

moving forward >>>

REVIEW OF NHS WHEELCHAIR AND
SEATING SERVICES IN SCOTLAND
MARCH 2006



moving forward »»

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SEATING SERVICES IN SCOTLAND
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membership of the steering group

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chairman's remarks



NHS Wheelchair and Seating Services are easily overlooked in the wider context of the National Health Service (NHS), and yet, for many, the equipment provided fundamentally affects their quality of life, capacity to carry out daily life tasks and opportunities to participate in family activities, education, work and play.

Failure to provide an effective service can have wide ranging implications, including postural deformities, pressure ulcers, contractures of the limbs, over-use syndrome in the hands, arms and shoulders, loss of self-esteem, developmental problems, social exclusion, lost opportunities and secondary injuries to carers.

Although the responsibility for delivering the service rests with NHSScotland, users have emphasised that this equipment should be provided to **enable** them to fully participate in society as well as to compensate for function they have lost. This forward-looking outlook focuses on social inclusion. These services are needed to provide safe mobility, a platform from which the user can function and the tools to achieve personal and family goals.

The petition that initiated this report highlighted serious shortcomings in the service. The independent report undertaken by Frontline Consultants provides ample evidence to support the concerns expressed by the petitioners. There is no doubt that this service has been neglected for decades, despite numerous reports commissioned by charities and government departments.

In preparing this report, and particularly in formulating its recommendations, every effort has been made to gather the opinions of people throughout Scotland with an interest in improving NHS Wheelchair and Seating Services. The consultation released an enormous passion for change, not only from users and carers but also from the dedicated professionals who, often in difficult circumstances, provide the best services they can with the limited resources they are given.

It has been a great privilege to contribute to the development of this report. I am sure that the commitment made by so many in developing our recommendations to the Minister for Health and Community Care will be redoubled to channel into their implementation.

Professor Martin Ferguson-Pell
Chair of Steering Group for Review of NHS Wheelchair and Seating Services in Scotland
ASPIRE Chair in Disability and Technology
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acknowledgements

This report is the product of hundreds of hours of discussion and consultation involving people with a wide range of interests and experiences in wheelchairs and seating, including users, carers, service personnel and people who advise on healthcare policy in Scotland. Their contributions have guided this report but are too large and varied to list individually. On behalf of the Steering Group – thank you! Thank you for your expertise, your wisdom and for caring so much about this important, but often neglected, part of our health service.

Sadly, at the final proof stage of this report, we have learned of the untimely passing of Margaret Scott, who for years has campaigned to improve the lives of children, like her daughter Fiona, by having the appropriate equipment provided timeously by the Health Service. As promulgator of the Petition to the Scottish Parliament, without Margaret's tenacity and dedication we would not have progressed this far. The baton has now been passed to us, so let us all now respond to the challenges ahead as a lasting tribute to Margaret.

structure of report

A Steering Group was assembled by the Scottish Executive Health Department in consultation with user representatives and wheelchair centre staff. A specification (Appendix 3) was then developed and tendered to enable the appointment of independent consultants (Frontline Consultants) to inform the Steering Group about the NHS Wheelchair and Seating Service and provide the necessary evidence upon which to develop specific recommendations. Frontline Consultants' report is produced in Appendix 1.

The Steering Group report comprises an Executive Summary that includes a list of the Steering Group's recommendations accompanied by a proposed timetable for their implementation. The Background and Context provides the backdrop for the development of the report's recommendations and the supporting rationale.

The Steering Group commissioned Frontline Consultants to estimate the cost of implementing its recommendations, and headline costings are provided in a section on costings and in Frontline Consultants' report. An illustrative cost-benefit analysis, undertaken by Frontline Consultants and reported in Appendix 1, provides information about the improvements in quality of life that might be expected following investment in the service compared to national norms.

glossary



glossary

Assistive technology

Assistive Technology (AT) is any product or service designed to enable independence for people with disabilities and older people. (King's Fund Consultation, Foundation for Assistive Technology.)

Augmentative and alternative communication

An area of clinical practice that attempts to compensate, either temporarily or permanently, for the impairment and disability patterns of individuals with severe and expressive communication disorders. (International Society for Alternative and Augmentative Communication.)

Augmentative and alternative communication system

An integrated group of components, including the symbols, aids, strategies and techniques used by individuals to enhance communication. (International Society for Alternative and Augmentative Communication.)

Bariatric

Any patient whose size, weight, or body dynamics exceed the safe working loads or capacity of the existing equipment or care capabilities, and whose size or body dynamics may also require exceptional staffing, equipment and environmental conditions. (Norwich Primary Care Trust.)

Bioengineer

A health professional qualified in bioengineering (engineering that is combined with the study of the human body).

Carer

Except where the context makes it clear that an alternative definition applies, the term carer should be taken to mean the following which is the definition used by Carers UK and Carers Scotland: Carers look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid.

Centre

Manages fully comprehensive regional services. Complex needs would be addressed at these comprehensively equipped facilities. Less complex requirements would be accessed through outreach services delivered to users and carers in local settings.

Cinderella service

Low priority service area and under-resourced.

Clinics

'Events' held at a variety of locations.

**District nurse**

A nurse that is specially trained to treat people in their own homes.

Duchenne muscular dystrophy

An inherited disorder characterised by rapidly progressive muscle weakness which starts in the legs and pelvis and later affects the whole body.

DWP

Department for Work and Pensions

Eligibility criteria

The rules that determine which type of wheelchair a person's mobility difficulties justify.

Gait analysis

Scientific investigation of walking, in order to diagnose specific orthopaedic or other conditions affecting mobility.

Holistic assessment

Assessment for wheelchair users, which takes into account not only medical requirements but the overall needs of the individual to lead a full life.

IHRQoL

The Index of Health Related Quality of Life (see also QALY)

Local facility

A location for outreach services, which may be in an NHS or local authority facility such as a school or clinic, or a community centre or hall. In very rare circumstances it may be a stand-alone building.

Manual propulsion chair

Standard manual wheelchair, propelled by either the user or their attendant.

MAVIS

Mobility Advice and Vehicle Information Service

Motor neurone disease

Degeneration of the nerves in the spinal cord and brain that are responsible for muscle movement, causing weakness and muscle deterioration.

Multi-agency approach

Where the needs of users and carers require co-ordination of expertise and/or resources that are the responsibility of a number of government agencies (e.g. health, education, social services).

Multiple sclerosis

A chronic progressive disease of the central nervous system in which gradual destruction of the coating on the outside of the nerves occurs. This occurs in patches throughout the brain or spinal cord (or both), interfering with the nerve pathways and causing muscular weakness, loss of co-ordination and speech and visual disturbances. It occurs chiefly in adults and is thought to be a defect in the immune system that may be of genetic or viral origin.

Neonatal mortality rate

This is the number of neonatal deaths per 1,000 live births.

Occupational Therapist (OT)

A health professional trained to help people, who are ill or have disabilities, learn to manage their daily activities.

Orthotics

An area of clinical practice that provides assessment, fabrication and fitting of equipment to support or modify the function of a body part.

Outreach services

Services provided away from the wheelchair centre, by centre staff or community-based staff, in collaboration with the centres.

Physiotherapist (PT)

A healthcare professional concerned with human function, movement and maximising potential.

Planned preventive maintenance (PPM)

A formal system of pre-planned maintenance and procedures for wheelchairs to ensure that regular inspections and routine servicing are carried out on a planned and controlled basis.

Prosthetics

An area of clinical practice that provides assessment, fabrication and fitting of equipment to replace a missing body part.

**Powered chair**

Wheelchair where propulsion is motorised.

Quality-adjusted life-year (QALY)

A common measure of health improvement used in cost-utility analysis, it measures life expectancy adjusted for quality of life.

Rehabilitation consultant

A consultant doctor who specialises in the rehabilitation of patients after illness or accident.

Rehabilitation Technology Information Service (ReTIS)

ReTIS is jointly funded by all Scottish NHS Boards to provide a national information service in the field of rehabilitation technology. The service provides information and support in the areas of wheelchairs and seating, prosthetics, orthotics and electronic assistive technology.

Ring-fenced funding

Funding which is only to be spent on a specified service.

SCAMP

Specialist Centre for Advanced Wheeled Mobility and Positioning

SEHD

Scottish Executive Health Department

Technologies for living independently

All equipment intended to alleviate difficulties in undertaking activities of daily living.

Trauma medicine

Treatment of patients who have suffered major accidents and/or trauma.

Wheelchair service centres

There are five wheelchair service centres in Scotland (Aberdeen, Dundee, Edinburgh, Glasgow and Inverness). These centres provide fully comprehensive services to wheelchair users (assessment, prescription, repair and maintenance).

executive summary



This report has been prepared by an expert Steering Group, supported by staff from the Scottish Executive Health Department (SEHD) and NHS Quality Improvement Scotland (NHS QIS). Frontline Consultants were selected by the Steering Group to undertake an extensive, independent, consultation exercise with users, carers and service providers throughout Scotland.

The Steering Group has undertaken an in-depth analysis of all the information gathered in this exercise culminating in 40 recommendations for improvements in the delivery of NHS Wheelchair and Seating Services in Scotland. Central to the recommendations are five key points that emerged from the formal consultation and stakeholder discussions:

- The remit of the NHS Wheelchair and Seating Service should address the lifestyle requirements of users and carers ensuring maximum possible social inclusion.
- Service delivery should be based on holistic requirements and not coloured by available funding for equipment.
- The service should measure performance and demonstrate accountability.
- The service should be adequately funded to meet its core values – additional resources should be provided to fill large gaps that exist in current service provision.
- A multi-agency approach to deliver a seamless service, from the user and carer perspective, should be established at national level, delivered locally.

The expectations for the service have been clearly and unanimously stated by users, carers and professionals in the form of a 'Declaration of Independence' delivered to the national conference in Edinburgh on 12 September 2005. It states:

"The service should be a basic human right, accessible through self-referral. It should ensure individuals are given all appropriate aids necessary to fulfil the basic rights of all citizens to play an active part in society and their daily life, regardless of physical limitations or differences."

Previous reports produced over more than three decades have highlighted the need for changes in NHS Wheelchair and Seating Services. They too identified serious gaps in services. They were thorough, realistic and grounded in the requirements of users and carers, yet despite obvious barriers to social inclusion, other inequities, inefficiencies and injustices in the delivery of the service, resources have not only been limited for this service but actually redirected to support other funding priorities of the NHS Boards. A health economics analysis provided in Frontline Consultants' report (Appendix 1) shows clearly and objectively that the cost-benefits of providing an excellent wheelchair service will give outstandingly good value, measured against national norms.



This report comprises a summary of the recommendations of the Steering Group, with proposed timelines for implementation, background information that defines the context in which the report is submitted, a more detailed discussion of the recommendations, estimates for the cost of implementation of each main recommendation category and finally, extensive appendices, including the report prepared by Frontline Consultants that provides, in detail, the primary evidence that underpins the recommendations.

The summary recommendations of the Steering Group have been prepared in the form of charts providing information about the urgency, estimated time to complete and ease of implementation for each recommendation. Indicative costs have been prepared that account for the timing of the implementation of the recommendations. In revenue terms this amounts to an additional £8.7 million initially, building to an additional recurring requirement of £15.8 million after three years, above the current funding level of £14.2 million per annum.

These changes can only be brought about in partnership between the professionals with the expertise to provide top quality services and the users and carers who provide guidance that ensures that these improvements make real differences to quality of life. The high levels of participation and partnership that were shown in creating this report are a testament to the importance of these services and the passion for improvement shown by all involved.

The response to this consultation far exceeded any others that have been co-ordinated by NHS QIS in recent years. The message from users, carers and service staff is clear: action is needed now.

The Steering Group respectfully urges the Minister for Health and Community Care to accept these recommendations and establish an implementation process as a matter of urgency.

The following section of the report contains the 40 recommendations made by the Steering Group. The Steering Group has scored each recommendation in terms of urgency, implementation time and ease of implementation. These are illustrated in the charts for each section of recommendations. The charts provide an indication of:

- the urgency of a recommendation, represented by the practical start date
- the time to implement, represented by the columns, and
- the ease of implementation, colour coded according to a traffic light system.

redesign of service delivery

RECOMMENDATION	PRACTICAL START DATE AND TIME TO IMPLEMENT		
	SHORT TERM < 1 YEAR	MEDIUM TERM 1-3 YEARS	LONG TERM > 3 YEARS
1	Yellow	Yellow	
2	Yellow	Yellow	Yellow
3	Green		
4	Red	Yellow	
5	Yellow	Green	
6	Red	Yellow	Yellow
7		Yellow	

Easy to implement ■ Moderate to implement ■ Hard to implement ■

Recommendation 1 – establish an Implementation Team

An Implementation Team will be established to take forward delivery of the recommendations made in this report on behalf of the Minister for Health and Community Care.

Recommendation 2 – reorganise into a national, integrated, assistive technology service

The provision of all assistive technology services (including wheelchairs, seating, prosthetics, orthotics, augmentative communication, environmental controls) will be integrated into a single national service, funded centrally but delivered locally. The NHS Wheelchair and Seating Service will pilot this change. The NHS Wheelchair and Seating Service will be accountable for expenditure through a budgetary process. With guidance from an Advisory Group comprising representatives of users, carers, service professionals and appropriate government departments, the national service will establish minimum performance standards for the service.

Recommendation 3 – maximise social inclusion

The central ethos of the NHS Wheelchair and Seating Service will be to maximise social inclusion. At referral, assessment and provision, services will be led by the requirements of users and carers embracing individual lifestyles and aspirations, taking into account domestic, educational, vocational and environmental requirements.

**Recommendation 4 – increase number of centres, local facilities and clinics**

The number of centres, local facilities and clinics will increase in a manner to be determined by further consultation. There will be a substantial increase in the number of local facilities and clinics that will be staffed by centre staff. Suitably trained community staff will also support local facilities as they become available.

Recommendation 5 – provide support for privately purchased wheelchairs

The NHS Wheelchair and Seating Service will support assessment and maintenance for a defined range of privately purchased wheelchairs.

Recommendation 6 – establish evidence-based mobility pathways

Documented, evidence-based mobility pathways (similar to ‘patient pathways’) will underpin all stages of the service provided to users and carers.

Recommendation 7 – improve co-ordination with community services

A review in the context of recommendations made in this report will be undertaken to improve co-ordination between wheelchair and seating provision and community services responsible for making home, school and workplace adaptations to ensure compatible solutions are developed in an efficient and timely manner.

referral, assessment and provision

RECOMMENDATION	PRACTICAL START DATE AND TIME TO IMPLEMENT		
	SHORT TERM < 1 YEAR	MEDIUM TERM 1-3 YEARS	LONG TERM > 3 YEARS
8	■		
9	■	■	
10	■		
11	■		
12	■	■	
13		■	
14	■		
15	■		
16	■	■	

Easy to implement ■ Moderate to implement ■ Hard to implement ■

Recommendation 8 – self-referral for reassessment

Users and carers will be informed that they can self-refer to the service for reassessment and repairs when they feel they are required. Any healthcare professional will be able to make a referral to the NHS Wheelchair and Seating Service. Training will be established to improve communications between referring community-based staff and service staff.

Recommendation 9 – phased removal of eligibility criteria

Current eligibility criteria for NHS Wheelchair and Seating Services will be removed by phased implementation, unless they relate to safety.

Recommendation 10 – agreed mobility and seating plan for each user

An individual mobility and seating plan will be developed for each user assessed and should form an agreement that is signed by the user, carer and wheelchair service clinician. In the event that there is a failure to agree on the mobility and seating plan then an independent review group will be available to arbitrate an agreement.

**Recommendation 11 – assessment to document optimum equipment specifications**

The assessment process will clearly document the optimum specifications to meet user and carer goals and requirements. Financial considerations should not be a key issue.

Recommendation 12 – assessment and provision for those who need the service

Assessment and provision of equipment will be available to all with mobility and/or postural support needs, including those in care homes, bariatric users and carers, people with terminal illness and people with acute needs.

Recommendation 13 – users and carers to be offered more information about the service

All users and carers will be offered a simple introduction to the NHS Wheelchair and Seating Service so that they understand:

- the purpose of the assessment and associated individual mobility and seating plan
- their right to appeal the specifications of the equipment to be supplied
- how to provide feedback to the service, including the complaints process, and
- procedures for obtaining repairs and preventive maintenance.

Recommendation 14 – assessment to be integrated, multi-disciplinary and multi-agency

Assessment leading to provision of equipment will be an integrated, multi-disciplinary and multi-agency approach. Deployment of staff will be flexible, with medical staff available when needed but reserved for assessment of those with complex, multi-factorial needs.

Recommendation 15 – assessment to ensure compatibility with carer requirements

The assessment will include review of the particular requirements of carers ensuring that any equipment provided is compatible with their requirements.

Recommendation 16 – equipment to be delivered within known timeframes

Systems will be established to ensure that equipment is available within a known timeframe following the assessment process. Agreed timescales and lead-times will be stated following the assessment, and a commitment will be made to communicate any unexpected delays.

management

RECOMMENDATION	PRACTICAL START DATE AND TIME TO IMPLEMENT		
	SHORT TERM < 1 YEAR	MEDIUM TERM 1-3 YEARS	LONG TERM > 3 YEARS
17	Yellow	Light Blue	Light Blue
18	Light Blue	Yellow	Yellow
19	Yellow	Yellow	Light Blue
20	Yellow	Green	Light Blue
21	Red	Yellow	Light Blue

Easy to implement 

Moderate to implement 

Hard to implement 

Recommendation 17 – establish as a national service delivered locally

The national service (as proposed in Recommendation 2) will be operated by a Management Group comprising members of the user and carer working groups (Recommendation 18) and representatives of other relevant stakeholders.

Recommendation 18 – each centre will establish user and carer working groups

User and carer working groups will be established in association with each centre. The groups will provide advice to the centre and will be supported with basic secretarial services to enable them to confer with other users and carers.

Recommendation 19 – governance and complaints overseen by national service

Governance and complaints processes will be specific to the wheelchair service and linked to the national service's governance system.

Recommendation 20 – services available to users and carers at any centre in Scotland

Users and carers will be able to obtain services from any centre in Scotland.

Recommendation 21 – services to support more effectively life-change transitions

Services will be provided so that critical life-change transitions affecting users and/or carers (child to adult service user, loss of key carer (e.g. parent), university to workplace) are continuous and driven by the wishes of the user and carer.



information management and systems

RECOMMENDATION	PRACTICAL START DATE AND TIME TO IMPLEMENT		
	SHORT TERM < 1 YEAR	MEDIUM TERM 1-3 YEARS	LONG TERM > 3 YEARS
22			
23			

Easy to implement ■

Moderate to implement ■

Hard to implement ■

Recommendation 22 – national IT system to support management

A robust national IT system allowing management of waiting lists and equipment, and facilitating performance comparisons will be established. This will have the facility to link to the electronic patient record and record comprehensive information about each user and the equipment they use.

Recommendation 23 – communication links between centres and staff working locally

Appropriate communication links will be established to ensure that staff working remotely from the centre can lead assessments, and access information and advice. Experienced staff in specialist centres (e.g. spinal injury/head injury, multiple sclerosis, stroke units) may wish to directly assess the requirements of the user and carer who may be based in their facility. They will need to seek approval for supply of the equipment based on the assessment and an agreed mobility and seating plan.

training

RECOMMENDATION	PRACTICAL START DATE AND TIME TO IMPLEMENT		
	SHORT TERM < 1 YEAR	MEDIUM TERM 1-3 YEARS	LONG TERM > 3 YEARS
24	Hard to implement	Hard to implement	
25	Hard to implement	Moderate to implement	
26	Moderate to implement	Moderate to implement	
27	Easy to implement	Moderate to implement	

Easy to implement  Moderate to implement  Hard to implement 

Recommendation 24 – improvements to infrastructure

The infrastructure to provide training on wheelchair and seating needs to be established and accredited. All staff, including reception, administration and technical staff, will receive training in 'customer relations' with an emphasis on the specific requirements of people with disabilities and their carers.

Recommendation 25 – review career structure for service staff

A review should be undertaken by NHS Education for Scotland (NES) to ensure that an appropriate career structure exists for clinicians and technicians delivering wheelchair services.

Recommendation 26 – review staffing levels throughout the service

A review will be undertaken to determine whether current staffing levels are adequate and whether the most appropriate skill-mixes are in place.

Recommendation 27 – appropriate training for service staff

Staff referring to the service should receive appropriate training.



repair, maintenance and support

RECOMMENDATION	PRACTICAL START DATE AND TIME TO IMPLEMENT		
	SHORT TERM < 1 YEAR	MEDIUM TERM 1-3 YEARS	LONG TERM > 3 YEARS
28			
29			
30			
31			
32			

Easy to implement ■

Moderate to implement ■

Hard to implement ■

Recommendation 28 – agreed response times for repair and maintenance

The NHS, at all levels in the service, will provide repair and maintenance support. It should have response times that are determined through the national service consultation process involving users and carers.

Recommendation 29 – provision of out-of-hours support

Out-of-hours support, including weekends and holidays, will be provided. The feasibility of using NHS 24 as a means for users and carers to contact centres and obtain emergency response outside normal business hours will be considered.

Recommendation 30 – review of in-house refurbishment practices

A review of using in-house workshops to refurbish and customise chairs will be carried out.

Recommendation 31 – provide mobile service

To provide dedicated area technician support for preventive maintenance and minor repairs, centres will consider provision of a suitably qualified mobile service.

Recommendation 32 – establish planned preventive maintenance programmes

Planned preventive maintenance (PPM) programmes should be established. Inventory management systems should include measures to remove obsolete equipment from use to ensure that stocks keep pace with currently available technology.

facilities

RECOMMENDATION	PRACTICAL START DATE AND TIME TO IMPLEMENT		
	SHORT TERM < 1 YEAR	MEDIUM TERM 1-3 YEARS	LONG TERM > 3 YEARS
33			
34			
35			

Easy to implement ■ Moderate to implement ■ Hard to implement ■

Recommendation 33 – ensure facilities are fully accessible to people with disabilities

All wheelchair service facilities must be fully accessible to people with disabilities and their carers.

Recommendation 34 – ensure facilities have adequate space for clinical assessment

All facilities should be provided with appropriate space for clinical assessment, storage and the equipment needed to support effective assessment.

Recommendation 35 – facilities will be family-friendly

All facilities will ensure that they are family-friendly with dedicated waiting areas and clinical facilities for children.



particular considerations for children's services

In addition to the above recommendations, the following particular considerations should be given to the provision of services for children.

RECOMMENDATION	PRACTICAL START DATE AND TIME TO IMPLEMENT		
	SHORT TERM < 1 YEAR	MEDIUM TERM 1-3 YEARS	LONG TERM > 3 YEARS
36			
37			
38			
39			
40			

Easy to implement ■ Moderate to implement ■ Hard to implement ■

Recommendation 36 – children to have access to a multi-disciplinary team

Children should have comprehensive access to a multi-disciplinary team when being assessed or reviewed for wheelchair and seating systems.

Recommendation 37 – all services for children provided in child-oriented facilities

All services for children will be undertaken in family-friendly, child-oriented facilities by staff specially trained in the assessment of children with requirements for wheelchairs and seating.

Recommendation 38 – provide access to specialist paediatric clinicians

Clinics will provide access to specialist paediatric clinical expertise as needed.

Recommendation 39 – extended equipment loan programmes

Extended equipment loan programmes will be introduced to provide longer periods of time for children to be trained so that they can learn to use equipment during the assessment process, prior to making a decision for its provision.

Recommendation 40 – establish multi-agency links

Centres will establish properly functioning multi-agency links.

background and context



NHS Wheelchair and Seating Services provide a wide range of equipment for people with widely varying complexities of need. There are approximately 96,000 registered users of the service who not only need the initial provision of the equipment, but ongoing support; in most cases for their lifetime.¹ The demands for the service are therefore accumulative and likely to grow rapidly in the next two decades. Chronic lack of profile and under-resourcing in the wider context of the healthcare delivery environment in which they are managed increases the challenges of such a diverse service.

An ageing society that is living longer, with an increasing number of frail elderly people requiring assisted mobility and postural management will need to be supported by a dynamic, efficient and effective service. Given the wider requirements of frail elderly people living independently in the community, a fully integrated assistive technology (AT) service is indicated. The recommendations presented in this report anticipate this model for delivering assistive technology services. The Steering Group suggests that methods and organisational structures proposed for the NHS Wheelchair and Seating Service be used to pioneer the evolution of a fully integrated assistive technology service for all age groups in the next five years.

There are five wheelchair and seating centres in Scotland based in Aberdeen, Inverness, Dundee, Glasgow and Edinburgh serving a population of over five million people. Host NHS Boards run these centres with income provided by neighbouring NHS Boards. The five centres vary greatly in the size of population that they serve. There are large variations in staffing levels, funding and expenditure per registered user between the centres.²

The NHS Wheelchair and Seating Service supports:

- young children with disabilities whose requirements have to be closely integrated with other services, including education and paediatric clinical care, and should promote full participation with the child's family members
- young people who make the transition out of children's services at a time when wheelchair and seating become increasingly important for vocational purposes, including employment
- people who acquire a physical disability as a consequence of an accident or who develop a progressive condition, and
- frail elderly people who use a wheelchair to provide mobility outside the home, or in nursing homes, frequently as a primary seating system.

1 Appendix 1, Section 1.1.1

2 Appendix 1, Section 2.2.10



Unlike most services provided by the NHS, NHS Wheelchair and Seating Services are not subject to specific performance standards. Important measures of service quality, such as timeliness of assessment and delivery of equipment, consistency in eligibility of users for the scope of possible services or the expected levels of experience and training of professionals and technicians delivering the service are lacking. Deficiencies in the service have been raised since the 1970s, in many cases through formal reports.³ The service has not been given adequate priority and has been starved of resources that has resulted in loss of opportunity and quality of life for thousands of its users.

Despite these challenges the commitment of service staff has been extraordinary in providing the best possible support under the circumstances, however this struggle has taken its toll. The service is not perceived by many ambitious and competent clinicians to be an attractive career choice.

Numerous reports and reviews of services for people with disabilities have been published, including at least nine specifically addressing NHS Wheelchair and Seating Services.⁴ It is widely recognised that these services have failed to keep pace with:

- the increasing aspirations of people with disabilities to participate fully in society and achieve the highest levels of self-sufficiency and independence possible
- advances in technology that can enable and enhance these aspirations
- improvements in the delivery of NHS services by setting basic quality and responsiveness standards as outlined for many services in the NHS Plan *“Our National Health. A plan for action, a plan for change”*, and
- the need for investment in physical facilities and workforce required to deliver services that are local, family-friendly, accessible to people with disabilities and responsive to the requirements and aspirations of users and carers.

On 8 December 2004, Petition PE798 was submitted to the Petitions Committee of the Scottish Parliament by a concerned parent, supported by 1,292 users, carers and staff, within the wheelchair services requesting it to:

- resolve the current critical problems in the provision of wheelchairs and specialist seating services within the NHS by both an immediate increase in funding and through a review, which in consultation with users, will address minimum standards, the scope of equipment provided and the delivery of services, and
- recommend a strategy for the integrated provision of all equipment for people with physical disabilities.

³ Appendix 1, Section 3.2.1

⁴ Bibliography, Appendix 6

Following the submission of the Petition, the Minister for Health and Community Care requested officials to take forward two pieces of work to:

- progress a wheelchair needs assessment review to be completed by 31 March 2006, and
- to investigate with the service what interim measures could be put in place in the short term to address the unacceptable waiting times.

Immediate steps were taken to address interim issues by an injection of £1.9 million for year 2005/6 to reduce waiting times. The Minister for Health and Community Care commissioned an independent report to review the NHS Wheelchair and Seating Service. A Steering Group, comprising of a wide range of interested stakeholders, chaired by Professor Martin Ferguson-Pell, has steered the review resulting in 40 recommendations outlined in detail in this report.

Following correct tendering procedures, Frontline Consultants were appointed to conduct the independent review of the NHS Wheelchair and Seating Service. Frontline Consultants' independent report is included in Appendix 1. This provides an extensive record of the findings of the consultation processes and comes to a consensus view of the service based on the responses to consultation.



recommendations and rationales

redesign of service delivery

referral, assessment and provision

management

information management and systems

training

repair, maintenance and support

facilities

particular considerations for children's services



The recommendations and rationales presented here have been developed by the Steering Group based on the evidence gathered by Frontline Consultants. Evidence quoted in the rationales has been cross-referenced to the Frontline Consultants' report which is in Appendix 1.

redesign of service delivery

Recommendation 1

An Implementation Team will be established to take forward delivery of the recommendations made in this report on behalf of the Minister for Health and Community Care.

Rationale

The recommendations of this report will require, in many cases, detailed development, the preparation of business cases and ongoing project management. Implementation will be best undertaken through a co-ordinated planning process and project management with the oversight of an Implementation Team.

Recommendation 2

The provision of all assistive technology services (including wheelchairs, seating, prosthetics, orthotics, augmentative communication, environmental controls) will be integrated into a single national service, funded centrally but delivered locally. The NHS Wheelchair and Seating Service will pilot this change. The NHS Wheelchair and Seating Service will be accountable for expenditure through a budgetary process. With guidance from an Advisory Group comprising representatives of users, carers, service professionals and appropriate government departments, the national service will establish minimum performance standards for the service.

Rationale

At present there are five wheelchair centres that are managed by geographically associated NHS Boards. Evidence gathered in this review has shown that there is a lack of co-ordinated provision with wide variation in the scope of services provided, funding allocation per user and staff to user ratios across Scotland.⁵ In 1996/7 funding was devolved to NHS Boards and was not ring-fenced, the funding therefore forming part of each NHS Board's annual allocation. Evidence shows that there has been an apparent shortfall in allocation using 1996/7 as a basis for 2004/5.⁶ There is little evidence to suggest that these differences can be explained by regional differences in need, but instead is a consequence of differences in priority given to these services by each NHS Board.

⁵ Appendix 1, Section 2.2.7

⁶ Appendix 1, Section 2.2.6



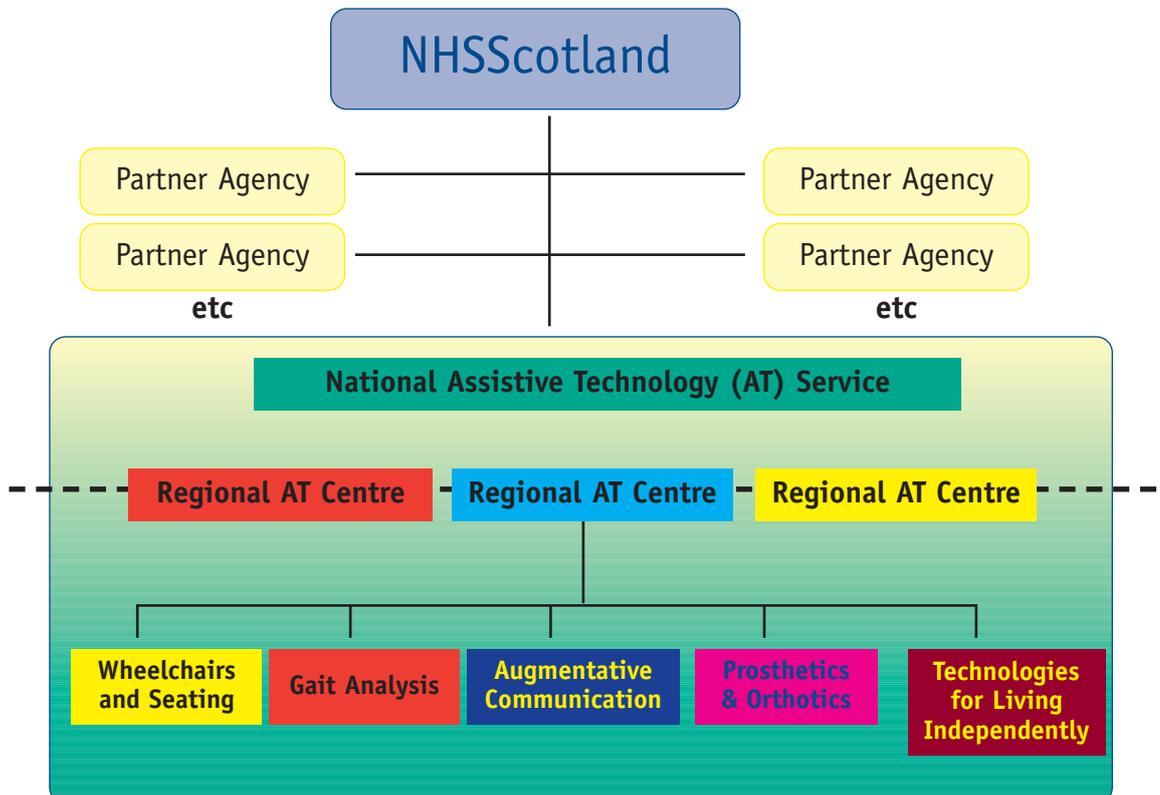
This recommendation seeks to ensure that given a long history of under-resourcing, these services should receive nationally protected funding.

At present the service is not routinely included in any of the monitoring systems common to NHSScotland.⁷ The framework for delivering a national service should support an approach where services are delivered locally but are accountable to nationally agreed minimum standards of scope and quality. A target benchmark specification has been developed which could constitute a useful basis from which to build standards.⁸

A review of these services in other countries has shown that NHS Wheelchair and Seating Services can be integrated into a more comprehensive service encompassing many other assistive technologies.⁹

In the long term a national, integrated assistive technology service should be established and it is proposed that the NHS Wheelchair and Seating Service should pilot this approach. The Steering Group discussed how a national focus would be organised and proposes that the details of this recommendation should be investigated in depth by the Implementation Team (Recommendation 1).

The suggested structure for the national service is illustrated below.



7 Appendix 1, Section 3.2.2
 8 Appendix 1, Section 3.2.3
 9 Appendix 1, Section 5

Recommendation 3

The central ethos of the NHS Wheelchair and Seating Service will be to maximise social inclusion. At referral, assessment and provision, services will be led by the requirements of users and carers embracing individual lifestyles and aspirations, taking into account domestic, educational, vocational, and environmental requirements.

Rationale

At present NHS Wheelchair and Seating Services are constrained by eligibility criteria based solely on medical need and lack of funding, rather than wider social requirements, and currently fail to recognise the requirements of carers. This narrow interpretation of how wheelchairs are provided is deeply resented by users¹⁰ because wheelchair services fail to provide equipment that enables full social inclusion. Users have reported that the assessment process is too limited, is rarely perceived to be holistic and appears to be too heavily orientated towards what equipment is available rather than what is required.¹¹ These concerns were at the centre of the 'Declaration of Independence' which was written and unanimously supported by users, carers and professionals at the national conference.

Users and carers emphasised that assessment should take account of:

- medical condition and needs around posture and seating, including neck/back support and extension
- lifestyle, leisure, environmental and employment requirements
- carer requirements
- accommodation, environment and car type, and
- likely future requirements.¹²

Recommendation 4

The number of centres, local facilities and clinics will increase in a manner to be determined by further consultation. There will be a substantial increase in the number of local facilities and clinics that will be staffed by centre staff. Suitably trained community staff will also support local facilities as they become available.

Rationale

Improved access for users could be achieved if there was a more local service they could identify with and access for most of their needs. This could be delivered by developing more local outreach facilities and empowering community staff to prescribe chairs for those with less complex needs. Enhancing the response to complex needs at the centres will provide the centre with a service which integrates local, outreach and community services and provides training and support for all staff.

¹⁰ Appendix 1, Section 2.1.2

¹¹ Appendix 1, Section 2.1.2

¹² Appendix 1, Section 2.1.6



Recommendation 5

The NHS Wheelchair and Seating Service will support assessment and maintenance for a defined range of privately purchased wheelchairs.

Rationale

NHSScotland does not currently repair privately purchased equipment. This is, in part, due to the diversity of makes and models that they might be required to deal with.¹³ However, many users who have purchased their equipment privately state that they would welcome advice from the NHS on private purchase and, importantly, professional assessment prior to making the purchase.¹⁴ In order to meet this need, a consultation should take place between the wheelchair service providers, users and the commercial sector to establish the most effective way to support service providers in giving appropriate assessment advice on a defined range of privately available chairs. This consultation should also explore whether it would be feasible for the NHS to stock parts for maintenance of that defined range of privately available chairs or merely issue a maintenance voucher. These options will be clearly stated in the mobility plan (Recommendation 10).

Recommendation 6

Documented, evidence-based mobility pathways (similar to 'patient pathways') will underpin all stages of the service provided to users and carers.

Rationale

At present, although referral pathways are similar between centres,¹⁵ practices vary considerably in detail in addressing the specific requirements of users and carers. As part of the recommendation to establish minimum quality standards, it is proposed that 'mobility pathways' be established for different groups of users and carers based on best practice. Although there are many examples of best practice in current wheelchair centres, there is a great deal of scope to adopt excellent practices used outside Scotland and also improvements in practice resulting from research and development in this field. One of the goals for the national service should be to develop consensus on a wide range of current best practices.

Recommendation 7

A review in the context of recommendations made in this report will be undertaken to improve co-ordination between wheelchair and seating provision and community services responsible for making home, school and workplace adaptations to ensure compatible solutions are developed in an efficient and timely manner.

13 Appendix 1, Section 2.2.21

14 Appendix 1, Section 2.2.5

15 Appendix 1, Section 2.2.3

Rationale

Significant delays occur when community services implement home or workplace modifications, but staff are unclear about the type of wheelchair being proposed by wheelchair services (e.g. power versus manual). Equally, wheelchair services are unclear about how to specify the wheelchair if they do not have adequate information about the proposed home/workplace modifications. Users have expressed frustration with poor communication and co-ordination between different services.¹⁶

referral, assessment and provision

Recommendation 8

Users and carers will be informed that they can self-refer to the service for reassessment and repairs when they feel they are required. Any healthcare professional will be able to make a referral to the NHS Wheelchair and Seating Service. Training will be established to improve communications between referring community-based staff and service staff.

Rationale

Users do not feel that they should have to return to the original referral pathway if they are uncomfortable or their wheelchair or seating system is not meeting their requirements. They should be able to approach the service directly to make an appointment so that these issues can be resolved.¹⁷ The referral process for healthcare professionals working with users and carers in the community should be direct to the NHS Wheelchair and Seating Service to expedite and simplify meeting their requirements.

Recommendation 9

Current eligibility criteria for NHS Wheelchair and Seating Services will be removed by phased implementation, unless they relate to safety.

Rationale

The current eligibility criteria are not driven by user or carer requirements and fail to support social inclusion. The criteria for powered wheelchairs in particular are reported as unfair and unrealistic.¹⁸ To avoid the service being overwhelmed by user demand at the outset, the removal of the current eligibility criteria will require to be undertaken in a controlled and phased manner as it will have major implications for existing service provider staff and on the provision of equipment.

¹⁶ Appendix 1, Section 2.1.6

¹⁷ Appendix 1, Section 2.1.12

¹⁸ Appendix 1, Section 2.1.6



Recommendation 10

An individual mobility and seating plan will be developed for each user assessed and should form an agreement that is signed by the user, carer and wheelchair service clinician. In the event that there is a failure to agree on the mobility and seating plan then an independent review group will be available to arbitrate an agreement.

Rationale

To support a requirements-led approach (Recommendation 3) the mobility plan provides documentation that is agreed by the user, carer and clinician. The mobility plan will include details of:

- the outcomes of the needs assessment
- assessment process
- technology specification, and
- proposed programme for follow-up/review of user/carers requirements and equipment.

If, for financial reasons, the specified equipment cannot be provided, the mobility plan will provide a record of unmet need.

Users and carers have stated that there is no routine follow-up and that regular follow-up should identify problems and changing needs before they begin to impact upon the usefulness of the equipment.¹⁹ Furthermore, review should ensure that the equipment supplied keeps pace with advances in technology.

Recommendation 11

The assessment process will clearly document the optimum specifications to meet user and carer goals and requirements. Financial considerations should not be a key issue.

