| **Wheelchair Services for children and adults with non-complex requirements**  **Equipment Solution and Ongoing Support** |
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**Preface**

**Introduction**

This implementation pack has been designed to support commissioners to deliver Any Qualified Provider for Wheelchair services for children and adults with non-complex requirements locally. It has been developed by NHS commissioners, clinical experts and DH officials, working in partnership. The use of this pack is not mandatory. Commissioners can refine it to meet local needs and, over time, help to improve it. The pack is simply a place to start, avoiding duplicating effort.

This pack should be used for services that are commissioned using the Any Qualified Provider (AQP) model – where commissioners are aiming to secure innovation or deliver more choice for patients for example. Other forms of procurement are also available, which might suit other circumstances, more details of these can be found in DH procurement guidance[[1]](#footnote-2).

This pack has been prepared by working with a range of professionals, from both clinical and commissioning backgrounds and we recommend that commissioners using these packs continue to engage with clinicians, professionals and a wide range of providers wherever possible.

Generally we expect there to be consistency across service specifications to sustain quality and help to spread best practice, but where necessary specifications should be amended to reflect local variations in need .

More information and further resources for commissioners can be found here: <http://nww.supply2health.nhs.uk/AQPRESOURCECENTRE/Pages/AQPHome.aspx>, including a pricing principles document that should be read alongside this implementation pack.

If commissioners do come up with innovative new ways to drive up the quality of care by offering choice of provider - please use the AQP resource forum to share your hard work.

**Workforce, education and training implications**

When commissioning a service under patient choice of AQP, there are some important workforce, education and training considerations, which commissioners must take into consideration. Annex 2 provides some additional details on these issues.

Commissioners should have regard to the Public Sector Equality Duty when commissioning services for patients. Refer to Annex three for more information and please visit the Department of Health website and search for 'Equality and Diversity'.

**Glossary**

A glossary of terms used within this implementation pack is included in Annex 4.

**Next Steps**

These packs should be used by commissioners undertaking AQP Wheelchair Services through 2012/13. An evaluation of the pack and the AQP process should be undertaken during this period. In the meantime, if you have any questions or comments on this pack, please contact [AQP.Queries@dh.gsi.gov.uk](mailto:AQP.Queries@dh.gsi.gov.uk)

**Document Management**

**Document Control**

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**Rationale for creating 2 specifications by separating assessment from provision**

Comprehensive engagement with people who use services, their families and carers, user representative organisations, commissioners and providers (NHS, independent and third sectors) has taken place in relation to wheelchair services.

From this, key principles for commissioning wheelchair services have been understood.

**Person Centred Approach**

Users repeatedly intimated that they want increased choice and control over the management of their conditions and particularly choice of equipment.

Users want to be treated like consumers.

**Improving quality of outcomes and the service user experience**

By aligning provision with capability ensures activities in the care pathway lie with those best able to manage them. For example, providers of equipment and maintenance aftercare utilise best industry supply chain and inventory management requirements to drive best value.

**Choice**

Opening up the marketplace for wheelchairs should operate like any other consumer driven market to enable wider choice. Offering packages of equipment solutions incentivises new entrants as well as existing providers and offers opportunities to innovate, provide solutions and increase visibility and accessibility of products for all wheelchair users, not just those whom the state supports

**Driving efficiencies**

This approach allows for the promotion of ‘critical mass’, such as potential for cross regional aggregation – in terms of clinical excellence best value equipment solutions and inventory utilisation

Aligning the provision of equipment with its repair, maintenance, inventory management and recycling to drive innovation in wheelchair design to ensure the best lifetime value

**The benefits to Commissioners**

Commissioners have options to open up the whole service to competition on quality issues, or to separately commission a range of providers to undertake referral and assessment and different providers for equipment provision repair and maintenance dependant on local circumstances.

Allows commissioners to move to a ‘pay to use’ model for equipment provision. There is evidence that the true cost of owning and maintaining the equipment as an NHS asset is not economically advantageous. The financial risk of poorly designed and highly maintained equipment is minimised if this sits with the provider.

# 

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## SERVICE SPECIFICATION

**Service: Wheelchair Service for children and adults with non-complex requirements (Access to Prescription)**

Mandatory headings 1 – 3. Mandatory but detail for local determination and agreement.

Optional headings 4 – 6. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement.

|  |  |
| --- | --- |
| Service Specification No. | [Local systems] |
| Service | Wheelchair Service (Prescription to Equipment Solution & Ongoing Support) |
| Commissioner Lead | [To be inserted] |
| Provider Lead | [To be inserted] |
| Period | [To be inserted] |
| Date of Review | [To be inserted] |

### Population Needs

#### National/ local context and evidence base

##### National Context

The Government has introduced a wide range of health and social care reforms and has produced a number of legislative, frameworks, policy and guidance documents which define the requirements that services shall deliver.

The White Paper ‘Equity and Excellence: Liberating the NHS, establishes clear tenets that put users, their family and carers at the heart of services and focus on improving healthcare outcomes:

**Putting patients and public first**

* Shared decision-making shall become the norm: ‘no decision about me without me’
* Patients will have access to the information they want, to make choices about their care
* Patients will have choice of any provider and choice of treatment
* The systems will focus on personalised care that reflects individuals’ health and care needs, supports carers and encourages strong joint arrangements and local partnerships

**Improving healthcare outcomes**

* Quality requirements will inform the commissioning of wheelchair services and payment systems
* Money will follow the patient through transparent, comprehensive and stable payment systems across the NHS to promote high quality care, drive efficiency, and support patient choice

##### Local Context

The aim of commissioning Any Qualified Providers (AQP) for the provision of wheelchairs, seating and associated equipment solution services (hereafter known as the service) is to develop a local, responsive network of providers that offers choice, is cost effective and responds quickly to the needs of children and adults where the permanent limitation of mobility/walking or postural management needs seriously hinders, or increases the risk, of their ability to safely participate in everyday activities and where providing a wheelchair will enable them to do so.

There is a required commitment for providers to work in partnership with people who use wheelchairs, their families and carers through a holistic approach to deliver a service best meeting their needs. The approach is person-centred and supports individuals, their families and carers to achieve improved quality of life and independence through the provision of the most suitable wheelchairs, seating and associated equipment in line with local eligibility criteria. This should be undertaken with individuals as well as Wheelchair Service User Groups and other networks representing the views of people who use the service.

A further aim is to align the supply base to the requirements of the service by moving from the purchase of chairs to the purchase of packages of wheelchair, seating and associated equipment solutions including maintenance and aftercare for a defined duration.

Service providers are expected to work as brokers for the wheelchair user, their families and carers, by helping them navigate the system where more than one service is involved and taking responsibility for some of the negotiation needed between the individual, statutory organisations and any private or third sector options.

The provision of services has been separated into two parts of the pathway:

* Access to prescription
* Equipment solution and ongoing support

This specification relates to Part 2, equipment solution and ongoing support.

**[DN: Commissioners may wish to insert details of their local demographics and other relevant information and data]**

#### Evidence Base

The number of people with disabilities is rising and it is estimated that there are 1.2 million wheelchair users in England – just over 2% of the population.

For those individuals, their wheelchair is integral to living an independent life in the community.

Thus wheelchair services need to be at the heart of local policy and service delivery, as the equipment supplied has a potential impact on several of the determinants of public health such as; improving individual lifestyle by increasing independence, improving access to transport and leisure by increasing social and community networks and reducing social isolation and consequent depression.

Two pilot sites in NHS South West and NHS East of England looked at complementary areas of concern to wheelchair users and then brought the work together in a series of workshops between January and March 2010. The workshops were aimed at understanding the needs of all stake-holders involved in the delivery of wheelchair services and ensured that the focus of discussion was always on the needs of the individual.

We sought opinion from users, their relatives and support agencies, providers, commissioners, charities, and government departments and these views have informed the work we have done.

Data and information from the regional workshops and with the assistance of the various stakeholders involved helped provide the building blocks for the changes that are being proposed in this specification.

Further involvement during the last few months of national stakeholders and the significant guidance available from the Department of Health has further shaped this specification and associated documents.

#### Legislation

* The National Health Services Act 1977 amended 2006
* Equality Act 2010
* The Carers Act 1995
* Human Rights Act 1998

Please see Appendix 1 of specification one for a full list of documents referred to and used.

### Scope

#### Aims and objectives of service

##### Aims

The White Paper ‘Equity and Excellence: Liberating the NHS (2009), sets out that users and carers shall have greater influence, choice in the system and a service that is responsive to their needs. The choices shall include a number of Any Qualified Providers (AQP) commissioned by PCT Clusters and Clinical Commissioning Groups.

For all children and adults with a permanent physical condition that impairs their mobility the service is to provide:

* A safe, effective, responsive and integrated service to meet the needs of service users, their families and carers
* Recognise the specific needs of service users and the impact of mobility and postural provision on their social, emotional, educational or work, physical and psychological outcomes
* A comprehensive holistic assessment that includes consideration of comfort, posture, function, pressure relief, social situation, education, employment and where relevant includes integrated, multi agency working.
* A prescription for wheelchair/seating to meet the individuals long term (more than 6 months) mobility and associated postural management need, while recognising and responding to the associated needs of carers, parents and families.
* According to the level of risk, and as defined in the individual care plan, to be proactive in responding to the changing medical needs of an individual with re-assessment for a different wheelchair in a timely manner.
* Working in partnership with all agencies and other AQP wheelchair providers, to make sure that joint assessments, when required, take place, so that the individual receives a comprehensive, timely and full assessment, which negates the need for multiple appointments.

The provider is to continue to offer both ongoing reviews of the individual’s needs and information on accessing equipment, equipment maintenance and repair.

##### Objectives

The service shall provide:

* A complete supply chain, including equipment trial, equipment issue, delivery, demonstration, handover, maintenance, on going support and collection that is readily available including emergency call out, repair and access to recovery arrangements
* Access to a choice of equipment solutions, including any modifications required, for the approved prescription within the timescales specified, to deliver their agreed goals and outcomes.
* High quality information, support and advice to individuals, their families and carers to explain their service, the choice of products and services available on prescription, the options for enhanced choice (top-up), maintenance and review arrangements.
* A responsive service that addresses customer needs, provides service support and demonstrates that feedback is acted on and informs and improves service delivery
* Alternative equipment solutions if service users wish to commission it and it complies with the prescription.

#### Service description

This service model is based on current best practice with a specific aim to align the supply base to the requirements of the service by moving from the purchase of chairs to the purchase of packages of wheelchair, seating and associated equipment solutions including maintenance and aftercare for a defined duration.

Providers shall establish a framework promoting service user involvement in the management and development of the service and to provide a forum for sharing, discussing and rating equipment and services

##### Safety, Confidentiality and Safeguarding

Confidentiality and safety are of paramount importance to individuals seeking to discuss their postural management and mobility options. The service shall ensure that confidentiality can be maintained while also recognising the need on occasion to share information in the interests of service users, and to ensure that guidelines on dealing with young and vulnerable people are observed. The service shall comply with the duties set out in this contract.

##### Prescription Receipt

Individuals who have undergone an assessment and are provided with an authorised prescription for wheelchair equipment solutions shall achieve the best outcomes if the equipment solution is fit for purpose and is provided by appropriately trained and competent staff at the most appropriate time and location. To ensure that individuals are able to access impartial advice and support to understand their choices, in surroundings which promote confidentiality and well-being.

The Provider shall receive prescriptions in a wide range of formats, including but not limited to service user held prescription, fax, email and electronic prescription via a web portal.

* Prescriptions shall be reviewed for completeness and adequacy. Incomplete or otherwise unacceptable prescriptions shall be returned to the assessor.
* Advice provided on options for equipment solutions shall meet the choices for issue against local eligibility criteria, including warranty and maintenance package and include information on top-up items. They shall be provided by staff who are competent to advise on the full range of options available. Service users shall be provided with choices relating to refurbished and reused equipment.
* If the Provider feels that a service user could benefit from services of other agencies to support and help them meet the outcomes of their integrated care plan then the Provider with the consent of the service user shall contact the original assessor.
* If the Provider has a query relating to the prescription then the Provider is to communicate with the original assessor for clarification or new prescription issue.
* Service users who do not wish to proceed with their prescription shall be referred back to the original assessor and the assessor shall be notified of the reason for this, in writing, providing the service user consents to this action.
* Service users shall be offered an opportunity to trial equipment available from the Provider prior to making their final selection. The process shall be flexible enough to offer trial equipment, short duration prescriptions etc to deliver a person centred solution.
* Service users who agree and choose to proceed with the selection of equipment shall be advised on appropriate measuring, ordering, fitting, issuing, and delivery, demonstration and handover arrangements and timescales. The service user’s wishes should be taken into account and the Provider shall signpost the user to another Provider if they are unable to undertake the chosen arrangements.
* If the user’s equipment solution is of more complexity than the Provider can cater for, or the user has a significant change to their solution requiring other specialist services, then the service user shall be referred back to the original Assessor into a more appropriate care pathway.
* Verbal advice shall be supported by accurate, impartial printed information that the service user can understand and may take away to consider further before the equipment solution is agreed. The Provider shall ensure that users, their families and carers understand the advice they have been given.
* All service users choosing to proceed with their equipment solution shall have their equipment ordered within the timescales following the decision to proceed has been taken.

##### Equipment Solutions

Individuals who have undergone an assessment and are provided with a prescription for wheelchair equipment solutions and individuals who wish to top up to obtain additional features or functionality will achieve the best outcomes if the equipment solution is fit for purpose and is provided by appropriately trained and competent staff at the most appropriate time and location.

* When appropriate the Provider shall develop a facility to have equipment available at the time of assessment, equipment for trial etc. and coordinate with the assessor for this.
* The Provider may be required to undertake equipment modifications. This involves either the alteration of a piece of equipment for use in a different way or the manufacture of bespoke items for a specific clinical need.
* Modifications shall be specified, including the preparation of technical drawings as necessary, by appropriately qualified prescribing individuals. Modifications must be undertaken by suitably qualified individuals and must be submitted to the prescriber for validation against the specification. There is a requirement for bespoke engineering solutions to be fully documented in a technical file, as required by the EEC Medical Devices Directive, 93/42/EEC.
* Informed consent to measurements and fittings must be obtained
* Measurement and fitting arrangements operated by the Provider shall be simple and streamlined and shall promote speedy access to equipment solutions. These arrangements shall be undertaken in an appropriate setting decided jointly by the service user and the clinical assessor undertaking the assessment as it shall reflect the intended use of equipment solutions.
* Providers shall include in the equipment solution a package covering equipment measuring, ordering, fitting, issuing, and delivery, demonstration and handover arrangements, warranty, planned preventative maintenance, scheduled reviews and provider uplift services in line with integrated care plans for the duration of the prescription. Expected timelines must be included.
* Predictable changes in users’ needs such as growth or deterioration shall be addressed prospectively and pro-actively in the equipment solution package thus avoiding delay and following the pathway agreed with the Commissioner.
* All service users shall be offered a delivery appointment at the time of equipment ordering.
* The content of the delivery, demonstration and handover appointment, the standards to which they are carried out and confidentiality users can expect to receive shall be the same regardless of which setting or settings are used to carry out the delivery, demonstration and handover.
* At delivery, demonstration and handover it is to be expected that there may also be clinical staff, who were involved in the assessment of the individual.
* Service users, their family and carers shall receive verbal and written information to comply with quality standards on equipment demonstration and handover, which explains the warranty, planned preventative maintenance, scheduled reviews, collection services, infection control, repair and access to recovery services in their equipment solution packages. Service Providers shall ensure service users understand the information they have been given and it shall be provided by staff that are competent to advise on the full range of services available.
* Service users, their families and carers shall receive the required level of training to operate the wheelchair equipment solution safely and effectively. This will require the Provider to establish appropriate training surfaces for the service user to undertake test drives of powered equipment.
* Appropriate written advice is to be provided relating to insurance, roadside assistance/recovery and public liability cover for service users of powered equipment.
* Providers shall maintain appropriate records relating to the provision of equipment solution packages.
* If a delivery fails, the Provider’s staff shall leave information relating to the failed delivery and details of who to contact to reschedule a delivery. The Provider shall attempt delivery on three agreed dates before referring back to the original assessor.
* Providers are to be registered with the Medicines and Healthcare products Regulatory Agency (MHRA) and comply with all relevant procedures and guidance. This is required to ensure all appropriate alerts are received and includes ensuring traceability of the equipment provided and it’s service history throughout the products life.
* Supply chain activities operated by the Provider will be simple and streamlined and will promote speedy access to equipment solutions

##### Aftercare and follow-up

Aftercare, including maintenance and follow-up are crucial to ensuring that service users experience the best possible outcomes. Service users are not routinely discharged from the service as in most cases are permanently disabled and in need of equipment solutions on a long term basis.

