a week are probably too small to be viable, both in terms of quality and cost (paragraph 15).	Little progress is reported – success in this area is dependent on the adoption of hub-and-spoke models of provision and on the integration of orthotic services into the wider mobility services.
Trust managers should review the scope for allowing more direct access for GPs and paramedical staff to orthotic services. Referral should be based on protocols that define the complexity of the clinical problem (paragraph 19).	Direct access is becoming more common, though it is by no means universal and could be extended significantly.
Clinical audit should be established throughout the orthotics service. Orthotists require access to, and should complete, medical notes (paragraph 23).	Auditors report very little progress. Commissioning standards need to specify and fund clinical audit. However, the PASA's standard specification does now include a requirement for clinical audit and research.
The services that are provided by surgical appliance officers (SAOs) should be reviewed to ensure that SAOs are adequately trained and supervised for any clinical work that they undertake (paragraph 26).	There is now widespread acceptance that SAOs should not be engaged in clinical activity, though auditors identified a few trusts where this is still common practice.
The provision of services that do not require the contribution of an orthotist – such as the supply of wigs, breast prostheses and burns garments – should be placed in a more appropriate service setting (paragraph 26).	There is general acceptance of this recommendation, though auditors identified a few trusts where these changes have yet to be made.
Clinicians, orthotists and managers should review current prescribing practice of orthopaedic footwear and aim to achieve a ratio of 75:25 respectively for adapted ready-made shoes and made-to-measure shoes (paragraphs 38, 39).	There is general acceptance of this recommendation, though judgement clearly has to be made on the basis of clinical need.
Trust managers should ensure adequate separation of duties where orthotists provide the services of both clinician and salesman (paragraphs 11 and 33).	There is general acceptance of this recommendation: auditors found few examples where this was now considered to be a major problem.
Trusts should use NHS Supplies' national framework agreements, unless they can clearly demonstrate that better value for money can be achieved by purchasing elsewhere (paragraph 41).	The PASA reports better compliance with contracts through the work of the Prosthetic Strategic Supply Group and the Orthotic Strategic Supply Group.

Specific recommendations for prosthetics services

Recommendation	Current position / Progress reported by auditors
Health authorities, working with referring clinicians, should agree criteria for access to specialist services (paragraph 52).	There has been little progress on the commissioning agenda.
Trusts should allocate, in consultation with users, a named prosthetist for each patient to manage treatment on a long-term basis. Appointments should then be arranged so that patients are able to see their named prosthetist (paragraph 53).	There is general acceptance that this is good practice, though users have emphasised that the quality of the outcome is more important than the process by which it is achieved.
Trusts must ensure that they report all product failures and adverse incidents to the Medical Devices Agency (paragraph 54).	Auditors report continued variation in practice in reporting.
Trusts should establish annual fee contracts for prosthetic repairs (paragraph 57).	Annual fee contracts are becoming more common, based on a standard PASA specification.
Health authorities, in conjunction with local trusts, should review their policies towards the provision of spare artificial limbs. Once an adequate repair service is established, the provision of a second limb for adults should be limited to the provision of specialist sports or swimming limbs (paragraph 58).	Judgement needs to be made on the basis of individual need – trusts should not fetter discretion in applying policies and many users will reasonably require a second limb.

Specific recommendations for wheelchair and seating services

Recommendation	Current position / Progress reported by auditors
Wheelchair service centres should arrange to assess most users at clinics that are close to the user's home, but they should ensure that the minority of cases that require more detailed assessment have access to multidisciplinary expertise (paragraphs 70 and 71).	This requires the development of hub-and-spoke models of provision and effective commissioning of services.
Health authorities, in conjunction with local trusts, should review all aspects of their current service standards for delivering wheelchair and special seating services and introduce proposals to deliver incremental quality improvement programmes and achieve current upper-quartile performance levels (paragraphs 74, 81).	Auditors report little progress, which is dependent on more effective commissioning.
Wheelchair service centres should introduce systematic reassessment programmes for all users (paragraph 79).	Auditors report little progress, which is largely dependent on funding for staffing and for replacement wheelchairs.
Wheelchair service centres should establish contracts with a limited number of approved suppliers that provide for integrated stock records, consignment stocking, and bar-coding (paragraphs 87 and 90).	Auditors report significant problems in some contractors' performance. All contractors should be required to provide integrated stock records and bar-coding.