Rationale

Users feel that current assessment for equipment is constrained by financial resources.²⁰ If these constraints are removed, the final decision to provide a specific wheelchair and seating system to meet the goals of the user may still require a compromise on optimal specifications. This compromise should be explained clearly to the user and carer and whether it is based on value for money, lack of funds, clinical or other considerations.

¹⁹ Appendix 1, Section 2.1.8

²⁰ Appendix 1, Section 3.3.1

Recommendation 12

Assessment and provision of equipment will be available to all with mobility and/or postural support needs, including those in care homes, bariatric users and carers, people with terminal illness and people with acute needs.

Rationale

The consultation identified a wide range of circumstances where assessment and provision of equipment was either inadequate or non-existent for certain groups of users and carers.²¹ Considerable concern was expressed about the limited support provided to users in care homes, despite significant need to provide postural support, pressure relieving cushions and lighter weight adjustable wheelchairs that could be used by frail elderly people.²² Services for people with terminal and progressive conditions were also reported to be inadequate with equipment being provided too late to meet the user's requirements, particularly in retaining dignity and comfort.²³ Obesity presents particular technical problems in providing an extensive selection of equipment whilst accommodating bariatric requirements in terms of structural strength, ample dimensions and operational safety. The role of the carer for bariatric wheelchair users also requires expert support in assisting with propulsion and transfers.

Recommendation 13

All users and carers will be offered a simple introduction to the NHS Wheelchair and Seating Service so that they understand:

- the purpose of the assessment and associated individual mobility and seating plan
- their right to appeal the specifications of the equipment to be supplied
- how to provide feedback to the service, including the complaints process, and
- procedures for obtaining repairs and preventive maintenance.

Rationale

An introduction to the wheelchair service should be offered to all new users and carers to ensure that they understand the level of service they should expect to receive and their role in identifying their requirements to specify their equipment.

The introduction should explain the goal setting process, role of professionals and the procedures used in selecting the best available solution for their requirements, and the appeals and complaints procedures of the centre.

Currently users and carers do not know how to make the most of the service, how they can obtain information about their assessment and the equipment they receive or how to obtain further information about wheelchair and seating products.²⁴

²¹ Appendix 1, Section 6.6

²² Appendix 1, Section 3.7.7

²³ Appendix 1, Sections 6.6.6 and 6.6.10

²⁴ Appendix 1, Section 2.1.12



Recommendation 14

Assessment leading to provision of equipment will be an integrated, multi-disciplinary and multi-agency approach. Deployment of staff will be flexible, with medical staff available when needed but reserved for assessment of those with complex, multi-factorial needs.

Rationale

Many service users and carers want to involve healthcare professionals who know them, their needs and personal circumstances best.²⁵ Many service users want a process that takes home, school, leisure and work environments into account.²⁶

The Scottish NHS Wheelchair and Seating Services should be included in local partnership arrangements for the NHS and local authorities and the Joint Performance Information and Assessment Framework.

Wheelchair centres should also review how best to include equipment suppliers in the assessment of users and carers with complex needs. In many services outside Scotland the supplier undertakes an active role in the assessment process by giving detailed technical expertise about their products. It could be considered in complex cases to ask suppliers to assist with, for example, trialling chairs.

Recommendation 15

The assessment will include review of the particular requirements of carers ensuring that any equipment provided is compatible with their requirements.

Rationale

The assessment will take into account any limitations or concerns that affect the carer (e.g. strength, risk of falls or injury, ability to assist with transfers) in supporting the user with the proposed equipment. In addition carers may face challenges due to their own health requirements, living environment or geographical location. Users have reported that they consider this to be an important part of the assessment.²⁷

Recommendation 16

Systems will be established to ensure that equipment is available within a known timeframe following the assessment process. Agreed timescales and lead-times will be stated following the assessment, and a commitment will be made to communicate any unexpected delays.

25 Appendix 1, Section 2.1.6

26 Appendix 1, Section 3.3.3

27 Appendix 1, Section 2.1.6

Rationale

Systems need to be developed to expedite the delivery of equipment once an assessment has been completed. Users have expressed concern about the delays between assessment and delivery of the equipment.²⁸ Audit systems should be put in place to monitor performance.

management

Recommendation 17

The national service (as proposed in Recommendation 2) will be operated by a Management Group comprising members of the user and carer working groups (Recommendation 18) and representatives of other relevant stakeholders.

Rationale

To ensure that the service is in touch with the requirements and priorities of users and carers, working in partnership with service providers, the national service will rely upon co-operative management principles. Each of the centres will support user and carer working groups and will provide a representative to the national service Management Group together with a representative of the service providers. Representatives of other relevant stakeholders will also be involved in the Management Group.

Recommendation 18

User and carer working groups will be established in association with each centre. The groups will provide advice to the centre and will be supported with basic secretarial services to enable them to confer with other users and carers.

Rationale

Each wheelchair centre should establish a user and carer working group to assist in providing representation of user and carer views in the development and management of the national service. The national service will be supported by a Management Group to manage funding and to monitor standards. The Steering Group emphasise that this is not intended to add another layer of bureaucracy to the service but to ensure equity of provision and to provide stronger advocacy for resources to support the requirements of wheelchair users and carers in Scotland.



Recommendation 19

Governance and complaints processes will be specific to the wheelchair service and linked to the national service's governance system.

Rationale

Currently, complaints are dealt with by the complaints office of the appropriate NHS Board. Users complained of having to take the initiative, a lack of information, no easy-access telephone number, poor response to queries and difficulties accessing an appropriate person on the telephone.²⁹ If complaints are managed by wheelchair services directly, resolution will be quicker and should result in future service improvements. In addition, wheelchair services are more likely to understand the consequences of complications associated with concerns expressed by users and carers.

Recommendation 20

Users and carers will be able to obtain services from any centre in Scotland.

Rationale

The artificial boundaries of individual NHS Boards should not dictate where a user goes to access services, especially given the key importance of easy access. Further, when equipment problems develop they should be able to access the closest service. The NHS should ensure that there is no barrier to this occurring, through the use of an appropriate mechanism such as out-of-area treatment charges, cross-boundary flow or a similar arrangement.

Recommendation 21

Services will be provided so that critical life-change transitions affecting users and/or carers (child to adult service user, loss of key carer (e.g. parent), university to workplace) are continuous and driven by the wishes of the user and carer.

Rationale

Young adults face difficulties in relation to transition from children to adult services. At this crucial time in their lives, young people often lose the influence of advocates (parents, teachers and specialist paediatric clinicians) to support and represent their case for equipment that meets their changing requirements. The range in choice of equipment available to children through the NHS can be better than for adults, and support services are often more extensive. Young adults may have inappropriate equipment and worsening access to support at a time when they might expect to be very actively seeking work etc.³⁰

Other transitions include: changes in clinical condition, changes in personal circumstances, moving house, and progression to powered mobility.

²⁹ Appendix 1, Section 2.1.12

³⁰ Appendix 1, Section 3.7.5

information management and systems

Recommendation 22

A robust national IT system allowing management of waiting lists and equipment, and facilitating performance comparisons will be established. This will have the facility to link to the electronic patient record and record comprehensive information about each user and the equipment they use.

Rationale

Although some progress has been made with the development of databases for rehabilitation technology by the Rehabilitation Technology Information Service (ReTIS), there are limitations in the capabilities of these systems and there is substantial potential for further development.³¹ In particular, databases are required that are accessible from all centres, local facilities and clinics. They should be accessible to all appropriately authorised staff involved in supporting users and carers (technical, clerical, clinical – including community staff). They should be linked to the electronic patient record.

Existing IT infrastructure does not support easy and accurate reporting of waiting times and waiting lists. Each centre interprets the phases of waiting differently and may well have several queues for different services or pieces of equipment.³² Current IT systems fail to keep reliable information about registered users and do not have consistent and clear definitions of user and equipment characteristics. Inter-centre comparisons of service characteristics have proved to be difficult and the review was weighed down by lack of accurate, easy to access performance and activity information.³³

Recommendation 23

Appropriate communication links will be established to ensure that staff working remotely from the centre can lead assessments, and access information and advice. Experienced staff in specialist centres (e.g. spinal injury/head injury, multiple sclerosis, stroke units) may wish to directly assess the requirements of the user and carer who may be based in their facility. They will need to seek approval for supply of the equipment based on the assessment and an agreed mobility and seating plan.

Rationale

Consistent with the proposal to increase the delivery of services more locally in local facilities and clinics, enhanced communication links will be required to provide support from the centres. Support should include the means to use video-links involving users, carers and clinicians. These systems will also provide important links between specialist clinical settings (such as spinal injury units) where improved communication links will support the effective handover of responsibility for the user and carer requirements to wheelchair services.

31 Appendix 1, Section 2.2.24

32 Appendix 1, Section 2.2.14

33 Appendix 1, Section 1.4.1



training

Recommendation 24

The infrastructure to provide training on wheelchair and seating needs to be established and accredited. All staff, including reception, administration and technical staff, will receive training in 'customer relations' with an emphasis on the specific requirements of people with disabilities and their carers.

Rationale

At present, training of service staff is often *ad hoc*, poorly resourced, infrequently accredited and no norms have been established that are associated with staff member responsibilities and roles. Training may also be neglected due to staff shortages. As a result of these constraints, the difficulties of recruitment and service quality can only be exacerbated.³⁴ Training is an important component in generating the culture of the service and to reinforce values. Training in this field is important due to rapid changes in technology. All staff and relevant community staff must receive accredited training, supported by appropriate continuing professional development opportunities.

Recommendation 25

A review should be undertaken by NHS Education for Scotland (NES) to ensure that an appropriate career structure exists for clinicians and technicians delivering wheelchair services.

Rationale

Failure to offer career structures fails to attract and retain the best staff into the field and demoralises those who join.³⁵ Staff from professions such as bioengineering and occupational therapy are not keen to come into what is seen as a 'cinderella' service. For bioengineers there are reported limited places on specialist courses and considerable problems with the time taken to become state registered and therefore an autonomous practitioner. Continuing professional development opportunities are largely *ad hoc* with formal training opportunities thin on the ground. There is no planned programme of post-qualification training in Scotland, unlike the provision for orthotists and prosthetists. There is seen to be little opportunity for career progression in the wheelchair service, which also affects recruitment.³⁶ Incentives should exist for staff to increase skills and knowledge and obtain higher level qualifications.

34 Appendix 1, Section 2.2.12

35 Appendix 1, Section 3.6.1

36 Appendix 1, Section 3.6.3

Recommendation 26

A review will be undertaken to determine whether current staffing levels are adequate and whether the most appropriate skill-mixes are in place.

Rationale

Many of the staff involved in delivering services at the centres come from hard to recruit professions, or technicians with highly specialised skills. It will be necessary in implementing the recommendations of this report to increase staffing levels, however the skill mix required should not be assumed to be the same as that in place at present.

Recommendation 27

Staff referring to the service should receive appropriate training.

Rationale

Training is required to ensure that people who work outside the wheelchair service, but have responsibilities to users and carers who use it, understand how best to make referrals to the service. This will help avoid duplication of some aspects of the assessment conducted when the user first makes contact with the service. This training could be combined with other training offered.

repair, maintenance and support

Recommendation 28

The NHS, at all levels in the service, will provide repair and maintenance support. It should have response times that are determined through the national service consultation process involving users and carers.

Rationale

Centralisation of repairs and maintenance, although providing some advantages in terms of efficiencies of service create major difficulties for users and carers who seek more local support. The National Service Management Group will establish methods of delivering Planned Preventive Maintenance (PPM) and repairs more locally in association with the development of the local facilities and mobile technicians.

Recommendation 29

Out-of-hours support, including weekends and holidays, will be provided. The feasibility of using NHS 24 as a means for users and carers to contact centres and obtain emergency response outside normal business hours will be considered.



Rationale

Many respondents to the consultation highlighted frustration at the lack of support for equipment failure outside business hours, particularly at weekends and during holidays. Furthermore, they reported difficulties in making contact with NHS Wheelchair and Seating Services by telephone outside business hours.³⁷ In some cases, users reported that they could be housebound as a result of unresolved equipment failures.³⁸ Respondents highlighted the potential for reducing equipment failure through improved PPM and the need for appropriate levels of back-up in the event failure occurs.³⁹ The need for equipment to provide equivalent function whilst equipment was taken away for repair was also emphasised.⁴⁰ There should be clearly defined response times so that users and carers can plan accordingly. These should be defined by the national service Management Group in conjunction with users and carers.

Recommendation 30

A review of using in-house workshops to refurbish and customise chairs will be carried out.

Rationale

Workshops at wheelchair centres traditionally carry out refurbishment of chairs and customise standard chairs to individual requirements. These practices should be reviewed, taking into account technological changes, user satisfaction and overall costs.

Recommendation 31

To provide dedicated area technician support for preventive maintenance and minor repairs, centres will consider provision of a suitably qualified mobile service.

Rationale

Following a successful pilot, Inverness has now rolled out a PPM programme providing a mobile technician who visits users to check the set-up and maintenance of their equipment. This has been very well received.⁴¹ This service will reduce equipment failure and therefore the need for repairs and associated loss of use if the wheelchair has to be returned to a central workshop to conduct simple repairs.

37 Appendix 1, Section 3.5.10

38 Appendix 1, Section 2.1.10

39 Appendix 1, Section 2.1.9

40 Appendix 1, Section 3.5.1

41 Appendix 1, Section 2.2.5

Recommendation 32

Planned preventive maintenance (PPM) programmes should be established. Inventory management systems should include measures to remove obsolete equipment from use to ensure that stocks keep pace with currently available technology.

Rationale

Preventive maintenance is intended to reduce the occurrence of equipment failure. However, it is thought that *excessive* minor repairs may result in a stock of outdated wheelchairs. Parts will become scarce and delays will occur while parts are acquired. This can also divert technicians from addressing more complex priorities. A balanced approach to PPM is likely to reduce equipment failure whilst it is in use and help to maintain an inventory of up-to-date equipment. This balanced approach will also help to reflect possible changes in the requirements of users and carers.

facilities

Recommendation 33

All wheelchair service facilities must be fully accessible to people with disabilities and their carers.

Rationale

There is evidence that some wheelchair centres are not fully accessible to users and their carers.⁴²

Recommendation 34

All facilities should be provided with appropriate space for clinical assessment, storage and the equipment needed to support effective assessment.

Rationale

Services have failed to invest in equipment needed to provide assessment services using up-to-date objective tools.⁴³ All facilities should have access to the following:

- moving and handling equipment
- plinths
- assessment and simulation equipment (including objective and outcome measurement tools) and procedures for their use (including calibration)
- weighing scales for wheelchair users
- an adequate stock of equipment to trial, and
- accessible facilities for users and carers to obtain product information (including web access).

⁴² Appendix 1, Section 2.2.19

⁴³ Appendix 1, Section 2.2.19



Lack of adequate stock for trialling often means users and carers have not had a chance to see and test the equipment that is to be provided to them. Adequate product information ensures that users and carers are fully aware of the options and accessories available. This also supports professionals in researching product options.

Recommendation 35

All facilities will ensure that they are family-friendly with dedicated waiting areas and clinical facilities for children.

Rationale

NHSScotland guidelines for services for children specify that clinical facilities should provide dedicated areas for children. These guidelines have not been fully implemented in all facilities delivering NHS Wheelchair and Seating Services. For children with disabilities and their carers it is important that their experience in receiving these services is positive and enabling.

particular considerations for children's services

In addition to the above recommendations, the following particular considerations should be given to the provision of services for children.

Recommendation 36

Children should have comprehensive access to a multi-disciplinary team when being assessed or reviewed for wheelchair and seating systems.

Rationale

To ensure that all the developmental needs of children are fully co-ordinated, all team members, including the child's family should be aware of decisions made by service staff and should participate in the process as necessary.

Recommendation 37

All services for children will be undertaken in family-friendly, child-oriented facilities by staff specially trained in the assessment of children with requirements for wheelchairs and seating.

Rationale

To be consistent with policy elsewhere in the NHS, children should be seen in a dedicated, family-friendly and child-friendly environment.

Recommendation 38

Clinics will provide access to specialist paediatric clinical expertise as needed.

Rationale

The skills required for the assessment of children differ from adults in some key respects, notably:

- staff should be trained to work with children
- the multi-disciplinary and multi-agency aspects of children's needs are generally more complex than adults, requiring links to different networks of expertise, and
- expertise in the developmental aspects of children is required.

Recommendation 39

Extended equipment loan programmes will be introduced to provide longer periods of time for children to be trained so that they can learn to use equipment during the assessment process, prior to making a decision for its provision.

Rationale

Many children and their carers find that they need an extended trial period with equipment that is proposed for their use so that they develop basic skills before it is possible to confirm that the proposed equipment will meet their requirements. This is also true for children with complex postural support needs where sitting stability, ability to control systems and comfort are all more accurately assessed after a period of extended use.

Recommendation 40

Centres will establish properly functioning multi-agency links.

Rationale

To ensure that all of the dimensions of the developing child are represented in the planning, delivery and follow-up of services, strong systematic links with these services are required. These links are important to ensure that people who work with the child in the multiplicity of environments that they are in (e.g. school, home, community activities) are able to provide advice and perspectives on the specification of equipment.

costings for recommendation categories



funding of recommendations

The NHS Wheelchair and Seating Service has, for many years, been seriously constrained in the support and mobility equipment it can offer service users. As a result of the service having a relatively low profile to date, allocation of financial resources has been severely restricted.⁴⁴ Further, since 1996 the funds available have reduced in real terms, apparently to meet alternative priorities within the host NHS Boards.

In line with the specification for this review, having prepared the recommendations, the Steering Group requested that Frontline Consultants prepare indicative costs for implementation of the main categories of the recommendations. Table 1 indicates that a substantial increase in funding is required if the service is to be brought up to an acceptable standard to provide users with a service that delivers social inclusion and freedom from unacceptably restrictive eligibility criteria. Given the broader scope of the service proposed in the recommendations, future funding for the service should be on a multi-agency basis, but hosted and managed by the NHS. At present it is common for users and carers as individuals to have to seek multi-agency funding for equipment needs. They are often not familiar with the funding structures of government and frequently fail to obtain the resources they need. It is therefore proposed that multi-agency funding for the service is agreed at Scottish Executive level to reduce this burden on users and carers and to improve equity in accessing multi-agency support for their needs.

The costs give a broad indication of the financial support needed to deliver the recommendations outlined in this document, based on available information, with some input from service providers. However it is important to note that the figures are very much an informed estimate. It will therefore be imperative that allocation of additional money to specific centres or projects would only follow on from the preparation of detailed proposals in the form of fully costed business cases and implementation plans, setting out financial requirements from both capital and revenue streams with the latter split between recurring and non-recurring revenue.

Table 1 summarises the estimated additional revenue consequences of the recommendations, including the recurring revenue effect of potential capital investments. It may be that capital rather than revenue investment will be required to fund specific elements of building development or expensive equipment but pending production of detailed proposals, an assumption has been made for the sake of simplicity that all investment will be of a revenue nature. What is important at this stage is not the source or nature of funding requirements, but the overall amount required.

44 Appendix 1, Section 2.2.6



The phasing suggested for improvements is ambitious, and it is anticipated that it may be constrained by the ability to recruit staff. If implementation takes place at a slower pace, it will be important to ensure that total funds are not lost.

Table 1 – Additional revenue funding required to support recommendations

Recommendation	Short term < 1 year full year (£000s)	Medium term 1-3 years full year (£000s)		Long term/ recurrent annual (£000s)
		Year 2	Year 3	
Redesign of service delivery	1,528	2,515	2,535	2,580
Referral, assessment and provision of equipment	6,475	10,020	9,985	8,905
Management of the service	87	147	147	147
Information management and systems	35	110	60	60
Training	210	560	560	560
Repair, maintenance and support	250	1,900	1,920	3,350
Facilities required to expand the service	100	75	75	75
Particular considerations for children's services	50	130	130	130
Total (£)	8,735	15,457	15,412	15,807

Source: Frontline Consultants (Appendix 1)

Notes

1. The current NHS Wheelchair and Seating Service has available funding of £14.2 million per annum.⁴⁵ In order to effect the implementation of the recommendations of the Steering Group additional funding will be required. This would be in the order of an additional £8.7 million for the first 12 months of implementation. For years 2 and 3 of implementation, a further additional £6.7 million would be required each year. Then to maintain a steady state after successful implementation of all the recommendations recurrently, an additional £15.8 million would be required from the 2005/06 position of £14.2 million, giving a total of £30 million.
2. Contained within this additional £15.8 million is a funding stream of £6.6 million per annum for additional wheelchairs and powered wheelchairs plus £1.2 million for modernising the existing fleet.
3. The highest cost programmes comprise:
 - **redesign of service delivery:** substantial increase in local access however provided – revenue costs of leasing facilities or the equivalent cost of building and owning them
 - **referral, assessment and provision:** funding for equipment, based on significant increases to the wheelchair fleet in years 1-3 due to the removal of current restrictive eligibility criteria, followed by more frequent replacement and increased demand
 - **referral, assessment and provision:** additional staff time for regular reassessment and full discussion of mobility plans with service users following assessment, and
 - **repair, maintenance and support:** introduction of a PPM programme across Scotland, plus regular replacement of older stock currently in the wheelchair fleet.
4. It should be noted that while costed recommendations specific to the children's service are included, the costs relating to additional staffing and equipment are contained within the recommendations that relate to redesign of service delivery for the service and referral, assessment and provision.

appendices



- 1 Frontline Consultants' independent report
"NHS review of wheelchair and seating services
in Scotland. Report for NHS Quality Improvement
Scotland"

Annex A: analysis of questionnaire

Annex B: public consultation paper

Annex C: NHS Quality Improvement Scotland report on
public consultation
- 2 petition PE798 to the Scottish Parliament
- 3 extract from tender specification for review
- 4 programme from national conference held on
12 September 2005
- 5 messages presented to the Deputy Minister for Health
and Community Care at the national conference
- 6 bibliography



REVIEW OF NHS WHEELCHAIR AND SEATING SERVICES IN SCOTLAND
INDEPENDENT REPORT FOR NHS QUALITY IMPROVEMENT SCOTLAND



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Frontline Consultants' Independent Report "NHS Review of Wheelchair and Seating Services in Scotland. Report for NHS Quality Improvement Scotland"



1 introduction

1.1. Background to this review

- 1.1.1 Scotland has had a national wheelchair service since the Second World War, when it was felt that an organised Government approach to, and provision for, the levels of disability following the war were required. From that time until 1996, the service was organised centrally. In 1996, responsibility for wheelchair services was transferred to NHS Boards, some of which came together in consortia to buy and/or provide services. In 2005 the wheelchair service had a budget of approximately £14.2m per annum, employed some 100 staff and provided services to approximately 96,000 registered wheelchair users.
- 1.1.2 There is a wide range of people who use wheelchairs: some may be entirely dependent on a wheelchair for their mobility and housebound without it, others use their chair once a week for a family outing. Some people will be lifelong wheelchair users as a result of a disability they were born with, others will suffer a traumatic injury as an adult, other groups have a progressive disease which attacks them in their 30s and increasingly affects their mobility. Everyone involved in this project will carry keen memories of particular individuals whom they met: very young children zipping around in small chairs, clearly enjoying their ability to explore, and young men who communicate through a keyboard and an electronic communication system yet who can crack a joke and are involved in local politics. For very many of these people, the Scottish wheelchair service has a direct and significant effect on their quality of life.
- 1.1.3 Following a submission to the Petitions Committee of the Scottish Parliament regarding the service, supported by concerned users, carers and NHS wheelchair service staff, the Minister for Health and Community Care announced that a full and independent review of wheelchair services in NHSScotland would be commissioned and funded. Responsibility for commissioning and oversight of the project was devolved to NHS Quality Improvement Scotland (NHS QIS). A steering group of service providers, service users, and clinical and technical experts was formed who together devised a project specification. The specification went out to tender with interested parties being invited to submit a bid to carry out the work.
- 1.1.4 Following this, in May 2005, Frontline Consultants were commissioned by NHS QIS to conduct a review of NHS wheelchair and seating in Scotland, to examine user needs and current service provision and to provide recommendations for the future development of the service to meet future need and demand.



- 1.1.5 This document is not intended to provide detailed solutions to all the current issues facing wheelchair provision in Scotland: rather it identifies the main issues, outlines the debate and suggests options and models which could move the service forward. Some changes may be implemented very quickly and may be cost neutral; others will need further work and additional funding before they can be put into practice.
- 1.1.6 We would like to thank the many members of the public and the NHS who have given their time to inform this project.

1.2 Approach

Objectives

- 1.2.1 This review took place between May 2005 and March 2006. The project was managed by a steering group, who monitored progress.
- 1.2.2 The broad aims of the review were to:
- identify, as far as possible, the people in Scotland who need wheelchair mobility and associated postural and seating support
 - identify potential benefits for patients and their carers (presently excluded) which may be realised by the full range of potentially available interventions to meet those needs
 - identify current service provision, and
 - undertake a gap analysis to highlight what is required to move from the existing service to one which more closely meets the needs and aspirations of users and carers and which is affordable for NHSScotland.
- 1.2.3 It has subsequently been agreed that the steering group will have responsibility for drawing up specific recommendations to Ministers, while this final report, which remains independent, will indicate our assessment of the service, its future challenges and the most appropriate direction of travel along with the underlying logic for our conclusions.

Approach

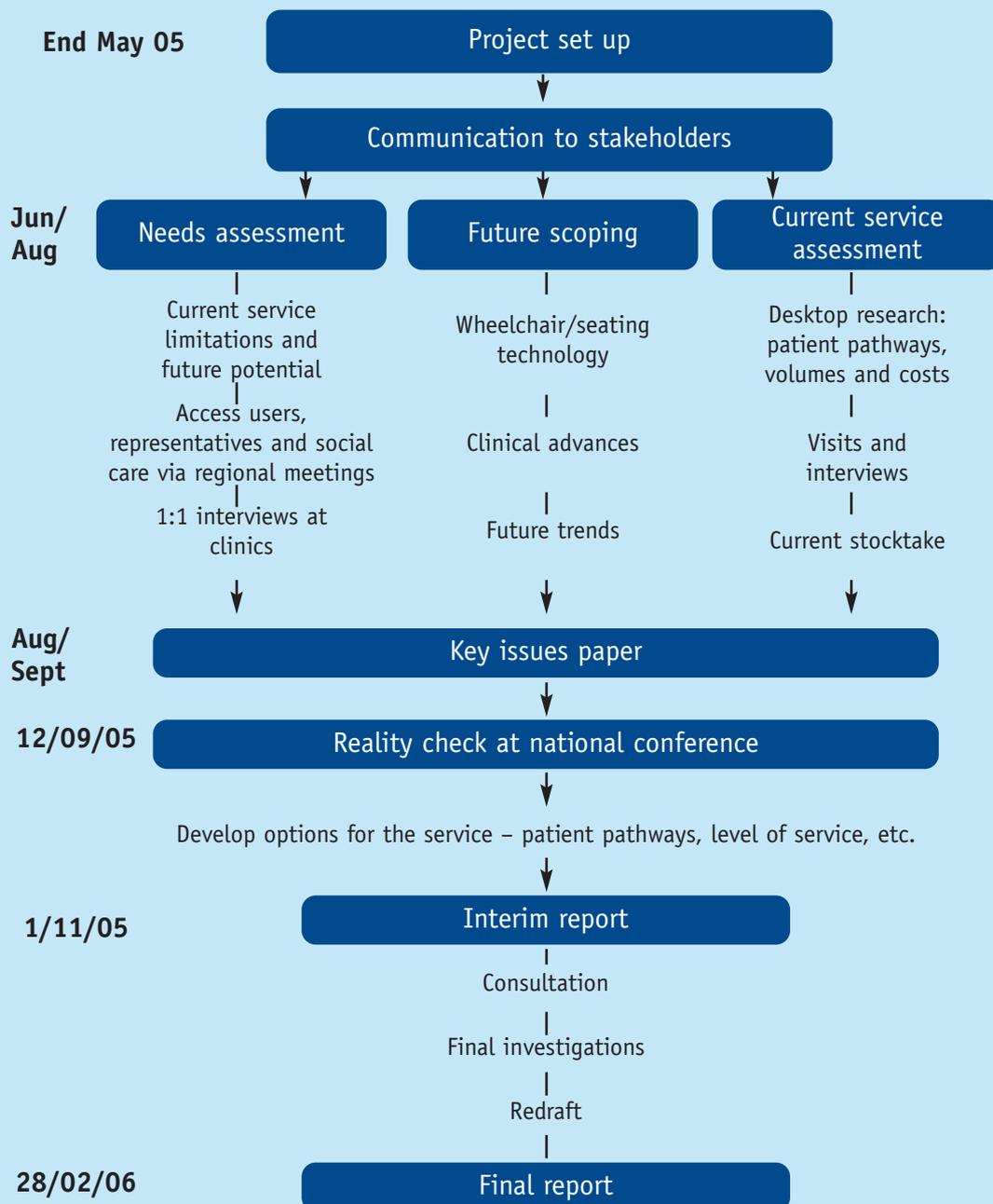
- 1.2.4 Our overall approach was:
- understanding users' and carers' views and needs, including those of individuals who may have communication constraints
 - exploring providers' perspectives, including clinical and training issues
 - understanding future trends, in terms of user profile and technological advances
 - looking at financial and service provision models, both current and future
 - showing the balance between benefit to service users and costs, and
 - assessing the overall efficiency of various provider approaches.



1.3 Method

The diagram below shows our method in schematic form.

Figure 1 Outline of key milestones and objectives





The project was carried out in 3 phases:

Stage 1: Information gathering and informal consultation

Users' views and needs assessment

- 1.3.1 We took part in a series of **regional workshops** to which wheelchair users and their carers were invited, to explain how the service worked for them and affected their lives. Fifteen meetings at five centres were held with users, carers and service providers to ensure that geographic differences in needs and models of provision could be represented. These events were organised by the Scottish Executive and the regional wheelchair service centres and facilitated by an independent company commissioned by the Scottish Executive Health Department (SEHD).
- 1.3.2 A **questionnaire** was circulated to wheelchair users to give us further detailed information from a wider group.
- 1.3.3 We **interviewed** a wide variety of individuals and groups, with the aim of accessing a cross section of views.

The current service

- 1.3.4 **Local consultation with service providers** allowed us to identify examples of good practice in Scotland and understand factors influencing the quality, scope and effectiveness of the service. We visited each of the five wheelchair centres and talked to a very wide spectrum of staff about the service and their roles, and accessed as much information as was readily available about finance, service delivery and user numbers.

Future scoping

- 1.3.5 We **interviewed a range of experts** in the fields of rehabilitation, spinal cord injury, technology, research, leading edge practice and equipment manufacturers in order to obtain their views about future trends which might affect the wheelchair service in Scotland. We sought to identify key issues including:
 - identification of strengths and weaknesses in current service and strategies for improvement
 - identification of examples of excellent practice throughout the world
 - benchmarking current NHS provision against wheelchair and seating technologies in use at centres of excellence worldwide, and
 - future-scoping clinical and technological developments.



Desk-based research

- 1.3.6 We supported these interviews with an extensive web-based review, and information-gathering was undertaken to collect a broad perspective on wheelchair and seating services throughout the world. Abstracts from conferences such as the Posture and Mobility Group in UK, Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) and the International Seating Symposium in North America were reviewed.

Health gain

- 1.3.7 Working with a leading expert in the field, we commissioned work to examine the levels of 'health gain' which might be expected from improvements in the wheelchair service, how a 'cost benefit analysis' might view investment in the service, and how this might compare with the use of funds elsewhere in the NHS.

Key themes

- 1.3.8 The work outlined above allowed us to identify a number of key themes for further investigation. It was notable how consistently the same weaknesses in the service were identified by users, carers and service providers across Scotland.

Stage 2: Debate and consultation

National conference

- 1.3.9 The informal consultation process culminated in a national conference "Moving Forward: Re-inventing the Wheelchair Service" on 12 September 2005. This meeting provided a reality check on the information gathered and confirmed identification of key issues for the service. The information and views gathered were to establish the emphasis of the options to be included in the formal consultation questionnaire.
- 1.3.10 All staff associated directly or indirectly with wheelchair and seating services were invited to a meeting to highlight key issues related to the aims of the review. A synopsis of the interim report was presented and broadly supported.
- 1.3.11 This was followed by a presentation to the conference delegates of the key themes presented in the Interim Report. This, combined with a presentation outlining the Norwegian Assistive Technology Services, provided substantive issues to be tackled by break-out sessions, each led by a facilitator.



1.3.12 Five breakout sessions were held, each tackling key themes outlined in the Interim Report. Delegates were invited to complete an index card with a message, comment or question for the Minister. In the afternoon session the facilitators were asked to report back their comments and suggestions to the main group. Some key points emerged and were captured by a unanimously supported 'Declaration of Independence' (see next chapter). On the whole the delegates were satisfied that the key themes of the Interim Report covered the issues that needed resolution.

Formal consultation

1.3.13 Further work led to the production of a consultation document endorsed by the steering group and centred on the key themes endorsed by the national conference. These were:

- structuring the service, making it local
- making the service accountable
- assessment
- provision of equipment
- maintenance of equipment
- gap analysis of equipment provision
- staffing, and
- funding.

1.3.14 The main consultation document identified the key themes and gave some background to the issues. Respondents were asked to consider the key issues in the service and give their preferences amongst a set of alternative options. The questions asked were structured in order to stimulate debate and produce informed reactions.

1.3.15 The consultation paper was widely advertised, available at the wheelchair centres and could also be downloaded from the NHS QIS website.

Interim report

1.3.16 An interim report, a precursor to this document, approved by the steering group, was available to support consultation. It included a review of the current state of the wheelchair service in Scotland and provided further background relating to the key themes.

Steering group workshop

1.3.17 We also attended a two-day workshop for the expert steering group overseeing this project, to hear their informed discussion of a range of views and their initial formulation of specific recommendations.



Stage 3: Final report

Analysis of responses to formal consultation

- 1.3.18 2,500 'packs' were issued. There were 511 responses, considered to be an unusually high response rate: details are included in the annexes. While, generally, there was a positive view of the consultation exercise, there were comments from some respondents expressing concern that the options were in some cases ambiguous or unclear. Others felt that certain questions tended to 'lead'. In the time available it was not possible to pilot the consultation paper to remove potential biases and ambiguities. Many responses, both from individuals but even more particularly those from interested groups, gave a more detailed input about their views, ideas and rationale.

Report

- 1.3.19 We re-examined our thinking in the light of consultation feedback, resulting in this final report, where we have:
- outlined our conclusions
 - corrected any errors identified in the draft report, implicit or explicit, and
 - included outline costings for key developments.

1.4 Access to information

- 1.4.1 Wheelchair service centres have been very helpful in providing data, and performance information provided by the Rehabilitation Technology Information Service (ReTIS) has also been useful. ReTIS is jointly funded by all Scottish NHS Boards to provide an information service in the field of rehabilitation technology. However, with no common information system across all service centres, it has not always been easy to compare like-with-like, nor to separate various components of cost or activity. Where it has been judged to be important for figures to be provided, these may well be estimates, extrapolated from available data. We would suggest that absolute accuracy is not essential at this stage – it is more important to give a 'best estimate' figure than none at all and this should be adequate for decision making at this level.



1.5 Needs analysis

1.5.1 A core approach to the method used for conducting the review was that of identifying the unmet needs of wheelchair users. A formal and full-scale needs assessment involves blending several considerations including epidemiology, economics and values, but in practice may be limited by time and by the resources and data available, and is not a one-off process. We would not claim to have conducted a definitive needs analysis for Scottish wheelchair users, but would suggest that we have, through the help of service users and providers, identified the key unmet needs, and checked our understanding through a consultation process. We have also quantified the key shortfalls, not to a high level of accuracy due to the lack of data, but sufficiently robustly to allow decisions to be made in the context of this review.

1.6 Clarification

1.6.1 Throughout this report, the term 'wheelchair users' should be assumed to include carers unless specifically stated otherwise. Likewise, the term 'wheelchair service' should be taken to include seating unless stated otherwise. A glossary of terms is included.

2 Findings and Emerging Themes

2.1 The views and experiences of service users

2.1.1 In order to gain a full range of views and experiences, we used several means of gathering information from service users during the project. These were:

- feedback and follow-up from the regional meetings with service users organised by SEHD and the wheelchair service centres during the summer of 2005 – three meetings were held in each of Scotland's five wheelchair centre areas
- discussions at a national conference for service users, carers and service staff held on 12 September 2005
- widespread distribution and analysis of responses to a questionnaire designed with input from service users, and
- one-to-one interviews with individual service users and carers, and representative organisations.



2.1.2 Many people we talked to were positive about aspects of the wheelchair service. However, the most striking aspect of all these events, investigations and conversations is the degree of agreement among service users about the main challenges facing the wheelchair service in Scotland. These are:

- **waiting times** are often too long for assessment, provision of equipment and repairs
- **the assessment process** takes too limited a view of mobility, is rarely perceived to be holistic and appears to be too heavily orientated to what equipment is available rather than what is required
- **equipment provision** is perceived as being of basic quality and limited choice; the eligibility criteria governing equipment provision, particularly for powered chairs, are deeply resented
- **follow-up and maintenance** is lacking in many areas, with little routine follow-up or maintenance of equipment, and limited ongoing assessment
- **out-of-hours cover** for repairs is not generally available, causing concern, inconvenience and distress for users
- **centralised service centre locations** can necessitate journeys of several hours for people who have severe mobility problems, and
- **information and communication** can be lacking, or not proactive.

Waiting times

2.1.3 Many service users told us that the waiting times from referral through assessment to provision of equipment and thereafter for equipment repairs were all excessive. Waiting to be assessed after referral to the service was reported to be anything from two weeks to over two years, with the longest delays apparently for powered chair assessment or for seating. Repairs may take anything from a few days to over six weeks and some wheelchair users did not have a replacement chair in the meantime.

2.1.4 Service users described the effects of long waits on them as including:

- having to sit in unsuitable and uncomfortable positions or equipment
- having to borrow a chair (from the Red Cross for example) while waiting for a repair; some bought a replacement chair privately
- being house-bound or even bed-bound, and
- suffering a worsening of their condition or postural difficulties.

2.1.5 Many users asked why wheelchairs were not included in the waiting time guarantees common for other parts of the health service.



Assessment for a wheelchair

- 2.1.6 The following themes emerged from service users in relation to the assessment process:
- assessment is not holistic – many service users perceived that the assessment process for getting a wheelchair did not take into account everything that might impinge upon the kind of chair they might require for a full life. They often felt that they were not listened to and that only needs that could be met by the NHS were assessed and taken into account. Users wanted the assessment to take account of:
 - medical condition and needs around posture and seating, including neck/back support and extension
 - lifestyle, employment and leisure needs and carers abilities
 - accommodation and car type
 - likely future needs
 - assessment is not flexible – service users believed that the process should be able to accommodate the involvement of the people who know the user, their needs and abilities best; for example, carers, family and community therapists
 - eligibility criteria for equipment – these were seen as being finance-driven, unfair and determined by medical need as opposed to wider social needs. The criteria for powered chairs in particular are reported as unfair and unrealistic. Perhaps the commonest complaints about rigid assessment were in relation to powered chairs
 - lack of joined up or co-ordinated provision – NHS wheelchair services do not provide all mobility equipment, and situations may arise where issue of a wheelchair is contingent on securing services and equipment from other agencies. For example, the scenario where a wheelchair cannot be issued until a ramp has been installed at the users home, but social services will not fit a ramp until a wheelchair has been issued was highlighted.

Provision of equipment

- 2.1.7 Service users' main comments on equipment were about:
- a lack of choice around basic chairs and other equipment
 - basic quality of equipment
 - poor fit – chairs were too big, too small, not comfortable
 - chairs not enhancing mobility and independence as much as they could, and
 - the unsatisfactory appearance of the chair.



