The Future of Wheelchair Services – Any Qualified Provider?

DOCUMENTS AND COMMENTS COLLATED BY
THE POSTURE AND MOBILITY GROUP

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PREFACE

Wheelchair Services: What is needed to make Government policy work?

The Government has recently published a document, 'Operational Guidance to the NHS: Extending Patient Choice of Provider' (July 2011), in which inter alia are the proposals that, in certain areas, patients should have a choice from 'any qualified provider' (AQP). One of the key services to be included initially within this initiative is the provision of wheelchair services for children. The reason for the inclusion of paediatric wheelchair services on their own in the initial phase would appear to have arisen from the All Party Parliamentary Group for Wheelchair Reform report 'My Wheelchair is My Shoes' sponsored by the charity Whizz-Kidz. (APPENDIX 3).

Whizz-Kidz' summary of the success of their proposed model in a limited geographical area has emphasised their areas of success, but has failed to include other areas which have not been covered by their model. Additionally, some feedback from the sources listed above relates to experiences of the Whizz-Kidz model that is not represented in their sponsored reports. (see Section C).

This letter brings together the input of over two dozen clinical and other specialists from around the UK, including contributions from members of the Rehabilitation Engineering Services Management Group (RESMaG), National Wheelchair Managers Forum (NWMF), Posture & Mobility Group (PMG), and British Healthcare Trades Association (BHTA). It hopefully paints a broader picture than the selective approach of the Whizz-Kidz sponsored reports.

The need for a holistic view and coordination of provision

Provision for people with disabilities has been heavily the responsibility of health budgets, and thus the 'medical' model has usually prevailed over the last few decades, if not longer. However, suitable provision has positive impacts in not only the medical area, but also social, education, and employment areas, amongst However, suitable provision has positive impacts in not only the medical area, but also social, education, and employment areas, amongst others. Indeed, as a second Whizz-Kidz sponsored report, Frontier Economics' 'Social Return on Investment for Whizz-Kidz' Services', points out, for every pound spent there were from £10 to £25 savings to be gained. The point made in this report is that at best only 1-5% of these savings were made on health costs, and the rest from social, educational, and employment costs/benefits. One example of a holistic, integrated service is seen in Norway, which has probably led the world in integrating service supply to those with disabilities; one centre in each region assesses and provides for all the needs of an individual.

There are individuals in the current Government who believe in the benefits to the individual and the State of combining budgets from different departments. The idea of placing control of health budgets for each individual with GPs was a first attempt to go along this route.

What seems in conflict with this view is the current proposal to introduce fragmentation of provision by separating off the provision for children and their wheelchair equipment from a) the rest of the population, b) from an holistic view of the individual's needs for their support beyond a limited range of wheelchairs, and c) what individuals need when they are not in a wheelchair.

Any Qualified Provider?

However broad or narrow the service, the bodies mentioned in our introduction are all adamant that there needs to be a level playing field for all entities tendering to provide the service. The following points, amongst others, have been specifically mentioned:

1. There must be well-defined benchmarks and criteria for the *Qualified* bit of the AQP. It needs to be clear what tenderers will be required to prove as to their abilities, and how this will be monitored.

2. Well-defined benchmarks are also needed for the *Provider* part of AQP. What will be provided, for which clients, in what timescales, to what quality level, and how will this all be monitored?

3. There should be a national contract of standards, thereby minimising the potential for a 'post-code lottery'.

4. The discussions around cost savings are important, but need to be presented in terms of which models of service and provision provide the best long term cost benefits for both the individual and the State, rather than being limited to short term price savings where service is commoditised around the cheapest equipment at the cost of whole life benefits.

5. There needs to remain in place a broad range of available solutions and equipment to help ensure the best outcome for each client.

6. There are very competent services within the NHS which are client-focussed and run a tight ship, who must be allowed to compete on a level playing field with other potential AQPs. For example, they should not be disadvantaged by not being exempt from VAT on their purchases. They should also not be disadvantaged because they can't fund advertising campaigns and produce glossy presentations. The criteria to be considered and the parameters for making choices must be carefully guided, with the focus on the patient at all times.

Broadening the picture

There needs to be a broadening of the total picture so that the AQP is able to, and required to, cover the whole spectrum of need, including social, educational, and employment, rather than just the medical need. Specific areas requiring consideration include:

1. *Continuity of provision, maintenance and review, and record keeping*

In the past, the term 'paediatric' has covered individuals up to 18 or 19 years of age. Even within the plans to extend this to 25, this still presents the challenges around one provider covering clients up to a certain age, and another thereafter. At any arbitrary age the individual's needs do not change. Indeed, the sort of children who are considered 'complex' and who therefore require specialist clinical expertise, will continue to require specialist input as they become adults and as they age. Within the spirit of Human Rights across Europe, there should be joined up rather than fragmentary provision as one ages.

The proposals should incorporate the need for continuity of medical and client records.

Ongoing review, as well as repair and maintenance, contracts must be included.

2. *Specialist support – the need for liaison to cover the breadth of related needs*

Feedback from the clinicians mentioned above has shown that the current model offered by Whizz-Kidz appears to be cheaper because it does not include the costs routinely incurred by current wheelchair services, e.g. provision for postural seating needs, special seating needs, qualified rehabilitation engineers, and home assessment. Thus the model is limited and incomplete, and does not reflect the whole picture of the service provision required just on the health front, let alone the broader picture beyond just ‘health’.

At the higher levels of clinical need (i.e. more complex and severe disability) it is essential that there are open and efficient links between the AQP and relevant surgeons, physicians, and other clinicians (related, for example, to spine or hip surgery, provision of alternative and augmentative communication, management of spasticity, provision of orthotics and prosthetics).

In summary

The Government needs to broaden its consideration of the needs of people with disabilities beyond the health funds being linked to the ‘patient’, to ***all*** funds being with the individual. AQP tendering must be on a level playing field, needs to be prescribed precisely, and needs to cover the broader picture, as opposed to covering only limited aspects.

Current plans seem to provide for one group of people (‘children’), at the simpler level of need, and just for wheelchair provision. For administrative and purchasing economies, and for patient benefits, it makes better sense that there is one service that covers cradle to grave, simple to complex needs, health through social through education through employment budgets, and thereby looks in toto at the individual, where payment by results benefits the individual, the State, and society as a whole. In view of these various concerns we would ask that paediatric wheelchair services are not put out to tender.

A separate report (attached) has been prepared which brings together the detail in the numerous contributions from which this letter has been produced. These individual contributions present a great depth of insight, knowledge, and constructive comment.

The different Associations who have contributed to this letter would welcome the opportunity of working with the Government, to help refine and shape the current proposals developing them into an holistic service reflecting the needs of wheelchair users of all ages.

Dr Barend ter Haar
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Member of PMG
Managing Director, BES Rehab Ltd

Dr Linda Marks
Consultant in Rehabilitation Medicine (Retired)
PMG member
National advisor to the Executive committee

with contributions from

British Healthcare Trade Association
National Wheelchair Managers Forum
Posture & Mobility Group
Rehabilitation Engineering Services Management Group

PROVISION OF WHEELCHAIR SERVICES:
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SECTION A: MOVING FORWARD TOGETHER

1. Lisa Ledger, Occupational Therapist, South Staffordshire District Wheelchair Service

Just a quick note as I don't know where to start with the Government plans - incredulous!!! How do they explain/justify separating a service for children? We have always been equitable in wheelchair services and if they do this it will make the issues of transition more difficult than they already are. More concerning is the lack of understanding around wheelchair services as a clinical service and there are different parameters of needs that are likely to need a different response. Also, they have no parameters of benchmarking for who is a qualified provider - guess we have to do this then.

I have drafted a clinical guide for commissioners and providers of services around the clinical nature and levels of need. If possible I also will share it with wheelchair managers and then hopefully it can be produced as a document to inform, amongst others, the new commissioning board.
Please note: This draft clinical guide is included at the end of this document. APPENDIX 1

2. Thurrock Wheelchair Service Team

INTRODUCTION
Whilst we would welcome an independent national review of Children's Wheelchair Services (WCSs) to ensure equity in eligibility criteria, resources, and budgets, we are very concerned by the recent 'All Party Parliamentary document' and media coverage.

Our GENERAL CONCERNS are as follows

- The report cannot be seen as impartial as parties who may in future benefit from the recommendations have been involved in the presentation of the document.
- The 'Expert Witnesses' do not include any representatives from National Wheelchair Managers groups, senior wheelchair service clinicians, PMG (Posture and Mobility Group), BAOT (British Association of Occupational Therapists) or CSP (Chartered Society of Physiotherapy), for example.
- No statistical evidence/outcome measures are included for NHS services as a comparison for the 'new model' proposed by 3rd sector.
- No counter discussion had been invited by the group (we are pleased that you are taking up the matter).

Our SPECIFIC CONCERNS are as follows

REFERRALS AND RECORD KEEPING

- Mechanism for referral, screening and prioritising needs clarification
- Networking of Outside Contractor (OC) with NHS colleagues in paediatric services, transfer of confidential information, and record keeping would need to be addressed
- Exchange of information re home, school, and 24 hour postural provision is invaluable – this would be needed to continue to ensure appropriate provision

BUDGET

- Would the tendering process be local or national? It would be necessary to ensure equity per capita, otherwise we would still have a postcode lottery for provision.
- Who would hold the budget and monitor the spend?
- Is there a danger that, should the children's budget become overspent by the OC, that other areas of the NHS Wheelchair Service budget (eg for adults) would need to be redirected. How are the charity's own funds used in conjunction with NHS funding?

EMERGENCY RESPONSE

- At present the Wheelchair Service, with its Approved Repairer and Rehabilitation Engineer Contracts, ensure that there is the facility for responding to urgent changes in situation (eg surgery/injury) for a long term user, and also to failure or breakdown of equipment. There have been countless examples of the team needing to respond, for example to ensure a child can be transported home from school or be discharged from hospital. The success of this service depends on all these facilities being in place and responding quickly. Where Outside Contractors have

- been involved in children's provision for WCSs, they have used the services of the local Approved Repairer and/ or Rehabilitation Engineer. Should the Children's Services be outsourced, would they be able to offer this type of back up service?
- Currently, clients with powered wheelchairs, also have a manual back up chair – would this still be the case?

REVIEW

- Clients are welcome to re-refer at any point, following initial assessment. We ensure children's families are contacted or seen regularly for review of their clinical needs, and adjustments and changes to equipment provision made as necessary. It would be important to retain at least this level of monitoring, to ensure there is no avoidable deterioration in posture, function, comfort, and pressure relief.

TRANSITION

- At present the children in our service are seen by therapists who have experience of working with adults and children, liaising as necessary with the client's care and therapy teams as necessary. The same team at the Wheelchair Service are involved into adulthood, which makes the transition much easier for the young person, their history is well known, and the family know the staff.
- With an Outside Contractor involved in children's provision, there may be inequitable criteria, provision, and budgets. Once the young person transfers back to the NHS Wheelchair Service, this may be a potential problem, as high specification equipment may not be automatically funded, and therefore private input and a greater call upon the NHS Voucher Scheme budgets may be required.

PROCUREMENT

- There have been great improvements in the past few years in purchasing procedures and lead times from manufacturers.
- WCSs are able to order direct from manufacturers, thus preventing further delays on lead times/delivery. We understand that the Outside Contractor would order via a third party, which would add to further delays. Also WCSs hold stocks which they are often able to use as final provision very promptly, or as an interim measure.

3rd SECTOR ROLE

- We have, in the past, welcomed the 3rd Sector (eg Whizz-Kidz and Action for Kids), in working with us to provide or top up finance for equipment that lies outside the remit of the Wheelchair Service. However, with this proposed change, we would lose this additional facility.

SPECIAL SEATING and REHABILITATION ENGINEERING SERVICES

- How would the Outside Contractor access these services, and how would the host WCS monitor the referrals, and potential expenditure
- Would the Outside Contractors have access to their own Special Seating and RE services for bespoke equipment and modifications? Would there be a regular review procedure?

BASE and INFRASTRUCTURE

- Where would the Outside Contractor be based?
- Would the NHS buildings and resources be shared?

CONTRACT MONITORING

- Approved repairer and Special Seating contracts are continually monitored and feedback is exchanged to ensure standards are upheld. There needs to be a facility in place to continue to ensure this is the case.

