

# Out and about

Wheelchairs as part of a whole-systems  
approach to independence

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Out and About**Author** Care Services Improvement Partnership**Publication Date** 20th October 2006**Target Audience** PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, PCT PEC Chairs, NHS Trust Board Chairs, Directors of Finance, Allied Health Professionals, GPs, Directors of Social Services, Directors of Childrens Services, Commissioners and Managers of Wheelchair Services**Circulation List** Local Authority CEs, Voluntary Organisations**Description** This document provides an overview of the current state of wheelchair provision. It makes recommendations on how the NHS, working with partners, can improve outcomes for wheelchair users. It outlines how timely and appropriate provision can contribute to health, well-being, independence, and inclusion.**Cross Ref** N/A**Superseded Docs** N/A**Action Required** N/A**Timing** N/A**Contact Details** Bernadette Simpson  
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## Foreword



I am delighted to welcome this comprehensive review of the wheelchair services in England.

In many ways, it could not have come at a more opportune moment. At the heart of the White Paper *Our health, our care, our say* is the need to shift the focus away from treatment in hospitals to better prevention in the community, with greater integration between the NHS and social care in community settings. The White Paper is clear: we must move our attention to promoting prevention as much as cure, and to enabling people to make choices for themselves about how and what they need in order to maintain their health and well-being.

Wheelchairs provide a significant gateway to this independence, promoting well-being and quality of life for thousands of adults and children. This report reinforces the messages in the Prime Minister's Strategy Unit's *Improving the life chances of disabled people* and Standard 8 of the National Service Framework for Children, Young People and Maternity Services, which recognise the role of wheelchairs in facilitating social inclusion and improving life chances through work, education and other activities that most of us take for granted.

I see this report and its recommendations as providing the foundation for developing a better service for individuals. It will be key in a new piece of work that my Department is developing through the Care Services Efficiency Delivery Programme.

The Transforming Community Equipment and Wheelchair Services Programme is working collaboratively with stakeholders to develop a new model of service delivery for community equipment and wheelchair services for children, young people and adults. It will build on this report's findings to ensure the recommendations and underlying aspirations might become a reality: a service that has the potential to be more effective and more efficient, and to deliver a higher quality, more consistent service to those who need support.

I would also like to acknowledge the role that the project steering group is playing in this, giving their time, expertise and support.

I trust that all NHS staff involved in wheelchair services – from chief executives and commissioners to practitioners on the ground – will take note of the recommendations contained in this report. Using up-to-date resources like this report helps ensure users, their families and carers can be confident that services are delivering to the highest standards.



**Ivan Lewis MP**  
Parliamentary Under Secretary of State for Care Services  
Department of Health

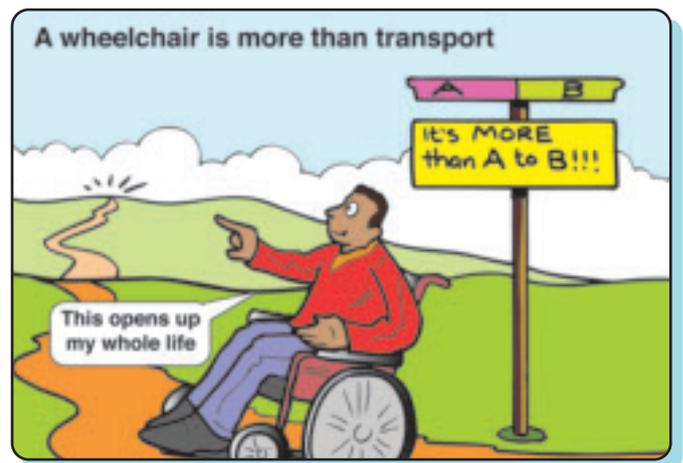
## Section 1:

# Introduction and recommendations

“My wheelchair is my life – without it I would not have a life. Things are not perfect but my chair goes a long way to making my life manageable, keeping me sane and sociable”

This statement indicates the high value that wheelchair users place on having an appropriate wheelchair. Timely provision of an appropriate wheelchair can be an important contribution to an individual's ability to be an actively engaged citizen leading a healthy, independent and fulfilling life, which is the essence of the White Paper *Our health, our care, our say*.<sup>1</sup>

This report, mindful of previous reviews, brings fresh evidence of the current state of wheelchair provision in England. Without change and investment, wheelchair services will not be able to meet the expectations of users or the current health and social care agendas, including requirements of the National Service Frameworks (NSFs), in particular the NSF for Long-term Conditions, the NSF for Children, Young People and Maternity Services and the NSF for Older People (see Appendix 1).



This review is intended to contribute to the development of new ways of health and social care service delivery and will form the basis for the next phase of development – the new government initiative 'Transforming Community Equipment and Wheelchair Services'.

Wheelchair provision affects quality of life, health and well-being and is important in facilitating social inclusion and improving life chances. Changes to ensure that businesses, services and workplaces are accessible to disabled people should go hand in hand with the improved use of technology.



As one wheelchair user put it:

“We are not asking to fly to the moon, just to do the things other people take for granted.”

From looking at the context of wheelchair provision, and the role of commissioners and service providers, this report recommends a shift in structures and culture to deliver uncompromised assessments and more flexibility in provision than exists now. It strongly supports a whole-systems approach to planning and provision.

## About this review

This review develops the work which the Wheelchair Services Collaborative completed in 2005.<sup>2</sup> It made significant inroads on service efficiency but, as with other initiatives over the last 20 years,<sup>3</sup> had little impact on increasing commissioners' understanding of wheelchair services.

This review makes recommendations that are non-mandatory. However, they will contribute to the development of new ways of health and social care service delivery in the direction outlined in the Prime Minister's Strategy Unit's *Improving the life chances of disabled people*, in *Our health, our care, our say* and in NSFs.<sup>4</sup> This review:

- outlines how improved, co-ordinated wheelchair services can contribute to social inclusion, opportunity, health and independence for disabled people
- identifies opportunities for 'invest to save' initiatives and efficiency measures
- focuses on service quality, such as products, outcomes and speed of response, and
- highlights services' contribution to maintaining people in the community, preventing ill health, aiding return to work and improving education.

The review was conducted between June 2005 and June 2006 by the Care Services Improvement Partnership (CSIP) and was overseen by a Steering Group comprising representatives from relevant organisations (see Appendix 4).

The methodology adopted for the review included:

- a literature review
- visits to wheelchair services in England
- a focus group of service commissioners
- comparative evaluations with services in Scotland, Wales and Norway
- interviews with service users and professionals
- written submissions from service users and professionals
- consultation events in the English regions for users, carers and service providers, attended by over 600 people
- a publicised telephone and online survey for users and carers.

## Structure of the report

- Section 1:** Introduction and recommendations.
- Section 2:** Background to wheelchair provision in England.
- Section 3:** Principal (and interdependent) areas of activity and current practice, eg commissioning; service provision; children. A common structure (introduction; current practice; issues; what is needed) is used to present the findings on each area.
- Section 4:** Suggested whole-systems approach for wheelchair service commissioning and provision.
- Appendices:** Including a checklist of best practice actions which could be useful for strategic health authorities (SHAs), commissioners, providers, and inspection and regulation bodies; and a list of wheelchair services by SHA boundaries.
- In addition:** A separate executive summary of findings and recommendations is also available.

A separate document, summarising the principal issues and concerns raised during the consultation, is available on the CSIP website at [www.cat.csip.org.uk/wheelchairs](http://www.cat.csip.org.uk/wheelchairs)

## Recommendations

### Recommendation 1: Whole-systems working and joint commissioning

A whole-systems approach to provision shows evidence of optimum outcomes for users and carers and best use of collective resources.

This can be achieved by:

- undertaking a fundamental review of local provision to enable SHAs to identify the potential to improve and co-ordinate services as part of ongoing joint strategic planning and commissioning
- linking such reviews with Local Area Agreements (LAAs), the Integrated Service Improvement Programme (ISIP), and Children and Young People's Plans (CYPPs), to enable wheelchair services to be repositioned within the wider agenda for social inclusion, health, well-being and independence
- benchmarking services, so that issues of equity across and between SHA areas can be examined. Consequently the development of shared standards and common eligibility criteria to deliver similar outcomes for users and carers can be encouraged.

### Recommendation 2: Responsive, person-centred services

The White Paper *Our health, our care, our say* establishes clear direction for commissioners to consider the need for services that are more responsive and person-centred: 'We will move towards fitting services around people, not people around services.' To contribute to this, services should consider:

- greater engagement with people who use wheelchairs and their carers, to bring insight, expertise and accountability to planning and provision
- voucher schemes, to include both manual and powered chairs, to support wheelchair users to exercise choice in selecting a chair that best suits their needs
- the development of partnerships with voluntary and independent sector providers, to encourage innovation and service development and support people who are either not eligible for state help or who wish to use their vouchers to enhance their choice of chair
- moving from blanket eligibility policies to flexible policies based on need and risk, to help match degrees of individuals' needs to their circumstances and life choices.



### Recommendation 3: Access to assessment and information

Improving access to services and making assessment and information available to all people with mobility problems can lead to systems that are fairer and provide more effective outcomes and choice. This can be achieved through:

- providing self-referral systems
- ensuring that assessment is proportionate to need, with self-assessment; or accredited/trusted assessors for low-level need; with rapid referral to regional services and to specialist medical, technical and engineering advice for the most complex seating and postural management, including 24-hour, whole-life needs
- improving access to information about all suitable products; and signposting to alternative funding solutions and assistance with co-ordination. People not eligible for statutory provision can be given advice and 'information prescriptions'.

### Recommendation 4: Co-ordinated assessment and provision

Where assessment includes whole-life needs (education, work, leisure and aspirations), and it is conducted in partnership with the service user, well-being and social inclusion are enhanced. Therefore, wheelchair assessment undertaken in conjunction with the single assessment process for older people, the proposed common assessment framework for adults and the common assessment framework for children, will help ensure that:

- goal-orientated 'independence plans' are established that build solutions around the wheelchair user and include the needs of carers and other family members
- primary consideration is given to the needs and wishes of the individual. Where necessary, financial contributions from a number of different organisations are co-ordinated to deliver this.

## Section 2:

# Wheelchair services in context

*For further details, see Appendices 1 and 2.*

**It is estimated that there are 1.2 million wheelchair users in England – just over 2% of the population.<sup>5</sup>**

The population of disabled people is large, highly diverse and changing.<sup>6</sup> The number of people with disabilities is rising and is likely to increase.<sup>7</sup> It can be assumed that the need for wheelchairs will increase.

In the course of this review, the possible differential impact of the recommendations on different population groups has been considered. It is not thought that there will be any adverse impact on any specific group. Although there are some differences in the use of wheelchairs through different health and disease profiles, the service provision envisaged is based on the needs of the individual on an equitable basis.

Provision of wheelchairs through the NHS falls under the National Health Service Act (1977), Sections 2 and 3 (see Appendix 1, Legislation).

There are over 150 wheelchair services in England located in a variety of organisations, including primary care trusts (PCTs), acute trusts, community trusts, healthcare trusts and mental health trusts.

Wheelchairs are also provided through other publicly funded services such as the education service and the Department for Work and Pensions' Access to Work scheme.

Recommendations about choice and independence relevant to users' legitimate expectations of wheelchair services are contained in recent policy documents such as the Government White Paper *Our health, our care, our say* and the report of the Prime Minister's Strategy Unit, *Improving the life chances of disabled people*, as well as NSFs (see Appendix 1, Policy context).

Previous reviews of wheelchair services are listed in Appendix 1. They have been taken into account in writing this report.

The Department of Health has not issued specific guidance on wheelchair services for some years. However, general guidance and standards for healthcare should be applied.

Appendix 2 references 'best practice actions' that have been established by relevant organisations and provide opportunities for national benchmarking.



## Section 3:

# Detailed findings

### Commissioning

High-quality commissioning is essential for efficient and effective services. It should be 'a process that involves planning, monitoring and quality assurance of services ... a process or cycle which covers, but is broader than, individual acts of planning and contracting'.<sup>8</sup> The Audit Commission issued comprehensive guidance on commissioning wheelchair services in March 2003, which remains largely relevant today.<sup>9</sup>

Central to the vision of the White Paper *Our Health, our care, our say* is that 'commissioning has to be centred on the person using the service'.<sup>10</sup>

This report concentrates on particular aspects of commissioning highlighted as major areas of concern by wheelchair professionals and service users:

- Health economics: wheelchairs as investment
- Finance
- Eligibility
- Choice
- Service specification
- Service structure.

### Health economics: wheelchairs as investment

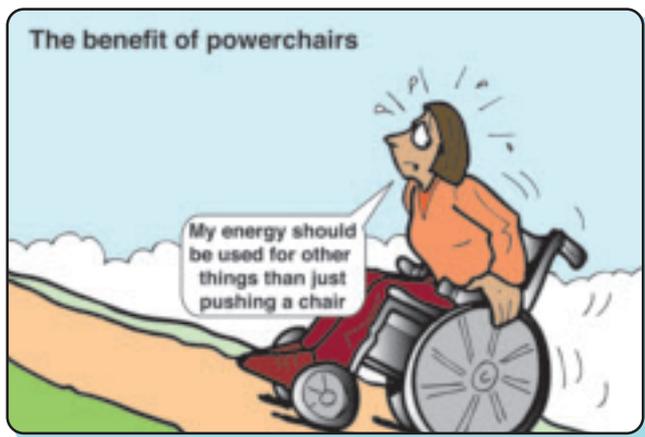
The person-centred approach to assessment and care management focuses on the individual within the context of his or her life and needs. It takes account of alternatives for meeting those needs and of the financial and humanitarian consequences of non-provision. Investment in an appropriate wheelchair can improve quality of life and well-being through increased independence and opportunities to work and participate in society. This can result in reduced need for care services and less dependence on benefits. Sustained financial investment alongside effective quality assurance mechanisms ensure such gains are maximised consistently.