Follow-up and maintenance

- 2.1.8 Service users commented that there was limited routine follow-up of wheelchair and seating users and that this was particularly important for children and adults with changing needs. Stories were recounted of the difficulties and physical hardship people faced when their needs changed more quickly than the service could respond to; users were of the opinion that regular follow-up should identify problems and changing needs before they begin to impact upon the usefulness of equipment and the wellbeing of the user.
- 2.1.9 There is no comprehensive, standardised, system-wide planned preventive maintenance (PPM) programme for equipment. PPM could offer good value for money and improve the service for users and carers. In some areas, users can get a refund for basic repairs to their chairs carried out at a local garage or bike shop – e.g. punctures and brake adjustments, but many wanted access to a more regular and specialist maintenance system to avoid problems arising in the first place, to advise or to check the set-up of their chair.

Out-of-hours cover

- 2.1.10 The lack of a facility for contacting the wheelchair service or having repairs undertaken after 5.00pm, at weekends and on public holidays was a source of great dissatisfaction for wheelchair users. The impact of this gap in the service was illustrated by the stories of service users, particularly those who lived alone or were completely dependent on their chair for mobility, sometimes unable to get out of their house for several days while waiting for an emergency repair.

Service-centre location

- 2.1.11 Many service users commented on the protracted and complex journeys they – and their carers, relatives or friends – may have to make, usually for assessment, to wheelchair service centres. This can involve days off school or work for the user and their carer and is made worse by the ongoing travel difficulties that wheelchair users' experience with public transport. For example, wheelchair users in Stranraer face a round trip of 170 miles and five hours to get to their nearest centre in Glasgow. The issue is a particular problem when repeated journeys are required and/or ambulance transport is necessary.

A further issue was the difficulty some users faced in accessing their centre of choice. Several service users told us that they preferred a wheelchair centre, for reasons of accessibility or quality of service, but had been denied access, since the NHS Board area they resided in had a contract with a particular centre, which they were constrained to use.



Information and communication

2.1.12 Service users complained of:

- a lack of information at every stage of the process from pre-assessment to post-equipment issue
- a lack of understanding and empathy about the impact of immobility on people's lives
- having to take the initiative, for example when chasing up equipment supply and repairs
- not having an easy access telephone number for the service and having to go through someone else, for example the community occupational therapist (OT)
- not having telephone calls and letters responded to, and
- the person who answered the telephone not having sufficient knowledge and therefore not referring the user to an appropriate person.

Regional events

2.1.13 The table below shows an analysis of the main themes raised at regional events. It should be noted that the individuals attending these were a very small sample of total wheelchair users in Scotland, and self selected, in that they volunteered to attend these events. Nevertheless, some patterns appear to be apparent.

Table 1

Theme	Glasgow			Edinburgh			Dundee			Inverness			Aberdeen		
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
Working groups:															
Lack of rapid repairs service	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Assessment not holistic/service not listening	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Poor equipment choice	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y
Re-assessment non-existent/not good enough	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y	Y	Y	Y	Y
Waits too long for assessment and/or provision	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y
More local services needed	Y	Y	Y	Y	Y	N	Y	N	Y	N	N	Y	Y	Y	Y
Consider different ways of funding, e.g. vouchers	Y	Y	N	Y	Y	Y	Y	N	Y	Y	N	N	Y	Y	Y
Staff attitudes unhelpful	Y	Y	Y	Y	Y	Y	Y	N	Y	N	N	N	N	Y	Y

(‘Y’ = appears as theme in event notes; ‘N’ = did not appear as theme in event notes)



Service user questionnaire

2.1.14 As part of the needs assessment part of the project, we designed, in conjunction with service users, issued and analysed a questionnaire about the experience of wheelchair users. We issued some 1,500 questionnaires and made the document available on our website, and some individuals photocopied questionnaires and shared them. It was therefore quite disappointing that only 258 completed questionnaires were returned, despite this being an above normal response rate. Nevertheless, we do appear to have a good cross-section of replies: a broad age group responded, with particularly high number of responses from 46-65 year olds. 47% of respondents had accessed services at Glasgow, 22% of respondents at Dundee, 15% at Edinburgh, 9% at Inverness, 8% at Aberdeen.

2.1.15 These completed questionnaires contained useful additional information, which has informed this report throughout. The areas of response are listed below, together with some of the findings where these are clear cut. Full details are available in annex A.

- pattern of wheelchair use
- waiting time profiles for assessment and equipment
- the effects of waiting for assessment and provision
- borrowed chairs
- repair profiles including waiting times: 61% of respondents had their wheelchairs repaired within 2 weeks of reporting the fault and 19% within 3-6 weeks, 20% had to wait in excess of 6 weeks: 22% of the total were offered a replacement chair
- assessment issues
- satisfaction with equipment: 41% were dissatisfied for a variety of reasons, especially younger users, however 72% found their chairs easy to use
- availability of equipment: 25% reported that they had been refused equipment they wanted, most often a powered chair, but including 'wheelchair accessories', different chairs (with additional functionality) and less frequently 'lighter chairs'
- interaction with the wheelchair service
- waiting for appointments other than assessment and the effects of this, and
- suggestions for improvement: 68% believed that the service could improve, highlighting repairs, communication, staff, assessment, and choice.



A declaration of independence

- 2.1.16 At the national conference on 12 September 2005, service users in the audience agreed on wording for a statement they called a 'Declaration of Independence' which was presented to the Deputy Minister for Health and Community Care, Lewis Macdonald, when he addressed the conference in the afternoon. The statement was agreed as follows:
- "The service should be a basic human right accessible through self referral and should ensure individuals are given all appropriate aids necessary to fulfil the basic right of all citizens to play an active part in society and their daily life regardless of physical limitations or differences."

2.2 Current service model

- 2.2.1 The findings in this report of the current service model across NHSScotland are based on:
- visits to all service centres
 - interviews with managers and staff at service centres
 - feedback from service users, carers and representative organisations
 - analysis of data relating to finance and activity, and
 - desk-based research on background, benchmarks and examples of good practice.

The organisation of services

- 2.2.2 The Scottish wheelchair service is provided from five regional centres in Edinburgh, Glasgow (known as WESTMARC), Dundee (known as TORT), Aberdeen (known as MARS), and Inverness (Highland). Together they receive 4,100 new referrals each year. The table below gives a breakdown of that figure by centre together with the number of registered users. There is significant variation between some of the centres in the number of registered users per head of population. There would not appear to be any reason why this should be the case, although we might perhaps expect a slightly higher density of wheelchair users in urban populations. It is likely that this variation is in large part because there is no standardised methodology for identifying 'active users' as distinct from 'registered users'.

**Table 2**

Centre location	NHS Boards served	Users registered	Population served	Users per thousand population	New referrals/year
Edinburgh	Lothian Fife Borders Dumfries & Galloway (small number only)	20,656	1,240,250	17.7	3,454
Glasgow	Greater Glasgow Lanarkshire Forth Valley Ayrshire & Arran Argyll & Clyde Dumfries & Galloway	60,699	2,614,850	22.2	6,282
Dundee	Tayside Forth Valley (small number only)	5,711	402,500	13.7	1,306
Aberdeen	Grampian Shetland Orkney	5,601	544,570	11.6	1,335
Inverness	Highland Western Isles	3,099	255,180	12.3	731

The above data was provided by the wheelchair centres

N.B. the figures for registered users are probably defined differently, with Inverness, Aberdeen and Dundee focusing more on 'active users': those who are likely to have ongoing contact with the service. A comparable figure for Glasgow and Edinburgh, allowing a similar rate of users per head of population, might give a Glasgow figure nearer 40,000, and Edinburgh perhaps 20,000. Due to this inconsistency, we have generally compared data by head of population.

Patient pathway

2.2.3 Although there are considerable variations in the details of the way the service is provided across the five centres, the overall patient pathway is similar:

- a referral form is required for any type of wheelchair. Although general practitioners (GPs) usually sign the referral form, they are not necessarily knowledgeable about wheelchair technology or eligibility criteria and the form is often completed by a district nurse or occupational therapist. Referrals can also come from hospital consultants. The referral form is sent to the wheelchair centre where it is screened: the referral rate per thousand of population served varies between roughly 2.4 (Aberdeen and Glasgow) and 3.2 (Dundee)



- the majority of referrals do not require the service user to be seen by the wheelchair centre team, and a wheelchair is ordered at this point, in most instances from the centre's workshop – these are typically standard manual propulsion chairs. Total attendances calculated as a ratio of the number of referrals varies between approximately 0.5 (Edinburgh) and 2.0 (Dundee)
- if an individual is likely to require something other than a standard manual chair, for example postural support, seating or complex adaptations, they will be seen for an assessment. All individuals likely to require a powered chair are assessed. Moulds may be taken for seating. A chair is prescribed according to assessment and the eligibility criteria, and is ordered, usually from the centre's workshop
- screening, assessment and prescription are generally managed in a team setting with bioengineers and occupational/physiotherapists sharing the workload and responsibility, sometimes with the involvement of a rehabilitation consultant. Appointments between the wheelchair user and the service may be at the centre, at school, at home, or at an outreach clinic, where centre staff will visit for a day and provide more local access, albeit with a more limited range of facilities. There are variations in the ratio of patients seen in a clinical setting compared to a residential setting, between around 2:1 (Aberdeen) to 1:3 (Glasgow)
- most chairs are purchased by the wheelchair centre, at prices negotiated on a bulk contract by the national NHS purchasing organisation. Some will need no modification and will be dispatched straight to the user, probably via the centre's workshop, which may keep a stock of standard chairs. More complex chairs may be ordered straight from the manufacturer in final form, but more commonly go via the centre workshop, where modifications may be made to a standard bulk-purchase chair. Adaptations may be modular in form, with a range of arm or footrests or seating being inserted. Due in part to this modular approach, many chairs are refurbished by the centre workshop for reuse
- some centres are able to offer 'one-stop' clinics, where the user is assessed and issued with the appropriate chair at the same appointment. However, some patients, particularly those needing complex chairs and seating systems, may need more than one visit, and
- once a chair has been dispatched, there may be a variety of arrangements for further help, assistance and follow-up.

Within this general pathway, variations between centre practices may be driven by a multiplicity of factors, which may include size, functionality, rurality, funding, staffing and history.



There are also differences in the way that repairs are dealt with: most centres have a mobile technician who can visit users to deal with problems, and has some discretion over dealing with urgent requests.

Complex repairs may need to be returned to the wheelchair centre, with resulting delays, and this is standard practice in some centres. PPM is not widely available, despite the reduction in repairs that this should yield.

There is no routine access to services or help out-of-hours.

Seating

- 2.2.4 Seating can be a very significant aid in providing comfort and postural support. For many users, a standard pressure relieving cushion may be all that is required. For some individuals, however, including children, a moulded seat is needed and this is fitted into the wheelchair frame. This may be to assist an individual who does not have full control of voluntary reflexes or to give a more beneficial seating position for those with postural difficulties or impaired motor skills. In such instances, the seating may need to be made to conform to a mould of the individual's body. This can take time, and certainly requires a system to ensure that the component parts of the wheelchair and seating system are properly and promptly married together and suitable for the individual user.

Good practice in Scotland

- 2.2.5 Throughout our visits and interactions with the wheelchair service centres, we encountered extremely dedicated and hardworking staff. This observation was confirmed by service users, who were keen to record their recognition of the effort and service provided by staff. We also noted a range of examples of good practice that should be highlighted. Some of these are widespread across the service, whilst others tend to be concentrated in certain geographical areas:
- team-based assessment model – screening and assessment shared between bioengineers and therapists, according to the needs of the patient and the particular skills of each individual. This is a very flexible model giving potential for an element of multi-skilling. While there are individual users whose needs are best assessed by a particular profession, the team-based model appears to enable better management of workload and flexibility around peaks and troughs of activity and recruitment difficulties.
 - training services – training users in effective operation of their equipment enables them to make the best use of it and ensures that they are confident and safe. In Dundee, powered chair users receive driver training.



- minor repairs – there is widespread use of a low cost reimbursement scheme, for users to claim back the cost of minor repairs up to perhaps £20. This enables repairs such as punctures and brake adjustments to be carried out quickly at a local bicycle repair shop or garage.
- Dundee has received temporary funding to allow a redesign of paediatric services giving more frequent clinics, service closer to patients and greater stock levels, producing an audited improvement in parent satisfaction from 82% to 94%.
- Edinburgh has recently implemented a 'Transition Policy', providing the option of an extended transition period for young people with complex physical needs when they move from the paediatric service to the adult service. This also includes excellent communication and the option of a joint meeting with therapists from adult and paediatric services.
- PPM – following a successful pilot, Inverness has now rolled out PPM to all users, providing a 'man in a van' who goes to users to check the set-up and maintenance of their wheelchairs. This has been very well received, will reduce equipment failure, the need for repairs, and allow adjustments and advice to be given.
- international conferences are hosted in Dundee, giving the service a much needed higher profile as well as information exchange on good practice.
- children's services – the rate of growth in children and the impact of equipment on their cognitive and physical development means that children's services tend to require a more intensive approach. Some centres are set up to respond rapidly, proactively and holistically: Edinburgh is supported by the mobility charity Fastrax who will fund additional 'lifestyle' equipment where the NHS currently does not. In Dundee and Inverness, clinics and/or servicing/repairs are carried out in schools, enabling minor adjustments and repairs to be made quickly and as required without interfering with children's education.
- patients' follow-up – some centres routinely send out an annual follow-up letter to service users who have not been in contact with the service during the past year. This is a useful way of keeping in touch with low demand users and also alerts them to changes of address etc.
- Edinburgh provides training for referring community therapists for uncomplicated wheelchair prescriptions, which is updated annually for new staff and as a refresher for current prescribers.
- workforce development – a number of centres are investing in on-the-job training and development for therapists and bioengineers, to enable them to achieve their state registration or take part in rotations through other parts of the NHS while being productive members of the team.



- Edinburgh offers adult wheelchair users the option of attending the centre to view and try a range of chairs.
- advice on private purchase – in Dundee the charitably funded Outreach Project provides independent advice on private purchase and, importantly, professional assessment for users who are not eligible for powered chairs via the NHS. Edinburgh children’s services support parents and children in the selection of private purchase chairs and buggies and will organise assessments with companies and be in attendance if the family chooses. Many users who have purchased chairs privately state that they would welcome such advice and assessment prior to making the purchase.
- we also note the work pioneered by the Scottish Service Wheelchair Group (SSWG) and the Scottish Rehabilitation Technology Service Providers Forum (SCOTReT) to improve equity and value, develop standards and databases. Efforts have also been made to develop target benchmark specifications, laying down standards for several aspects of service provision.

Funding

2.2.6 In 1996/7 the funding for the wheelchair, seating and artificial limb and appliance service was devolved to NHS Boards. This was not ‘ring fenced’ and formed part of the overall annual allocation. The table below shows, to the best of our knowledge, the current budgets for wheelchair services, compared with the original allocation uplifted for inflation.

It is important to note that, although there appear to be discrepancies between these figures, they may, at least in part, be due to difficulties in identifying funding flows, for example, between wheelchair and other rehabilitation services. Nevertheless, it would appear that the level of expenditure devolved to NHS Boards for expenditure on wheelchairs and seating has, in some cases, not kept pace with inflation and other uplifts, or has even been reduced.



Table 3

Summary of NHS Board expenditure				
	Estimated SEHD Allocation (£'000s)	Current NHS Board Budget (£'000s)	Budget Shortfall (£'000s)	Budget Shortfall as a % of SEHD Allocation (%)
NHS Board				
Argyll & Clyde	1,334	1,271	63	4.72
Ayrshire & Arran*	1,117	1,105	12	1.07
Borders	168	168	0	0.00
Dumfries & Galloway	453	385	68	15.01
Fife	676	652	24	3.55
Forth Valley	971	805	166	17.10
Grampian*	1,582	887	695	43.93
Greater Glasgow	3,552	3,521	31	0.87
Highland*	704	553	151	21.45
Lanarkshire	1,976	1,943	33	1.67
Lothian*	2,338	1,546	792	33.88
Orkney	67	58	9	13.43
Shetland*	80	50	30	37.50
Tayside*	1,525	1,185	340	22.30
Western Isles*	67	n/a	n/a	n/a
	16,610	14,129	2,414	14.53

*Scottish Executive allocation estimated using 1996-97 Artificial Limb and Appliance allocation as a basis

2.2.7 The current expenditure breaks down to an average annual spend per head of population as outlined in the following table. The allocation per user should be viewed with caution, as different methodology may be used to identify 'active users' and 'registered users'.

**Table 4**

Centre	NHS budget £'000s	Population served	Allocation per head of population served £	Allocation per user £
Aberdeen	1,059	544,570	1.9	189
Dundee	1,182	402,500	2.9	207
Edinburgh	2,333	1,240,250	1.8	113
Glasgow	6,460	2,614,850	2.5	106
Highland	811	255,180	3.2	262

Even allowing for several inaccuracies in the figures, the difference between the highest allocation per capita in Highland and the lowest in Edinburgh is dramatic and, although rurality and other issues may be contributing factors, it appears likely that there is an inequity in funding provided.

- 2.2.8 Spending by the wheelchair centres is broken down as follows. Please note that some assumptions have been made in compiling these data.

Table 5

Summary of NHS Board spend by centre

2003-2004 Allocation (Based on ReTIS Report)

	NHS Income by Service Centre											
	Aberdeen		Dundee		Edinburgh		Glasgow		Highland		Total	
	£'000s	%	£'000s	%	£'000s	%	£'000s	%	£'000s	%	£'000s	%
Staffing & Travel	472	45	559	47	688	29	2,151	33	166	20	4,036	34
Overheads	7	1	168	14	230	10	501	8	255	31	1,161	10
Equipment	580	55	455	38	1,415	61	3,808	59	390	48	6,648	56
	1,059	100	1,182	100	2,333	100	6,460	100	811	100	11,845	100

Again, we should allow for some differences in cost attribution. Even so, there appears to be marked variation in the spend on staffing, equipment and in charging of overheads to the wheelchair budget.

Staffing

- 2.2.9 We would again like to emphasise the real commitment and concern shown by so many staff in the service, whether office staff, technicians or therapists. Many told us how distressed and demoralised they were by long waiting times, and what they saw as services severely limited by a lack of funds, hampering them in offering the service that users need.



2.2.10 There are considerable variations in staffing arrangements between the five centres, as the charts below show.

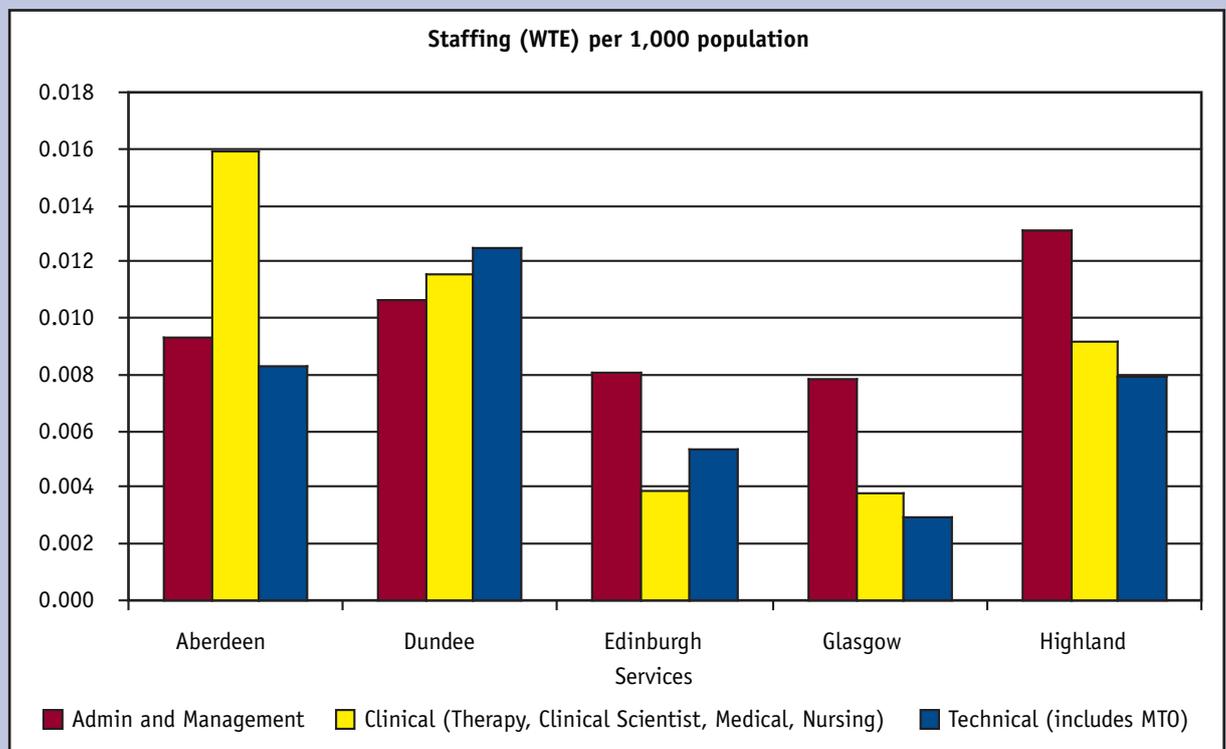
Table 6

Centre	Number of technical/clinical staff (per million population)	Funds per capita (£)
Aberdeen	22	1.9
Dundee	25	2.9
Edinburgh	14	1.8
Glasgow	7	2.5
Highland	n/a	3.2

Although there may well be economies of scale in staff numbers at Glasgow and Edinburgh, it seems unlikely that this is sufficient to account for the differences between ratios seen above.

2.2.11 There are also striking differences in the mix of staff across the five centres.

Figure 2



Again, this variation is unlikely to be entirely related to direct patient need – some centres recognised that their staff mix was due to historical patterns or ability to recruit. Others reported that they had a particular assessment/provision model that they wanted to follow.



2.2.12 Many service centres reported constraints to recruitment and retention, in some cases to such a degree that staff shortages were clearly affecting waiting lists for assessment. Staff from professions such as bioengineering and occupational therapy may not be keen to come into what is seen as a 'cinderella' service. Several centres operated a rotational model for therapists through other disciplines within an acute hospital: there was no apparent short specific training course for such practitioners. For bioengineers there are reportedly limited places on specialist courses and considerable problems with the time taken to become state registered and therefore an autonomous practitioner. Continuing professional development opportunities are largely ad hoc, with formal training opportunities thin on the ground. There is no planned programme of post-qualification training in Scotland unlike the provision for orthotists and prosthetists. There is seen to be little opportunity for career progression in the wheelchair service, also affecting recruitment.

Types of chair issued

2.2.13 The table below illustrates the differences in provision of manual and powered chairs between centres, figures are per annum.

Table 7

Centre	Powered chairs issued (per million population)	Manual chairs issued (per million population)	Population served	Funds per head of population served (£)
Aberdeen	160	3,500	544,600	1.9
Dundee	420	4,000	402,500	2.9
Edinburgh	100	4,000	1,240,300	1.8
Glasgow	270	3,900	2,614,900	2.5
Highland	300	4,700	255,180	3.2

Again, although there are some specialist referral patterns, for example to the Edinburgh children's service, there is no clear explanation for these variations in terms of user need.



Waiting times

- 2.2.14 Despite the efforts of the service to collaborate through projects such as ReTIS, there is currently no standardised definition of 'waiting time' and the existing IT infrastructure does not support easy and accurate reporting of waiting times or waiting lists. Centres may interpret the various phases of waiting differently, and may well have several queues for different services or pieces of equipment – there are plans to address this in the near future. There is no nationally agreed target for waiting times within the wheelchair service that is applied and monitored consistently and independently.
- 2.2.15 Despite a lack of comparable data, it is clear that there can be some very long waiting times in some parts of some services. This could be due to a variety of factors, including:
- problems recruiting and staffing
 - staff sickness
 - rationing due to shortage of funds
 - logistical problems with workflow, and
 - lack of integrated facilities.
- 2.2.16 Some centres have commendable waiting times, reporting only a 3-4 week average wait for both adults and children from referral to provision of a chair. However, as might be expected, the wait for seating and powered chairs was often longer, with the shortest average waits generally varying around 12-22 weeks. Some centres had 'outliers' waiting considerably longer than this, with 48 and 59 weeks being reported, typically for specialised powered chairs with seating systems, potentially for particularly dependent individuals who could be very reliant on a chair for mobility. During our visits we were advised that the backlog in the workshops in some centres had, at times, been a year from assessment to the provision of more complex, customised equipment.

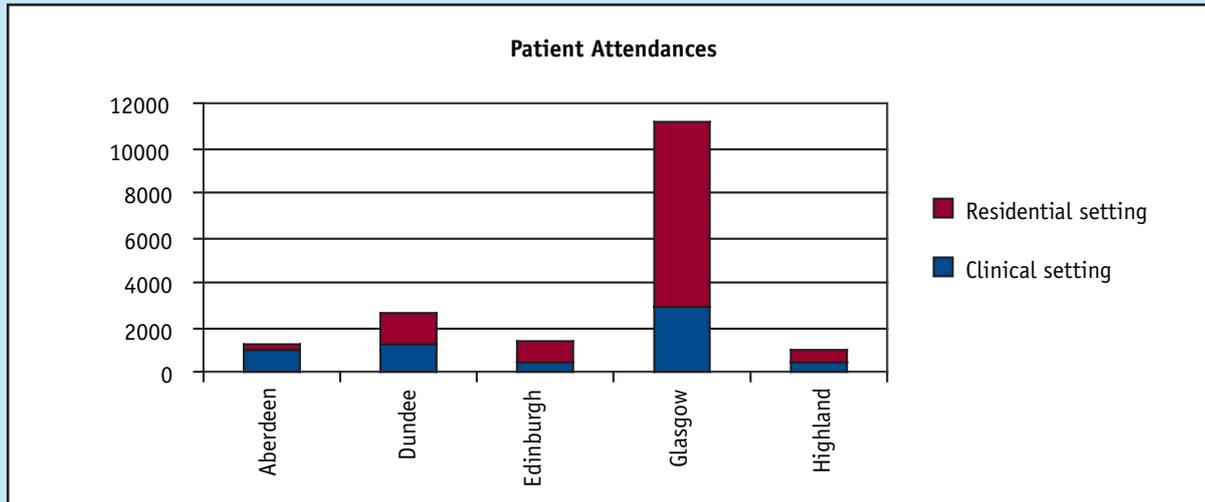
By comparison, recent additional funding has allowed some centres to support initiatives that have effectively provided immediate delivery for individuals on some waiting lists.

Size of centre

- 2.2.17 There are obvious variations in the size of the population served by each centre with WESTMARC in Glasgow serving half the Scottish population, making it probably the largest wheelchair centre in the UK. Differences in size of population served are a common feature within NHSScotland across many clinical specialties and even if WESTMARC only served the population of Glasgow, it would still be Scotland's, and one of the UK's, biggest centres. The chart below graphically demonstrates the size of WESTMARC, and also the number of assessments carried out in a clinical setting or at home.



Figure 3



2.2.18 The current wide variation in the size of population served by each centre reported above arguably has both advantages and disadvantages. Those highlighted to us include:

- economies of scale, in staffing and facilities.
- recruitment difficulties may be exacerbated in smaller centres.
- data and data systems requirements may be more complex in a bigger centre with potential hindrance to planning and performance management.
- a wider geographical area to cover can mean a slower response to repairs and delivery of chairs.
- greater user dissatisfaction at the journey time and complexity involved for larger centres such as Glasgow, particularly when people are used to having most health services available within their own locale; although journey times in Highland for example can be as great and greater than journey times from outlying areas to the Glasgow centre, users from Highland did not voice the same level of complaint about this, presumably because they accept that living in a rural area means travel complexity for many things.
- greater user dissatisfaction as a result of the perceived 'emotional distance' from some larger centres.
- the biggest centre, WESTMARC in Glasgow, attracted noticeably more adverse comments from users. There is a tendency on the part of users to suggest that this must be due to its larger size. An encouraging degree of emphasis on improving service delivery has been noted at WESTMARC over recent years and continues.
- many observers suggested that there is no 'right' size for a centre, but that a balance between accessibility, cost and geography is important.



- it is also important to note the discrepancies in staff:user ratios, staff:patient attendance ratios, and staff:spend issues, which may explain some performance issues and variation across the service.

Functionality and infrastructure

2.2.19 There are variations in the layout of centres and the grouping of component services. There do seem to be some clear ground rules that would allow a good service to wheelchair users and a cost efficient service where staff may be scarce and these would include:

- ensuring disabled access, including toilets – amazingly, this is not always available
- having sufficient clinic space available for assessments
- having a workshop adjacent to the clinic to allow running modifications and assist a ‘one-stop-shop’ approach, and
- having a wheelchair store on site, or very close by to allow assessments to include a trial of a range of chairs.

Lack of such facilities does cause delays in the service to users, and can make it more difficult to deliver the most appropriate equipment. In Inverness, for example, the service is hampered by lack of clinic facilities with main workshop facilities half a mile away. This makes it difficult to run sufficient clinics, have a selection of equipment available for users to view and try out, as is offered in some centres, and for quick modifications to be made whilst an individual is present at the clinic.

We also heard that outreach clinics could provide a wider range of services if they had more equipment, whether this was lifting hoists or more specialist assessment facilities.

Customisation/refurbishment/modularisation

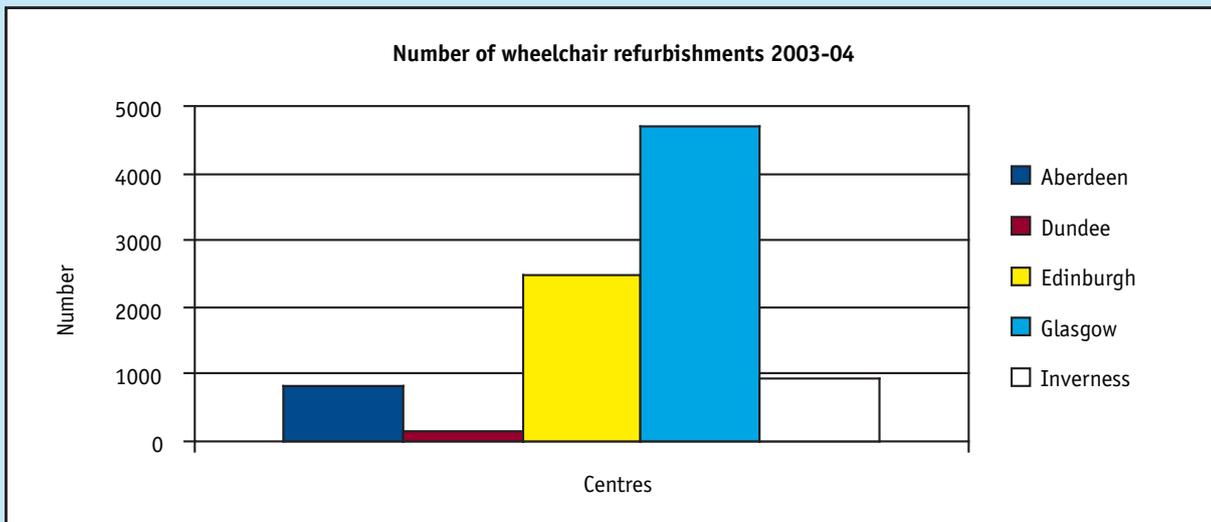
2.2.20 Many wheelchairs provided by NHSScotland are refurbished: that is they are recycled and adapted for the next user. In order to deliver this, centres generally have their own workshops staffed by the NHS, and a system of modularisation, where a standard chair is adapted by inserting a longer footplate, armrest, etc.

This then generates a cycle where standard chairs are purchased, adapted with modular parts, returned, and refurbished. We are advised that this provides a cost effective model and, intuitively, it seems to make good sense, although examples of instances where it is cheaper to replace than repair goods are commonplace – computer keyboards, DVD players and the like.



The chart below gives an indication of the number of refurbishments carried out across NHSScotland. Again, there are variations between centres in the extent of refurbishment, with Dundee in particular at noticeably lower levels.

Figure 4



There are, however, alternatives. Lomax, the only remaining Scottish manufacturer, is offering a modularisation system that is designed for quick delivery using an interactive design and build database. It has been pointed out to us that such chairs would come with a warranty that is invalidated if the chair is adapted by the NHS. The NHS does currently purchase through such routes, but in comparatively low numbers.

Private purchase

2.2.21 Across the UK, an uncertain but significant number of service users will buy their own chairs; either because they are dissatisfied with the service provided by the NHS, or because they want a specialist chair that is not funded by the service. With some notable exceptions, NHSScotland does not routinely provide information for private users, nor help assess individuals for a privately purchased chair, so that the individual user is very dependent on the dealer's recommendation. NHSScotland does not repair privately purchased equipment (except in very occasional, exceptional circumstances) in part because of the diversity of makes and models that they might be required to deal with.



2.2.22 The service does not have a recognised system to allow individuals to ‘top-up’ the funds available through the NHS and get a more expensive chair by paying the difference, although some centres will facilitate this on an ad hoc basis. There is no voucher system comparable to that in England, where the NHS will contribute a fixed sum of money if a wheelchair user wishes to purchase their choice of chair privately. As many in Scotland pointed out to us, both systems are dependent on ability to pay or access funds elsewhere.

Research/evaluation and fit for purpose

2.2.23 There is very little research, audit or evaluation being undertaken in the wheelchair service despite staff enthusiasm. What there is seems to be carried out by interested staff in their own time, without specific research monies. The following areas have been identified as worthy of investigation:

- longitudinal outcome measurement and tracking
- small scale piloting and assessment of new equipment prior to procurement
- post-issue equipment evaluation, and
- sharing of results across the service to ensure knowledge transfer and consistency.

Evaluation of chairs as fit for purpose is seen as important in purchasing the correct equipment. Allied to this are considerations about quality, ‘maintenance free’ chairs and costs spread over the life of a chair. Research into such issues could save the NHS money and provide service users with the most appropriate equipment.

Information systems

2.2.24 One of the key developments that we have observed in the wheelchair centres – and that has supported the preparation of this report – is the IT system developed by ReTIS. This is currently being rolled out to all the centres giving greater consistency in data capture and analysis, allowing benchmarking and information-based service development in the future. This IT system also enables allocation of workload to the most appropriate clinical and technical staff, and tracking of work packages through what may be a complex equipment provision. The system has potential for further development, specifically to enable more meaningful measurement and management of waiting lists and to provide the kind of information that would support the further development, implementation and monitoring of service standards.

One note of caution: we noted that the development and rollout of the ReTIS IT system is heavily dependent on one software developer. His in-depth knowledge of the wheelchair service and ability to respond to the needs of the centres is excellent; however, we wish to highlight the risk inherent in having so much knowledge and capability vested in one person.



Any further investment in IT systems should take account of developments in the national health systems, including the electronic patient record, which should allow information about individuals to be accessed by appropriately authorised NHS staff regardless of location. Specialist advice would clearly be required: for example, we are advised that a web-based front end would allow ready access in a user-friendly format.

In making a decision about future investment in IT systems, it should be noted that, as well as the current in-house programme, there are a variety of alternatives already running in England and Scotland.

2.3 Emerging trends in technology, medicine and demographics

2.3.1 Our observations on emerging trends for the future are based on:

- desk-based research into development in wheelchair science, manufacturing and services worldwide
- interviews with representatives of wheelchair services across Europe, the United States, Australia and New Zealand
- interviews with wheelchair manufacturers in the UK and Europe, and
- interviews with individual specialist clinicians and other expert individuals in the field of disability.

Developing technology

2.3.2 There are some dramatic developments in wheelchair technology, particularly at the powered chair end of the market; these include:

- the iBOT mobility system that can climb stairs, balance on two wheels, climb kerbs, traverse grass, gravel, sand, mud, puddles and all types of uneven ground. iBOTs also have detachable control sticks that can allow the user to guide the chair into a vehicle.
- power-assistance for manual chairs, which gives the option to manually propel a chair, but offers powered assistance that can be adjusted dependent on the user's push strength. This type of wheelchair is seen as being somewhere between a manual chair and a fully powered chair.
- standing chairs allowing users to operate at the eye level of able-bodied people and assisting independence indoors and out, without some of the usual adaptations to the built environment.
- chairs with tilt-in space, recline and lift capabilities are all designed to act as pressure relieving and postural support aids.



- ‘smart’ wheelchairs are essentially robot wheelchairs that allow those with impaired physical, perceptual or cognitive abilities to use a powered chair programmed to meet individual needs. Some chairs now coming onto the market can be controlled by facial expression and eye movement. ‘Smart’ chairs can also be used to teach children how to operate a powered chair with the programme adjusted to the child’s developing abilities.
- lightweight manual wheelchairs that are more transportable and energy efficient.
- modular chairs and seating and positioning systems can give better shock and vibration dampening, respond to and reduce spasticity and give improved comfort.
- aesthetics are important to many wheelchair users and recent developments allow for bespoke design features to be incorporated into an individual’s chair, including a wide range of colours.
- some manufacturers have commented on the drive to reduce the cost of wheelchairs for NHS provision, with, in their view, little regard for durability and reliability, maintenance costs or manufacturing standards. Any drive to reduce unit costs may also limit research and development.

Medical advances and demographics – projections for the future

- 2.3.3 Some advances in medical care and treatment, and changes in the health and life expectancy of the population are likely to impact on wheelchair users and services. These include:
- advances in neonatal care have meant declining neonatal mortality, but some very low birth weight babies have a developmental disability of some kind which may include mobility difficulty.
 - advances in trauma medicine are seeing more people surviving road traffic accidents for example, albeit with long-term disability.
 - improvements in the care of individuals with spinal cord injury mean that their life expectancy is now approaching that of the general population.
 - maintaining the general health of people with progressive illnesses such as multiple sclerosis and motor neurone disease means that individuals with these conditions and disabilities are living longer. There are around 10,000 people in Scotland living with multiple sclerosis and as their life expectancy rises, so will the pressure on the wheelchair service to provide increasingly complex technology to optimise their independence.
 - the trend towards care in the community, where possible in people’s own homes, will lead to more demand for increasingly complex wheelchairs.



- Scotland has an ageing population, a trend likely to continue and increase. This means more people will be living with the after-effects of stroke for example, while the growing number of people who live alone in old age without support from extended families drives greater demand for wheelchairs of all types. Older people usually have older partners who may have their own problems with mobility and illness or long-term conditions who cannot for example, propel a manual chair.
- the UK is also an increasingly obese population; obesity can bring its own mobility problems, particularly as people get older, but it can also exacerbate other medical conditions such as arthritis or make diabetes more likely.
- although research into spinal cord repair is progressing rapidly, there does not seem to be a realistic prospect of this affecting those with spinal injuries in the near future, and would anyway affect a very small proportion of current wheelchair users. The effects of improvements in immediate post-trauma treatment to reduce swelling appear uncertain.

2.3.4 In summary, we can expect the demand for wheelchairs to rise over future years. It is not possible to provide an exact assessment of this effect, but our research suggests that:

- the rise in numbers of individuals requiring mobility aids will be most closely correlated with an ageing population, and
- the pattern of need for more complex wheelchairs is unlikely to change dramatically from current ratios.

3 Key Issues – Discussion and Alternatives

3.1.1 This review is an opportunity to revisit the ways in which we approach providing the wheelchair service in Scotland. This section of the report discusses options and alternatives for future service patterns. We have concentrated on a shortlist of key issues identified from the review described in section 2. These are:

- localising the service and infrastructure
- standards, performance monitoring and accountability
- assessment
- equipment provision pathway
- staff training and education
- gap analysis, and
- funding.



3.1 Infrastructure and localising the service

3.1.2 Earlier in this report we remarked on the disparity in size of service centre, with five wheelchair centres serving the total population of around five million people, and one centre serving around 2.5m of these. As the Kerr Report (SEHD 2005) makes clear, 'localising' services where appropriate and feasible is the accepted way forward in health and community care in Scotland. People with mobility difficulty and their carers face not only the disruption and discomfort of long round trips to get to service centres, but also have to confront the added difficulties that mobility difficulty brings to travel by public transport. Wheelchair services should be organised in such a way that trips to distant centres happen only rarely and when unavoidable.