CLINICAL SUPERVISION

- Opportunities for clinical forum, support, training, and supervision currently exists in the WCS. A clinical supervision structure is important to ensure sound clinical reasoning and accountability.

As we stated at the outset, we are happy for a national independent impartial review of children's wheelchair services, but feel that the above issues should be addressed.

Comments made recently about past experiences, and the proposed ‘new model’ of the provider -
“One size (wheelchair) fits all”
“It would be a disaster to transfer services”
“A wheelchair was still too large for a child, 2 years after provision”
“Anybody could offer anything, with the right amount of funding”

3. Linda Marks, External Advisor to PMG; Consultant in Rehabilitation Medicine (Retired)
One aspect of supporting our colleagues in learning to become competitive is showing our positive outcomes, which is why I was keen for PMG to get GAS (Goal Attainment Scaling) scores adopted across our services. This measure seems very appropriate for our services as it can capture the straightforward and the complex end of our work - this is critical if we are to get away from the 'logistics' view of what we do.

The PMG response to Andrew Lansley is very important. One point is that 'competitive tendering' will actually disadvantage the NHS services. They neither have the personnel, the time, or the money to spend on preparing elegant presentations, statistics, and glossy brochures - so they will be immediately disadvantaged. I've been through such an exercise, and even with top level support from my Trust (EXEC Board members on the presentation team) we spent HOURS and HOURS of time, let alone meeting on Bank Holidays and working till the wee hours of the mornings. Most Trusts won't be in a position to support this kind of activity so NHS services will go under by default even if they are better than any of the others.

4. Henry Lumley, Group Manager - Rheumatology & Rehabilitation, Southmead Hospital, Bristol
If you want to offer choice then we’ll have some of that but we play the game on a level playing field. The commissioners have to take responsibility for what they are introducing which means the cost as well. There needs to be a tariff set and that should apply to any provider. It should cover the full service, including assessment, delivery, re-assessment, fitting, tweaking, repairing, etc for the full episode. I would be happy to compete with any of them but it must be fair. If the equipment is wrong and has to be replaced, then you don’t get another tariff. You carry that cost. Like the CQUIN targets on re-admissions within 30 days.

VAT is an issue. A charity may be able to provide the chair free of VAT. Certainly if an individual buys disabled equipment as a disabled person then it’s zero rated. If the NHS buys and issues we can’t recover the VAT. This needs resolving.

The DH guidance clearly states that AQP is about quality not price/cost. It only works if there is a common tariff that everyone gets paid. Lynne Turner-Stokes still heads a group looking at HRGs and tariffs for rehab and has just asked if I’d like to lead a project looking at tariffs for all our services. (I’m not sure I would but I suspect I should and probably will. I need to get some advice from my Trust first). This could help.

Locally, our SHA are saying they want to push all wheelchair services down this route (adult and paediatrics) but then talk about separating assessment from provision, suggesting the choice could be about who provides the equipment. I have said this would be madness. You cannot separate provision. It just wouldn’t be possible to issue a prescription which would enable a dealer/manufacturer to issue a wheelchair/seating without the benefit of the clinicians fitting at delivery. You just can’t do it.

5. Lone Rose, Physiotherapist, National Spinal Injuries Centre, Stoke Mandeville Hospital; ex member of PMG Executive Committee
Have just read your circular regarding the plans for wheelchair services. Speaking on behalf of the SCI (spinal cord injuries) lobby - if you would like to use some positive evidence for how wheelchair services have improved in recent years feel free to use the data presented at PMG in 2009 from the national surveys. This showed a distinct improvement in types of wheelchairs provided which led to less abandonment of wheelchairs (= better use of resources) and great satisfaction scores amongst users. Also the most recent standards produced by the wheelchair managers’ forum in collaboration with others show that they have taken on board emerging evidence - e.g. having as one of the standards that active users should be provided with high performance lightweight wheelchairs in accordance with the recommendation from the Consortium for Spinal Cord Medicine (2005). So even though funding has not been increased in real terms the services seem to be able to move forward in accordance with evidence (for SCI anyway). No small feat. All this helps to foster greater equality of provision across boundaries, reducing the 'postcode lottery'. Putting these services out to private tender will presumably blow this completely out of the water.

Above evidence not yet published as article but should be available soon on the UCL website as part of my MPhil dissertation. And then published as articles, is the plan.

6. Olwen Ellis, PMG Administrator
I am in the same situation as the people who are making decisions on wheelchair services because, like most of them, I don't work in a wheelchair service, and have never used one. It's only because I work for PMG, and live with Pete (rehab engineer), that I have come to understand that it is a service which fits perfectly into the remit of the NHS, caring as it does for the health of our most physically compromised citizens.

Prescribing a wheelchair is more than providing a disabled person with the means to move around, but most people don't understand this. Perhaps it is the nomenclature itself that is to blame: “Wheelchair Service” sounds more like an equipment store than a highly sophisticated health department which requires a range of clinical expertise, where Consultants in Rehabilitation Medicine, physiotherapists, occupational therapists, rehabilitation engineers and clinical scientists all work together to provide complex seating solutions for their patients/clients.

The reality is that these clinicians need high levels of skills to prescribe for complex postural issues, and by getting the prescriptions right, will save the NHS huge amounts of money further down the line - by helping avoid hospitalisation for a range of complications that would otherwise ensue, from chronic pressure sores to respiratory issues. It is true at all ages, but in particular while children are growing and developing, where the correct postural management interventions can improve their prospects radically. Preventative medicine at its best.

Because the majority of clients/patients remain with a wheelchair service for most of their lives, their postural and mobility requirements will change continuously, so that repeat assessments and prescriptions cannot be avoided. It can never be like having a cataract removed, or taking a course of antibiotics, which fix a medical problem. All prescriptions are for the condition at that time, until things change. Disability is, for most, a life-long condition.

The need for national standards for these services is as great as for all other NHS services: the postcode lottery is particularly prevalent in wheelchair services. PMG was set up to help change this, and is best placed to advise government departments about training needs, best practice and competency requirements.

7. Margaret Hannan, Clinical Scientist, Kings College Hospital
What I believe our organisation must do is demand that there is clear accountability during and after the process of opening up to any qualified provider.

i) Commissioners must publish the results of their initial engagement with patients, healthcare professionals and providers regarding local priorities for extending choice so that inaccurate information can be challenged
ii) The evidence for dissatisfaction with the current providers must be made public so that the impact of any change of provider can be assessed in the future
iii) The potential benefits of opening up to AQP should be identified (just because there is current dissatisfaction in certain areas there is no guarantee that simply opening up to AQP will improve matters, eg if the service commissioners wish to control eligibility criteria and these criteria are the source of the dissatisfaction)
iv) Clear service delivery criteria must be published as soon as possible so that all qualified providers have the same opportunity to tender for the contract and so that contract monitoring can take place
v) The 'qualified' in 'any qualified provider' needs to be defined
vi) Criteria need to take account of the ongoing maintenance of equipment (This does not have to be included in the service contract. Responsibility for maintenance could be passed on to the service user via insurance schemes, for example, but this needs to be explicitly stated if there is to be a change from the current situation where maintenance costs are covered directly by the service)
vii) Monitoring of the contract should include some longer term outcomes, for example the lifetime of each prescription, perhaps giving some measure of the average yearly cost of the provision. This might help with identifying services that were able to deliver good value (perhaps better at getting the initial prescription right or providing equipment that might be more expensive but which lasted longer because of the equipment's potential for adapting to growth or change)
viii) The emphasis in the white paper is on choice. Will there actually be specific contracts for providers in specific geographical areas? Or will there simply be a tariff system with any qualified provider being able to **offer** a

wheelchair prescription service to any wheelchair user and charging for this on an individual basis (but not **necessarily** getting any work)?
ix) While each provider must take responsibility for providing data to support monitoring of the service, there should be some objective means of assessing the effectiveness of the provision. I note that much of the information supporting the effectiveness of certain organisations has been provided by the organisations themselves.

8. David Porter, Clinical Application Specialist, Dynamic Europe Ltd; PMG Executive Committee Member; Chair of PMG Research sub-committee
My view is that the terms of reference for the PMG political action group should focus on engaging with and advising policy makers. It is important we are not seen as simply resisting the suggested changes. However, given our concerns about what we think is being proposed, this might be easier said than done. Obviously we have all invested a huge amount of time and emotion into the NHS wheelchair services and want to protect the good things. However there will always be things that can be improved. If the political group can engage in the process, maybe this will help to nudge things in a more appropriate direction. Unfortunately, change for the better usually needs significant investment of time and resources and, given the current financial climate, it is very unlikely this will be available. It is more likely that these changes are connected with the aim of saving money. As others have said, at the very least the political action group should be trying to ensure wheelchair services can compete on a level playing field if services do go out to tender. Also, if it is inevitable that the wheelchair services do go out to tender, it would be good to push for certain parts of the service (i.e. those requiring greater clinical expertise and coordination with other parts of the NHS) remain within the NHS, perhaps allowing other parts of the service to end up being carried out by a different provider.

9. Dr Imad Soryal, Dr Martina Walsh and Dr Sudha Balakrishnan; Consultants in Rehabilitation Medicine
Qualified providers of wheelchair / posture and mobility services to people with long term conditions need to ensure that patient pathways are maintained and further developed in line with other NHS / Social Care services professionals. Patients accessing Local Wheelchair Services benefit from timely intervention of many rehabilitation services, e.g. spasticity management, developing an integrated and holistic management plan. Further development should be extended to include specialist charities e.g. MS, MD, MND, Whizz-Kidz.. For this to happen services need to further develop the network of professional, charitable and industrial links.

Multi-disciplinary assessments for those with complex disabilities, e.g. the management of neurological and neuromuscular disabilities, need to be protected with career pathways for professionals leading from student practitioner level to specialist within the rehabilitation field becoming commonplace. This network will encourage continuity of care (no longer a given in service provision) for patients as retention of appropriately trained staff becomes less of an issue and staff have established contacts to interact with. Services working in isolation should be discouraged and all service provision should link to larger (regional) organisations whilst maintaining their local autonomy and ability to tailor services to the local requirements. This is facilitated by a hub and spoke model which also ensures that the peripheral service providers are trained to recognise when, how and where to refer their complex clients..

Education and training of professionals should include all members of the multi-disciplinary team (Consultants, Rehabilitation Engineers, Therapists) and are best delivered at regional level (involving appropriate Higher Education Institutions, such as Coventry and Birmingham Universities) supporting all Local Wheelchair Service practitioners and assistant practitioner support staff. All services need to commit to continuing professional development.

Agreed national / regional commissioner specifications, policies and procedures should be developed which can be used to advise commissioner tariffs in line with activities. This will reduce the “post code” lotteries that currently exist. Appropriate Care Quality Commission audits should be identified and introduced, led by either national or regional groups. Medical device standards already exist to protect the health and safety of patients’ equipment.

The West Midlands “hub and spoke” model and its potential for future development go a long way towards addressing the above service requirements. As an example Birmingham Wheelchair Service have developed, with their commissioners, specifications that incorporate relevant CQC specifications and the service reflects the DH model. We are currently (for the past year) running a “shadow” cost and volume contract to test a method of specifying defined levels of service and provision, and therefore tariffs. We have also defined quality measures and as a matter of course set individual patient goals, followed by a questionnaire to test outcomes.

10. Dave Harrison, Clinical Engineering Services Senior Manager, West Midlands
Local and regional provision was discussed by a representation of local and regional staff with Donna Carr during a visit dated 20th April 2010. As a result of the DH work and Donna's visit, the Local Wheelchair Service completed a service redesign project that has never been discussed outside of the West Midlands. It was our interpretation that the group would receive DH feedback and have further opportunities for inputting into the programme.
Our interest is to protect / improve the levels of provision all of our patients/ clients receive and thank PMG, RESMaG and West Midlands Wheelchair Managers Group for inviting us to add further comments.
Reference "Any **Qualified** provider":
We would like to understand the criteria that exists to enable an organisation to become "qualified" and more importantly that within the criteria assurances exist to protect patients' assessment, provision and safety. The current levels of provision, to include the points raised in this paper, should be considered as the base line standard.