#### Current practice

There is little evidence that commissioners consider the wider economic issues when allocating resources. Parameters for budget setting reflect concern for quantity of activity; there is often little systematic commissioning focusing on quality and whole-life costs. Specific health-related areas of interest in 'invest to save' opportunities include:

- the provision of appropriate seating, including pressure redistribution cushions on prevention of pressure ulcers<sup>11</sup> (total cost of pressure ulcers has been estimated at 4.1% of NHS gross annual expenditure<sup>12</sup>)
- timely and appropriate provision of a wheelchair, thus impacting on the prevention of falls<sup>13</sup>
- integrating additional features such as tilt-in-space and standing devices into a wheelchair to improve circulation; maintain bone mineral density; reduce tone and spasticity; maintain respiratory, gastro-intestinal, bowel and bladder functioning; and enhance independence and productivity.<sup>14</sup>

Detailed evaluation studies are beginning to emerge that provide measured evidence of these opportunities.



A 'silo approach' to budget allocation between health, social care, education and work is common. It results in people being sent to different services for equipment according to the reason for their need. This results in the retention of small discrete services, increased overhead costs and fragmented provision, and militates against delivery of whole-person, whole-life assessment and provision.

The fragmented approach affects not only provision of the actual wheelchair but of other equipment needed. For example, people with complex impairments may need a combination of equipment, including environmental controls, communication aids and moving and handling equipment. Such people need items of equipment that work together for their optimal benefit. Some services have succeeded in managing to deliver creative and flexible approaches and negotiate joined-up solutions which prevent duplication and waste (see case study B), but this is not universal.



### Case study A Invest to save – a missed opportunity

Arif is a young man of 20 with spastic quadriplegia who weighs about 18 stone. He is assessed for a custom-moulded seating system to accommodate his severe postural problems.

His parents request an attendant-controlled electrically powered indoor/outdoor chair (EPIOC) to assist with daily management and mobility, since they have difficulty pushing a manual transit-type chair. They are informed by the wheelchair service that, as a matter of policy, they do not supply attendant-controlled powered wheelchairs.

Arif's father is already suffering with back problems and his mother has arthritis in her hands so finds pushing a manual chair very difficult and painful. They are in their late fifties/early sixties.

Three weeks after supply of the new seating in the transit chair, Arif's father is out pushing the chair and loses control of the chair, which tips up, injuring his son. In an attempt to stop the chair tipping, Arif's father acquires a severe prolapsed disc and is unable to assist with any daily management of his son from that point on.

Several weeks later, Arif is placed into full-time care as his mother cannot cope with the physical demands and his father is still not showing any signs of recovery and will require surgery on his back.

Needless to say, Arif's parents are very distressed having looked after him at home up to this point.

Three years later, Arif is still in full-time care placement. The cost of an attendant-controlled EPIOC is about £2,000 plus annual maintenance costs – a small fraction of the costs that resulted from non-provision.

Source: CSIP



## Case study B

### An example of how investment in a high-specification wheelchair can reduce health and social care costs and improve independence and well-being

Sarah is quadriplegic and a full-time wheelchair user.

The multidisciplinary assessment team carried out a detailed consideration of Sarah's needs and tested selected chairs against the key criteria identified. These included clinical, physical and psychological needs and transportation, employment and social needs. It also included the needs of carers. A rating system of 0 to 3 was developed for an option appraisal: 0 indicating failure of a wheelchair to meet a performance criterion and 3 indicating optimum performance. Scores for each chair were debated and agreed. Choices were narrowed to two chairs that would meet Sarah's critical needs but one, chair A, which incorporated a standing facility, scored significantly higher in meeting her primary needs, which related to health and care.

#### Comparative costs of two selected chairs:

Chair A: £20,244 + VAT

Chair B: £6,700 + VAT

Although chair A was significantly more expensive, the option appraisal indicated that its provision would result in a number of important benefits and cost savings, including:

- reduced risk of autonomic dysreflexia, which can lead to a sudden increase in blood pressure – life threatening if it remains unchecked
- improved bowel and bladder management
- the production of normal bone density and joint and tendon flexibility and tone control
- improved chest/respiration/infection management due to optimum changes in posture influencing chest drainage
- no need for a separate tilt table and use of three trained staff to operate the table (£1,295 + VAT for the tilt table alone, plus staff costs)
- positioning controls which enable Sarah to perform physiotherapy exercises in her chair, as opposed to being hoisted into bed to perform the same exercises. This would help manage

Sarah's blood pressure and reduce the number of carers required throughout the day

- powered leg rest elevation reduces the risk of carers suffering back injury.

*Source: Yorkshire Spinal Injury Centre*

#### Efficiency gain:

Based on an analysis of the details in the above case study, it is estimated that the difference in capital cost between the two chairs would be recovered in around three months through reduced care costs. After that, estimated annual savings of around £53,500 in nursing and care costs alone would be made through the provision of chair A. The risk of emergency hospital admission is also greatly reduced by the selection of the more efficient chair, providing further potential significant savings.

*Source: Care Services Efficiency Delivery (CSED) programme, Department of Health*

## Issues

The 'silo' approach to budget allocation and service management encourages managers to prioritise the protection of hard-won and scarce service resources. This leads to short-term planning and discourages joined-up thinking. Concerns about economy rather than overall good value predominate. The consequences for individuals, families and carers can be profound (see case study A).

Technical advances are also affected by this fragmented approach, since industry is not encouraged to develop integral systems for environmental control, communication and mobility.

## What is needed

- Joint commissioning and strategic planning across health and social care, linked to LAAs, ISIP and CYPP co-ordinated through local partnership boards for physical disabilities.
- Local systems and protocols for service partnerships which involve education, housing, health and social care, to allow flexibility in responding to individual needs and exceptional cases.
- Whole-system evaluation of wheelchair provision and investment opportunities (see case study B).

# Finance

Establishing the real value of wheelchair provision in the context of the wider health and social care agenda should help commissioners decide on the appropriate level of investment required and how to approach issues of unmet need.

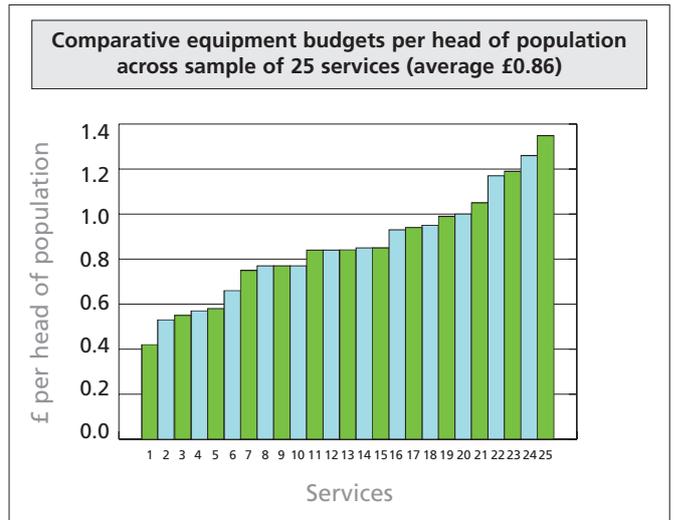


## Current practice

Insufficient funding is frequently cited as the underlying factor in inadequate wheelchair provision. Comparisons with other countries show that England spends less on wheelchairs than comparator countries.

Exhibit 1 illustrates the wide variation in 'per head of population' annual budget allocations for wheelchairs and special seating across a sample of wheelchair services in England. The figures include all wheelchairs, buggies, seating, cushions and accessories, but exclude spares, recycling, staff, overheads, etc. They have been represented by cost per head of the total population each service serves. It has not been possible to make any links with quality of provision.

## Exhibit 1



Finance for wheelchair provision comes from the central resources of NHS provider trusts and PCTs. Ring fencing was removed in 1994 when the allocation for wheelchairs was integrated into overall local funding. Additional funding for EPIOCs and the voucher scheme was announced in 1996 and ring fenced for four years, but then became part of general allocations.

Budget setting for the majority of commissioners is based solely on the previous year's allocation and is usually adjusted for inflation, but no associated risk analysis or review of need is performed. The task of justifying and securing resources in wheelchair services appears, in general, to be left to service managers, with commissioners taking a reactive role. Faced with immediate budgetary pressures, the long-term and wider benefits of providing an appropriate wheelchair are often lost in favour of what appear to be short-term financial savings. Services that are in competition for funding with acute services find themselves the target of cost cutting, as they are not immediately visible to the public and have no national targets associated with them. The current financial climate may serve to exacerbate this approach, but as case studies A and B demonstrate, there can be very immediate and significant savings to the public purse through appropriate provision.

Some services operate a ceiling on the amount they will spend on any one chair. Many are required to deliver year-on-year efficiency savings.



Vouchers in lieu of chairs are provided by some services but by no means all. Of the total number of user respondents to the online survey for this report, only 22% were offered a voucher. Of these, less than half said that they then went on to use it.

## Issues

Wheelchair services are often required to operate within historically-set budgets. Cost pressures resulting from increasing demand and complexity, advances in technology, costs associated with improved health and safety requirements or the aspirations of society are unable to be addressed.

Short-term funding results in short-term solutions rather than planning for long-term health gains. In addition, service managers are dually accountable for financial and clinical needs assessment in a system that prioritises financial responsibility. This can lead to a lack of responsiveness to user need and restriction of choice and empowerment.

The desirability of separating assessment and provision decisions was an issue raised by many contributors to this review. They perceived that the dual responsibility caused confusion and a lack of objectivity in the process.

Splitting the responsibilities would enable users to obtain clear, holistic assessments and appropriate recommendations. How the recommendations should be funded (including from contributions by the user or other agencies) would then be a transparent debate.

Many service managers are concerned about how to manage resources over the annual budget cycle. In some cases, by the end of the financial year the backlog of unfunded cases is so high that the next year's budget is spent in the first few months of the new year. Consequences of this scenario include:

- people having to wait several years for funding for an EPIOC
- difficulties for wheelchair suppliers over the management of their businesses when demand is so volatile within the year.

Voucher schemes enable some flexibility in provision and are greatly valued by many service users, but they are not universally available. However, in some services they are viewed as a way to mitigate tensions between assessed needs and local resources.

Geographical variations in service provision, colloquially known as the 'postcode lottery', result in inequitable provision. They are a major cause of concern to service users.

## What is needed

- Financial allocations for wheelchair services should be related to needs within the population and be developed as part of joint health and social care strategic planning.
- Decision making should be transparent.
- Service level agreements should be in place to help manage the separation of roles and responsibilities in relation to resource allocation (see case study C).
- Ensuring that assessors remain focused on the needs of the individual can help overcome obstacles of joined-up funding from different sources and with apportioning contributions (see case study D).

## Eligibility

The construction of eligibility criteria is based on two main considerations: the allocation of service funding and its fair distribution among service users with different needs, and the legal duties and powers of different statutory agencies.



### Case study C

## Benefits of a detailed service specification

**Mid and West Essex Wheelchair Service has a clear separation of responsibilities between clinical and budgetary decisions.**

There is a detailed service level agreement with commissioning PCTs which outlines the scope of the service and how decisions about funding of wheelchairs will be made.

The budget is managed in equal installments over a 12-month period, with any underspends carried forward. Monthly performance and activity reports are sent to the PCTs, and budgetary pressures are brought to their attention. Decisions on expenditure in exceptional individual cases or where volume of demand is outstripping capacity are passed back to the commissioning organisation with full details so that they can make agree about how they wish to proceed.

*Source: Mid and West Essex Wheelchair Service*

### Case study D

## Person-centred working leading to joined up solutions

**Michael is an 18-year-old student who has cerebral palsy. He has been offered a place at university and requires a powered wheelchair, environmental controls and communication aids. He needs to be able to operate a computer for word processing.**

Physicians, clinical engineers, therapists and other staff involved in his care met to decide a co-ordinated approach to providing the optimum technical solution to the obstacles he will face at university. Having identified an appropriate solution and agreeing it with Michael, they then decided how to apportion the costs to the various related budgets.

*Source: CSIP*

## Current practice

Commissioners should be making the decisions about the allocation of resources based on an analysis of need in the local population. The reality is that wheelchair services themselves are frequently left to make these decisions.

Services therefore determine eligibility criteria not for the benefit of users but to manage their budgets, and the criteria themselves become a gate-keeping mechanism. This situation was described in the Audit Commission's report *Fully Equipped 2002* and appears to have remained much the same.

The Wheelchair Services Collaborative made considerable inroads into encouraging services to agree and publicise eligibility criteria. Many now do that and make clear how provision decisions are made, leading to positive results.

## Issues

Eligibility criteria focus primarily on addressing basic mobility and postural needs. As such they are largely fixed within a medical model that relates to functional impairment and the physical and medical needs of an individual, rather than the barriers to independence and whole-lifestyle needs that they face.

Criteria for wheelchairs are often constructed as a set of rigid rules relating to the frequency of use or whether usage is for indoors or outdoors. This is an approach that leaves services unable to respond to the critical needs of individuals which do not conform to these criteria.