Hubs and spokes

3.1.3 The current model, with service centres operating as 'hubs' with outreach clinic 'spokes' has been tried and tested in other countries and can work well, but do we have the optimal balance between the numbers of hubs and spokes and their functionality? Factors to consider include:

- population centres and geography
- availability of appropriate facilities or cost of providing these
- gains in accessibility for patients
- staff availability
- efficiency
- equipment duplication or portability
- additional costs
- management arrangements, and
- other innovative ways of providing local access.

3.1.4 A formal review of the entire pattern of service centres and outreach clinics would be the most thorough method of ensuring that support is provided as close to population centres as possible. However, this would be time consuming and could arguably delay other changes that are more fundamental.



3.1.5 A more pragmatic approach would be to target the bigger centres, WESTMARC and perhaps Edinburgh. WESTMARC is doing much to improve its service, and in some respects user feedback was positive. However, given the size of the area it covers, it is probably no surprise that WESTMARC users expressed more concern than users at other centres about access to appointments. The area presently served by WESTMARC and possibly Edinburgh could be split into perhaps five service centres, giving a total of eight service centres for Scotland, determined by a mixture of population size, population density and geography. Purely as an illustrative example, we might then see a service which could be configured something like this:

Table 8

Centre location	Areas served	Base	Total population served	Main outreach locations
South-West Scotland	Ayrshire and Arran Dumfries and Galloway	Ayr	514,000	Dumfries Stranraer Irvine
West Central Scotland	Argyll and Clyde South Glasgow	Glasgow	1,125,000	Dumbarton Greenock
North Central Scotland	Lanarkshire Forth Valley	North Lanarkshire	829,000	Stirling Falkirk Wishaw
Lothian and Borders	Edinburgh West Lothian Borders	Edinburgh	888,000	Melrose Livingston
East of Scotland	Fife	Kirkcaldy	352,000	Dunfermline
Tayside	Dundee Perth	Dundee Angus	387,000	Perth Montrose
North-East Scotland	Grampian Orkney Shetland	Aberdeen	565,000	Fraserburgh Elgin Kirkwall Lerwick
Highlands and Islands	Highlands Western Isles Argyll and Clyde North	Inverness	250,000	Wick Thurso Fort William Oban Portree Stornoway



- 3.1.6 This is only an example of how more equitable coverage might be achieved. It could involve working across existing boundaries, allowing users to access the most convenient service, regardless of the NHS Board area they live in. There are several well-recognised contractual arrangements within the NHS which should allow this, for example 'cross-boundary flow' or 'out-of-area treatment' payments.
- 3.1.7 This type of model would reduce travelling time for users with complex needs who had to attend a wheelchair centre. We would expect an increase in cost, while recruitment in some areas could be a constraint, and there could be a continued need for some tertiary referrals out-of-area. An increased number of service centres should allow the development of yet more outreach services within reasonable travelling distance for service staff, thus making best use of a scarce resource. This could perhaps occur on a flexible basis dependent on users' needs.
- 3.1.8 Another option would be to retain the current service centres, but increase both the number of outreach services and the range of support they can offer, across all areas of Scotland. This would, in effect, be a speeding up of a trend already under way. From the user's perspective, this could be a good option in terms of physical access for many, although the likelihood would be that a small number of individuals requiring particularly comprehensive mobility aids would still need to travel to a service centre.
- 3.1.9 Costs of premises to provide additional outreach services could be kept to a minimum by using existing buildings, public or private. However, staff travel costs and, more importantly, lack of staff availability given additional travelling time might make this a more difficult option to deliver. We could envisage outreach clinics running for very small numbers of users leading to pressure for them to run at very infrequent intervals. This option may not readily address the closer affiliation with centres that some users wanted.
- 3.1.10 One way of addressing some of the limitations of outreach clinics as currently configured could be to develop some to give a more permanent presence: perhaps dedicated local administration support and a part-time therapist, linked to a local hospital or clinic. It could be possible to develop mobile assessment units, with equipment in a large van, which could travel round to local clinics and allow the provision of a wider range of local services. This approach could offer benefits to service users, including a local base with which they can develop contact, and might be a more pragmatic solution to staffing constraints.



Centre size

3.1.11 Given the wide variation in centre size, we have explored whether there is any evidence as to the 'right' size for a centre. The current performance of the wheelchair service in Scotland suggests no obvious benefit to be derived from having larger centres:

- there are quite marked differences between the two largest centres, making it difficult to draw conclusions about centre size
- access and travelling is generally perceived as more difficult
- users find it harder to develop a continuous relationship with remote centres
- there is no apparent correlation between centre size and waiting time experienced by service users
- there are no readily apparent economies of scale in the budgeted funds per head of population
- size does not apparently aid bigger centres in delivery of more comprehensive equipment, such as more powered chairs: levels of funding appear more closely linked, and
- there may be a modest inverse relationship between staff numbers and size of centre. This could indicate economies of scale, but it is likely to be related to other factors, including quality of service.

Smaller centres generally find it more difficult to attract and retain staff, while service users appear to be more supportive, however, both factors could well be related to rurality, rather than any intrinsic benefit within the operation of a smaller centre.

3.1.12 In conclusion, there is no evidence to suggest that there is any key reason why we should retain our larger centres, and some indication to the contrary from service users, although we should be cautious about creating more very small centres.

Functionality and facilities

3.1.13 During our research it became clear that the variation in facilities provided at wheelchair centres did hinder efficient services. For example, lack of space in centres may prevent a range of chairs being available, so that an individual attending a centre cannot readily try out a wheelchair. This could necessitate a further visit, or hinder the customisation of a wheelchair to best suit a user's needs. The shortlist of facilities identified in section 2.2.9. represents the ideal infrastructure of a centre and should be provided wherever possible: centres lacking any of this basic infrastructure should be working to achieve this.



3.2 Standards, performance monitoring and accountability

Service profile

- 3.2.1 The wheelchair and seating service has not enjoyed a high profile in Scotland or indeed in the UK generally. Despite a series of reports recommending changes and improvements, at best only modest progress has been made in implementing these. The service is fragmented: it has no central body such as the ambulance service does, with a clear responsibility to drive performance. There is a lack of high profile clinical champions agitating for more resources or for improved performance, in the way that senior consultants, Royal Colleges or 'Czars' do in other areas of the NHS. Wider public interest, whether from MSPs or the media, is generally restricted to local stories about individuals: there is no ready locus for a national interest story such as might arise from a public board meeting, formal annual report or similar.

Monitoring and standards

- 3.2.2 NHSScotland has a fairly comprehensive system for setting standards, monitoring performance and reporting results in public. These include waiting time guarantees, developing standards for clinical services, and annual performance reviews for NHS Boards with the Minister for Health and Community Care. However, these do not currently apply directly to the wheelchair service, although work has been done within the service in recent years to develop standards. Inevitably, this means that other services, subject to targets and formal review, receive a higher profile within the health service; these are the services that are likely to attract a greater investment of effort and resources. Chief executives of NHS Boards are likely to direct maximum attention to the issues for which they are held personally accountable through monitored targets and performance reviews. Further, we believe that, in some areas, the service is not seen as a priority by senior managers within NHS Boards, and therefore tends to suffer when the NHS as a whole is under pressure.
- 3.2.3 The wheelchair service has a dedicated group of managers who have, largely through their own initiative, worked towards some commonality across the country. A target benchmark specification has been developed, and this could constitute a useful basis from which to build standards that would be stretching, achievable, measurable and observable, that would be developed in conjunction with service users, staff and managers, that would be open and that would be subject to external measurement, the results of which would be reported publicly.



Variation

3.2.4 There is general consensus that our health service should offer equal access to individuals, free at the point of delivery on the basis of need. Yet there is considerable variation in a range of factors across the five wheelchair service centres in Scotland, including:

- funding levels received from NHS Boards
- amount charged for 'overheads' by the host NHS Board
- apparent 'shortfall' in funds against the allocation originally made by SEHD
- input from local NHS Boards to the way the service is run by the five centres
- number and mix of staff employed
- number of powered chairs issued
- length of wait for assessment, provision of equipment and repairs, and
- perceptions of the service from wheelchair users and carers.

Alternative accountability models

3.2.5 One way to ensure managerial attention and priority would be to revert to a single national service, which, although delivered regionally, would have a single dedicated management team. This would presumably need a 'top slice' of existing budgets, which would then be 'ring fenced'. The allocation of funds currently held by NHS Boards to a central entity would be problematic: there is no easy formula to determine how much money should be committed. This arrangement would achieve the necessary improvements in direct accountability and focus, and could be a rapid way of introducing national standards and processes. It would not, of course, automatically lead to any increase in funding: indeed it would add to management costs, as a central team would need to be set up to provide an accountable officer and a board. The structure would need to be reasonably flexible in order to deliver locally. Service users could readily have a voice in such an organisation.

3.2.6 Other services in Scotland are run in this manner, the ambulance service for instance. There could be particular difficulties in separating the wheelchair service from other components of the local NHS: for example, staff, support functions and premises are likely to be shared. This is not insoluble financially, but other aspects, such as loss of co-operation, reluctance to provide therapy support, etc, may be more problematic. The approach is also somewhat at odds with the trend towards devolution within NHSScotland, while services with modest budgets, such as the wheelchair service tend to become part of a bigger cohort, whether a host NHS Board or a central body, thus potentially losing their independent voice while saving money. Even if rehabilitation services as a whole were brought together into a central service, there would be some doubt as to their viability and value for money as a single entity with a top-heavy infrastructure.



- 3.2.7 It may be possible to achieve a similar national focus and drive through other arrangements such as a national network. This could have a lead clinical champion and a small supporting team, but management responsibility for wheelchair centres would remain with NHS Boards. This arrangement would be unlikely to have the same level of impact as an independent central entity, but would also avoid most of the problems involved in separating wheelchair services from their hosts. It would also be cheaper, as there would be no need to change accountability arrangements and set up a Board and an executive team.
- 3.2.8 There are other options: although it could be argued that performance targets can have disadvantages, they undoubtedly bring benefits too. For example, if NHS Board chief executives were held to account for the performance of local wheelchair services against agreed waiting times targets, they would arguably make it their business to ensure that attention is being paid to this aspect of the service. Conversely, if there are monitored targets for most other services and not for wheelchairs and seating, funding and attention for wheelchairs and seating is vulnerable. Giving wheelchairs higher priority may well be advantageous in persuading NHS Boards to change resource priorities and invest financially in the service from existing funding streams.

Voice of service users

- 3.2.9 It is to be expected that following the rise in profile of the wheelchair service and user expectations that this review has fuelled, stakeholders will want to be involved in the way that standards are set, monitored and reported. This would be consistent with developments in standard setting and monitoring in Scotland over the last six years and should be encouraged as the best way of continuing to bring the service closer to user needs. A national users forum would be one way of providing such an input, in hand with local users groups, which already exist in some areas.
- 3.2.10 Although there are active national bodies and user groups who meet regularly, their sphere of influence appears limited: they apparently have little power to lever comprehensive change or alter policy at a national level. **Whatever the accountability framework for the future, the important concept of user involvement in standard setting and service direction should be taken into account.**



Information

- 3.2.11 Despite the best efforts of centre managers, and the laudable development of the ReTIS annual report about the service across Scotland, there is not a standardised data collection system or common definitions of waiting times and similar matters. This makes it difficult to assess and compare performance. It is also difficult to quantify waiting list problems, to assess the scale of gaps in the service, or to plan for the future, as comprehensive data are not widely available.
- 3.2.12 Just as importantly, while service managers have made progress in developing IT systems, the lack of a standard, supported, fit-for-purpose system in every centre adds to the difficulties of managing the active caseload, expediting complex equipment delivery, and in recording, monitoring and reporting data about standards and service delivery.
- 3.2.13 There are a number of tailor-made wheelchair IT systems currently in use in the NHS in both England and Scotland, which could be reviewed.

Scrutinising investment

- 3.2.14 One of the questions arising from this project was how any additional funds should be managed. Assuming that additional money is made available, this should not merely be allocated to NHS Boards on a per capita basis without scrutiny of the benefits expected. Our cost estimates are not accurate enough to control the allocation of public funds: business cases should be produced when bidding for additional monies, and these should be assessed for optimum benefit to local populations. Accountability models should provide a solution regarding a transparent mechanism for the allocation of funds.
- 3.2.15 There is the added complication of shared funding between NHS Boards where a centre takes referrals across boundaries: there is no reason why any NHS Board should not be charged with delivering standards of care for its residents, regardless of whether it hosts a wheelchair centre or not: if the current out-of-area provider is not delivering, financial penalties can be applied, the service can be purchased from elsewhere or a local service can be established.



3.3 Assessment

Transparency

- 3.3.1 Assessment was one of the main concerns from service users. It was commonly viewed as being non-holistic and limited by what the service could provide as opposed to being a full exploration of users' needs in relation to their aspirations and individual circumstances. Our review of the service suggests that there is some excellent technical practice but, ultimately, the equipment prescribed as a result of any assessment is constrained by the eligibility criteria, which are widely seen as being tailored to fit the budget available. The entire assessment is consequently seen as being 'unfair' and 'unholistic'. One way of addressing this problem would be to separate assessment from the prescription and provision of equipment. The results of the assessment could be given direct to users.
- 3.3.2 Of course, greater clarity in the assessment process would not itself alter the equipment provided, but it would increase transparency between the service and users. It could also potentially open a wider range of equipment options and choice, albeit many of these would have funding implications. For those who wanted to source equipment other than that offered by the NHS, a professional NHS assessment would be of great value.

Assessment would also be an ideal opportunity for users and carers to be fully briefed on the service, its structure and how to access further information and support: this happens informally in many centres at the moment, but could be done in a structured way through a mobility plan or information about mobility pathways and links with local authority services.

Simple and complex assessment

- 3.3.3 Service users told us that they wanted to involve the health professionals who knew them, their needs and their personal circumstances best in referral and assessment; those people were most often occupational therapists, physiotherapists, district nurses and, on occasion, hospital consultants. Not all service users felt the need to have the assessment carried out in their home, but many service users wanted a process that took home, school, work and leisure environments into account.
- 3.3.4 There is no doubt that a relatively small percentage of wheelchair users have a very real need for intensive expert assessment. However, perhaps 70% of the less complex referrals currently made to the service are not seen at wheelchair centres, with equipment being provided based on information from the referring professional. Currently such referrals are received by the centres and screened by a member of the team, ensuring that no-one who needs a full assessment slips through the net.



However, with some training and the help of a well designed decision-tree flow chart, basic chairs could potentially be prescribed by community professionals, whether employed by the NHS or local authorities, fulfilling users' wishes as well as saving time for the referral to be sent to and processed by the centre, and releasing some much needed professional capacity at the centre. Most centres already have a good relationship with health professionals who are regular referrers, and some may provide training.

Ongoing assessment and review

- 3.3.5 Assessment may be a one-off process for a number of users whose needs do not change much from month to month or year to year. For service users with complex needs, those with progressive disease and children experiencing periods of growth, regular reviews are required. These service users need an individual ongoing management plan that includes forward planning. This should ensure that their needs are anticipated and/or responded to and met on a continuous basis and that avoidable complications of inadequate mobility or support do not occur.
- 3.3.6 Whilst all the centres we visited told us that existing wheelchair users were welcome to contact them directly with any concerns, in practice this may not be straightforward. Some centres contact all users annually to ask them if they have any issues, allowing follow-up arrangements to be made very easily. This could be a model for the future.

3.4 Equipment provision pathway

Procurement

- 3.4.1 Provision of chairs is currently solely the responsibility of the NHS, unless an individual chooses to buy a chair privately. Following assessment, a chair is resourced through one of several routes:
- from a national contract that is negotiated centrally at rates advantageous to the NHS: we are advised that the range of chairs procured in this way has been extended in recent years. It is significantly cheaper for the NHS to bulk buy chairs in this way than for an individual to buy direct from the manufacturer, despite these purchases being VAT exempt (surely NHS purchases are effectively VAT exempt also).
 - direct from a supplier, especially if the chair is specialised and purchased in small numbers.
 - from a wheelchair centre workshop where the chair has been refurbished having been returned from a previous user.
 - in the case of any of the above, a chair may be modified by a wheelchair centre workshop to fit it specifically for a given individual: this is known as 'customisation'.



Refurbishment and customisation

- 3.4.2 The issues of refurbishment and customisation have attracted much debate. We note that:
- refurbishment to a high standard appears to produce chairs which are nearly indistinguishable from new, but this practice maintains a stock of chairs which only slowly gets replaced to reflect advances in technology.
 - customisation may have a similar effect and also reduces choice by encouraging the use of modular, standardised chairs.
 - some manufacturers argue that customisation does not represent value for money: they assert that they could produce a modern chair as quickly, tailored to the specification for an individual user, saving the NHS the costs of an extensive centre workshop, plus the chair would be covered by their guarantee, which the NHS voids when it alters a chair. Some manufacturers offer a facility where a chair can be ordered online, including precise specification of components to individual needs.
 - wheelchair centres argue that both practices save money: although this looks logical with respect to refurbishment, we have seen insufficient evidence to convince us one way or another with regard to customisation.
 - some services in England refurbish chairs via a private contractor, reducing the need for extensive NHS workshops.
 - several suppliers and manufactures have told us that margins on the supply of wheelchairs to NHSScotland are so tight that they have ceased to invest here.
- 3.4.3 **The NHS should review these practices particularly with regard to customisation and the value and role of extensive centre workshops. However, we have taken the approach that this issue is tangential to this review as it does not fundamentally affect the more strategic decisions considered here.**

Multiple providers

- 3.4.4 The negative effect that waiting for equipment has on wheelchair users is a theme throughout this report. Yet there are other providers who could help reduce waiting times: is it appropriate for the NHS to provide all wheelchairs? NHS provision does have advantages, albeit these are largely financial:
- a good way to manage a tight budget and ration wheelchair issues
 - bulk purchasing power
 - a limited range of models and manufacturers reduces maintenance difficulties
 - maximum refurbishment opportunities, and
 - user feedback for professionals in the service who both assess and prescribe.



- 3.4.5 However, a multiplicity of providers could potentially provide significant benefits for users:
- competition could drive down waiting times – if one provider cannot let you have your chair quickly, maybe another can: a common feature of retail competition is the ability to get rapid delivery
 - logistical difficulties such as sickness, staff shortages, lack of facilities, which slow down a single provider, would have less impact on the user if there are multiple providers
 - basic chairs could be supplied by high street retailers, or delivered direct to home
 - NHS staff would be freed to concentrate on complex patients
 - competition could drive down costs, and
 - more choice.
- 3.4.6 If we imagine a situation where assessment is done by the public sector, divorced from equipment provision, we could see a multiplicity of providers competing to give patients options in fulfilling their equipment prescription. Providers might include the NHS, and for complex chairs with seating systems, the NHS might very well be the provider of choice, even the sole provider.

A customer could take their NHS assessment to a dealer or specialist provider and order a chair direct from the manufacturer. Some manufacturers now boast a chair which can be computer-designed on screen with the detailed order transmitted direct to the factory: this system could work for basic chairs and potentially some with a higher degree of complexity.

- 3.4.7 What about the potential problems? We would need to consider quality control, whether in the form of spot checks, customer feedback, licensing, or kite marks, which could add to costs. The biggest drawback of this method of equipment provision is the increase in cost. The NHS will not be able to make the major cost savings it does now by bulk purchase of a limited range of chairs. Another potential cost pressure would come from the decrease in levels of refurbishment currently carried out by the NHS: changes in technology and reduced workshop costs will go some way to balance the savings from recycling chairs, but is unlikely to bridge the gap entirely.

Setting up a system of private providers would take some time, and would need a professional commercial approach. If the NHS wanted to make changes to the system, or bring it back in house, this could also take time.



- 3.4.8 Whilst, in theory, the NHS could offer more choice and reduce waiting times given the will, management attention and funding, the use of private sector providers would be an additional driver in this direction. The NHS is well placed to provide a wider range of models and manufacturers at an economical cost if additional funds are committed to this. However, the same advantages in speed of delivery that we would expect from private sector provision due to competition would not necessarily follow unless there was a mechanism to drive this.
- 3.4.9 We have considered whether individuals could buy their chairs direct with some type of refund arrangements from the public purse. While private purchasers do not have to pay VAT, even with this advantage the NHS purchasing power ensures that the service pays a significantly lower cost per chair than the individual wheelchair user. Although we would expect that if an increasing number of individual wheelchair users were purchasing equipment direct, prices would fall. The table below shows that there would need to be a very significant decrease to equal NHS purchase prices.

Table 9

Wheelchair	NHS price (£)	NHS price (£) + VAT @ 17/5%	General public price (£)
Lomax 2 Active	997	1,171	1,396
Lomax Active Square	450	529	630

Source: Lomax Wheelchairs, Dundee

- 3.4.10 We have also considered whether the advantages of bulk purchase could be retained by a single private sector provider. This is probably a more likely alternative, although the addition of a profit margin is likely to lead to an increase in costs even before we consider any increase in diversity of models and manufacturers. Further, even subject to regular competitive tendering, a single provider could decrease some of the benefits of competition.

Repair and maintenance considerations with multiple providers

- 3.4.11 A wider range of chairs would give individual users more choice, but the diversity of models and manufacturers would make fast maintenance and repair a greater challenge. A larger range of spare parts would need to be carried, and the skills required to carry out repairs and maintenance would be broader. This applies regardless of whether the NHS or another provider supplies the chairs. The range of equipment supported could be controlled to balance choice, cost and repair complexities.



3.5 Maintenance and repairs

Current provision

- 3.5.1 All maintenance/repair of equipment issued by the NHS is presently carried out by the NHS wheelchair service. In most centres this is done on a reactive basis: equipment is not routinely maintained or serviced but is repaired when a fault develops and is reported. Sometimes repairs are performed by a 'mobile technician' who comes out from the wheelchair centre to the users home or school, or, on occasion, minor repairs like tyre punctures are carried out by local garages or bicycle shops. However in some instances, repairs are carried out at the wheelchair centre and no matter where repairs are carried out, there can be long delays. Loss of a personal chair – particularly pronounced where chairs are removed for repair at a service centre – can be a serious matter for an individual who relies on it, regardless of whether a temporary replacement is offered and so a fast repair service is very important. Even better would be a system that minimised equipment failure in the first place.

Local repairs

- 3.5.2 Several centres offer users the option to take minor repairs (typically under £20 or so) to a local garage or bike shop, where they can be carried out quickly. We have had some mixed views about this approach with some centres telling us that they offer the facility but it is little used as repairs would be minor only: e.g. brake adjustments. Local repair outlets do not carry a stock of wheelchair specific replacement parts and therefore repairs requiring these need to be carried out by wheelchair centres. It has been suggested that local repair could be extended to all areas and given a broader base through the use of accredited suppliers. If a straightforward, easy to administer system could be set up, this would sound attractive: there is, however, a danger that it could develop a life of its own, becoming over complicated and expensive.

Other potential service providers

- 3.5.3 There are perhaps other organisations, in some respects, better placed to provide a breakdown service than the NHS, for example Mobility Scotland who already provide a repair service across central Scotland which the user pays for. National organisations that deal with car breakdowns, for example, might also be able to extend their services to repair faulty wheelchairs since they already operate 24/7 in an equipment maintenance market. It is important to recognise, however, that the spare parts and product knowledge required would be different. Response and return times could be improved through the contracting system and could potentially include a 6/12/24-hour response service for urgent circumstances, for example, older people living alone who are bed-bound or house-bound without their wheelchair. The costs of such a system are difficult to assess and



would ultimately require a detailed specification and competitive tendering. However, we can assume that there will be a significant price tag attached, offset somewhat by savings in NHS workshops. It is important to understand that there will still be some repairs which cannot be dealt with at the user's home, and these chairs will presumably still need to be removed to a workshop for repair. NHS staff would also need to monitor a quality control system for any contracted-out service.

Planned preventive maintenance

- 3.5.4 Some parts of the NHS are now running a PPM service, with a technician visiting the user to check their chair. This has the major advantage of potentially preventing breakdowns and also giving contact with the wheelchair user who may welcome advice about minor adjustments. The investment required to start this programme should be offset by the expected reduction in breakdowns and therefore repairs: reports from the USA even suggest that it can be cost neutral in the long term.
- 3.5.5 PPM could potentially be extended and integrated into a mobile repairs service, visiting users both to address planned maintenance issues and to carry out repairs on site. A service that travels to the user and carries out a high proportion of repairs on site is greatly preferred to a system that uplifts chairs to return to a central depot for rectification. Although this currently happens on many occasions under NHS provision, it is not universal. PPM could potentially be extended to a mobile repairs service and/or an out-of-hours service for emergencies.
- 3.5.6 Various pressures, including Health and Safety legislation, fear of litigation, NHS advisories and manufacturers' recommendations have put pressure on the service to implement PPM uniformly for all chairs, regardless of the user's circumstance and type of chair. A risk assessment framework plus individual user preferences should be used to determine the frequency of PPM: it is unlikely to be necessary or cost effective to apply a one-size-fits-all approach: PPM should be concentrated on complex and/or much used equipment.
- 3.5.7 Again, it should be emphasised that, whatever new arrangements are made, some repairs will still require specialist parts and/or expertise and will need to be returned to a central depot. The wider the range of chairs and manufacturers, the more complex the range of spares and skills will be needed for a repair service, of whatever sort.



Private chairs

- 3.5.8 At the moment, anyone who buys a wheelchair privately cannot get it maintained or serviced by the NHS. This stems from concerns about taking on a wider range of wheelchairs, which will increase the challenges of any maintenance service with a greater variety of spare parts and skills being required, plus worries about the suitability of chairs for some individuals. Wheelchair users may argue that, having saved the cost of a chair, a private purchase should at least be maintained by the NHS.
- 3.5.9 A solution to this impasse might be to agree that the NHS would support a privately bought chair if:
- it fitted the individual needs determined at an open, holistic assessment (see section 2)
 - it was part of an extended range of specific chairs which the NHS could support for servicing and repairs, and
 - a voucher of equivalent cost could be offered towards maintenance costs if the chair was outside this range: however there could be complications to this approach. The sum involved would only be modest and the purchaser and NHS should, in theory, be able to reach agreement about a chair acceptable to both with regards to maintenance.

Out-of-hours and emergencies

- 3.5.10 There is normally no facility to have a chair repaired 'out-of-hours' (after 5.00pm, at weekends or on public holidays). There is no doubt that equipment failure out-of-hours can be a very serious situation for a wheelchair user, particularly one who lives alone. While we have received mixed views as to how such an emergency should be dealt with, not surprisingly there seems to be general support for access to an emergency repair service if this proved practical. The need for this should diminish if PPM were introduced, reducing breakdowns, and a rapid response to an emergency were provided the following day, including weekends and public holidays.

3.6 Staffing, staff training and education

- 3.6.1 The wheelchair service finds it difficult to recruit staff at present, and the commitment of existing staff can be strained. The underlying cause is the profile of the service, with few opportunities for further training or career progression, and staff, at all levels, feel demoralised and frustrated in a specialty that can fail to meet users' needs within a reasonable timeframe.



- 3.6.2 The numbers of staff employed in the service and the skill mix vary widely from centre to centre. In some cases, for instance, senior medical staff are centrally involved in the assessment process – particularly for powered chairs – in others the whole process is managed by bioengineers, technical officers and therapists, who involve medical staff in the small number of cases that require specialist advice. There are also differences in skill mix between those with technical, therapy and bioengineering backgrounds, perhaps due to historical factors or local availability. A reasonable mixture of therapy and bioengineering/technical skills is necessary to provide balanced assessment, variations in skill mix could be accommodated. There are issues which particularly affect the paediatric service: assessment of children should involve a range of staff who have appropriate skills in communication as well as clinical and technical matters, and medical advice may be more frequently sought, particularly about developmental issues.
- 3.6.3 There are very few courses established to provide training in wheelchair and seating provision. This can be a problem not only in attracting permanent staff, but also in equipping staff who are willing to rotate into the service for a short period. For engineering and technical staff in particular, there is no easy route to becoming autonomous practitioners, a significant pre-requisite to career progression.
- 3.6.4 This issue could be tackled in several ways in parallel.
- Morale and recruitment will improve if this report leads to a service more focused on users' needs.
 - Short-term courses, for example, five days in length, could be commissioned for qualified professionals on arrival in the service. This might be particularly useful for those who will be working in the wheelchair service for a limited time, perhaps on rotation.
 - Commissioning longer courses, giving a professional qualification at the end should be considered and providing a career path for those who wish to stay in the service, encouraging retention and creating independent practitioners should be considered.
 - Further support could be given to practical continuous professional development (CPD) opportunities.
 - Considerations of multiskilling could be designed into training, so that, for example, bioengineers have a basic understanding of physiotherapy issues and vice versa. As well as being good practice for almost any interaction with a wheelchair user, this could also increase the number of assessments that could be carried out by a single professional, bringing efficiencies and more opportunities for outreach work.



- There is a marked discrepancy in the involvement of consultants in routine assessment in provision. In most centres there is no routine medical involvement, whilst in others, medical staff are involved in assessing for provision of powered chairs. We would suggest that medical staff should be available for some complex consultations and to input to particular situations, for example, the need for a cognitive assessment. However, we do not see a need for consultants to be routinely involved in centre assessments, including assessment for powered chairs.
- Centres have considerable variation in skill mix. Some are in the process of changing this; others are constrained by ability to recruit. The best arrangement appears to be a team approach, with physiotherapy, occupational therapy and technical/engineering staff in the mix. However, given the difficulties of recruiting in some areas, we suggest that flexibility is needed over skill mix.
- This service may never be top of the list when staff have many options to choose from. This is another good reason to consider outsourcing and decentralisation of various sorts, thus minimising the workload for specialist staff.

Attracting and retaining staff is a key issue, which will undoubtedly constrain some of the developments outlined in this paper: indeed, it could prevent some improvements, not merely hold them up. Unless this is addressed, NHS service providers will not be able to make the changes both they and service users want.

3.7 Gap analysis of equipment provision

- 3.7.1 The NHS provides a limited range of equipment both in terms of stakeholder choice and in relation to the full range available from manufacturers. Eligibility criteria for some types of equipment are acknowledged to be limiting and are widely understood to have been driven by the need to stay within a limited budget. There can be no doubt, for example, that some individuals who would benefit in clinical and wider terms from the provision of a powered chair do not currently qualify for one and, consequently, the range of mobility and independence they have is more limited than it might be. Changing the range of providers, or the assessment process, as suggested above, will not automatically change the equipment provided to the user, unless funds are provided to support this.



3.7.2 During the course of the review and through our discussions with all the various stakeholder groups, we have identified several potential gaps in the service. These are primarily in the following areas:

- children
- young adults
- those with progressive disease
- people with limited functional mobility
- older people with carers
- people with terminal illness and those with temporary disability, and
- balancing capacity and demand: a minimum standard.

Additionally, individuals in any of these groups may be termed bariatric due to their heavy body/mass index and find it difficult to access equipment due to their weight.

Children

3.7.3 Children with disability are like any other child in that they need to interact with their environment as they grow and develop, sometimes predictably and sometimes in fits and starts. It follows then that their equipment requirements will also change along those lines. Since the service is currently not uniformly proactive in relation to users' needs, it may only react when children re-present because they have outgrown their equipment. Reassessment and re-provision takes time and so children may well spend longer than they should in uncomfortable chairs and outgrown seating, or worse, may be bed bound while waiting for new equipment, missing out on education and social interaction.

3.7.4 Older children making the transition from primary to secondary school face new difficulties in remaining in mainstream education. All secondary school children need the ability to move around easily, rapidly and frequently from class to class. This means that children who use wheelchairs have to be very proficient and able with a manual chair, or use a powered chair.

Young adults

3.7.5 Young adults may face further difficulties in relation to transition from children's to adult services. The range and choice of equipment available to children through the NHS can be better than for adults and support services are often more extensive. Studies such as SCAMP have shown that young adults may have an inappropriate chair and worsening access to support, at a time when they might expect to be very active, seeking work or moving into further education, etc. Targeted input can help, for example additional funds may be available from access to work schemes via the Department for Work and Pensions (DWP).



People with progressive disease

- 3.7.6 Wheelchair users with progressive disease, for example multiple sclerosis, motor neurone disease, Duchenne muscular dystrophy, or even arthritis can find their physical abilities and postural support needs changing relatively slowly or over very short periods of time.

There are two particular issues with services for this group. Firstly, the lack of regular planned reassessment means that they can be subject to similar difficulties as children in relation to changing needs, although these are generally not as rapid. Secondly, people with multiple sclerosis and similar diseases, where abilities may vary over time, may not qualify for a powered chair because they can sometimes propel a manual chair, although they cannot do so reliably.

People with limited functional mobility

- 3.7.7 Under current assessment criteria, to qualify for a powered chair, the individual must be unable to walk or propel a manual chair at all. This excludes some people who can walk a very short distance, for example around their living room using furniture for support, or can propel a chair for 20 or 50 yards. However, this limited mobility does not necessarily allow them to get to the bus stop, the local shops, the library or their place of work. Many service providers told us that individuals in care homes were particularly penalised in provision of all chairs, but powered chairs in particular. Scooters, which are generally less expensive than powered outdoor chairs, could be an alternative for some individuals, but they are currently not routinely provided by the NHS.

Older people with carers

- 3.7.8 Many manual wheelchair users depend from time to time on carers to push their chair – uphill, up and down kerbs, over rough ground for example – or to lift a heavy chair into a car. This may present a hazard to even the most fit and able carer. A carer or care worker may be put in the invidious position where they have to choose whether to risk back injury or muscle strain in this way. Further, older people often have older carers who are not as able as they might be, or who have medical conditions themselves, angina for example, that preclude them from pushing a chair. However, the needs and requirements of carers are not routinely considered in the assessment process, which may leave the wheelchair user effectively unable to leave their home.



Those with terminal illness or temporary disability

- 3.7.9 Some individuals, such as those with terminal illnesses and those with temporary disability need a wheelchair quickly, often for a short period of time. While their situations are clearly very different in other respects, the requirement for a fast response is similar. At present, there is no easy way to circumvent waiting lists and no ready stock of wheelchairs to be given out at very short notice. People who may have only a few weeks to live, but who may gain enhanced quality of life for that time by having the use of a wheelchair, may not easily access one. People with temporary disability, for example a broken leg, may face similar difficulties: although theirs is a disability from which they will recover, they may face inconvenience and disruption to education or employment.

Balancing capacity and demand: opportunities for service re-engineering

- 3.7.10 The service currently has variable waiting times for assessment and for equipment provision. Some centres are very responsive in dispatching standard equipment, while most centres have longer waits for complex equipment such as powered chairs with seating systems. This may be due to several factors:
- lack of staff, inability to recruit, sickness or absence
 - lack of funds for equipment
 - poor organisation
 - logistical problems
 - backlog of orders or referrals, and
 - minimal outsourcing.

Due to the complexity of obtaining reliable waiting list information, it is difficult to attribute cause and effect. Providing powered chairs with adaptations and seating, with the need perhaps for final adjustments with the user, is intrinsically more time consuming than issuing a simple manual chair. In such cases a prompt response will be dependent on well-designed logistical pathways bringing together the various equipment components.

- 3.7.11 The limited information we have suggests that in some centres the service could potentially cope fairly well with the number of current referrals in a timely manner, and has the funding to cope with demand accommodated under current eligibility criteria if the accumulated backlog of work was cleared. Clearing the backlog of equipment for which individuals have already been assessed and are waiting, would significantly improve their perception of the service. Once this backlog was addressed, the speed of equipment delivery should also be improved for new assessments. Some additional funds have already been provided to assist with clearing the backlog.



3.8 Funding

3.8.1 Some of the improvements in the service explored in this document should be deliverable without additional costs although they may, perhaps, require 'pump priming' to make the transition. Others, such as addressing the equipment gaps identified above, could cost comparatively large sums of money to address. If we do want to make changes, how will we finance them?

Equality of funding

3.8.2 Figures shown in section 2 indicate that the various wheelchair centres have considerable variation in the funds available to spend per head of population or per registered user, far more than can readily be accounted for on the basis of rurality etc. When funds for the service were devolved to NHS Boards, they were not 'ring fenced' – some NHS Boards appear to have moved funds out of the service, others seem to have left the revenues intact or uplifted for inflation. In any event, the funds allocated by the Scottish Executive seem to have been determined by historical spend, rather than on the basis of need or population: there has never been a formula to determine appropriate expenditure for this element of the NHS.

3.8.3 In theory, the total funding for all NHS Boards should be based on an allocation per capita adjusted for rurality and deprivation. An argument could therefore be made that NHS Boards should be asked to produce an action plan which would see them all moving towards a common level of funding for wheelchair services. Unless additional funding was made available, this could require money to be moved from another service. An alternative, perhaps more in line with current devolved management arrangements, might be to set and monitor realistic service standards and leave the details of funding these to the NHS Boards.

Efficiency and service redesign

3.8.4 We do not have direct productivity measures for the wheelchair service, however, the information we do have suggests some potential opportunities for efficiency gains through service redesign. For example:

- examining the range of funds allocated and comparing this with other variations, there appears, not surprisingly, to be a correlation between the numbers of powered chairs issued per head of population and the funding available
- examining this in more detail, there are some services that appear to provide above the average level of powered chairs for the funding they receive, some below
- the range of staffing per head of population and skill mix variation also appear to provide some interesting patterns which might merit investigation



- there are some parts of the service that appear to provide a more acceptable and timely service despite relatively low levels of funding and vice versa
- inefficient infrastructure in some services consumes staff time, suggesting that improvements could be made in productivity, and
- the variation in numbers of repairs between centres could also merit further investigation.

As discussed in further detail later in this document, the Modernisation Agency in England provided support to wheelchair providers to assist them in improving their services through process redesign. This initiative was very successful in a number of areas, although we understand that several have subsequently reverted to their original performance as resources were once again withdrawn. Nevertheless, this does indicate that there are opportunities in this area.

There is some potential for service redesign to improve service standards.

Joint working and flexible funding packages

- 3.8.5 Some studies have shown that equipment more closely matched to users' needs can be funded through a more flexible approach, accessing funds from a mixture of the NHS, DWP, social care, support organisations, charities, insurance, court settlements for injuries and private funding. An approach of this nature could help bridge some funding gaps. There could well be other service improvements that could be achieved by more joint working between health and other agencies. As a minimum, some of the difficulties we heard about could be resolved (e.g. no house adaptations from the local authority until a wheelchair is delivered, but no wheelchair from health unless the house is modified).
- 3.8.6 The voucher scheme operating in England sees the NHS 'giving' service users a voucher equivalent to the sum that would have been spent on their individual equipment by the NHS to be used towards the cost of the equipment the user chooses. Evidence from England shows mixed success. The scheme may – not surprisingly – work best in affluent areas where people have money to add to the vouchers, however, there are signs that the concept is gaining in popularity as confidence grows over its application to powered chairs.
- 3.8.7 A 'top-up' scheme allows individual users to add their own funds to those of the NHS and obtain the chair they want. Some Scottish centres may occasionally operate this system already on an ad hoc basis, in which case choice is restricted to models that the NHS is willing to maintain.



3.8.8 The best approach could be a compromise, where funding from several sources can be used to bridge any gap between the chair the NHS is funded to provide, and the one the user wants, presumably in keeping with the professional assessment provided by the public sector.

Leasing schemes

3.8.9 A major constraint to the current service pattern is the lack of funds to purchase higher priced equipment: standard powered chairs cost approximately £1,000 and a complex version can cost £5,000. An alternative might be for the NHS to set up a leasing scheme whereby instead of paying the capital cost, the NHS leases the chair, probably from the manufacturer through a central contract (there could be variations on this including the NHS holding the capital centrally). There would be savings in the early years, although the cost of capital might make it more expensive by, say year five.

