

Wheelchair & Seating Services Modernisation Project

Standards and Eligibility Working Group

CLINICAL HEALTHCARE QUALITY STANDARDS FOR WHEELCHAIR & SEATING SERVICES

These standards were developed by the Wheelchair & Seating Services Eligibility and Standards Working Group as part of a modernisation project. The standards were developed in line with the principles used by Quality Improvement Scotland (QIS):

- adopt an open and inclusive process involving a wide range of both members of the public and professional people through a variety of mechanisms;
- work within NHS QIS policies and procedures; and
- test standards through undertaking pilot reviews to ensure that they meet the principles of NHS QIS.

It should be noted, however, that these standards are being issued as good practice recommendations rather than mandatory guidelines and should be used appropriately to support NHS Boards in improving services locally.

The Clinical Healthcare Quality Standards for Wheelchair & Seating Services should be read in conjunction with the Wheelchair & Seating Services Quality Improvement Framework

CLINICAL HEALTHCARE QUALITY STANDARDS

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1. Introduction

Wheelchair and seating provision affects quality of life, health and well-being and is important in facilitating social inclusion and improving life chances. Changes to mobility and posture bring challenges to people living with a variety of conditions and these can be life-long and life-limiting. These impairments impact on people's ability to lead active and full lives with dignity and autonomy. Wheelchairs and seating can enable greater activity, including wider participation in work, education and society as a whole, and produce health benefits (for both wheelchair users and their carers).

Wheelchair users are not a homogeneous group. They have a great variety of physical and sensory impairments, which along with other needs and expectations can be either stable or subject to change over time. They include:

- children who often need better integration between education, health and social work services,
- young people who make the transition out of children's services at a time when their wheelchair and seating becomes increasingly important for further education and employment,
- people who have an accident or who develop a progressive condition that now affects their mobility,
- people whose medical condition makes them vulnerable to skin damage and pressure sores, and
- older people who develop the need to use a wheelchair to provide mobility for longer distances, e.g. when outside the home.

Wheelchair users also have a wide variety of carers with different needs, capabilities and involvement, from parents and other family members to friends and neighbours.

NHS Scotland Wheelchair and Seating Services (WSSs) provide a broad range of wheelchairs and postural support equipment for people with widely varying complexities of need. They aim to provide a comprehensive service to people who have mobility impairments, including the consideration of function, posture, pressure relief and comfort. They support people's mobility and independent living to help enhance their and their carers' quality of life. They offer not only initial provision of the equipment, but ongoing support; in most cases for the lifetime of the user. Seating is provided to those who need additional support in their wheelchair due to postural instability or irregular body shape. Many wheelchair users, and especially those with special seating requirements, are effectively in a continuum of care that is punctuated by specific episodes of intervention.

WSSs work in collaboration with other, health and social work based, rehabilitation services to ensure that wheelchair mobility and postural needs are managed effectively as part of an integrated care management approach. It is essential that these services form an integral part of care pathways within and between agencies, to ensure the support they provide offers smooth and seamless provision for users and their carers.

In Scotland there are currently five WSS centres. These are located in Aberdeen (NHS Grampian), Dundee (NHS Tayside), Edinburgh (NHS Lothian), Glasgow (NHS Greater Glasgow and Clyde) and Inverness (NHS Highland). They provide specialist, integrated services for children and adults that includes specialist assessments, review, provision, follow up, maintenance and repairs, to people living in their own NHS Board area. Four of the centres also provide specialist services to other territorial NHS Boards.

2. Development

Background

The development of clinical healthcare quality standards for WSSs builds on the Scottish Government's (SG) previous work in this area. In 2005, a Steering Group was established, supported by the Scottish Executive Health Department and NHS Quality Improvement Scotland (QIS), to conduct an independent review of WSSs in Scotland. This culminated in the publication of the *Moving Forward* report in 2006 [1]. The report highlighted a chronic lack of profile and under-resourcing, set against a background of an increasing wheelchair user population and greater expectations. A situation reflected in other parts of the UK [2]. In response, the Scottish Government (SG) established the WSS Project Board to take forward the review's recommendations [3]. In 2009, the *Wheelchair and Seating Services Modernisation Action Plan* was published [4]. The *Action Plan* set out the direction of travel for the WSSs in Scotland over a 3-year period, forming a programme of service modernisation, intended to introduce service and practice change in keeping with the person-centred approach that is core to the SG's commitment to developing health services with users as partners.

Working Group

A Working Group was convened in January 2010 to develop the standards. When establishing the Working Group, the WSS Project Board ensured, where possible, representation was drawn from across Scotland and included as many healthcare professions as necessary. The group also included user, carer and voluntary sector representatives. All members were obliged to liaise regularly with the group(s) and/or organisation(s) that they represented; communicating updates, discussing points, canvassing views and feeding these back to the Working Group.

Dr Michael J. Dolan was recruited as a Clinical Advisor to lead the work of the group. Dr Dolan, a clinical scientist based in NHS Lothian, took up his post in February 2010. Mr Richard Hamer, Director of External Affairs, Capability Scotland, was appointed as Chair of the Working Group.

To support the Working Group and provide input from people with a broader range of knowledge and experience from across the UK, a Reference Group was recruited. Their remit was to sense check the standards and evaluation tool before publication.

The methodology employed to develop the standards is set out in Appendix A. The Working Group membership is set out in Appendix B.

Context

It was recognised that the development of clinical healthcare quality standards that are evidence-based and person-centred must be set within the context of the wider desire to provide a health service that is "safer, more reliable, more anticipatory and more integrated, as well as being quicker still" [5]. The SG's *Better Health, Better Care* report proposed the adoption of the Institute of Medicine's six *Dimensions of Quality* [6] as key to the systematic improvement of services. The dimensions are:

- **Person-centred:** providing care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions
- **Safe:** avoiding injuries to patients from care that is intended to help them
- **Effective:** providing services based on scientific knowledge

- **Efficient:** avoiding waste, including waste of equipment, supplies, ideas, and energy
- **Equitable:** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socioeconomic status
- **Timely:** reducing waits and sometimes harmful delays for both those who receive care and those who give care

Each criterion within the standards is applicable to at least one of these quality dimensions.

The SG's new *The Healthcare Quality Strategy for NHSScotland* [7] sets out the need to concentrate action and interventions on three of these dimensions:

- Put **people at the centre** of care and ensure that all staff, patients and carers can report that they are supported to work together in a relationship which recognises their needs and plans to deliver care to meet those needs
- Improve **clinical effectiveness**, with a focus on reducing unnecessary and harmful variation in the models and methods of delivering care and treatment, and on the standards of care for long-term conditions
- Improve **safety** throughout primary, community, and acute services, achieving significant reductions in mortality and adverse events

The SG's focus for action will be on these three key drivers, but there is a commitment to pursuing these in a way which ensures equity, efficiency and timely access.

Within the context of WSSs, the independent report, *Moving Forward* [1], established the need for improvements in services. The *Action Plan* [4] for service modernisation is being implemented by NHS Boards to ensure more integrated services are in place to meet the needs of wheelchair users and their carers. It identifies those areas of service delivery where improvement is needed and charges accountable NHS personnel with delivering the required changes. The standards are critical to supporting change and ensuring that improvements are sustained.