Criteria are also often applied before needs are fully assessed. In this way they are not used to decide on the level of provision but to exclude people from full access to the service. Some of these people might, for example, have benefited from advice and information, even if they were not eligible for state-funded provision.

## What is needed

- Undertaking assessments before applying eligibility criteria for state-funded provision: more people would get the advice they need and make informed choices.
- Assessment covering whole-life implications and opportunities for investment by other parties.



- Eligibility criteria reviewed and 'blanket' policies removed.
- Flexible criteria based on risk to health and independence, in order that services are capable of responding to the diversity of individual need (as for example in the Department of Health's Fair Access to Care Services (FACS) framework applied by adult social care functions<sup>15</sup>).
- The use of voucher schemes to increase choice.
- A closer co-operative partnership between health and social care which takes account of whole-life economic costs in order to arrive at the optimal solution (see case study E).

## Choice

Eligibility criteria influence how decisions are made about who gets what from available resources. However, as featured in the section above, this should not compromise the individual's right to information.

### Current practice

There are occasions when wheelchair services are overly preoccupied with meeting people's 'eligible needs'. In these instances they are unlikely to provide assessment and advice on the provision of equipment for work, education or leisure when people fall into categories outside their particular criteria.

In many places criteria exclude wheelchairs for short-term or occasional use.



### Case study E

## Example of social services providing a wheelchair under FACS

Alan has a manually propelled wheelchair from the NHS. He has increasing difficulty propelling it up a ramp to his home, and also up and down the inclines in his neighbourhood. This is beginning to affect his independence seriously. He has requested a powered outdoor wheelchair from the NHS but has been refused.

Social services' assessment shows that replacement of his ramp with a larger one of lower gradient would be expensive, and might not be practical anyway. Furthermore, even if the ramp were replaced, it would not overcome the difficulties he is having getting around the neighbourhood. Having been assessed according to FACS guidance, he was provided with a powered wheelchair, it being the most cost-effective way of meeting his wider needs.

*Source: CSIP*

Frequently, people only get a powered outdoor chair if they also need a powered indoor chair. This means many people have unmet outdoor mobility needs. However, some services will help (see case study F).

There are schemes to help with the purchase or lease of a powered chair such as the Motability scheme, Route to Motability (R2M). But many staff in statutory services lack knowledge and understanding of such schemes, so users remain uninformed.

### Issues

Widespread concern about 'raising expectations' of service users, coupled with limited finance and resources, means services may block access to people who might benefit from advice and information or offer solutions that do not maximise individual potential for independence and inclusion.

Eligibility criteria can completely exclude some people who are left to find their own way around a maze of alternative provision, often from the voluntary and independent sectors.

Criteria that exclude people with 'lower level' needs disproportionately affect older people or others who have recently been in hospital. It can even delay or prevent hospital discharge. These criteria also have a substantial impact on carers where provision may mean the difference in being able to cope or not.



## What is needed

- Service users need access to information and advice to make choices and informed decisions. Choice is also enhanced by helping people join up funding from different sources.
- Considering unmet need and the consequences of non-provision can lead to creative and alternative methods of provision, including agreements with third sector organisations such as the British Red Cross or Shopmobility (see case study G).

### Case study F

## Advice on self-purchase of powered wheelchairs

Bromley Wheelchair Service has an information pack it sends to people who contact the service regarding the purchase of a powered wheelchair.

It includes a publication from the local mobility centre which has a list of things to consider when buying a powered wheelchair. It also has a checklist to use when viewing a chair, which can be used for each model considered so that a true comparison can be made. The service advises going to a locally-based supplier and includes a list of reputable local dealers.

The service also gives advice such as to have the chair on trial for a few days and not to rush into a purchase because of a 'one-day only' special offer.

*Source: Bromley Wheelchair Service*

### Case study G

## Example of a service level agreement with the third sector

In the Isle of Wight, the Red Cross has a contract to provide all short-term loan wheelchairs. It has established a good working relationship with the NHS wheelchair service and has sound processes with agreed protocols for referral and management of more complex cases.

Monthly reports ensure that there is clear communication of information between services.

*Source: British Red Cross and Isle of Wight Wheelchair Service*



## Service specification

The foundation for ensuring that quality and service standards are maintained is a detailed and comprehensive service specification produced by the service commissioners. The Audit Commission has issued guidance for wheelchair service specifications to include details on timescales, quality standards (including procurement standards), recycling and repair and maintenance.

### Current practice

Wheelchair services and commissioners are largely unaware of the available guidance on service specifications.

In many instances, there is an absence of a written agreement between the commissioner and the service detailing the level and quality of service required. Agreements that exist are often no more than one or two lines about wheelchair provision within a service level agreement for a number of other services. Where detailed service plans exist, they are often drawn up by the service provider and accepted by the commissioner with little or no comment.

Services with detailed specifications were able to monitor and report internally against standards and be clear about roles and responsibilities.

### Issues

The absence of detailed service specifications makes it almost impossible to monitor service provision and assure quality. This leads to reactive services and places a heavy burden on service managers.

### What is needed

- Detailed and comprehensive service specifications in line with Audit Commission guidance<sup>16</sup> drawn up by commissioners in consultation with service users and carers.
- Systems for regular standards performance monitoring and reporting through physical disability partnership boards.
- The monitoring system to identify the remedial action that commissioners need to pursue.

## Service structure

The structure of wheelchair services is fundamental to many of the issues highlighted in this report. Structures need to be fit for purpose and provide good value.

### Current practice

Wheelchair services vary enormously in size, catering for 1,500 to 42,000 registered users each, with approximately a quarter having fewer than 4,000 registered users. Per 1,000 head of population, services range from 7 to 65 registered users.<sup>17</sup>

Staff numbers, disciplines and skill mix are equally varied.

Many services lack up-to-date IT systems that can provide the information required for efficient management.

The size and configuration of services appear to have evolved haphazardly. Some services lack the specialist skills to be able to carry out complex assessments. They can depend on wheelchair suppliers who, in some instances, run regular clinics without charge, relying on the sale of products to finance them.

### Issues

The huge variation in service structure and skill mix leads to equally significant variation in levels of service provision and service quality. Inequity of provision is something that service users and service providers rated as one of the greatest concerns within the consultation exercise for this report.

Some smaller services find it difficult to deal with complex cases, run into problems of staff cover and experience staff recruitment and retention problems that can threaten service viability. Staff may also lack career structure and training opportunities.

Small services also have greater difficulty in getting good value in procurement and have a smaller pool of equipment for recycling.

The system of using private sector suppliers to undertake assessment can cause concern when not appropriately managed: there are issues around governance, supplier bias and conflicts of interest. Incentives in this area vary but can be perverse for either party.

## What is needed

- Mapping wheelchair services' geographical coverage within SHA boundaries (see Appendix 3), leading to joint review of services' efficiency and effectiveness.
- Consideration of the Audit Commission's<sup>18</sup> 2002 recommendation that services develop hub-and-spoke arrangements.
- Contractual arrangements, within a clear governance framework, with third sector and independent providers.
- Investment in robust, industry-standard IT systems.

## Service provision

There is, inevitably, some duplication in findings between this section and that on commissioning. The agreed, detailed, local service specification is a key bridge between them. In this section the emphasis is placed on action(s) by the service provider, and these are presented under four headings:

- Access to services
- Assessment and service delivery
- Reviewing users' needs
- Equipment procurement, maintenance and repairs.

## Access to services

Throughout the consultation for this report, service users highlighted the need for greater communication and partnership. User involvement was identified as bringing insight, expertise and accountability.

People said they want services that listen to their individual needs and involve them in identifying solutions. They want access to information that enables them to make choices, and they want to know about the whole range of services and products that are available.



## Current practice

It is challenging to provide a full range of information where and when people need it. Although many services publish information, the public often experience difficulty in finding it. Once they have, they can find that the range of information is limited to the service available and does not point to other solutions.

As with the wide variety of services, there is a range of assessment referral systems. Some allow self-referral; others still operate on formal referral. The latter sometimes reflects fears of 'opening the floodgates', but evidence suggests that this is not the case where services have tried self-referral.

Some services have actively involved users in the planning and design of services (see case study H).

## Issues

Timely, adequate, appropriate, two-way information is a high priority for users and a major challenge for services. Constraints include staff time, production of materials and lack of IT systems to access product information.



### Case study H

## Service users involved in planning and design

In Tameside and Glossop, service users came together and wrote a specification of the service they wanted to see delivered. This has helped break down barriers and has opened up access to communication and information.

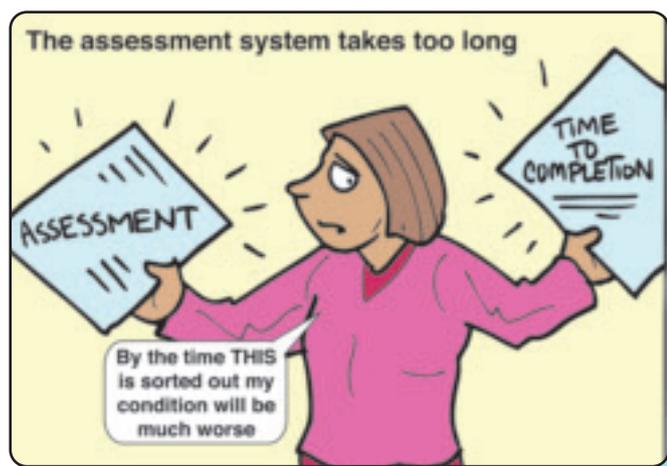
One result is that the service now takes referrals directly from the public as well as professionals.

*Source: Tameside and Glossop Wheelchair Service*

Service users complain of spending a lot of time trying to find out about alternative sources of provision. Services with open access, such as drop-in services, report that it reduces waiting times and complaints and thus improves productivity and user satisfaction.

Some users conclude that services construct barriers to entry to manage demand and that the referral process can be an unreasonable obstacle course.

Complaints about lack of communication also came from professionals outside the service who said that in some parts of the country it is very difficult to discuss issues with wheelchair services.



## What is needed

- High-quality, accessible information about services and alternatives, drawn up in conjunction with users, carers and other stakeholders.
- Publicising information in a variety of ways, including public places, the internet and other media.
- Partnerships with community equipment services, independent living centres, local authority one-stop shops, the third sector and independent sector organisations.
- Drop-in services and self-referral systems.
- Opportunities for regular general discussions between service staff and users.
- Use of section 31 Health Act (1999) flexibilities to combine resources to facilitate joined-up approaches across health and council services.

## Assessment and service delivery

Mobility problems are diverse and wide-ranging in their complexity and associated issues. A wheelchair is often just a part of a solution. A timely, comprehensive assessment is fundamental to ensuring that outcomes are improved. A multidisciplinary assessment process is also a means of ensuring a co-ordinated and coherent approach between different professionals and different agencies.

The NSF for Long-term Conditions puts the individual at the heart of care and emphasises the need for health and social care to work together for better co-ordination of services and information.

## Current practice

Wide variation in assessment, service delivery and quality of provision characterises wheelchair services. Some are highly responsive, but others are struggling to cope day to day.

Assessment processes range from the use of a specialist therapist to assess every person needing a wheelchair to services where specialists assess only the most complex cases. In the latter, the most complex cases typically amount to approximately 20% of the total workload, with the remaining 80% being assessed by 'accredited prescribers'. The specialist service provides training in wheelchair assessment skills and screens all assessments, providing advice and support. This is found to be cost-effective, helps manage demand and ensures the most appropriate use of assessors.

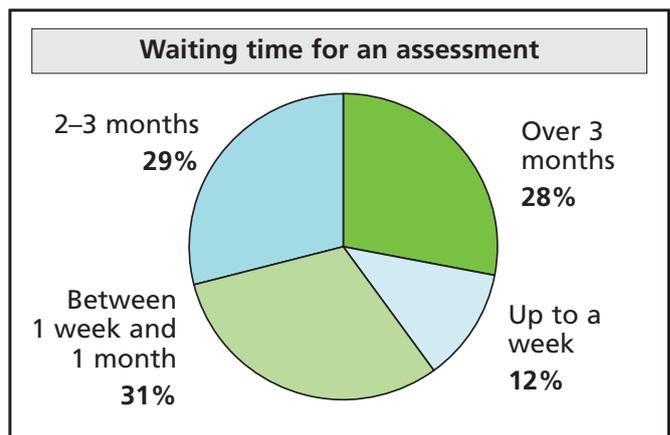
Specialist seating staff are often restricted to applying their skills to wheelchair provision alone, rather than extending the benefits of their expertise to assessment and recommendations covering 24-hour whole-life postural management.

Waiting times are variable and can be significant. There is concern that this is not being addressed by the 18-week target, which does not apply to most wheelchair provision.