* Service users and or their carer shall receive verbal and written information on equipment handover, which explains the warranty, planned preventative maintenance, scheduled reviews, collection services, repair and access to recovery services, ensuring service users understand the information they have been given.
* As well as any verbal and written advice given at handover, service users or carer shall have access to 24 hour telephone support.
* Any other service which provides the aftercare and follow-up is to be informed in writing of the date of handover, the equipment solution package and any other relevant information
* The Provider shall provide details of the emergency call out and repair services operated to agreed response times
* Equipment parts are to be of the correct specification and their quality and compatibility match those supplied by the original equipment manufacturer (OEM) specification.
* The Provider shall only refurbish and reuse equipment where it is economically viable and the refurbished devices perform at an acceptable level and complying with European Association of Notified Bodies for Medical devices document: Recommendation NB-MED/2.1/Rec 5 [24].
* Service users and/or their carers shall always be made aware if they are being offered refurbished equipment.
* Aftercare and follow-up arrangements operated by the Provider will be simple and streamlined and shall promote speedy access to maintain service user mobility and independence
* Suitable loan equipment shall be provided in the event that repair cannot be effected immediately.

##### Care Pathway

**DN: IF AVAILABLE The care pathway flowchart shall be completed by the Commissioner. It shall provide a brief overview of the main organisations and agencies involved in or linked to the provision of wheelchairs, specialist seating and associated equipment, and the roles they play at the different stages of the pathway and shall reflect the service model. If necessary this flowchart shall be supplemented by details of broader local pathways available to other providers, services and the public to facilitate rapid access to and delivery of a comprehensive wheelchair equipment solution service.]**

#### Population Covered

**[DN: The commissioner may determine, based on local needs, the scope of population to be covered by this contract, such as, by Age, e.g. Children (age range), Adults etc; by disease, e.g. Motor Neurone Disease.**

**Additionally the commissioner must have regard for any provider/contractual limitations]**

#### Any acceptance and exclusion criteria

##### Acceptance Criteria

Individuals who have undergone an assessment and are provided with an authorised prescription for wheelchair equipment solutions.

Equipment already in circulation will continue to be repaired and maintained until the individual transitions to a new equipment solution package.

##### Exclusion Criteria

Only individuals who meet the eligibility criteria shall be issued with a prescription, for the sake of completeness the following definition of those who do not qualify under this AQP provision is given below:

Individuals who require a specialised wheelchair service, that is, those with the most profound disabilities who can only function adequately in a wheelchair with unique modifications and inserts.

Specialised wheelchair services are required by people who meet the following criteria:

* Individuals whose posture or mobility needs can only be met with a high level of specific design input resulting in unique prescriptions which may use combinations of bespoke and/or off the shelf components; consideration of static seating and 24-hour postural management systems may also be required to ensure optimal outcomes
* Individuals whose posture and mobility needs may not be complex in their own right but nevertheless significantly impinge on the overall level of functional ability
* Individuals who have the ability to control a powered wheelchair but are unable to use standard joystick controls
* Individuals requiring multiple items of equipment integrated via the wheelchair control methods

.

#### Interdependencies with other services

**DN the commissioner is to identify the interdependency depending on the option chosen as to specification 1 or 2 and local network of services]**

It is a requirement that all AQP providers of wheelchair services work together to meet the users needs through joint assessments (where relevant) to provide a seamless service, good communication, joint care planning and where necessary, joint provision.

To liaise with other agencies, such as Education and Social Services transport services regarding wheelchair safety, such as transport clamps..

### Applicable Service Standards

#### Applicable National Standards eg NICE, Royal College

#### Applicable Local Standards

This is intended as a non-exhaustive list. Clause [16] takes precedence

##### **Learning and Continuous Improvement**

Individuals and their carer’s are at the centre of wheelchair services,the provider is to develop a culture of continuous quality improvement and capability within the staff to achieve this. Continuous learning and improvement from feedback, promotes the implementation of evidence-based practice.

##### Capability

Capability is the skills and competencies required to carry out the activities within the assessment; a competence-based approach to service delivery is required. Competence-based approaches and skills maximisation will also provide information on which to base more efficient use of resource and for enriching the skill mix through developing and extending roles of all staff to improve the service delivered to individuals, their families and carers.

**[DN: Commissioners and providers are to agree a competency based skills and experience framework and appropriate measures.]**

##### Training

The service shall provide education and training to other professionals when required in particular to those working in care homes for children, young people and adults.

### Key Service Outcomes

Service users shall achieve their agreed health outcomes through improved mobility as a result of timely access and provision of the most suitable equipment solutions including wheelchairs, seating, associated equipment and aftercare (maintenance, repair and access to recovery services) to a specification that meets their prescription whilst maximising their choice.

### Location of Provider Premises

Services shall be carried out in the most appropriate environment, in order to best meet the individual’s needs. This should include the full range of community settings, such as home, education, place of employment, in addition to the provider’s premises. Where there are different providers for the assessment and provision of wheelchair service, then where possible joint location is to be provided.

The premises as a minimum are to -

* Comply with the mandatory requirements of the Equality Act and Part M of the Building Regulations.
* Have convenient ample supply of designated Disabled Parking close to the clinic, with help and a method of accessing help when assistance is required.
* Have sign posting suitable for people with physical and sensory disabilities.
* Have a reception/waiting area clearly identified.
* Be easily accessible to local transportation systems.
* Have suitable facilities and equipment available for the effective assessment of individuals, their families and carers needs
* Have wheelchair accessible W.C. including changing facilities.
* Have access to beverages, a telephone and food for individuals and their carers.
* Clearly display information on the service, and for information to be available to take away in appropriate formats.

The service shall be available, such that:

* It operates for the hours per week required to meet the individuals needs
* Should the individuals need be such as to cause potential injury (following emergency criteria) then the service will provide a contact emergency number.
* The service should be continually operated and unaffected by periods of absence, planned or unplanned.
* It complies with all targets and Key Performance Indicators

.

### Individual Service User Placement

[Insert details including price where appropriate of Individual Service User Placement]

## ESSENTIAL SERVICES

[For local agreement]

## INDICATIVE ACTIVITY PLAN

### **Indicative Activity Plan**

|  |
| --- |
| **Indicative Activity Plan** |
| There is no guarantee of activity or minimum payments under the Any Qualified Provider Framework Agreement  **[DN: Without giving commitment to business volumes commissioners may wish to indicate some historical data to show the size of the market]** |

## ACTIVITY PLANNING ASSUMPTIONS

### **Commissioning Ambitions based on Activity Plan**

Not Applicable

### **Capacity Review**

Not Applicable

### **Prices and Payment**

**[DN: commissioners to refer to the separate ‘Pricing methodology’ document provided with this Implementation Pack to determine their local tariff]**

This is a Tariff based service based on a currency:

#### Currency

The term ‘currency’ refers to the unit of healthcare for which a provider is funded. Each aspect of care within the scope of the currency can be costed and then aggregated to produce a total cost for the currency of care for an individual. Costing should be done from the bottom-up where possible.

For wheelchair services three currencies have been defined.

* Currency 1 = Assessment
* Currency 2 = Provision and ongoing support
* Currency 3 = Assessment, Provision and ongoing support

Commissioners are able to choose which combination of currencies they wish to use locally based on their service needs.

Table 1: Breakdown of currency types

|  |  |  |  |
| --- | --- | --- | --- |
| Currency 1 - Assessment | Currency 3 – Assessment, Provision and on-going support | Manual Assessment £ = |  |
| Powered Assessment £ = |  |
| Currency 2 – Provision and on-going support | Wheelchair & Equipment Package 1 £ = |  |
| Wheelchair & Equipment Package 2 £ = |  |
| Wheelchair & Equipment Package 3 £ = |  |
| Wheelchair & Equipment Package 4 £ = |  |
| Wheelchair & Equipment Package 5 £ = |  |
| Wheelchair & Equipment Package 6 £ = |  |
| Wheelchair & Equipment Package 7 £ = |  |
| Wheelchair & Equipment Package 8 £ = |  |
| Wheelchair & Equipment Package 9 £ = |  |
| Wheelchair & Equipment Package 10, etc £ = |  |

**[DN: commissioners may wish to consider introducing a marginal tariff if they believe that this is appropriate to their local circumstances]**

## ACTIVITY MANAGEMENT PLAN

[Insert/append Activity Management Plan]

## NON-TARIFF AND VARIATIONS TO TARIFF PRICES

### **Non-Tariff Prices**

[For local agreement]

### **Variations to Tariff Prices**

[For local agreement]

## EXPECTED ANNUAL CONTRACT VALUES

There is no guarantee of activity or minimum payments under the Any Qualified Provider Framework Agreement

## QUALITY

### **Part 1 - Quality Requirements**

Table 2: Quality Requirements

| Technical Guidance Reference | Quality Requirement | Threshold | Method of Measurement | Consequence of breach |
| --- | --- | --- | --- | --- |
|  | All service users receive an equipment solution that is based on evidence to fulfil their prescription  Exception reporting: service user declines equipment solution | Year 1 98%  Year 2 100% | Number of users issued with equipment(divided by) number of prescriptions received  Signed handover certificate from service user | [**DN: Commissioners to insert agreed consequences**  **Clause 32 is the mechanism to allow Commissioners to apply consequences.**  **Applies wherever Clause 32 is shown.]** |
|  | Providers are operating from fully accessible premises with accessible parking close to the building | Year 1 95%  Year 2 98% | User satisfaction surveys | Clause 32 |
| CQC Essential Standards of Equality & Safety | Service users and carers unable to communicate effectively in English shall be provided with an  interpretation service  Providers must also make provision for patients with impaired hearing and/or impaired sight, and those with impaired cognitive abilities. | Year 1 95%  Year 2 98% | Reported through activity data set  Monthly reporting | Clause 32 |
| CQC Essential Standards of Equality & Safety | Evidence that the range of literature for service users and carers is available in accessible formats.  Including formats that appeal to children and young people and take into account their special needs. | 100% | Production of Physical evidence that is updated yearly  User survey | Clause 32 |
|  | All service users are offered choice of equipment solutions based on evidence for delivery of their prescription against local eligibility criteria | Year 1 95%  Year 2 98% | Reported through activity data set – monthly reporting  Number of users offered choice of equipment/number of prescriptions issued  User feedback mechanism for products and services that all can access real time | Clause 32 |
|  | Providers must have interoperable, IT systems in place with other local providers, to support and encourage the regular exchange of up-to-date and comprehensive information (including, where appropriate, a care plan) between all those who may be providing care to service users | 100% | An IT system that is   * Interoperable * Shared data sets * Shared information | Clause 32 |
| Health Care standards for NHS- Commissioned wheel chair services  May 2010 | Evidence that equipment delivery times are within following targets.  (Please see below)  Completion of prescription receipt to handover | 98%  12 weeks | Activity data sets  Monthly information to Commissioner | Clause 32 |
| Transforming community services | Providers shall confirm details of the equipment solution package to the original assessor for inclusion in the care plan | Year 1 95%  Year 2 98% | Reported through activity data set  Monthly information report to Commissioner | Clause 32 |
| EEC Medical Devices Directive, 93/42/EEC | There is a requirement for bespoke engineering solutions to be fully documented in a technical file | 100% | Quarterly report to Commissioners | Clause 32 |
| European Association of Notified Bodies for Medical devices document | Wheelchair solution equipment is refurbished in accordance with Recommendation NB-MED/2.1/Rec 5 [24] | 100% | Quarterly report to Commissioners | Clause 32 |
| MHRA guidelines | All adverse incidents involving any equipment provided to NHS users are reported to the MHRA in accordance with the guidelines | 100% | All incidents reported to the MHRA are also reported to Commissioners and any advice and guidance that is recommended by the MHRA is implemented by the  Provider | Clause 32 |
| Innovation | Providers, with other partners as appropriate, shall participate in Research & Development to identify innovative products and solutions for users needs. | To work with commissioners to develop thresholds over time | Annual report to Commissioners | N/A |
|  | Providers shall provide training to transfer product knowledge and share learning with assessors | To work with commissioners to develop thresholds over time | Training activity reported quarterly | N/A |
|  | All service users shall have access to 24 hour telephone support | 100% availability | Quarterly report to Commissioners of usage | N/A |
|  | Evidence that equipment emergency call out and repair is within following targets.  (Please see below) | 100% | Reported through activity data set  Monthly information report to Commissioners | Clause 32 |
|  | Service user surveys shall be conducted in accordance with the terms of the contract.  The development of an on-line tool is preferred. | 100% | Annually | Clause 32 |
| CQC Essential Standards of Equality & Safety | Formal forums exist where service users may provide feedback (i.e. forums, service user groups, including children and their parents.) | 100% | Terms of reference and copies of notes of meetings with attendees quarterly to Commissioners | Clause 32 |

Table 3: Performance times

| ACTION | Measure | Currently Recommended  MAXIMUM |
| --- | --- | --- |
| **Referrals, Access & Assessment (Episode)** | | |
| All referrals will be screened by approved personnel within the service | Working Day | 2 |
| Incomplete referrals will be returned to the referrer for completion | Working Day | 2 |
| Referrals will be acknowledged. | Working Week | 1 |
| From receipt of referral to assessment & prescription issue (Urgent) | Working Week | 2 |
| From receipt of referral to assessment & prescription issue (Standard) | Working Week | 6 |
| **Provision (Episode)** | | |
| Incomplete Prescriptions returned to prescriber | Working Day | 2 |
| From prescription to delivery of equipment: |  |  |
| *Basic Standard Chair* | Working Week | 3 |
| *Orders from manufacturers* | Working Week | 6 |
| *Made to measure (Bespoke seating)* | Working Week | 6 - 12 |
| **Repairs & Collections** | | |
| Non-emergency Repairs will be completed in | Working Day | 3 |
| Emergency Repairs/Responses will be within | Hours | 24 |
| Collections should be completed within | Working Day | 5 |
|  | | |
| The 18 week 'Referral to Treatment' times will continue to be measured and monitored | | |

