**Why splitting wheelchair services on grounds of age does not make sense**

**Introduction by Carolyn Nichols:** *Dealing with provision for children* ***is*** *different, both clinically and socially, from dealing with adults--- the effects of growth and motor development on ability and structural issues, dealing with families and family lives, and understanding the sorts of things that children do/or want to do.  But these are not reasons for splitting the service by age; rather they are reasons for staff to be properly trained and aware.*

Outlined below are clinical and financial reasons which suggest that it is unwise to interrupt the continuity of care for those with mobility and seating needs. Any age chosen for the jump between ‘paediatric’ and ‘adult’ provision has to be arbitrary, and will not relate to developmental, clinical, or even educational, need. We are not discussing the supply of commodities, but the means for people to get the most out of life, be as productive (and cost-effective to the State) as possible, and have continuity of clinical and social care as needed. On the other hand, it is not clear what advantages there are to either the State or the individuals involved by making an arbitrary split in provision. What benefit would it give socially or clinically?

1. **Stability of support.** Unfortunately the majority of children who require a wheelchair for mobility will continue to require a wheelchair for the rest of their life. During their childhood years, they, and their families, will have formed relationships with the team looking after them, and many are relieved to have familiar faces around when they transition from paediatric to adult services, and every other aspect of their healthcare seems to be changing. The continuity issue is one of the most important things raised by families and service users. They are relieved to know that amongst major life changes, wheelchair and seating service relationships will be stable.  The wheelchair & seating service also provides a good reference point for other community staff who take on care/treatment for the young adults moving to adult services.

2. **Clinical continuity.** The staff who have looked after that child will have a wealth of knowledge about their individual needs and this cannot be simply ‘passed over’ in a file/discussion; it takes years to build up. Continuity of care is vital for both the child and the caring staff.

3. **Continuity of care and treatment.** The clinical skills required for paediatric wheelchair/seating provision are similar to those required for adult prescription. However, experienced clinicians will be aware of the need for an emphasis on developmental neurological patterns, rapid growth changes and the neuroplastic implications of childhood provision. Many of these skills are transferable and will benefit adult neurological clients in improved awareness of their complex needs for equipment provision.

There will obviously be differences in approach and environment, to put the child at ease, and clearly the equipment needs to be age appropriate and adaptable for growth. These are issues already known to wheelchair services.

4. **Efficiency.** The critical mass of a service needs to be considered. The more cases a service sees, the broader the experience gathered, and the better the treatment as a result. A service also needs a certain number of users to cover the numbers of staff needed for administration and clinical work. If services are split into paediatric and adult, this critical mass will then only be achieved by each service having greatly increased catchment areas. This will result in greater travelling times and distances for both users and staff, creating inconvenience and reducing efficiency.

5. **Cost implications.** There are issues around cost if the services are split. Premises will be duplicated, staff members will be duplicated, and significant equipment costs will be incurred as equipment is changed or withdrawn on transfer of clients between services.

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