3.8.10 However, the income flow would allow a new chair to be issued at year five for example, for no additional cost. Refurbishment of chairs funded in this way would become a thing of the past for the NHS – but there might well be additional costs if the chair is not used for its full lease period – five years in the illustration below. These arrangements would be invisible to the user. Information about life expectancy of chairs would be needed for a full assessment of the viability of this concept.

Table 10

If we currently buy 100 chairs per annum @ £1k		=	£100,000 capital every year
5 year cost		=	£500,000
If we lease	100	chairs for 5 years @	
£250 per annum	=	£25,000 in year 1	
	200		= £50,000 in year 2
	300		= £75,000 in year 3
	400		= £100,000 in year 4
	500		= £125,000 in year 5
		5 year cost	= £375,000

There are a number of issues here that would need to be clarified and worked through. For example, the above illustration assumes that a third party will fund the original capital purchase and that the NHS will pay 5% interest on this sum. This may not be a commercially viable proposition for manufacturers or banks/finance companies.

We should therefore emphasise that this is an outline suggestion that will require a substantial amount of investigation to assess its practicality.



Hire purchase schemes

- 3.8.11 The Motability scheme whereby people with disabilities can use their disability allowance to buy a car through a hire purchase scheme could be replicated in relation to wheelchairs. This scheme is run by a government-sponsored organisation with close links to motor manufacturers. The end result is a car modified for a driver with disabilities, which can be purchased, over a period of several years, for the cost of the disability allowance. For interest, the scheme also offers cars suitable for wheelchair users, but for additional cost.
- 3.8.12 Such a scheme also readily allows purchase of a wheelchair through monthly payments. Involvement could be attractive to wheelchair manufacturers in the same way as motor manufacturers if they believe that additional or higher priced sales might result, also driving down costs to the user. In theory, this could be run in parallel with concepts like the voucher scheme and other flexible funding arrangements.

A high proportion of the cost of the service (40-60%+) is attributable to equipment purchase. We therefore suggest that to make significant and lasting improvement in the current service will require additional funds for equipment, although this should be supported by service redesign.

4 Health Gain and Social Inclusion

4.1 Assessing health gain

- 4.1.1 Clearly, many of the possible changes to the service under discussion would cost more money. Can these be justified when the NHS faces many other competing priorities? Work commissioned as part of this report suggests they can. We used economic evaluation to show what health benefits could be achieved by spending more money on the services, then applied the same rules as are used by the National Institute for Health and Clinical Excellence (NICE).¹
- 4.1.2 The key concept in this approach is the quality-adjusted life-year (QALY). This takes a period of time such as a year of life (or life-year) and weights it by a factor that reflects quality-of-life (hence quality-weighted life-years or quality-adjusted life-years). The weight is expressed as a number between 1 and 0, where 1 equals full health and 0 is a state that is as bad as being dead (negative states are also possible). So if a wheelchair improved someone's quality of life from 0.5 to 0.7 for one year, then that would be a gain of 0.2 QALYs. If the gain lasted for four years that would be $0.2 * 4$ or 0.8 QALYs, and so on. If a hundred people each gained 0.2 QALYs that would be an overall gain of $100 * 0.2$ or 20 QALYs.

¹ NICE has a remit to advise the NHS in England and Wales but its recommendations on health technologies are generally accepted by NHS Quality Improvement Scotland and issued as guidance to the NHS in Scotland as well.



- 4.1.3 A full economic evaluation of a policy or service would involve working out what the change costs (including savings) and comparing this to the additional health benefit measured in QALYs. The cost-effectiveness of the change is the additional cost per QALY gained. So if the change that produced 20 QALYs cost £300,000, the additional cost per QALY gained would be $£300,000/20 = £15,000$ per QALY.
- 4.1.4 A health economist's perspective on policy changes was included to weigh the additional costs of a change in priorities against the additional benefits, measured in terms of QALYs. The main data sources were Scottish clinical opinion and a review of published research.
- 4.1.5 Wheelchairs generally do not make any difference to the length of life so the main challenge is to identify the main utilities, in other words to try to value people's quality-of-life with and without a wheelchair. The values obtained from the literature were as follows:

Table 11

Research study	Health state
IHRQoL study	Manual chair
	Powered chair
Newcastle Multiple Sclerosis Study	Intermittent or unilateral constant assistance (cane, crutch, brace) required to walk about 100 metres with or without resting (Expanded Disability Status Scale (EDSS) state 6)
EQ5D survey (used in NICE health technology assessments)	Confined to bed, some problems with self-care and usual activities
	As above but with some anxiety/depression
	Some problems walking, with self-care and with usual activities

- 4.1.6 The lack of relevant, generalised economic research in this field makes estimating the QALY gains of improved access to wheelchair services very uncertain. The clinicians consulted presented a consistent and coherent picture of the types and numbers of patients who might benefit from reductions in waiting times and improved access to power chairs but the data are lacking to present a definitive QALY calculation based on these insights. Despite this it is possible to estimate the orders of magnitude involved in reducing waiting times and in improving access to powered chairs.



Reducing waiting times for a standard chair

- 4.1.7 The situation we have considered is reducing the wait by three months. Individuals with stable disease might be walking with a stick – in the Newcastle MS study in the table above, they might be walking with a stick, valued at 0.49. With a chair they might get to 0.64. This is a gain of 0.15 over three months. The QALY gain is $0.15 * 25\%$ of a year, or 0.037 QALYs.
- 4.1.8 A more optimistic scenario would be to use the data from the IHRQoL study: in this case with a chair, their quality-of-life might rise to 0.70. This would be a gain of 0.21, and given that this lasts for three months, it is equivalent to 0.0053 QALYs.
- 4.1.9 NICE's guidance on an acceptable cost per QALY states that up to £20k/QALY is usually acceptable and up to £30k/QALY may be acceptable under certain circumstances. If NICE are willing to pay at least £20k for a QALY then they should be willing to pay £20k* 0.037 for 0.037 of a QALY. This comes to £745. If we use the £30k cut-off instead, NICE would be willing to pay £1,118. If we use the IHRQoL study then all these figures would be about 50% higher.
- 4.1.10 So even for the less optimistic health gain estimate, by the criteria that are used to set NHS priorities we should be willing to pay at least £745 and maybe up to £1,118 to reduce the wait by three months for one person. This is equivalent to between £248 and £373 per month of reduction per person. Under more optimistic assumptions about gain, these figures should be 50% higher.

Table 12

Reduced wait	Health gain from chair		
	0.25	0.15	0.05
1 month	£417	£248	£83
2 months	£833	£497	£167
3 months	£1,250	£745	£250



4.1.11 Alternative hypotheses could be constructed; for example:

- under the least favourable scenario, people are still able to walk with a stick when they are considered for a chair so the gain is much smaller, possibly in line with the final column of the table above. However, having earlier access to the chair may allow the person to stay mobile, maintaining social contacts outside the home.
- alternatively for some service users who might either suffer from pressure sores or lack of posture support, the gain might be closer to 0.25 in the first column of the table (or even higher) – the willingness to pay for a waiting time reduction in these cases is correspondingly greater.

Reducing waiting time for seating

4.1.12 This is problematic: for example, one of the benefits described by clinicians in reducing waiting times would be the (unquantified) reduction in risk of pressure sores, but further literature searches failed to locate any studies that estimated the consequences of a pressure sore in terms of QALYs.

4.1.13 However, it seems reasonable to suppose that the benefits of reducing the wait for seating will be at least as great as those estimated for ‘standard wheelchairs’ above. If the potential benefits are higher, as seems likely, the NHS should be willing to pay more to achieve them. The costs of reducing the wait may also be high as the services are more specialised.

Improving access to powered chairs

There are two groups of wheelchair users to consider.

4.1.14 The first group would have got a standard chair and now get a powered chair. From the IHRQoL study, the additional benefit is 0.12 per person per year (ie 0.82 rather than 0.70). To illustrate the cost-effectiveness of a powered chair, suppose the person uses a chair (whichever the type) for five years and that powered chairs cost £1,000 more than standard chairs with an additional maintenance cost of £500 per year (to really stack the calculation against the powered chair). Even if the chair is scrapped at this time, the additional cost is £3,500 and 0.6 QALYs are gained so the cost per QALY is £5,833, which is well within acceptable limits.²

² Discounting to present values only makes a small difference to the calculation.



4.1.15 The second group might not have got a chair at all. Even making fairly modest assumptions about the benefits that a powered chair could bring to an individual, providing a chair still seems cost-effective: the costs are the same as in the example above, but now the QALY gain is 1.6 QALYs and the cost per QALY is £2,170. Again this is well within acceptable limits.

4.1.16 With this level of cost, a powered chair would be a cost-effective alternative to a standard chair so long as it yielded an additional 0.175 QALYs, equivalent to a gain of only 0.035 per year for five years. This is an extremely modest gain, and it does not include any benefits to the carer who no longer has to push the chair.

Conclusion

4.1.17 The two changes considered, reducing waiting times and greater provision of powered chairs, will both cost more money. However, the NHS frequently pays out more money for services that offer more health gain. Even the crude calculations presented here suggest that under reasonable assumptions, these interventions will be highly cost-effective.

4.2 Employability and wider economic gain

4.2.1 Some service users of working age reported that their ability to get and sustain a job is hampered by their mobility and current wheelchair equipment. While they constitute a minority within the total service user group, the impacts of facilitating their employment (by providing a chair which is more work-friendly) should not be under-estimated.

4.2.2 Recent work undertaken by Frontline for NHS Greater Glasgow and the Wise Group revealed the profound economic impact of enabling the economically inactive (as a result of ill health, including mobility difficulties) to achieve sustainable employment:

- reduction in benefits claims – the average reduction in benefits per person securing a job is £5,495 per year; this excludes reductions in housing benefit, tax credits and other benefits as a result of achieving a higher income, and
- economic output – a previously economically inactive individual securing work in Greater Glasgow generates an additional £25,700 of economic output per year.

4.2.3 Consequently, the potential value of providing a higher specification chair to an individual to enable them to work may well outstrip the additional cost of the chair.



5 Lessons from Elsewhere

As part of the review, we examined models of service elsewhere in the world, to identify good practice and lessons that could be applied in Scotland. Our discussions with staff and managers of other wheelchair services revealed a range of interesting and potentially instructive experiences, highlighted below.

For example, services in the United States have adopted an off-the-shelf purchase model, to reduce in-house adaptation. They also have an innovative approach to providing equipment for users with progressive conditions. Services in Norway are based on a holistic, human rights based model that joins up social and healthcare provision to meet the totality of client need. We discuss the various service models in more detail below.

5.1 England

5.1.1 England does not have a single common model for the delivery of wheelchair services, but a variety of different service configurations across the country. There are 151 wheelchair services in England, a ratio of 1:300,000 of the population, in comparison with Scotland's current ratio of 1:1,000,000.

5.1.2 In 2002, the Department of Health, the Modernisation Agency and the Accounts Commission set up a collaboration with around one-third of wheelchair services in England and one of the two Welsh centres to look at:

- reducing delays
- maximising efficiency
- ensuring user and carer needs were addressed, and
- ensuring the outcome of contact with services was an enabling experience, promoting independence.

Selected reported improvements were:

- North Bristol – reduced wait for routine assessment from 120 to 50 days
- North Cumbria – reduced maximum wait from referral to assessment for a powered chair from 12 weeks to 6 weeks, and
- Brighton – reduced the wait from assessment to delivery of a powered chair from 47 days to 4 days.



Staff involved in the initiative have suggested that the improvements were achieved through:

- making small changes, for example streamlining processes like collecting and monitoring data
- taking time out to evaluate the use of resources, and
- sharing and learning from the experiences of others.

The initiative finished in May 2004 and it is not entirely clear how many of the improvements have had a lasting effect, or if any additional advances have been secured without the concentrated effort of the initiative being brought to bear. However, we understand that several of the improvements have not been sustained, for whatever reason.

- 5.1.3 The current situation in England continues to vary from area to area. The north of England has a 'super-centre' in Newcastle for complex cases, with smaller regional services dealing with less complex cases. Yorkshire has multiple centres each covering around 2,000 users; the general perception here is that the 'localness' of services is good, but that their 'smallness' means that no one has the critical mass of staff to deal with complex cases.
- 5.1.4 Chailey Heritage is an NHS-based assessment and treatment centre for children and young adults with complex physical disabilities. Chailey covers a range of services including rehabilitation engineering, clinics and assessment services, a head injury service, respite and outreach services. Referrals come from consultants and local therapists, with around 300 a year made to the rehabilitation engineering service. Funding comes from Primary Care Trusts through service level agreements and wheelchairs are then funded through local wheelchair services.
- 5.1.5 Chailey is also a specialist centre for research into children's postural needs and is able to offer robust assessment, multi-disciplinary working and continuity for service users. However, waiting times are currently around 5-6 months for assessment, and then a further four months 'post-Chailey' for the fitting and delivery of equipment.

5.2 Wales

- 5.2.1 Wales has a single wheelchair service with two centres, one each in the north and south of the country. There are in addition three rehabilitation centres each specialising in a different clinical area. Repairs, maintenance and refurbishments are contracted out on a three-year contract basis. Interestingly, Wales has no eligibility criteria for equipment, preferring instead that the individual's needs are assessed and met, including buying outside of the contract if necessary.



- 5.2.2 Funding of the service in Wales appears to be at a higher rate per capita with, for example, the service in north Wales receiving £3m for 17,000 service users as opposed to the £14.2m Scottish services receive for 100,000 service users. Waiting lists are however still long, with some users waiting up to two years for equipment. They do however achieve a delivery time of 21 days for standard equipment that does not require the user to be assessed face to face. There is a PPM programme – annually for powered chairs, but not for manual, as funding would not allow. Repairs are carried out on a basis of three days as standard, with a response within 24 hours for emergencies.
- 5.2.3 Wales has also developed a training programme for OTs, which is about to be accredited by the University of Wales, and all OTs have completed at least part of the programme available to them.

5.3 Netherlands

- 5.3.1 Responsibility for provision of wheelchairs and other mobility equipment lies with local authorities, with the onus on the person with disability or their carer submitting a written request to their local town hall. Following an equipment aid assessment, the selection of equipment is made between the authority and the client and the supplier. There is potentially no restriction on the specification of the chair. Waiting times from referral to delivery are commonly 4-6 months, but can be up to one year.

5.4 Norway

- 5.4.1 Norway has the most impressive of all the services we looked at. Their approach is based on the fact that access to assistive technology is seen as a basic right and is provided on the user's terms. The service incorporates all assistive technologies from wheelchairs to hearing aids and home adaptations. The service receives about £250m a year in funding with around £50m being spent on wheelchair services. This is for a population size comparable to Scotland. Norway has a total of 22 centres, 19 of which are in the 19 regions providing solutions to complex needs, with three national centres including a vehicle centre and two IT centres. Funding is allocated to the autonomous local centres, but if they have to overspend, more money is made available by local health authorities.

5.5 United States

- 5.5.1 As with England, there are various models of service delivery across the United States. The main difference between Scotland and the US seems to be that they purchase 98% of their equipment 'off the shelf' meaning minimal levels of local customisation, which they have found to be cost-neutral when all factors are taken into account. The practice in the United States is also to purchase a higher basic specification chair, leading to minimal



repair and maintenance costs. Users with progressive disease are offered a 'lend-lease' service where the chair can be returned if and when needs change. Reassessment and renewal of equipment is automatic after five years and service users are then allowed to keep the old chair as back up.

- 5.5.2 PPM is done routinely on all products – annually for manual chairs and 3-monthly for powered chairs. Equipment is also checked at any patient appointment.
- 5.5.3 There is a separation of assessment and purchase, enabling mobility and seating professionals to act as advocates for the client's holistic need without reference to eligibility criteria. However, it must be noted that the insurance-based funding system in which the model operates is considerably different to Scotland's.

6 Conclusions

In November 2005, NHS QIS issued a consultation document to seek views on the provision of wheelchair services and how these might change to better serve the population. The final section of this document has been produced after full analysis and input from the consultation experience. Again, we have dealt with the issues identified as key to a successful future for the service:

- a local service structure
- accountability
- assessment
- provision of equipment
- maintenance of equipment
- gap analysis
- staffing, and
- funding.

6.1 Structuring the service, making it local

- 6.1.1 Throughout this document, the need for access to services to be as easy as possible for wheelchair users and carers has been emphasised. How could physical access to wheelchair services be improved?
 - While there is no 'right size' for a wheelchair centre, there seem to be no clear benefits of scale from large Scottish centres, while very small centres may find it difficult to recruit.
 - Outreach clinics provide valuable access to many patients, but are limited in the range



of service they offer and consume scarce staff time in travelling.

- Innovative options are worth considering, such as the use of an equipped mobile van to extend the range of services at an outreach clinic, or the development of more local facilities by employing a therapist and administrator.
- Efficiency and users' experience can be optimised if whatever facility used is fit for purpose, has disabled facilities and appropriate workshop, storage and clinic space.

Future options

More outreach clinics and local facilities

- 6.1.2 Outreach clinics are currently provided by a mobile team of staff travelling from a wheelchair centre. The concept of expanding these received reasonably good levels of support at consultation.
- 6.1.3 Benefits:
- additional outreach clinics would probably be the quickest way of providing much improved access for many service users.
 - recruitment to a centre, which then provides outreach clinics, may be a practical way of providing staff.
 - the costs of running an outreach clinic will be about £16-£26k per annum for each location which has a basic monthly clinic staffed entirely by a team from the centre. Costs would be significantly less if existing facilities such as clinics and community centres could readily be used. Making some allowance for this, a total of 25 additional clinics across Scotland could cost <£400-£650k; this compares well with the costs of additional centres.
 - a network of outreach clinics could be a good base for future integration with local authority services.
- 6.1.4 Drawbacks:
- outreach clinics take more staff time in travelling than fixed regional centres, and
 - the clinic is unlikely to be able to offer a full range of skills, as there will usually not be a full complement of staff, and equipment will normally also be a limitation.
- 6.1.5 The possibility of a mobile clinic, using a fully equipped van or lorry, has been suggested: this would allow a wider range of assessments to be offered, for example. Costs could be in the region of an additional £10-£15k per annum for a single leased vehicle, perhaps £100k across the country, plus running costs.



6.1.6 More local contact and benefits to service users could be delivered by employing some permanent staff at outreach clinics. An administrator, based in a local clinic or similar location, and a mobile physio or occupational therapist, possibly part-time, could do much to provide a local service and get to know their clients. Such a model, with an administrator and part-time therapist, would cost about £1.3m for 25 outreach locations running fortnightly clinics (this might not be the ideal configuration, but it gives an indication of costs). It could potentially provide the best solution to staffing, giving flexibility to employ appropriate staff in a wider variety of locations.

Additional regional centres with outreach clinics

6.1.7 There was no clear consensus for any one of the options outlined at consultation, but good levels of support were received for this option, particularly from groups. Additional regional centres could be provided by splitting Glasgow and possibly Edinburgh. They would be located in a conurbation to be decided largely on the basis of demographics, giving maximum access benefits. This concept was well supported at consultation.

6.1.8 Benefits:

- the centres would be permanently staffed and, given funding, would also be able to provide local outreach clinics. Service users would be able to relate to staff who are less remote in location.
- setting up additional outreach clinics from this base will incur perhaps less than half the costs of an outreach clinic run from the current centres because travelling distances are reduced.
- there may be advantages, particularly in the medium to long term, in splitting bigger centres, which, at least in the case of Glasgow, do not seem to deliver benefits of scale, yet are remote from many of their clients.

6.1.9 Drawbacks:

- for many, the centre will still be some distance away.
- ideally, we would look to see staff at the existing centres redeployed to the new locations, but there may be only limited potential for this. If so, a recruitment and training scheme will be required: the ability to attract and retain staff may make it more difficult to deliver this option.
- we estimate that it may cost between £330-£400k per annum to run each additional centre, less if premises were already available, dependent on the level of new versus reallocated services.
- there will be additional costs associated with the transition from the current arrangements.



- this option is likely to take longer to deliver benefits than additional outreach clinics, while planning and delivery will need an investment of time and resource that could be spent on other priorities.

6.1.10 It has been suggested that this option could evolve over time, reflecting Glasgow's current working model which organises the service in a three-way geographic split: this is attractive in that it could potentially produce some local staffing fairly quickly, with minimal disruption and reduced cost. The danger could be that further changes are not driven through.

Radical restructuring

6.1.11 As outlined in the consultation document, it is not feasible to deliver this in the short term: it is more a target for gradual evolution over a period of years. There was good support for this option at consultation, although largely from individuals rather than groups. This is a model seen in other countries, pre-eminently Norway where significant funding is invested in local mobility centres which are to be found in most medium sized conurbations, lead by local authorities. Applying a similar pattern in Scotland would result in 15-22 service centres. This would undoubtedly produce very significant improvements in access and travelling for service users.

6.1.12 However, the difficulties of moving to this option in the short term are so great as to be almost insurmountable, with significant challenges to be overcome whenever introduced.

- Staffing – an integrated partnership between health and social care is the most likely way to success, given that the NHS already has problems with recruitment in smaller centres. A substantial training programme for local authority and health staff would be needed, as well as additional recruitment.
- Disruption – this would be a major change, needing planning and resources from integrated public services. We think that some disruption to a range of services could well follow.
- Cost and value for money – we estimate that this solution could cost as much as £5m-£8.8m plus training and transition costs. Our view is that there are other immediate priorities for such substantial expenditure within the wheelchair service. Further, we suggest that some, although certainly not all, of the access benefits can be achieved more rapidly by other more practical routes. Finally, the indications are that costs will be much lower with a gradual transition.



6.1.13 This could be a long-term goal, to be moved to gradually following ongoing assessment of other service changes, perhaps hand in hand with the Joint Future agenda within Scotland. The benefits could include:

- holistic and integrated services offering support in healthcare, home support, housing, adaptations and mobility aids, employment
- a service which is not based on responding to illness alone
- easy local access, and
- a more personal approach from local staff who know and are known to clients.

Status quo

6.1.14 As outlined above, the indications from the current situation in Scotland are that there are no obvious advantages to be gained from a large centre, although staffing may be a problem for the smallest centres. Large centres may have some disadvantages in terms of travel to access services. The status quo does not, therefore, appear a particularly attractive option, and responses to consultation support this. The only obvious reasons for retaining the current configuration are:

- no additional cost
- no disruption to services, and
- other changes are a higher priority.

6.1.15 The potential benefits of change may outweigh these disadvantages through:

- better access for service users
- improved value for money, and
- opportunities for further redesign.

Facility infrastructure

6.1.16 The efficiency of services and the experience of users can be much more positive if basic infrastructure is in place, such as disabled toilets, sufficient clinic space, a workshop facility, space to store a range of chairs.

It is of vital importance to service users that they can minimise travelling, and access a local service, with staff and systems that they get to know. This could be provided by more centres, more outreach services, innovation in extending the range of support available locally or a mixture of all of these. The local involvement of community staff should also be promoted. Costs could be minimised by making use of existing community premises, but all facilities should be fit for purpose.



6.2 Making the service accountable

6.2.1 It could be argued that one of the main disadvantages the service suffers from is the lack of visible accountability to service users.

- The wheelchair and seating service has not enjoyed a high profile: despite a series of reports (see appendix) recommending changes and improvements, at best only modest progress has been made in implementing these.
- The service is fragmented: it has no central body with a clear responsibility to drive performance: there is a lack of high profile champions agitating for more resources or for improved performance.
- There is no system for setting standards, monitoring performance and reporting results in public, so that when the NHS is under pressure, the wheelchair service may be the first to feel the effects.
- There is considerable variation in the service offered across the five centres.
- Funding levels are not scrutinised: the overall spend has not kept pace with inflationary uplifts since central funds were devolved to NHS Boards, giving apparent shortfalls against the original allocation.
- The lack of a standardised information system makes it difficult to compare performance, quantify issues and manage the caseload.
- The voice of service users is limited, certainly at a national level
- If additional funds are made available, there is no ready mechanism to scrutinise investment.

Future options

No change to current accountability arrangements

6.2.2 We would argue that unless the wheelchair service receives a higher profile, this report and recommendations will go the way of previous documents and very little will change. Service users and, indeed providers, will continue to struggle even to retain their existing share of resources and will remain a low priority. Given the benefits to be gained from improving the service, this cannot be acceptable.

6.2.3 We would strongly suggest that there is a need for more robust accountability arrangements, so that executives who have accountable officer status for wheelchair funds are incentivised to drive improvements in performance, and invest resources, whether time or money, in the service. This will not be achieved from the current arrangements. There was little support for the status quo at consultation.



Maintain regional management with measures to ensure equity

- 6.2.4 This option, which received most support at consultation, would involve nationally agreed standards and targets which would be monitored, made public, included in performance reviews of NHS Boards and their management teams, and in the national waiting times initiative. Performance measures should be designed with the input of service users, carers and staff. However, each NHS Board would continue to have the authority to design a service that met local needs, provided it also met national targets. Those NHS Boards who did not host a wheelchair centre would also have responsibility for ensuring that the service for their population met national standards, thus exerting further pressure on the provider NHS Board, or incentivising the set-up of a more local service.
- 6.2.5 Benefits:
- a raised profile, attracting more resources and higher priority
 - the requirement to deliver common standards, thus driving improved performance
 - little, if any, disruption to the service
 - flexibility at a local level to cope with differences in staff availability, rurality etc
 - minimal costs: a national users forum with support might cost £45k per annum
 - this structure provides an incentive for NHS Boards to consider moving additional funds into wheelchair provision to help meet targets, and
 - the prospect of rapid action and results.
- 6.2.6 Disadvantages:
- some benefits could be delayed due to the lack of a robust national data collection system (see below)
 - less focus on the service than would be delivered from option 6.2.7 below
 - no clear single voice to champion the wheelchair service nationally
 - no ready vehicle to oversee allocation of any additional funds to the wheelchair service: this would probably need to be managed by SEHD, and
 - unless there is a mechanism to keep reviewing standards and driving higher performance, priorities for the service could slip again with time.



A single co-ordinating body

6.2.7 This option, which also received significant support at consultation, would see a national body to focus on the service and co-ordinate provision. This would see the development of a single organisation for Scotland responsible for all wheelchair centres and funded directly by the SEHD, similar to the Scottish Ambulance Service. This would require a sum of money to be removed from each NHS Board's existing annual allocations and re-routed to the new organisation. The current centres would report to the central organisation and, once in place, a national body could be the fastest way to implement any subsequent changes across all wheelchair centres. Support services, such as human resources and payroll could continue to be provided locally or might, over time, become centralised.

6.2.8 Benefits:

- a single organisation could readily introduce common standards, policies and procedures
- elimination of the current regional variations in funding
- a clear focus on improving services with no distractions
- a voice for the future, which can continue to lobby for users, undeterred by complications in other aspects of the service, and
- a good vehicle for sharing out any additional funding.

6.2.9 Drawbacks:

- costs associated with setting up a central body could easily amount to £450k
- more short-term disruption to the service than option 6.2.2 above
- there would be no more money available purely as a result of this move and attempts to even out existing funding across centres would mean withdrawing money from those better off
- withdrawing funds from NHS Boards would present some problems as there would be several different ways in which the amount could be calculated: too high a level would put pressure on other services, the reverse would 'short-change' the new organisation
- once funds were removed, there would be no incentive for NHS Boards to put any additional resource or goodwill into the wheelchair service to deliver targets
- confusion for staff who may work both for the wheelchair and seating service, and in other areas such as rehabilitation
- a more robust national data collection system would be required to yield full benefits (see below), and
- this would be a very small organisation with a very modest budget, which could be in danger of being brought under another umbrella, whether a 'host' board or national services, for instance: this could be the worst of both worlds.



A national wheelchair network

- 6.2.10 A further alternative is a hybrid: this would see a wheelchair network being set up along similar lines to managed clinical networks for cancer, stroke or diabetes. Wheelchair centres could remain under the management of NHS Boards, but a national network, with a clinical champion, could provide leadership and a voice for the service. The network could embrace user and provider forum(s), which could input into the development of standards and priorities. This approach could have many of the advantages of both the above options, without significant drawbacks. It would be ideal in determining additional allocations and scrutinising business cases. Costs might be £150,000 per annum.

Information technology

- 6.2.11 The current system in use by several centres has been developed with very modest resources and due to the initiative of service staff. A more robust, fit-for-purpose system seems to us to be a priority, both to monitor performance and to assist with service delivery. This might be achieved by adopting the current system and extending it, or through an off the shelf package, several of which are available. The costs might be around £100k. Any such system should have the potential to be connected to an electronic patient record when it becomes available.

The lack of visibility and accountability for the wheelchair service is one of its primary problems, and this must be resolved. A user voice will be essential within any accountability framework. Information systems are needed to allow monitoring and delivery.

6.3 Assessment

- 6.3.1 As previously reported, assessment is currently heavily influenced by what the NHS can afford, and is controlled by wheelchair centres regardless of the complexity of an individual's case. Key issues that need to be addressed are:
- the use of eligibility criteria to restrict equipment offered results in user distrust, frustrated staff and, most importantly, unmet need
 - assessment is seen as too focused on medical criteria, and is therefore perceived as unholistic, taking little account of users' aims or carers' situation
 - not every centre has a core of staff with paediatric training and communication skills
 - reassessment may not take place at an interval which addresses the individuals needs and wishes
 - there is an element of double handling, in that a community therapist may carry out an assessment, this is then authorised by a GP before being sent to the wheelchair centre for screening, and
 - an NHS assessment service for those buying equipment privately.



Future options: assessment of simple and complex needs

NHS services continue to be the sole assessor, but with assessment separated from provision

- 6.3.2 Consultation revealed only very modest support for this option, which would allow a transparent assessment not influenced by considerations of what could be afforded, or by eligibility criteria. The assessment could be discussed with users and carers and the options explored, including an understanding of what the NHS would provide and why, and recording unmet need. If wheelchair users could access additional funds, they would make a more informed choice about the equipment best suited to their needs. The costs of introducing this approach would be about £315k, largely due to additional staff time during assessment.
- 6.3.3 During consultation, service providers have emphasised that they see no need for different staff to take the decision about equipment provision: what would be needed would be more time for staff to have a full discussion with each individual wheelchair user during assessment. We accept this argument.
- 6.3.4 Benefits:
- easy to introduce
 - minimal disruption
 - wheelchair users would have a clear understanding of their assessment, allowing informed choice about further equipment options
 - lessening of mistrust between staff and patients, and
 - clarity about the level of unmet need, which could drive further change and/or funding.
- 6.3.5 Disadvantages:
- all referrals would still go to wheelchair centres, causing some delay and using up staff time, which is in short supply
 - the possibility of increased dissatisfaction from wheelchair users as unmet need becomes more transparent
 - a phased introduction could be necessary as additional staff time would be in short supply, and
 - the possibility of a lost opportunity for further decentralisation.



NHS centres assess complex cases only

- 6.3.6 This option, which attracted very considerable support at consultation, would see service users with less complex needs assessed in the community by local professionals. In practice, we envisage that this would allow community physiotherapists, occupational therapists and nurses, many of whom currently refer to wheelchair centres, to carry out basic assessments themselves. This would require additional training for many staff involved. In due course, this approach could potentially be extended to appropriate local authority staff and to a wider group of wheelchair users. The costs involved would be around £200-£500k per annum dependent upon the additional time needed by community staff, less savings in wheelchair centres. These costs would be in addition to those above if the changes in assessment practice at wheelchair centres are also delivered.
- 6.3.7 During consultation, it has become clear that there would be benefit in seeing such an approach as an integrated service between the specialist centres and community staff. The centres would be best placed to provide training and guidance through standardised flow charts and advice. Indeed, for some services, this would only be an extension and formalisation of their current approach. There would be further opportunities for decentralisation and integration with other possibilities outlined in this paper, giving further benefits to users and carers, for instance, increased numbers of outreach clinics could provide additional support, and this could be a stepping stone towards gradual development of the model outlined in section 6.1.11.
- 6.3.8 Benefits:
- the potential to extend into further decentralisation and integration with local services over time
 - time saved in processing straightforward referrals
 - the release of some staff time in wheelchair centres
 - more holistic assessment as it involves those who know the individual best, and may well take place in their home, and
 - should be relatively quick to introduce, but there may be some disruption and delay if community staff cannot be released for training, for instance.
- 6.3.9 Disadvantages:
- an increased risk of inappropriate prescribing of equipment
 - additional responsibilities and pressure for community staff
 - it is unclear how much support this approach would receive from primary care services, and
 - lack of clarity about funding and financial control.



No change

6.3.10 There was little support for this approach at consultation. Clearly, none of the above benefits would be delivered, and the difficulties of the current situation would remain as would the one obvious benefit: if funds are tight, the status quo is a reasonable way of sharing scarce resources. However, the picture would be very different if additional funding were made available, since many of the current difficulties relate to shortage of money.

Future options: follow-up and reassessment

The initial assessment should include a personal plan for follow-up

6.3.11 This suggestion produced overwhelming agreement at consultation. It would see the initial assessment process including a date for the next planned assessment or contact and should be based on the individual's own situation. For those with changing needs, this might mean reassessment in six or twelve months, for others, it might amount to an annual letter offering contact if required. The service, whether provided by a centre, outreach team, or community staff, should take responsibility for ensuring that this happens. The additional staff time associated with this will depend on how many users wish to take up the invitation for reassessment: our estimate of additional costs is £480,000.

6.3.12 Advantages:

- greater responsiveness to individual needs giving greater user satisfaction
- less unmet need
- more appropriate equipment
- reduced delays, and
- improved equipment adjustment and advice on use.

6.3.13 Disadvantages:

- additional costs of patient contact and equipment
- some delay in implementation if additional recruitment is required, and
- reduced prioritisation of staff time, which can be in short supply.

No change

6.3.14 There was little support for this at consultation, but some respondents made the point that a lot of staff time could be committed to follow-ups for users with less complex conditions: if staff time is a constraint, individuals with greater wheelchair dependency could suffer. It would therefore be important to introduce changes in a planned way. The pros and cons of the status quo are the opposite of those outlined above.



Paediatric assessment

- 6.3.15 It is clearly particularly important that children have access to an appropriately skilled team, when appropriate. Medical advice, for developmental and cognitive issues, will need to be sought more often than is the norm. Reassessment needs to be carried out on a planned and regular basis for some children. The assessment team need to be skilled in communicating with children, as well as understanding their mobility needs.

Assessment should be based on the needs of users and carers. While value for money must be a consideration, financial issues should be secondary: for this reason, assessment should be holistic, transparent and decoupled from affordability. Initial assessment should include a plan for follow up agreed with the individual. Paediatric assessment is particularly important and should be provided by staff with the relevant communication, technical and clinical training. Other therapists with appropriate backgrounds should be empowered and actively encouraged to assess and prescribe equipment: community staff in particular have a role here for less complex needs.

6.4 Provision of equipment

- 6.4.1 The current route for providing equipment is designed, in great part, to reduce costs, and appears to succeed well in so doing. The range of equipment purchased is controlled, allowing central bulk purchasing and significant savings on unit cost, and reducing the range of skills and spare parts needed to service and maintain equipment. There are, however, several issues which should be considered in designing the future of the service:
- increased choice
 - a multiplicity of providers
 - introducing new technology
 - the cycle of refurbishing chairs
 - the cycle of purchasing standard modular chairs and customising them in NHS workshops
 - greater use of alternative supply routes direct from the manufacturer, and
 - the impact on repair and maintenance.

Future options

The NHS continues to provide all wheelchairs following assessment

- 6.4.2 A modest majority of respondents supported this approach. It is worth emphasising that, were some financial constraints lifted, the NHS could provide a wider choice of chairs, yet retain much of its purchasing power. If community assessment is implemented, less complex chairs could be delivered direct to a service user from the warehouse or manufacturer and, indeed, this is only an extension of the practice already adopted by some centres.



6.4.3 Benefits:

- lower purchasing costs: the NHS would still be able to buy in bulk
- ready potential to save money through some refurbishment and customisation if appropriate
- lower cost and, in theory, faster repairs and maintenance, and
- given a will to improve choice, this could be delivered quickly.

6.4.4 Drawback:

- loss of an additional mechanism to drive down waiting times.

A number of providers including the NHS

6.4.5 This option was also well supported by a minority at consultation. Again, the range of models provided could be expanded to give more choice, but balanced with cost and repair issues. The more providers, potentially the greater the competitive effect, but the more serious the loss of bulk purchasing discounts.

6.4.6 Benefits:

- the element of competition should be a force to reduce waiting times, and
- increased drive for more choice.

6.4.7 Drawbacks:

- higher equipment purchase costs: our estimate is £600k, with no change in the functional specification of the equipment, and
- a commercial system will take some time to set up and change should the need arise.

Refurbishment and customisation

6.4.8 The issues of refurbishment and customisation have attracted much debate. We suggest that the NHS should review these practices particularly with regard to customisation and the value and role of extensive centre workshops. However, we have taken the approach that this issue is tangential to this review as it does not fundamentally affect the more strategic decisions considered here. There is further discussion of this issue in section 3.4.



Service users require equipment to be delivered promptly and the NHS has not always been reliable in this respect. There are significant cost advantages in the bulk purchase of wheelchairs via the NHS, but, if this continues to be standard practice, it is essential that long delays are eliminated. If this is not accomplished, a competitive route with multiple providers might well be preferable. The NHS should be flexible about equipment provision pathways, and review its practices with regard to customisation, refurbishment and the role of extensive central workshops.

6.5 Maintenance of equipment

6.5.1 This is another element of the service that can create frustration for service users and providers alike. Being without a functioning wheelchair has serious consequences for individuals who rely on their chair for their mobility. If a chair has to be taken away for repair, the NHS may not offer a replacement, and a substitute is in any event unlikely to be equivalent. Key issues are:

- most centres do not run a PPM programme, which can reduce breakdowns and promote user safety
- some centres have a mobile technician who can visit schools and homes to carry out a range of repairs, some centres take all repairs back to a central workshop
- several centres will refund basic repairs carried out at a local garage or cycle shop
- could other organisations be better placed to provide a breakdown service?
- determining the level of need for an out-of-hours service and how best to provide it, and
- maintenance of private chairs.

Future options

The wheelchair centres continue to run the maintenance and repair system, but with a programme of PPM introduced in all centres

6.5.2 This received equal support with option 6.5.5 below, with groups being particularly supportive of the introduction of PPM. Inverness is now providing a PPM service and other centres are keen to follow suit. Many centres operate a mobile technician scheme where many repairs can be carried out at home without the loss of a chair to a central workshop. The two approaches could be integrated.



6.5.3 Benefits:

- reduced breakdown rate so fewer problems for users
- lower costs in wheelchair centre workshops
- regular contact with the service, perhaps for minor adjustments or advice
- the potential to extend the PPM service to cover call outs in the case of breakdown, including out-of-hours emergencies
- NHS staff are keen to introduce a PPM system, and
- the opportunity to address health and safety issues and concerns.

6.5.4 Drawback:

- additional cost estimated to be <£1.2m–£2.4m.

All minor repairs to be contracted out to accredited local providers, for example, garages and bicycle repair shops, combined with PPM run by wheelchair centres

6.5.5 This option was equally well supported, but particularly by individuals. Some responses from organisations raised doubts about the practicalities of a local repair scheme, with concerns about the volume of work that could realistically be carried out and the costs of setting up accreditation.

6.5.6 Benefits:

- fast access to local repairs, and
- reduced workload on wheelchair services.

6.5.7 Drawbacks:

- small volumes of repairs involved, and
- costs, including setting up accreditation, could be £210k.

All maintenance and repairs contracted out

6.5.8 There was little support for this approach. Whilst it could yield benefits, the costs and practicalities are uncertain. This option should not be considered further at the moment.

No change to the current method of maintaining equipment

6.5.9 This received little support: in our view the only obvious benefit – no cost increase – is far outweighed by the potential improvements in the service which could be delivered through PPM.