Specific recommendations for community equipment services

Recommendation	Current position / Progress reported by auditors
Health authorities and local authorities should agree and publish local charters in consultation with users and carers, setting out standards for a range of long-term care services. These should include standards for equipment services, with target times for assessment and delivery, and standards for providing information about services (paragraph 96).	Subsumed within DH guidance to trusts and social services stating that single assessment arrangements (NSF for Older People) and integrated community equipment services (HSC 2001/08 and LAC (2001)/13 are to be introduced).
NHS trusts and local authorities should review the quality of their community equipment services in the light of guidance from the Disabled Living Centres Council (paragraph 103).	This is being pursued by the work of the DH Implementation Team and the Disabled Living Centres Council.
NHS trusts and local authorities should establish joint community equipment services and stores (paragraphs 106, 108).	DH guidance has been issued to trusts and social services stating that integrated community equipment services are to be provided by 2004.
A recommended formula should be agreed between the NHS Executive and the Local Government Association for the respective contributions of the NHS and local authorities towards joint community equipment stores (paragraph 108).	No progress. DH guidance suggests that this should be resolved locally but this is proving to be a major obstacle to progress. This issue is being pursued by the work of the DH Implementation Team.
Trusts should use NHS Supplies' national framework agreements for supplying community equipment, unless they are convinced of, and can demonstrate that they can achieve, better value for money elsewhere (paragraph 110).	The PASA report improved compliance.
The NHS PASA's remit should be extended to enable social services authorities that run joint equipment stores to purchase community equipment through national contracts (paragraph 110).	The PASA currently has no legal framework to widen access for existing contracts. However, the new PASA contract which incorporates pressure area care products, wheelchair cushions and mattresses, and is due to commence in October 2002, will allow access by both NHS and social care bodies.
Loan store managers should place a premium on the recycling of equipment, concentrating their efforts on the recycling of high-value items, and should aim to recycle 70 per cent of items by value (paragraphs 117, 118, 119, 121).	Auditors report steady improvement in this area.
Agreement should be reached between the NHS Executive, the Local Government Association and HM Customs and Excise regarding the application of VAT to community equipment services (paragraph 122).	Guidance has now been issued by the DH, though local difficulties are common.

Specific recommendations for audiology services

Recommendation	Current position / Progress reported by auditors
To reduce waiting times, health authorities should ensure that there are mechanisms in place to allow direct referral from GPs to hearing aid centres. They should also ensure that the capacity of the hearing aid clinics is adequate to manage an increased workload and range of tasks (paragraph 130).	The RNID's publication <i>Still Waiting to Hear</i> reports increasing delays and increased numbers of people waiting for referrals.
The sites selected for the ministerial study should publish and disseminate their quality standards and methods of working (paragraph 135).	Likely to be available upon completion of the evaluation in 2003.
The current investigations into the provision of improved hearing aids should attempt to compare the opportunity cost of providing better hearing aids against the current cost to society of the isolation experienced by deaf and hard-of-hearing people. (paragraph 135).	NICE's review recommended that audiologists spend more time with patients; that investment in new technology (not necessarily digital) takes; and the use of binaural aids. The review did not undertake an opportunity cost review, as recommended by the Audit Commission. Implementation may be jeopardised by a shortage of qualified audiologists.
Health authorities, in conjunction with local trusts, should review their current service standards for the delivery of audiology services and deliver quality improvements to achieve current upper-quartile performance levels (paragraph 135).	Auditors report little progress – dependent on more effective commissioning and funding.
Health authorities and social services authorities should establish joint audiology services to combine the provision of hearing aids and rehabilitation services with environmental listening devices (paragraph 137).	Auditors report little progress.

Recommendations for the Department of Health and the Welsh Assembly government

Recommendation	Current position / Progress reported by auditors
The DH should make specific reference to the provision of equipment in the National Priorities Guidance. Specific reference should be included in the NSF for Older People. The Welsh Assembly Government should undertake a similar policy review (paragraphs 80, 145).	National Priorities Guidance is based on the NHS Plan and the NSF for Older People, which make little direct reference to equipment services.
These policy reviews should be underpinned by using the National Patients' Survey specifically to seek the views of equipment users and their carers (paragraph 78).	Little progress.
Examples of good practice and service standards should be prepared and disseminated by professional groups, in concert with user groups, as the basis for enhancing local services (paragraphs 80, 96, 144).	Some progress in the prosthetics service and community equipment service. The DLCC is gathering examples of good practice in community equipment services.
NHS Supplies' and the Welsh Assembly Government should establish an effective partnership with the supply industry aimed at increasing the level of investment in research and development where needed (paragraph 152).	Little progress.