The Development of the Draft Clinical Standards and Evaluation Tool

Between February and April 2010, a scoping exercise was led by Dr Dolan. The purpose of this was to identify any quality gaps and make recommendations on how the process could be taken forward. The scoping exercise consisted of a review of the current research and clinical literature and other available evidence, including the *Moving Forward* report [1] and the *Wheelchair and Seating Services Modernisation Action Plan* [4]. Both these documents were produced following extensive consultation with wheelchair users and their carers, the voluntary sector and the wider public in Scotland.

The overall aim of the Working Group was to develop evidence-based standards that quality assure NHS Scotland WSSs. When developing the standards, the Working Group made the decision to focus on areas that would help improve the WSSs the most. A person-centred approach was used to identify themes and areas of concern. In particular the disabled person's journey through and with the service was employed and the supporting structures were considered.

An internal report summarising the scoping process and findings, was produced to inform the development of relevant standards and associated project management

processes. The report identified a number of areas for consideration and emerging themes. The report was used as a basis for the Working Group to develop the draft standards and the draft evaluation tool. During this time, members of the Reference Group were recruited to sense check the drafts before their publication.

Consultation and piloting

The Draft Clinical Standards and Evaluation Tool were published on 3rd December 2010 at the start of a 12 week long public consultation [8]. The purpose of this consultation was to secure the views of stakeholders and members of the public in advance of the final publication of the Standards and Evaluation Tool and to afford them the opportunity to influence the detail of the documents.

In addition, two NHS Boards (NHS Grampian and NHS Highland) were peer reviewed against the Draft Evaluation Tool in a pilot exercise in January 2011. The purpose of this was to test the measurability of the standards and identify possible sources of evidence to support compliance and to check how a review might work in practice (e.g. whether the right questions are being asked to the appropriate people).

Finalising the Standards and Evaluation Tool

A wide range of organisations and individuals responded to the Scottish Government consultation on the Draft Clinical Standards and Evaluation Tool for NHS Scotland WSSs. The majority of the responses were supportive, recognising the need to encourage and measure improvements, and highlighted the need for a consistent approach to the delivery of these services across Scotland. The consultation responses and a consultation analysis report have been published [9, 10].

The consultation responses were considered, along with the outcomes from the piloting of the Evaluation Tool, by the Working Group and, where appropriate, used to develop the final versions.

The final versions have been tailored to fit with a Healthcare Scrutiny Model that provides risk-based and proportionate scrutiny.

3. Scope

The standards apply to all territorial NHS Boards in Scotland, regardless of whether or not the board hosts a WSS centre. They apply to any care setting within an NHS Board where wheelchair services are provided including primary, secondary and tertiary care, and to anyone using the services regardless of a person's background or personal circumstances.

The following special health boards and non department public bodies will not be directly reviewed against the standards, but the development of the standards may have implications for them:

- Healthcare Improvement Scotland
- NHS 24
- NHS Education for Scotland
- NHS Health Scotland
- NHS National Services Scotland (in particular National Procurement and Information Services Division)

The standards are intended to support equity of service provision across the NHS in Scotland and the delivery of quality services for users and their carers. The standards are not intended to tell NHS Boards how to arrange services as each board will develop solutions according to its local circumstances. The standards, therefore, focus on outcomes rather than processes.

Clinical professions

The standards apply to all clinical professions involved in the care of people with mobility impairments that require the use a wheelchair within the NHS Boards specified above, but also those that may be employed in local authority social services or in the voluntary sector. This includes general practitioners, physicians, nurses, allied health professionals (AHPs) and healthcare scientists (HCSs).

Wider applicability

The standards have been developed for NHS Scotland WSSs within the context set out in Section 2. It is recognised that aspects of these standards may be applicable to services based in other parts of the UK and elsewhere. However, these standards are developed to apply to the policy context, model of service delivery and national healthcare in Scotland.

4. Clinical Healthcare Quality Standards

The first four standards relate to the disabled person's journey through and with the NHS WSS, whilst the latter one is concerned with the supporting mechanisms and structures that underpin their journey. The relationship between the first four standards and the clinical decision making and provision processes is illustrated in the diagram in Appendix C. High level pathways with the target times set out in the standards are given in Appendix D.

Standard 1: Assessment of mobility and mobility needs

Standard Statement
The clinical assessment of mobility and mobility needs should be person-centred.
Rationale
<p>The population of disabled people with mobility impairments that require wheelchairs is highly diverse with a great variety of physical and sensory impairments, which along with other needs and expectations can be either stable or subject to change over time. Mobility impairments are varied and wide-ranging in their complexity and associated issues and a wheelchair may only be part of a solution. A timely, person-centred assessment that is responsive to clinical needs and made within a framework of the Social Model of Disability is fundamental to ensuring that an individual's mobility needs are addressed.</p> <p>Disabled people may have carers who have different needs, capabilities and level of involvement. Assessments should cover the needs of carers with regular or substantial caring responsibility.</p> <p>Registered healthcare professionals assess mobility needs and identify or confirm the need for wheelchair assisted mobility, or a change to existing need. The initial assessment includes taking measurements and submitting a request for a wheelchair to be issued or for a specialist assessment. The initial assessor must be skilled in the assessment of mobility and mobility needs and aware of the range and type of wheelchair equipment available to meet the specific needs of the disabled person. Wheelchair need and provision should be recorded as part of the mobility assessment within the Single Shared Assessment (SSA) when the latter assessment is used.</p> <p>Children and young people are physically, mentally and socially distinct from their adult counterparts. The mobility impairments that they experience and the ways that certain illnesses and conditions can affect them are significantly different. Assessments of children and young people must be conducted by people trained in child development, employ multidisciplinary approaches and consider age-related transitions and educational needs.</p> <p>Accurate and clear information needs to be provided when wheelchair requests are made to ensure optimum outcomes and reduce unnecessary delays. Information governance and data protection standards, procedures and practises must be employed.</p>
References¹: 1, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

Essential Criteria	
No.	Criteria statement
1.1	Clinical assessments of mobility and mobility needs are person-centred and anticipatory.
1.2	Assessments are conducted in accordance with evidence-based national or local good practice guidelines, where these exist.

¹ See numbered references listed in Appendix I.

1.3	Assessments are conducted by competent, registered clinical staff ² .
1.4	Assessments of children and young people should also: <ul style="list-style-type: none"> • address physical and social development • consider age-related transitions from pre-school to school, primary to secondary education, youth to adult services.
1.5	Assessments should consider the needs of primary carers ³ .
1.6	Wheelchair need is recorded within the mobility section of the SSA when this assessment is used.
1.7	Referral forms (and supporting guidance) should conform to the recommended content and format (Appendix E) and be readily available.
1.8	Referral forms (and prescription forms if in use) can be submitted in a variety of formats, including electronically.

Desirable Criteria	
No.	Criteria statement
1.9	Any unmet mobility needs and/or any unresolved disagreements should be recorded.
1.10	Non-WSS Centre staff trained to an agreed level of competence should be able to directly prescribe from an agreed list of equipment.
1.11	Prescription forms (and supporting guidance) for use by non-WSS Centre staff should conform to the recommended content and format (Appendix E) and be readily available.