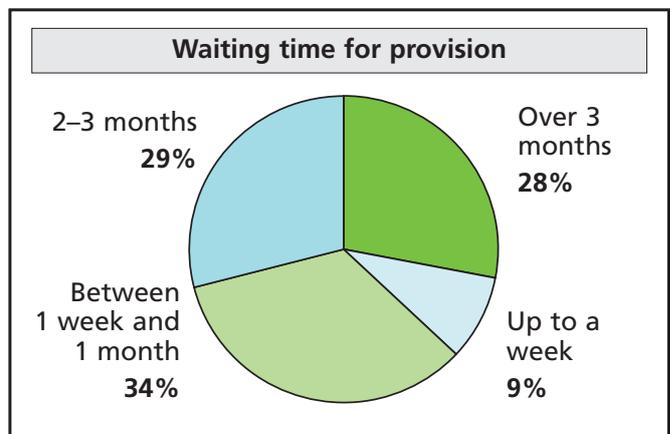
Many services may postpone assessment when there is no immediate funding for provision, because if there is delay in provision, needs can change. Assessments may also be delayed due to lack of clinical capacity. The longest waiting times relate mostly to the provision of powered chairs, where delays of up to five years following assessment are reported in some parts of the country. Insufficient budget is invariably cited as the reason for these delays. Exhibits 2 and 3 show the results of the online survey conducted for this review in response to questions on how long people waited for assessment and provision.

When looked at together, these responses indicate that the total care pathway for the majority of wheelchair users falls considerably outside of an 18-week care pathway, the benchmark for other NHS provision.

**Exhibit 2**



**Exhibit 3**



However, some services demonstrate the ability to operate within very efficient timescales with appropriate investment, adequate staffing and careful management of resources. This timescale is of course affected by complexity of need, with bespoke seating systems sometimes requiring up to three appointments for assessment and fitting.

A number of wheelchair services operate a telephone assessment service, where details are taken by trained personnel. If there are no unusual or exceptional requirements and certain criteria are met, wheelchairs are issued directly. This has helped keep down waiting times.



### Case study I

## Mobile assessment service

Manchester Wheelchair Service provides specialist assessment services to a wide geographical area. This can cause difficulties for service users if they have to travel to the centre.

In response, the service has developed a purpose-equipped van that takes specialist wheelchair assessment services into the local community. The service can be provided where and when it is needed. It provides choice and flexibility and helps make a scarce resource available more widely.

*Source: Manchester Wheelchair Service*

### Case study J

## Integrated working

Since 2001, North Lincolnshire has had an integrated Community Health and Social Services Occupational Therapy Service.

Assessment for wheelchairs is within the same building as the other services, and therapists have developed excellent working relationships. They carry out joint visits to assess clients' mobility needs and environmental or rehabilitation needs. If a rehabilitation or equipment and adaptations therapist is competent in wheelchair provision, he or she is able to carry out the assessment and provide the wheelchair and any associated equipment.

Knowledge and skills are shared across the services via in-service training sessions. This has helped the technical instructor in wheelchairs, who carries out the environmental checks for EPIOC provision and can now produce plans of the layout to people's homes, bring them back and discuss any issues with an occupational therapist (OT) in the equipment and adaptations team. This discussion could lead to a joint visit, or the specialist OT could take over the case to provide appropriate adaptations or give advice to the technical instructor.

In November 2005, the maintenance/repair and delivery side of the wheelchair service was integrated with the community equipment service.

As a result, maintenance staff share skills and training across the two areas. It also allows the service to send one maintenance person to carry out all checks and repairs on all the equipment within a person's home, rather than on just the wheelchair or just the bed. The service collects wheelchairs and equipment in the same van. Soon staff from both services will be competent in setting up and demonstrating the full range of equipment, rather than specific pieces.

With the integration of services, a further major change is the ability to run 'one-stop shop clinics', to which people come to seek advice or have a single assessment of their needs. These clinics are held in different areas of North Lincolnshire. They provide access to:

- assessment for equipment, minor adaptations, standard wheelchair provision, rehabilitation needs and major adaptation needs and carer assessments
- safety screening for people over 65 and their carers
- information on other services.

*Source: North Lincolnshire Wheelchair and Community Equipment Service*

Some regional centres provide specialist outreach services into the community (see case study I).

Partnership working and user-focused solutions are encouraged whereby wheelchair services are co-located with other services such as community equipment services, environmental controls and communication aids services (see case study J).

To ensure that users are adequately involved some services, for example in both Newcastle and Shropshire, ensure that users sign, and are given a copy of, their assessment and recommendation.

## Issues

Waiting times for assessment and provision are often unacceptably long, with consequent adverse effects on individuals' well-being, independence and health.

User involvement and participation and choice can be compromised by fear of raising expectations that cannot be met through the public sector.

Some services may be more concerned about providing the least expensive solution than exploring users' optimal solutions. In response to the online survey for this report, 37% of respondents said that all their needs were not taken into account. In the same survey, when asked if they were happy with the wheelchair that had been provided, 41% of all respondents said that they were not.

Many services only assess people who they expect will meet their stringent eligibility criteria for provision. Many people are therefore turned away.

Issues relating to work, leisure and education are often referred elsewhere, and users then have difficulty in obtaining the independent specialist advice they need.

The current separation of both budgets and wheelchair equipment services from other related services leads to fragmented assessments and fragmented solutions. Individuals and families find themselves 'forced to become expert campaigners for the services they need' (see case study K).<sup>19</sup>

## What is needed

- Services that meet people's needs for assessment and provision within agreed timescales.
- Account taken of individuals' work, educational and social aspirations, as well as physical needs.
- The use of accredited prescribers and mediated assessments.

## Case study K

### Case shunting between providers

A 17-year-old man with cerebral palsy in the process of preparing for university was assessed as needing a powered wheelchair for use at home and at university.

The wheelchair service refused to fund the chair since it would be used mostly at university where he would spend most of his time. The service believed it should be funded by the education authority. The education authority refused to fund it since the young man wanted to use the chair at home and for shopping, etc.

*Source: CSIP*

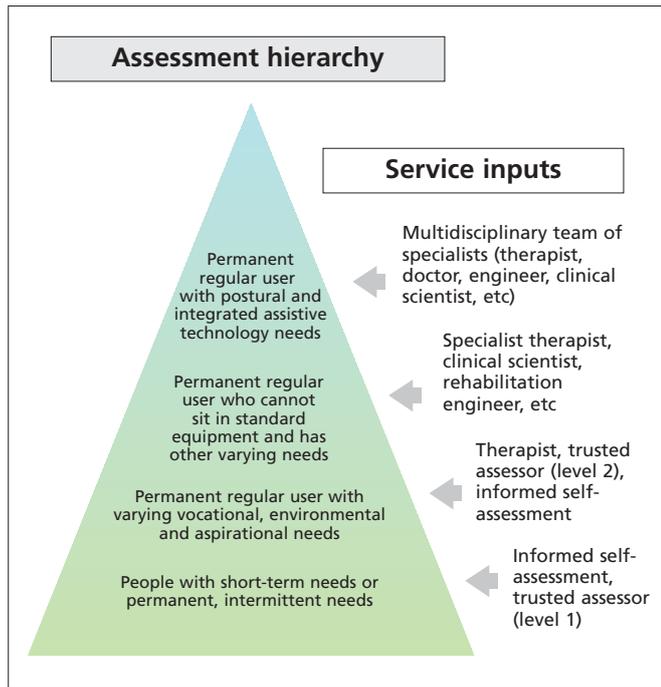
- Proportionate wheelchair assessments: widespread access to the 'assessment hierarchy', as illustrated at Exhibit 4.
- Protocols for communicating and co-ordinating provision with related services.
- Greater use of the specialist assessment skills of seating and mobility therapists, engineers and scientists to address 24-hour postural management and seating.
- Links and outreach services between specialist centres, community equipment services and community assessors for training and support.
- Examination of the benefits of co-location and integration with related services and use of Section 31 agreements.

## Reviewing users' needs

Being provided with a chair is not the end of the story for most wheelchair users. Many are lifetime users whose needs will change and develop as their lives progress. Even without any changes in their needs, equipment will deteriorate and require maintenance or repair.



## Exhibit 4



## Current practice

Some services provide regular reviews for most of their users; some prioritise those who will receive a review, others rely on the user or carer to trigger a review when they feel it is necessary.

## What is needed

- Risk assessments forming part of the initial assessment and leading to proactive review of users' needs according to agreed timescales.
- Informing users and carers about problems to look out for, and when and how to call for a review.

## Equipment procurement, maintenance and repairs

Delivering the standards for procurement, maintenance and repairs set out in the commissioner's service specification is an important part of the service provider's role.

## Current practice

According to the NHS Purchasing and Supply Agency (PASA), over 60% of wheelchairs purchased by the NHS are general purpose steel-framed models which are almost unchanged from the original 1970s Department of Health and Social Security (DHSS) specification.

The NHS has a high reliance on robust equipment which is able to undergo numerous refurbishment cycles. In some instances, this is as high as 70% of general purpose issue.

Repair and maintenance systems are as varied as the services themselves. Some are in-house; many are contracted out to small local businesses.

In many parts of the country, users complain that repair and maintenance services are slow, cannot respond outside office hours and are unable to manage complex situations, leaving them without essential means of mobility for unreasonable amounts of time. Some services work closely with service users to ensure that meeting their needs is central to repair and maintenance contracts.

## Issues

Users and clinicians indicate that in many cases the general purpose steel-framed models no longer meet users' needs. Product and fleet development is inhibited because:

- reliance on high levels of reconditioning means that many services look for equipment that is 'backwardly compatible' with their current fleet
- most purchases are for general purpose steel-framed models, and the volume of purchase of lighter and better alternatives remains low, causing unit prices to remain high.

High levels of wheelchair recycling are not necessarily cost-effective or appropriate, owing to the lack of 'traceability' of refurbished equipment, compliance with statutory requirements and increased incidence of repair. Consideration needs to be given to whole-life costs.

There is evidence to suggest that a critical mass is needed for a service to be able to achieve good value and provide adequate expertise. The NHS PASA believes this is reached with 12,000 plus registered users. Statistics taken from the emPOWER mapping report 2004 indicate that only around 13% of services have this number of registered users. Services combining to create user bases of this size would benefit from savings owing to common service standards, staff skill mix, stock control, fleet management, etc, as demonstrated by existing services that work as part of a hub-and-spoke arrangement (see case study L).

### What is needed

- Purchase appropriate products for service users.
- Repair and maintenance service response times, emergency replacements, how to deal with equipment failures outside the local area and outside office hours, and their financial implications defined in contracts in conjunction with local user groups.
- Comprehensive IT systems.
- Critical mass for services and collaborative procurement hubs supported by PASA to provide volume commitment and reduce the cost of enhanced models.

## Children

The issues raised so far in this report relate to people of all ages, including children, but enough specific issues have been raised that it was considered appropriate to include a special section on children.

### Current practice

Children's wheelchair provision is usually carried out alongside the services for people of all ages. Some have specific eligibility criteria for provision defined by the age of the child. Examples include no buggies to be provided for children under three and no powered wheelchairs for children under a specific age – which can be as old as eight or more.

### Case study L

## Benefits of hub-and-spoke arrangements

The Regional Rehabilitation Engineering Mobility Service (RREMS) in Newcastle procures and maintains all powered chairs across 19 PCTs in the northern region. It attracts major discounts for wheelchairs and spares due to the volume of equipment being purchased. It also has the buying power to influence the build specifications of equipment.

RREMS purchasing power has also managed to get major wheelchair manufacturers to offer maximum discounts on purchases of manual wheelchairs to all district wheelchair services served by RREMS. The manufacturers agreed because as soon as the wheelchairs are purchased they become the responsibility of RREMS for repair and refurbishment.

Returned powered wheelchairs are 'regionally pooled' so they can be allocated to any local wheelchair service. There are safeguards to ensure equity of provision across the wheelchair services. The number of powered wheelchairs being held in stock for allocation dropped from 620 to just over 350 across the region.

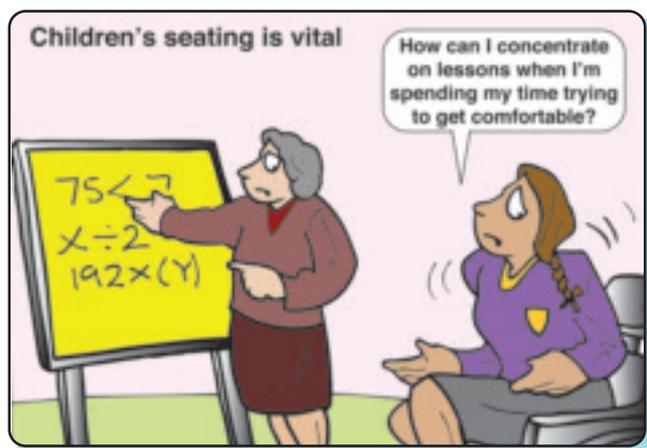
Typical additional annual savings achieved through bulk buying for the NHS trusts within the region have been:

Powered wheelchairs £125,119 (approx 11%)

Spares manual/powered £150,158 (approx 26%)

Manual wheelchairs £86,046 (approx 13%)

*Source: RREMS*



Services generally focus on clinical, rather than whole-life, needs. If a child requires equipment for education, he or she will generally be assessed for this separately, and this can result in the provision of two chairs, one for home and one for school, when a single higher-specification chair would have sufficed.

Accessories such as trays, rain covers, leg muffs or shopping baskets that can make significant difference to day-to-day management at relatively low cost will not usually be provided. Since families with disabled children are recognised as on average having a disproportionately low income,<sup>20</sup> these additional financial demands are impossible for many to meet. Other equipment such as communication aids and environmental control systems are not always co-ordinated by services, leaving parents and carers trying to bring a variety of systems together without help.

Multi-adjustable chairs and chairs that incorporate a riser mechanism are rarely provided through wheelchair services but can be important for children for clinical, independence and social reasons.

At the stage of transition between childhood and adult services, disabled young people and their families often face significant challenges in trying to navigate new systems of provision and issues about the ownership of equipment provided by children's services.