Table 4: Performance times – future stretched targets

| ACTION | MAX TIME | |
| --- | --- | --- |
| **Referrals & Access** | | |
| Telephone & on-line SPOC | Immediate | |
| Paper | 1 | Hr |
| Paper - telephone referrer | 5 | Hr |
| Telephone & on-line SPOC | Immediate | |
| Paper | 1 | Wd |
| from SPOC to Assessment Centre | @ 1630hrs | Daily |
| *needs further work* | *? As received??* | |
| **Assessment** | | |
| Urgent – offer appointment | 1 | Wd |
| to assess within | 5 | Wd |
| Standard - offer appointment | 1 | Wd |
| to assess and issue prescription/voucher within | 20 | Wd |
| **Provision** | | |
| From presentation of prescription to delivery | | |
| Inform user of collection/delivery options | 1 | Wd |
| Basic Standard Chair: | | |
| provide (delivery/collection) within | 5 | Wd |
| Orders from manufacturers | 10 | Wd |
| Made to measure (Bespoke seating) | 4 - 8 | Wk |
| **Repairs** | | |
| Non-emergency Repairs will be completed in | | |
| fix or provide temporary solution | 3 | Wd |
| Completed solution | 10 | Wd |
| Emergency Repairs/Responses will be within | | |
| fix or provide temporary solution | 12 | Hr |
| Completed solution | 10 | Wd |

### **Nationally Specified Events**

Table 5: Nationally Specified events

| Technical Guidance Reference | Nationally Specified Event | Threshold | Method of Measurement | Consequence per breach |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |
|  |  |  |  |  |

### **Never Events**

Table 6: National Definition (part of standard contract)

| Never Events | Threshold | Method of Measurement | Never Event Consequence (per occurrence) |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |

**Not relevant**

## QUALITY INCENTIVE SCHEMES

### **Part 1 - Nationally Mandated Incentive Schemes**

[For national determination]

### **Commissioning for Quality and Innovation (CQUIN)**

**[DN: For local commissioners to agree applicability or not]**

**Table 1: CQUIN Scheme**

[The Parties are recommended to use the on-line standard template for CQUIN schemes 2011/12 available on the website of the NHS Institute for Innovation and Improvement:

<http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html>) to facilitate the completion and recording of their CQUIN scheme.

Where the Parties use the on-line standard template, a copy of the completed scheme must still be printed and appended to this Schedule 18 Part 2 in place of the tables below.]

Quality Incentive Payments can be agreed to be paid monthly or by single annual payments.

**PLEASE DELETE AS APPROPRIATE** “The Parties agree that Quality Incentive Payments shall be paid monthly and therefore the provisions set out in paragraphs 5 to 13 below shall apply.” **OR “**The Parties agree that Quality Incentive Payments shall be paid annually and therefore the provisions set out in paragraphs 14 to 19 below shall apply.

Table 7: Summary of goals[[2]](#footnote-3)

| Goal Number | Goal Name | Description of Goal | Goal weighting  (% of CQUIN scheme available) | Expected financial value of Goal (£) | Quality Domain (Safety, Effectiveness, Patient Experience or Innovation) |
| --- | --- | --- | --- | --- | --- |
| 1 |  | [insert locally agreed goals] |  |  |  |
| 2 |  | [insert locally agreed goals] |  |  |  |
| 3 |  | [insert locally agreed goals] |  |  |  |
| 4 |  | [insert locally agreed goals] |  |  |  |
| etc |  | [insert locally agreed goals] |  |  |  |
|  |  | **Totals:** |  |  |  |

Table 8: Summary of indicators

| Goal Number | Indicator Number**[[3]](#footnote-4)** | Indicator Name | Indicator Weighting  (% of CQUIN scheme available) | Expected financial value of Indicator (£) |
| --- | --- | --- | --- | --- |
| 1 |  | [insert the indicator or indicators that are agreed in respect of each goal] |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| Etc |  |  |  |  |
|  |  | **Totals:** |  |  |

Table 9: Detail of Indicator (to be completed for each indicator)

|  |  |
| --- | --- |
| Indicator number |  |
| Indicator name |  |
| Indicator weighting (% of CQUIN scheme available) |  |
| Description of indicator |  |
| Numerator |  |
| Denominator |  |
| Rationale for inclusion |  |
| Data source |  |
| Frequency of data collection |  |
| Organisation responsible for data collection |  |
| Frequency of reporting to commissioner |  |
| Baseline period/date |  |
| Baseline value |  |
| Final indicator period/date (on which payment is based) |  |
| Final indicator value (payment threshold) |  |
| Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner) |  |
| Final indicator reporting date |  |
| Are there rules for any agreed in-year milestones that result in payment? |  |
| Are there any rules for partial achievement of the indicator at the final indicator period/date? |  |

Table 10: Milestones (only to be completed for indicators that contain in-year milestones)

|  |  |  |  |
| --- | --- | --- | --- |
| Date/period milestone relates to | Rules for achievement of milestones (including evidence to be supplied to commissioner) | Date milestone to be reported | Milestone weighting (% of CQUIN scheme available) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  | Total: |  |

Table 11: Rules for partial achievement at final indicator period/date

| Final indicator value for the part achievement threshold | % of CQUIN scheme available for meeting final indicator value |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |

1. Subject to paragraph 2, if the Provider satisfies a Quality Incentive Scheme Indicator set out in Schedule 18 Part 2 Table 1, a Quality Incentive Payment shall be payable by the Commissioners to the Provider in accordance with this Schedule 18 Part 2.
2. The Commissioners shall not be liable to make Quality Incentive Payments under this Schedule 18 Part 2 to the Provider in respect of any Contract Year which in aggregate exceed the applicable Actual Outturn Value percentage for the relevant Contract Year set out below:

Table 12: Outturn Value percentage for the relevant Contract Year

|  |  |
| --- | --- |
| Contract Year | Maximum aggregate Quality Incentive Payment |
| 1st Contract Year | [For national determination and local insertion] |
|  |  |
|  |  |

In addition, for the avoidance of doubt this paragraph shall limit only those Quality Incentive Payments made under this Schedule 18 Part 2, and shall not limit any Quality Incentive Payments made under any Quality Incentive Scheme set out in Schedule 18 Part 1 or Schedule 18 Part 3.

1. The Provider shall in accordance with clause [33] of this Agreement submit to the Co-ordinating Commissioner a Service Quality Performance Report which shall include details of the Provider’s performance against and progress towards the Quality Incentive Scheme Indicators set out in Schedule 18 Part 2 Table 1 in the month to which the Service Quality Performance Report relates.
2. The provisions set out in paragraphs 5 to 13 below apply in respect of Quality Incentive Payments made by monthly instalments. The provisions set out in paragraphs 14 to 19 apply in respect of Quality Incentive Payments made by a single annual payment.

**Monthly Quality Incentive Payments**

1. Where the Co-ordinating Commissioner and the Provider have agreed that Quality Incentive Payments should be made on a monthly basis by any Commissioners, then in each month after the Service Commencement Date during the term of this Agreement each relevant Commissioner shall make the default Quality Incentive Payment set out below to the Provider:

Table 13: Quality Incentive Payment

|  |  |
| --- | --- |
| Commissioners | Monthly Quality Incentive Payment – 1st Contract Year |
| [insert name of each Commissioner making monthly CQUIN payments] |  |
|  |  |
|  |  |

In addition, the Provider and the Co-ordinating Commissioner may from time to time, whether as a result of a review performed under paragraph 6 below or otherwise, agree to vary the default monthly Quality Incentive Payment for any Commissioner set out above.

1. The Co-ordinating Commissioner shall review the Quality Incentive Payments made by the Commissioners under paragraph 5 on the basis of the information submitted by the Provider under this Agreement on the Provider’s performance against the Quality Incentive Scheme Indicators. Such reviews shall be carried out as part of each Review under clause [8].
2. In performing the review under paragraph 6 the Co-ordinating Commissioner shall reconcile the Quality Incentive Payments made by the relevant Commissioners under paragraph 5 against the Quality Incentive Payments that those Commissioners are liable to pay under paragraph 1 on the basis of the Provider’s performance against the Quality Incentive Scheme Indicators, as evidenced by the information submitted by the Provider under this Agreement.
3. Following such reconciliation, where applicable, the Provider shall invoice the relevant Commissioners separately for any reconciliation Quality Incentive Payments.
4. Within [10] Operational Days of completion of the review under paragraph 6, the Co-ordinating Commissioner shall submit a Quality Incentive Payment reconciliation account to the Provider.
5. In each reconciliation account prepared under paragraph 9 the Co-ordinating Commissioner:
   1. shall identify the Quality Incentive Payments to which the Provider is entitled, on the basis of the Provider’s performance against the Quality Incentive Scheme Indicators set out in Schedule 18 Part 2 Table 1 in those months of the relevant Contract Year that have elapsed at the time of the review;
   2. shall ensure that the Quality Incentive Payments made to the Provider in respect of completed Contract Years comply with the requirements of paragraph 2;
   3. may correct the conclusions of any previous reconciliation account, whether relating to the Contract Year under review or to any previous Contract Year; and
   4. shall identify any reconciliation payments due from the Provider to any Commissioner, or from any Commissioner to the Provider.
6. Within [5] Operational Days of receipt of the Quality Incentive Payment reconciliation account from the Co-ordinating Commissioner, the Provider shall either agree, or, acting in good faith, contest such reconciliation account.
7. The Provider’s agreement of the Quality Incentive Payment reconciliation account (such agreement not to be unreasonably withheld) shall trigger a reconciliation payment by the relevant Commissioner(s) to the Provider, or by the Provider to the relevant Commissioner(s), as appropriate, and such payment shall be made within [10] Operational Days of the Provider’s agreement of the reconciliation account and the Provider’s invoice.
8. If the Provider, acting in good faith, contests the Co-ordinating Commissioner’s Quality Incentive Payment reconciliation account:
   1. the Provider shall within [5] Operational Days notify the Co-ordinating Commissioner, setting out reasonable detail of the reasons for contesting such account, and in particular identifying which elements are contested and which are not contested;
   2. any uncontested payment identified in the Quality Incentive Payment reconciliation account shall be paid in accordance with paragraph 12 by the Party from whom it is due; and
   3. if the matter has not been resolved within 20 Operational Days of the date of notification under paragraph 13.1, either Party may refer the matter to dispute resolution under clause [28] (*Dispute Resolution*),

and within [20] Operational Days of the resolution of any Dispute referred to dispute resolution in accordance with this paragraph 13 the relevant Party shall pay any amount agreed or determined to be payable.

**Single annual payment of Quality Incentive Payments**

1. Where the Provider and Co-ordinating Commissioner have agreed that one single Quality Incentive Payment should be made to the Provider by any Commissioner at the end of each Contract Year, then at the end of each Contract Year during the term of this Agreement each Commissioner set out in the table in this paragraph 14 shall, subject to the Provider’s performance against the Quality Incentive Scheme Indicators, make a single Quality Incentive Payment to the Provider in accordance with the procedure set out in paragraphs 15 to 19 below.

|  |
| --- |
| Commissioners making single annual Quality Incentive Payment at the end of the Contract Year |
| [insert name of any Commissioner making a single annual CQUIN payments]  [Insert amount of the single annual CQUIN payment for each relevant Commissioner] |
|  |
|  |

1. The Co-ordinating Commissioner shall, within [10] Operational Days of the end of the Contract Year to which the Quality Incentive Payments relate or its receipt of final information from the Provider on its performance against the Quality Incentive Scheme Indicators during that Contract Year (whichever is the later), submit to the Provider a statement of the Quality Incentive Payments to which the Provider is entitled on the basis of the Provider’s performance against the Quality Incentive Scheme Indicators during the relevant Contract Year, as evidenced by the information submitted by the Provider under this Agreement.
2. Within [5] Operational Days of receipt of the Quality Incentive Payment statement from the Co-ordinating Commissioner under paragraph 15, the Provider shall either agree, or, acting in good faith, contest such statement.
3. The Provider’s agreement of the Quality Incentive Payment statement (such agreement not to be unreasonably withheld) shall trigger a payment by the relevant Commissioner(s) to the Provider, and such payment shall be made within [10] Operational Days of the Provider’s agreement of the statement and the Provider’s invoice.
4. In the event that the Quality Incentive Payment under paragraph 17 is paid before the final reconciliation account for the relevant Contract Year is agreed under clause [7] (*Prices and Payment*) of this Agreement, then if the Actual Outturn Value for the relevant Contract Year is not the same as the expected Annual Contract Value against which the Quality Incentive Payment was calculated, the Co-ordinating Commissioner shall within [10] Operational Days of the agreement of the final reconciliation account under clause [7] send the Provider a reconciliation statement reconciling the Quality Incentive Payment against what it would have been had it been calculated against the Actual Outturn Value, and a reconciliation payment in accordance with that reconciliation statement shall be made by the relevant Commissioner to the Provider or by the Provider to the relevant Commissioner, as appropriate, within [10] Operational Days of the submission to the Provider of the reconciliation statement under this paragraph 18.
5. If the Provider, acting in good faith, contests the Co-ordinating Commissioner’s Quality Incentive Payment statement under paragraph 15 or reconciliation statement under paragraph 18:
   1. the Provider shall within [5] Operational Days notify the Co-ordinating Commissioner, setting out reasonable detail of the reasons for contesting the relevant statement, and in particular identifying which elements are contested and which are not contested;
   2. any uncontested payment identified in the relevant statement shall be paid in accordance with paragraph 17 by the relevant Commissioner or the Provider, as the case may be; and
   3. if the matter has not been resolved within 20 Operational Days of the date of notification under paragraph 19.1, either Party may refer the matter to dispute resolution under clause [28] (*Dispute Resolution*),

and within [20] Operational Days of the resolution of any Dispute referred to dispute resolution in accordance with this paragraph 19 the relevant Party shall pay any amount agreed or determined to be payable.

### **Locally Agreed Incentive Schemes**

Not Applicable (tariff-based service)

## ELIMINATING MIXED SEX ACCOMMODATION PLAN

Not Applicable

## SERVICE DEVELOPMENT AND IMPROVEMENT PLAN

Table 14: Service Development and Improvement Plan

| Description of Scheme | Milestones | Timescales | Expected Benefit | Consequence of Achievement/ Breach |
| --- | --- | --- | --- | --- |
| [insert as defined locally] | [insert as defined locally] | [insert as defined locally] | [insert as defined locally] | Subject to clause [32] (Contract Management) |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

## SERVICE USER, CARER AND STAFF SURVEYS

### **Service User, Carer and Staff Surveys**

Feedback from service users is essential to developing quality wheelchair, seating and associated equipment provision services, and is used to assist performance management and improve service delivery

All service users shall be asked to complete an anonymous post-handover satisfaction survey within a [DN: **timescale agreed by the Commissioner and the Provider]**. The survey results shall be available to the Commissioner on a yearly basis so that they can be used for performance management and service planning. The information gathered by the user satisfaction survey shall be taken into account when reviewing Requirements and commissioning arrangements.