² Staff should have the level of knowledge, skills and experience appropriate to their role and be registered with the GMC, HPC or NMC.

³ Under the Community Care & Health (Scotland) Act 2002, carers have a legal right to a carer's assessment from their local authority and the NHS and local authorities have a duty to inform carers of their rights.

Standard 2: Specialist assessment

Standard Statement

The specialist assessment of wheelchair and seating needs should be person-centred, anticipatory and conducted in the context of a multidisciplinary team.

Rationale

Disabled people's mobility needs can be complex and diverse and referrals for specialist assessment need to be screened by registered healthcare staff trained to an agreed level of competence. To minimise adverse effects resulting from delays to assessment and subsequent provision, referrals should be screened, prioritised and subsequently actioned within reasonable timescales. If delays are anticipated, referrers and those referred should be advised so that they may take steps to take mitigating action.

A timely, comprehensive and person-centred assessment is fundamental to ensuring that outcomes are improved. Specialist assessments should be conducted in accordance with evidence-based good practice guidelines by competent, registered clinical staff in the context of a Multidisciplinary Team (MDT) approach. Specialist knowledge and skills are required to assess disabled people who have complex clinical needs and/or require additional or complex technological solutions to address their mobility and associated seating needs effectively.

Assessments must be outcome-focused with goals agreed with the disabled person, and, if relevant, a primary carer. These should be recorded and shared, and appropriate measures administered to evaluate the effectiveness of intervention.

Healthcare clinical staff who assess for wheelchair mobility must have access to the necessary equipment. This may include portable investigative resources to support assessment at home or in other community settings. Disabled people with specific and complex needs should be seen in suitable clinic facilities with access to appropriate assessment resources and skills.

People requiring complex equipment solutions and/or have complex needs should be managed collaboratively by relevant health and social care services using case management approaches. This ensures that an individual's wheelchair mobility and their carer's needs are managed appropriately in the most clinically effective and efficient way.

References: 2, 11, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31

Essential Criteria

No.	Criteria statement
2.1	Referrals for specialist assessment are screened by competent, registered clinical staff ⁴ .
2.2	Referrals for specialist assessment are prioritised in accordance with publicly available criteria based on clinical need.
2.3	Referrers and those referred are advised if a specialist assessment will not occur within 4 weeks of receipt of a referral.
2.4	Specialist assessments are conducted within 4 weeks of referral in at least 95% of cases and within 8 weeks for 100% of cases, in each major pathway through the services ⁵ .

⁴ Staff should have the level of knowledge, skills and experience appropriate to their role and be registered with the GMC, HPC or NMC.

⁵ All urgent cases should be within the lower target time. Times are from the point of receipt of a referral by the WSS that contains all essential information in accordance with Appendix E.

2.5	Specialist assessments are person-centred and anticipatory, and based on the factors listed in Appendix F.
2.6	Specialist assessments are conducted in accordance with evidence-based national or local good practice guidelines, where these exist.
2.7	Specialist assessments are conducted by competent, registered clinical staff ⁶ .
2.8	Appropriate measures ⁷ should be administered to evaluate the outcome of each intervention, covering both service users' and carers' needs.
2.9	Any unmet mobility needs and/or any unresolved disagreements should be recorded.
2.10	A written summary of the agreed specialist assessment outcome and prescription should be shared with users and, with their agreement, carers and other appropriate, interested parties ⁸ .
2.11	Clinic facilities should comply with the minimum requirements set out in Appendix G.
2.12	At least 85% of users should be seen within their own local NHS Board area subject to the availability of suitable clinic facilities (as set out in Appendix G).

⁶ Staff should have the level of knowledge, skills and experience appropriate to their role and be registered with the GMC, HPC or NMC.

⁷ Any outcome measures administered should be proportionate to the complexity of need and intervention.

⁸ For example, case/care manager, primary care services, paediatric and education services.

Standard 3: Clinical follow up and planned review

Standard Statement

Service users should be followed up after each significant clinical intervention and planned clinical reviews are offered to those who need one.

Rationale

To ensure that any significant clinical intervention meets the needs identified at an initial or specialist assessment, a follow up should be undertaken. This should be done as soon as the user and/or carer(s) have had adequate time to assess whether or not the equipment provided meets the agreed assessment outcome. This is the responsibility of the initial assessor who identified or confirmed the need for wheelchair assisted mobility or, when a specialist assessment has been undertaken, the specialist clinician responsible.

Wheelchair users have complex and changing needs caused by their underlying medical condition(s) and other health or social factors. Some users may require periodic, planned reviews to ensure that any changes in their impairment(s) or circumstances, that could be reasonably anticipated, can be addressed in a timely manner.

Children also have rapidly changing needs as they grow and develop, both physically and cognitively. Developmental needs can be adversely affected if a child does not have the right wheelchair and seating provision. Services need to anticipate and plan for growth and changes in body shape, as well as transitions through the education, health and social care systems.

The frequency of review should be determined individually to minimise any potential negative impact on user's educational, vocational, health or social care arrangements. The progressive nature of their underlying medical condition(s), planned medical or surgical interventions, child development and growth, planned transitions or changes to domestic, vocational or social care arrangements should be taken into account when determining review periods.

Existing users, and/or their family and carers, should be aware of how they can request a clinical review should their current wheelchair and/or seating provision no longer meet their mobility or postural support needs.

References: 1, 7, 11, 12, 14, 18, 25, 26, 31, 32, 33

Essential Criteria

No.	Criteria statement
3.1	Significant clinical interventions are followed up to ensure that these meet the agreed outcomes identified at an initial or subsequent assessment.
3.2	Planned clinical reviews are offered to all users identified as having complex and changing needs, including: <ul style="list-style-type: none"> • those with progressive conditions • children (< 16 years old) • those with anticipated transitions • those with anticipated changes to their domestic, vocational or social care arrangements.

3.3	<p>The frequency of review will be agreed with the user taking into account, where appropriate:</p> <ul style="list-style-type: none"> • progression of condition • children’s physical and social development • planned transitions or changes to domestic, vocational or social care arrangements.
3.4	<p>Existing NHS wheelchair users, family and carers (where appropriate), are aware of how they can request a clinical review.</p>

Standard 4: Equipment provision and management

Standard Statement

Wheelchairs, seating and associated equipment are medical devices and should be safe and fit for purpose and provided in a timely manner in accordance with risk management principles.

Rationale

Wheelchairs, seating and associated equipment are Class I medical devices and must comply with the Medical Devices Regulations (MDR) (2002) as regulated by the Medicines and Healthcare products Regulatory Agency (MHRA). Any risks associated with the equipment provision should be minimised. Adverse incidents, problems (or the potential for problems) should be managed in accordance with Medical Device Alert (MDA) recommendations.

Provision should be conducted by or overseen by a competent, registered clinical staff member who is responsible for managing the case and acts as the contact person for the disabled person and/or their carers. The time from assessment to provision should be minimised to avoid the need for reassessment should needs change in the meantime (e.g. due to children growing).

The introduction of new product lines and technologies to NHS provision must involve wheelchair users and be objectively evaluated to ensure that they fulfil their intended purpose from both clinical and device management perspectives. Their introduction should be managed to ensure that adequate spares are stocked and that they can be maintained and repaired. A planned approach to ensuring wheelchair and seating equipment responds to user needs and advancing technology must be in place.