SECTION B: GROUP RESPONSES

1. Krystyn Jarvis, Chair of National Wheelchair Managers Forum
The current NHS providers offer an equitable service across all age groups ensuring children coming into adulthood can anticipate the same level of service. These services with limited resources are tasked to provide an efficient, cost effective service to all wheelchair users, and specialised clinicians will prioritise all clients with the most urgent need, very often with children being given priority. The NHS services' budgets are mostly taken up with complex seating and bespoke wheelchairs and so the high volume, low cost items are largely not supplied, therefore where there have been budget pressures it is the elderly, social user who has been most affected.

It should be noted that the *(Whizz-Kidz sponsored)* reports are based solely on the experience in Tower Hamlets, which is by no means typical of the rest of the country. Many of the statements that are made in these reports are irrefutable and express many of the concerns that the current providers of these services in the NHS have been stating for a number of years, such as the impact of well assessed, well-engineered equipment and timely provision specific to each child's needs on maximising their development. Therefore the 'invest to save' principle has been a long standing argument put forward to commissioners over the years.

The variation of provision of services around the country resulted in National Healthcare Standards being set by members of the National Wheelchair Managers Forum in 2005, and reviewed in 2010, in collaboration with a number of other professional bodies e.g. Posture and Mobility Group, British Society of Rehabilitation Medicine, emPower and Whizz-Kidz. These were subsequently presented to the Department of Health to adopt, and although this was refused, many services and commissioners implemented the standards as best practice recommended by the NWMF et al.

There are undoubtedly conflicting interests, as all the specific age groups and diagnoses will lobby for their interests. The reports also raise grave concerns, particularly as they advocate a fragmenting of wheelchair provision across age groups. The reasoning put forward by these reports can also be applied to young adults, those with long-term neurological conditions, trauma, war veterans, the terminally ill and the elderly. All have their priorities in terms of quality of life, independence, social interaction, reduction and prevention of further medical complications such as tissue viability, postural management and comfort.

Currently the NHS provides wheelchair and postural seating services from 'cradle to grave', giving a seamless service to all. To fragment the children's services away from adult provision solicits the question as to what happens when the child reaches adulthood. Transition to adult services has been a long standing problem for parents and children. It is with a sense of relief that parents enter the wheelchair service and are informed that they will continue to be assessed by the same team.

As experienced professionals in this field of work we are aware of the many omissions in the narrative of these reports: there is no mention of the range of diagnoses encountered, the provision of highly specialised, bespoke postural seating, ongoing maintenance and repairs and the handling of returned equipment/re-cycling. We are then led to assume that the 'child in a chair in a day' is only targeting the least complex of cases, as bespoke solutions for a child with complex postural deformities cannot be addressed in this way, entailing the manufacture of individual items which cannot be taken off the shelf. It is these complex cases which NHS services address consistently, changing the equipment with the development of the child. The availability of a repair service is not mentioned; however, a timely repair service is essential, therefore has the cost of ongoing repairs to keep these children mobile been accounted for?

The overall apprehension regarding these documents is the misrepresentation of all the services in the country, the ill-evidenced claims being made and the lack of real narrative to support the claims, which on face value will entice commissioners and service users to believe changing providers of children's services would be of advantage. Further consideration regarding all aspects of service provision needs to be examined and the overall effect on all service users and the subsequent issues of creating two services out of one. If this proposal is adopted, will this lead to further fragmentation of these already comprehensive services, which will result in more costly overall provision. It is advisable at this moment to further examine each service within its locality prior to including the provision of children's wheelchair services in the initial 'any qualified provider' arena (Extending Patient Choice of Provider).

2. Dr Chris Daniel, Chair of RESMaG

RESMaG (Rehabilitation Engineering Services Management Group) is an organisation that aims to promote the work of Rehabilitation Engineers. It feels that the assessment and provision of children's wheelchairs by non-NHS organisations could have a deleterious effect on the safety of wheelchair users. Rehabilitation Engineers in the NHS are largely responsible for the correct provision of wheelchairs as well as postural assessments and prescriptions. Rehabilitation Engineers design bespoke solutions and authorise modifications to mobility equipment, including special seating and associated accessories.

Gains have been made in recent years by the DoH funding of an MSc course in Rehabilitation Engineering at Coventry University and the promotion of professionalism and accountability through the Voluntary Register of Clinical Technologists (VRCT). Further enhancement is promised in the programme of Modernising Scientific Careers (MSC) when Rehabilitation Engineers will become Healthcare Scientist Practitioners and will be subject to statutory registration. Currently registration with the VRCT is little known in private industry and the charitable sector and the MSC programme is confined to the NHS.

We would ask the NHS to consider the risks to wheelchair users in cases where provision is being made by individuals who do not have the experience, training and accountability of Rehabilitation Engineers in the NHS.

3. Ray Hodgkinson, Director General, British Healthcare Trades Association (BHTA)

BHTA considers it illogical to treat paediatric wheelchair services separately when whole life costs of supporting an individual need to be considered and addressed if the state is truly to achieve savings across not just health, but also social care, education and work budgets. We welcome the concept of "any qualified provider", but a clear definition of service requirement and the tariff that applies to it needs to be developed in consultation with all interested parties – making clear the scope and responsibilities – and "qualified provider" must also be clearly defined in context.

Defining "qualified" when looking beyond the arena of professionals registered with the Health Professions Council will require identification of means other than "qualifications" to evidence appropriateness – examples might be that trading entities (charities, social enterprises, limited companies etc) should be signed up to an OFT-approved Code of Practice; and that individuals working in the service should be signed up to a relevant body which has an appropriate Code of Conduct, looks at competence of those it admits, and which requires Continuing Professional Development.

SECTION C: LESSONS TO LEARN FROM WHIZZ-KIDZ EXPERIENCES

1. Libby Bradshaw, ex-manager of Tower Hamlets wheelchair service, 1992-2011

Critique of the Frontier / Whizz-Kidz report (Impact of Whizz-Kidz support to Primary Care Trusts, October 2010) *refer to* ADDENDUM 2.

i) **Page 16** figures and **page 20** conclusions: Many of the conclusions of the report are based on the figures on page 16 which cannot be accurate. Despite raising this with my manager and with Whizz-Kidz, Whizz-Kidz has declined to provide an answer as to the source of these figures but claim they are in the public domain. They have been unable or unwilling to point me in the direction of the 'public domain'. The key one is the claim we had £108K for staffing –

our 2005/6 budget for staffing, RE contract and maintenance contract was a total of £268,718 for ALL users, I haven't got 2006/7 to hand but it would probably only have gone up by inflation. (The 2010-11 budget was £320,111. However, this figure is slightly academic as we were not allowed to utilise all this funding.) How they reached a figure of £108K for less than 300 service users when we had a total of 4,500 users I don't know. Our records and calculations at that time show we had a budget of approx. £94 per user to cover all staff, equipment and maintenance costs. Obviously a lot of those users are only using the repair service but, if their figures are being reported as an overall average, their costs per user (quoted at £800) are more than 8 times higher than ours were. The report concludes Whizz-Kidz is 60% cheaper.
ii) Shorter waiting times were achieved in Tower Hamlets for both children and adults – this was due to the huge injection of money to Whizz-Kidz (£600K over 2 years) and the original budget remaining in the service for the adults (over 26 yrs old) thus increasing the amount per capita. Various places imply this was due to Whizz-Kidz rather than acknowledging it was the increase in resources all round.
iii) **Page 7** final paragraph more or less admits the information is not robust!
iv) **Page 9** onwards compares Whizz-Kidz with the 'Typical PCT'. It is not clear what is meant by the 'Typical' PCT and it seems more like the worst case scenario from the Barnados and Whizz-Kidz report – most of the things listed under Whizz-Kidz were in place in TH service and all our neighbouring wheelchair services. **Page 11** on stock – our information has always been very clear and I am surprised if other PCTs are not expected to keep robust records of their stock.

2. David Allen, Rehabilitation Engineer, Tower Hamlets Wheelchair Services

I make these comments from my position of an NHS rehabilitation engineer finding himself in a service with Whizz-Kidz (WK) as a partner looking after the paediatric and young users (up to age 26) initially, but from April 2011 as the sole provider of service. It will be easy for many to see which service that is of course.

I am aware of the contents of the existing "Frontier" report and "My Wheelchair is My Shoes" together with any comments I have read in the regular press etc. I am also aware of the BHTA's comments on the same topic. Essentially I find myself having much agreement with the latter despite currently being an NHS employee not from the private sector. I have tried not to simply repeat anything already included in it. Like many I was a private sector employee in my pre NHS career.

I do not have access to detailed data regarding finance and user numbers etc. and would not expect to have, being a sub contractor's representative myself anyway.

I do feel that this whole issue is driven by WK and simply presents things in the best light for them. It assumes that others have little to offer. We in the NHS would never realistically be in a position to commission any reports anyway.

I am all for improvement to any services offered by the NHS. I am close to retirement myself and expect to be a user of various NHS services over time. I also have family members now who depend upon NHS services. I am certainly not opposing any improvement, but let us get things clear and on the commonly quoted "level playing field".

When WK arrived as a partner they enjoyed the use of a new budget provided for those young users only.
The existing budget was retained for the "adults" with provision continuing to be made by the original NHS Trust wheelchair service. Put another way, this clearly amounted to a significant budget increase all round. Any improvement was not simply the result of more efficient provision - there was more money available overall.

I do see improvements in provision here but not simply because of a supplier change. In fact I believe it is very largely due to a funding increase. I ask myself what the same funding increase would have provided if passed to the existing wheelchair service. To maximise this they would have needed some warning to enable staffing and systems to be adjusted accordingly but I believe that is all. My answer is that the original service could have achieved *at least* the same improvements given the same opportunity.

When WK took over they were able to move into good modern well equipped NHS premises. The basic facilities to underpin any service were already available and continued to be used. The same facilities could easily cope with increased activity. The "critical mass" point applies here.

NHS wheelchair services are essentially required to supply against agreed criteria. It can be argued that this restricts provision of anything at all to some and choice to others. We all have our own personal views and opinions of course but are nevertheless required to adhere to these criteria. WK seem to me to take much less notice of any criteria and so claim that service is better, whereas the NHS service staff would be criticised to not supplying to agreed criteria.
Not a level playing field.

I consider that WK sometimes issues equipment which is more expensive than it needs to be. There is cheaper equipment that meets the statement of needs. Some of this more expensive equipment is perceived as “better” as it may look more attractive to some and perhaps carries a “premier” product image. This is described by some as “over provision”. The result can easily be heavier, less convenient items. I myself have heard users making much this comment. This cannot be an increase in efficiency. Yes I do realise that an end user may well not know what is going to be good or bad until he has had time to learn from actual use. However the experienced supplier should be able to point out at least some of this in advance.

The use of a single supplier seems rather strange. This happened very quickly but I saw no real evidence of evaluation or competition. It seemed to be taken as fact that this simply must be “better”. There are national NHS agreements in place for the purchase of most of the equipment used by wheelchair services. These are not used by WK who make purchases through the one supplier. Almost everything is delivered initially to his base and he re-delivers to any other location required. I have not been offered any evidence of this being more efficient, cheaper or faster. I have not considered any environmental issues which may relate. My own experiences working in other NHS wheelchair services is that it is certainly not faster! It seems to me that this way additional people must be involved in the supply chain too.

The use of specialist representatives from other manufacturers or suppliers is discouraged even if not banned.
The use of the sole supplier also seems to assume that he has full knowledge of everything. I do not believe that person to exist. If they do then I have certainly never met him or her, and I have been working in such services for many years.

One way that has been suggested of providing equipment much more quickly is to provide “direct delivery” of some items under some circumstances. In short this is where no face to face assessment is carried out. The situation is evaluated from, say, a paper referral and basic chair delivery to the user is arranged immediately. This will usually be from a restricted stocked range. However there is nothing new here. Every wheelchair service I have worked with does essentially the same. It may not be called “direct delivery” or any other actual name but it happens frequently. No improvement or greater efficiency is seen by me.

Once WK had taken over the service they decided to change the basic range of equipment used. I and others have no objection to that. In fact I believe such action should be considered regularly. However there was no consultation, despite much experience being available from existing staff etc. I was not even informed until after the fact. I continue to work regularly in other wheelchair services where actually I find communication and consideration processes more open than here. Essentially I find much out by accident rather than design since the service was taken over.