The needs of the whole family are important when assessing disabled children's needs. Managing a wheelchair and another child's buggy is impossible for one adult. There are systems that would enable a parent or carer to manage two children together, but wheelchair services will not usually provide these and generally take a view that their responsibility is to the disabled child alone.

### Case study M

## Responding to the needs of the whole family

Darren, Matt and Luke are three lively boys who share a rare dystrophy condition. Unfortunately, given the nature of their condition, none of them are able to propel themselves in their manual chairs – they are reliant on their mother and father. Lately it has become more and more difficult to take their sons out as they cannot push more than one wheelchair each at a time.

The family approached Whizz-Kidz and asked the charity to take their needs as a family into account. The boys' existing NHS chairs did very little to improve their independence or enable family activities to take place. Darren and Matt's chairs were self-propelling, which restricted them to completely flat ground and meant they quickly became exhausted. Luke's chair limited him to indoor use only and had no facility to enable him to change position by himself.

The equipment funded by Whizz-Kidz has changed the situation. All three boys were provided with powered chairs that can be used indoors and outdoors, as well as having tilt-in-space facilities that allow them to change position whenever they choose.

Not only are Darren, Matt and Luke no longer reliant on their parents each time they want to make a snack or go to the post box at the end of the road, but the whole family has benefited. Now they can all go out together and get around in relative ease and comfort. Something as simple as a visit to the local shopping centre has now become possible.

*Source: Whizz-Kidz*

There are similar problems when families have more than one disabled child (see case study M).



## Issues

Children have rapidly changing needs as they grow and develop, and therefore the importance of responsive and timely services, for both assessment and repairs and maintenance, is particularly high.

Developmental needs can be adversely affected if a child does not get the right equipment at the right time.

Where there is inadequate consideration of the needs of carers and siblings, significant problems can arise, imposing additional stress. This is unacceptable on humanitarian grounds and can be inefficient in terms of economics: the cost of dealing with resulting problems transfers to other health or social care services.

Providing better information and support at the time of transition from childhood to adult services can remove unnecessary stresses on disabled young people and their families.

As with other user groups, assessment and provision are often defined by what is available and the limitations of finance, rather than being needs-led.

## What is needed

Explicit commitment to the overarching aims as stated in Standard 8 of the NSF for Children, Young People and Maternity Services<sup>21</sup> and the outcomes and aims of Every Child Matters.<sup>22</sup>

Standard 8 of the NSF states: 'Children and young people who are disabled or who have complex health needs receive co-ordinated, high-quality, child and family centred services which are based on assessed needs, which promote social inclusion and, where possible, enable them and their families to live ordinary lives.'

The Every Child Matters framework sets clear targets and indicators which relate to all children, including disabled children, and provides for a more holistic approach to the needs of children. The Department for Education and Skills (DfES) is currently looking more closely at how the Every Child Matters framework works for disabled children.

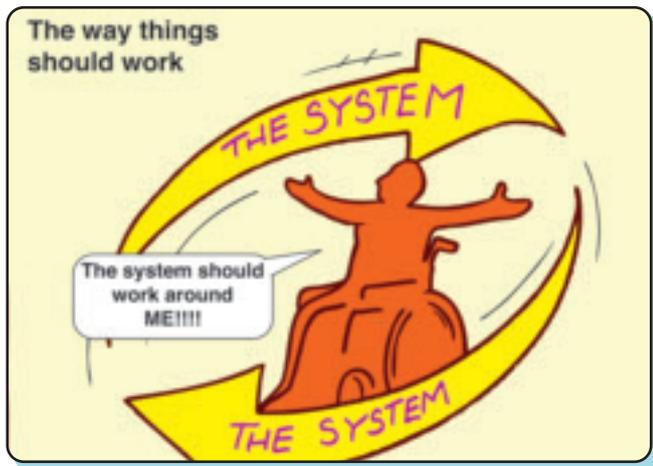
More specifically commissioners, in partnership with providers, need to ensure that:

- children, young people and parents are involved in decisions about their care and the provision of equipment
- disabled children are able to use all the equipment in all the places where they typically spend time
- equipment is tailored to the individual needs of the child and his or her future development and reflects the needs of the whole family
- there is better planning for transition from childhood to adult services to alleviate unnecessary stress on disabled young people and their families
- multiagency protocols are in place for the assessment and provision of equipment, including wheelchairs, and is provided promptly based on multiagency assessment that takes place as soon as the child's needs have been identified
- children are provided with systems that can 'grow' to meet their changing needs – an investment in the life chances of disabled children and their families
- systems are established by directors of children's services for jointly commissioning and funding children's wheelchair services across health, education and social care, and, where possible, in partnership with voluntary organisations
- blanket or rigid rules on provision are removed
- there is a reasonable balance between risk to safety and the risk of denying wheelchair-using children opportunities that others take for granted. Any remaining risk should be minimised through training.

## Section 4:

# Conclusion and whole-systems approach

## Conclusion



This report has raised issues and identified good practice in the current systems for both the commissioning and the provision of wheelchair services.

It makes recommendations on how SHAs, commissioners and wheelchair services might improve current poor practice and make these services more efficient, particularly from the point of view of users of the service.

The current system reform agenda provides an ideal opportunity to introduce a radical change in the way wheelchair services are delivered by local health, education and social care commissioners.

## Whole-systems opportunity and approach

This section of this report describes a whole-systems approach for wheelchair services which encompasses all of the improvements suggested earlier in this report.

The desired shift in service focus encompasses not only posture and basic mobility but also the well-being, lifestyle choices and emotional and mental needs of individuals. This will require a change in service culture to one in which the social model of disability (see Appendix 5) is seen as a fundamental value, and provision promotes social inclusion and increased opportunities.

In a whole-systems model (Exhibit 5), the individual is central. Assessment takes into account a wide range of considerations and focuses on effective outcomes through joined-up thinking and working.

### Exhibit 5 Joined-up thinking

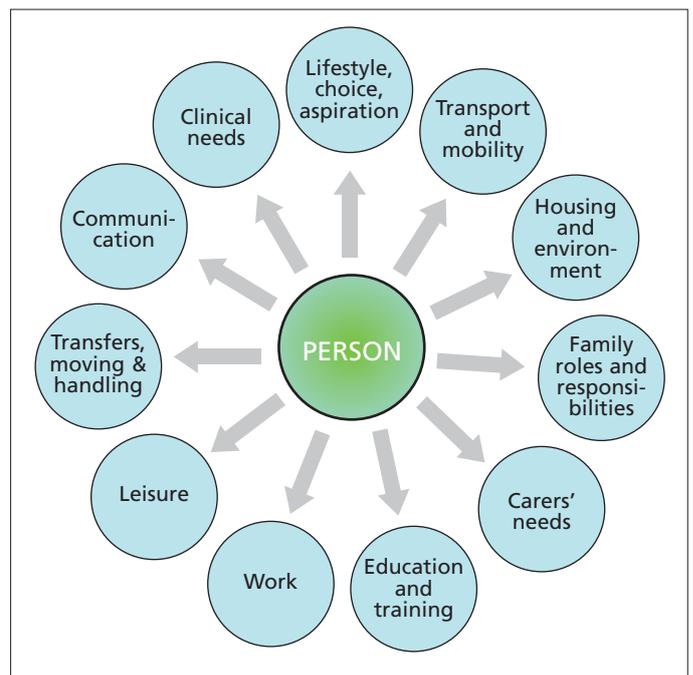
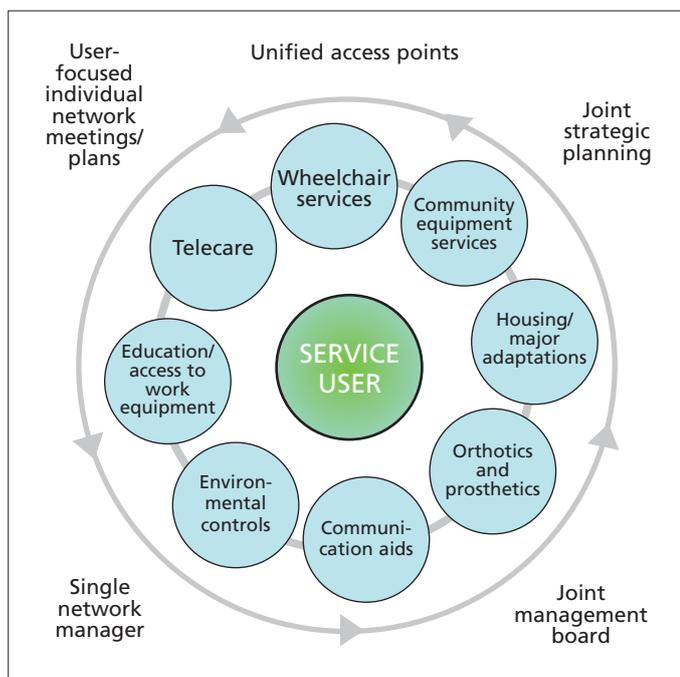


Exhibit 6 shows some of the services that will need to be brought together as a network and co-ordinate provision around individuals' and carers' needs. Services may be provided from different locations or by different specialists, but they all need to communicate and liaise to ensure a joined-up approach to provision and effective use of resources.

**Exhibit 6**  
Co-ordinated services



goal-oriented outcomes for individuals and how decisions will be reached about appropriate solutions and financial contributions. The strategy should also demonstrate how good value is being achieved through effective use of resources and contractual arrangements

- co-ordinated arrangements for assessment that are appropriate to the level and complexity of need
- unified goal-oriented independence plans that are owned by the individual and address all areas of need, leading to potential for joined-up solutions where appropriate
- a system for user-focused network meetings involving all parties, to negotiate independence solutions and agree financial contributions to individual plans
- unified person-based IT systems capable of linking information on assessment, stock tracking, repairs, equipment re-use and other management information.

Within the model there are three main levels of provision – these are illustrated in Exhibit 7 and described below.

**Exhibit 7**  
Three levels of wheelchair provision



A whole-systems model benefits from characteristics such as:

- unified points of access and information for the public to all assistive technology services through internet, telephone and demonstration centres
- an identified joint commissioner across health and social care, with lead responsibilities for assistive technology and reporting arrangements agreed between partners
- a comparable identified commissioner for children's assistive technology services across education, health and social care
- a network management board that includes representation from all areas of assistive technology and includes service users
- a joint strategy that outlines how wheelchair services will work with other services to achieve

The elements of provision highlighted above have different functions but complementary roles. There is a need to consider their respective contributions in a whole-systems approach.

### Mainstream wheelchair services and community equipment working in an integrated way

Wheelchair services and community equipment services co-operate and work to make the most effective use of resources in their locality, including on providing information and services to the public, for example through a shared centre, common stock management and common assessment framework.

Wheelchair assessors assess and specify ramps; community equipment services assessors assess and prescribe transit and occasional-use wheelchairs.

Health and social care partners use Health Act flexibilities to pool funds. Social services make contributions under Section 28BB of the NHS Act 1977 towards the performance of NHS functions (ie wheelchair provision). They do this either generally or in specific cases (ie in order to ensure social care needs are met, as well as healthcare).

Social care involvement in wheelchair provision is viewed as an option to be considered in individual cases on the grounds of cost-effectiveness when measured against risk to independence under FACS guidance.

### 'High street' provision

Following assessment, statutory services provide signposting and 'information prescriptions' for non-eligible needs. Services from the independent and third sectors play a significant role and are recognised as offering choice to users.

Self-help guides for users on how to select a wheelchair and when to seek specialist advice are available, and staff undertake accredited/trusted assessor training.

High street provision provides for short-term and occasional use in less complex situations and may also cater for people who use vouchers, who self-fund or who use charitable donations or benefits to purchase the wheelchair of choice.

Intermittent and occasional wheelchair users use high street services to access transit chairs, electrically powered pavement vehicles and attendant-controlled powered outdoor chairs.

### The regional specialist service (complex disability service)

This service includes the disciplines of:

- environmental controls
- communication aids
- computer access
- complex manual handling
- postural management
- switch access
- electronic engineering
- mechanical engineering
- wheeled mobility
- research, training and development.

It provides assessment, design and engineering for the most complex individual solutions. It works with other service providers to develop learning and education for practitioners. It provides specialist advice and consultancy to wheelchair services and community equipment services.



# Appendix 1

## Putting wheelchairs into context

### Background

It is 20 years since the McColl report, which recommended restructuring wheelchair services to provide more accessible local services. As a result of the recommendations of that report, wheelchair services transferred to the management of the Disablement Services Authority (DSA) between 1987 and 1991. Following this there was a further restructure in health services, and from April 1991 onwards the management of wheelchair services devolved to 151 local health authorities and trusts.

The last guidance from the Department of Health on wheelchairs was issued in 1996, when EPIOCs and vouchers became available for severely disabled people through the NHS. Additional ring-fenced funding totalling £50 million was made available for EPIOCs and vouchers over the initial four-year period, and from April 2000 the funds were placed in health authority revenue recurrent allocations.

In 1996 a voucher scheme was introduced to allow people who require a wheelchair to purchase one that is not provided by the NHS, using their own money and a voucher from the NHS, the voucher being equivalent to the cost of the recommended NHS wheelchair.