The modification of CE-marked medical devices, in-house manufacturing and off-label use of devices to meet particularly needs are subject to the requirements of the MDR. A risk assessment, which is necessary to minimise any potential hazards, should be conducted in accordance with the International Standards Organization's (ISO) risk management standard (ISO14971).

The provision, and updating, of instructions, and if necessary training, that takes into account the knowledge and training of the intended user(s), is crucial to the safe and effective use of equipment. Adequate instructions, and if necessary training, should be provided to new and existing users and/or carers. These should, as a minimum, cover how to report faults and adverse incidents, how to carry out routine checks and basic maintenance, and general wheelchair management, such as how to negotiate kerbs.

Maintenance and repair policies and procedures should ensure user safety and continuity of care using a risk management approach. The frequency and type of planned preventive maintenance (PPM) should be specified, taking account of the manufacturer's instructions, the expected usage and the environment in which the equipment is to be used.

References: 11, 12, 25, 26, 34, 35, 36, 37, 38, 39, 40, 41

Essential Criteria

No.	Criteria statement
4.1	Provision of devices to individuals is conducted by or overseen by competent, registered clinical staff ⁹ .
4.2	Standard provision, for which a specialist assessment was not required, is provided within 2 weeks of referral in at least 95% of cases and within 3 weeks for 100% of cases.

⁹ Staff should have the level of knowledge, skills and experience appropriate to their role and be registered with the GMC, HPC or NMC.

4.3	Standard provision, for which a specialist assessment was undertaken, is provided within 6 weeks of referral in at least 95% of cases and within 11 weeks for 100% of cases.
4.4	Specialist provision is provided within 14 weeks of referral in at least 95% of cases and within 18 weeks for 100% of cases.
4.5	Services should adhere to local equipment management policies and procedures that are based on a risk management approach and conform to MHRA guidance.
4.6	In-house manufacturing and off-label use of devices should be in accordance with the MDR, including design and risk assessments records.
4.7	NHS wheelchairs are provided from national contract in accordance with policy and legislative requirements.
4.8	A model of equipment renewal is in place that responds to technological advances and involves users and carers.
4.9	New product lines should only be introduced with adequate staff training.
4.10	Adequate instructions, and if necessary training, should be provided for all devices in accordance with MHRA guidance.
4.11	Adequate instructions, and if necessary training, should be provided on using wheelchairs and/or equipment for new and existing users and/or carers.
4.12	Users and carers have information on how to report faults and adverse incidents, carry out routine checks and basic maintenance, and on the potential danger of inappropriate modifications or adjustments.
4.13	Repairs are prioritised and completed in accordance with publicly available criteria and targets.
4.14	Planned Preventative Maintenance (PPM) is undertaken based on a risk management approach that conforms to MHRA guidance.
4.15	Services should adhere to MHRA adverse incident guidance on the reporting of incidents and responding to alerts.
4.16	All service users with equipment on issue are contacted at least annually.
4.17	Urgent ¹⁰ repairs should be completed within one day in at least 75% of cases.
4.18	Routine repairs should be completed within five days in at least 90% of cases.
4.19	Deliveries, repairs and PPM appointments are arranged at times to suit user's lifestyles as far as it is practical.

Note on Criteria 4.2, 4.3 & 4.4

All urgent cases should be within the lower target time. Times are from the point of receipt of a referral by the WSS that contains all essential information in accordance with Appendix E.

Note on Criteria 4.17 & 4.18

The targets given are calendar days, not working days.

¹⁰ Defined in Appendix J.

Standard 5: Quality management and service improvement

Standard Statement

Services should, in partnership with all stakeholders, create and sustain a culture of continuous quality improvement to deliver a person-centred, clinically effective and safe service.

Rationale

Better outcomes are achieved when services are provided in partnership with users, carers and staff. Clinical governance, evidence-based practice and quality assurance underpin person-centred, safe and effective service provision. Surveys of user and carer satisfaction can provide valuable insights to improve provision and outcomes.

Quality Management Systems (QMSs) imbed quality assurance and encourage service improvement. These should conform to an internationally recognised standard for the providers of medical devices, for example, ISO13485. QMSs should be integral to the day-to-day policies and procedures and culture of the service. This ensures that services are safe and effective and able to respond to the ever changing and challenging external environment.

Leadership, user, carer and staff involvement and on-going, focused initiatives are critical to achieving and sustaining service and quality improvements. Staff training and education and adherence to evidence-based clinical practice are an underlying necessity. Research and development not only furthers the knowledge of the field, but is also a means of motivating and developing staff. Safety is a key driver of service change and development.

The recording and sharing of outcomes from quality improvement, product evaluation and research and development activities promote further improvements and spreading of best practice. Collating and reporting unmet needs supports this endeavour.

References: 1, 7, 15, 39, 42, 43, 44, 45, 46, 47, 48

Essential Criteria

No.	Criteria statement
5.1	NHS Boards should integrate or link their local wheelchair user and carer groups or networks with their Patient Focus Public Involvement (PFPI) structures and processes.
5.2	Services should commission an independent survey of users at least once every two years to check their and their carers' satisfaction with the service provided and how well their equipment meets their needs.
5.3	Information made available to users and carers should comply with the Scottish Accessible Information Forum's (SAIF) standards and be provided in alternative formats consistent with equality and diversity duties.
5.4	Information (as outlined in Appendix H) should be readily available to disabled people, their families and carers, and other interested stakeholders.
5.5	Each territorial NHS Board should have an identified and active strategic lead with a responsibility for WSSs.
5.6	A comprehensive QMS should be in place that drives continuous service improvement.
5.7	Each WSS should identify lead roles for quality and service improvement.
5.8	Each WSS should identify lead roles for product evaluation, research and development.
5.9	WSSs should report on their quality improvement, product evaluation and research and development activity.

5.10	Records of unmet needs should be collated and reported on annually.
5.11	All staff should undergo wheelchair and seating specific induction training appropriate to their role.

Desirable Criteria	
No.	Criteria statement
5.12	QMSs should conform to an internationally recognised standard.
5.13	Outcomes from quality improvement, product evaluation and research and development events and activities should be shared with other Scottish services and the wider field.

Appendix A: Standards development methodology

The methodology employed by the WSS Standards & Eligibility Working Group to develop these standards was based on that developed by NHS QIS¹¹. The NHS QIS methodology has been developed over a number of years and has resulted in the publication of clinical standards covering many different aspects of healthcare in Scotland. It was adapted to suit the purposes and timescales of the project.

Basic principles

The standards have been developed in partnership with healthcare professionals, the voluntary sector and users and carers. The Working Group has endeavoured to ensure that consideration of equality and diversity issues featured prominently in the development of the standards and that they were developed in accordance with the commitments of the *National Health Service Reform (Scotland) Act (2004)* that states that 'individual patients receive the service they need in the way most appropriate to their personal circumstances and all policy and service developments are shown not to disadvantage any of the people they serve'.