Private chairs

- 6.5.10 An open commitment from the NHS to cover maintenance of any private chair could produce a number of problems:
- staff training and familiarisation with the product
 - spare parts not held and potentially difficult to obtain
 - delays for users due to the above
 - warranty issues, and
 - cost.
- 6.5.11 A more feasible alternative might be for the NHS to undertake maintenance where:
- the chair fits the NHS assessment
 - it is within a range of chairs which the NHS has determined that it will support, or the wheelchair centre has agreed that it can accommodate a variant, and
 - if an individual chooses to buy outside these parameters, the NHS will offer a voucher towards maintenance that is equivalent to in-house costs (it should be noted that this may only amount to perhaps £10-20 per annum).

Out of hours support

- 6.5.12 The options for this should be reviewed in the light of decisions over PPM. A network of mobile technicians, who provide PPM as well as a repair service from users homes, could potentially be used to provide support for emergencies out-of-hours. The knowledge of a prompt response the next working day may well alleviate much of the current concern. Risk assessment of individuals who live alone and are dependent on their chair for mobility could also be helpful in identifying urgent need. It might also be possible to link the wheelchair service to call-out alarms carried by many people with disabilities who live alone.

A PPM system should be established, with a frequency based on risk profiles. This will deliver major benefits by reducing breakdowns and the consequent cycle of repairs. PPM should be integrated with mobile repair technician schemes: this approach could be extended to deal with emergency and out-of-hours breakdowns.



6.6 Gap analysis

6.6.1 Many of the changes discussed in this paper could lead to improvements in the service currently offered, potentially giving faster responses, clearer assessments, easier access and more choice. However, broadly speaking, the equipment provided is not likely to significantly change for the better unless additional funding is made available. Unless the criteria currently used to determine what type of chair is prescribed are abolished, or relaxed, entitlement to some equipment will not improve.

Future options

6.6.2 Minimum common standards – due at least in part to the differential funding across Scottish centres, some are able to provide higher standards than others. We would suggest that the funding levels at Dundee should provide a benchmark standard: the centre has the highest budget per capita (outside the very small centre at Inverness serving a scattered population); a good level of service as assessed by users; a high ratio of staff to users; and higher levels of issue of powered chairs. There would then be no good reason for other centres not to deliver to the same standards. This would cost around £2.4m per annum recurrent.

6.6.3 Responses at consultation concurred with the gaps in equipment provision listed below, with costing information and additional comments now included. There seems little doubt that all the groups identified would benefit if extra funds were available. If not all can be afforded, health gain analysis could be useful in prioritisation.

6.6.4 **Children** – equipment needs change as they grow and they need new chairs and seating more frequently than most users. Several respondents at consultation took the view that insufficient importance was attached to the special needs of children throughout the whole process, and made the case for a specialist service with staff trained accordingly. We would endorse the need for such an approach and for staff interacting with children to be properly trained in both technical and communication skills. However, with the exception of some specific communication issues, the current shortfalls, in our view, come less from staff competence than from funding constraints.

Costs estimated at £1m–£1.8m.

6.6.5 **Young adults** – face similar difficulties to children, with the additional challenge of a reduced range of services available to them as adults. Costs estimated at £140–£280k.



- 6.6.6 **People with progressive disease** – two particular needs are not currently being addressed: first, the need for new equipment as needs change; secondly, powered chairs are not routinely prescribed for this group where there is self-mobility, even though this may vary from day to day. Costs may be duplicated in minimum common standards above, or could be < £360k additional to this.
- 6.6.7 **People with limited functional mobility** – if an individual can move around their own home, using furniture, sticks or a walking frame for support, they do not currently qualify for a powered chair for indoor use. Furthermore, in order to obtain a chair for outdoor use, the person must first qualify for an indoor powered chair. Outdoor chairs are not directly prescribed.
- 6.6.8 **Older people with carers** – carers' requirements should be included when assessing the needs of the wheelchair user and may drive the prescription of a power-assisted chair.
- 6.6.9 It has been difficult to separate costs for the two groups above, but it is clear that the constraints on powered chairs are particularly problematic. For example, eligibility criteria prevent an outdoor chair being issued unless an individual qualifies for an indoor powered chair – and this will not occur if they can walk a few steps around the house, regardless of the health of a carer, who may be frail themselves. Our estimate for the costs of issuing powered chairs in this situation are £4m–£5.6m.
- 6.6.10 **Those with terminal illness** – long waiting times for assessment and provision of equipment mean that it is difficult for the service to make a timely response to these individual's very immediate and often short-term needs.
- 6.6.11 **Those with temporary disability** – for example those with broken legs, may also be unable to readily access chairs.
- 6.6.12 Again, while 6.6.10 and 6.6.11 represent very different groups of people, they have in common the need for a fast response. In terms of assessing numbers of individuals involved it has been difficult to differentiate the statistics between these two groups. However, the costs of delivering a fast response for those who need it are estimated at up to £136k.



- 6.6.13 Many of the above costs are for equipment and this investment in wheelchairs could be spread over time, although centres will need to consider how this might be fairly accomplished. A three-year time line for investment might well be in pace with the additional staffing required to implement improvements. Once a new wheelchair fleet is established, annual investment in equipment can reduce somewhat, since replacement is likely to be needed on a three- to five-year cycle.

The mobility equipment provided by the NHS is currently based on eligibility criteria, which were designed with an underlying financial bias. As a result there are major gaps in the range of wheelchairs provided. The situation will not significantly change for the better unless additional funding is made available, and the criteria currently used in prescribing chairs are abolished or relaxed.

6.7 Staffing

- 6.7.1 The wheelchair service finds it difficult to recruit staff at present, and the commitment of existing staff can be strained. The underlying cause is the profile of the service, with few opportunities for further training or career progression, and staff, at all levels, feel demoralised and frustrated in a specialty that can fail to meet users' needs within a reasonable timeframe. In addition there are considerable differences in staffing levels and skill mix between centres.
- 6.7.2 Attracting and retaining staff is an important consideration, since the availability of key skills will undoubtedly constrain some of the developments outlined in this paper: indeed, it could prevent some improvements, not merely hold them up. Unless this is addressed, NHS service providers will not be able to make the changes both they and service users want.

Future options

NHS Education for Scotland (NES) should conduct a training needs analysis for wheelchair services

- 6.7.3 Not surprisingly, there was overwhelming support for this option. This could include the needs of community staff who may be empowered to prescribe 'basic' chairs, the needs of those staff who may wish to work in the wheelchair service for a short time – six months up to two years – and for those who wish to move their career forward within the wheelchair service. Courses to meet these needs should then be commissioned and funded. The costs of scoping this work would be about £25k: the costs of commissioning and providing the relevant courses would be dependent on the results of the training needs analysis.



- 6.7.4 Due attention should be paid to issues which particularly affect the paediatric service: assessment of children should involve a range of staff who have appropriate skills in communication as well as clinical and technical matters, and medical advice may be more frequently sought, particularly about developmental issues.

Staffing should be based on national agreement but should be flexible enough to allow local recruitment, with the input of medical staff reserved for assessment of those with complex needs.

- 6.7.5 Again, there was overwhelming support for this option. Wheelchair centres should move towards any required change at a speed which suits local circumstances. While a reasonable mixture of therapy and bioengineering/technical skills is necessary to provide balanced assessment, variations in skill mix could be accommodated.

Attracting and retaining staff is a key issue, which will undoubtedly constrain some of the developments outlined in this paper: indeed, it could prevent some improvements, not merely delay them. The status of the service and lack of training and career progression are key issues. Unless this is addressed, NHS service providers will not be able to make the changes both they and service users want.

6.8 Funding

- 6.8.1 While some of the options presented in this paper will not need additional money to implement, others, such as the provision of more powered chairs, will. We need to consider how some of this finance might be sourced.
- 6.8.2 It should be noted that analysis of health gain suggests that additional funding for the wheelchair service would compare very well with investment in other parts of the NHS that we take for granted.
- 6.8.3 All permanent recurrent funds for the wheelchair service come from the public purse. Wheelchair centres may have access to some charitable or endowment funds, some at quite significant levels.



- 6.8.4 As has already been noted, there are a number of anomalies in funding between centres.
- Allocation per head of population served. The funds devolved to NHS Boards in 1996 were at historical levels, reflecting budgeted expenditure rather than need or population size. Since then, some NHS Boards have maintained levels, some have uplifted for inflation, and others have reduced the allocation in real terms.
 - Considerable variation in the overheads charged to wheelchair centres to cover capital charges on building use, heat light and power, rates, etc and a share of support services such as payroll, personnel, financial support and possibly a share of management costs.
 - Value for money. There could be merit in further attention to this issue, exploring the link between levels of income per capita and key deliverables, such as staffing or the ratio of chairs issued.

Social inclusion

- 6.8.5 There may be financial savings to be made across the public sector by providing people with the mobility equipment they need in a reasonable timeframe. For example, getting people back to work could lead to a reduction in benefit claims and increased economic output. Recent national initiatives around incapacity benefit could support this approach. One of the Scottish centres has obtained funding from local authorities to support a training programme for wheelchair users, and it is conceivable that initiatives such as Joint Future will open more opportunities of this sort.
- 6.8.6 It seems anomalous that, although much of the need for wheelchairs is not due to ongoing health or ill-health issues, often the entire cost is borne by the NHS; it could be argued that social services, education, housing and the DWP could play an increasing role in ensuring mobility needs are met, or at least funded. Applying a joined-up model of funding from a number of different agencies may be a way to secure additional funding for the service, while maintaining bulk purchasing power.

Future options

Flexible funding

- 6.8.7 Consultation revealed widespread support for such an option. This would, in principle, allow money from different sources to be used towards the cost of a chair. Funds could come from the NHS, the individual, charities, various local authority departments, DWP or from national initiatives such as 'back to work'. The details of how such a scheme could function would need to be worked out. They might, as in England, allow an individual to take a voucher equivalent to the sum of money the NHS would have spent on their chair, and use it towards the cost of a chair purchased privately. Perhaps more likely in Scotland



would be a 'top-up' facility, where the NHS purchases the chair with the user 'topping-up' the cost difference between the chair the NHS would have bought and the one the user wishes to purchase.

- 6.8.8 Although these schemes are restricted to those who can access additional funds, the individuals will be better off, and, if other initiatives outlined in this paper are adopted, the chair they access could be selected with the guidance of an NHS assessment and covered by NHS repair and maintenance regimes.

Leasing schemes

- 6.8.9 This was acceptable to a little over half of all respondents at consultation, especially to those who replied as individuals. In order to offset the cost of providing a wider choice of complex equipment, the NHS could lease equipment through manufacturers or a finance house, with new chairs being replaced after an agreed period, for example five years. This would end the practice of repeated refurbishment and re-issue of chairs, a practice that uses a sizeable amount of NHS staff time and resources and can cause delays, and it may save money, or provide more up-to-date chairs without commensurate additional cost. Further research would be needed to fully understand the economic equation.

Hire purchase

- 6.8.10 A scheme like Motability (which is set up to provide cars for people with disabilities) could be developed for wheelchairs. The user pays (or has paid for them from their benefit allowance) a set amount every month towards equipment and when the agreed term is at an end, the equipment can be retained or a new agreement entered into. A minority of those responding to consultation found this attractive. Nevertheless, this option would, in our view, be worth further investigation, perhaps with Motability. It does allow a wide choice of wheelchairs and this can become the individual's property, but it does, of course, penalise them financially.

Funding of recommendations

- 6.8.11 The Wheelchair and Seating service has for many years been seriously constrained in the support and mobility equipment it can offer service users. As a result of the service having a relatively low profile to date, allocation of financial resources has been severely restricted. Further, since 1996 the funds available appear to have reduced in real terms, apparently to meet alternative priorities within the NHS Boards.



- 6.8.12 Having prepared recommendations, the Steering Group requested that Frontline prepare indicative costs for implementation of the main categories of their recommendations. The resulting costs are shown in the table below and indicate that a substantial increase in funding is required if users are to be provided with a service that delivers social inclusion and freedom from unacceptably restrictive eligibility criteria.
- 6.8.13 The costs give a broad indication of the support needed to deliver what we believe would be a world-class service. However it is important to note that the figures are very much an informed estimate, based on available information with some input from service providers. It will therefore be imperative that allocation of additional money to specific centres or projects is scrutinised through an appropriate business case process prior to release of funds, with fully costed proposals and implementation plans, setting out financial requirements from both capital and revenue streams, with the latter split between recurring and non-recurring revenue.
- 6.8.14 Table 13 summarises the estimated additional revenue consequences of the recommendations, including the recurring revenue effect of potential capital investments. It may be that capital rather than revenue will be required to fund specific elements of building development or expensive equipment, but pending detailed proposals, an assumption has been made for the sake of simplicity that all investment will be of a revenue nature. At this stage, what is important is not the source or nature of funding requirements, but the overall amount required.
- 6.8.15 The phasing suggested by the steering group for introducing improvements is ambitious, and we anticipate that it may be constrained by the ability to recruit staff. If implementation takes place at a slower pace, it will be important to ensure that total funds are not lost to the service.



Table 13 – Additional revenue funding required to support recommendations

Recommendation	Short term < 1 year: full year effect (£000s)	Medium term 1-3 years: full year effect (£000s)		Long term/ recurrent annual
		Year 2	Year 3	
Overarching Principles for the Service	1,528	2,515	2,535	2,580
Referral, Assessment and Provision of equipment	6,475	10,020	9,985	8,905
Management of the service	87	147	147	147
Information Management and Systems	35	110	60	60
Training	210	560	560	560
Repair, Maintenance and Support	250	1,900	1,920	3,350
Facilities	100	75	75	75
Particular Considerations for Children's Services	50	130	130	130
Total (£000s)	8,735	15,457	15,412	15,807

Notes

- The current NHS wheelchair and seating service has available recurrent annual funding of £14.2 million. In order to effect the implementation of the recommendations of the steering group, additional funding will be required. This would be in the order of an additional £8.7 million for the first 12 months of implementation, followed by a further additional £6.7 million each year in years 2 and 3. Thereafter, to maintain a steady state, with allowance for some increased demand after successful implementation of all recommendations, a recurrent £15.8 million would be required additional to the 2005/06 position, giving £30 million in total.
- Contained within this additional £15.8 million is a funding stream of some £6.6 million per annum for additional wheelchairs and powered wheelchairs, plus a further £1.45 million for modernising the existing fleet.
- The highest cost programmes comprise:
 - Overarching principles:** substantial increase in local access however provided – revenue costs of leasing facilities or the equivalent cost of building and owning them.
 - Referral, Assessment and Provision:** funding for equipment, based on significant increases to the wheelchair fleet in years 1-3 due to the removal of current restrictive eligibility criteria, followed by more frequent replacement and increased demand.
 - Referral, Assessment and Provision:** additional staff time for regular reassessment and full discussion of mobility plans with service users following assessment
 - Repair Maintenance and Support:** introduction of a PPM programme across Scotland, plus regular replacement of older stock currently in the wheelchair fleet.
- It should be noted that while costed recommendations specific to the children's service are included, the costs relating to additional staffing and equipment are contained within the recommendations that relate to: Overarching Principles for the Service and Referral, Assessment and Provision.



To make significant and lasting improvements additional funds will be needed, in particular for equipment purchase.

Work on health gain clearly indicates that there are major improvements to be achieved for relatively modest additional costs when compared to other health investments.

Approaches to funding should be flexible in order to achieve maximum benefits as quickly as possible and value for money should be maximised through service redesign.

The recommendations outlined by the Steering Group will cost approximately an extra £15.8 million per annum to deliver, in addition to the current £14.2 million budget. Given that this figure is an informed estimate, any release of funds should be subject to a full business case analysis. This level of investment would deliver a world-class service.

7 Summary and final remarks

- 7.1.1 Those of us who have worked on this project are in little doubt that the majority of staff within the wheelchair and seating service in NHSScotland are struggling hard to give a good service. Despite being successful in many instances, there is demoralisation and frustration at the limitations of the service. The most telling comment came from a member of clerical staff in a wheelchair centre: *“We can walk away at the end of the day, they can’t”*.
- 7.1.2 The level of user dissatisfaction and growing frustration at the shortcomings of the service can almost be felt. Despite a series of reports clearly outlining the need for change, the same problems remain: delays in assessment, provision and repairs, individuals who are unable to get the equipment they need to fulfil quite basic needs, and staff shortages causing further delays and difficulties. There are two issues that underpin all of these symptoms:
- shortage of funds due, at least in part, to a low visibility and status, and
 - lack of accountability to drive up standards.



7.1.3 The main findings of our report are summarised below.

The remit of the service

- Assessment should embrace social inclusion and be based on the needs of users and carers and should reflect their lifestyle. While value for money must be a consideration, financial issues should be secondary: for this reason, assessment should be holistic, transparent and decoupled from affordability. Initial assessment should include a plan for follow-up and be agreed with the user/carer.
- Paediatric assessment is particularly important and should be provided by staff with the relevant communication, technical and clinical training.
- Other therapists with appropriate backgrounds should be empowered and actively encouraged to assess and prescribe equipment: community staff in particular have a role here for less complex needs.
- It is of vital importance to service users that they can minimise travelling, and access a local service, with staff and systems that they get to know. This could be provided by more centres, more outreach services, innovation in extending the range of support available locally or a mixture of all of these. The local involvement of community staff should also be promoted.
- Costs could be minimised by making use of existing community premises, but all facilities should be fit for purpose.

Resources

- Mobility equipment provided by the NHS is currently based on eligibility criteria, which were designed with an underlying financial bias. As a result there are major gaps in the range of wheelchairs provided. The situation will not significantly change for the better unless additional funding is made available, and the criteria currently used in prescribing chairs are abolished or relaxed.
- Additional funds will be needed to make significant and lasting improvements; many of the current problems with the service are directly linked to lack of money.
- Approaches to funding should be flexible in order to achieve maximum benefits as quickly as possible, and value for money should be maximised through service redesign.
- Work on health gain clearly indicates that there are major improvements to be achieved for relatively modest additional costs when compared to other health investments.



- The recommendations outlined by the Steering Group will cost approximately an additional £15.8 million per annum to deliver, in addition to the current £14.2 million budget. Given that this figure is an informed estimate, any release of funds should be subject to a full business case analysis. This level of investment would deliver a world-class service.
- It should be noted that, even if funds were to be freely available, improvements will take some time to implement, due in large part to staffing constraints.

Delivery

- Service users require equipment to be delivered promptly and the NHS has not always been reliable in this respect. There are significant cost advantages in the bulk purchase of wheelchairs via the NHS, but, if this continues to be standard practice, it is essential that long delays are eliminated. If this is not accomplished, a competitive route with multiple providers might well be preferable.
- The NHS should be flexible about equipment provision pathways, and review its practices with regard to customisation, refurbishment and the role of extensive central workshops.
- A PPM system should be established, with a frequency based on risk profiles. This will deliver major benefits by reducing breakdowns and the consequent cycle of repairs. PPM should be integrated with mobile repair technician schemes: this approach could be extended to deal with emergency and out-of-hours breakdowns.
- Attracting and retaining staff is a key issue, which will undoubtedly constrain some of the developments outlined in this paper: indeed, it could prevent some improvements, not merely delay them. The status of the service and lack of training and career progression are key issues. Unless this is addressed, NHS service providers will not be able to make the changes both they and service users want.

Accountability

- The lack of visibility and accountability for the wheelchair service is one of its primary problems, and this must be resolved. Clear targets, regular information about performance and managers who are held to account for delivery are essential. There are several ways in which this key goal could be delivered: whichever is chosen, a mechanism for ensuring involvement of both users' and carers' voices are incorporated.
- Information systems are needed to allow monitoring and delivery.

We hope that this report will lead to these issues being addressed.

March 2006

Frontline Consultants

annex a: analysis of questionnaire



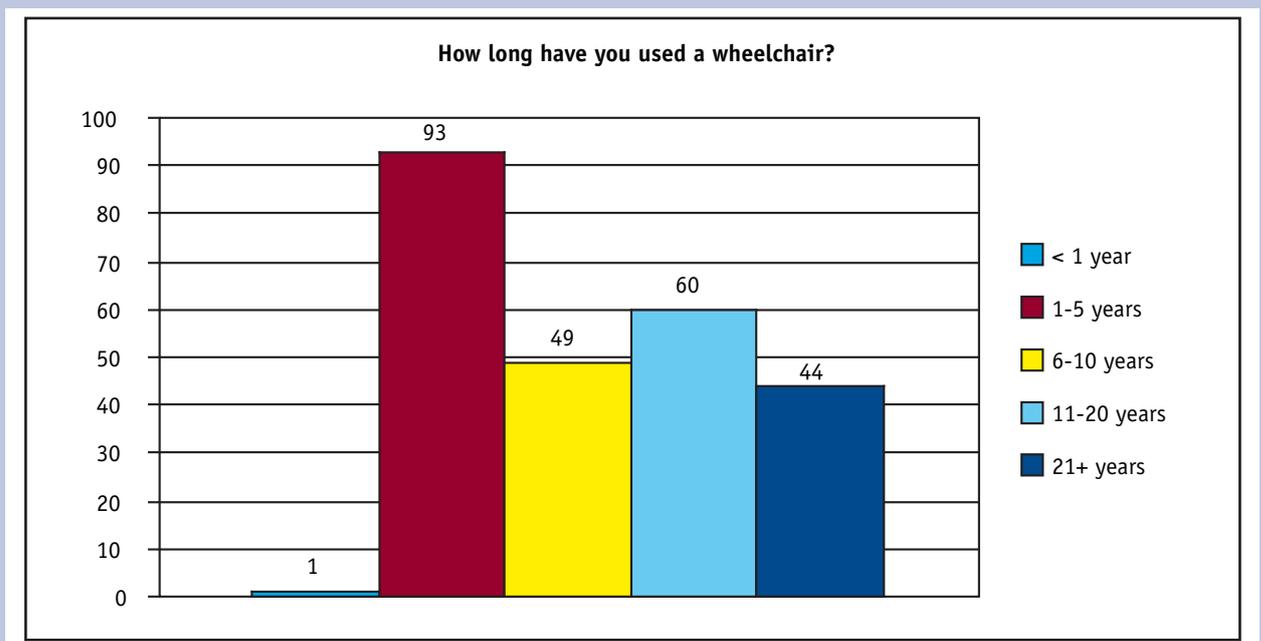
Service-user questionnaire

These findings are based on a combination of quantitative and qualitative analysis from 258 wheelchair users. This number of responses had been submitted by midday on Tuesday 9 August 2005. The following software tools were used in analysing data: SNAP survey software and Nvivo.

Section A

Question 1: How long have you used a wheelchair?

The diagram below illustrates how long respondents had used a wheelchair. There was a good spread across – 38% reporting having used a wheelchair for 1-5 years, 20% for 6-10 years, 24% for 11-20 years and 18% for over 21 years. One respondent had used a wheelchair for less than one year.

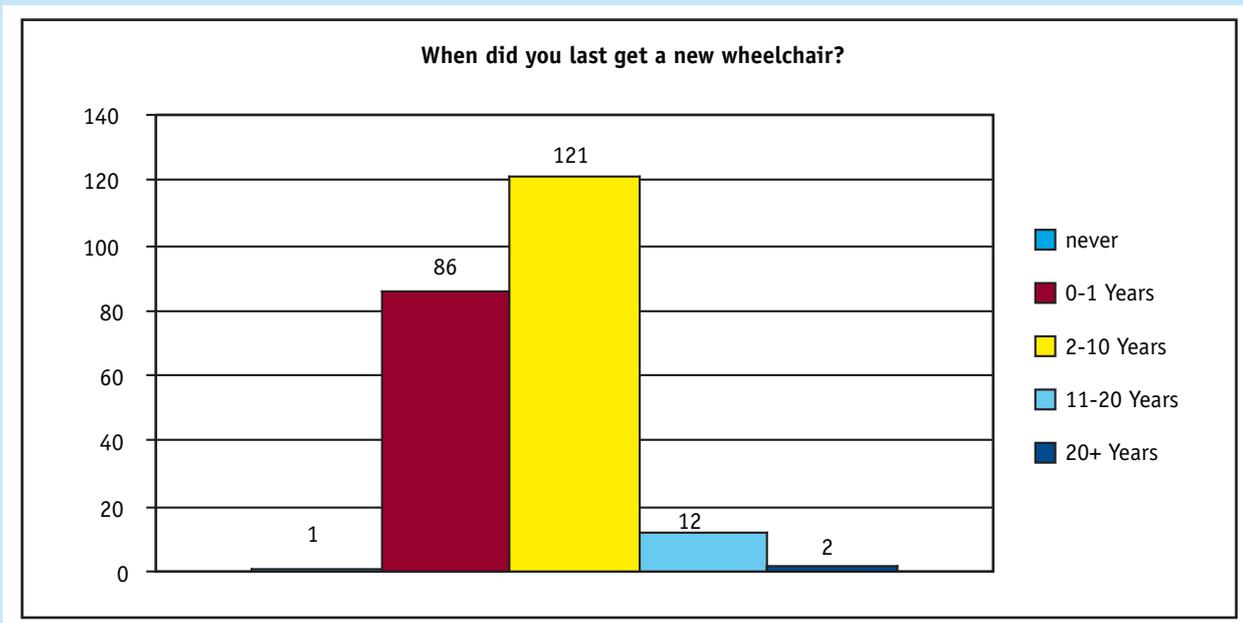


Base: 247 – No reply 11



Question 2: When did you last get a new wheelchair?

The majority of respondents had had their wheelchairs replaced in the last 10 years. In the past year alone, 35% of respondents had had a new wheelchair so we can expect that their views of the process will be particularly fresh. A further 49% of respondents have had their wheelchairs replaced in the last 10 years.

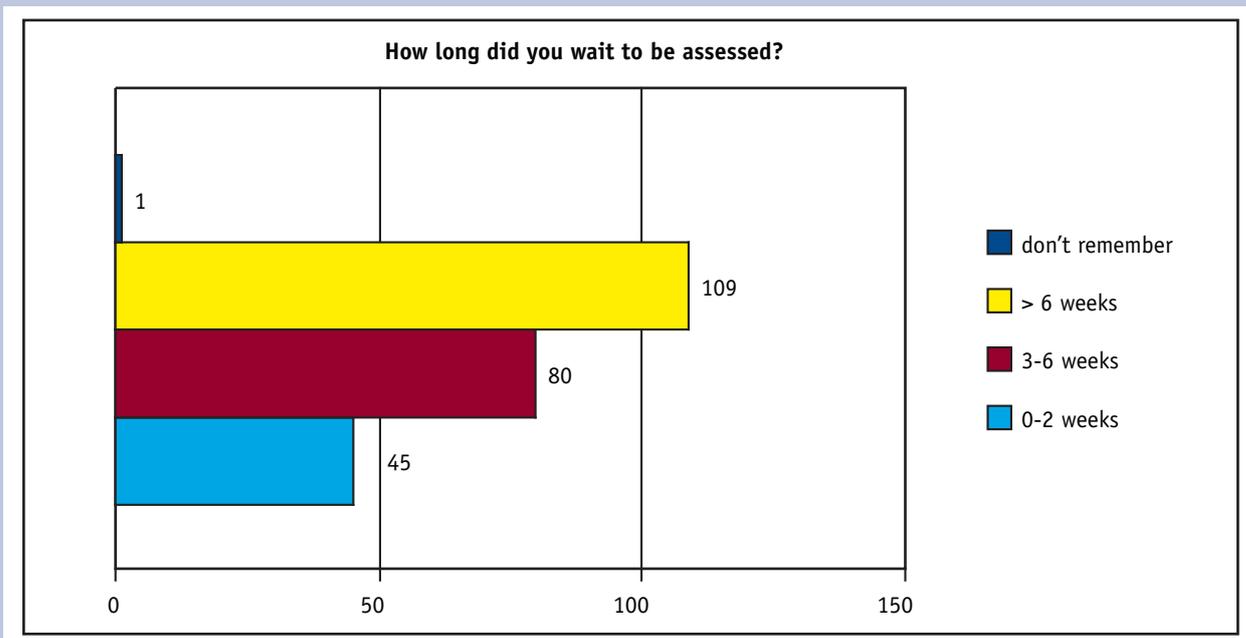


Base: 238 – No reply: 20



Question 3: How long did you wait to be assessed for your wheelchair?

The diagram below examines how long users waited to be assessed for their chair. Almost half of respondents waited in excess of 6 weeks. 34% waited for between 3-6 weeks with only 20% having their assessment within 2 weeks of requesting it.

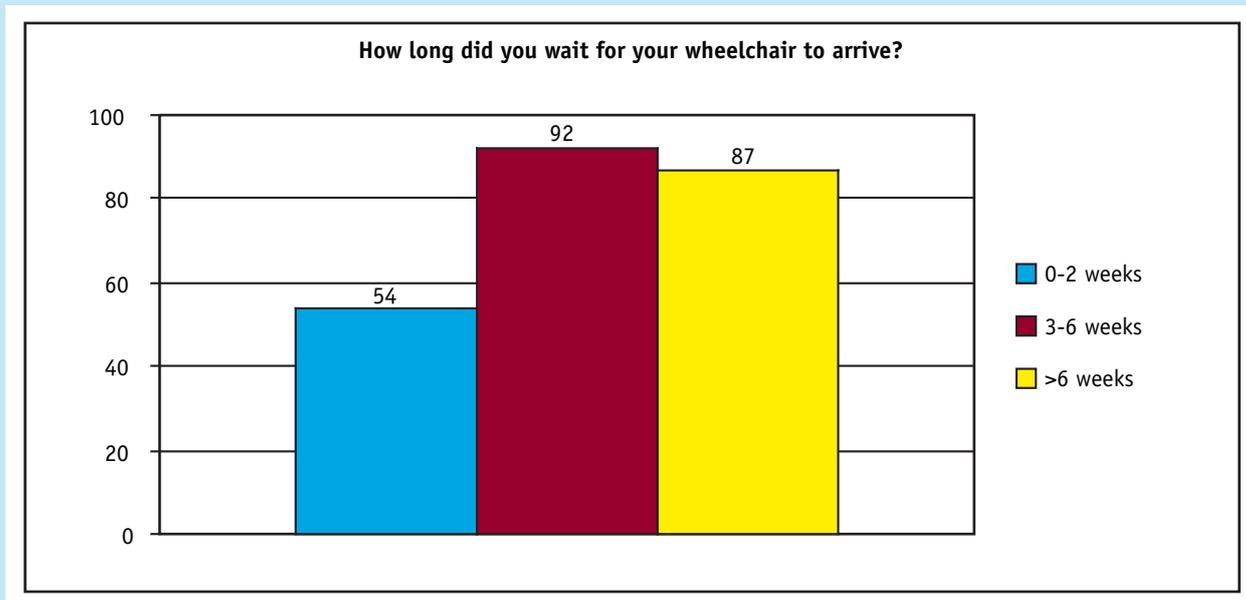


Base: 235 – No reply: 23



Question 4: How long did you wait after your assessment until the chair arrived?

Following assessment, the waiting time for users varied significantly. As is illustrated in the graph below, 37% of users had to wait in excess of 6 weeks for their chairs to arrive. 39% of respondents had their chairs delivered within 3-6 weeks of their assessment and 23% within two weeks of assessment.



Question 5: How did having to wait for your wheelchair affect you?

The following key themes and quotes provide a flavour of the response to this question.

Themes

- The main split was between those who said that they had been affected in a detrimental way by the wait from assessment to receiving their wheelchair and those who said they had not.
- There was a 'sliding scale' of how negative the affect had been ranging from slightly inconvenient to difficult, to very negative.
- As a direct result of the waiting time, a small number of respondents had been sitting in positions/chairs that led to conditions such as scoliosis.
- Many respondents had borrowed a wheelchair from the Red Cross and this service appeared to be important to wheelchair users, covering the gaps that the wheelchair services were not covering.
- Some respondents also had either a spare, 'old', or privately bought wheelchair that they could use whilst waiting for their NHS chair.
- For those who had been in hospital, either during or after the assessment, waiting for the wheelchair did not seem to be an issue.
- Many of those who were affected by the wait said that it reduced their quality of life by making them housebound and/or bed bound.

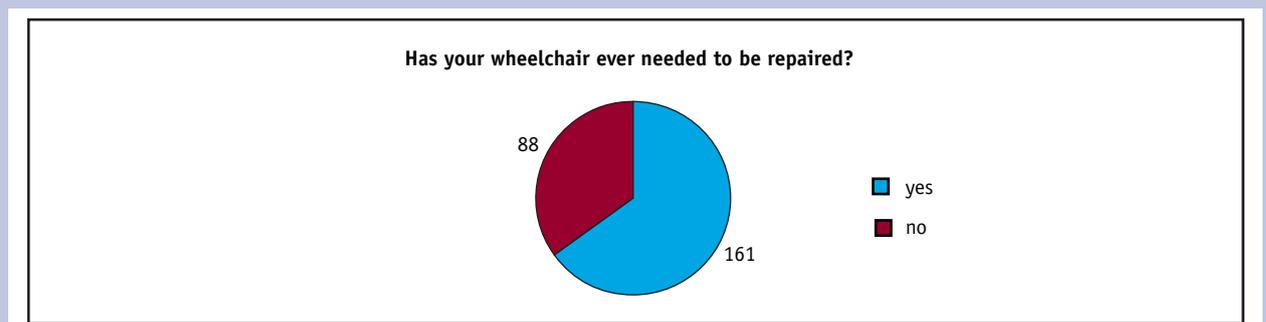


Quotes

- My daughter had a special pushchair, then a MacLaren junior buggy, before getting a wheelchair. She developed a curvature of her spine whilst we were waiting to be assessed and eventually got the wheelchair; I was told the curvature was due to the fact that she had long since grown out of the junior MacLaren buggy and I blame the hospital for not organising something sooner; she still has curvatures on her spine.
- I could not manage to get out and about. I was housebound.
- I was not able to sit properly and was uncomfortable and in pain.
- I have muscular dystrophy and my neck muscles and sitting position was deteriorating all the time. By the time I got the chair, my head was leaning on my shoulders.
- I was unable to walk so I was bed bound and I had to do everything in bed, including the toilet.
- Very quick service, 2 days.
- My daughter's posture got progressively worse as she was in a chair that was too small for over 1 year. She ended up having to have surgery on her hip.
- Not able to go out places. Having to rely on people for my mobility needs.

Question 6: Has your wheelchair ever needed to be repaired?

From the 249 respondents that replied to this question, 65% had had their chairs repaired in the past.

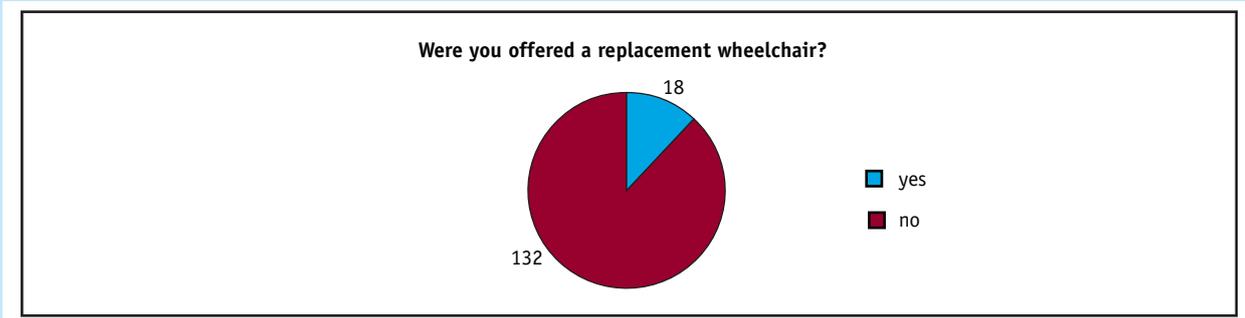


Base: 249 – No reply: 9



Question 7: Were you offered a replacement wheelchair while your wheelchair was being repaired?

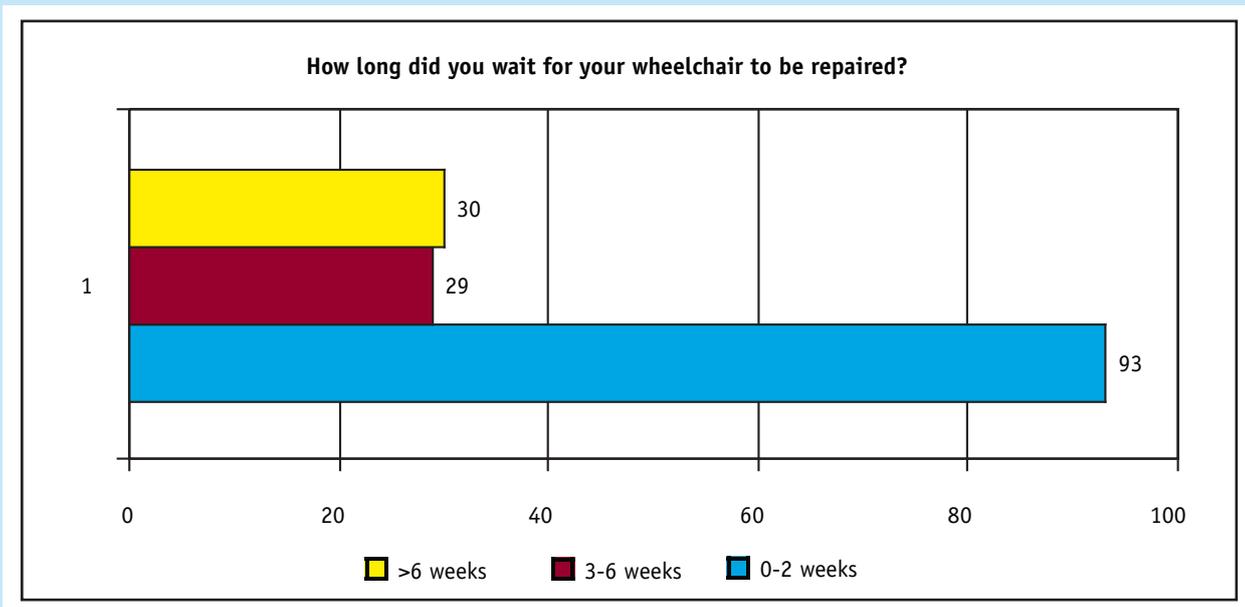
When asked if they had been offered a replacement wheelchair for the repair period, an overwhelming majority of 88% replied that they had not. Only 18 users (22%) were offered a replacement chair.



Base: 150 – Not asked=97 (due to question 6) – No reply=11

Question 8: From the time you reported a fault with your wheelchair, how long did you wait for it to be fixed?

The waiting time for wheelchair repairs varied significantly among respondents. 61% of respondents had their wheelchairs repaired within 2 weeks of reporting the fault and 19% within 3-6 weeks, however 20% of respondents to this question had to wait in excess of 6 weeks for their chairs to be repaired and returned.





Question 9: How did having to wait that length of time for your wheelchair to be repaired affect you?

The following themes came through in analysis and are supported by a number of quotes.

Themes

- As with question 5, the main difference is between those who were adversely affected and those who were not.
- Negative experiences were largely due to long waiting times for the repair to be made.
- For those who were affected, the main issue was the lack of mobility and being housebound and/or bed bound. This in turn affected the quality of life.
- It was highlighted that some of the chairs could be used while waiting for the repair. However, at times this compromised the safety of the respondent, i.e. if the problem was relating to the wheelchair brakes.
- Some respondents carried out temporary repairs themselves or got repairs done in local garages.
- The Monday to Friday, 9-5 repair service was viewed as inadequate. Weekend cover and/or emergency cover is required.
- Those who had bought their own wheelchair were struggling with repairs, as they are not covered by the wheelchair services repair service.
- Some respondents were very satisfied with the quick service they experienced.

Quotes

- Could not go out safely.
- I could not use my chair whilst waiting for the repair to be made so I was housebound.
- Wasn't affected as my chair was repaired the next day.
- Had to wait 3 months and couldn't use the chair whilst I was waiting. This was difficult at school.
- Self repaired as a temporary measure.
- Wheelchair needed repair on the Friday before my daughter arrived home, but there is no service from 3.30pm Friday until Monday morning, an absolute disgrace.