Providers shall respond positively to any comments offered about the standard of service they provide, for example from services users, assessors, other Providers, or from the wider public.

The Provider shall give individuals and carers the opportunity to comment on their experience of using the service on an ongoing basis, through user surveys, Patient and Public Involvement work, PALS, complaints, compliments and other activities.

**[DN: Suggest yearly sample user and carer survey run by the commissioner or an independent person/organisation to verify provider results.]**

## CLINICAL NETWORKS AND SCREENING PROGRAMMES

[For local agreement and not to conflict with any information in Service Specifications]

**[DN: such as:**

* Local clinical networks
* Regional groups
* National groups
* Users groups
* All local and national forums
* Appropriate trade organisations

## REPORTING AND INFORMATION MANAGEMENT

All information gathered for the purposes of reporting is subject to the requirements set out in clause [27], (*Data Protection, Freedom of Information and Transparency*) and clause [56] (*Compliance with the Law*).

### **National Requirements Reported Centrally**

1. The Provider and Commissioner shall comply with the reporting requirements of SUS and UNIFY2. This includes compliance with the required format, schedules for delivery of data and definitions as set out in the Information Centre guidance and all Information Standards Notices (ISNs), where applicable to the service being provided.
2. The Provider shall ensure that each dataset that it provides under this Agreement contains the Organisation Data Service (ODS) code for the relevant Commissioner, and where the Commissioner to which a dataset relates is a Specialised Commissioning Group, or for the purposes of this Agreement hosts, represents or acts on behalf of a Specialised Commissioning Group, the Provider shall ensure that the dataset contains the ODS code for such Specialised Commissioning Group.
3. The Provider shall collect and report to the Commissioner on the patient-reported outcomes measures (PROMS) in accordance with applicable Guidance.
4. The Provider shall comply with the national reporting requirements in relation to Sleeping Accommodation Breaches as set out in the Professional Letter.

### **National Requirements Reported Locally**

### **Local Requirements Reported Locally**

[Insert information that is local required and agreed - to include format, method of delivery and Frequency.]

For further information please refer to:

* Information Standards Board - Community Information Data Set

Date Published 03/08/2011

DH Gateway Ref 16476

Implementation Completion Date 01/04/2012

Standard Number ISB 1510

* And the ‘Community Information Data Set – Data Model’

Table 15: ‘Community Information Data Set – Data Model’

| Equipment Provider | | | From Prescription |
| --- | --- | --- | --- |
| The Person | NHS Number | *Or sufficient locally agreed data to verify user; such as name, post code etc* | Yes |
| Local Patient ID |  |  |
| Org Code (Provider) |  |  |
| NHS Number Status Indicator |  | Yes |
|  |  |  |  |
| The Referral | Referral Request Received Date | *Presentation of Prescription = Referral* |  |
| Waiting Time Measurement Type |  |  |
| Referral to Treatment Start Date | *Treatment = provision of equipment* |  |
| Referral to Treatment End Date |  |  |
| Referral to Treatment Period Status |  |  |
| Referral Request Received Date | *Presentation of Prescription = Referral* |  |
|  |  |  |  |
| The Contact | Care Contact Date | *Of face to face appointment* |  |
| Contact Duration |  |  |
| Activity Location Type |  |  |
| Site Code |  |  |
| Attended or Did Not Attend |  |  |
| User/Carer Objectives Reviewed | *To ensure equipment meets agreed criteria* | Yes |
| Provision Type Code to meet Prescription | *(In line with local currency)* |  |
| Was equipment provided exactly to prescription | *Patient Choice* |  |
| Reason If user changed equipment prescription |  |  |
| If user changed equipment prescription what was source of funding if in excess of tariff | *Commissioner only pays for agreed prescription provision* |  |
| Care Plan (Key Worker Updated re outcome) |  | Yes |
| Assessor (Updated re outcome) |  | Yes |
|  |  |  |  |
| Activity | *To be agreed locally* | *To establish base-line data and other performance issues*  *(such as chair trials; prescriber in attendance etc* |  |
|  |  |  |  |
| Outcomes | Surveys to establish user/carer satisfaction | *To be agreed locally* |  |
|  |  |  |  |
| Other | To measure the requirements of B2 – Quality not covered above | *To be agreed locally* |  |

### **Data Quality Improvement Plan**

Table 16: Data Quality Improvement Plan

| Data Quality Indicator | Data Quality Threshold | Method of Measurement | Milestone Date | Consequence |
| --- | --- | --- | --- | --- |
| [for local definition] | [for local definition] | [for local definition] | [for local definition] | [for local definition] |
|  |  |  |  |  |

**[DN: Local commissioners to agree with their Data Systems Managers all applicable Improvement Measures necessary for providers to comply with the NHS Operating Framework requirements for Secondary Users Systems (SUS) and Unify Reporting as mandated or recommended]**

* + - * 1. – DOCUMENTS USED

**SECTION 1 APPENDIX 1 – DOCUMENTS USED**

**[DN: this may be more appropriately inserted into one of the contract schedules when published by the DH]**

* Equity Excellence: Liberating the NHS 2009
* CQC Essential Requirements of Equality & Safety
* Guidance on The Commissioning Wheelchair Services 2003
* Health and Safety & Manual Handling Regulations
* NSF Older People
* NSF Children
* Improving Services For Wheelchair Users 2004 Good Practice Guide 9
* Fair Access to Care Services 2001
* Health Care Requirements for NHS Commissioned Wheelchair Services 2010
* Audit Commission - Assisting Independence
* How to Consult: Your User Guide – An Introductory Guide
* NHS Act 1977 and NHS Act 2006 (Consequential Provisions)
* Can You Hear Us? (Save the children)
* Fair Access to Care Services
* National Strategy for Carers
* Fully Equipped and Assisting Independence
* Equality Act 2010 (and Disability Discrimination Act 1995)
* The Carers (Recognition and Services) Act 1995
* Human Rights Act 1998
* Green Paper 2011: *Support and aspiration: A new approach to special educational needs and disability*
* Wheelchair and Seating Modernisation Action Plan Scotland 2009
* Transforming Community Services: Demonstrating and Measuring Achievement: Community Indicators for Quality Improvement, March 2011
* Information Standards Board - Community Information Data Set 2011
* DH Better Care Higher Standards – A charter for long term care
* DH Access to Health Services for Military Veterans – Priority Services, Dear Colleague Letter, 9 Feb 2010

# 

1. Currency & Pricing Methodology
   1. Currency

The term ‘currency’ refers to the unit of healthcare for which a provider is funded. Each aspect of care within the scope of the currency can be costed and then aggregated to produce a total cost for the currency of care for an individual. Costing should be done from the bottom-up where possible.

For wheelchair services three currencies have been defined.

Currency 1 = Assessment

Currency 2 = Provision and aftercare

Currency 3 = Assessment, Provision and aftercare

Commissioners are able to choose which combination of currencies they wish to use locally.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Currency 1 - Assessment | Currency 3 – Assessment, Provision and Aftercare | Manual Assessment £ = |  | |  | | --- | |  | |
| Powered Assessment £ = |  | TBC |
|  |  |  |
| Currency 2 – Provision and Aftercare | Wheelchair & Equipment Package 1 £ = | | TBC |
| Wheelchair & Equipment Package 2 £ = | |
| Wheelchair & Equipment Package 3 £ = | |
| Wheelchair & Equipment Package 4 £ = | |
| Wheelchair & Equipment Package 5 £ = | |
| Wheelchair & Equipment Package 6 £ = | |
| Wheelchair & Equipment Package 7 £ = | |
| Wheelchair & Equipment Package 8 £ = | |
| Wheelchair & Equipment Package 9 £ = | |
| Wheelchair & Equipment Package 10 etc £ = | |

* + 1. Definition for Currency for Assessment
       1. Activities common to both currencies
* Receiving referral
* Categorising users/screening
* Identifying Assessor/prioritisation/triage
* Identify the location of assessment
* Schedule assessment appointment
* Prepare and organise assessment
* Undertake assessment (see further detail)
* Discuss options for equipment
* Provide information including reviews
* Signposting for adaptations/other services
* Agree care plan
* Agree prescription
* Provide information on re referral/ reassessment
* Signpost to equipment providers
  + 1. Criteria for Manual Assessment

Assessment for individuals who have

* Relatively low need - supported self care
* Are eligible for manual mobility equipment
* May require basic modifications to the equipment

Requires a trained assessor considering all aspects of health and wellbeing with routine review with one face to face contact

Assessment for individuals who

* Need more clinically focused assessment with skills around management of a condition including tissue viability, posture care and seating options – care management approach
* Are eligible for manual mobility equipment
* Require regular review

Requires holistic assessment by a professional whose core role is to undertake assessments and reviews based on a comprehensive analysis of need that considers all aspects of health and wellbeing and likely to involve more than one face to face contact

* + 1. Criteria for Powered Assessment

Assessment for individuals who

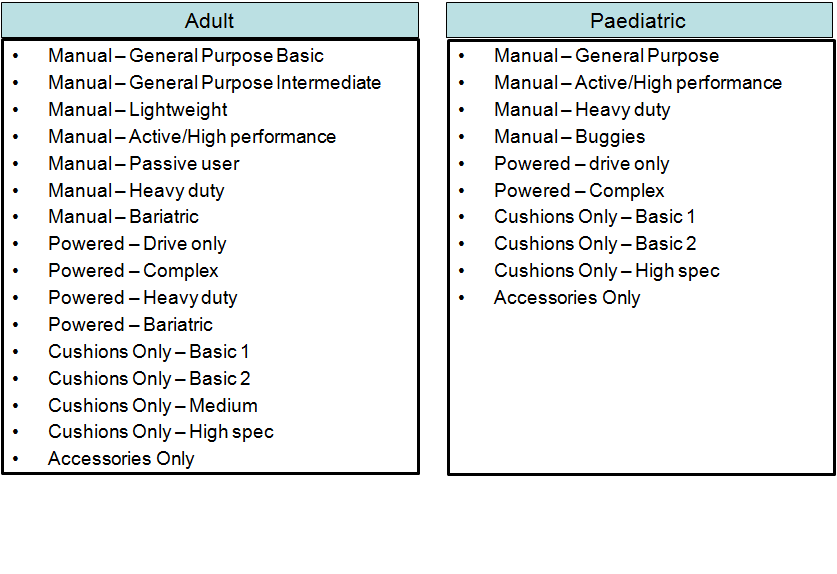
* Are eligible for powered mobility equipment
* Requires holistic assessment by a professional whose core role is to undertake assessments and reviews based on a comprehensive analysis of need that considers all aspects of health and wellbeing and regular review

Requires an assessment of physical and cognitive ability to operate powered mobility equipment with more than one face to face contact

* + 1. Definition for Currency for Equipment Provision and Aftercare

Detail is included in the embedded spreadsheet. It should be noted that cushions and accessories are included in the main equipment packages for the duration of the prescription. However, cushions only and accessories only packages are included where additional items are required during the prescription, for example, to enable changing conditions to be accommodated.





* 1. Pricing Methodology

The approach to costing/pricing the currencies identified above is based on the following assumptions and closely follows the draft Department of Health guidance regarding high level principles for pricing of ‘any qualified provider’ tariffs and the mandatory costing guidance in the latest version of the NHS Costing Manual.

* That under the ‘Any Qualified Provider’ model, commissioners will pay any potential providers the same rate for each service delivered to achieve a specified outcome (as defined in the service specification).
* The currencies identified above imply tiered services for assessment, based on whether the patient/client is being assessed for a manual or powered chair and for the provision of wheelchair and equipment packages, based on the nature of the chair and accessories provided.
* The pricing methodology is common to all of the currencies identified. Assessment currencies reflect direct costs of administrative and clinical staff time required to carry out the assessments and their role in ensuring that the patient receives the prescribed solution, together with indirect costs associated with staff training, travel and annual leave and sickness cover. All other costs are treated as an overhead and added to the direct and indirect elements to arrive at a total cost.
* The proportion of staff time included in the handover and checking element of the assessment currency reflects the assumption that 100% of powered wheelchair assessments will require staff attendance but only 25% of the manual chair assessments will require staff from the assessment service to attend.
* The wheelchair and equipment package costs/price reflects the purchase of a wheelchair (from a range of manual and powered models available) together with the costs of delivering this to the patient/client and the estimated lifetime costs of accessories, e.g. seat cushions and back rests, and a repairs and maintenance warranty covering the same 3 to 5-year life expectancy of the chair.
* Whilst the local work within the East of England has been based on purchase costs of the equipment and associated warranties there is no logical reason why procurement could not be undertaken on a lease basis, with the tariff price representing annual payment options and ownership of the chairs and other items remaining with the supplier rather than transferring to a commissioner or patient/client.
* There is no nationally agreed wheelchair currency/tariff and wheelchair activity and costs are not specifically identified within the national reference costs exercise. It may be possible in future to collect such information if the proposed currencies above are endorsed and implemented for AQP purposes.
* The East of England work on costing/pricing has been informed by work undertaken within the South West of England some years ago, together with more recent data collected by NHS Wheelchair Service providers within the East of England, and by the published accounts of three Community NHS Trusts (Norfolk, Hertfordshire and Cambridgeshire) at 31 March 2011.
* The table overleaf includes the timings and other components of the costing/pricing model developed locally. It must be stressed that these are indicative prices, based on averages and the relationships between staff and non-pay costs at a small number of East of England community provider organizations in 2010/11. They will also reflect the Market Forces Factor relevant to this group of trusts. Tariffs appropriate to other geographies will need to adjust for differences between East of England and local MFF.
* Before the prices associated with each proposed currency are circulated more widely there is a need to conduct a ‘sense-check’ with existing wheelchair service providers and with wheelchair and accessory suppliers to understand the extent to which the calculated prices will encourage appropriate commissioning and provider behaviours.
  + 1. Assessment

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Activity | Staff Group | Manual | | Powered | |
|  |  | Time  (hrs) | Cost  (£) | Time  (hrs) | Cost  (£) |
| Referral | Band 3 | 0.25 |  | 0.25 |  |
| Triage | Band 3 | 0.25 |  | 0.25 |  |
|  | Band 7 | 0.5 |  | 0.5 |  |
| Assessment | Band 7 | 0.75 |  | 2.0 |  |
| Prescribe | Band 7 | 0.25 |  | 0.25 |  |
| Re-assess | Band 7 | 0.75 |  | 0.75 |  |
| Handover | Band 7 | 0.25 |  | 1.0 |  |
| Checking modifications | Band 7 | 0.25 |  | 1.0 |  |
| Customer feedback | Band 3 | 0.17 |  | 0.17 |  |
| Direct costs |  |  |  |  |  |
| Indirect costs (as % of direct costs) | 10% travel; 10% training; 16.5% annual leave & sickness |  |  |  |  |
| Overhead costs (as % of direct costs) | All other costs 30% |  |  |  |  |
| **Totals** |  |  |  |  |  |

* + 1. Wheelchair and Equipment Packages

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Component | Chair 1  (£) | Chair 2  (£) | Chair 3  (£) | Chair 4  (£) | Chair 5  (£) | Chair 6  (£) | Chair 7  (£) | Chair 8  (£) | Chair 9  (£) | Chair 10  (£) |
| Wheelchair | tbc | tbc | tbc | tbc | tbc | tbc | tbc | tbc | tbc | tbc |
| Accessories (lifecycle cost) | tbc | tbc | tbc | tbc | tbc | tbc | tbc | tbc | tbc | tbc |
| Repair and maintenance warranty (lifecycle cost) | tbc | tbc | tbc | tbc | tbc | tbc | tbc | tbc | tbc | tbc |
| **Totals** | tbc | tbc | tbc | tbc | tbc | tbc | tbc | tbc | tbc | tbc |

TBC – to be confirmed through local pricing exercise

# 

1. Information requirements for Service Users

**Section 2 Information requirements for Service Users**

**User Information Leaflet/Booklet**

**WHEELCHAIR SERVICES**

**[DN: It is for commissioners to engage with suitable user groups and other interest bodies to ensure that the contents are relevant to their local population]**

As a minimum we recommend that the following information is included:

**Background**

How the NHS obtains services and what choices this offers to the individual (i.e. what is AQP)

**Do I qualify for an NHS Funded Wheelchair?**

List criteria to qualify for NHS Funded wheelchair

Explain that what was previously referred to as a ‘Voucher’ is now called a prescription.