Standards format and definition of terminology

The standards are designed to be clear and measurable, based on appropriate evidence, and written to take into account other recognised standards and clinical guidelines. Each standard has a title that summarises the area on which that standard focuses. This is followed by the standard statement, which explains the level of performance to be achieved. The rationale section provides the reasons why the standard is considered to be important. The references are listed in order of citation and year of publication. The numbers refer to the listing in Appendix I.

The standard statement is expanded in the section headed criteria that states exactly what must be achieved for the standard to be reached. Some criteria are essential, in that it is expected that they will be met wherever a service is provided. Other criteria are desirable in that they are being met in some parts of the service, and demonstrate levels of quality that other providers of a similar service should strive to achieve. The criteria are numbered for the sole reason of making the document easier to work with, particularly for the assessment process. The numbering is not a reflection of priority.

Evaluation tool

The Evaluation Tool has been developed in parallel with the standards and consulted upon as part of the standards development process. It includes guidance on how it can be completed. By completing all areas of the tool, service providers will be able to identify priority areas for improvement and development, highlight areas of good practise, and determine if the standards have been met.

Clinical governance and risk management standards

Every individual using healthcare services should expect these to be safe and effective. There are existing NHS QIS Standards for Clinical Governance and Risk Management [15] to ensure NHS Boards can provide assurance that clinical governance and risk management arrangements are in place, and that they are supporting the delivery of safe, effective, person-centred care and services. These standards underpin all care and services delivered by the NHS in Scotland and provide the context within which NHS QIS service and condition-specific standards apply.

¹¹ NHS QIS is now part of Healthcare Improvement Scotland.

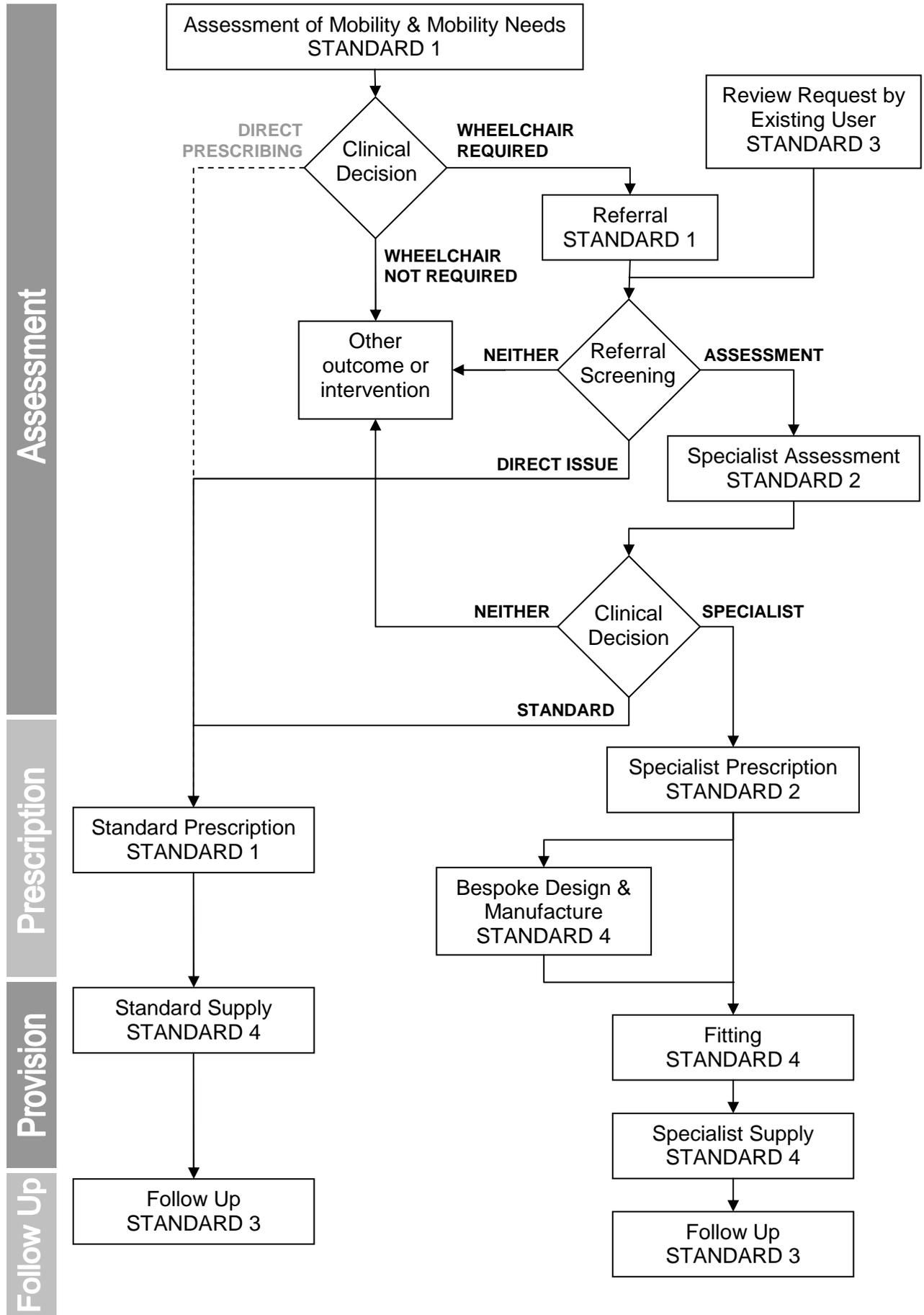
Appendix B: Working Group membership

The members of the WSS Standards & Eligibility Working Group during the development of the standards were as follows.

