Any Qualified Provider

Implementing Choice in Wheelchair Services

Guidance notes for commissioners

North Bristol NHS
NHS Trust

Royal Devon and Exeter NHS
NHS Foundation Trust

Dorset HealthCare University NHS
NHS Foundation Trust

NHS
Gloucestershire
Gloucestershire Care Services

NHS
Wiltshire Community Health Services

Introduction:

This document is an attempt by existing service providers across the South West to provide some advice and guidance for lead commissioners in their area as they consider the implementation and expansion of the Any Qualified Provider initiative for Wheelchair Services. The information given below is designed to provide an informed, but unbiased, perspective on some of the issues that commissioners may need to consider as they develop plans to extend patient choice across Wheelchair Services.

If there is a suggestion that the guidance or advice is defensive or protectionist; that is very much not the intention. As the current providers of this service, we feel we understand the issues that need to be resolved if patient choice is to be extended into a competitive marketplace.

It is absolutely fair to suggest that a number of the issues raised may contradict recommendations that have or may emerge from the Department of Health as part of the implementation plans. However the advice, guidance or statements are provided in good faith from a consortium of your existing service providers who have a genuine belief in the services that we are delivering and a desire to ensure that patients continue to receive the highest level of service at an affordable price to the NHS.

This is not intended to be an exhaustive summary of all of the concerns but, in many areas, a means of highlighting specific issues and where possible suggesting solutions.

We have not had the benefit of seeing the final draft of the implementation plans for either complex or non complex pathways and it may be that further redrafting of this statement will be necessary when those implementation plans are made public.

The report is split into sections dealing with various aspects of transition and the new service.

1. Overall Assumptions:

In considering the need for this advice we have had to make assumptions as to the reasons for the change. We all accept that there is scope to extend choice within wheelchair services but up until now have been subject to financial constraints. We have assumed that these constraints will remain in place in some shape or form but that choice will be extended potentially by further use of top up funding or vouchers. We assume that demand management will remain the responsibility and the requirement of the commissioners.

However, we have also assumed that the main driver for these changes has been to extend patient choice rather than to drive down price and we have assumed that tariffs will be in place for all aspects of the service so that patient choice can be solely based on clinical outcomes rather than financial advantages to individual providers or commissioners.

2. Model of Service

The Department of Health have indicated a preference for separating the **assessment** and **prescription** of equipment from the **procurement, issue** and **maintenance**. The Department of Health have suggested that this would offer financial advantages to the NHS overall by way of opening up a cheaper supply network. Thus far there we, as a group of providers, have seen no evidence that this would happen.

Clinicians working locally and nationally have expressed major reservations about the ability of a supplier to interpret anything other than basic prescriptions accurately due to clinical interpretation and the range of equipment that they can provide for anything other than a very basic wheelchair. This would only be guaranteed if the individual chair was specified including the fitting of any accessories or modifications such that it could be built from a prescription form. However, this would require the prescriber to identify the individual chair which then would appear to go against any choice for the user other than where they could buy this from. Essentially the user would buy the same chair from different suppliers.

We recommend consideration is given to offering competition for the **entire package of care** to ensure that the assessor is responsible both for the prescription and the meeting of that prescription as well as the ongoing consequences of that assessment and prescription. A single tariff would be paid for the episode to include ongoing maintenance until such time as the chair is unsuitable for repair or patients needs have significantly changed.

Duty of care

A process should be in place to ensure that patients' whose needs appear to change within a very short period of time are reviewed to see whether it was a wrong assessment and therefore should be replaced free of charge or whether it is a genuine deterioration in the condition that could not have been foreseen at the outset. This would mirror the current in-patient 30 day re-admission protocol.

It is assumed that further arrangements would need to be in place for patients who require a second assessment for whatever reason. This should therefore be a separate element of the overall tariff covering the assessment.

3. **Qualification of Providers:**

A key area for commissioners to consider is the process by which providers of these services are qualified. We would like to make some recommendations or observations here:

There is an assumption that all services will meet the same standards and will provide a full patient pathway. As mentioned, it is our recommendation that this pathway should be from referral to delivery of equipment and ongoing maintenance and support and therefore any prospective provider should be expected to demonstrate their ability to meet all aspects of that pathway.

It is assumed that commissioners will establish a process to evaluate whether potential providers have:

a. Clinical knowledge and skills to complete the assessment
b. The ability to monitor all equipment, including traceability
c. Have appropriate information and clinical governance

d. Demonstrate appropriate processes in place to provide a responsive, reliable maintenance service for all equipment they issue.
e. Have compatible systems to ensure there is adequate governance over the data stored on databases.
f. Prospective providers would need to be able to demonstrate that they will undertake assessments against agreed eligibility criteria. If commissioners wish to extend choice by removing the constraints of eligibility they need to be aware of the financial consequences of that.

4. Tariff Structure:

Early drafts of the DH implementation plan suggest a tariff structure. As provider organisations currently largely restricted by block contracts, we welcome this change.

Proposed tariffs

- Assessment
- Provision and ongoing support
- Assessment, provision and ongoing support

5. Points to consider:

a) Existing Clients – ongoing maintenance:

If it is to be assumed that the new model will include the ongoing **maintenance** of equipment, commissioners need to consider what systems are put in place to **maintain equipment on issue with existing patients**. For a period of time, and often for well over 5 years, equipment that has already been issued and which is supported by the NHS through existing services, will need to be maintained away from the new qualified provider network. Of course our recommendation would be that this should be contracted through existing services but either way commissioners need to have a plan in place. Using existing providers would ensure continuity for service users who know how to access services, and would ensure continuity of care.

b) Existing Clients – ongoing clinical support:

Furthermore, **existing users** will self refer back to wheelchair services for **reviews** of equipment currently on issue. For a period of time, many users will not require new equipment but will require adjustments, modifications or advice on existing equipment. Systems need to be in place to ensure that someone, and in fairness probably the **existing NHS services,** needs to remain in a position to support these users, with some sort of limited tariff. Again, this would reassure the current service users during this period of change and ensure on-going continuity of care until a new episode begins.

The alternative is that a new referral would be raised, the consequence being that new equipment is likely to be issued when it is not yet required, with ongoing modifications being more appropriate.

6. Special Seating & Complex Equipment:

The DH have estimated that this represents a very small percentage of existing service users but services across the South West would place this estimate as higher. The reality is that where a wheelchair needs to be individually specified, and then individually manufactured, it probably requires a complex assessment and further discussion on how to separate these services and commission them would be welcome.

7. Consideration of Processes:

It is worth understanding that the assessment and provision of the equipment represents the beginning of the pathway rather than the end. Most service users to whom wheelchairs are provided will need to access the repair service, which has already been mentioned. However, many clients will continue to need to contact the assessment service for advice on posture, supportive seating, pressure relief etc. Consideration needs to be given as to how this service is

provided and paid for. Commissioners will need to consider their definition of an episode of care.