**What are my choices? for example:**

**General Service information**

Waiting times to access service and the time between each stage of the pathway.

Provision of additional support mechanisms available (e.g. patient and carer

support groups, expert patients etc.)

Availability of additional integrated care services

Choices in provision of care (e.g. setting for appointments)

**Provider specific information**

Information on range of services and products

Quality assurance and requirements of care information (including service user experience data, skill-sets and experience)

**How do I access the service?**

Provide referral/access routes and options

**Where can I get help/advice?**

List local, regional and national sources of information and assistance, and contact details for any call centre type arrangements that may be available locally, such as a Single Point of Contact..

*An example from a national charity is included on following pages.*

**What if things go wrong?**

How to challenge decisions, and escalate problems

What if my equipment fails

**EXAMPLE OF:**

**Further Information and advice**

Wherever you live there will be information agencies that know about what's available locally. Many areas have a local disability organisation or action group. Ask at your library or council information services. It is also worth looking under disability in your local classified telephone book.

[DN: Commissioners to insert details any other organisations available locally]

**The BHTA**

The British Healthcare Trades Association (BHTA) is the trade association for the healthcare industry. It has a national membership of manufacturers and suppliers of mobility aids and other products. The BHTA code of practice sets out requirements that its members must meet.

Shops and suppliers will display their BHTA membership if they have one.

Suite 4.06

New Loom House

101 Back Church Lane

London

E1 1LU

Tel: 020 7702 2141

Email: [bhta@bhta.com](mailto:bhta@bhta.com), [complaints@bhta.com](mailto:complaints@bhta.com)

[www.bhta.net](http://www.bhta.net)

**DIAL UK**

DIAL UK is a network of some 120 local Disability Information and Advice Line services (DIALs). They are run by disabled people for disabled people. They give information and advice on anything to do with living with a disability. They can help you find a local mobility shop.

To find your nearest DIAL contact:

St Catherine's

Tickhill Road

Doncaster DN4 8QN

Tel: 01302 310123

Fax: 01302 310404

Textphone: 01302 310123 and use voice announcer

Email: informationenquiries@dialuk.org.uk

[www.dialuk.info](http://www.dialuk.info)

**Disabled Living Foundation (DLF)**

The DLF provides comprehensive information about equipment and where to get it. Their website includes clearly written guides about a range of daily living equipment. They produce a range of factsheets and guides.

AskSARA is a very helpful online system that will tell you what kind of equipment may help you. You choose a topic (such as bathroom, gardening, hobbies or leisure or hearing) and answer a series of very simple questions. AskSARA then will give you a rundown of things that might help, things to think about and advice on what to do next.

Their helpline will give you information by phone, and they can send you printed guides and information.

380-384 Harrow Road

London W9 2HU

Local rate Helpline: 0845 130 9177

Fax: 020 7266 2922

Textphone: 020 7432 8009

Email: [advice@dlf.org.uk](mailto:advice@dlf.org.uk)

[www.dlf.org.uk](http://www.dlf.org.uk)

[www.livingmadeeasy.org.uk](http://www.livingmadeeasy.org.uk)

www.asksara.org.uk

**Disabled Living Centres**

There are over 40 Disabled Living Centres (called independent living centres in some places) up and down the country. Most centres have displays of equipment that you can see and try out they stock and display a variety of products to meet most needs. They can advise you about the range of equipment and solutions available to meet your needs and where it is available. They will often advise you about the best way of getting equipment too, whether this be by buying privately or through the social or health services. Most DLCs operate as charities and offer impartial advice. If they do sell equipment their main consideration is to provide you with the information for specific solutions and give you a choice. If possible ring to make an appointment before you visit a DLC so they can make sure there is someone free to talk to you.

To find your nearest centre contact **Assist UK**:

Redbank House

4 St Chad Street

Manchester

M8 8QA

Tel: 0161 832 9757

Email: [general.info@assist-uk.org](mailto:general.info@assist-uk.org)

[www.assist-uk.org](http://www.assist-uk.org)

www.livingaidsdirect.co.uk

**Shopmobility**

Independent charity supporting shopmobility schemes throughout the UK. To find your nearest scheme contact:

P O Box 6641

Christchurch BH23 9DQ

Tel: 08456 442446

Fax: 08456 444442

Email: [info@shopmobilityuk.org](mailto:info@shopmobilityuk.org)

www. shopmobilityuk.org

**Ricability**

**Motability**

[DN: Following is an example Information Leaflet for Children’s Equipment & Wheelchair Services]

Provision of equipment / wheelchair services in the........... ............... area is a partnership between the following agencies.

We promise that we will seek to work together to deliver a high quality service for children and young people. If you feel we are not meeting these expectations, please contact us and let us know and we will tell you what we are doing to get it right

Telephone number .........................

E-mail ...........................................

Postal address ..........................................................................

List of agencies involved

* NHS commissioners\*
* Local authority
* Community health care services and or hospital services
* Local Equipment Provider
* Other relevant third sector group

\*Commissioners are people who make decisions about what services in an area will be purchased and who will be providing them, based on knowledge of the local population’s needs, the resources available and best practice guidelines and requirements.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 in collaboration with

**When receiving equipment (and wheelchair services) in the ....................area**

**You have the right to expect……**

**C:\Users\lynda\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\ZTKFJPJA\MC900354126[1].wmf**

1. **TIMELINESS**

**Assessments, provision, reviews and repairs to equipment will be done in a timely way to meet the needs of your child or young person.** These timescales will be made clear to you at the beginning of your involvement with the services and assessments will include your wider family needs.

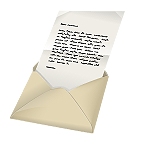
1. **TRANSPARENCY**

**C:\Users\lynda\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\ZTKFJPJA\MC900355983[1].wmfClear criteria for what equipment and services are available to you.** These will be given to you at the beginning, and updated as required. There will be clear and understandable ways that decisions are made, with no unnecessary delays, and written explanations will be

given to you if requests for equipment are turned down because they do not meet the criteria.

1. **CUSTOMER CARE**

C:\Users\lynda\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\4BLSRO32\MC900056778[1].wmf **A good service** e.g. when equipment is delivered you have warning of its arrival, it is fitted, and you are shown how to use and care for the equipment. You will have a choice as to where this happens - at home/school or the wheelchair centre etc. You will be given product manuals and an easy way to contact the service if there are problems or difficulties with the equipment, or when you need a repair or a replacement.

****

1. **COMMUNICATION**

**To be kept informed of progress.** If you make a complaint or have a concern about the service you are being given you will get a speedy response with clear written answers and the actions being taken to sort out the problem.

**C:\Users\lynda\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\Z5HTX1FJ\MC900354154[1].wmf**

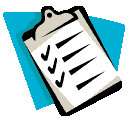
1. **INFORMATION**

**To be given helpful information, especially when you are not supplied equipment by the service.** You will be given information about local and national voluntary sector groups for advice and guidance, help to find local or national charities who provide grants for special equipment, support for applications, and information and help regarding suitable equipment for your child’s needs.

1. **C:\Users\lynda\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\8OM2HHCO\MC900436992[1].wmfPARTNERSHIP and PARTICIPATION**

**To be working together with services**. You and, where possible your child, will have your voice heard in the selection of any particular piece of equipment – if it’s not right for your child they will not benefit from it.

1. **FEEDBACK and INVOLVEMENT**

**MC900197723[1]To be asked for your views by the services which provide the equipment and the assessments etc**. This information will be used to monitor the services and inform the way the services are developed.  Services and those who \*commission them will work with parents, carers, children, and young people in their area when planning or reviewing services.

Parent and Carers Expectations of Equipment Services – Author Lynda Niles, March 2011

# 

1. Recommendations on Qualifications

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**Section 4 – Recommendations on Qualifications**

* 1. AQP Wheelchairs
     1. Recommendations on Qualifications

The qualification process consists of an on-line questionnaire (Supply2Health) consisting of 8 sections, 6 of which are generic, one are standard questions but the responses based on your local specification (Section 5) and a final Declaration section.

In the qualifications section a number of professions may be listed with the HPC. People listed in this area are expected to be involved in the provided service in the location of the advertised requirement.

It is recognised that there is no accredited qualification specific to wheelchair services; however, operation of the service will require at least one individual registered with the Health Professions Council (HPC) who is the individual responsible for clinical governance.

Clinical governance should provide clear assurance that the appropriate processes, reporting, audit procedures and potential responses to untoward events are in place. It should include an annual formal audit where a random sample is examined to establish amongst others delivery against care plan, outcomes, and speed of issue, review process, customer experience and appropriateness of issued equipment. The approach to poor performance should also be illustrated. The specification also requires monthly clinical quality performance information to be provided to commissioners and this should be included in the response.

Where registration with a profession body is voluntary it is desirable that professionals providing these services are registered.

It is also desirable for equipment solution providers to be registered with the Medicines and Healthcare products Regulatory Agency (MHRA) and comply with all relevant procedures and guidance. This is required to ensure all appropriate alerts are received and includes ensuring traceability of the equipment provided and it’s service history throughout the products life.

A CRB check is required on all appropriate staff before service commencement. Providers can potentially indicate no to currently fulfilling this, provided commissioners are assured that this will be rectified before service commencement.

* + 1. Local requirements

It is for local commissioners to use the specification to set their own acceptable criteria, and as such a local question can be used that establishes a providers competency and capability.

Within Section 5 there is the opportunity to complete up to 3 questions based on your local priorities and service requirements.

1. As the driver for AQP is to place the user in the position of driving the service it is critical to ensure that potential providers are user focused, collect feedback and utilise information to improve user outcomes and experiences. It is therefore suggested that a local question focused on understanding user feedback and how any gathered information is utilised and made available to future users, will be helpful in your evaluation of the providers who will be most successful in the future market.

**Suggested question** ***“Explain how you capture and use customer feedback in the development of the service and where appropriate how this information is made available to future potential users.”***

1. Local qualifications are a key section to add in order to provide further assurance on quality and safety of services. It is suggested that the qualifications or required competencies are added to this section that are specifically appropriate to wheelchair services – more than one may be added. Examples of training requirements that should be considered are highlighted in table 1.

**Suggested question** ***“Do you have a competency based system for training, monitoring and maintaining staff capability? If YES, please attach. If NO, What plans and systems do you have for this?”***

1. Innovation should relate to service improvements to drive QIPP but should also be expected to involve improving the customer experience.

**Suggested question** ***“Do you measure a basket of indicators to demonstrate innovation and service improvement, for example no of new products, services and process improvements introduced per annum; average turnover accounted for by new or significantly improved products and services? If YES, please attach latest report. If NO, What plans and systems do you have for measuring this?”***

The following table includes some attributes for staff involved in both the provision of assessment services and equipment solution services for wheelchairs.

Table 17: Recommendations on qualification attributes for the wheelchair service

| Attribute | Essential | Desirable | Notes |
| --- | --- | --- | --- |
| CQC Registration |  | √ | Wheelchair services activities do not fully fall within procedures in scope of regulated activity although many providers will have CQC regulation due to their organisational alignment |
| Health Profession Council | √ |  | Operation of the service will require at least one individual registered with HPC and who is the identified individual responsible for clinical governance |
| Qualifications and Competencies  Assessment Providers | √ |  | Individuals are employed with the appropriate clinical assessment competencies and skills including proof of posture and mobility management, including spasticity management , understanding of posture on respiratory function, tissue viability , wheelchair skills /knowledge and knowledge and understanding of the impact of clinical conditions on function prognosis.  Individuals are employed with the appropriate competencies in listening and advocacy skills, capable of communicating effectively and knowledgably with customers, of demonstrating products and of offering advice on suitability of products to customers with evidence of equipment specific training.  Competent staff will have at least 3 years’ experience in the disability/mobility/health sector with proof they have received appropriate training or 6 months experience in the disability/mobility/health sector with proof of health care related professional qualification.  Equipment specific training may have been part of their professional qualification or have come from educational courses like the Trusted Assessor course or have come from equipment suppliers. |
| √ |  | Professional Body registration as a physiotherapist, occupational therapist is essential for the assessment process.  Professional Body registration as a rehabilitation engineer is desirable (only voluntary registration with a relevant body is currently available) |
| Qualifications and Competencies  Equipment Solution Providers | √ |  | Individuals are employed with the appropriate technical skills and competencies to comply with the requirements of EEC Medical Devices Directive, 93/42/EEC.  Individuals are employed with the appropriate competencies, capable of communicating effectively and knowledgably with customers, of demonstrating products and of offering advice on suitability of products to customers with evidence of equipment specific training.  Competent staff will have at least 3 years’ experience in the disability/mobility/health sector with proof they have received equipment specific training.  Equipment specific training may have been part of their professional qualification or have come from educational courses like the Trusted Assessor course or have come from equipment suppliers  Adherence to OFT (or similar)approved codes of practice to safeguard and promote the interests of consumers |
| Qualifications and Competencies  Equipment Solution Providers |  | √ | Professional or trades association membership |
| Registration with Medicines and Healthcare products Regulatory Agency (MHRA) | √ |  | The provider must follow MHRA guidelines and procedures |
| Continuing Professional or Personal Development (CPD) –  Assessment Providers | √ |  | All staff undertaking assessments shall undergo appropriate clinical courses in the assessment process, including posture and mobility function and tissue viability, as part of training and refresher training at a maximum of 2 yearly cycles as well as fulfilling CPD requirements.  All staff undertaking assessments are expected to have regular updates on products and be in possession of relevant information to assist user choice. |
| Continuing Professional or Personal Development (CPD) –  Equipment Solution Providers | √ |  | All staff undertaking equipment modification, repair and maintenance activities shall undergo appropriate technical courses as part of training and refresher training at a maximum of 2 yearly cycles as well as fulfilling CPD requirements.  All staff involved in the provision of equipment solutions are expected to have regular updates on products and be in possession of relevant information to assist user choice. |

# 

1. Additional Notes

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**Section 5– Additional Notes**

* 1. Introduction

This Implementation Pack has been produced to provide a guide for commissioners on best practice in the commissioning of wheelchair services within the framework of Any Qualified Provider.