3. Martin Davy, Managing Director, Delichon Ltd.

In the past, I have been a keen supporter of Whizz-Kidz. In 2005, and again in 2006, my wife and I ran the London Marathon in support of them and for a number of years they were the major beneficiary of our corporate charitable donations. Times have changed though, and now it seems I am not alone in feeling sceptical about the move to 3rd party provision of wheelchair services and in particular the involvement of Whizz-Kidz and the unrelenting focus on children in all of this. I am so concerned about where all of this is headed that I am in the process of organising a visit by our MP so we can show him some actual examples of the effects of recent changes, not the rose-tinted PR spin that those driving this new agenda would have us believe.

Our experience at Tower Hamlets is a mile away from the glossy report that proposes it as a model solution for service provision. Our experience in other centres which have experimented with alternative models of service provision (including Plymouth) is just as worrying. We have been told recently by a therapist employed by Whizz-Kidz that they are in effect compensating for a drop in donations by using NHS funding to cover what would previously have been supplied through their charitable arm. The severely involved adults with complex needs just seem to be forgotten in all of this. On numerous occasions we have seen children taking precedence over adults in clinics, and last minute list changes because children have been given a higher priority. In one recent instance this led to the delay of a delivery appointment and an adult client had to wait another month before we could hand over a bespoke item we had already made for her. In another case we have had a delay of 5 months in the supply of a powered chair (nothing more exciting than a Spectra XTR) – hardly a "seat in a day"! Our standard turnaround time for a Foam-Karve seat from casting to delivery is 2 weeks. We are no longer achieving anything like that speed of supply in any of the affected services.

Just to make matters more interesting for us, we have now been told by Whizz-Kidz that we cannot proceed with the selection process they currently have underway to choose their "Approved Seating Contractors" because we only supply one sort of seating and are not trying to sell ourselves as a "Jack of all trades" like some of our competitors. We are a specialist supplier, delivering a product which was my own invention in a unique way and are still one of the very few companies that genuinely can make "a seat in a day" – and quite complicated seats at that. This is a very worrying trend, and is a real blow to those of us who believe that the UK was actually better off having a variety of highly skilled smaller providers rather than the model of standardisation that applies elsewhere. If this is actually allowed to happen, then patients will end up being offered a more limited choice of chairs and seating from one or two big suppliers, with decisions made on the basis of what is easiest to supply and not what is clinically correct.

I know that some of the Whizz-Kidz therapists are not happy with some aspects of this either, as it undermines their professional judgement, and restricts patient choice. We already have the feeling that there is a problem recruiting staff with suitable experience in these new services. Certainly in Plymouth, none of the existing therapy staff were willing to transfer to either Whizz-Kidz or Millbrook, so there is a skills gap and a lack of continuity for patients. The therapist we have mostly been working with at Tower Hamlets is leaving to take up a post at Rookwood. Some of the more recent recruits have little or no previous wheelchair experience. All anecdotal stuff I know, but add it all up and it paints a depressing picture of what may face our patients in the future.

It isn't all about one charity though. If those responsible for making commissioning decisions think that it is safe to make cost-savings by getting rid of high-cost professionals (consultants, physios, OTs, REs) then they are bound to feel that they can get better value that way. Many users of more basic equipment will be largely unaffected. The vociferous active users will probably stand a chance of getting a better service. Some of the kids will get sparkly new chairs (although not necessarily appropriate seating to go in them). Complex seating clients just won't be seen as often – but that's ok because they take up a lot of time and their equipment is expensive anyway…

I can't help but wonder that if a charity can sponsor a government report, use that report to persuade one London service to change the way it works, pay for a private economic report which paints the rosiest of pictures, and then use that same report to persuade others to follow suit, then how much more influence should the industry trade body backed by 3 major professional organisations be able to achieve?

Given that wheelchair services often control sizeable budgets, I do find it extraordinary that they can be moved into the control of private companies or 3rd parties without a formal tendering process, and with no mechanism to ensure that the quality of care is maintained.

Change doesn't have to be a bad thing, as long as things change for the better!

4. Anonymous Locum worker

I have been asked to contact you with some feedback on my recent contact with Whizz-Kidz (WK) services. I work as a locum Occupational Therapist within Wheelchair Services. Since I commenced my recent locum position we have seen 33 children that had been seen by WK but have been re-referred to the service. 3 had equipment for handover. The re-referrals came mainly from parents and school therapists. All were seen in clinic with RE and OT. Equipment that was ready for handover was often deemed inappropriate due to lack of postural support or the wrong size. Parents reported difficulties with pushing the chairs; children's ability to transfer out of the chair was compromised, and on one occasion the chair identified for issue was second hand and had none of the recommended written information for parents.

Whizz-Kidz used to provide excellent service to families for powered mobility. My recent experience suggests that they have lost sight of their original core skills and in attempting to provide 'a chair in a day' are compromising their

service. It is my recent experience that a proportion of children neither received a 'chair in a day', nor an appropriate prescription. I saw a child in clinic this morning. They had waited 5 months for a chair and now the lack of postural support is beginning to have a significant effect.
Writer wishes to remain anonymous

5. Colin Plumb, Former Wheelchair & Special Seating Service Manager, Plymouth DSC, 2002-2011
The first thing that needs to be understood is that Millbrook hold the contract for providing a wheelchair, special seating and maintenance service to the residents of Plymouth and South Hams. Millbrook in turn have sub-contracted the paediatric (although I believe this is up to 25 years) service to Whizz-Kidz and also the clinical supervision of the adult service to Whizz-Kidz. Although the Plymouth children's commissioner had initially directly approached and negotiated with Whizz-Kidz separately, it is my understanding that (apparently due to their charitable status and being registered as a children's charity) they could not be seen to be taking on the running of adult and maintenance services, therefore Millbrook front the operation.

I have already raised my concerns through the PCT board, NHS counter fraud team and my MP so I have no problem whatsoever in sharing information with PMG. I will forward some emails I sent to my local MP for your info. The shameful thing about this whole mess is that despite the counter fraud team recommending an audit of the process and despite the PCT board knowing that the procurement process was not followed, nothing was done. Skilled staff have been lost and the "seating specialist" taken on by Millbrook had no postural assessment experience at all. How can this be in the best interests of the patients and represent best value for tax payers’ money????? It's beyond me.

There was no tendering process undertaken. No OJEC advert, no supplies2health notice, no service specification to tender against and no formal, transparent evaluation process. The existing service only received verbal notice that the service was being decommissioned a few weeks before the termination date.

I should point out that the Plymouth commissioner is of the belief that the service was tendered because back in 2009 a tendering process was undertaken for Plymouth's community equipment service and written in the tender advert document was the following line "There may be an option to extend the scope of the services to include paediatric **equipment**, wheelchair approved repairer **equipment** and functions, **equipment** associated with DGF functions......all subject to proven cost effectiveness". There was nothing in this tender document about providing a clinical assessment service for wheelchairs and special seating.

From my own involvement with formal tendering processes I am strongly of the opinion that there has been a massive breach in NHS procurement rules as the commissioners have been unable to demonstrate that a tendering process took place, have been unable to demonstrate that an impartial evaluation process took place to demonstrate value for the public purse, and have been unable to demonstrate transparency in their undertakings.

I feel it’s very important to point out that the new providers do not appear to be required to work to the same standards and targets that we had in the NHS. We had to record and report to the commissioners on a weekly basis the number of referrals we were receiving, assessments completed within the 6 week target, deliveries completed within the 18 week referral to delivery target, cost of equipment etc. It would seem that although the commissioner stated that the new provider would be contract managed in exactly the same way, in reality the new providers don’t do this. I've attached some interesting documents for you. The freedom of information document clearly shows that data was available when we were running the service but is not available now that Millbrook is running it. The other document/s shows the workings of the Plymouth commissioner and puts in black and white that no tender process was undertaken for the outsourcing of the Plymouth Wheelchair and Special seating service. These documents are in the public domain (I downloaded them from a Google search) so they can be included as well if you wish. *(we will provide on request – PMG)*

One final point is that the quality assurance and safety checks that the rehab engineers had in place to monitor the maintenance contracts do not happen with the commercial contracts. This is a major concern as you've only got to ask any RE around the country if he/she would be happy to let the maintenance contractor issue equipment straight to a patient without an RE check and the answer would be very definitely no.

6. Peter Lane, Senior Rehabilitation Engineer, Exeter Mobility Centre

Whizz-Kidz (WK) confuse NHS wheelchair provision with social services and educational provision (*My Wheelchair is My Shoes* (MWIMS) page 13). *See* APPENDIX 3.

The report makes claims that earlier provision of a tilting wheelchair would prevent surgery (MWIMS page 13), but there is no clinical evidence to support this. At the Exeter Mobility Centre (EMC), we have had clients as young as 9 months old in tilting bases with special supportive seating systems, but we cannot predict the outcome for these children, hence we regularly re-asses them for growth and postural changes. There is research to support the provision of 24-hour postural management to improve outcomes for clients, part of which is met by the wheelbase and seating system, but would not predict a zero intervention of corrective surgery if adhered to.

My colleagues and I have first-hand experience of WK and the inadequate postural support of seating systems they have supplied. Their rush to source locally and supply quickly has highlighted how little their therapists understand about Neuro-muscular development in children. I know also of a 10 year old WK client who was supplied a class 3 powered wheelchair which is illegal under the Highway Regulations 1988 Act. Fortunately the chair was banned from the Primary School on safety grounds. The carer was repeatedly ignored when they requested a re-assessment for growth. Fortunately, they had the NHS to fall back on!

WK's mantra "a child in a chair in a day" (MWIMS page 7) is at odds with their claim to be holistic. We (EMC) routinely provide information to parents/carers allowing them to make informed decisions and choices regarding equipment and how it fits into their daily lives. Clinicians have left WK because of the impossible pressure to supply "a chair in a day", when they know the prescription is far more complex. Please note that WK are now actively advertising for therapists from the NHS.

WK's CEO, Ruth Owen, claims that WK can provide even complex seating in 3 days, which raises grave concerns about their ability to complete a full postural assessment, and what best meets a client's clinical needs. These are amongst the most vulnerable and complex NHS clients, who will need continual review in provision for growth and neuro developmental changes.

WK claim to commission resources, but their preferred business model is to use only 2 or 3 suppliers for everything. They mention lowest prices, but I have seen receipts for powered wheelchairs of £7K to £8K supplied with no maintenance or servicing agreement (which is free in the NHS). It is difficult to see how this "opens up the market" for improvement and innovation as claimed.

As therapists and REs we are regularly asked for input before products come to market, because we have vast experience. Access to greater choice allows for better outcomes, contrary to the WK claims (MWIMS page 8). WK prescribe mostly modular systems that allow growth but not best clinical outcomes. They are easy to supply and often used in clinics where company reps play a key role. In the report they (WK) do not tell us about types of, or who will supply, the bespoke equipment.

The NHS services would benefit from the sort of attention we assume MPs gave to this WK document. Our services have repeatedly requested government review and help to improve wheelchair provision, and provide standardised best practice, but we have been ignored for years. We cannot allow these insidious reports (including the Frontiers Economics report) to ring the death knell of Paediatric Wheelchair and Special Seating provision in the NHS.

Our politicians should be ashamed that they are abandoning the NHS's most vulnerable patients to a market philosophy.

SECTION D: LETTERS TO MPs

1.

Dear Sir/Madam

I am writing to you to express my serious concerns regarding the proposal to outsource to the private sector paediatric wheelchair provision, currently provided by the National Health Service (NHS).

At present the NHS holds the wheelchair and specialist seating provision for paediatrics in experienced hands. Paediatric clinicians involved in the provision of this equipment have amassed a great wealth of knowledge and experience over the years, which surmount any service that can be offered by outside providers. These NHS clinicians, who may be occupational therapists, physiotherapists or rehabilitation engineers, have often chosen to enter this service particularly to further their specialist interests in the fields of paediatrics, neurology, postural control and motor development, or assistive technology, special controls, and equipment modification.

The Whizz-Kidz commissioned Frontier report infers that a ‘typical PCT wheelchair service’ is ‘unlikely’ to have ’paediatric specialists’ available for assessments (Frontier report page 10). I would suggest that this generalisation is completely inaccurate, as can be proven by identifying the personal employment of many of the members, researchers and conference presenters who attend conferences on the subject of wheelchair and seating provision e.g. The Posture and Mobility Group National Training Event.