Section B

Question 1: Who first decided you needed a wheelchair?

The individual most commonly cited in relation to this question was a hospital specialist – the main influence for 94 respondents. 77 respondents said that their GP first decided that they needed a wheelchair. 13% of respondents cited more than one individual. In addition to those mentioned above, a small number of respondents also mentioned the following influences; 'wheelchair provider/service provider', 'carer' and 'school'.

Question 2: Who assessed what kind of chair you needed?

79% said the wheelchair centre or therapist assessed the type of chair needed; technicians, hospital consultants and bioengineers were also mentioned. 6% said more than one person was involved.

Question 3: Where did the assessment first take place?

Almost two thirds (61%) of respondents' assessments took place in either the 'hospital' or the 'wheelchair centre'. 55 respondents had their assessment at 'home', 12 in the medical centre and 9 in 'school'. 6 respondents had their assessment in two locations.

Question 4: Do you feel the assessment covered all of the areas it needed to?

71% of respondents felt that the assessment covered all of the areas it needed to, while the remaining 29% did not.

Question 5: If you answered 'NO' to the question above, can you describe what else it should have included?

Themes

- Respondents felt that they were not being listened to during the assessment.
- The assessment model should move towards a more holistic approach.
- The model lacks the flexibility that is required when assessing different people with different needs.
- The majority of respondents would like the following people to be involved in the assessment:
 - carers
 - family, and
 - physiotherapist.



- The majority of respondents would like the assessment to take into account:
 - carers abilities
 - type of car used
 - social life
 - medical condition
 - best clinical seating posture
 - lifestyle
 - accommodation
 - entry and exit barriers
 - neck/back support/extension
 - progression of disability, and
 - future development needs.

Quotes

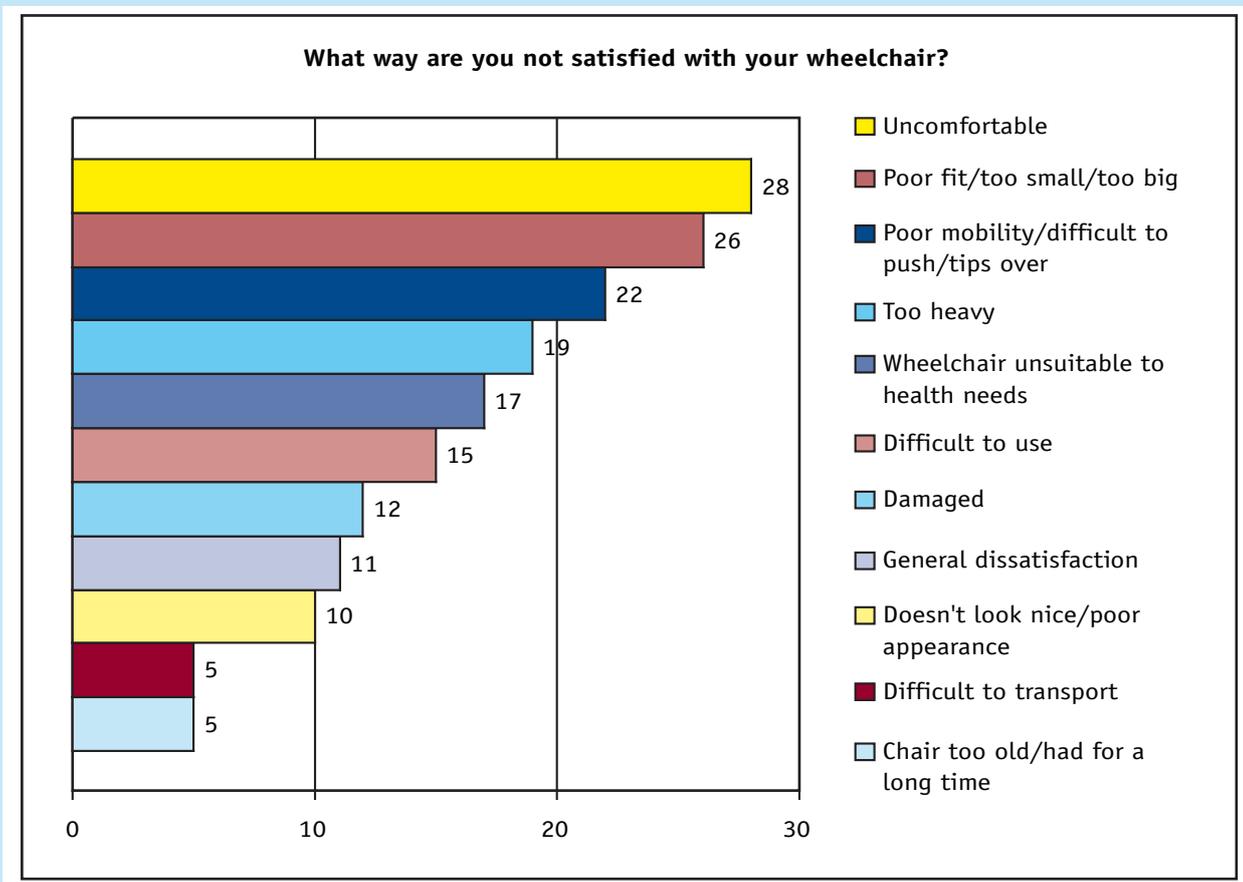
- Totally ignored medical condition! Social needs didn't even come into it.
- Not very good at looking at the whole person; me in my normal environment or good seating posture for me.
- The doctor did not take into account the family lifestyle and how the type of wheelchair would impact on my son's life. Nor did he ask what vehicle we had and if the wheelchair would fit.
- Not sure it was the most suitable chair I could have got.
- Was firstly told that one chair fits all and if we needed a chair we could push and see over, we would have to compromise my child's sitting position. We argued and said that we would not do this and asked if there was a chair that tilted low, and lo behold there was.



Section C

Question 1: Are you satisfied with the wheelchair you have now?

245 respondents replied to this question, of these, 59% reported that they were satisfied with the wheelchair they have now. The remaining 41% were not. The following graph illustrates reasons for dissatisfaction that were provided by users.



Base: 101 – No reply: 0

Question 2: If you answered 'NO' to the above question, can you describe in what way you are not satisfied with your wheelchair?

The most frequently cited reason for users not being satisfied was that their wheelchair was 'uncomfortable' (27% of respondents). The majority of users who reported that their wheelchair was uncomfortable were in the following age brackets: 17-45 (12 users) and 40-65 (11 users).



A similar number of users reported that 'poor fit/too small/too big' was the reason for their dissatisfaction. In total 26 respondents were unhappy with the fit of their chair, more than half of these respondents were in the 17-45 age group, with four aged under 16 and the remainder between 66-88.

'Mobility' was also a relatively big issue (this was mentioned by 21% of dissatisfied users). 22 users reported that they experienced difficulty with poor mobility. To provide a break down by age of respondents: nine were aged between 46-65, five between 17-45, four were under 16, three were between 66-80 and one was over 80.

Ten respondents were unhappy with the appearance of their wheelchairs. We expected that these respondents would tend to be younger users, however, analysis of data revealed that there is a spread across age groups. Four of those unhappy with appearance fell into the 17-45 age group, a further four were between 46-65, the final two were aged 80+.

A small number of respondents reported other reasons for their dissatisfaction, these included: 'noisy', 'provided with refurbished chair' and 'no review systems/poor review system'.

Question 3: Do you/your carer find your wheelchair easy to use?

72% of respondents reported that they, and/or their carer found their wheelchairs easy to use. Of the 69 respondents who had difficulty in using their chairs, 62% were aged between 46-80. Eight users under the age of 16 reported having difficulties using their chairs and a further 18 users aged between 17-45. No-one aged 80 or over reported any problems in this area.

Question 4: If you answered 'NO' to the above question, can you describe the difficulties you/your carer have using the wheelchair?

Themes

- The majority of respondents found the wheelchairs heavy and difficult to handle and fit in the boot of cars – this was an issue for all age groups.
- Many respondents identified the handles as a particular issue. They were often too high for the user, too low for the carer and generally difficult – this was an issue for all age groups.
- The general weight of the chair was a particular issue for the age group 46-61.
- It was highlighted that the wheelchairs were generally difficult to push and manoeuvre. The reasons given included:
 - wheels
 - control functions
 - stability, and
 - weight distribution to avoid tilting.



Quotes

- Too heavy, too cumbersome; does not dismantle sufficiently for storage in car.
- Handle bars too low for carer.
- Difficult to manoeuvre, particularly indoors on carpets.
- The only suitable place for the chair is a museum. It is prehistoric.
- The wheels on my manual wheelchair are small so it's hard to push up and down kerbs.
- It is old, rusty, heavy, falling apart and far, far too big for a small child.

Note: The vast majority of issues were the same for all age groups.

Question 5: Have you ever been refused a piece of equipment that you felt you needed?

25% of respondents reported that they had been refused a piece of equipment in the past. (247 users responded to this question in total.)

The most frequently cited piece of equipment refused was a 'power chair/electric wheelchair' this was mentioned by 31% of respondents to this question. 21% of respondents were refused 'wheelchair accessories' and 16% were refused 'different chairs', e.g. moulded, recline etc. A small number of respondents reported that they were refused the following: 'lighter chair' and 'financial help'.

Section D

Question 1: Apart from being assessed for your wheelchair, have you ever had contact with the wheelchair service?

Outside of the wheelchair assessment process, 58% of respondents had contacted the wheelchair service.

Question 2: If you answered 'YES' to the above question, can you tell us when and why you have been in touch with the service?

Of the 107 respondents who reported having contact with the wheelchair service (aside from assessment), 42% have had their wheelchairs replaced in the last year and 44% of respondents have had a replacement between the last 2-10 years.

Question 3: Did you find it easy to contact the person you needed to speak to in the service?

79% of those who had contacted the service relating to issues other than assessment found it easy to make contact with person they needed to speak with. (Base 140, No reply 5)



Question 4: If you answered 'NO' to the above question, can you describe the difficulty you experienced contacting the person you needed to speak to?

Themes

- It was repeated that it is difficult to get through on phone lines.
- A number of respondents also said that they did not even have the number of their wheelchair service and had to go through someone else, i.e. OT.
- It was common that respondents did not have their phone calls or letters responded to, despite leaving several messages.
- It was felt that those answering the phone calls knew too little about wheelchairs and wheelchair user issues.
- Many suggested that there appeared to be a lack of communication within the service itself and that this was one potential reason why phone calls were not returned.
- A number of respondents had been passed from 'pillar to post' without reaching the appropriate person for their query.

Quotes

- I was told I had to put my query in writing.
- Continuous phone calls but unable to reach the required person
- Can't get through.
- Left lots of messages but no-one phoned back for over 3 weeks.
- They said the people I needed to contact didn't carry a phone.

Question 5: If you needed an appointment, how long did you wait for one?

Respondents requiring an appointment with the wheelchair service for issues other than assessment, experienced various waiting times. 63% of respondents to this question had to wait longer than 14 days for an appointment. 37% of respondents were provided with an appointment within 14 days of requesting one.

Question 6: How did waiting for an appointment affect you?

Waiting for an appointment had various implications for wheelchair users, a number of key themes emerged during analysis and are provided below.



Themes

- For those waiting between 0-7 days, the majority of respondents reported no major detrimental affects.
- For those waiting 14+ days, the vast majority of respondents said that it had quite serious negative affects.
- The most common negative affect of waiting for an appointment were:
 - being house/bed bound
 - inconvenience
 - safety risks
 - discomfort, and
 - pain.
- Most respondents could not understand why getting an appointment was so difficult.
- Many said that they had been passed from person to person when trying to get an appointment.

The following are a selection of quotes provided by users who had to wait on appointments:

Quotes

- I could not take my wife out of the house.
- Managed to keep myself busy without the proper use of my chair, but after some time I couldn't keep my impatience any longer.
- Physically it hurts my body, mentally it is stressful and very depressing, and my condition gets worse.
- Several letter of complaints to NHS Chief Executives and local MP/MSP.
- Dissatisfied with the service and constant excuse of why I cannot get appointments and repairs.

Question 7: Did you get an appointment that suited you/your carer?

82% of wheelchair users who requested an appointment were provided with an appointment that suited them and/or their carers. 31 respondents did not provide an answer to this question.

Question 8: If you answered 'NO' to the above question, please give details.

(none given)



Question 9: When you contact the wheelchair service, do you always get enough information? (Question 10: If 'NO', please explain; Question 11: Is the information you get always easy to understand?; Question 12: If 'NO' how could it be made easier?)

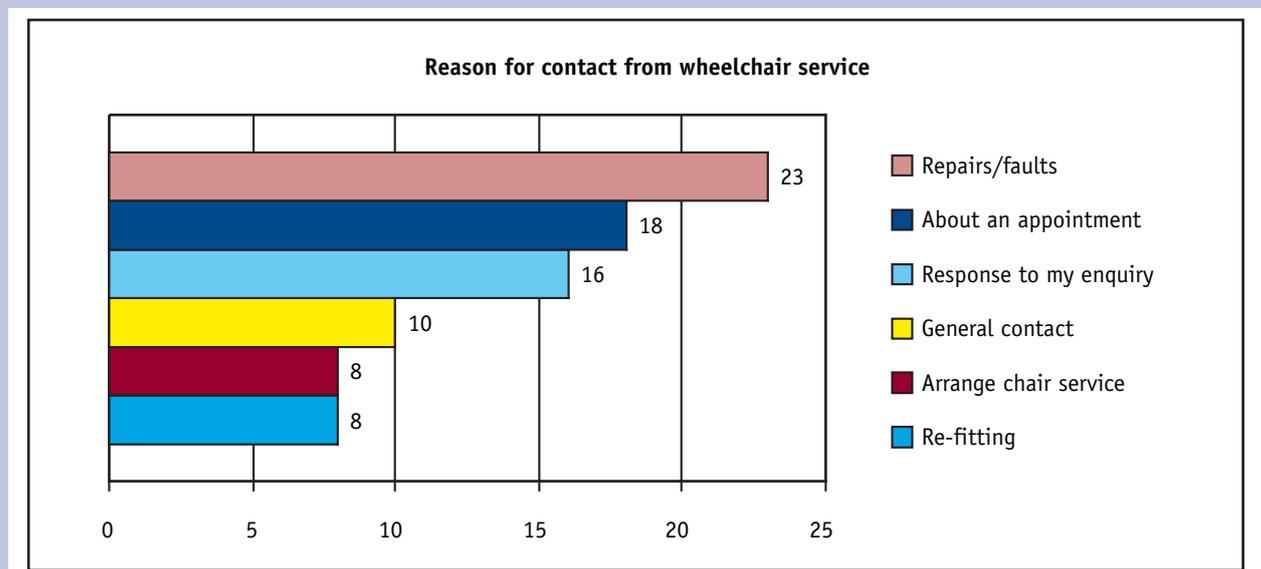
- 70% of those who contacted the wheelchair service, for issues other than assessment, said that they always got enough information.
- 82% of users who contacted the service felt that the information was easy to understand.

Question 13: Has anyone from the wheelchair service ever contacted you?

58% of respondents to question 27 had been contacted by the wheelchair service.

Question 14: If you answered 'YES' to the above question please give details.

Reasons for contact from the service are listed in the graph below. The most frequently cited reason for contact was regarding 'repairs/faults' (cited by 28% of respondents who had been contacted by the service). 23% of respondents to this question cited 'appointment' as the reason for contact. Other reasons for contact reported by a small number of respondents were; 'customer satisfaction/quality control' and 'user group meetings'.



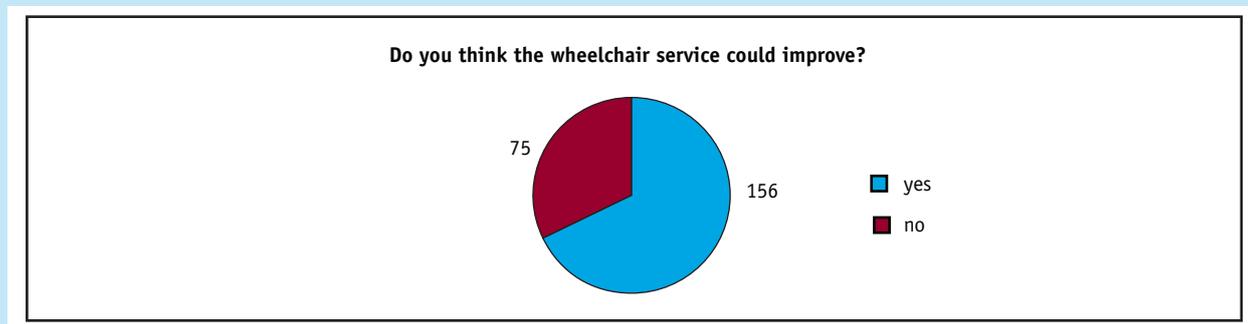


Section E

Question 1: Do you think the wheelchair service could improve?

68% of respondents believe that the wheelchair service could improve.

Of the 75 respondents who felt that that no improvements were necessary, 56% were aged between 16-65, with the remainder aged 65+.



Base: 231 – No reply; 27

Question 2: If you answered 'YES' to the above question, please give details of how you think it could improve.

A high percentage of respondents felt that the service could improve and provided a wide range of suggestions. The following are some of the key themes, which emerged in analysis.

Themes

- Repair:
 - local repairs
 - quicker repairs
 - annual or 6 monthly service like an MOT
 - weekend breakdown cover, and
 - include privately bought wheelchairs.
- Communication:
 - respond to letters and phone calls
 - increased and improved information provision
 - easier to get hold of, and
 - open 7 days per week.



- Staff:
 - nicer
 - more knowledgeable, and
 - increased training.
- Assessment:
 - holistic approach (lifestyle/family/carer/etc)
 - redefine eligibility criteria
 - flexible criteria
 - home visits, and
 - automatic follow-up and review after receiving equipment.
- Choice:
 - different chairs
 - wheels
 - fittings
 - new technologies
 - comfort, and
 - options for powered and manual chairs.
- Other:
 - more funding
 - suit service to user – not the other way around
 - improved access to appointments
 - reduced waiting times
 - seamless referrals
 - local service, and
 - voucher system.

The following are a selection of quotes from respondents regarding potential improvements to the service.



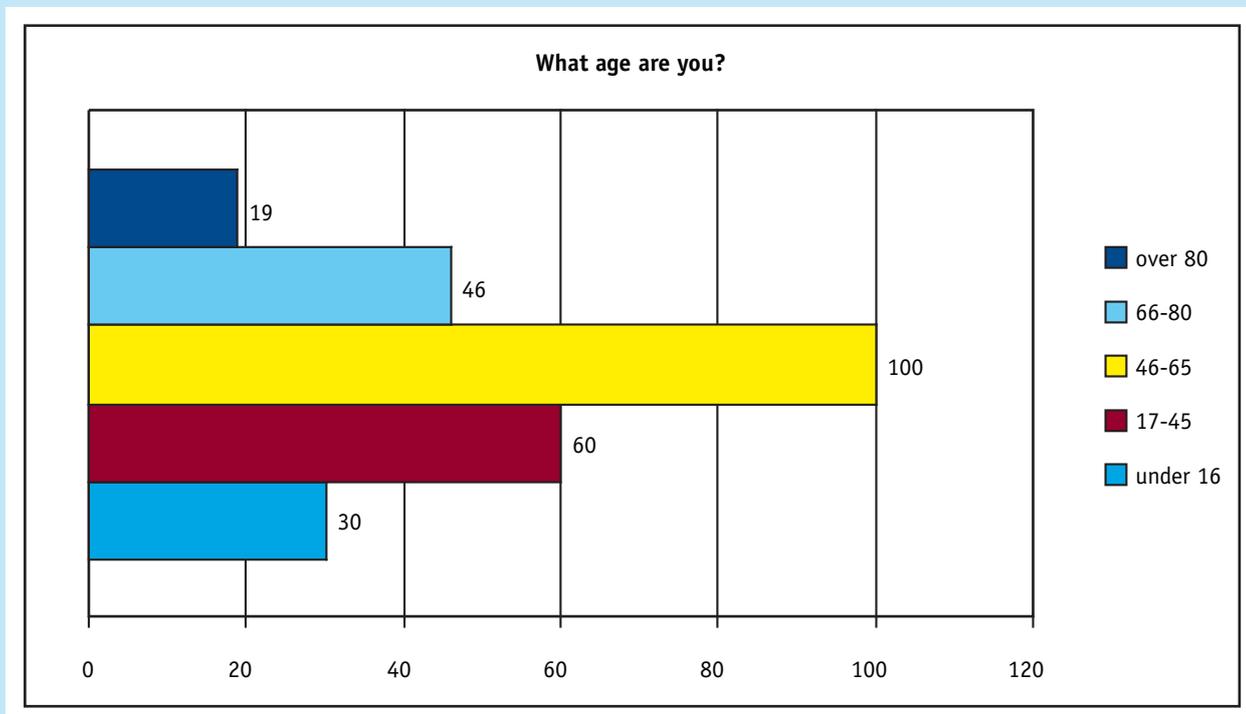
Quotes

- I think they should hold clinics outwith Aberdeen, as it is difficult and time consuming having to travel to Aberdeen (a busy city) when a lot of the assessments can be carried out at clinics nearer the wheelchair user's home.
- Regular 6-monthly service checks of all chairs used by full-time users.
- Need to take account of whole lifestyle/circumstances when assessing wheelchair needs.
- More staff and more money.
- Adopt a customer driven culture. It is a 'service'. Embrace social inclusion and move away from prescriptions on medical need. Recognise lifestyle. Adopt a culture of 'get it right the first time'.

Section F

Question 1: What age are you?

We have had a good response rate across all ages. A broad age group responded, with particularly high number of responses from 46-65 year olds.



Base: 255 – No reply: 3



Questions 2 and 3: What is your postcode, which wheelchair service do you use?

Table 1 Wheelchair Services

Wheelchair Service	No of respondents	As % of overall respondents
Aberdeen (MARS)	20	8
Dundee (TORT)	53	22
Inverness (Raigmore)	21	9
Edinburgh (Mobility Centre)	33	14
Edinburgh (Children's Centre)	2	1
Glasgow (WESTMARC)	113	47

Base: 242 – No reply: 16



annex b: public consultation paper

Formal Consultation Paper

NHS Review of Wheelchair and Special Seating Services in Scotland

Your Responses to the Consultation Paper

Outlined below are the options from the consultation paper. Please indicate which one of each group you support by ticking the relevant box.

Thank you for taking the time to give us your responses.

Section 1 Structuring the Service, Making it Local

Which of these options do you support? (please tick one of the following four boxes)

Option 1A Maintain the five centres as at present, but with more outreach clinics

OR

Option 1B Increase the number of service centres, splitting the Glasgow and probably the Edinburgh centre, with additional outreach clinics; less complex cases could be seen locally in outreach clinics with more complex cases being seen in the seven/eight regional centres

OR

Option 1C Restructure the service across Scotland to meet user needs, taking account of geographical and demographic patterns, along the lines of some of the models seen in other countries

OR

Option 1D No change to the current structuring of the service



Section 2 Making the Service Accountable

Which of these options do you support? (please tick one of the following three boxes)

Option 2A Maintain a regionally managed service, but introduce nationally agreed standards and performance targets to ensure equity of service

OR

Option 2B Have a single wheelchair service co-ordinating body for Scotland, responsible for all wheelchair centres, and funded directly by Scottish Executive Health Department, responsible to them and managed by a single organisation

OR

Option 2C No change to the current accountability of the service

Section 3.3 Assessment

Which of these options do you support? (please tick one of the following three boxes)

Option 3.3A The NHS wheelchair service continues as the sole assessor for wheelchairs and special seating, but with assessment separated from provision of equipment

OR

Option 3.3B The NHS regional centres assess complex cases only, while users with less complex needs are assessed in the community and by community based professionals, whether employed by the NHS or by local authorities

OR

Option 3.3C No change to the current assessment process



Section 3.4 Follow up and Reassessment

Which of these options do you support? (please tick one of the following two boxes)

Option 3.4A The initial assessment process should include a date for the next planned assessment or contact for the wheelchair user and this should be based on that individual's own situation. The wheelchair service – or community-based staff – should take responsibility for ensuring that this happens

OR

Option 3.4B No change to the current follow up and reassessment Process

Section 4 Provision of Equipment

Which of these options do you support? (please tick one of the following three boxes)

Option 4A The NHS continues to provide all wheelchairs following assessment

OR

Option 4B Provision of wheelchairs is devolved to a multiplicity of providers, including the NHS where appropriate (for example for very complex provision)

OR

Option 4C No change to the current method of providing equipment



Section 5 Maintenance of Equipment

Which of these options do you support? (please tick one of the following four boxes)

- Option 5A** The wheelchair centres continue to run the maintenance and repairs system, but with a programme of planned preventative maintenance (PPM) introduced in all centres
- OR**
- Option 5B** The NHS contracts out all minor repairs to accredited local providers, for example, garages and bicycle repair shops. This could be combined with a PPM being run by wheelchair centres
- OR**
- Option 5C** The entire maintenance and repairs service is contracted out to external providers
- OR**
- Option 5D** No change to the current method of maintaining equipment

Section 6 Gap Analysis of Equipment Provision

children
 young adults
 people with degenerative disease
 people with limited functional mobility
 carers
 the terminally ill
 those with temporary disability

Do you agree that these are the key gaps? (tick 'yes' or 'no') Yes No

Are there any additional gaps? (please list below)



Section 7.1 Staffing

Which of these options do you support? (please tick one of the following two boxes)

- Option 7.1A** NHS Education for Scotland should conduct a Training Needs Analysis for wheelchair services staff
- OR**
- Option 7.1B** No change to the current staff training opportunities

Section 7.2 Staffing Skill Mix

Which of these options do you support? (please tick one of the following two boxes)

- Option 7.2A** Staffing of wheelchair centres and outreach clinics should be based on national agreement about numbers and skill-mix levels, but should be flexible enough to allow for local recruitment conditions. The skills of medical staff should be reserved for those individuals who need complex or additional clinical intervention.
- OR**
- Option 7.2B** No change to the current staffing establishment

Section 8 Funding

Which of the funding schemes outlined in the report seem attractive to you?

(please tick 'yes' or 'no' for each of the schemes listed below)

- | | | |
|------------------|------------------------------|-----------------------------|
| Flexible Funding | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Leasing Schemes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Hire Purchase | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

annex c:

NHS QIS report on public consultation



NHS QIS Report On Formal Consultation

Final analysis of responses to consultation paper received by 27 January 2006

Comments on the consultation paper were invited from 14 November 2005 until the consultation period closed on 27 January 2006. The consultation paper was distributed to over 150 professional, patient and charitable organisations including GP practices, the College of Occupational Therapists, Directors of Social Work, Scottish Society of Rehabilitation, Local Access Panels, Disability Resource Centres, Barnardo's and Sense Scotland. In addition, a version of the consultation response questionnaire was posted on the NHS Quality Improvement Scotland website. The website version contained the same list of questions as the paper version, but in addition asked respondents to give their name and contact details including their organisation if applicable.

The consultation paper invited comments in the form of a questionnaire with space for free text responses. The responses to this questionnaire are given below. For the questions relating to Sections 1, 2, 3.3, 3.4, 4, 5, 7.1, 7.2 and 8, respondents were asked to select one option from two or more possible alternatives. Some respondents did not choose any of the given alternatives and some chose more than one option and this has been shown in the tables below. However, these respondents have been omitted from the calculation of percentages of responses indicating support for a particular option.

Responses given below have been categorised as originating from an organisation/group; as from an individual or as of unknown origin. Where a respondent included information making it possible to determine if they were responding on behalf of a group, or as an individual, this was recorded as such. Where there was no indication on the response form or covering letter etc, the response was recorded as coming from an unknown source.

Section 1: Structuring the Service, Making it Local

In relation to the structure of the service, four possible alternatives were given in the consultation paper. Most of the respondents chose the option to increase the number of service centres with additional outreach clinics or a restructuring of the service across Scotland to meet user needs along the lines used in other countries. However, fewer respondents representing groups indicated the latter option to be preferable.



Preferred option	Number of respondents			
	Group (n=48)	Individual (n=110)	Unknown (n=350)	Total (n=508)
1A Maintain five centres with additional outreach clinics	8 21.1%	15 14.6%	70 20.5%	93 19.3%
1B Increase the number of service centres and add additional outreach clinics	20 52.6%	34 33.0%	129 37.8%	183 38.0%
1C Restructure the service across Scotland	9 23.7%	52 50.5%	122 35.8%	183 38.0%
1D No change to the current structure	1 2.6%	2 1.9%	20 5.9%	23 4.8%
More than one option selected	3	4	6	13
Missing/no answer	7	3	3	13

Section 2: Making the Service Accountable

With almost 60% of respondents selecting the first option, there was a clear preference to maintain a regionally managed service with nationally agreed standards and performance targets. This preference held across the three categorisations of respondents.

Preferred option	Number of respondents			
	Group (n=48)	Individual (n=110)	Unknown (n=350)	Total (n=508)
2A Maintain regional management with measures to ensure equity	25 64.1%	61 58.1%	203 59.2%	289 59.3%
2B A single co-ordinating body	12 30.8%	43 41.0%	123 35.9%	178 36.3%
2C No change to current accountability arrangements	2 5.1%	1 1.0%	17 5.0%	20 4.1%
More than one option selected	2	2	0	4
Missing/no answer	7	3	7	17



Section 3.3: Assessment of Simple and Complex Needs

There was a clear preference among respondents for NHS centres to assess complex cases only, with users with less complex needs assessed in the community and by community-based professionals, whether employed by the NHS or by local authorities. This option was supported by almost 75% of respondents and this preference held for each of the respondent categories.

Preferred option	Number of respondents			
	Group (n=48)	Individual (n=110)	Unknown (n=350)	Total (n=508)
3.3A NHS service is sole assessor but separated from provision	3 7.9%	15 15.6%	50 14.6%	68 14.3%
3.3B NHS centres assess complex cases only	31 81.6%	74 77.1%	252 73.5%	357 74.8%
3.3C No change to current service	4 10.5%	7 7.3%	41 12.0%	52 10.9%
More than one option selected	0	1	0	1
Missing/no answer	10	13	7	30

Section 3.4: Follow-up and Reassessment

The overwhelming majority of respondents (91%) indicated a preference for the initial assessment process to include a date for the next planned assessment or contact for the wheelchair user and this should be based on that individual's own situation. The wheelchair service – or community-based staff – should take responsibility for ensuring that this happens.

Preferred option	Number of respondents			
	Group (n=48)	Individual (n=110)	Unknown (n=350)	Total (n=508)
3.4A Initial assessment should include personal plan for follow-up	37 90.2%	102 94.4%	314 90.2%	453 91.1%
3.4B No change to current follow-up	4 9.8%	6 5.6%	34 9.8%	44 8.9%
More than one option selected	0	0	0	0
Missing/no answer	7	2	2	11



Section 4: Provision of Equipment

The majority of respondents (54%) indicated a preference for the NHS to continue to provide all wheelchairs following assessment over provision of wheelchairs being devolved to a multiplicity of providers, including the NHS where appropriate.

Preferred option	Number of respondents			
	Group (n=48)	Individual (n=110)	Unknown (n=350)	Total (n=508)
4A NHS continues to provide all wheelchairs following assessment	23 59.0%	50 48.5%	191 55.0%	263 53.8%
4B There are a number of providers, including the NHS	13 33.3%	49 47.6%	137 39.5%	200 40.8%
4C No change to current equipment provision	3 7.7%	4 3.9%	19 5.5%	26 5.3%
More than one option selected	0	0	0	0
Missing/no answer	9	7	3	19

Section 5: Maintenance of Equipment

There was an almost equal division of support for the wheelchair centres to continue to run the maintenance and repairs system with a programme of planned preventative maintenance and for the NHS to contract out all minor repairs to accredited local providers. Respondents representing groups were more likely to indicate a preference for the former alternative.

Preferred option	Number of respondents			
	Group (n=48)	Individual (n=110)	Unknown (n=350)	Total (n=508)
5A Centres continue with maintenance and repairs with addition of planned preventative maintenance (PPM)	23 57.5%	42 40.0%	147 43.6%	212 44.0%
5B NHS contracts out minor repairs to contractors with PPM at wheelchair centres	14 35.0%	46 43.8%	146 43.3%	206 42.7%
5C All repairs and maintenance contracted out	2 5.0%	14 13.3%	24 7.1%	40 8.3%
5D No change to current service	1 2.5%	3 2.9%	20 5.9%	24 5.0%
More than one option selected	1	1	4	6
Missing/no answer	7	4	9	20



Section 6: Gap Analysis of Equipment Provision

Of the 460 respondents who answered the question, 423 agreed that the list covered the key gaps and 37 respondents did not agree these were the key gaps.

Respondents were given the opportunity to identify additional gaps, and 119 responses were provided. The majority of these, however, did not highlight further gaps, but provided more detailed information on the areas of provision already listed in the report. Some respondents gave responses relating to gaps in provision when asked for 'any other comments' at the end of the questionnaire. The responses given there are included in the discussion of these general comments.

Eleven of the responses received related to specific aspects of children's services. Firstly the lack of provision of specialised chairs (eg with three wheels or with bigger tyres) for children living in rural areas and farms was highlighted. Also noted was the difference that the provision of a wheelchair can make in determining whether a child is able to attend mainstream school or not. The transition from child to adult services at the age of 18 was felt to be poorly managed, and at the other end of the age scale, services for the under 5s were considered inadequate. Respondents believed that there should be specific staff dedicated to children's services.

Three respondents identified people with progressive diseases as a gap area in equipment provision, noting how disability can change gradually and the associated impact on the carer(s). Carers as a whole, were identified by four respondents as being inadequately considered in the provision of equipment. This has implications for the carer and the wheelchair user.

Two responses related to people with limited functional mobility. Both centred on the need for some individuals falling into this category to have access to a powered chair for outside use, even though they might not be eligible or able to have a powered chair for indoor use.

As well as the temporary need for a chair following injury or an operation, temporary provision is also required for specific occasions such as holidays, visiting relatives and attending health centres. Temporary provision was highlighted by 12 respondents as being inadequate.

Areas with gaps in provision, not already highlighted in the report and mentioned by those questioned, included the elderly, particularly in rural areas, (21 responses), individuals over 25 stones, which has major implications for carers (12 responses), nursing/care home residents (8 responses), learning disabled adults with postural management issues (5 responses), people with particular physical problems such as heart conditions, diabetes and amputees (4 responses), and individuals living alone with no carers (5 responses).



The provision of specialist chairs (15 responses), powered chairs (16 responses) and also specialised seating (8 responses) was highlighted frequently as a gap in provision. There was felt to be a gap between the basic chair provided to some users and that actually required to suit their lifestyle. Examples include the supplying of specialist sports chairs for people whose wellbeing is geared around sports, or the provision of a head rest and tilt-in space facility for those needing to rest during the day. Likewise, accessories such as cushions and leg rests, which are key to the comfort of the user, are often not available as required. Respondents felt very strongly that the eligibility criteria for powered chairs needed to be broadened to include people who were able to manage without a chair in their own home, but required a chair for outdoor use. Specialist seating for those with progressive diseases, and with complex postural difficulties, is felt to be a neglected area and should be considered in conjunction with the provision of chairs.

Lastly, 21 responses were provided which related to the structure, funding and running of the wheelchair service rather than directly to the gaps in the provision of equipment. These included comments on the need for a more holistic approach to the assessment of clients for chairs, and a desire for a more responsive, customer driven service.

Section 7.1: Staffing

With 95% of respondents indicating support, the overwhelming majority of respondents would prefer that NHS Education for Scotland (NES) should conduct a training needs analysis for wheelchair services staff.

Preferred option	Number of respondents			
	Group (n=48)	Individual (n=110)	Unknown (n=350)	Total (n=508)
7.1A NES should conduct training needs analysis	38 97.6%	100 97.1%	318 93.5%	456 94.6%
7.1B No change to current staff training	1 2.6%	3 2.9%	22 6.5%	26 5.4%
More than one option selected	0	0	0	0
Missing/no answer	9	7	10	26



Section 7.2: Staffing Skill Mix

An overwhelming majority of respondents (93%) indicated that staffing of wheelchair centres and outreach clinics should be based on national agreement about numbers and skill-mix levels, but should be flexible enough to allow for local recruitment conditions with the skills of medical staff being reserved for those individuals who need complex or additional clinical intervention.

Preferred option	Number of respondents			
	Group (n=48)	Individual (n=110)	Unknown (n=350)	Total (n=508)
7.2A Staffing should be flexible with medical staff reserved for assessment of those with complex needs	36 97.3%	100 96.2%	315 92.1%	451 93.4%
7.2B No change to the current staffing establishment	1 2.7%	4 3.8%	27 7.9%	32 6.6%
More than one option selected	0	0	0	0
Missing/no answer	11	6	8	25

Section 8: Funding

Respondents were asked to indicate which of a number of funding schemes they would find attractive. Flexible funding found greatest support with respondents, with 66% indicating support for this option. Least support was given to hire purchase schemes which was supported by only 30% of respondents.

Preferred option	Number of respondents indicating yes to form of funding			
	Group (n=48)	Individual (n=110)	Unknown (n=350)	Total (n=508)
Flexible funding	24 50.0%	80 72.7%	231 66.0%	335 65.9%
Leasing schemes	12 25.0%	58 52.7%	204 58.3%	274 53.9%
Hire purchase	8 16.7%	33 30.0%	113 32.2%	154 30.3%
Gave no positive response to any of the funding options	21	18	58	97

NB: Respondents could indicate more than one type of funding scheme to be attractive, therefore, columns total more than 100%.



Other comments

The final section on the consultation response form gave respondents the opportunity to specify 'Any other comments' that they wished to make. A significant proportion of respondents used this section to provide comments on specific sections of the consultation, some giving the rationale for the responses they had given in some or all of the sections, whilst others made general comments or comments on topics not covered in the consultation. All the comments were analysed to identify the major themes emerging, and in addition to the areas corresponding to sections in the consultation response form, seven additional themes were identified. In total then there were 13 themes emerging which were as follows: Structure of the service; Accountability; Assessment; Provision of equipment; Maintenance of equipment; Staffing; Funding; Current service; Reuse of chairs; Exemplar services; Integration with other bodies; Children's issues; Provision of information. Each of these themes, and their related issues, is discussed in detail below. As this thematic analysis approach was adopted, it should be noted that not all comments given are covered. Some comments provided were very lengthy so this summary can only offer a flavour of the material covered. Not surprisingly, the greatest number of responses centred on funding.

Structure of the service

A desire for more local services was expressed, particularly for maintenance. There would be considerable benefit in having local clinics for people with complex needs who often find it very difficult to travel to centres. This could include clinics in schools for children with complex needs. Local staff are more likely to know and understand the environment and situation of the client. Definitions are required, however, on what exactly is meant by outreach clinics, satellite clinics and regional centres, and the level of provision that they would each offer. Also efforts must be taken to ensure equity of service to avoid 'postcode provision'. Further research into the location of the clinics was suggested, taking into account demographic trends.

Accountability

There was a strong feeling among respondents that standards and targets were required to improve the service provided. Benchmarking and auditing were also considered appropriate. All relevant professions, as well as users and carers, should be involved in agreeing appropriate measures to be assessed. It was noted that work had already been done in this area as part of the ReTIS project (<http://www.retis.scot.nhs.uk/>) and that this should be built upon in the future.



Assessment

Separating the assessment and provision components of the wheelchair service was generally not looked upon favourably. It was felt that the assessing and providing of a chair was an iterative process and therefore the two components could not be effectively separated. Also greater delays could result from the need to transfer information between two services. This issue was felt to be strongly linked to resourcing and it was suggested that if wheelchair services were adequately funded, there would be no conflict between prescribing the most appropriate device and providing that device. Some respondents suggested, however, that assessment has been successfully separated from provision elsewhere, and the example of the Greater Glasgow Independent Living and Equipment Service was given. Having the two aspects separated would highlight clearly unmet needs.