The development of this guidance was itself commissioned by the Department of Health during 2011 as part of a wider initiative to modernise the provision of community services. Within this initiative, 8 services were identified and NHS East of England and NHS South West were selected to develop the Wheelchair Services through the principles of Any Qualified Provider.

To support this developed approach to contracting, the pilot sites in NHS East of England and NHS South West undertook a significant amount of work with users, carers, pressure groups, statutory agencies and suppliers to understand the issues facing stake-holders and to develop a knowledge base about the factors which would be important in specifying services in the future.

Great importance was placed on the needs of users, carers and parents as being key commissioners and central to the process. Feedback from workshops and conferences highlighted issues of poor communication, lack of integration, inappropriate and late provision, fragmentation of services and multiple layers of bureaucracy and over provision of professional contribution.

This guidance has been developed, in addition to the Specifications etc contained elsewhere in this pack, to inform commissioners who are looking to procure and contract wheelchair services about the sorts of issues they might need to consider when strategically developing their service specifications.

* 1. Local Inputs
* In several areas of the template documentation there are Drafting Notes, shown as **[DN: ….]** which indicates an area that either needs to be completed locally or a choice made based on local needs etc.
* Commissioners should also fully understand the implications of accreditation within the Any Qualified Provider process, and their attention is particularly directed to Section 3 of this Implementation Pack
* Commissioning Flexibility – based on **Local Needs** the commissioner has options as to whether to open up the whole service to competition on quality issues or to give them options around separately commissioning for a range of providers to undertake referral and assessment and/or just that of equipment provision repair and maintenance. That is:
* AQP for Access to Prescription only
* AQP for Prescription to Equipments Solution & on-going support only
* AQP Access to Prescription AND Prescription to Equipments Solution & on-going support (i.e. specifications issued separately to the market)
* AQP for Access to Equipments Solution & on-going support (both specifications combined to the market)
* Commissioners may also decide, based **on Local Needs,** to apply these specifications to specific population groups such as by Age (e.g. Children’s or by Disease (e.g. MND)

These specifications do not advocate discrimination on age or other grounds, however, if commissioners decide to determine their services by age related criteria they SHOULD make adequate provision for the transition of users from one service to another.

Much previous work has been used and encapsulated into the specifications, but much is also out of scope of the AQP process. As such, we also include here a possible future vision of what Wheelchair Services as part of an Integrated Independent Living Service could look like.

* 1. The Future
     1. Background

The Specification and other matters covered by this contract are intended to be the start of a transformation process that puts users, carers, parents and their families at the heart of wheelchair services.

In the future it is envisioned that the services will further develop and change to be part of a more integrated and holistic approach to service provision.

Commissioners need to consider the impact that wheelchair services have on wider commissioning objectives, such as the reduction of hospital admission rates, A&E attendances and delayed discharges.

Wheelchair service provision should be explicitly linked to the strategic aims of other key national/local policies/strategies, such as accident prevention, independence and improved life chances for young disabled people through greater education and employment opportunities.

Individuals with mobility and posture management difficulties usually require a wider range of services to enable them, supported by their parents, families and carers, to live life as independently as possible. Our vision for NHS wheelchair services in England is not to have separate wheelchair services but to commission much broader independent living services integrated across health, social care, education and employment.

The outcomes for the service should include:

* Enhancing quality of life for people with long-term conditions
* Helping people to recover from episodes of ill health or following injury
* Ensuring that people have a positive experience of care
* Treating and caring for people in a safe environment and protecting them from avoidable harm
  + 1. Person Centred Commissioning

Establishing person centred outcomes and committing to collaborate across agencies will drive assessments considering whole life needs that enable individuals to live their life to their fullest potential. Whole life assessments including all home, education or work requirements considered as standard result in a number of potential enablement options being provided to individuals and included in their integrated care plans. Whole life assessment also results in carers needs being fully considered, consequential costs of non–provision are understood and the required equipment is funded therefore improving outcomes. The agreed outcomes are documented as part of an integrated care plan.

If we are serious about developing person centred approaches, we need to move towards the individual becoming the commissioner for services that support their health and care needs and support their families and carers. The commissioner should, based on local needs, consider some form of ‘up-front’ investment to facilitate these changes to maximise the longer term return on investment, looking at the whole health economy.

Improving the individual’s experience needs to focus on the pathway through the whole journey of care and be embedded in all changes and related improvements measured. It starts by taking a holistic approach to an individual’s needs providing the right solution at the most appropriate time for the individual in a cost effective way. It should be an easy system to navigate and responsive when things go wrong. It should not be regarded as a separate service but a seamless element in a package of care.

* + 1. The Model

To assist commissioners the following model for wheelchair and seating services is one that starts the process by focussing on commissioning wheelchair services as part of a person centred approach.

Figure 1: Wheelchair Services Model (EXAMPLE)

AQP WS Model

The new example model supports a care management approach (Figure 2) and identifies three differing levels of expertise and knowledge required to deliver safe and effective wheelchair and seating services. These levels also align to different service user pathways.

Figure 2: Care Management Framework

clinical guide

(above based on Wheelchair and Specialist Seating Services: A Clinical Guide for Commissioners and Provider Services, Lisa Jayne Ledger, 2011)

It is intended in the new model that Commissioners stimulate and develop the market to support the individual service user to commission their own services. Commissioners can utilise a number of approaches, which are suitable for the different care management pathways, which are detailed in the table below.

Table 18: Wheelchair Services Market Approaches

| Care Management Level  Approach | Level 1 | Level 2 | Level 3 |
| --- | --- | --- | --- |
| **Specialist Commissioning Process** | Out of scope | Out of scope | Specialist Wheelchair Service |
| **AQP**  **Process** | √ | √ | Out of scope |
| **Market development for personal health budget holders and wider population** | √ | √ | √ |

* + 1. Integrated Working

Once the development of the above care pathway is complete then different aspects of the service can be contracted in a variety of ways with many organisations involved.

It is understood that many Commissioners will need to work closely with their colleagues across other agencies and organisations over the medium and long term to develop an integrated independent living service. To explore opportunities to collaborate across existing organisational boundaries to create services of sufficient size that economies of scale and greater efficiencies emerge.

Establishing ways of working that ensure the seamless funding across health, social care, work and education underpin the whole life assessment process without onerous or delaying authorisation processes. Sharing across agencies facilitates patient choice.

Increasing the range of services offered through an independent living service - examples could include rehabilitation, aids to daily living, assistive technology, orthotics, prosthetics, podiatry, transport solutions, equipment for school or work and care packages to enable them to live life as independently as possible.

* + 1. Person Health Budgets

Subject to the evaluation of the personal health budget pilot programme it is the Government’s intention to roll out personal health budgets to those who would benefit from one, This could include mobility equipment. Increasing the availability of personal health budgets underpinned by skilled support staff and improved and accessible information with corresponding stimulation of marketplaces will empower individuals to exercise choice including equipment and other aspects of their enablement needs. It requires a marketplace to enable the individual to spend their budget on products and services that will deliver the outcomes agreed in the integrated care plan.

* + 1. Single Point of Contact

We envisage a Single Point of Contact (SPOC) being the enabler of many service delivery changes, and could include some or all of the following:

Integrated with local authorities and other health services for users, carers, professionals, 3rd Sector, Independent Sector, and others. With many integrated services, not just Wheelchairs to give details/advice regarding: -

* Eligibility to access services. Establishing common eligibility criteria across organisations including health, social care, Department of Works and Pensions and education criteria means that anyone ineligible for state funded services can be informed at the beginning of the process. Individuals can be given information relating to the services provided by the State, options for self funding of equipment and signposting to the accredited marketplace where they can have their needs meet. The criteria in the new cross-service model will in due course effectively act as a budget setting mechanism rather than access criteria.
* Explain Choices
* There will be a strong emphasis on customer services, actively seeking feedback to help drive choice and areas for improvement. This feedback will be broadened from just consideration of wheelchairs to individuals enablement needs and will be based on measuring outcomes to maximise their effectiveness and will be used to assist user choice
* On Line & Telephone referral methods
* Utilise ‘Choose and Book’ so individuals would benefit from improvements in referral processing and appointment booking being able to choose the assessment location of their choice and the date and time of their assessment. Call centre staff will be able to triage and act as a knowledge resource that provides advice relating to a wider range of equipment and services and not just relating to posture and mobility.
* It is proposed that existing community based staff across health and social care, who currently refer individuals to wheelchair services, will be trained and provided with decision support tools to undertake the initial assessment for low level needs which will include obtaining physical and environmental measurements as required.
* Screening for very basic needs and sign-posting, allowing choice, direct to providers eliminating un-necessary clinical assessment, including on-line self referral tools.
* Future deployment of decision support tools will enable accredited assessors to carry out whole life assessments. The systemisation of the assessment process minimises rework, applies requirements across services and establishes baseline financial allocations for categories of assessment.
* Sign-posting to other services, such as 3rd Sector, support organisations, Government Schemes, Motability
* Provide information and support to users of ‘legacy fleet’.
* Offer the facility to arrange maintenance and repairs for all people who use wheelchairs or special seating and may initially deal with breakdown requests. This will negate the need for users to have a range of contact numbers for chair repairs and deal with a single point of contact.
* Integrate information and data from providers (and possibly invoice verification methodologies) – The “Black Box” approach.
* Independent collection and verification of user and carer and family satisfaction and outcomes surveys.
* The capture of customer feedback via the Call Centre is vital in driving improvements in quality and efficiency in the marketplace
* Personalised budgets can be supported through the call centre that will be able to offer advice and also be able to signpost to potential appropriate managing agencies for their integrated personalised budgets. “Brokerage Services”

Figure 3: Example of SPOC process



* + 1. Performance
* Increased use of outcomes as a measure of success, and related to payments. Establishing person centred outcomes and committing to collaborate across services will drive assessments considering whole life needs that enable individuals to live their life to their fullest potential. Whole life assessments including all home, education or work requirements considered as standard result in a number of potential enablement options being provided to individuals. Whole life assessment also results in carers needs being fully considered, consequential costs of non–provision are understood and the required equipment is funded therefore improving outcomes.
* There should be a strong emphasis on customer services, actively seeking feedback to help drive choice and areas for improvement. This feedback could be broadened from just consideration of wheelchairs to an individual’s enablement needs and could be based on measuring outcomes to maximise their effectiveness and will be used to assist user choice.
  + 1. Market Development
* Improved pathways for NHS owned wheelchair support, maintenance and repair/break-downs. By aligning the supply base to the requirements of the service we move from the purchase of chairs and seating systems to the purchase of packages of wheelchair equipment and support. Commissioners will source packages of wheelchair equipment and support from an accredited provider marketplace. Packages of wheelchair equipment and support will include all equipment, modification, servicing and maintenance requirements. Packages of wheelchair equipment and support could be any appropriate timescale depending on the clinical assessment. Packages of wheelchair equipment and support are supported by a tariff and provide clarity of equipment ownership. This moves the responsibility for repair, maintenance, inventory management and refurbishment of equipment to providers.
* Review of ‘legacy fleet’ and options for the future. Subject to the evaluation it is the Government’s intention to roll out personal health budgets to those who would benefit from one. This could include mobility equipment. Increasing the availability of personal health budgets/personal budgets underpinned by skilled support staff and improved and accessible information with corresponding stimulation of marketplaces will empower individuals to exercise choice including equipment and other aspects of their enablement needs. It requires a marketplace to enable the individual to spend their budget on products and services that will deliver the outcomes agreed in the support plan. The potential of the Buying Solutions national government framework that enables funds to be provided to individuals through prepayment ‘virtual cards’ should be examined as part of the detailed analysis. This approach has in other service areas shown significant reductions in back office processing. Commissioners will therefore have to seek local solutions regarding funding, including scrapping and write-off, in relation to the ‘legacy fleet’. In the future, it will be for NHS providers to make their own business decisions as to whether they provide equipment themselves or in partnership, or that they concentrate on ‘clinical’ matters.
* It is proposed that the marketplace for wheelchairs, specialised seating and other associated equipment should operate like any other consumer driven market. Stimulating and accrediting the marketplace to innovate, provide solutions and increase visibility and accessibility of products for all wheelchair users, not just those whom the state supports, is critically important to the development of the new system.
* The marketplace can be developed to provide a sustainable alternative to current provision, thereby enabling those with the lowest level of needs to self-support. New entrants to this market already are the national grocery chains (Tesco and ASDA) and retail park retailers (Halfords and Argos)Existing marketplace providers should be encouraged to provide increased choice to those who self fund including individual/personal health budget holders.
* Stimulating the marketplace in this way develops the capacity to absorb increased demand as a result of population growth.

An increasingly normal marketplace for wheelchairs, specialised seating and other associated equipment enables people who could benefit from the current range of low cost/value products to self-help

* + - * 1. – NHS WHEELCHAIR PRESCRIPTION

**SECTION 5 APPENDIX 1 – NHS WHEELCHAIR PRESCRIPTION**

|  |
| --- |
| **Name: ………………………………………………………………………………………**  **NHS No: …………………………………………………………………………………….**  **Address: ……………………………………………………………………………………** |

**Non powered: ……………………………………………………………………………..**

**Powered: ……………………………………………………………………………………**

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| --- | --- | --- | --- |
| **Seat size:**  **Width: ……………………………….**  **Length: ……………………………..**  **Seat base:**  **Canvas**  **Tension adjustable**  **Firm**  **Postural**  **(complete page )** | **🞏**  **🞏**  **🞏**  **🞏** | **Seat back:**  **Canvas**  **Tension adjustable**  **Firm**  **Postural (complete page )**  **Angle adjustable**  **Recline**  **Angle from vertical**  **Fixed**  **Removable**  **Folding** | **🞏**  **🞏**  **🞏**  **🞏**  **🞏**  **🞏**  **🞏**  **🞏**  **🞏**  **🞏** |

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| --- | --- | --- | --- |
| **Frame:**  **Fixed**  **Folding**  **Built in growth**  **Modular**  **Lightweight**  **Box**  **U**  **Seat to ground**  **Brakes:**  **Extension**  **Single lever**  **Attendant operated**  **Other …………………………………** | **🞏**  **🞏**  **🞏**  **🞏**  **🞏**  **🞏**  **🞏**  **🞏**  **🞏**  **🞏**  **🞏** | **Rear wheels**  **Type ……………………………….**  **Size…………………………………**  **Axle position …………………….**  **Hand rims**  **Spoke guards**  **Castors:**  **Size ………………………………..**  **Type ……………………………….**  **Position …………………………..**  **Other……………………………….** | **🞏**  **🞏**  **🞏** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Footrest hangers:**  **Swing aside**  **Fixed**  **Elevated**  **Angle (degrees)**  **Calf strap**  **Stump Board**  **Size ……………………………………** | **🞏**  **🞏**  **🞏**  **🞏**  **🞏**  **🞏** | **Foot rests:**  **Plates/bar**  **Adjustable angle**  **Heel loop**  **Foot board**  **Foot rest extension**  **Fore and aft adjustable** | **🞏**  **🞏**  **🞏**  **🞏**  **🞏**  **🞏** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Push handles:**  **Folding**  **Detachable**  **Height adjustable**  **None** | **🞏**  **🞏**  **🞏**  **🞏** | **Armrests:**  **Detachable**  **Fixed**  **Height adjustable**  **None**  **Outrigged size ……………………** | **🞏**  **🞏**  **🞏**  **🞏** |
|  | | | |
| **Miscellaneous:**  **Safe working load ………………………………………………………………………**  **Client transported in wheelchair …………………………………………………….**  **Additional information ………………………………………………………………..**  **………………………………………………………………………………………………**  **………………………………………………………………………………………………** | | | |

|  |  |
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| **Powered:**  **Indoor**  **Indoor/outdoor**  **Outdoor/Indoor** | **🞏**  **🞏**  **🞏** |