My colleagues and I work for one of the largest wheelchair services in the country; we serve a client base of 12,000 plus active clients at any one time. A large proportion of these are our paediatric caseload. We cannot prioritise our paediatric service clients above our adult users as we do not have ring fenced budgets, and to do so would be unfair and ageist. However “children” are not “lumped in with adults” (My wheelchair is my shoes page 9). In fact I would propose that by serving both adults and children, wheelchair service clinicians do not compromise their clinical ability, but enhance it. We are able to see and monitor the long term effects of our interventions regarding seating and wheelchair provision. This allows us to build long term, positive, friendly relationships with our clients. In doing so we accept and embrace our ongoing responsibilities to the children we serve, knowing they will become our future adult service users.

Our centre provides regular wheelchair service clinics for paediatrics in special schools, learning disability units, locality hospitals, and NHS service centres; we also attend clients in their own homes. Our eligibility criteria are not used to “exclude users based on the category of specific disability” (My wheelchair is my shoes page 11) but to guide the clinician in prescription or protect the user or general public. The child’s family and representatives are always invited to attend appointments, and the children are assessed by a seating team comprising of a rehabilitation engineer and a specialist seating therapist. Equipment provision is not confined to manual chairs as is suggested (Frontier report page 11) by Whizz-Kidz. In fact we provide equipment to meet clinical need, ranging from basic manual, through lightweight active users chairs and from indoor powered to indoor outdoor chairs with dual or special controls. We also offer vouchers to upgrade equipment or enhance client choice.

The Frontier report statistics identify Whizz-Kidz involvement from the period April 2008 to March 2010 (Frontier report page 13); this shows a maximum number of 21 assessments per month in Tower Hamlets with a maximum of 7 reviews per month. In our service it is not unusual for a specialist seating team to see 12-20 children in a single day’s school clinic. From this comparison it can be easily established that paediatric demand on our service is considerably higher than Whizz-Kidz have previously experienced.

Posturally challenged or mobility compromised children in our area are seen by our specialist clinicians from the developmental age at which they would be expected to be able to sit independently (approx 8 months) and they may remain service users throughout their lifetime. We complete holistic assessments of all our clients, which encompass full physical assessments of neurological and developmental potential. We also collate and record relevant information from all parties involved with the child on psychological, environmental, and lifestyle influences which may influence our choice of clinical prescription. We then order and deliver that equipment as quickly as our suppliers can get it. Our current service target time set by our service commissioners is for 18 weeks from referral to equipment delivery. To my knowledge nobody referred to our service has had to wait for “12 to 13 months for initial assessment and roughly the same time again for equipment provision” (My wheelchair is my shoes page 6).

Given that the above factors gathered at the initial assessment are all relevant to the clinical needs for provision, I would suggest that Whizz-Kidz "child in a chair in a day" programme (Frontier report page 11) is not only unrealistic for most children with complex needs, but is likely to result in incorrect or inappropriate prescription of equipment. We have recently had our attention drawn to a case in our area where Whizz-Kidz had issued equipment which was above the stated weight limit for a pavement vehicle to a child who was below the legal age to use it. On hearsay from parents this is not an isolated case.

The Frontier report suggests that by using three preferred suppliers and a dealer as a strategic partner a better value-for-money service can be achieved (Frontier report page11). This must prejudice their clinical decisions and bias their prescription choice. By ***not*** limiting themselves to specific suppliers but by prescribing equipment based on the presenting clinical need, NHS clinicians are able to assess without manufacturer bias and prioritise the clinical needs of the child above the loyalty to a manufacturer to use only their product.

Once referred into our service we operate an open referral system for our clients: should any problems be identified with postural control or equipment a review can be requested by either parents or GPs. We also offer planned maintenance service and have contracted approved repairers on call should our service users need them. This is in contrast to the scenario of a 'typical wheelchair service' depicted by the Whizz-Kidz document (Frontier report page12).

Whilst all those involved in the current system of wheelchair service provision would acknowledge that there are areas of weakness in the service as it stands, these can be primarily attributed to lack of funding and resources. There is a very real danger here that by allowing privatisation and losing the specialist services of NHS provision of paediatric wheelchair services, we are going to throw our baby out with the bathwater.

In conclusion, I consider, given due analysis and consideration, that both the Frontier report (2010) and My Wheelchair is my Shoes (2011) (the two documents on which the future of wheelchair services for paediatrics depend upon) are heavily biased and littered with factual inaccuracies and unfounded subjective comments, which have little or no basis in the truth.

The NHS wheelchair services have historically provided a clinician led service which strives to provide best practice for our users, giving a client centred assessment and providing equipment prescription based on clinical knowledge and evidence led research within a limited budget. The Whizz-Kidz model cannot and will not provide a better service to our paediatric client group and I would suggest that we make a very strong stand to defend against this motion.

Yours sincerely

Mrs Marion May Msc Bsc (Hons)
Senior Centre Therapist
Exeter Mobility Centre

2.

Mr Peter Luff MP
House of Commons,
London SW1A 0AA
18 August 2011

Dear Mr Luff,

I am a Rehabilitation Engineer (RE) employed by Birmingham Community Healthcare NHS Trust at the West Midlands Rehabilitation Centre (WMRC), Selly Oak, Birmingham. WMRC contracts RE services to all Wheelchair & Seating services within the West Midlands. I have been employed in my current role since August 1988. I work primarily in the Worcestershire Wheelchair & Seating service within the Worcestershire Health and Care NHS Trust (WHACT)

I last wrote to you in February 2010 regarding proposals to radically change the provision/structure of wheelchair and seating services in England and the National Wheelchair Service Advisory Group (NWSAG). Within the West Midlands we were able to meet with Donna Carr (part of the NWSAG) on 20 April 2011 and present our constantly developing and collaborative work.

The purpose of this letter is to highlight some of my concerns regarding the implications of recently issued NHS document (Gateway reference 16242) dated 19 July 2011, Operational Guidance to the NHS, Extending Patient Choice of Provider, in particular some of the reference material which may have had some influence on its formulation.

The recently published All Party Parliamentary Group for Paediatric Wheelchair Reform report "My wheelchair is my shoes", making the case for wheelchair reform June 2011 makes some inaccurate assumptions. It is unfortunate that a representative from a Wheelchair & Seating service was not in the group of Expert Witnesses.
I have highlighted a few issues raised in the aforementioned report which are of concern:
<u>Page 4</u>
"The right seating is of paramount importance to someone who must sit in a chair for more than 12 hours per day. According to May, et al (2004) prescribing the correct seating facilitates:
"the management of abnormal tone, accommodation or prevention of deformity, improvement or maintenance of functional skills, accommodation for impaired sensation and provision of comfort"

It is vital to understand that a wheelchair with supportive seating is only part of the issue. Children and adults with the need for postural support should be supported appropriately at all times during their daily routine. 24 hour postural care is an area sadly neglected. I have often seen children and adults who are understandably uncomfortable and poorly supported after spending extended periods in their wheelchair due to unavailability of other forms of supportive sitting/lying equipment. I would not expect anyone to be comfortable if spending 4 hours or so seated in one position. Often the wheelchair and supportive seat is the only option available and therefore is "over used" and feels uncomfortable due to inappropriate use.

<u>Page7</u>
"The NHS uses the same suppliers that it has been using for many years. It engages with these suppliers using framework agreements, as opposed to negotiating actively with suppliers and engendering competition. As a result the NHS ends up purchasing the same equipment year after year, and does so at inflated prices. Whizz-Kidz, on the other hand, can spend the same amount of money but receive much more sophisticated equipment, equipment which is suited specifically for the young person who needs it"

Within the Worcestershire and some of the other West Midlands services, we have negotiated preferential terms of provision better than the framework agreement. Contract prices are constantly monitored to ensure best value.

Page 8
"One of the things we wanted to do was to improve our supply chain, and actually our wheelchair provision is more consumer led than it ever has been......."

Consumer led provision is great for the customer but one needs to take a view of the bigger picture to ensure that costs of maintenance and repair do not escalate. Economies of scale result in better costs of parts for repair agents and familiarity with equipment results in a more timely response when repairs and maintenance are required. The service has to be aware of the needs of ***all*** the customers we serve.

I would not disagree that reform is needed. Certainly within the West Midlands and particularly in Worcestershire we have worked tirelessly to advance and improve the service for many years, our main driver being the NHS Modernisation Agency Wheelchair Services Collaborative announced in November 2002. We have also been drivers of innovation working collaboratively with equipment manufacturers to improve equipment design and function and liaise regularly with them for this purpose.

It should be noted that the Wheelchair & Seating service is one of the few community services which is seamless in service provision. We assess and provide from "cradle to grave". Parents see this as a tremendous benefit as they expend great efforts with other agencies during the transition from child services to adult services. I agree that paediatric provision is extremely important but so are other groups of our customers such as those with deteriorating medical conditions such as Multiple Sclerosis and Motor Neurone disease, not to mention those who have suffered strokes and are in need of mobility and seating support assessment to improve quality of life and mobility, independent or otherwise.

There are a number of other questions to raise:
With customer choice, how does the money "follow" the service user"?
Will the funds come out of existing wheelchair & seating service budgets?
Will customer choice also be available to those who have very complex seating and mobility needs?
How will ongoing assessments be funded, particularly if a customer has provision and then needs/wants change after a relatively short period?
When does a child transfer from children's to adult services?
Will there still be an accessible repair and maintenance service free to customers?

It may be fact that non-NHS service providers have improved services in some areas of England but there must not be an assumption that all services are poor, so let us not "throw the baby out with the bath water". One relatively simple change would be to introduce National Criteria of provision. This would assist greatly by removing the "postcode lottery" effect which is evident throughout the Wheelchair & Seating services in England.

During my 24 years or so service within the NHS I have experienced many changes and developments, many good, some poor. It often seems that there is change for change sake. I, together with many of my colleagues, am not against change as long as there are benefits for our customers.

I would finally like to raise one other issue. I have recently been given a copy of the "Frontier economics" report: Impact of Whizz-Kidz support to Primary Care Trusts. There are some blatant untruths in some of the general statements made in the report and I feel that these need to be challenged. I will be taking this forward via the National Posture & Mobility Group and will request that the matter is raised at the National Wheelchair Service Manager's Forum. These reports surely must be verified before being used as reference material although it is unclear if this was used as a reference for any policy formulation.

I would appreciate this being passed on to the relevant parties within government and any comments you may have.

Peter Rowell I.Eng. IIPEM. Rehabilitation Engineer
Birmingham Community Healthcare NHS Trust, West Midlands Rehabilitation Centre (WMRC), Selly Oak, Birmingham

3.

29/08/2011

**Rt Hon Alistair Darling
22A Rutland Square
Edinburgh
EH1 2BB**

Dear Mr Darling,

Re: Andrew Lansley's announcement - NHS services being opened up to competitive bids from the private sector.

I am a Bioengineer working at the Southeast Mobility and Rehabilitation Technology (SMART) Centre base at the Astley Ainslie hospital which provides wheelchairs and customised seating for wheelchair users throughout Lothian, Fife and the Borders.

I am writing to you as my local MP whose party I have supported for a number of years.

I have been following current developments in England regarding Andrew Lansley's, Secretary of State for Health, announcement that several NHS services are being opened up to competitive bids from the private sector – this includes some areas of wheelchair services in England. I have read that the Bill enters the report stage and third reading on September 6 and 7.

Reform of wheelchair services has been on the political agenda for some time, even prior to the current government.

Although this does not affect my current position working in the NHS in Scotland, I have considerable experience of working in England within wheelchair services.

My fear is that decisions on transforming wheelchair services will be based on recent adverse press for NHS paediatric wheelchair services, such as the Whizz-Kidz commissioned Frontier report (**http://www.whizz-kidz.org.uk/wp-content/uploads/2010/02/Frontier-Economics.-Impact-of-Whizz-Kidz-PCT-Support.-2010.pdf**) and the All Party Parliamentary Group for Paediatric Wheelchair Reform recent publication (also heavily influenced by Whizz-Kidz), My Wheelchair is My Shoes (**http://www.whizz-kidz.org.uk/wp-content/uploads/2011/06/APPG-Report-My-Wheelchair-is-My-Shoes-Final2.pdf**). Both these reports make the case for wheelchair service reform. However, these reports do not give a balanced view of provision in England but focus on a single experience Whizz-Kidz have had on taking over a single service in trouble, based in Tower Hamlets.