The Department of Health commissioned the York Health Economics Consortium to evaluate the powered wheelchair and voucher scheme initiatives. Its report, published in March 2000, recommended that the continuation of voucher schemes should be a matter for local decision 'in consultation with services users'. However, schemes should only be disbanded if there is not significant local support for vouchers and/or if the core services provide users with a reasonable amount of choice, especially regarding lightweight and folding wheelchairs. Initially, separate amounts were provided for EPIOCs and vouchers. When the funding was placed in health authority baselines,

the separation was removed and all health authorities were asked to maintain a voucher scheme.

In 2002 the Department of Health set up a Wheelchair Service Collaborative in partnership with the NHS Modernisation Agency and the Audit Commission, which involved 44 wheelchair services in England. A panel of leading professionals, service users and carers set the framework for this programme. They identified areas where there was potential for significant improvement spanning four key strategies: improving the overall experience for users and carers; minimising delays; maximising efficiency; and improving the overall outcome for users and carers. Each participating team committed themselves to sharing the results of their work directly with other wheelchair services in their locality.

### Legislation

Provision of wheelchairs through the NHS falls under the National Health Service Act 1977 (NHS Act) Sections 2 and 3. Under Section 3 there is a duty to meet all reasonable requirements for (i) such facilities for the care of persons suffering from illness and (ii) such services for the diagnosis and treatment of illness. 'Illness' includes any injury or disability requiring medical or nursing treatment. The provision of a wheelchair can therefore be seen as a facility or service for the care and aftercare of people who have suffered from such injury or disability. Section 2 gives a more general power to discharge duties imposed by the 1977 Act or to do any other thing whatsoever which is calculated or is conducive or incidental to the discharge of such duties.

Relevant legislation in relation to carers' needs includes the Carers (Recognition and Services) Act 1995, which provides for the assessment of the ability of carers to provide care; the Carers and Disabled Children Act 2000, which makes provision about the assessment of carers' needs, provision of services to carers and the provision of payments to carers and disabled children aged 16 and 17 in lieu of the provision of services to them; and the Carers (Equal Opportunities) Act 2004. In particular, this last Act contains a new duty placed on certain NHS bodies, including any PCT, any NHS trust or NHS foundation

trust and any local health board, to give due consideration to requests made by social services for assistance from the NHS in meeting informal carers' needs. For instance, social services might request that the NHS provide a certain type of wheelchair (perhaps a bit more expensive than usual) in order not only to meet the needs of the disabled person, but also to make life easier for the carer.

### Policy context

A number of recent government reports and policy initiatives over the last three years set standards and outline strategies for improving services for disabled people, including children and carers. Most recently and of particular relevance to this report are the following:

- The White Paper *Our health, our care, our say – a new direction for community services* commits the Government to improving services to enable people to maximise their health and well-being and to ensure that people are empowered to participate fully in society. It sets out the Government's vision for more effective health and social care services outside hospital and identifies clear areas for change:
  - more personalised care
  - services closer to people's homes
  - better co-ordination between the NHS, social care and wider universal services
  - increased patient choice
  - focus on prevention as much as cure.
- *Improving the life chances of disabled people*, published in the autumn of 2005, addresses the issues of independent living, transition into adulthood, employment and support for families with disabled children: 'By 2025 disabled people in Britain should have full opportunities and choices to improve their quality of life and will be respected and included as equal members of society.' The report includes examples that describe the problems faced by disabled people regarding fragmented silo-based approaches to wheelchair service provision. The report outlines key goals for services that will only be achieved by removing barriers to inclusion, meeting individual needs and empowering people to make choices regarding their lives. An early outcome of the strategy document is the formation of the Office for Disability Issues, launched in December 2005 with the purpose of taking forward the agenda outlined in the report. The vision is for substantive equality by promoting joined-up policy and service delivery to reduce gaps in service inconsistencies.
- The NSF for Children, Young People and Maternity Services was published jointly by the Department of Health and the DfES in September 2004. It sets standards for services for disabled children and their families against which services will be inspected in future. The NSF requires that all disabled children have access to any equipment, including wheelchairs where they need it, at home or school, and that the commissioning of services considers, all equipment, including wheelchairs, as well as ensuring services are integrated across health, social care and education, to enable multiagency assessments and streamline provision.
- The NSF for Long-term Conditions aims to transform the way health and social care services support people who live with long-term conditions. The report sets out quality requirements and evidence-based markers of good practice. It aims to promote quality of life and independence by ensuring that individuals with long-term conditions receive co-ordinated care and support planned around their needs and choices. Provision of wheelchairs is particularly relevant to the successful implementation of many of the quality requirements, but in particular to Quality Requirement 6: Vocational rehabilitation and Quality Requirement 7: Providing equipment and accommodation. Under these requirements, people with long-term conditions are to receive timely, appropriate assistive technology/ equipment and adaptations to accommodation, to support them to live independently; help them with their care; maintain their health; and improve their quality of life.
- The NSF for Older People, published in 2001, outlined a 10-year programme of action to improve services, with the aim of supporting



independence and promoting good health and cultural change in the treatment of older people. The report acknowledges the importance both of equipment services and of older people as 'major users of wheelchairs'. It establishes key principles in the provision of community equipment services, which include:

- identifying equipment needs as integral to any assessment and care plan, both in hospital and the community
- providing information and choice in equipment provision
- recognising the preventative value of equipment and its role in maintaining independence at home, slowing down deterioration in function and consequent loss of confidence and self-esteem, and preventing accidents and pressure sore damage, as well as its role in supporting and protecting the health of carers better. Co-ordinated working and joint investment between health and social care are seen as pivotal to improving service delivery. The need to ensure that services do not restrict access on the basis of age is emphasised.

### Previous reviews

These include:

- *NHS wheelchair and seating services mapping project, 2004*: a report by emPOWER funded by the Department of Health. This report provides data gathered from a survey of wheelchair services on a range of activities and processes from finance to waiting times and user involvement. The report highlights 'snapshots of excellence' in service delivery and the changes that services would like to see.
- *Fully Equipped 2002*: an Audit Commission report. This reports little progress on recommendations for wheelchair services since the previous *Fully Equipped* report in 2000 and identifies commissioning as a key weakness. It recommends hub-and-spoke models of provision for wheelchair services.
- *Fully Equipped 2000*: a report by the Audit Commission. This identifies the important role of equipment provision, including wheelchairs, and

recognises the financial pressures services face and the regional variations in service provision. It recommends that wheelchair services be more responsive to users' views and needs and that they implement a quality improvement programme, including, in particular, improvements in user reassessment and stock management.

- *Evaluation of the Powered Wheelchair and Voucher System 2000*. This reported wide variations in the application of the voucher system and poor uptake by service users, due, in part, to a lack of information. It reported significant unmet need for powered chairs and lengthy waiting times for provision. Quality of life was improved for those who did receive a powered chair.
- *National Prosthetic and Wheelchair Services Report 1993–1996*: a project on NHS prosthetic and wheelchair services by the College of Occupational Therapists, London, 1996 (often referred to as the Holderness report), funded by the Department of Health. This was an influential report which triggered debate about the numbers of wheelchair users and potential growth in demand. It recognised users had different levels of need and that resources for service funding were limited.
- The McColl Report 1986. Professor (now Lord) McColl reviewed and reported on the adequacy, quality and management of the various services received by patients in artificial limb and appliance centres in England. It influenced the establishment of the Disablement Services Authority in 1987.

### Quality standards

The Department of Health has not issued specific guidance in relation to wheelchair services for some years, but there are general guidance and standards for healthcare that should be considered in relation to these services.

- *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06–2006/07* sets out a standards-based planning framework for health and social care; standards for NHS healthcare to be used in planning, commissioning and delivering services; and targets for 2005–2008. Of particular relevance to wheelchair services is Priority III: Access to services. This priority requires that services ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment. Although this target relates specifically to elective hospital treatment, PCTs are encouraged to agree local plans to reduce waiting times for other types of treatment. Average waits in 2008 are expected to be around nine weeks from GP referral to treatment, with waits for an outpatient consultation not normally exceeding six weeks. PCTs, in partnership with the NHS and other provider organisations, are encouraged to set and achieve even more ambitious goals locally. PCTs are required to ensure they have robust plans to deliver the 2008 maximum waiting time target. Also of relevance is Priority IV: Patient/user experience, which includes improving the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible. An identified intervention to improve quality of life and independence is the provision of equipment and adaptations to help individuals to live in their own home.
- *Standards for Better Health* describes the level of quality that healthcare organisations, including NHS foundation trusts and private and voluntary providers of NHS care, will be expected to meet in terms of safety, clinical and cost-effectiveness, governance, patient focus, accessible responsive care, care environment and amenities and public health. There is much that is relevant to wheelchair services within these standards.

There is specific guidance outside of the Department of Health in relation to wheelchair services:

- *Health Care Standards for Wheelchair Services under the NHS*, March 2004. These best practice standards were developed and endorsed by the National Wheelchair Managers' Forum, the British

Society of Rehabilitation Medicine, the Posture and Mobility Group, emPOWER, NHS PASA, National Forum of Wheelchair User Groups and Whizz-Kidz. The standards are accepted by many as the benchmark for services. Standards from referral through to assessment and provision are outlined. Target response times for each stage of the process are listed, and the minimum data set that should be held by a service is identified.

- *Improving services for wheelchair users and carers: good practice guide – learning from the Wheelchair Services Collaborative*, NHS Modernisation Agency, February 2005. This document identifies the four principal strategies and opportunities for service improvement within the programme and identifies best practice and learning against each of these. The principal strategies relate to the overall experience of each user and carer, minimising delay, efficient use of resources and outcome.
- *Procurement Guide – Contracted wheelchair support services*, NHS PASA, June 2004. This document provides information on procurement of support services for repair, modification and maintenance of wheelchairs. The market is explained, as well as the procurement process and European Union guidance. There are helpful template and sample documents, and detailed guidance on processes.
- *Specialised Wheelchair Seating – National Clinical Guidelines: Report of a multidisciplinary expert group* (Chair: Marks LJ), British Society of Rehabilitation Medicine, 2004. This report includes standards for benchmarking and delivery.
- *Guidance on the Commissioning of Wheelchair Services*, Audit Commission, 2003. The guidance outlines information needed and includes helpful facts on wheelchair services generally, for example current numbers of wheelchair users and how services contribute to the wider healthcare agenda.



## Appendix 2

# Self-assessment checklist of best practice actions

	SHA	Commissioner	Provider
<b>Health economics: wheelchairs as investment</b>			
Joint commissioning and strategic planning across health and social care linked to LAAs, ISIP and CYPP co-ordinated through local partnership boards for physical disabilities		✓	
Local systems and protocols for service partnerships which involve education, housing, health and social care, to allow flexibility in responding to individual needs and exceptional cases		✓	
Whole-system evaluation of wheelchair provision and investment opportunities	✓	✓	✓
<b>Finance</b>			
Financial allocations for wheelchair services should be related to needs within the population and be developed as part of joint health and social care strategic planning	✓	✓	
Decision making should be transparent		✓	
Service level agreements should be in place to help manage the separation of roles and responsibilities in relation to resource allocation		✓	
Ensuring that assessors remain focused on the needs of the individual can help overcome obstacles of joined-up funding from different sources and with apportioning contributions		✓	
<b>Eligibility</b>			
Undertaking assessments before applying eligibility criteria for state-funded provision: more people would get the advice they need and make informed choices			✓
Assessment covering whole-life implications and opportunities for investment by other parties		✓	✓
Eligibility criteria reviewed and 'blanket' policies removed		✓	✓
Flexible criteria based on risk to health and independence, in order that services are capable of responding to the >			

	SHA	Commissioner	Provider
diversity of individual need (as for example in the Department of Health's Fair Access to Care Services (FACS) framework applied by adult social care functions)		✓	
The use of voucher schemes to increase choice		✓	
A closer co-operative partnership between health and social care which takes account of whole-life economic costs in order to arrive at the optimal solution		✓	✓
<b>Choice</b>			
Service users need access to information and advice to make choices and informed decisions. Choice is also enhanced by helping people join up funding from different sources		✓	✓
Considering unmet need and the consequences of non-provision can lead to creative and alternative methods of provision, including agreements with third sector organisations such as the British Red Cross or Shopmobility		✓	✓
<b>Service specification</b>			
Detailed and comprehensive service specifications in line with Audit Commission guidance drawn up by commissioners in consultation with service users and carers		✓	
Systems for regular standards performance monitoring and reporting through physical disability partnership boards		✓	
Using the monitoring system to identify the remedial action that commissioners need to pursue		✓	
<b>Service structure</b>			
Mapping wheelchair services' geographical coverage within SHA boundaries, leading to joint review of services' efficiency and effectiveness	✓	✓	
Consideration of the Audit Commission's 2002 recommendation that services develop hub-and-spoke arrangements		✓	
Contractual arrangements, within a clear governance framework, with third sector and independent providers		✓	✓
Investment in robust, industry-standard IT systems		✓	✓
<b>Access to services</b>			
High-quality, accessible information about services and alternatives, drawn up in conjunction with users, carers and other stakeholders			✓
Publicising information in a variety of ways, including public places, the internet and other media			✓