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| --- | --- | --- | --- |
| **Speed:**  **3k per hour**  **6k per hour**  **Other: ………………………..............**  **Drive:**  **Front wheel**  **Mid wheel**  **Rear wheel** | **🞏**  **🞏**  **🞏**  **🞏**  **🞏** | **Control:**  **Left**  **Right**  **Central**  **Tray mounted**  **Integral**  **Modular** | **🞏**  **🞏**  **🞏**  **🞏**  **🞏**  **🞏** |

|  |
| --- |
| **Additional information:** |

|  |  |
| --- | --- |
| **Kerb climber:**  **Central**  **Dual**  **Removable** | **🞏**  **🞏**  **🞏** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Additional information:**  **Recline**  **Tilt**  **Seat raise**  **Elevating leg rests** | **🞏**  **🞏**  **🞏**  **🞏** | **Electric/manual**  **Electric/manual**  **Electric/manual**  **Electric/manual** | **🞏**  **🞏**  **🞏**  **🞏** |
| **Other information:**  **Limitations on overall weight …………………………………………………………….**  **Tie down restrictions ………………………………………………………………………**  **Size restrictions …………………………………………………………………………….** | | | |
| **Attach copy of agreed outcomes/goals.**  **Provide cover sheet with full details of assessor, e.g. organisation, contact numbers etc** | | | |

* + - * 1. – VISION FOR FUTURE WHEELCHAIR SERVICES

**A collation of national and regional project conclusions**

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**SECTION 5 APPENDIX 2 – VISION FOR FUTURE WHEELCHAIR SERVICES**

Executive Summary

The Vision for Wheelchair Services

1. Individuals with mobility and posture management difficulties usually require a wider range of services to enable them, supported by their families and carers, to live life as independently as possible. The vision for NHS wheelchair services in England is not to have separate wheelchair services but to commission much broader independent living services integrated across health, social care, education and employment.
2. The outcomes for the service include

* Enhancing quality of life for people with long-term conditions
* Helping people to recover from episodes of ill health or following injury
* Ensuring that people have a positive experience of care
* Treating and caring for people in a safe environment and protecting them from avoidable harm

1. It is understood that many Commissioners will need to work closely with their colleagues across other agencies and organisations over the medium term to develop an integrated independent living service.
2. To assist commissioners the following model for wheelchair and seating services is one that starts the process by focussing on commissioning wheelchair services as part of a person centred approach. The model is explained in more detail from paragraph 9 below.

Figure 4: Wheelchair Services Model

AQP WS Model

**Person Centred Approach**

1. Establishing person centred outcomes and committing to collaborate across agencies will drive assessments considering whole life needs that enable individuals to live their life to their fullest potential. Whole life assessments including all home, education or work requirements considered as standard result in a number of potential enablement options being provided to individuals and included in their integrated care plans. Whole life assessment also results in carers needs being fully considered, consequential costs of non –provision are understood and the required equipment is funded therefore improving outcomes. The agreed outcomes are documented as part of an integrated care plan.

**Service User as Commissioner**

1. If we are serious about developing person centred approaches, we need to move towards the individual becoming the commissioner for services that support their health and care needs and support their families and carers.
2. Improving the individual’s experience needs to focus on the pathway through the whole journey of care and be embedded in all changes and related improvements measured. It starts by taking a holistic approach to an individual’s needs providing the right solution at the most appropriate time for the individual in a cost effective way. It should be an easy system to navigate and responsive when things go wrong. It should not be regarded as a separate service but a seamless element in a package of care.

**Personal Health Budgets**

1. Increasing the availability of personal health budgets underpinned by skilled support staff and improved and accessible information with corresponding stimulation of marketplaces will empower individuals to exercise choice – of equipment, of provider, of other aspects of their enablement needs. It requires a marketplace to enable the individual to spend their budget on products and services that will deliver the outcomes agreed in the integrated care plan.

**Care Management Approach**

1. The new model supports a care management approach and identifies three differing levels of expertise and knowledge required to deliver safe and effective wheelchair and seating services. These levels also align to different service user pathways.

Figure 5: Care Management Framework

clinical guide

(above based on Wheelchair and Specialist Seating Services: A Clinical Guide for Commissioners and Provider Services, Lisa Jayne Ledger, 2011)

1. It is intended in the new model that Commissioners stimulate and develop marketplaces to support the individual service user to commission their own services. Commissioners can utilise a number of approaches which are suitable for the different care management pathways which are detailed in the table below.

Table 19: Wheelchair Services Market Approaches

| Care Management Level  Approach | Level 1 | Level 2 | Level 3 |
| --- | --- | --- | --- |
| Specialist Commissioning Process | Out of scope | Out of scope | Specialist Wheelchair Service |
| AQP  Process | √ | √ | Out of scope |
| Market development for personal health budget holders and wider population | √ | √ | √ |

**Specialist commissioning process**

1. It has been proposed that specialised wheelchair services, which provide equipment to the small percentage of wheelchair users (less than 5%) with the most profound disabilities who can only be adequately seated and function effectively in a wheelchair having bespoke modifications and inserts, will be contracted for through specialist commissioning processes to be further defined.
2. The rationale here is to balance incentives of efficiency and quality whilst minimising risks associated with complexity.

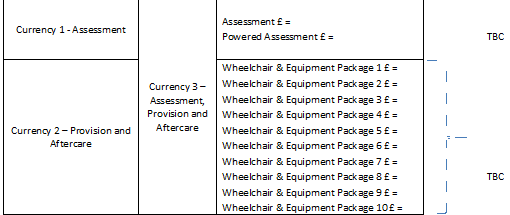
**Any Qualified Provider (AQP)**

1. Commissioners will be able to extend patient choice of provider by utilising the AQP process, which has a currency and pricing model to incentivise improvements in the quality and value of services.
2. The term ‘currency’ refers to the unit of healthcare for which a provider is funded. Each aspect of care within the scope of the currency can be costed and then aggregated to produce a total cost for the currency of care for an individual. Costing should be done from the bottom-up where possible.
3. For wheelchair services three currencies have been defined:

* Currency 1 = Assessment
* Currency 2 = Provision and aftercare
* Currency 3 = Assessment, provision and aftercare

1. Commissioners are able to choose which combination of currencies they wish to use locally, as indicated in table 2 below.

Table 20: Currency Options



1. Wheelchair & equipment packages are supported by a currency. By aligning the supply base to the requirements of the service we move from the purchase of chairs and seating systems to the purchase of packages of equipment solutions. Commissioners can choose to define the range of wheelchair and equipment packages for their service users from the qualified provider marketplace. Packages could be of 6 months to 5 years duration. The process should be flexible enough to offer trial equipment, short duration prescriptions etc to deliver a person centred solution meeting the outcomes agreed between the service user and the assessor within the eligibility criteria, or exceptional pathway processes that exist now.
2. Commissioners will have to agree the most appropriate payment mechanism for the package (weighted funding formulas for monthly, annual or for the full term of the prescription) with their providers to maximise the opportunity for providers to innovate whilst being flexible to accommodate service user changing needs. Risk can be minimised by closely defining the package offered under the currency.
3. By contracting for packages of equipment solution over a time period, it offers commissioners the benefits of lease back of equipment, so the asset belongs to the provider. This should drive improvements and innovation into the products and increase choice for the service user.
4. This moves the responsibility for repair, maintenance, inventory management and refurbishment of equipment to manufacturers and their dealership networks as those most equipped to deliver it cost effectively. Breakdown assistance may be commissioned as a service that is paid by individuals. This also supports individuals with personal budgets by increasing the visibility and accessibility of equipment and supporting services in an accredited marketplace.
5. Criteria will need to be established within a service specifications to trigger reassessment should an individual’s condition change.
6. Quality requirements including measures to track innovation and providers incorporating consumer feedback into service offerings are included in the commissioning toolkit.

**Improving the service user experience**

1. The benefits of implementing the wheelchair and seating services model include the incentivisation of improved care across all care management pathways. This approach supports and empowers service users to effectively self manage their needs.
2. Feedback from service users is essential to developing quality wheelchair and seating services. The new model aims to ensure that feedback from service user, together with other information, is used to assist performance management and improve service delivery
3. There should be a culture of getting it right first time including

* Quality and accessibility of information available to support user choice - of provider, appointments, treatments, equipment solutions, links to other services etc
* Standard data captured throughout the referral process
* Assessment using a validated assessment tool
* Measuring improvement using a validated assessment tool
* Obtaining feedback from service users via forums, web feedback, questionnaires etc about their experience, reviews and ratings on products and services, etc

By analysing the output it will be possible to identify areas of under performance and take the necessary actions to foster improvements.

**Developing high quality services**

1. There are a number of other components that Commissioners may choose to develop with other organisations and/or providers to deliver integrated services. These could include:

* Virtual funding mechanisms - Cross sharing across agencies facilitates patient choice. Establishing ways of working that ensure the seamless funding across health, social care, work and education to underpin the whole life assessment process without onerous or delaying authorisation processes.
* Single point of contact - Users, carers and professionals would benefit from a single point of contact for a wide range of services. Utilising ‘Choose and Book’ individuals would benefit from improvements in referral processing and appointment booking being able to choose the assessment location of their choice and the date and time of their assessment. This delivers improved referral to treatment (in this case provision) timelines.

A single point of contact could triage and act as a knowledge resource that provides advice relating to a wider range of equipment and services and not just relating to posture and mobility It is envisaged that specialist assessors based in wheelchair centres will also provide expert advice that complements that of local assessors.

A single point of contact could offer the facility to arrange maintenance and repairs for all people who use wheelchairs or special seating and may initially deal with breakdown requests. This will negate the need for users to have a range of contact numbers for chair repairs and deal with a single point of contact.

There should be a strong emphasis on customer services, actively seeking feedback to help drive choice and areas for improvement. This feedback could be broadened from just consideration of wheelchairs to an individuals enablement needs and could be based on measuring outcomes to maximise their effectiveness and will be used to assist user choice.

* Common eligibility criteria - Establishing common eligibility criteria across wider localities including health, social care, Department of Works and Pensions and education criteria means that anyone ineligible for state funded services can be informed at the beginning of the process. Individuals can be given information relating to the services provided by the State, options for self funding of equipment and signposting to the accredited marketplace where they can have their needs met.
* Increasing the range of services offered through an independent living service - Examples of services could include rehabilitation services, aids to daily living, assistive technology services including orthotics, prosthetics, electronic assistive technology services, podiatry services, transport solutions, equipment for school or work and care packages to enable them to live life as independently as possible

**Market Development**

1. It is proposed that the marketplace for wheelchairs, specialised seating and other associated equipment should operate like any other consumer driven market. Stimulating the marketplace to innovate, provide solutions and increase visibility and accessibility of products for all wheelchair users, not just those whom the state supports, is critically important to the development of the new system.
2. The marketplace can be developed to provide a sustainable alternative to current provision. An increasingly normal marketplace for wheelchairs, seating and other associated equipment enables people who could benefit from the current range of low cost/value products to self-help. National grocery chains, Tesco and ASDA and retail park retailers, Halfords and Argos have already entered the marketplace with ‘off the shelf’ wheelchair equipment solutions. Existing marketplace providers should be encouraged to provide increased choice to those who self fund including individual budget holders. Stimulating the marketplace in this way develops the capacity to absorb increased demand as a result of population growth. This enables state funding to support people with the greatest need.

Background

Aims and objectives

This document has been produced to provide Commissioners with a comprehensive understanding of the vision for wheelchair services as part of an independent living service.

Its aim is to share the learning from work commissioned by the DH since 2006 involving people who use services, their families and carers, commissioners of NHS services, providers of NHS services, private sector and third sector organisations.

Its objectives are to:

* Provide focus on the outcomes for the service
* Provide focus on the key policy drivers relating to improving health and social care outcomes for people
* Develop understanding of why the commissioning of wheelchair services needs to change
* Share information about the development of care frameworks and pathways to support equitable service provision
* Provide detail about the components that deliver responsive and outcomes focussed independent living services
* Understand the benefits to individuals and organisations delivered through the vision for independent living services

Key outcomes

The outcomes for the service reflect the NHS Outcomes Framework and Operating Framework and include:

* Enhancing quality of life for people with long-term conditions
* Helping people to recover from episodes of ill health or following injury
* Ensuring that people have a positive experience of care
* Treating and caring for people in a safe environment and protecting them from avoidable harm

Policy objectives

The Government has introduced a wide range of health and social care reforms and has produced a number of legislative, frameworks, policy and guidance documents which define the requirements that services should deliver. The key policy drivers include:

**Person centred approach**

* The system will focus on personalised care that reflects individuals’ health and care needs, supports carers and encourages strong joint arrangements and local partnerships
* The system will focus on improving healthcare outcomes

**Shared decision making**

* Shared decision-making will become the norm: no decision about me without me
* Patients will have access to the information they want, to make choices about their care. They will have increased control over their own care records

**Extending patient choice of provider**

* Patients will have choice of any provider, choice of consultant-led team, choice of GP practice and choice of treatment
* With specific reference to wheelchair services, the Any Qualified Provider (AQP) approach will be implemented in 2012/13
* Extending choice is not limited to one part of the pathway and can be over the whole or any part of it. Commissioners will decide if AQP in their area should be over the whole or part of the service.

**Joint arrangements and local partnerships**

* Devolving power and responsibility for commissioning services to the healthcare professionals closest to patients
* Strengthening democratic legitimacy at local level through local authorities promoting the joining up of local NHS services, social care and health improvement

**Supporting carers**

* Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages
* Enabling those with caring responsibilities to fulfil their educational and employment potential
* Personalised support both for carers and those they support, enabling them to have a family and community life
* Supporting carers to remain mentally and physically well

**Quality requirements informing commissioning and payment systems**

* Quality standards, developed by NICE, will inform the commissioning of all NHS care and payment systems. Inspection will be against essential quality standards
* Money will follow the patient through transparent, comprehensive and stable payment systems across the NHS to promote high quality care, drive efficiency, and support patient choice

Rationale for change

The system of care for wheelchair users is confusing and not well integrated. This can lead to sub optimum care and also poor value for money, for example:

* several hundred thousand pounds were being considered by education to alter a school rather than the NHS provide a rising chair;
* in another case substantial expenditure used by social services on altering a kitchen rather than the NHS adapting a chair; and
* the service may provide a chair for indoor outdoor use only to find it cannot be used effectively as a ramp is yet to be fitted.