There is no doubt that there will be some wheelchair services that are in a poor state, providing a quality of service that is not acceptable. The number of these services is not known. Equally there are many centres providing an excellent service. I personally know of many.

The most important thing is that the excellent services should not be judged by a single example of a failed service.

I am not against privatisation if it results in a higher quality service. I also believe that reform is no doubt required in some services.

However, if reform is required, all parties should have an equal opportunity to tender for running a service; this includes the current NHS service provider. All parties should have to demonstrate their capabilities for running a good service and should demonstrate evidence for any claims made. The current NHS service should be given the opportunity to tender under the same criteria set out for the private or charitable sector. They should also be given support to do so. This will prevent good NHS run services being dismantled on the basis of unrelated service failures.

Additionally, if private or charitable sectors do bid for wheelchair services it is important that a national contract of standards is produced that all services should adhere to. There is already a post code lottery within the NHS, bringing in the private and charitable sectors may only increase the post code lottery.

Please could you do everything in your power to ensure good services are given the opportunity to protect their service users by being able to compete if they come under threat of take over from the private or charitable sector.

Yours sincerely

James

James Hollington
Bioengineering
SMART Centre
Astley Ainslie Hospital
Edinburgh

4.

improving lives

Oxleas NHS
NHS Foundation Trust

Greenwich Wheelchair Users Service
Greenwich Community Health Services
Memorial Hospital
Shooters Hill
Woolwich
London
SE18 3RZ

Tel: 020 8836 8536
Fax: 020 8856 5473
Website: www.oxleas.nhs.uk

19th August 2011

Dear Nick,

I am writing to you as the Manager and Clinical Lead for Greenwich Wheelchair Service to voice my concerns regarding the announcement by Andrew Lansley in July that, from April 2012, wheelchair services for children will be one of eight services to be opened up to competitive bids from the private sector.

I fear that this decision has been influenced by unfair, negative press and sweeping statements made by influential organizations without allowing the situation in both Paediatric and Adult wheelchair services in England to be properly assessed and to have the voices of those who work directly in this field heard. If these negative statements are to be believed it would suggest that a third of the 320 children in Greenwich who need buggies, manual or powered wheelchairs have their needs unmet. It is suggested that children are provided with adult type equipment instead of specific paediatric equipment, that young children who could be active wheelchair users are denied equipment, that children are often refused power chairs until they are 10 years old and that in a typical PCT wheelchair service there is no paediatric expertise. It also suggests that services waste money through inappropriate procurement processes and high management costs. I can assure you that this is not the case in Greenwich nor in the neighbouring wheelchair services of Bromley, Croydon, Lambeth, Southwark, Lewisham and services in Kent. Our services work closely to secure the best prices with manufacturers through consortium agreements and support each other with service improvements through the South East Thames Wheelchair Managers Forum.

Though the clinical team in Greenwich is small, we are supported by, and work closely with, a large, experienced Community Paediatric Therapy team who assess and treat children in the mainstream and special schools and we work closely to achieve maximum functional independence through the provision of lightweight manual wheelchairs or powered wheelchairs and provide appropriate special seating for those children with complex physical disabilities. There are naturally some financial constraints to equipment provision and access criteria are necessary to ensure fair access to the service. But we use these criteria to guide our decisions rather than to restrict provision and work with the child and family to achieve the agreed outcomes.

Children with long-term mobility needs are able to progress through the service, supported through their childhood and teenage years with a transition into adult hood that enables them to feel confident that the service is aware of their previous medical and social needs without having to start again in an adult service that knows nothing about them as happens in most other areas of health and social care.

In 2007, considerable time and effort was invested by the Department of Health and the wheelchair services in England to review the wheelchair services. Unfortunately the opportunity to compare services and achieve fair and appropriate investment to improve and reform these services was lost due to a lack of clear guidance or recommendation at the end of the review.

No-one would deny that children throughout the country should have the same opportunities across all wheelchair services with appropriate clinical and financial investment and that at the moment there are inequalities of service throughout the country. I am very worried, however, that reports such as “My wheelchair is my shoes” all too often seem to rubbish the current wheelchair services and do not allow any good practice from other services to be considered and would suggest that the “Whizz-Kidz way” is the only way to go. Separating children and adult wheelchair services is not the way and offering this very specialist area out to tender is in my mind a dangerous thing to do.

There are many highly experienced Physiotherapists, Occupational Therapists and Rehabilitation Engineers in the specialist field of posture and mobility who should be allowed to influence both paediatric and adult wheelchair services nationally and the government should not be making national decisions based on a report concerning one or two services in London. By offering the paediatric service out to tender it will fragment the services and the opportunity to truly reform wheelchair services across the population of England will be lost. The government should consult clinicians and managers in this specialist field before it is too late.

Yours sincerely,

Maggy Hevicon
Physiotherapist/Greenwich Wheelchair Service Manager

5.

Mr Greg Mulholland
Wainwright House
12 Holt Park Centre
Holt Road
Leeds
LS16 7SR

25th August 2011

Dear Mr Mulholland
I am writing to you, as my local MP who I have supported for a number of years, and as the chair of the All Party Parliamentary Group for Paediatric Wheelchair Reform.

I am a Rehabilitation Engineer working at Leeds Wheelchair Centre at Seacroft Hospital and at Wakefield and District Wheelchair Services on Trinity Business Park, Wakefield. I am also a member of Posture and Mobility Group whose aims are to advance and disseminate knowledge about the posture and mobility needs of people with disabilities.
Whilst I work in these centres, I am expressing my personal views and, I believe, the views of many of my colleagues.
You recently published a report "My wheelchair is my shoes". This report was written by Sally Waters, the Public Affairs Officer for Whizz-Kidz, and highlights the improvements that were achieved at Tower Hamlets, an area which appeared to have a lot of problems with wheelchair provision, especially for children. The report includes statements from a number of prominent people involved with Whizz-Kidz and the Tower Hamlets area. What the report does not do is look at existing provision at other NHS centres and seek the opinions of recognised experts and organisations involved with the provision of wheelchairs and specialist seating.

If you had visited Leeds or Wakefield Wheelchair Services I know you would have seen a similar situation to the one your members found at Tower Hamlets. We have minimal waiting lists, we provide wheelchairs and special seating that are clinically appropriate, our Paediatric Therapists work alongside school therapists to provide appropriate equipment and overcome environmental issues, we work within the budgets available to us and we maintain all the chairs we have on issue.

Looking at a couple of the points you raise in your introduction, you state that 'there are still 70,000 children who have their mobility needs unmet. That is 108 children in each MP's constituency'. This is a very large number. Based on the Leeds and Wakefield client numbers I would expect the total number of paediatric wheelchair users in the UK to be around 90,000. It is difficult to find published data which relates to children only, but if this is the case, you are saying that very few of the children in the UK have their mobility needs met. I would be interested to know where your number comes from and whether you can identify some or all of the 108 children in your Leeds Northwest constituency who are without appropriate mobility.

You say that 'In Tower Hamlets there is no waiting list and the equipment provided is appropriate'. In Leeds and Wakefield District there are minimal waiting lists and the equipment provided meets clinical need. While the equipment is always suitable, it does not mean that it always meets expectations. We could provide 'more sophisticated' equipment, as Whizz-Kidz are able to do, but the funding is not available.

I imagine, in this current climate, you will focus on the fact that the 'model also offers a saving of 60% for each wheelchair issued'. Without the breakdown of the £1,100 average cost per wheelchair supplied by Whizz-Kidz it is difficult to know what this statement means. I understand that when they took over at Tower Hamlets there were significant start-up costs incurred - who funded this and are they included? Do the costs include the supply of special seating? A high proportion of the total Leeds special seating budget goes on the provision to children. Do the costs include the ongoing maintenance and management of the chairs on issue?

Within the NATIONAL Health Service why do different wheelchair services have to buy wheelchairs at different prices when there is one NATIONAL Health Service Supply Chain fixing the contracts? We could save a lot of money if the NHS purchased and supplied goods to the Wheelchair Services on a similar basis as any commercial organisation would do, at the lowest possible price, to all their sites nationally.

While I am arguing for more NATIONAL arrangements we have seen successive governments push for competition and localised decision making, to the point where Wheelchair Services all have different eligibility criteria and prescribe a vast array of equipment. Now there is a Post Code Lottery nobody seems to want it. The only solution appears to be to open parts of the NHS to private or charitable organisations as they will be able to “fix it”. Why can’t these changes take place within the NHS?

In my limited experience the NHS is made up of some very hard working, conscientious and caring people who find this report and others like it unrepresentative and very demoralising.

I would like to see reports and subsequent decisions being made about the NHS based on facts and transparency; these are sadly lacking in this report.

I would urge you and your colleagues to come and see what is actually happening on the ground in the National Health Service.

Yours sincerely,
Chris Bayford,
Rehabilitation Engineer,
Leeds Wheelchair Centre and Wakefield and District Wheelchair Services

SECTION E: ADDITIONAL COMMENTS

1. Craig Egglestone, Clinical Technologist in Rehabilitation Engineering, James Cook University Hospital, Middlesbrough; member of PMG Executive Committee

Having now read the APPG report I feel it does not compare like for like provision within the NHS and refers to provision of powered chairs with riser and standing facilities. These are not available from wheelchair services ordinarily. It also mentions savings incurred when providing these types of chairs as opposed to providing a one to one carer or height adjustable desks in school, what it fails to realise is that funding for this is via the Local Education Authority and not from a wheelchair service mobility budget!!!!!. We in the Northern Region have tried in the past for joint funding of riser function for a child in a school situation and although funding was agreed it never materialised. How they work out their average cost per unit to be approx £1100 is beyond me, as the powered chairs they have issued to children in our Area have been the likes of high end Permobil ones. Also I echo the comments of others the service around the country is so varied since services devolved into NHS in 1991.
I also intend to send an e-mail to my local Labour MP Jenny Chapman.

2. David Long, Clinical Scientist MSc CEng MIPEM, Nuffield Orthopaedic Centre, Oxford, OX3 7LD; former chair of PMG

It is vitally important that areas where NHS provision is healthy are not ignored. It is entirely feasible for the NHS to deliver these services. The transition of the child into an adult should not be forgotten. Personally, I think many adults suffer very poor services as the focus is so often on children. There are many, many vulnerable adults who are not articulate and are unable to advocate for themselves. Please can we ensure that this proposal does not increase the gulf between paed and adult services any further?

3. Jo Purvis, Occupational Therapist, Surrey Community Health Services

I work for a wheelchair service that has been going through a process of continual change since 2007 and is currently in the midst of procurement change, the outcome of which is likely to be that our current community health body will be run by a private company in the very near future. The rationale for this, we have been told by our Chief Executive, is because 'Change must happen'.

In relation to the evaluation produced for Whizz-Kidz. We read the 'evaluation' by Frontier Economics on the 'Impact of Whizz-Kidz support to Primary Care Trusts' some months ago with dismay, some anger, and disbelief that such a document would be taken seriously by a government department.

I have just learned today that Frontier Economics is a high profile company giving advice on the economics of change on a very wide range of issues, often to top levels of government departments, whose chairman is Conservative peer Baroness Hogg, wife of former MP Douglas Hogg.