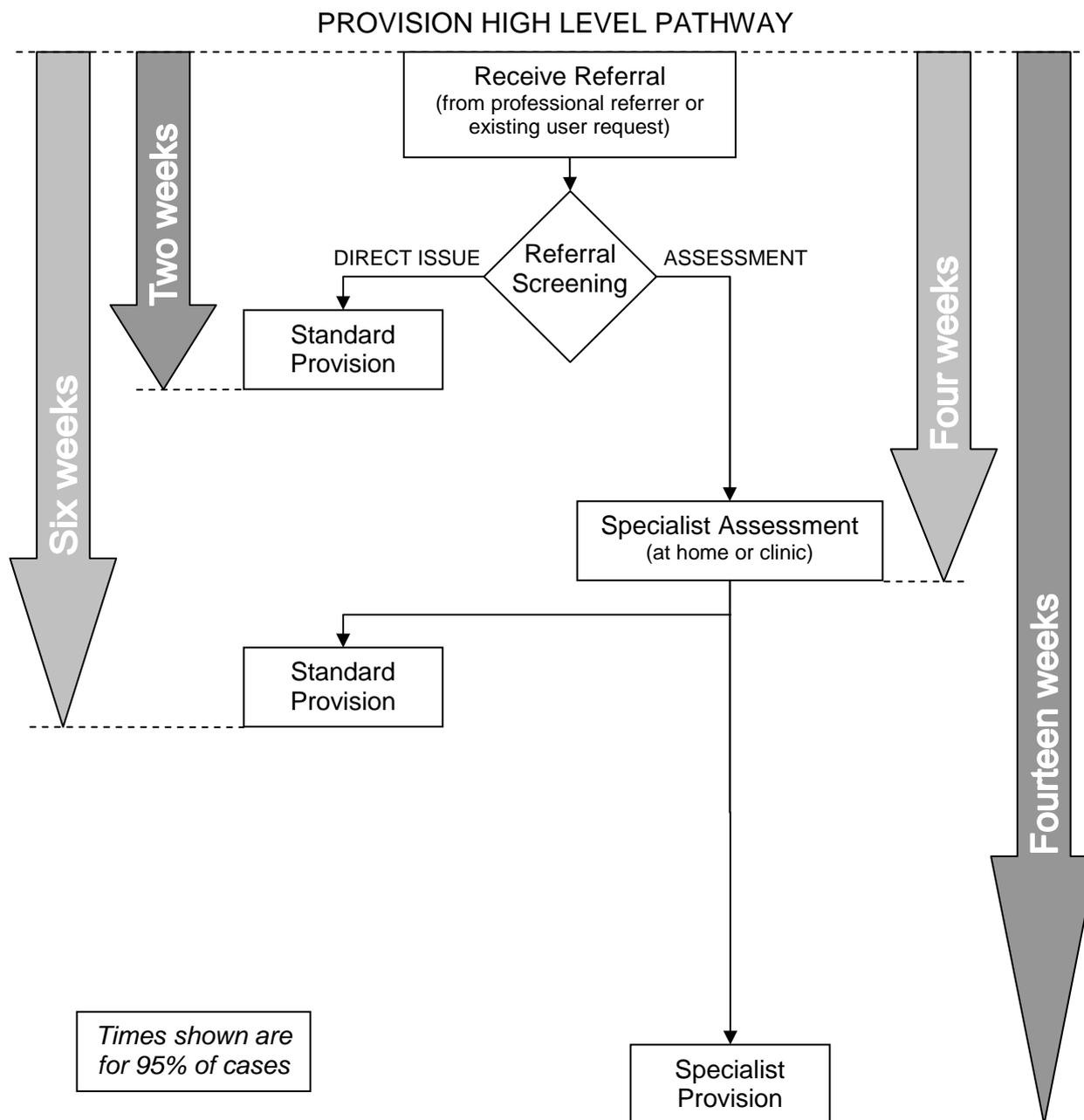
Mr Richard Hamer	Director of External Affairs, Capability Scotland - <i>Chair</i>
Dr Michael Dolan	WSS Clinical Advisor, Health & Healthcare Improvement Directorate, Scottish Government
Mrs Isobel Allan	<i>Representing users and carers [from June 2010]</i>
Ms Jane Arroll	Lead on Shared Assessment & Review, Equipment and Adaptations, Health & Healthcare Improvement Directorate, Scottish Government <i>[until August 2010]</i>
Mrs Amanda Beech	<i>Representing users and carers</i>
Mr John Colvin	Head of Service, WestMARC, NHS Greater Glasgow and Clyde - <i>Representing the Scottish Health Sciences Forum</i>
Mrs Catherine Dowell	Head of Mobility, SMART Centre, NHS Lothian - <i>Representing Centre Managers</i>
Ms Hazel Dykes	Associate Director AHP, NHS Dumfries and Galloway - <i>Representing the WSS Project Board</i>
Ms Clare Echlin	Acting Head of Standards Development, NHS Quality Improvement Scotland
Mr Steven Fenocchi	Policy Manager, Health & Healthcare Improvement Directorate, Scottish Government <i>[from April to August 2010]</i>
Janet Garcia	WSS National Project Manager, Health & Healthcare Improvement Directorate, Scottish Government
Ms Susan Gold	Head Occupational Therapist, WestMARC, NHS Greater Glasgow and Clyde - <i>Representing the Allied Health Professions Forum</i>
Ms Dawn Kofie	Policy Manager, Health & Healthcare Improvement Directorate, Scottish Government <i>[until March 2010]</i>
Mrs Elizabeth Porterfield	Head of Strategy and Planning, Health & Healthcare Improvement Directorate, Scottish Government <i>[from April 2010]</i>
Ms Jessie Roberts	Senior Co-ordinator, PAMIS
Mrs Muriel Williams	<i>Representing users and carers</i>
Mr Graham Wood	WSS Project Officer, Health & Healthcare Improvement Directorate, Scottish Government <i>[until March 2011]</i>

The Working Group acknowledges the input from the members of the Reference Group who commented on the draft versions. In particular, the group would like to thank Professor Andrew Frank, Kevin McGoldrick and Dr Chris Roy.

Appendix C: Relationship between standards and clinical decision making and provision processes



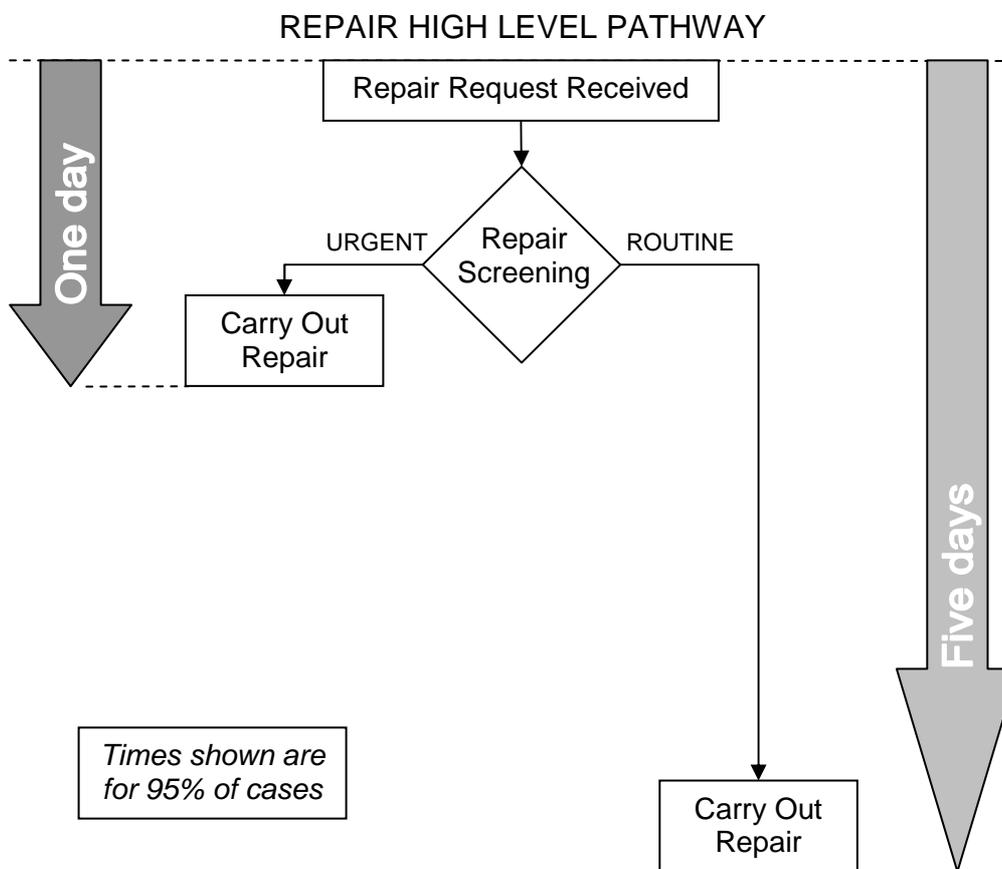
Appendix D: High level pathways with target times



Essential Criteria	
No.	Criteria statement
2.4	Specialist assessments are conducted within 4 weeks of referral in at least 95% of cases and within 8 weeks for 100% of cases, in each major pathway through the services.
4.2	Standard provision, for which a specialist assessment was not required, is provided within 2 weeks of referral in 95% of cases and within 3 weeks for 100% of cases.
4.3	Standard provision, for which a specialist assessment was undertaken, is provided within 6 weeks of referral in at least 95% of cases and within 11 weeks for 100% of cases.
4.4	Specialist provision is provided within 14 weeks of referral in at least 95% of cases and within 18 weeks for 100% of cases.