	SHA	Commissioner	Provider
Partnerships with community equipment services, independent living centres, local authority one-stop shops, the third sector and independent sector organisations		✓	✓
Drop-in services and self-referral systems			✓
Opportunities for regular general discussions between service staff and users			✓
Use of section 31 Health Act (1999) flexibilities to combine resources to facilitate joined-up approaches across health and council services		✓	
<b>Assessment and service delivery</b>			
Services that meet people's needs for assessment and provision within agreed timescales		✓	✓
Account taken of individuals' work, educational and social aspirations, as well as physical needs			✓
The use of accredited prescribers and mediated assessments			✓
Proportionate wheelchair assessments: widespread access to the 'assessment hierarchy'			✓
Protocols for communicating and co-ordinating provision with related services			✓
Greater use of the specialist assessment skills of seating and mobility therapists, engineers and scientists to address 24-hour postural management and seating		✓	✓
Links and outreach services between specialist centres, community equipment services and community assessors for training and support		✓	✓
Examination of the benefits of co-location and integration with related services and use of Section 31 agreements		✓	✓
<b>Reviewing users' needs</b>			
Risk assessments forming part of the initial assessment and leading to proactive review of users' needs according to agreed timescales			✓
Informing users and carers about problems to look out for, and when and how to call for a review			✓
<b>Equipment procurement, maintenance and repairs</b>			
Purchase of appropriate products for service users		✓	✓
Repair and maintenance service response times, emergency replacements, how to deal with equipment failures outside the local area and outside office hours, and their financial implications defined in contracts in conjunction with local user groups		✓	✓

	SHA	Commissioner	Provider
Comprehensive IT systems	✓	✓	✓
Critical mass for services and collaborative procurement hubs supported by PASA to provide volume commitment and reduce the cost of enhanced models	✓	✓	✓
<b>Children</b>			
<p>Explicit commitment to the overarching aims as stated in Standard 8 of the NSF for Children, Young People and Maternity Services and the outcomes and aims of <i>Every Child Matters</i>. Standard 8 of the NSF states: 'Children and young people who are disabled or who have complex health needs receive co-ordinated, high-quality, child and family centred services which are based on assessed needs, which promote social inclusion and, where possible, enable them and their families to live ordinary lives.'</p> <p>This will include ensuring that:</p> <ul style="list-style-type: none"> <li>• children, young people and parents are involved in decisions about their care and the provision of equipment</li> <li>• disabled children are able to use all the equipment in all the places where they typically spend time</li> <li>• equipment is tailored to the individual needs of the child and his or her future development and reflects the needs of the whole family</li> <li>• there is better planning for transition from childhood to adult services to alleviate unnecessary stress on disabled young people and their families</li> <li>• multiagency protocols are in place for the assessment and provision of equipment, including wheelchairs, and is provided promptly based on multiagency assessment that takes place as soon as the child's needs have been identified</li> <li>• children are provided with systems that can 'grow' to meet their changing needs – an investment in the life chances of disabled children and their families</li> <li>• systems are established by directors of children's services for jointly commissioning and funding children's wheelchair services across health, education and social care, and, where possible, in partnership with voluntary organisations</li> <li>• blanket or rigid rules on provision are removed</li> <li>• there is a reasonable balance between risk to safety and the risk of denying wheelchair-using children opportunities that others take for granted. Any remaining risk should be minimised through training</li> </ul>		✓	✓



# Appendix 3

## Wheelchair services mapped to SHAs



### North East SHA – 12 services – population 2,545,073

1. City of Sunderland Social Services – Sunderland Wheelchair Service
2. Gateshead Health NHS Trust – Wheelchair Services
3. Newcastle Upon Tyne Hospitals NHS Trust – Newcastle Disablement Services Centre
4. North Tyneside PCT – North Tyneside Wheelchair Service
5. Northumberland Care Trust – Northumberland Wheelchair Service
6. Durham and Chester-le-Street PCT – North Durham Wheelchair Service
7. Hartlepool and East Durham NHS Trust – Hartlepool Wheelchair Service
8. North Durham Health Care NHS Trust – Occupational Therapy Department
9. North Tyneside PCT – North Tyneside Wheelchair Service
10. Sedgfield Primary Care Trust – South Durham Wheelchair Service
11. South Tees Acute Hospitals NHS Trust – Disablement Services Centre
12. South Tyneside Healthcare Trust – Wheelchair Services

### North West SHA – 22 services – population 6,827,170

1. Chorley and South Ribble & West Lancashire PCT – Chorley and South Ribble & West Lancashire Wheelchair Service
2. Lancashire Teaching Hospitals NHS Trust – Preston Disablement Services Centre
3. North Cumbria Acute Hospitals NHS Trust – Disablement Services Centre
4. North Cumbria Acute Hospitals NHS Trust – Disablement Services Centre
5. Ashton, Leigh & Wigan PCT – Wheelchair Service
6. Bolton Primary Care Trust – Lever Chambers Centre for Health
7. Halton NHS Primary Care Trust – Halton Wheelchair Service
8. Rochdale Healthcare NHS Trust – Bury & Rochdale Wheelchair Service
9. Salford NHS Trust – Salford Wheelchair Services
10. South Manchester University Hospitals NHS Trust – Manchester Disablement Services Centre
11. Stockport PCT – Independent Living Centre
12. Tameside & Glossop Primary Care Trust – West Pennine Wheelchair Service
13. Aintree Hospitals NHS Trust – Walton Centre for Neurology & Neurosurgery (BRSM)
14. Aintree Hospitals NHS Trust – South Sefton & Kirkby Wheelchair Service
15. Birkenhead and Wallasey Primary Care Trust – West Cheshire Wheelchair Service
16. Birkenhead and Wallasey Primary Care Trust – Wirral Wheelchair Service
17. Community Loans Service – St Catherine's Hospital
18. East Cheshire NHS Trust – Wheelchair Assessment Centre
19. Mid Cheshire Hospitals NHS Trust – Crewe Wheelchair Assessment Centre
20. Royal Liverpool & Broadgreen University Hospitals NHS Trust – Liverpool Wheelchair Service
21. Southport and Formby PCT – Southport and Formby Wheelchair Services
22. St Helens and Knowsley Hospitals NHS Trust – Wheelchair Assessment Unit

### Yorkshire and the Humber SHA – 17 services – population 5,038,849

1. Hambleton and Richmondshire Primary Care Trust – Wheelchair Centre
2. Harrogate Health Care NHS Trust – Harrogate Joint Equipment Store
3. Hull and East Riding Community Health NHS Trust – Service to Aid Independent Living (SAIL)
4. North Lincolnshire PCT – Wheelchair Service
5. Northern Lincolnshire and Goole Hospitals NHS Trust – Wheelchair Services
6. Scarborough and North East Yorkshire Healthcare NHS Trust – Wheelchair Centre
7. Selby and York Primary Care Trust – Wheelchair Centre
8. Airedale NHS Trust – Wheelchair Services
9. Bradford Teaching Hospitals NHS Trust – Wheelchair Assessment Centre
10. Calderdale & Huddersfield NHS Trust – Huddersfield & Dewsbury Wheelchair Service
11. Calderdale & Huddersfield NHS Trust – Calderdale Wheelchair Services
12. Sheffield Teaching Hospitals NHS Trust – Mobility and Specialised Rehabilitation Centre
13. The Leeds Teaching Hospital NHS Trust – Leeds Wheelchair Centre
14. Wakefield West Primary Care Trust – Wakefield & Pontefract Wheelchair Services
15. Doncaster & South Humber Healthcare NHS Trust – Wheelchair Service, Disability Resource Centre

16. Rotherham Primary Care NHS Trust – Rotherham Equipment & Wheelchair Services (REWS)
17. Sheffield Teaching Hospitals NHS Trust – Mobility and Specialised Rehabilitation Centre

### East Midlands SHA – 9 services – population 4,279,707

1. Derbyshire Dales and South Derbyshire PCT – Southern Derbyshire Wheelchair Service
2. Mansfield District Primary Care Trust – District Wheelchair Service
3. North Eastern Derbyshire Primary Care Trust – Disability Services
4. Nottingham City Hospital NHS Trust – Nottingham City Hospital Mobility Centre
5. United Lincoln Hospitals NHS Trust – Lincolnshire Wheelchair Service – Grantham Site
6. United Lincoln Hospitals NHS Trust – Lincolnshire Wheelchair Service – Lincoln Site
7. Northampton Primary Care Trust – Northampton Wheelchair Service
8. Northamptonshire Heartlands PCT – Wheelchair Service
9. University Hospitals of Leicester NHS Trust – Leicester Disablement Services Centre

### West Midlands SHA – 16 services – population 5,334,066

1. Herefordshire Primary Care Trust – Hereford Wheelchair Service
2. Redditch & Bromsgrove NHS Primary Care Trust – Wheelchair & Equipment Loan Service
3. South Birmingham Primary Care NHS Trust – Birmingham Wheelchair Service
4. South Birmingham Primary Care NHS Trust – Regional Wheelchair Trading Service
5. South Warwickshire Primary Care Trust – South Warwickshire Wheelchair & Special Seating Service
6. Coventry Primary Care Trust – Widdrington Road
7. North Birmingham Community Health NHS Trust – Equipment Loan Service
8. Oldbury & Smethwick PCT – Sandwell Wheelchair Service
9. Solihull Primary Care Trust – Solihull Wheelchair Service
10. The Dudley Group of Hospitals NHS Trust – Dudley Wheelchair Service
11. Walsall Community Health Trust – Distribution centre
12. Mid Staffordshire General Hospitals NHS Trust – Mid Staffordshire Wheelchair Service
13. North Staffs (NHS) Trust – North Staffordshire Wheelchair Service
14. North Warwickshire NHS Trust – North Warwickshire & Rugby Wheelchair Service
15. Telford and Wrekin Primary Care Trust – Shropshire Wheelchair Service
16. Wolverhampton City Primary Care Trust – Wolverhampton Wheelchair Service Maltings Mobility Centre

### East of England SHA – 19 services – population 5,491,293

1. Addenbrooke's NHS Trust – Disablement Services Centre
2. Central Suffolk PCT – Great Yarmouth & Waveney Wheelchair Service
3. Central Suffolk Primary Care Trust – East Suffolk Wheelchair Service
4. Central Suffolk Primary Care Trust – West Suffolk Wheelchair Services
5. Huntingdonshire Primary Care Trust – Huntingdon Wheelchair Service
6. Kings Lynn and Wisbech Hospitals NHS Trust – Wheelchair Service
7. Norwich NHS Primary Care Trust – Wheelchair Assessment Centre
8. Peterborough Hospitals NHS Trust – Wheelchair Services
9. Bedfordshire Heartlands PCT – Wheelchair Service
10. East & North Hertfordshire NHS Trust – North Herts Wheelchair Service
11. East and North Hertfordshire NHS Trust – Wheelchair Centre
12. Watford & Three Rivers Primary Care Trust – West Herts Wheelchair Service
13. Barking, Havering and Redbridge Hospitals NHS Trust – Redbridge Wheelchair Service
14. Epping Forest Primary Care Trust – Holly Wheelchair Service
15. Essex Rivers Healthcare NHS Trust – North East Essex Wheelchair Service
16. Havering Primary Care NHS Trust – Havering Wheelchair Service
17. Maldon & South Chelmsford PCT – Mid Essex Wheelchair Service
18. Southend on Sea PCT – Southend Wheelchair Service
19. Thurrock Primary Care Trust – Wheelchair Service

### London SHA – 25 services – population 7,428,590

1. Barnet Healthcare Trust – Barnet Wheelchair Service
2. Camden & Islington Community Health Services NHS Trust – Wheelchair Service
3. Hillingdon PCT – Wheelchair Service
4. North Middlesex Hospital NHS Trust – Haringey Wheelchair Service
5. North West London Hospitals NHS Trust – Stanmore DSC
6. City and Hackney Teaching Primary Care Trust – City & Hackney Wheelchair Service
7. Newham Primary Care Trust – Wheelchair Services
8. Tower Hamlets Primary Care Trust – Tower Hamlets Wheelchair Service
9. Whipps Cross University Hospital NHS Trust – Waltham Forest Wheelchair & Special Seating Service
10. Bromley Primary Care Trust – Wheelchair Assessment Service

11. Greenwich Primary Care Trust – Wheelchair User Service
12. Queen Mary's Sidcup NHS Trust – Queen Mary's Hospital
13. Southwark PCT Wheelchair Service – Rehabilitation Centre
14. Thameslink Healthcare Services NHS Trust – Wheelchair Service
15. Brent PCT (hosting Ealing, Hammersmith & Fulham, Hounslow) – Wheelchair Service
16. Croydon NHS Primary Care Trust – Croydon Wheelchair Services
17. Hillingdon PCT – Wheelchair Service
18. Royal Hospital for Neuro-disability – Royal Hospital for Neuro-disability
19. Wandsworth Primary Care Trust – Merton and Sutton Wheelchair Service
20. Wandsworth Primary Care Trust – Roehampton Specialist Seating Service
21. Wandsworth Primary Care Trust – Roehampton Wheelchair Service
22. Brent PCT (hosting Kensington & Chelsea, Westminster, Ealing) – Wheelchair Service
23. Enfield Community Care NHS Trust – Enfield Wheelchair Service
24. Haringey Teaching PCT – Haringey Wheelchair Service
25. North West London Hospitals NHS Trust – Harrow Wheelchair Service