The points we most immediately took issue with were these:

a) The evaluation was done 'pro bono' - who requested it?

b) The evaluation is not based on any properly collected data, being merely the reporting of 'detailed conversations with Whizz-Kidz staff', as the evaluation itself clearly admits on page 7. Why was there no scope to conduct a bespoke data collection exercise, we in public sector employment are frequently required to audit aspects of our service, I would have thought objective data collection and analysis was the least requirement of an evaluation like this.

c) With a sweeping generalisation the evaluation also suggests on page 7 that 'the specific experience from which this analysis is drawn .... is representative of wheelchair services more widely'.

d) The comments on page 9 and 10 about the comparison between a Whizz-Kidz and a typical PCT assessment are ridiculous. Contact and data collection prior to meeting a client/patient and holistic assessment is routine to occupational therapists in whatever field they may work, the suggestion that this is 'innovative' is laughable.

e) In any case, the suggestion of a one off 'chair in a day' appointment does not tally with the preparation time that is actually required, even by Whizz-Kidz, to have correct data and equipment ready to allow a child to go home with a chair following a 'first appointment'. At a minimal level, is there an appropriate vehicle if required and ramp at home to allow the child to get home, do Whizz-Kidz care, or do they only see children for whom all the groundwork has already been done by wheelchair therapists doing the nitty gritty liaison work with other professionals?

f) In the case of our wheelchair service, I would say that we work entirely in the way Whizz-Kidz describe as their own way in terms of supply chain, on page 11, and we do operate with NHS bulk pricing and from a useful range of modifiable wheelchairs. Surely it is Whizz-Kidz who have learned this approach from NHS services; the opinion of them amongst NHS professionals is that they supply one off chairs that couldn't be economically maintained by a public service.
We hold stock assessment wheelchairs, and often use more specialised, loaned consignment chairs on planned days, and are able to take them out to clients' own environments by van if trial is needed. We also have a large stock of consignment cushions available for trial.

g) I would disagree with comments on page 12; we review clients on request, never mind the wheelchair, they may be deteriorating themselves or suffer some other problems requiring review or modification, such as a broken limb to be managed. In this team, any work for children is allocated without a wait unless it is something that really can wait a little while, like a physio referral for a mildly disabled child who is just beginning to outgrow a standard buggy. Any repairs that can't be dealt with by our approved repairer are seen by a rehabilitation engineer often the same day or certainly within a very short time.

h) What about children in need of highly specialised seating and/or specialised equipment carriage, whose referrals would undoubtedly slow the rate of provision made? How many staff were Tower Hamlets employing when Whizz-Kidz came in?

i) The tone of the evaluation seems to be that the 'right' wheelchair for every child is a powered one. This may be true for the majority of people who typically apply for Whizz-Kidz funding but is not the case for every young wheelchair service client.

In relation to the private bidding for provision of public services:

I would also say that changes made, and still in process, to this team since 2007 take us further and further away from working in a way that allows us ease of access to appropriate equipment and to making our own plans as a professional and informed team. We used to have a base where we held our own stock, running clinics from which people often went home with a chair in a day. We understand that coming changes planned by our Chief Executive will aim to have us working from home (with what equipment!!?) along with other community health staff.

Our experience of working with private companies for equipment provision/maintenance using public sector funding has been that they cause increase in spending levels, using only brand new stock, sometimes for limited use, with poor stock control and very slow service. The only exceptions to this have been Medequip and T Brown in the Kingston area, in my experience. Control of such private companies should remain with suitably informed and qualified staff who understand all the processes and potentials for system abuse, not managed by finance departments from ivory and disinterested towers. I worry about the handing of public services over to those whose motivation is profit. See what happened to the handing over of hospital domestic services to private companies away from nurses, in terms of nutrition management and hygiene control.

Thanks for the opportunity to spur the recording of some of our thoughts. It's a shame a national response has been left so late, and although I now have the Whizz-Kidz document 'My wheelchair is my shoes' I haven't been able to read it properly yet, except to say from flicking through it that the comments in it are mainly from Whizz-Kidz staff or ambassadors and are therefore bound to be biased in favour of their view. No one has asked us what would work best. Nor for our direct opinion of what would work best.

4. Alison Johnston, Physiotherapist, Bromley Wheelchair Service; member of PMG Executive Committee
In Bromley we run a very good paediatric wheelchair service with timely assessments and provision of equipment. I know this is also the case of many services around the country. We were visited by Whizz-Kidz to discuss the service

they offer (the Tower Hamlets model), and they went away as good as saying they couldn't do any better and it would cost us more!

I think it is time we really made a stand on this. If Andrew Lansley is basing his decisions on the information he gets from Whizz-Kidz then he does not have the full picture and we are doing ourselves (wheelchair services) out of a job. Sorry for the rant, but this is something I feel very passionate about. These are reports sent round by an "independent" body that class Tower Hamlets as a typical service prior to Whizz-Kidz, when they quite obviously weren't. However we know that, but Jo Public and politicians who read the reports don't know that!

5. Christine Rice, Occupational Therapist, East Surrey Wheelchair Service
We would like to register our dismay at the proposed plans to tender out Paediatric Wheelchair provision.

This client group is particularly specialised and requires considerable time and skill. Our clients are often referred to us at a very early age and we develop a relationship with them and their parents over many years. The equipment provided for them is very bespoke and has to be heavily modified by experienced Therapists and Engineers. This then needs constant adjustment and adaptation. This service will not be provided by Third Party providers.

The current Paediatric Wheelchair provision is not perfect. Examples such as the provision of equipment by Whizz-Kidz in certain areas have shown that it cannot be provided better by alternative suppliers. The skill and experience you have in NHS staff is second to none. I am aware that Whizz-Kidz have promoted and evaluated their own services but if you talk to any staff or parents involved you will realise that what they do is very superficial with no ongoing responsibility or flexibility. We have several instances where parents have come back to us after provision from Whizz-Kidz and asked us to provide them with a service because they have felt the Whizz-Kidz Service to be inadequate and unsafe. Whizz-Kidz aims to provide chairs in one day. This is unrealistic if the job is done properly because individual modifications require time and expertise. Therefore what happens is clients are given equipment that is not individualised for them and therefore does not maximise their efficiency with it.

Whizz-Kidz will have the benefit of all of the funding allocated whereas we have money transferred down through many levels.

In addition, tendering out Paediatric Wheelchair Services will make the transition between children’s services and adult services almost impossible because the equipment will not be able to be transferred onto the Approved Repairer contracts and clients will not get the same types of equipment because the equipment ranges are different.

I have been a Wheelchair Service Manager for Surrey for over 10 years. If you try to section off the Paediatric Service you will destroy the adult Wheelchair Service because the contracts for repairs and maintenance, Rehabilitation Engineering, and Special Seating will be unviable.

The complaints received relating to the Paediatric Service are mostly in relation to waiting list times and in relation to the limited range of equipment provided by ourselves, and this is simply because we cannot expect our repairer service to repair items not under their contract and because our budget is too tight.

The way to improve Paediatric Wheelchair Services is to put more resources into the current Service and ensure separate contracts are properly managed. At present we pay a specialised seating contract at a PCT level which is not monitored at all. This money would be better spent given to local level and allowing us the flexibility to call in the supplier most appropriate and would improve our waiting times.

What clients want is localised expertise with people that they know and trust. At present the service is disjointed and uncoordinated and it needs refinement but not by tendering it out.

6. Helen Critten-Rourke, Clinical Lead Wheelchair Therapist, Warrington Wheelchair Service; member of PMG Executive Committee
I have been quietly reading and absorbing all the information that we have been issued with over the last few weeks before writing my opinions, but this has got my goat, it is the biggest piece of rubbish I have read. We obviously need to get our commissioners and other decision makers to understand that this is not a fair representation of NHS services; unfortunately we haven’t got the resources that their publicity department have. I am however particularly impressed

that Whizz-Kidz believe that their provision of a wheelchair will prevent any back injury to a school care assistant, maybe they have invented the levitation device that I have long been wishing for!

7. Gill Searle, Physiotherapist, Swindon Wheelchair and Special Seating Service
The reports (Frontier / Whizz-Kidz) indicate a very successful service and makes interesting reading.
In Swindon Wheelchair and Special Seating Service we achieve many of the things that Whizz-Kidz do - we have a specialist paediatric OT, no waiting list, provide powered mobility for young children (as young as 2).

My comments/questions from quickly reading the 2 reports attached include:

i) What are the urgent repair and maintenance services offered by Whizz-Kidz, as well as reassessment?

ii) I would imagine one of the reasons wheelchair unit costs go down is because the current NHS services only provide for the more complex user, so requiring more complex chairs - if the unmet need (by the NHS)is largely with the less immobile, I would think chairs issued to them would be less costly (and more likely to achieve the 'chair in a day') - I would like to know the percentage of Whizz-Kidz chairs that require custom or complex seating and how they provide this?

iii) Do they also provide a manual chair to children with powered chairs (as we do)?

iv) The bottom line cost to the State in order to meet the unmet need for children as stated by Whizz-Kidz is nearly double the current cost, using the Tower Hamlets example.

8. Dawn Osborne, Wheelchair Therapist, Airedale Wheelchair Services, West Yorkshire
I can only speak for our service and what I know from meeting and talking to other wheelchair services in the Yorkshire region, but I totally disagree with many of the comments made in this report **(**Frontier report on the impact of Whizz-Kidz support to paediatric wheelchair services).

The long winded and inappropriate referral and assessment process identified as the nationwide NHS model is not the way our service works. What is identified as a Whizz-Kidz “innovation” is a process widely used in the NHS. The difference is that in the NHS we are not as good at publicising our success stories.

Whizz-Kidz refer to NHS Wheelchair Services as not staffed by expert paediatric therapists. This is a sweeping generalisation and not true of all services and furthermore we have direct access to the Child Development team of experienced and skilled paediatric staff.

Our service, and I know many others, have an extremely accurate, accessible and up to date stock system and, what is more, the stock and the repair service is on site so equipment can be brought to clinic from stock on the day of the appointment and supplied if suitable.

Special seating is done locally and there is no waiting list.

The sweeping derogatory statements about repair services do not apply to our service.
Neither do statements about the NHS supplying heavy, outdated, old fashioned equipment.

The NHS is in danger of “throwing out the baby with the bathwater” if it listens only to Whizz-Kidz and takes Tower Hamlets as the model for the whole country.

PROVISION OF WHEELCHAIR SERVICES: DOCUMENTS AND COMMENTS COLLATED BY THE POSTURE AND MOBILITY GROUP
APPENDIX 1

WHEELCHAIR AND SPECIALIST SEATING SERVICES:

A Clinical Guide for Commissioners and Provider Services

Lisa Jayne Ledger BA, BSc, MSc
August 2011

DRAFT

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PROVISION OF WHEELCHAIR SERVICES: DOCUMENTS AND COMMENTS COLLATED BY THE POSTURE AND MOBILITY GROUP
APPENDIX 1

BACKGROUND

In December 2009 the Department of Health (DOH) set up an advisory group to review the model of wheelchair and seating services and to inform the future direction for commissioners across the NHS. The key political drivers underpinning this work are *Quality, Innovation, Productivity Prevention (QIPP)* (2009) and the White Paper *Equality and Excellence: Liberating the NHS* (July 2010) which proposed radical changes to commissioning with GPs taking more control and the setting up of a national NHS commissioning board. The advisory group identified a number of emerging themes that they believe commissioners should build into any future wheelchair model including *'a needs led approach, timely intervention, equity of provision, preventative, and encouraging innovation'*. Two pilot sites were set up in the East and South West of England and to date the common themes to arise from their work include the need for '*a single point of contact, common eligibility criteria, core assessment and partnership working across health, social care and the private sector'*. The DOH produced a document in December 2010 entitled '*Local innovations in wheelchair and seating services'* that builds on examples nationally of service improvement. The pilot sites are due to report their findings to the DOH this autumn to inform a commissioning document around future models of provision.

The rationale for this clinical paper has been brought about through concerns by the author that the multifaceted clinical nature of wheelchair service provision has not been clearly articulated nor understood to date. Both pilot sites on reporting back to a meeting at DOH in April 2011 agreed that they were struggling with the assessment element to provision and the differing clinical levels of need, from simple to mid to complex needs. It is the author's opinion that unless the clinical nature of provision is understood, the future model will be unsuccessful in meeting needs or driving efficiencies within the system. More recently the government has produced a document entitled '*Operational Guidance to the NHS: Extending Patient Choice of Provider'* (July 2011) which intends to increase choice and personalisation in NHS funded services whereby a patient should be able to choose from a list of *qualified* providers for their care. Within this paper, wheelchair services for children are listed as one of several key services to be included within this initiative. The concern within the wheelchair domain is that the parameters and measures for '*any qualified provider'* has not yet been clearly defined or scoped.