Note on Criteria 2.4, 4.2, 4.3 & 4.4

All urgent cases should be within the lower target time. Times are from the point of receipt of a referral by the WSS that contains all essential information in accordance with Appendix E.



Essential Criteria	
No.	Criteria statement
4.17	Urgent repairs should be completed within one day in at least 75% of cases.
4.18	Routine repairs should be completed within five days in at least 90% of cases.

Note on Criteria 4.17 & 4.18

The targets given are calendar days, not working days.

See 'Repair' definition in Appendix J for the distinction between routine and urgent repairs.

Appendix E: Referral and prescription form requirements

Referral and prescription forms should request the following, essential information:

- patient's full name
- Community Health Index (CHI) number or, if not available, date of birth (DOB)
- sex
- diagnosis and other relevant clinical information¹²
- residential address¹³ and telephone number(s)
- name and contact details¹⁴ of GP/GP practice
- name, profession and contact details of referrer
- reason for referral and summary of mobility needs
- weight, height and other anthropomorphic measurements
- environmental and life-style considerations

Forms received that do not have all the essential information provided may result in delays to assessment and/or provision.

Referral and prescription forms should request the following, desirable information:

- name, profession and contact details of any other relevant professionals involved
- name and contact details of case/care manager
- name and contacts details of day centre/residential centre/work
- name, contact details and relevant needs of main carer(s)
- parental and/or caring responsibilities
- transfer requirements
- anticipated changes/transitions
- details of requested equipment
- delivery preferences for equipment (e.g. alternative address)
- assessment preferences (e.g. location and availability)
- any prioritising factors, whether clinical or social/personal
- whether or not patient is aware of referral
- whether or not patient has agreed that referral information can be passed to other agencies

Format and other guidance

1. Referral and prescription forms should be clear and specific.
2. Essential information should be highlighted.
3. Supporting guidance should be readily available to referrers/prescribers to enable them to complete the forms correctly.
4. All forms and supporting information should clearly state that referrers/prescribers will be responsible for any delays resulting from incomplete and/or incorrectly completed forms, and not the supplier of the equipment or specialist centre/service.
5. All data collected and recorded should be consistent with the data definitions and standards set out in the national *Health and Social Care Data Dictionary* [49].

¹² For example, hearing/visual/communication ability, previous/planned medical or surgical information, medication, alcohol and drug use, skin care/pressure sore problems, descriptions of fixed deformities, limitations in ranges of joint motion and abnormal muscle tone.

¹³ Including postcode for all required addresses.

¹⁴ Including full address and telephone number(s).

Appendix F: Specialist assessment factors

The following factors should be considered during specialist assessments:

- diagnosis, status and progression of condition(s)
- any planned medical intervention(s)
- physical function and posture
- cognitive and sensory abilities
- pressure care and tissue viability
- challenging behaviour if relevant
- relevant daily living activities¹⁵
- Augmentative and Alternative Communication (AAC) needs¹⁶
- Electronic Assistive Technology (EAT)¹⁷ needs
- parental and/or caring responsibilities of the person being assessed
- domestic and other accessed environments
- transfer needs in the different settings where the wheelchair will be used
- impact of the wheelchair on continence care routines or management
- continuity of healthcare during health and/or social service transitions
- vehicular transport arrangements
- level of dependency on others in daily living
- care package
- carer profile and requirements
- strengths, goals and aspirations
- need for informed consent

In addition, for children and young people, the following factors should also be considered:

- physical and social development
- age-related transitions from pre-school to school, primary to secondary education, and youth to adult health and social services

¹⁵ Such as getting out of and in to bed, dressing, toileting, washing, eating, operating household appliances, etc.

¹⁶ For example, use of communication aids.

¹⁷ For example, the use of special switches to control a powered wheelchair, or the need for integrated control systems.

Appendix G: Clinic facilities

All clinic facilities should be fully accessible to people with mobility and/or sensory impairments and provided in accordance with the Disability Discrimination Act 2005, the Disability Equality Duty and current Building Regulations. Further information on ensuring that premises are accessible for disabled people can be found in the SAIF's *Standards for Disability Information and Advice Provision in Scotland* [50] and the British Standards Institution's (BSI) Code of Practice on the *Design of Buildings and their Approaches to Meet the Needs of Disabled People* [51].

The minimum facilities and/or equipment that should be available at each type of clinic location are listed below.

Temporary clinics held in schools, day centres or similar:

- private, dedicated space for the duration of the clinic
- a separate reception/waiting area
- a wheelchair accessible toilet
- patient handling equipment (e.g. hoists, slings and plinths)
- a pressure mapping kit*
- wheelchair accessible weighing scales*

Satellite clinics, in addition to that listed above:

- space to accommodate 6 people and equipment
- access to local transportation systems
- designated disabled parking nearby
- available ambulance transportation
- access to food and beverages
- information on the service available to take away
- a range of assessment wheelchairs
- a range of assessment base cushions
- a range of postural supports and seating systems
- access to workshop space to allow for simple repair and modification of equipment

Main centres, in addition to that listed above:

- nursing cover
- wheelchair accessible toilet with changing facilities¹⁸
- child friendly facilities, including a safe play area for waiting children
- access to a range of ground surfaces, ramps, kerbs, floorings
- access to a workshop for modifying and repairing equipment with technical staff available

* Investigative resources may be kept at a clinic location or portable devices taken to the clinic when in use.

¹⁸ For example, in accordance with the 'Changing Places' standards [52].

Appendix H: Public information requirements

The following information, as a minimum, should be made be readily available to disabled people, their families and carers, and other interested stakeholders (in accordance with Criterion 5.4):

- opening times for services and clinic facilities
- how to contact services
- how to request a clinical review (as Criterion 3.4)
- how to request a repair
- how to make a complaint or appeal a decision
- directions and public transport links to clinic facilities
- how to contact local wheelchair user and/or carer groups and/or networks
- timescales for assessments and repairs
- referral forms and supporting guidance (as Criterion 1.7)
- the criteria used to prioritise referrals for specialist assessment (as Criterion 2.2)
- how to report faults and adverse incidents (as Criterion 4.12)
- how to carry out routine checks and basic maintenance (as Criterion 4.12)
- the potential danger of inappropriate modifications or adjustments (as Criterion 4.12)
- the criteria used to prioritise repairs (as Criterion 4.13)
- the procedures for PPM
- the service's performance against the Essential Criterion 2.4, 4.2, 4.3, 4.4, 4.17 and 4.18

This information should comply with the Scottish Accessible Information Forum's (SAIF) standards and be provided in alternative formats consistent with equality and diversity duties (in accordance with Criterion 5.3).