As evidenced by the large percentage of respondents selecting Option 3.3B, assessing less complex user needs in the community was felt to be a sensible option. It was stressed by many of the respondents, however, that additional resources would need to be made available to community staff to enable them to take greater responsibility in this area. Also noted was the need for good joint strategic and operational planning between the NHS and local authorities to ensure professional and managerial accountability if responsibility for assessment was spread out. Some of the more negative responses to Option 3.3B expressed concern over cases which might appear superficially simple, but would actually require complex assessment, and others suggested that community staff should receive training in appropriate referral rather than undertaking assessments.

While having a planned review assessment was considered a good idea, respondents were clear that firstly more resources need to be made available to allow this to happen, and secondly that the timing and details of this review should reflect individual need and not be one size fits all. Audits could be undertaken to determine best practice in reviews for different client groups. Some respondents did worry about the cost-effectiveness of review visits for all and suggested, instead, the use of routine telephone follow-up and improving education for professionals so that they are more alert to indications for reviews. Individuals should always have the option to self refer if they feel that they require a review assessment sooner than the specified date.

A view coming out strongly throughout many of the responses was the need to adopt a holistic approach to wheelchair assessment. Consideration must be given to the whole lifestyle of the client and not just their medical needs. The long-term health needs of the client must also be taken into account and wheelchair/seating services should form part of a total postural care package.



Provision of equipment

Some respondents felt that having the NHS as the sole state supplier of chairs would ensure that clients were assessed by staff with appropriate skills and provided with chairs that were suitable for them. Others felt that having a multiplicity of wheelchair providers would be similar to the situation for other aids and would increase patient choice.

Currently the range of NHS chairs is felt to be very restricted. Comparisons were drawn between prosthetics where state of the art high tech equipment is supplied, and the unavailability from the NHS of chairs employing modern design technology. Consideration needs to be given to chairs for rural locations, greater provision of powered chairs, reducing effort for carers in manoeuvring chairs, and the provision of more than one chair to some clients. A national evaluation of equipment involving users and providers, would encourage changes and improvements in design.

Lack of availability of chairs for nursing home residents was a concern to a number of respondents. The wheelchair services expect the nursing homes to provide the chairs, but this frequently doesn't happen, leaving individuals having to use someone else's chair or provide their own. There are also considerable delays in patients in hospitals receiving chairs, resulting in inability to access rehabilitation services, and the risk of falls and pressure sores.

Maintenance

In-house maintenance was felt by many to be the most cost-effective option, offering more control over standards and performance. WESTMARC brought maintenance in-house and this was thought to have resulted in significant improvements in the service provided.

It was felt by several respondents that more information on the costs and benefits of PPM was required to enable them to make an informed decision regarding this option. Most seemed keen on the idea, suggesting that the scheme would help to maintain equipment at a high level, but felt that significant additional funding would be required. A risk management approach to PPM could perhaps be adopted to control some of the costs. The need for such a system in terms of fulfilling health and safety requirements was noted.

Opinions on the use of local providers to offer a maintenance service varied. Some queried whether small providers would want to develop the necessary infrastructure. It was stated that the AA/RAC had been approached previously on this matter, and had not been keen. AA/RAC vans are too full already to permit the carrying of additional spares and equipment. Others felt that garages and bike shops could provide a useful service reducing delays for users, especially in remote areas. It was suggested that users themselves be allowed to keep spares if they wish. Puncture free tyres are now available cutting down the need for this type of repair.



Whatever their views on where responsibility for the maintenance of equipment should lie, respondents wanted a flexible, easily accessible service with evening and weekend cover. Users should be able to contact the service electronically. Appointment times should be specified and the service should stick to these. It appeared that repairs are often done in the user's home, but when chairs are taken away, a like for like replacement should be provided.

Staffing

Respondents strongly supported the role of NHS Education for Scotland (NES) carrying out a training needs analysis for wheelchair services. It was also felt that NES should have a role in defining the skills required to provide for a more devolved service and that detailed workforce planning should be undertaken. Wheelchair centres would be best staffed by a multidisciplinary team to cater for all aspects of the user's needs. The implications for training, if there are a greater number of local services, were highlighted and also the challenges in recruiting bioengineers and certain allied health professional (AHP) posts noted. It was suggested that wheelchair centres could provide employment for disabled people, both in administrative posts and in the repair and maintenance of wheelchairs.

A number of comments and suggestions were made regarding the staff training that should be provided, with the involvement of service users considered to be crucial. It was felt that there should be more informal sharing of ideas and experiences between centres, and that shadowing would be very useful. Manufacturers and suppliers could be asked to give training courses at their own expense. In terms of particular staff groups, it was suggested that therapists in hospitals and social work services could have rotations or secondments to the wheelchair service as part of their continuing professional development (CPD). All relevant hospital staff should have training on wheelchair health and safety issues and maintenance. The training needs of carers must also be considered. Staff in wheelchair centres need improved customer care skills.

Funding

The most common point made in the response form was the need to increase funding for wheelchair services. In terms of how this funding should be organised, there were a variety of responses. Respondents were nearly all in favour of a more flexible system to meet user needs, however while some favoured the options suggested in the consultation report, including multiple options to suit varied needs, others felt that all funding should be through the NHS to ensure equity of provision. Other approaches might lead to two-tier systems. They felt that all clients should have access to increased choice, but through the NHS. Some respondents felt that wheelchair users already have significant additional expenses as a result of their conditions and should not be asked to pay additionally for what they considered to be a basic right. Having to finance a chair would add to the stresses and strains already being experienced. Whatever approach was adopted, respondents felt that a one-year pilot should be carried out in a single location before rolling out the scheme to the whole of Scotland.



There was some support put forward for voucher or top-up systems, with some respondents feeling that it would enable greater user-led assessment and choices, and noting that the opportunity to fund extras could have a huge impact on self worth and mobility. Others suggested that it would promote inequity and inequality, result in extra costs for patients and extra administration for the NHS. It was alleged that such a voucher scheme was fraught with problems when it was introduced in England, with uptake being much higher in affluent areas. According to one respondent, a health economic analysis of the English scheme concluded that it was not cost effective.

A variety of opinions were expressed on the suggestion of sharing wheelchair funding between agencies. Most respondents felt that this would not be a good idea, with some suggesting that it would be a 'logistical nightmare', or that other agencies do not have sufficient resources either. A view was expressed by others, however, that responsibility for costs should be shared, for example with education for chairs required for schools and Further Education use, and the Department of Work and Pensions for chairs required mainly for work. Some respondents noted that this was already taking place. It was suggested that under the Joint Futures agenda, it might be possible to justify the provision of very complex expensive equipment resulting in gains for one agency, by that service cross-funding the provider of that equipment.

Leasing/hire purchase schemes did not gain much support. They were thought unlikely to be cost effective – indeed one respondent states that such systems had been found not to be effective when costed by Scottish Health Service Supplies. Concerns were expressed about what would happen to customised chairs at the end of the lease periods, how the length of the lease periods would be determined, and the unsuitability of such arrangements for clients with rapidly deteriorating or terminal conditions. It was suggested however that leasing might be more popular than outright purchase as chairs do not hold their value.

Several general concerns emerged in relation to all- or part-funding, by clients. Firstly it was felt that national procurement saves money. Any cost reduction through competition generated by having a multiplicity of providers is likely to be offset by a loss of bulk purchasing power to the NHS. There was a lack of clarity about where the responsibility for assessment would lie when purchasing privately. It was felt that clients would still need advice from the NHS to determine the most suitable product for them. There was a potential for them to buy equipment not appropriate to their needs. There are also issues around ownership and responsibility for maintenance. It is not clear whether the NHS would continue to carry out maintenance on these chairs. Also, many users require major adaptations to their chair, and it is uncertain who would finance these. Some respondents were worried that their Motability allowance would be required for wheelchair purchasing, when this is already used up in purchasing a car.



A number of respondents pointed out that there was insufficient information available on the costs and benefits of each suggested funding option to allow them to make an informed choice.

Current service

Respondents felt that the current service is inadequate. In particular, the lack of flexibility in the system was noted. A far more flexible system which can allow for the growth of children, the need for power chairs for outdoor use, varied carer needs and the terminally ill, is required. Other areas attracting criticism were the excess paperwork, the time taken for visits to the centres, lack of specific dates for reviews and the absence of evening or weekend clinics. The inefficiency of having GPs signing for wheelchairs rather than district nurses, physiotherapists and occupational therapists, who often know the patient better, drew particular criticism. It was felt that the service had suffered from a history of underfunding and lack of research and was very reactive in its approach. Assessment was felt to be driven by available resources rather than client needs.

Delays at various stages in the process were a concern to a number of respondents. There are long waits for appointments, delays in obtaining a chair - which in nursing homes often means residents using someone else's chair, delays in repairs being carried out and adaptations being made, and the time taken to provide chairs for people needing customised seating is often too long. Waiting can lead to social exclusion, mental health problems and increased morbidity.

There was a general feeling that greater clarity in the vision and purpose of the wheelchair service is required. It is currently unclear whether the goal of the service is to provide mobility, or to address issues of social inclusion and quality of life.

Reuse of chairs

It was suggested that it is more efficient, and better for the environment, to reissue chairs to other clients after use. Another respondent points out however that modern chairs are difficult to reuse, [presumably because of issues around adaptability]. Clearer guidelines are needed for users, families and carers on what should be done when they are finished with a chair. A bar code system could be employed for issuing and receipting of chairs.



Exemplar services

Interest was expressed in the wheelchair service in use in Norway and an opinion given that the Scandinavian model seems like the best available.

Several respondents picked out the service provided to clients in Fife as being particularly good. Front line staff are described as courteous and helpful, and the model employed for meeting the needs of clients with profound disabilities drew particular praise. The service provided by the Dundee centre was felt to be exemplary in many areas and surprise was expressed that this was not recognised anywhere in the consultation document. Other services drawing particular praise were the employment of disabled people in wheelchair services in the Isle of Man and the repair van provided by the Inverness centre.

Integrated approach

It was a concern to a number of respondents that future wheelchair services must integrate more with other agencies concerned with mobility. Particular groups specified were NHS physiotherapists, government agencies, local authorities, transport agencies and charities. There is a need to work with local authorities to address issues relating to pavements and road crossings. Working with, and helping to educate, Department of Work and Pensions and social work staff could help to improve the integration of wheelchair users into the community. The current role of the Red Cross in providing chairs was felt to be very important and it was suggested that services that cannot be provided by the NHS could be met by working closely with charities and also the private sector. Pressure could be put on publicly trading companies to provide chairs for people visiting their sites. To reduce administrative overheads, short-term loan of chairs could be handled through social work departments or the voluntary sector, perhaps making use of local Shopmobility offices, rather than the statutory wheelchair service.

Children's issues

Services for children attracted a lot of negative comments. These mainly related to the impact of time delays, with children growing out of chairs and not receiving another one in a timely manner, or indeed being too big for the next chair by the point when it arrives. It was felt that children should be assessed by specially trained services and have their needs considered separately from adults. This occurs currently in Lothian. Children nearly all require chairs because of ill health, unlike many adults who require them as a result of ageing, and reassessment is particularly important for them. A view was expressed that the emphasis of the consultation was very much towards adult services and that children had not been adequately considered, or indeed consulted. UK wide research by Barnardo's on the provision of wheelchairs to children, will be published in March 2006.



Provision of information

The quality of the information available needs to be improved and full use made of technology. For example, a website could give information on referrals and progress through the system. Specific delivery dates for the equipment should always be given, guidance provided on routine (self) maintenance and information made available on accessories such as raincovers and sunshades. After a chair has been delivered it would be beneficial for a member of staff to visit the client and explain how to make adjustments, provide details on insurance cover, and contact points for maintenance. Such a visit would also ensure that the chair is being used, and used properly. A single point of access to the wheelchair service for clients would be beneficial. It was also felt to be important that information should be made available to clients on all the possible wheelchair options, not just those available through the NHS. Wheelchair user groups independent of wheelchair services should be supported, and consideration given to setting up a Managed Clinical Network for wheelchair services.

Consultation process

A number of comments were given relating to the consultation process itself. Appreciation and support were generally expressed for the undertaking of the consultation exercise, however, there was considerable criticism, especially in the group responses, of the consultation document itself. This relates mainly to the lack of evidence and data provided to back up the statements made, the leading nature of the questions asked, the lack of context provided, e.g. legislative developments, personnel issues, failure to reference other relevant research and the vague language used. A number of factual errors and omissions were pointed out and reference should be made to the summary below and the response provided by the Scottish Rehabilitation Technology Service Providers Forum (SCOTReT) regarding these. Lastly the use of cartoons in the document was felt to be very inappropriate.

Errors

- Remploy also manufacture at Springburn.
- Warranty information provided is incorrect.
- NHS is not the sole provider of chairs.
- Presumption of 5-year equipment life is incorrect.
- MAVIS (Mobility Advice and Vehicle Information Service) is in the same building as the Edinburgh wheelchair service, but is a separate national service.
- Motability already provides a hire purchase and lease scheme for wheelchairs.
- Additional errors listed in the response provided by SCOTReT.

petition PE798 to the Scottish Parliament

PE798

Petition by Margaret Scott calling for the Scottish Parliament to urge the Scottish Executive to resolve the current critical problems in the provision of wheelchairs and specialist seating services within the NHS by both an immediate increase in funding and through a review, which in consultation with users, will address minimum standards, the scope of equipment provided and the delivery of services.

The Scottish Parliament

Public Petitions Committee – a template for public petitions

Should you wish to submit a public petition for consideration by the Public Petitions Committee please complete the template below. Please refer to the Guidance on submission of public petitions for advice on issues of admissibility before completing the template. You may also seek advice from the Clerk to the Committee whose contact details can be found at the end of this form.

Details of principal petitioner:

Please enter the name of person and organisation raising the petition, including a contact address where correspondence should be sent to, email address and phone number if available.

**Margaret Scott,
Edinburgh**

**Text of petition:**

The petition should clearly state what action the petitioner wishes the Parliament to take in no more than five lines of text, e.g.

The petitioner requests that the Scottish Parliament considers and debates the implications of the proposed Agenda for Change legislation for Speech and Language Therapy Services and service users within the NHS.

The petitioner requests that the Scottish Parliament...

Resolve the current critical problems in the provision of wheelchairs and specialist seating services within the NHS by both an immediate increase in funding and through a review which, in consultation with users, will address minimum standards, the scope of equipment provided and the delivery of services.

Recommend a strategy for the integrated provision of all equipment for people with physical disabilities.

Additional information:

Any additional information in relation to your petition, including reasons why the action requested is necessary, should not be included here. However, it may be appended to the petition and will be made available to the Public Petitions Committee prior to its consideration of your petition. Please note that you should limit the amount of any additional information which you may wish to provide in support of your petition to no more than four sides of A4.

Action taken to resolve issues of concern before submitting the petition:

Before submitting a petition to the Parliament, petitioners are expected to have made an attempt to resolve their issues of concern by, for example, making representations to the Scottish Executive or seeking the assistance of locally elected representatives, such as councillors, MSPs and MPs. Please enter details of those approached below and append copies of relevant correspondence, which will be made available to the Public Petitions Committee prior to its consideration of your petition.

1. Initiated independent Scottish survey on children's wheelchair provision (1998)
2. Carried out consultation with young wheelchair users (Playback) 1998 Results of both of the presented to Health Minister 1998
3. Presentation carried out to 25 MSP's by young wheelchair users highlighting issues (2001)
4. Collection of stories of individual circumstances presented to Scottish Executive May 2003
5. Many contacts by parents throughout Scotland with Individual MSPs

Request to speak:

All petitioners are given the opportunity to present their petition before the Public Petitions Committee. The Convener will then make a decision based on a number of factors including the content of the petition and the written information provided by the petitioner as to whether a brief statement from the petitioner would be useful in facilitating the Committee's consideration of a petition.

Please indicate below whether you wish to request to make a brief statement before the Committee when it comes to consider your petition.

Yes/No*

**Delete as appropriate*

**Signature of principal petitioner:**

When satisfied that your petition meets all the criteria outlined in the Guidance on submission of public petitions, the principal petitioner should sign and date the form in the box below. Other signatures gathered should be appended to this form.

Signature *Margaret A. Scott*

Date *7/12/04*

Please note that any additional information, copies of relevant correspondence and additional signatures should be appended to this form and submitted to:

**The Cleric to the Public Petitions Committee
The Scottish Parliament
Edinburgh
EH99 1SP**

Tel: 0131 348 5186 Fax: 0131 348 5088

e-mail: petitions@scottish.parliament.uk

extract from tender specification for review

Extract from Tender Specification for Review

1. Objectives

All those who need NHS Wheelchair and Seating services are entitled to expect that the service they receive is efficient, acceptable and meets the highest standards deliverable within the resources to be provided. Services will need to recognise the lifestyle of the wheelchair user and the needs of carers.

The broad aims of the work that NHS QIS wishes to commission are to:

- identify, as far as possible, the people in Scotland who need wheelchair mobility and associated postural and seating support
- identify potential benefits for patients and their carers (presently excluded) which may be realised by the full range of potentially available interventions to meet those needs
- identify current service provision
- undertake a gap analysis to highlight what is required to move from the existing service to one which more closely meets the needs and aspirations of users and carers and which is affordable for the NHS.

This involves improving the current information base.

3.1 Identify as far as possible, the people in Scotland who need wheelchair mobility

From the available data outlined in paragraph 2 and Appendix 3, we already have some understanding of the expressed need for wheelchairs. However, this is very high level and we need to obtain better information about current and future need so that evidence based decisions about future service delivery can be made.

Requirement

NHS QIS is seeking to commission work to undertake an exercise to confirm current known needs and to aim to identify as many as possible that are currently unknown to the NHS. This should include an analysis of:

- user dependency levels which highlights those who are fully dependent on their wheelchair
- users who are having to use their wheelchair inappropriately in the absence of any other suitable seating or the means to access suitable seating.



Based on these findings, an assessment of the impact of demographic change on the service over the next 10 years is also required.

In addition to existing data sources, consultants will be expected to obtain the views of a range of stakeholders.

3.2. Identify and cost potential benefits for patients and their carers which may be realised by the full range of potentially available interventions to meet those needs

A range of potential wheelchairs is outlined in Appendix 2. This needs to be confirmed to ensure that we are as aware as possible of potential interventions.

Requirement

NHS QIS wishes to commission an assessment of the suitability and costs of different chairs for patients to meet their individual needs.

The kind of information required to assess this is outlined in Appendix 5.

3.3. Identify current service provision

The current service provision is summarised in Appendix 3. This needs to be confirmed and developed.

Requirement

This requires a mapping exercise at both local and national levels showing how existing systems work and identifying (e.g. via benchmarking) where there are opportunities to improve them.

This will require information/evidence along the lines outlined in Appendix 6.

3.4 Undertake gap analysis

The gap analysis should bring together the findings from your information gathering and your analysis. Your synthesis must provide NHS QIS with an understanding of what current and future service users should be able to expect from a quality service and what it will take in terms of investment and effort to achieve that standard.

Requirement

NHS QIS wishes to commission work to identify the gaps between needs and provision including an assessment of the costs and benefits of filling those gaps.

2. Outcomes required/Deliverables

4.1 The commissioned work should achieve the following outcomes for NHS QIS by 28 February 2006⁴⁶

- clarity about the extent and type of need for wheelchairs currently and an assessment of how that will change over the next 10 years
- clarity about the range of potential interventions to meet the needs
- clarity about the existing systems in place with good practice identified. This should cover the **whole system**⁴⁷ that ensures that user and carer needs are met and continue to be met on an ongoing basis
- highlight any areas where the service is currently failing users
- clarity about the extent of the gap between need and current provision
- practical recommendations, including resource implications, on what needs to be done to improve current services – this needs to differentiate between how things are supposed to work in theory and how they are actually working at ground level
- clarity about the range of professional skill mix required to address potential interventions and the general training requirements associated with the skill mix proposal
- clarity about how to achieve meaningful user and carer involvement to inform, determine and shape policy and practice from an early stage
- proposals for how outcomes should be monitored locally and nationally.

⁴⁶ **NB: This deadline is non-negotiable and the contractor will incur penalties in the event of any over-run, to be confirmed during final negotiations.**

⁴⁷ i.e. not just initial supply



It will be for the contractor to determine how to achieve these outcomes. However, NHS QIS's expectation is that proposals will include plans for desk top reviews and structured information gathering from the main stakeholders, as well as any postal and/or electronic surveys. Given the importance of the stakeholders in this exercise, the SEHD has already committed to hold one national conference on 12 September 2005 and five regional meetings to solicit views from users and get their active involvement in shaping policy. The successful bidder to this contract will be expected to participate in these events.

4.2 The output required is an interim report by 1 November 2005 and a final report by 28 February 2006 which delivers the outcomes specified in 4.1. In particular, the **practical** recommendations must take account of likely costs and benefits of any proposal.

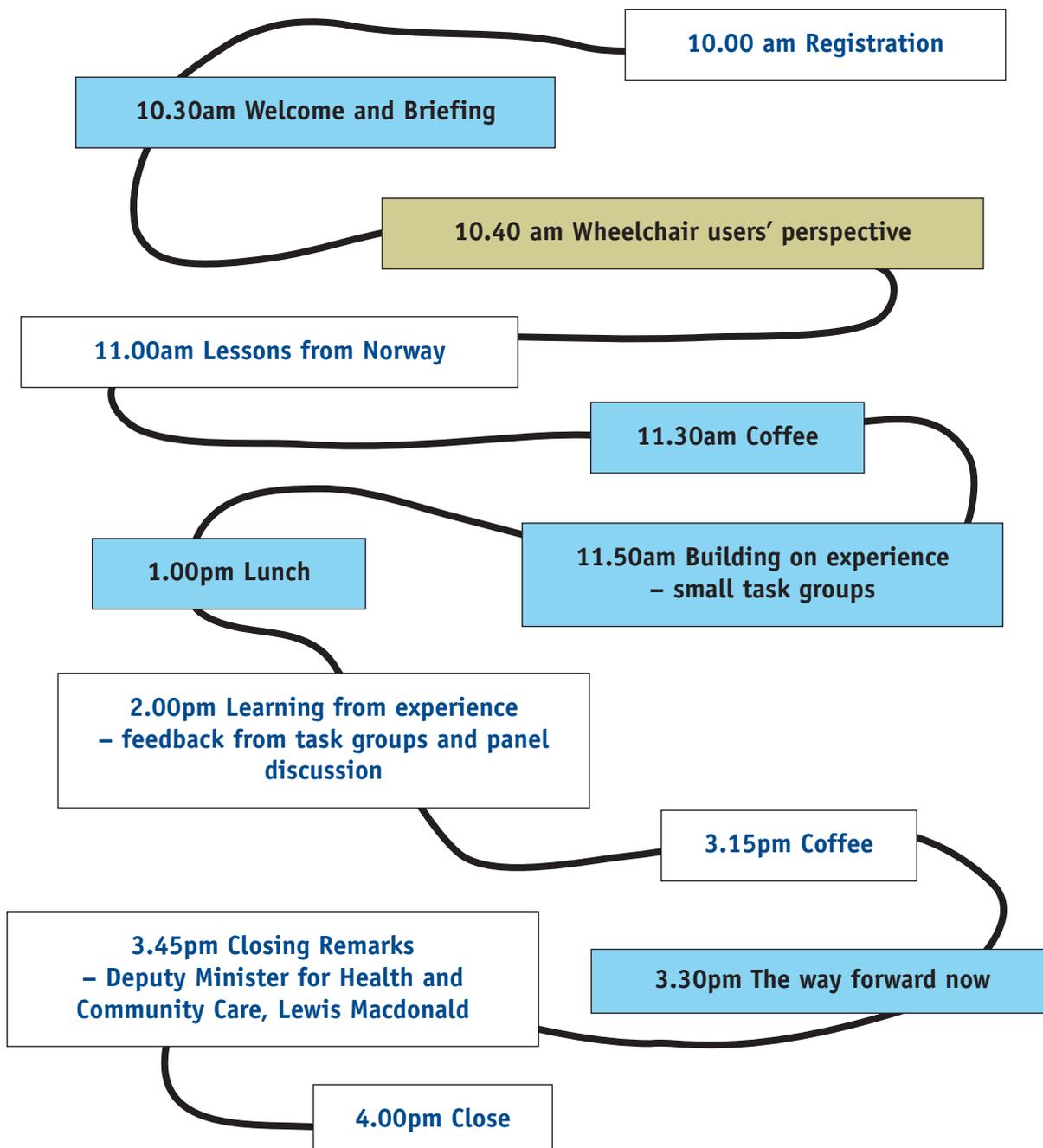
The report should be in black and white and available in both hard copy and electronic form.

programme from national conference held on 12 September 2005

Moving Forward:

reinventing the wheelchair service in Scotland

A national conference on Monday 12 September 2005
at The Corn Exchange, Edinburgh



messages presented to the Deputy Minister for Health and Community Care at the national conference



- WHEELCHAIRS
 - SERVICE
 - FUNDING
 - NORWAY
 - PERSONAL VIEWS/SOCIAL INCLUSION
 - JOINT FUTURE
 - MISCELLANEOUS
-

- WHEELCHAIRS

Wheelchair users

Wheelchair users chair should be checked and reassured on a regular basis.
The chair should be checked for health and safety reasons.

A part of society

With a powered wheelchair I would be able to participate in society and I would not have to wait indefinitely, isolated within the four walls of my house.

Should be listened to at assessments instead of being tricked into propelling a manual chair with one hand and to be turned down for a power chair.

Fit the services to the person

The wheelchair user is the true 'expert'. A wheelchair is more than a mode of transport, it is the key to quality of life.

Priority service

Need for those with rapidly progressing conditions to be given quick access to assessment and delivery of suitable wheelchairs, e.g. motor neurone disease – average life expectancy from diagnosis is 14 months.

Identify the wheelchair service model for Scotland:

- plain English for all stakeholders. Little translation needed
- each area can then show how to meet the local needs against the model
- pathways to the service would be clear
- meet needs clearly listed – look for funds
- no provision of equipment.

Consider holistic healthcare and save yourself a fortune

People with profound and multiple learning disabilities and their carers have a right to self refer and participate fully in the assessments process as regards to their most appropriate wheelchair requirements. If this was considered then attendant wheelchairs would be made available when necessary.

Equitable services for all ages and provision of wheelchair for elderly in nursing homes. Better wheelchair provision and wheelchairs to be promoted with cushion equipment.

There is a need to develop a robust database nationally. Also to develop a national scoping system to prioritise waiting lists and deal with problems in relevant and diverse ways.

Can we please have an improved wheelchair service based on each centre's area using 'best practice' to provide standardised quality service across the country?

Adopt a 'deliver what you promise' approach to the findings of the wheelchair service review. It's the only way of 'moving forward'.



Information given to users (carers) on receipts of appearance – with follow-up helpline essential. Standardisation of wheelchair services with training for services.

The wheelchair service in Scotland should maintain the lifestyle of the individual post-illness or accident or, in the event of a child being born with a lifelong disability, the service should enable equal opportunities to enjoy a high quality of social inclusion.

A repair service for wheelchair users who have bought their chair privately, i.e. vouchers towards cost.

£140 per centre is not nearly enough for wheelchair provision.
A specialised seating system and chair = £120 approx.

Disabled children and young people

It is essential that services for this group are separate to adult users. Timely provision that enables children and young people to develop social skills and integrate into society is not only a right, but allows them to grow up to be active members of society – college, uni, and tax payers!

Support for staff

I am fully in agreement that the wheelchair services need a shake-up and a huge increase of funding, but I am concerned that this review will end up pumping cash and new ideas onto the already stressed and overworked services. I would very much like the Executive to ensure that the staff on the ground who have to implement these changes get the full support of the Executive at all stages and all levels, and the public is made fully aware that the suggestions will take time to implement. Please don't drop us even deeper in it!

Increase the funding for wheelchairs and other assistive technology devices and provide powered wheelchairs more freely to improve quality of life and levels of independence.

Better wheelchairs

Much more choice as this leads to better posture which means better quality of life.

Mobility for everyone.

Using the members of Shopmobility Scotland

The NHS should work with local shopmobility groups with reference to provision of temporary equipment as there are now many groups around Scotland. As all the shopmobilities are independent companies set up by like minded people, some Scottish Executive funding would be nice.

From the perspective of a staff member within wheelchair services. I feel that the users of services are presenting a picture of an ideal service, which will never be catered for, however many specific issues are being repeatedly issued.

Legless

Please don't leave us legless. Improve our access to and maintenance of our means to get about, have independence and live life to the max.

Outdoor mobility

Improved and easier access to outdoor places.
Improved outdoor environments, e.g. increase number of drop kerbs, less adverse/negative pavements to improve efficiency of outdoor devices.

Voice of wheelchair service staff

As an OT who has worked in wheelchair service for over 9 years I feel that the review is overdue. However as much as I appreciate the user's view of the wheelchair service produced, I feel that those who work in the service have not had an equal opportunity to voice their opinion on the service. We work damn hard to provide a service of excellence to the high expectations of users and feel that this has been overlooked. Yes the service is under funded, under resourced and over stretched, but those of us who work in the service are committed and dedicated to the users' needs, and provide the best service we can under extremely difficult working conditions.



Time of delivery

It is not acceptable for a child with a deteriorating condition to have to wait 6-8 months for a powered chair that will meet his/her needs.

Please recognise that an enormous amount of people require wheelchairs and that each and everyone deserves the right to lead their life to the full. Money isn't all the answer, but the correct control is.

Children

When assessing children, take into account that they have the right to participate fully in school, the curriculum, a social life and sport. The criteria for self propelling is a prison sentence.

Power chair eligibility

These should be available to those who would benefit regardless of ability to push indoors.

Freedom

Until you get a powered wheelchair, you do not realise what freedom means.

Requirements for improved service:

- standardised service throughout the service
- one-stop-shop for all aids and wheelchairs
- replacement wheelchairs, automatic when repairs required.

Self-referral

Anyone can refer or themselves or another for advice and assessment or choices of wheelchairs on the market!

Wheelchair service included in one-stop rehabilitation service, addressing all equipment needs by multidisciplinary team.

Ongoing assessment at different levels depending on the individual's level.

If chairs are taken away for repair, a 'courtesy chair' should be issued temporarily. It's like an MOT.

Holistic approach

More consideration to individual lifestyles and of their environment indoors and outdoors. Listening to users and carers on what their needs are.

Why do we have to wait so long for repairs to be done? Repair systems should be localised and accredited.

Provision of biotechnology

Any chair which requires specific individual adaptations can take over 2 years to get to the user – even then it is not guaranteed to work as originally discussed.

Mobility aids are for more medical management. They allow for social interactions and lifestyle as well. The current service allows predominantly for the most basic of provision. Reassessment if left for such long periods that responsibly of care risk assessment and the legal issues of old condemned or faulty equipment is relied upon. In the changing climate of personal/client choice, legal cases may become more popular.

Listen to wheelchair users.

Criteria for NHS power chairs

Too strict – users should be given more information about why they have been assessed in a certain way. Nor given valid reasons. Assessment not wide enough in scope.



Wheelchairs must be supplied (to people who require them) speedily and suitably sized/shaped and postural needs of the user. They must be safe, reliable, regularly serviced (recycled as and when appropriate) by a person who has the knowledge and experience to do it cost effectively and with repairs effected in the minimum of time.

Users should be reassured regularly and frequently in case of growing children by staff who know the client and his/her lifestyle.

Meeting need

If a wheelchair could meet a need of a user or carer, then it should be provided.

1. Regular reviews of people's wheelchairs will require more manpower, but give the advantage of reducing breakdowns and prolonging the life of wheelchairs. This would result in an easier life for the wheelchair user.
2. The criteria for electric wheelchair provision is too limited.
3. There is a huge issue with back-up chairs when the person's regular wheelchair breaks down.

From a carer of a profoundly disabled person with complex medical needs

Emergencies dealt with promptly.

Attendant powered wheelchairs – not everyone is capable of using a powered chair. Profoundly disabled people rely on carers to push. My daughter also has complex health needs and we carry equipment on her chair adding weight to it. I'm exhausted pushing.

Adequate funding a reality figure

To enable wheelchair service to offer a good reliable service and not have to say the NHS. Funding cannot cover these issues, e.g. regular maintenance, choice of chair power packs on NHS and lap straps.

Provision of wheelchairs that meet the needs of the users rather than supplying cheaper inappropriate equipment. Recognition that for people with severe mobility problems more than one wheelchair may be essential for them to have a life rather than existence only.

The control of the wheelchair service by the wheelchair service is inappropriate. A transparent appeal process is required.

SERVICE

Transition from child health to adult service

Services fall apart when person reaches 18 if they have a chronic disability.

24-hour repair service.

More money for the service.
 Ensure that there is accountability.
 Most of us are not sick, we just have a mobility problem.
 Embrace social inclusions.

Would like to see the NHS continuing with the wheelchair service but being completely modernised. Great need for skilled professionals to assess the holistic needs (a need here for encouraging people into these professions!) and for the service to be managed locally but accountable nationally.

To provide an expert and appropriate service the Scottish Executive needs to:

Carry out a comprehensive needs assessment.
 Provide – planned

- co-ordinated/integrated
- locally delivered
- client/users centred
- adequately funded service.

More funding for localised services

More funding is necessary for current wheelchair services to have more local bases of skilled staff.



I'm a new staff member to the wheelchair service in Scotland and, after 3 weeks, I am becoming demotivated and stressed. The staff I work with are all very dedicated but also very much overlooked. The exercise has concentrated on what the users want, but how is this going to happen? Staff are already overworked and under extreme pressure. Be careful how you change things. If you don't, you may not have any staff to run a service. Change is needed, but the staff need to be involved and it must be modernised.

Improve the efficiency of the service.

Complete restructuring

We need a national service with a clear vision that will be applied consistently across the country. Start again and get it right. Ask the people who know what they need, and provide it as locally as possible.

If local services are wanted, significant infrastructure investment is required.

All units of assisted technology to become one service throughout Scotland.

Look and learn

Acknowledge the views of service users and carers.

Be proactive and not reactive.

Acknowledge that to invest now in a service that meets an individual's needs will cost less in the future.

Empowering partnerships

We need to acknowledge the expertise.

Knowledge of users, carers and therapists involved.

Work together to deliver a secure service.

Training is imperative for all concerned and can remove boundaries.

Assessment

There must be a holistic approach to assessment and the users' perspective has to be an integral part.

Locality of service

People should be given what they need in aid to fulfil their life, regardless of their circumstances it should be the same country wide, not different in different areas.

We need a service our country is proud of!

There should be a continuity of quality service nationally. Provision should be needs led and a more holistic assessment and treatment approach is required.

 **FUNDING**

Voucher scheme would be a sticking plaster to hide the massive under funding of services

Research current unmet need for wheelchair services – needs of assessment of adequate funding required.

The wheelchair services are capable of doing so much more, and better. Give us the money to meet all the needs of patients and we will give you a service that will be second to none.

Funding and adequate funding

Consideration must be given to funding health and individuals and carers.



Please work to provide a wheelchair service that is centred on the wheelchair user, taking account of their health and social needs.
This requires adequate funding and integrated provision.

More funding for disabled/wheelchair users.
More provision of disabled access by law.
Less money spent unwisely, e.g. Scottish Parliament.
Less money spent on expenses for MPs.

People should be able to have a choice in the aids that they need to help them in their day-to-day life without cost.

Please fund wheelchair and social services more generously. I am a third class citizen at the bottom of the Scottish heap.

Service provider

Does £2.20 per week seem enough to you?
This is what a wheelchair and seating service currently costs.

'More money'

Users/carer choice and control

User/carer shape service.
Improved infrastructure with added resources.
Financial skilled personnel.

Wheelchair service needs to be standardised and equitable across Scotland. Better funded and more consideration to providing wheelchairs for school pupils and elderly nursing homes.

Put more money into essential service for wheelchairs users. They can't get about without them, there is always money for some things. Make it meaningful and give it to wheelchair users.

Please increase funding and provision of good quality wheelchairs and adaptations, both mechanical and electrical.

Give us the funding for staff training and equipment and you can have the service the patients need.

Require equal standardised provision which is national with the necessary funds to meet clients needs.

Equipment based on need rather than cost.

Please fund us, short term and long term, to do our job.

Bioengineer
Special seating

More funding to enable equal access to provision of assessment and equipment, and equity of provision in Scotland.

More funding required to provide.
Regular assessment of patients' needs.
Regular servicing and maintenance programme to prevent breakdowns and accidents – big impact on patients' lives.
To increase staff levels and hence service provision.
Improve staff training and development.



Proper and adequate funding

Increase funding

Less restrictions:
 – funding
 – criteria
 – equipment choices
 – when/how repairs.
 Life is for living!

Money should not be an issue where people have difficulties through no fault of their own.

More funding please

NORWAY

Look carefully at what we can learn from the Norwegian model.

AT centres

Why don't we have any assisted technology centres in Scotland? Norway has 19.

Role model

Are you going to visit Norway to learn from their experienced and superior service? We need to use a role model such as this to make the changes needed.

Involve users and carers. They are the ones who know all the issues and are possibly best placed to offer solutions! We need to think far more latterly and probably visit Norway for advice.

Equality for all

Do you foresee a similar structure to the Norwegian one, e.g. users are the main priority and all disciplines are dealt with at one centre.

Have a good look at Norwegian models of multidisciplinary assisted technology centres. Better value for money as well as better service provision.

Duplicate the Norwegian model. It should be the right of every person to be able to live their lives to their fullest potential.

Decrease paper work involved in wheelchair provision, it takes up to 3 months from request to provision, in Norway it takes a maximum of 1 month.



PERSONAL VIEWS/SOCIAL INCLUSION

Equality of Service = Equality of life.

Please don't just listen – Act.

This is about the quality of people's lives, not about money. When you're a wheelchair user you want to live your life and the finances don't matter as much. Obviously there will be contrasts, but much needs to change.

Equality

Provision which allows users to have equal opportunities with the general population.

Civil rights

Everyone has the right to take a participatory role in society – self-referral the person with the disability and the carer are the professionals about their needs.

Voice

Listen, learn, act!

Right

Basic human right to be able to live an independent, active life in society.

Freedom of choice.

Decision making

Users should be informed at the start.

We need more people with a disability in government and positions of power to address issues in a relevant way.

Don't manage the deck chairs.
Make a meaningful vision and direction for the future.

Stop making us feel like 3rd class citizens.

User led.

Basic right

To be given what is needed to have a 'normal' life.

A person-centred approach to assessment

That which incorporates a holistic approach, incorporating the needs and abilities of carers and chosen lifestyle of client.

I think it is really important to establish independent living centres.



JOINT FUTURE

Need to integrate rehabilitation services (within Joint Future!)

Please make it easier for disabled people to have stair lifts installed in their homes, especially when stair lifts would give them the vital link with the outside world.

Kick start Joint Future for an integrated service.
Service has to be equitable and not subject to regional variations/postcode prescribing as at present.

Please ensure that the Joint Future initiative is made to work!

Impose Joint Future agreement on all of Scotland.
Publicise lower tax equals less service provision.
Set up website/group for all users/providers/groups to put comments and pressure on politicians to make things happen.

Wheelchairs are part of the solution to independence

Wheelchairs must move out of the medical model and into social model of provision. Joined up thinking – joined-up solution – whole system – whole lives.

 MISCELLANEOUS**Why black?**

Can young people choose their own colour of chair?

A website to email in problems.

Same service for rural areas as central belt.

Simple clock – to record number of miles/hours use to regulate for service.

I'm an educational professional and I've heard some shocking stories today. The system fundamentally needs more friendly – more qualified staff, better equipment and the 'one-stop' approach may also be worth a look.

Duty of care

The duty of care professionals have to adhere to can, at all times, limit the choices of the users.

bibliography



Reports and references specific to Scotland

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