It is the intention of this paper to clearly articulate the clinical levels of need within wheelchair service provision, so that commissioners of services are able to understand the differing levels and that these may require a different service response. The author will also suggest that through an understanding of the clinical synergies within wheelchair provision to other services such as Tissue Viability and Specialist Community Equipment, that more integrated services may be procured and efficiencies drawn. This paper is not intended to be seen in isolation to the above political drivers around choice, partnership and personalisation, but rather it is hoped that it may enhance the understanding of the critical importance of the clinical interface in wheelchair service delivery being understood by future commissioners and evolving providers of services**.**

PROVISION OF WHEELCHAIR SERVICES: DOCUMENTS AND COMMENTS COLLATED BY THE POSTURE AND MOBILITY GROUP

APPENDIX 1

KEY FACTS

- The wheelchair service costs approximately £125.8m a year to operate and is receiving around 184,230 referrals per annum.

- 40% of referrals are already known to the service.

- There are approximately 570,000 disabled children in England, around 100,000 of whom have a complex care need.

- In the past 10 years the prevalence of severe disability and complex needs has risen and will continue to increase due to a number of factors including increased survival of children and adults who suffer severe trauma or illness.

Figures taken from www.papworth.org**.**

THE CLINICAL NATURE OF WHEELCHAIR PROVISION:

Wheelchair service provision differs nationally both in terms of eligibility criteria and types/levels of response; however the clinical demands on the service remain largely the same. Wheelchair services generally provide for a long-term, permanent mobility need across the whole age spectrum from children through to adults and cover a range of clinical diagnosis including congenital and acquired disability. Over the past 10 years however, due to the increase both in the rate of service users presenting with more complex needs and the increasing severity of the need, wheelchair services have moved from simple off the shelf type input to become a specialist service incorporating wheelchairs, posture management and related tissue viability. This has placed increasing demands and challenges not least in terms of budgetary pressures, but also in terms of the necessary clinical response to manage more complex needs. The risk is that in the current financial environment, it would be easy to assume that a '*procurement led*' model could be utilised, where '*any qualified provider*' could bid for an '*equipment type contract*'. The emphasis within a '*procurement led*' model is on equipment purchased at cheaper cost and equipment delivery aspects, with little attention paid to the measurement of quality and the clinical delivery interface. This is not such an issue where the wheelchair need is simple and one off, however where the need is more complex, the individual will require regular clinical review and service delivery must be firmly grounded within the patient care pathway. In addition, with regard to the assessment process, where the need is simple, the '*trusted assessor*' will need basic competencies to prescribe the appropriate chair, however where the need is more complex the '*assessor*' will need to have specialist skills in wheelchairs, tissue viability and posture management. The focus shifts from solely the equipment solution to management of an individual's condition which may include advice, changes in care, therapy input, medical management of tone and provision of equipment.

Issues for Commissioning Wheelchair and Community Equipment Services:

Historically the commissioning of wheelchairs has largely been locally driven, with a 'post –code' lottery seen across the country in terms of patterns of delivery. Equally, the commissioning of wheelchairs has been within a block contract with little detail around commissioning according to level/type of response. It may be suggested that a more suitable arrangement would be whereby a pricing mechanism is used to reflect the different levels of complexity and time taken for assessment. Whatever the system, the major challenge is that the demand will continue to increase and have to be met within an ever reducing financial envelope. In order to meet this demand, there will be a requirement to create more innovative solutions to the provision of wheelchair and specialist seating services. However, in order to do this there will need to be a major shift in thinking and a movement away from 'silos' of provision to clinically focused integrated care pathways of provision. For example, historically, wheelchair provision has been commissioned separately; the same can be said for provision of more specialist community equipment options such as static/arm chairs and tissue viability services. Should the service be commissioned within a clinically led integrated model, then it may be suggested that the 'qualified provider' may potentially focus on different elements from simple to the more complex needs.

<u>The use of the Kaiser Permanente Triangle for Wheelchair Provision:</u>

The Kaiser Permanente Triangle is a well recognised population management approach that has been adopted by the government and others to providing health services for people with long term conditions. The triangle describes three main tiers of clinical need as Level One: Self-Management, Level Two: Disease Management, and Level Three: Case Management. At Level One, this describes 70-80% of patients who can be taught to 'self manage' their condition and require minimal input from health and social care professionals. At Level Two, deemed as higher risk patients, the model describes a disease management approach that must draw on current best evidence to reduce episodes of acute ill-health and unnecessary hospital admissions with individuals requiring regular monitoring of their condition. At Level Three, a Case Management approach is described for people that have multifaceted conditions and require a high degree of ongoing personalised care and multidisciplinary input.

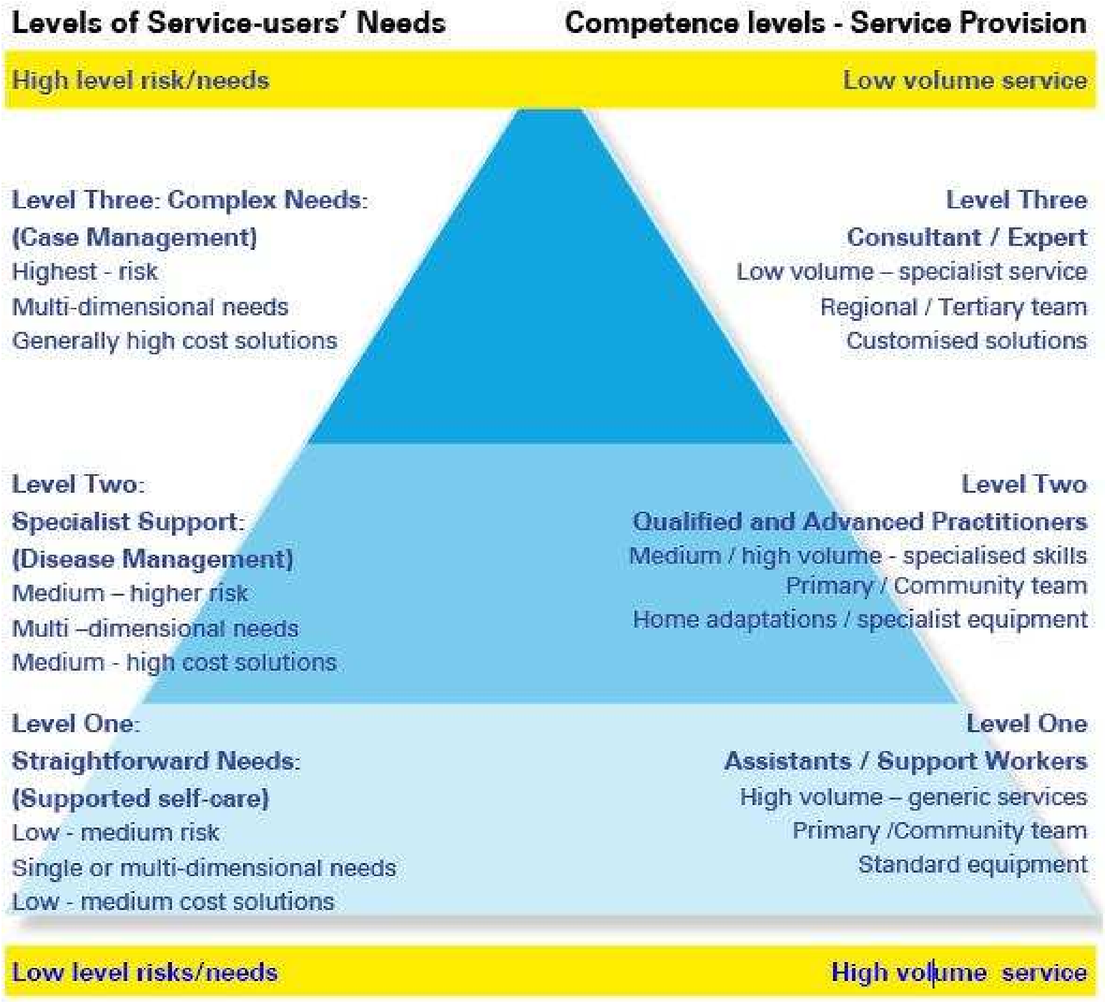
This model is supported in the government document *Supporting People with Long Term Conditions* (2005) which presents an NHS and Social Care Model in line with the above changes, with an emphasis on independence and prevention. The model is not intended to be static but rather dynamic in the sense that at any one point in time, patients may move from one level to another and thus by focusing on a preventative approach and maintaining independence, the intention is to prevent people moving further up the triangle.

Winchcombe M & Ballinger C (2005) expand on the above in their paper entitled *A Competence Framework for Trusted Assessors* in response to the changes around Community Equipment Services (CES) at that time. It is useful to consider these changes to equipment services, as similarities can be drawn to Wheelchair Services. Within this model, the authors directly apply the different clinical domains of equipment provision to the three tiers of the Kaiser Permanente Triangle (See Figure 1).

PROVISION OF WHEELCHAIR SERVICES: DOCUMENTS AND COMMENTS COLLATED BY THE POSTURE AND MOBILITY GROUP

APPENDIX 1

Figure 1



Level 1: Straight forward needs

This describes individuals who have a relatively simple need who can largely be self supporting. With regard to wheelchair provision at this level, individuals could be assessed by a '*trusted assessor*' with core basic assessment skills and competency in wheelchair prescription. Provision could then be through a number of options, including the use of personal health budgets or a voucher type option for use at any 'approved retailer' outlet. The need is likely to be one off, simplistic, and would not require review in a clinical sense; the individual could also be given general advice around related health aspects such as maintenance of healthy skin and good posture care.

However, further consideration would need to be given to who the '*trusted assessors*' are and competencies around this would need to be determined. In addition, consideration would need to be made in respect of the 'recycling' aspect and if/how the equipment would be collected and potentially re-used in the future. An example of this level of need would be an individual who only requires a wheelchair for outdoor, occasional use.

Level 2: Specialist Support

A large proportion of wheelchair users would likely fall in this category, where assessment would need to be more specialist and clinically focused, with skills around management of a condition including tissue viability, posture care and more specialist wheelchair and seating options. Individuals at this level require regular review and inter-agency liaison and involvement within a care pathway approach. A robust clinical interface is essential at this level so that timely and appropriate intervention can occur to prevent individuals moving up the triangle. At this level, it is unlikely that equipment will be the only provision, but rather specialist advice, information, therapy, medical management to name a few of the related responses that may be indicated. Therefore, at this level the ‘equipment’ component cannot be separated from the clinical assessment and handover/delivery components. An example of this level would be an individual who uses their wheelchair on a full-time basis and requires a degree of postural support in the form of a contoured cushion and backrest. This type of equipment would need to be set up to the individual user’s posture, lifestyle and mobility requirements, thus requiring a clinician to be involved at handover/fitting stage.

Level 3: Complex Needs

These are individuals who have highly complex requirements and are at greatest risk to their health and well being. As in level 2, the response here regarding wheelchair provision must be met within a specialist service and as part of the multi-disciplinary, interagency team. These individuals are at high risk of secondary complications due to their level of disability, such as pressure ulcers, contractures, chest infections and respiratory illness and may require an individual bespoke equipment solution. Regular review and a timely response are crucial at this level using a case-management type response. In this sense, ‘*any qualified provider*’ would need to be clinically focused with proven expert specialist skills and competencies within the field of wheelchairs, tissue viability and posture management.

CONCLUSIONS

- The intention of this paper has been to describe the different clinical layers that wheelchair provision entails through use of the Kaiser Permanente Triangle.
- The author suggests the movement away from separate elements of provision to the commissioning of a more integrated care-pathway type approach which acknowledges that equipment provision is only one part of the overall necessary response.
- There are specialist clinical elements to wheelchair and equipment provision and therefore quality assurance will come from competent and adequately trained personnel and robust clinical interface.
- The further up the Kaiser Permanente Triangle the service user presents, the more necessary it becomes that the assessment and equipment fitting/handover elements sit together.

RECOMMENDATIONS

- Future commissioning of wheelchair services must take into account the different levels of clinical need and how this necessitates differing levels of provider response.
- The further up the Kaiser Permanente Triangle the service user presents, the more necessary it becomes that the assessment and equipment fitting/handover elements need to sit together.
- Future commissioning for the provision of specialist, complex needs should adopt a more integrated approach to provision, whereby an individual that presents with a posture, mobility and tissue viability need could be assessed by one team/service and the necessary equipment/provision actioned accordingly.
- There is a national need to formalise training and competencies within the field of postural management, wheelchairs and equipment against which to benchmark provision.

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Other Useful References:

www.pmg.co.uk

www.wheelchairmanagers.nhs.uk