General recommendations for Commissioners

Recommendation	Current position / Progress reported by auditors
<p>Health authorities should supplement the National Patients Survey by undertaking their own surveys that seek and act upon the views of users and their carers. These should be reflected explicitly in service specifications in all equipment services (paragraphs 30, 77).</p>	<p>Auditors report little progress.</p>
<p>Health authorities, in conjunction with regional offices of the NHS Executive and the Welsh Assembly Government, should review, in consultation with social services, the current provision of equipment services within their areas. Where necessary, they should reorganise and consolidate services to provide specialist multidisciplinary centres which integrate the specialist provision of orthotics, prosthetics and wheelchair services. These specialist centres should operate a 'hub-and-spoke' model of provision, taking responsibility for providing specialist support and professional leadership, including clinical audit, to satellite services. Existing tertiary prosthetics centres should assume responsibility for local orthotics and wheelchair services (paragraphs 17, 27, 150).</p>	<p>Auditors report little progress.</p> <p>Requires co-ordination across existing health authority boundaries.</p> <p>Requires co-ordination by Strategic Health Authorities.</p>
<p>Health authorities should ensure that fast-track protocols are established to ensure that users with complex needs are referred to specialist centres (paragraph 52).</p>	<p>Auditors report little progress on the development of protocols. Dependent on the establishment of 'hub-and-spoke' systems of care.</p>
<p>Health and social services authorities should ensure that the totality of users' needs are met by ensuring that there are referral mechanisms in place to provide comprehensive packages of care (paragraphs 83, 97, 100, 101).</p>	<p>There are still major practical problems associated with achieving integrated services.</p>

General recommendations for NHS trusts and social services

Recommendation	Current position / Progress reported by auditors
Trust boards/social services committees should review the management of their equipment services ensure that they are clinically led and that there are managers of adequate calibre directly accountable for service performance (paragraph 148).	Auditors report variable progress.
Trust boards/social services committees should ensure that equipment services are included within integrated strategies for risk management, infection control and adverse incident reporting (paragraph 148).	Auditors report little integration and often poor compliance with the Controls Assurance Framework.
Trust boards/social services committees should ensure that equipment services are adequately funded to meet legislation on lifting and handling and CE marking (paragraph 148).	Auditors report progress in terms of awareness, but funding provision is often inadequate to meet legislative requirements.
Service managers should ensure that product ranges are standardised (as far as appropriate, given the need to offer user choice) to permit the aggregation of demand for product ranges into properly negotiated contracts (paragraphs 33, 84,111).	Auditors report some local progress.
Trust boards should ensure that the supplies procurement aspects of their equipment services are incorporated within a trust's overall supply strategy, ensuring that the strategy meets the requirements of HSC 99/143 (paragraph 149).	There has been significant progress in reporting supplies procurement strategies to trust boards. However, auditors report that equipment services do not commonly feature in work plans to deliver the strategy.
Service managers should ensure that, within the framework of the overall IT strategy, there are adequate information systems to support all aspects of the equipment services.	Auditors report increased use of bespoke packages and the use of databases that are improving this aspect of management.
Such systems should record all aspects of patient treatment equipment issues, stores management maintenance requirements, tracking and recycling (paragraphs 88, 89, 90, 116).	Auditors report the adoption of bespoke packages and an increase in the use of databases are improving this aspect of management.
Service managers should review and eliminate the potential conflicts of interest that arise when commercial suppliers discharge the services of both clinician and salesman (paragraphs 11, 85).	Auditors report that this problem is largely addressed.
Managers should ensure that in-house services offer best value by market testing or benchmarking the services (paragraphs 36, 41).	Little systematic review of models of service provision.
Trusts need to organise user involvement to ensure feedback on the quality of equipment to suppliers and to the MDA if appropriate (paragraph 54).	Little evidence of this recommendation being implemented.

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