### South East Coast SHA – 13 services – population 4,187,941

1. Canterbury and Coastal PCT – Wheelchair Service
2. Canterbury and Coastal Primary Care Trust also providing services to Ashford PCT, East Kent Coastal Teaching PCT and Shepway PCT – Wheelchair Service
3. Invicta Community Care NHS Trust – Wheelchair Assessment Service
4. Maidstone Weald Primary Care Trust – Wheelchair Services
5. West Kent NHS & Social Care Trust – Medway Wheelchair Service
6. Adur Arun and Worthing PCT – Worthing Wheelchair Service
7. Bexhill & Rother PCT – Wheelchair Centre
8. Eastbourne & County Healthcare NHS Trust – Eastbourne & County Wheelchair Service
9. Guildford and Waverley PCT – Wheelchair Services
10. Maidstone Weald Primary Care Trust – Wheelchair Hospital
11. South Downs Health NHS Trust – Sussex Rehabilitation Centre (Brighton)
12. South West London Community NHS Trust – Merton & Sutton Wheelchair Service
13. Surrey & Sussex Healthcare NHS Trust – Horsham Wheelchair Unit

### South Central SHA – 8 services – population 3,922,301

1. Nuffield Orthopaedic Centre NHS Trust – Posture, Independence & Mobility Service
2. Royal Berkshire and Battle NHS Trust – West Berkshire Wheelchair Service
3. Vale of Aylesbury Primary Care Trust – Vale of Aylesbury Wheelchair Service
4. Isle of Wight Healthcare NHS Trust – Occupational Therapy & Wheelchair Service Centre
5. North Hampshire PCT – Basingstoke Wheelchair Service
6. Portsmouth Hospitals NHS Trust – Disablement Services Centre
7. Southampton City Primary Care Trust – Southampton Wheelchair Service
8. Winchester and Eastleigh Healthcare NHS Trust – Wheelchair Service

### South West SHA – 8 services – population 5,038,200

1. Kennet and North Wiltshire Primary Care Trust – Wiltshire Wheelchair Service
2. North Bristol NHS Trust – Wheelchair & Special Seating Service
3. West Gloucestershire PCT – Gloucestershire NHS Wheelchair Service
4. North Dorset Primary Care Trust – West Dorset Wheelchairs
5. Royal Devon & Exeter Healthcare NHS Trust – Exeter Mobility Centre
6. South and East Dorset PCT – East Dorset Wheelchair Service
7. Cornwall Healthcare NHS Trust – St Lawrence's Hospital
8. Plymouth Teaching Primary Care Trust – Disablement Services Centre

*(Wheelchair services listed geographically under each of the 10 new strategic health authorities (SHAs). NHS trust name and centre name are as listed on the National Wheelchair Managers' Forum website at [www.wheelchairmanagers.nhs.uk](http://www.wheelchairmanagers.nhs.uk))*

## Appendix 4

# Acknowledgements and members of the steering group

CSIP and the Department of Health are very grateful to the members of the steering group (listed right), the National Wheelchair Managers' Forum and the many individual service users, carers and professionals who gave of their time and knowledge to help inform this review.

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The cartoons in this report were created by Graham Ogilvie, conference illustrator, who captured in pictures the views expressed by participants at the events.

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## Appendix 5

# Glossary

### **Access to Work**

Access to Work is a service to help overcome the problems resulting from disability. As well as giving advice and information to disabled people and employers, Jobcentre Plus pays a grant through Access to Work towards extra employment costs owing to a person's impairment(s). This can fund aids, equipment and adaptations to premises. [www.jobcentreplus.gov.uk](http://www.jobcentreplus.gov.uk)

### **Accredited assessor**

A term commonly used by wheelchair services to refer to people who have undertaken a level of basic training in assessment for wheelchair provision. Any 'accreditation' is currently a local matter.

### **Assistive technology**

Any product or service designed to enable independence for disabled or older people.

### **Audit Commission**

An independent public body responsible for analysing and commenting on the expenditure of public money in the areas of local government, housing, health, criminal justice and fire and rescue services. It works to promote good practice, improve services and help them to achieve better outcomes for citizens. [www.audit-commission.gov.uk](http://www.audit-commission.gov.uk)

### **Autonomic dysreflexia**

Also known as hyper-reflexia. This neurological condition can produce a rapid rise in blood pressure caused by pain, irritation or overstimulation in a paralysed part of the body because with certain spinal cord injuries normal control mechanisms do not operate. If unchecked, this can lead to fits, cerebral haemorrhage and, though rarely, death.

### **British Red Cross**

In addition to the emergency work for which it is famous, the British Red Cross offers a range of services, including care in the home, transport, equipment and wheelchair loan provision, to help people with health issues lead a full and independent life. [www.redcross.org.uk](http://www.redcross.org.uk)

### **Care Services Efficiency Delivery (CSED) Programme**

The Care Services Efficiency Delivery (CSED) programme was set up by the Department of Health in June 2004 to support the implementation of the recommendations of *Releasing Resources to the Front Line* – the 'Gershon Report' on public sector efficiency. The CSED team works with councils, the NHS and service providers to develop and support adult social care efficiency initiatives.

### **Care Services Improvement Partnership (CSIP)**

Commissioned by the Department of Health and other agencies to help services implement national policies for local benefit, CSIP works with health, local government and the public, voluntary and private sectors in England. Created in April 2005, it helps improve services and outcomes for children and families, adults and older people, including those with mental health problems, learning and/or physical disabilities, and people in the criminal justice system. [www.csip.org.uk](http://www.csip.org.uk)

### **Children and Young People's Plan (CYPP)**

The Children and Young People's Plan (CYPP) is an important element introduced by the Children Act 2004. The Government intends that all areas should produce a single, strategic, overarching plan for all local services for children and young people to integrate services to secure the outcomes set out in *Every Child Matters: Change for Children*.

### **Commissioners**

People appointed to be responsible for the strategic level process of specifying, securing and monitoring services to meet people's needs. This term is used in all local authority, NHS, other public services and by the private and voluntary sectors. [www.cat.csip.org.uk](http://www.cat.csip.org.uk)

## Common assessment framework

The common assessment framework is a standardised approach to conducting an assessment of an individual's needs and deciding how they should be met. It forms a key part of delivering focused and integrated services. It is already in place for children's services, is a 'single assessment process' for older people and is in development for all adults.

### emPOWER

emPOWER is the Charities Consortium of Users of Prosthetics, Orthotics, Wheelchairs, Electronic Assistive Technology and Rehabilitation Services. emPOWER campaigns for a 'national look' based on individual needs while member organisations foster local initiatives and spread best practice nationwide.

[www.limbless-association.org/empower](http://www.limbless-association.org/empower)

### Fair Access to Care Services (FACS)

Fair Access to Care Services policy guidance (FACS) was published in 2002 by the Department of Health. It is a framework for determining eligibility for adult social care services. Councils are required to provide or commission services, subject to their resources, so that people in their area with similar eligible needs receive services that deliver equivalent outcomes no matter where they live.

### Independent living centres

Independent living centres focus on providing information and access to see and try products and equipment designed to assist disabled people with independent living. Some centres include sales.

### Integrated Service Improvement Programme (ISIP)

ISIP is intended to provide a way for local health communities to be more efficient and productive, transform service delivery and enhance service quality, and to do so while extracting maximum value from investments in people, process and technology. [www.isip.nhs.uk](http://www.isip.nhs.uk)

## Local Area Agreement (LAA)

LAAs set out the priorities agreed between central government and the local authority and other key partners at the local level (forming a Local Strategic Partnership). LAAs simplify some central funding, help join up public services more effectively and allow greater flexibility for local solutions.

[www.communities.gov.uk/laa](http://www.communities.gov.uk/laa)

### Mediated assessment

An assessment process where someone, often a support worker, helps a person assess their own needs.

### Motability

Motability is a charity that oversees the Motability scheme, which enables disabled people to obtain a car, powered wheelchair or scooter by using government-funded mobility allowances.

[www.motability.co.uk](http://www.motability.co.uk)

### National Service Framework (NSF)

National Service Frameworks provide a systematic approach for improving healthcare standards and quality. NSFs are implemented in partnership with social care and other organisations. They:

- set national standards and define service models for a service or care group
- put in place programmes to support implementation
- establish performance measures against which progress within agreed timescales will be measured.

### NHS Purchasing and Supply Agency (PASA)

The NHS Purchasing and Supply Agency is an executive agency of the Department of Health. Its role is to act as a centre of expertise, knowledge and excellence in purchasing and supply matters for the health service. [www.pasa.doh.gov.uk](http://www.pasa.doh.gov.uk)



## **Section 31 agreements**

Section 31 of the Health Act 1999 allows more flexible working between health and local authorities by pooled funding. This helps joint commissioning, integrated provision, partnerships and collaborations for a wide range of NHS and social services operations.

## **Shopmobility**

Shopmobility schemes promote equality of access and encourage the independence of disabled people through the provision of mobility equipment such as scooters, wheelchairs and power chairs, particularly in shopping areas. Schemes are generally self-funding and are either charities, established by local authorities or managed by their local shopping centre or other commercial organisations. [www.justmobility.co.uk](http://www.justmobility.co.uk)

## **Social model of disability**

The social model of disability takes the approach of focusing on structures and their barriers which disabled individuals experience (for example, inaccessible transport, housing and education provision) and provides tools for dismantling and preventing these. This contrasts with the medical model, which looks at medical impairments as the main reason for difficulties experienced by disabled people.

## **Strategic health authority (SHA)**

Strategic health authorities are responsible for developing plans for improving health in their local area and making sure health services are performing well. They are responsible for the capacity and prioritisation of local health services. Strategic health authorities are a key link between the Department of Health and the NHS

## **Trusted assessor**

This term describes staff such as assistants and support workers who have undergone specific training to provide people with disability equipment, usually in relation to 'straightforward' and low-risk needs.

## **Whizz-Kidz**

Whizz-Kidz is a campaigning charity that provides a range of powered, manual and sports wheelchairs; specially adapted tricycles, bicycles, buggies and walking aids; wheelchair training; information; and advice not available through the NHS. [www.whizz-kidz.org.uk](http://www.whizz-kidz.org.uk)

## **Wheelchair Services Collaborative**

Launched in November 2002, this was a coming together of wheelchair services (in partnership with the NHS Modernisation Agency, the Department of Health and the Audit Commission) to develop and share knowledge to bring about significant improvements in services.

## Appendix 6

# References

- 1 Department of Health (2006) *Our health, our care, our say: a new direction for community services*. London: The Stationery Office.
- 2 National Health Service Modernisation Agency (2004) *Improving services for wheelchair users and carers: good practice guide – learning from the Wheelchair Users Collaborative*. London: Department of Health.
- 3 See Appendix 1: Previous reviews.
- 4 See Appendix 1: Policy context.
- 5 emPOWER (2004) *NHS wheelchair and seating services mapping project: final report*. Limbless Association, p. 6. Available online at <http://kcl.ac.uk/content/1/c6/01/64/85/MappingProjectFinalReport1.pdf>
- 6 Prime Minister's Strategy Unit (2005) *Improving the life chances of disabled people*. London: Prime Minister's Strategy Unit, pp. 33–51.
- 7 Wanless D (2006) *Securing Good Care for Older People: patterns of need for social care*. London: King's Fund.
- 8 Bramley-Harker E and Lewis D (2005) *Commissioning in the NHS: Challenges and opportunities*. London: NERA Economic Consulting.
- 9 Audit Commission (2003) *Guidance on the commissioning of wheelchairs*. Available online at: [www.audit-commission.gov.uk/olderpeople/olderpeopleguidance](http://www.audit-commission.gov.uk/olderpeople/olderpeopleguidance).
- 10 Department of Health (2006) *Our health, our care, our say: a new direction for community services*. London: The Stationery Office.
- 11 Robinson SM, McLeod HST, Williams IP, Freeman T, Harley MJ, Peck E (2005) *Stepping-Stones: Evaluation of the Action On Plastic Surgery Programme*. Health Services Management Centre: University of Birmingham, Publication: 34452 (confidential report).
- 12 Bennett G, Dealey C, Posnett J (2004) The cost of Pressure Ulcers in the UK. *Age and Ageing* 2004; **33**: 230–235.
- 13 Woollard FA (2005) *The Effects of Mobility Device Use on Strength, Fatigue and Quality of Life in Persons with Multiple Sclerosis*. University of Pittsburgh: PhD thesis.
- 14 Arva J and Scmeler MR (2006) *RESNA's position on the application of wheelchair standing devices* (draft). Washington DC: Rehabilitation Engineering and Assistive Technology Society of North America.
- 15 Department of Health (2003) *Fair Access to Care Services: guidance on eligibility criteria for adult social care*. London: Department of Health.
- 16 Audit Commission (2003) *Guidance on the commissioning of wheelchairs*. Available online at [www.audit-commission.gov.uk/olderpeople/olderpeopleguidance.asp](http://www.audit-commission.gov.uk/olderpeople/olderpeopleguidance.asp)
- 17 emPOWER (2004) *NHS wheelchair and seating services mapping project: final report*. Limbless Association, p. 7. Available online at <http://kcl.ac.uk/content/1/c6/01/64/85/MappingProjectFinalReport1.pdf>
- 18 Audit Commission (2002) *Fully Equipped 2002*. London: Audit Commission.
- 19 Korner J (2004) *Hard Pushed – how the NHS fails powered wheelchair users*. London: Muscular Dystrophy Campaign.
- 20 Prime Minister's Strategy Unit (2005) *Improving the life chances of disabled people*. London: Prime Minister's Strategy Unit, p. 102.
- 21 Department of Health and Department for Education and Skills (2004) *National Service Framework for Children, Young People and Maternity Services*. London: Department of Health.
- 22 Department for Education and Skills (2004) *Every Child Matters: Change for Children*. Nottingham: Department for Education and Skills Publications.



# Notes





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