Appendix I: Evidence base

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Appendix J: Glossary

Anticipatory approach

Identifying and addressing potential problems before they occur.

Assessment

The process of measuring a person's needs or the quality of an activity, service or organisation.

Carer

A person who looks after relatives, partners or friends in need of help because of age, physical or learning disabilities or illness on a voluntary, unpaid basis.

Case management

A collaborative process of assessment, planning, facilitation and advocacy to meet individual needs to promote quality cost-effective outcomes.

Clinical effectiveness

The extent to which specific clinical interventions do what they are intended to do, i.e. maintain and improve health, securing the greatest possible health gain from the available resources.

Clinical follow up

The task of checking that a significant clinical intervention resulted in the outcome expected. This task may be delegated to non-clinical staff who are able to pass on issues that require clinical knowledge to the clinician responsible.

Clinical intervention

An intervention carried out to improve, maintain or assess the health and/or needs of a person in a clinical situation. A significant clinical intervention in the context of clinical follow up (Standard 3) is one that would be reasonably expected to have the potential for consequences that are not immediately apparent at the time of the intervention and for which further intervention might be required.

Clinical governance

The system through which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services and safeguarding high standards of care and services.

Clinical review

Any assessment undertaken after a first assessment. These can be planned or unplanned.

Clinician

Any healthcare member of staff, e.g. doctor, HCS, nurse, AHP, who is involved in diagnosing and/or treating patients.

Equipment

Any device, whether acquired commercially off-the-shelf, modified or customised. Standard equipment can be used to meet non-complex needs and does not need to be

adapted for the individual, though there may need to be slight adjustments (e.g. the height of wheelchair footplates). Specialist equipment will usually require a specialist assessment and will need to be uniquely specified and sourced for an individual. Specialist equipment may need to be individually adjusted and modified and/or designed and manufactured.

Initial assessor

The person who undertakes the initial assessment that identifies or confirms the need for wheelchair mobility. They must be skilled in the assessment of mobility and mobility needs and aware of the range and type of wheelchair equipment available to meet the specific needs of the disabled person. The initial assessment includes taking measurements and submitting a request for a wheelchair to be issued or for a specialist assessment.

Medical device

An instrument, apparatus, appliance, material or other article, whether used alone or in combination, together with any software necessary for its proper application, which is intended by the manufacturer to be used for medical purposes, such as the diagnosis, monitoring, treatment, alleviation of, or compensation for, an injury or physical impairment.

Multidisciplinary Team (MDT)

A group of people, including NHS, community care and local authority staff, who work together to provide care for patients.

Outcome

The end result of a system, process or care, treatment and/or rehabilitation.

Outcome measure

A measure of the quality of healthcare. It is a measure of change, the difference from one point in time (usually before an intervention) to another point in time (usually following an intervention). An outcome measure should be standardised, with explicit instructions for administration and scoring.

Planned Preventive Maintenance (PPM)

The correction or prevention of faults by a programme of servicing, inspection and replacement of parts carried out at fixed intervals by appropriately trained and qualified staff, in order to keep a medical device performing as intended by the manufacturer.

Provision

The supply of a wheelchair and/or seating equipment. Standard provision is the supply of standard equipment that does not require clinical involvement beyond the prescription stage. This can occur after referral screening (direct issue) or, occasionally, after a specialist assessment. Specialist provision is the supply of specialist equipment usually after a specialist assessment. It will require additional clinical involvement beyond the prescription stage, e.g. a fitting appointment. Depending on individual's needs, an identical piece of standard equipment could be supplied via either route.

Repair

The restoration of a device to correct working order, after it has either broken down or stopped working properly. In the context of this document, repairs are classified as

being either urgent or routine. A repair is urgent when a wheelchair and/or seating is/are not safe to use and the user is dependent on it. Any other repair is routine. A repair that would normally be classified as urgent may be classified as routine when the user needs their device only occasionally. An urgent repair may result in a follow up routine repair or provision, when a temporary alternative device is provided that is safe to use.

Risk management

The systematic identification, evaluation and treatment of risk. It is a continuous process with the aim of reducing risk to organisations and individuals alike.

Single Shared Assessment (SSA)

The SSA is for people with community care needs seeking help from social work, health or housing authorities, and who may require the services of more than one professional discipline or agency.

Seating

Seating provides postural support to a wheelchair occupant who, due to irregular body shape or instability, needs additional support in order to function. Seating is made up of postural support devices that are attached to a wheelchair, which have surfaces that are in contact the occupant's body and are used to either modify or accommodate the occupant's sitting posture. For example, a seat, back support, lateral trunk support, and head support are all postural support devices. In the context of this document, seating refers only to that provided in a wheelchair and does not cover seating provided in static chairs.

Social Model of Disability (SMD)

The SMD provides a framework for assessment of mobility and makes an important distinction between 'impairment' and 'disability'. It suggests that many problems faced by people with impairments are caused by the way society is organised rather than the impairments themselves. It provides an alternate way of understanding access issues and social exclusion and sees the problem as a 'disabling world'. The model explores why society does not treat all its members as equal. The International Classification of Function developed by the World Health Organisation uses the distinctions identified in the SMD as its base.

Wheelchair

A wheelchair is a medical device with a seating support surface and wheels that provides wheeled mobility for people with impaired mobility. A walker with wheels is not a wheelchair as it does not provide wheeled mobility, but provides support to a person while walking. In the context of this document, wheelchairs are also deemed to include children's buggies/pushchairs. A manual wheelchair requires the occupant or an attendant to propel the wheelchair. A powerchair (or electrically powered wheelchair) generally has an electric motor that propels the wheelchair and is controlled by the occupant or an attendant.

WSS Centre

A WSS Centre is a central NHS resource where people can have specialist assessment and fitting for wheelchairs and wheelchair seating systems. These centres also manage the provision and delivery of the equipment and operate repairs and maintenance services for the NHS wheelchairs they provide.

Appendix K: Abbreviations

AAC	Augmentative and Alternative Communication
AHP	Allied Health Professional
BS	British Standard
BSI	British Standard Institution
CHI	Community Health Index
CHQS	Clinical Healthcare Quality Standards
DOB	Date of Birth
EAT	Electronic Assistive Technology
GMC	General Medical Council
GP	General Practitioner
HCS	Healthcare Scientist
HPC	Health Professions Council
ISO	International Standards Organization
MDA	Medical Device Alert
MDR	Medical Devices Regulations
MDT	Multidisciplinary Team
MHRA	Medicines and Healthcare products Regulatory Agency
NES	NHS Education for Scotland
NHS	National Health Service
NMC	Nursing and Midwifery Council
NP	National Procurement
NSS	National Services Scotland
PCR	Planned Clinical Review
PFPI	Patient Focus Public Involvement
PPM	Planned Preventive Maintenance
QIS	Quality Improvement Scotland
QMS	Quality Management System
SAIF	Scottish Accessible Information Forum
SG	Scottish Government
SSA	Single Shared Assessment
WSS	Wheelchair and Seating Service