There is a lack of understanding of demand, with user growth, additional referral growth, increasing complexity and expectations due to product improvements all leading to potential cost growth significantly ahead of that seen in the wider NHS.

Users are not being fully considered in the design of the service:

* people can wait in the system for an appointment for many weeks;
* there are few assessments considering the lifestyle needs of the individual and the needs of those who care for them;
* there is a limited choice available and communication and information provision on this issue is limited;
* the voucher scheme has a low take up as there are significant disincentives for user and provider; and
* users feedback on required areas of service improvement over a number of years has not resulted in desired change

Commissioning is often on the basis of block contracts, this causes potential restrictions on the numbers and types of patients that can be served in a year with potential stops on provider services.

Best practice is not consistently being achieved with providers operating different approaches, systems, offering different assessment processes and solutions, delivering varying levels of outcomes for individuals. This also increases manufacturer’s costs to services.

There are a number of areas of inefficiency inherent in the system:

* duplication of assessment activity and data collection;
* many small scale engineering units;
* significant rework due to inadequate referrals; and
* significant returns due to the product not being right.

The manufacturers are not working in alignment with the service to drive value:

* the NHS and public sector partners carry all the risk as we modify and adjust, repair and maintain products;
* modifications would be most effectively undertaken through production processes; and
* products are not being designed to maximise lifetime value; when questioned on what they would do if they had to repair and maintain chairs themselves, suppliers responded, “we would design them differently”.

The work has concluded that services discriminate against individuals with the most complex needs with these individuals waiting months even years for their chairs and being less likely to receive what they need to live independently – this is particularly true for children.

The vision for Wheelchair Services Individuals with mobility and posture management difficulties usually require a wider range of services, e.g. treatments, rehabilitation services, aids to daily living, assistive technology services including orthotics, prosthetics, electronic assistive technology services, podiatry services, transport solutions, equipment for school or work and care packages to enable them to live life as independently as possible.

The vision for NHS wheelchair services in England is not to have separate wheelchair services but to commission much broader independent living services integrated across health, social care, education and employment. It is one that assimilates into an integrated independent living service taking a holistic approach to an individual’s needs providing the right solution at the most appropriate time for the individual in a cost effective way. It should be an easy system to navigate and responsive when things go wrong. It should not be regarded as a separate service but a seamless element in a package of care.

The vision for Wheelchair Services

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Design principles for the new vision

It is the conclusion of the collated project reviews that a fundamental change to the current approach is needed to deliver this new system and this has generated a number of design principles:

* The system should work across services and overcome the barriers to joint working. This will enable flexible solutions that best meet the needs of the individual and enable them to live independently;
* There needs to be a culture of getting it right first time and of continuous improvement;
* Commissioners should source provision of solutions from providers who are best able to improve quality and productivity;
* The system should be able to absorb demographic growth;
* Effort and resources should be focused on people with the greatest need;
* The marketplace should be stimulated to offer sustainable alternatives to public provision for people with low level needs.

Key aspects of the vision include:

* Users driving the service through feedback on outcomes and these driving their choices;
* Driving quality improvements and cost savings through effective commissioning collaborating across consortia;
* Cross agency cost sharing to enhance patient choice;
* Whole life assessments including all home, education or work requirements considered as standard and a number of potential enablement options provided to individuals;
* The introduction of personalised health budgets alongside social care budgets allowing broader choice supported by specialist advice;
* Real time access to appointments for patients at point of referral allowing choice of provider and driving service efficiency;
* The systemisation of the assessment process minimising rework through deployment of validated assessment tools;
* Improving front end assessor skills to reduce rework, improve responsiveness and increase specialist capacity for people with complex needs;
* Aligning supply base to the requirements of the service by moving from the purchase of equipment to the purchase of packages of equipment solutions;
* Stimulating and accrediting the marketplace to innovate, provide solutions and increase visibility and accessibility of products for all wheelchair users, not just those whom the state supports, thereby enabling those with the lowest level of needs to self-support; and
* Driving standardisation of criteria, information requirements and measures to increase benchmarking and drive continuous improvement.

It is understood that many Commissioners will need to work closely with their colleagues across other agencies and organisations over the medium term to develop an integrated independent living service.

The following sections contain information that could form part of commissioning improvement plans in the short term to build towards a fully independent living service in the medium to long term. To assist commissioners the following model for wheelchair and seating services is one that starts the process by focussing on commissioning wheelchair services as part of a person centred approach.

Figure 6: Wheelchair Services Model

AQP WS Model

The service user as commissioner

Person centred approach

If we are serious about developing person centred approaches, the current fragmentation and silo working across services should change. We need to move towards the individual becoming the commissioner for services that support their health and care needs and support their families and carers.

Improving the individual’s experience needs to focus on the pathway through the whole journey of care and be embedded in all changes and related improvements measured. It starts by taking a holistic approach to an individual’s needs providing the right solution at the most appropriate time for the individual in a cost effective way. It should be an easy system to navigate and responsive when things go wrong. It should not be regarded as a separate service but a seamless element in a package of care.

Establishing person centred outcomes and committing to collaborate across services will drive assessments considering whole life needs that enable individuals to live their life to their fullest potential. Whole life assessments including all home, education or work requirements considered as standard resulting in a number of potential enablement options being provided to individuals. Whole life assessment also results in carers needs being fully considered, consequential costs of non –provision are understood and the required equipment is funded therefore improving outcomes.

People who use services will be contributing, through their feedback, to the development of a service that puts their needs, and those of the people who care for them, at its heart. They will benefit from a service that meets their needs effectively and more timely

Personal health budgets

Personal health budgets are one way of giving people more choice and control over how their health needs are met. The current pilot programme includes one pilot specifically looking at wheelchair services, others may include mobility aids depending on individual needs. Personal budgets are included in the scope of the Special Educational Needs and Disability Pathfinders announced by DfE in the summer. These pathfinders will include children with complex needs, including mobility needs. Subject to the evaluation, it is the Government's aim to rollout personal health budgets to those who would benefit from one, this could include mobility equipment.

Increasing the availability of personal health budgets underpinned by skilled support staff, and improved and accessible information with corresponding stimulation of marketplaces will empower individuals to exercise choice including equipment, and other aspects of their enablement needs. It requires a marketplace to enable the individual to spend their budget on products and services that will deliver the outcomes agreed in the support plan.

The potential of the Buying Solutions national government framework that enables funds to be provided to individuals through prepayment ‘virtual cards’ should be examined. This approach has in other service areas (Transforming Community Equipment Services) shown significant reductions in back office processing.

Work has been undertaken with In-Control, a third sector organisation, whose mission is to create a fairer society where everyone needing additional support has the right, responsibility and freedom to control that support. In Control operates as an extensive community network that is working for change and to provide people with the knowledge, power and tools to control their support. They have considerable experience in the Self Directed Support and Personal health budget arenas and were able to provide key learning for shaping the way forward for wheelchair services. More detail is available in Annex 7.1

Care Management Approach

The vision for wheelchair services supports a case management approach and identifies three differing levels of expertise and knowledge required to deliver safe and effective wheelchair and seating services. These levels also align to different service user pathways.

Figure 7: Levels of service user needs versus competence levels

**clinical guide**

(above based on Wheelchair and Specialist Seating Services: A Clinical Guide for Commissioners and Provider Services, Lisa Jayne Ledger, 2011)

Straightforward Needs (Supported self-care management)

This level describes individuals who have a relatively simple need who can largely be self-supporting. The need is likely to be one off, simplistic, and would not require review in a clinical sense; the individual could also be given general advice around related health aspects such as maintenance of healthy skin and good posture care. Further information relating to indicators for each level is available in Annex 5.1 and definitions in Annex 5.2.

Specialist Support (Disease/Care management)

This level describes individuals whose needs include the management of a condition including tissue viability and posture care. Individuals at this level require regular review, inter-agency liaison and involvement within a care pathway approach. It is likely that specialist advice, information, therapy and medical management is involved in conjunction with setting up and fitting of appropriate equipment solutions. A robust clinical interface is essential at this level to ensure timely and appropriate intervention occurs to prevent more complexity. Further information relating to indicators for each level is available in Annex 7.2 and definitions in Annex 7.3.

Complex Needs (Case management)

These are individuals who have highly complex requirements and are at high risk of secondary complications due to their level of disability, such as pressure ulcers, contractures, chest infections and respiratory illness. They require a case management approach and may require an individual bespoke equipment solution. Regular review and a timely response are crucial at this level using a multi-disciplinary, inter- agency team with proven expert specialist skills and competencies within the field of wheelchairs, tissue viability and posture management. Further information relating to indicators for each level is available in Annex 5.1 and definitions in Annex 5.2.

3.3.4 Supporting the wider population

The marketplace can be developed to provide a sustainable alternative to current provision, thereby enabling those with the lowest level of needs to self support. National grocery chains, Tesco and ASDA and retail park retailers, Halfords and Argos have already entered the marketplace with ‘off the shelf’ wheelchair equipment solutions. Existing marketplace providers should be encouraged to provide increased choice to those who self-fund including individual budget holders. Stimulating the marketplace in this way develops the capacity to absorb increased demand as a result of population growth.

An increasingly normal marketplace for wheelchairs, seating and other associated equipment enables people who could benefit from the current range of low cost/value products to self-help. This enables state funding to support people with the greatest need.

Process Pathway

We envisage the process pathway, based on a Single Point of Contact looking like: -

Figure 8: Process pathway



Commissioning Approaches

It is intended in the new model that Commissioners stimulate and develop marketplaces to support the individual service user to commission their own services. Commissioners can utilise a number of approaches, which are suitable for the different care management pathways, which are detailed in the table below.

Table 21: Wheelchair Services Market Approaches

| Care Management Level  Approach | Level 1 | Level 2 | Level 3 |
| --- | --- | --- | --- |
| Specialist Commissioning Process | Out of scope | Out of scope | Specialist Wheelchair Service |
| AQP  Process | √ | √ | Out of scope |
| Market development for personal health budget holders and wider population | √ | √ | √ |

Specialist commissioning process

It has been proposed that specialised wheelchair services, which provide equipment to the small percentage of wheelchair users (less than 5%) with the most profound disabilities who can only be adequately seated and function effectively in a wheelchair having bespoke modifications and inserts, will be contracted for through specialist commissioning processes to be further defined.

The rationale here is to balance incentives of efficiency and quality whilst minimising risks associated with complexity.

Any Qualified Provider (AQP)

Commissioners will be able to extend patient choice of provider by utilising the AQP process which has a currency and pricing model to incentivise improvements in the quality and value of services.

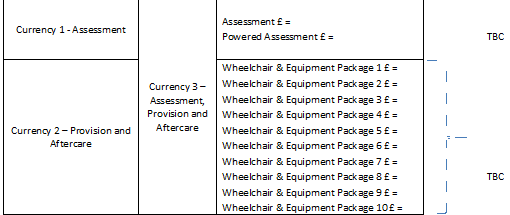
The term ‘currency’ refers to the unit of healthcare for which a provider is funded. Each aspect of care within the scope of the currency can be costed and then aggregated to produce a total cost for the currency of care for an individual. Costing should be done from the bottom-up where possible.

For wheelchair services three currencies have been defined:

* Currency 1 = Assessment
* Currency 2 = Provision and aftercare
* Currency 3 = Assessment, provision and aftercare

Commissioners are able to choose which combination of currencies they wish to use locally, as indicated in table 2 below.

Table 22: Currency Options



Commissioners may choose to contract with separate referral/ assessment providers to providers for equipment solutions (as many do now with approved repairers and special seating solution providers) or they may choose to contract for the entire pathway.

Providers of assessment services are able to also provide equipment services if they wish provided they meet the provider qualification criteria.

It is reasonable to expect providers to work in partnership to ensure the process remains streamlined. This currently happens when equipment solutions are provided through approved repairers and specialist seating contractors.

Wheelchair & equipment packages are supported by a currency. By aligning the supply base to the requirements of the service we move from the purchase of chairs and seating systems to the purchase of packages of equipment solutions. Commissioners can choose to define the range of wheelchair and equipment packages for their service users from the qualified provider marketplace. Packages could be of 6 months to 5 years duration. The process should be flexible enough to offer trial equipment, short duration prescriptions etc to deliver a person centred solution meeting the outcomes agreed between the service user and the assessor within the eligibility criteria, or exceptional pathway processes that exist now.

Commissioners will have to agree the most appropriate payment mechanism for the package (weighted funding formulas for monthly, annual or for the full term of the prescription) with their providers to maximise the opportunity for providers to innovate whilst being flexible to accommodate service user changing needs. Risk can be minimised by closely defining the package offered under the currency.

By contracting for packages of equipment solution over a time period, it offers commissioners the benefits of lease back of equipment, so the asset belongs to the provider. This should drive improvements and innovation into the products and increase choice for the service user.

This moves the responsibility for repair, maintenance, inventory management and refurbishment of equipment to manufacturers and their dealership networks as those most equipped to deliver it cost effectively. Breakdown assistance may be commissioned as a service that is paid by individuals. This also supports individuals with personal budgets by increasing the visibility and accessibility of equipment and supporting services in an accredited marketplace.

Criteria will need to be established within a service specifications to trigger reassessment should an individual’s condition change.

Quality requirements including measures to track innovation and providers incorporating consumer feedback into service offerings are included in the commissioning toolkit.

Market Development

It is proposed that the marketplace for wheelchairs, specialised seating and other associated equipment should operate like any other consumer driven market. Stimulating and accrediting the marketplace to innovate, provide solutions and increase visibility and accessibility of products for all wheelchair users, not just those whom the state supports, is critically important to the development of the new system.

Accreditation criteria and processes will be developed, similar to that already established as a national standard for community equipment provision, that give people who use wheelchair services confidence that accredited manufacturers, dealerships and other willing providers are competent in wheelchair assessment and provision and provide good quality services.

The marketplace can be developed to provide a sustainable alternative to current provision, thereby enabling those with the lowest level of needs to self support. National grocery chains, Tesco and ASDA and retail park retailers, Halfords and Argos have already entered the marketplace with ‘off the shelf’ wheelchair equipment solutions. Existing marketplace providers should be encouraged to provide increased choice to those who self-fund including individual budget holders. Stimulating the marketplace in this way develops the capacity to absorb increased demand as a result of population growth.

An increasingly normal marketplace for wheelchairs, specialised seating and other associated equipment enables people who could benefit from the current range of low cost/value products to self-help. This enables state funding to support people with the greatest need.

Measuring success

The current management information and key performance indicators are very weak and focus on the operation of current services rather than effectively measuring individual’s outcomes.

The NHS performance regime reflected in the NHS Outcomes Framework and Operating Framework, the proposed outcomes framework for social care and the GP Survey define the national reporting requirements.

Measurement tools should be developed to measure:

* Quality, covering safety, effectiveness and patient experience
* Resources, covering finance, capacity and activity and
* Reform, covering commissioning, provider markets, building capability and partnerships

In order to effectively deploy these tools it is recognised that data needs to be managed more effectively. Standard minimum data sets are being developed nationally and good practice suggests measures and data capture approaches should be deployed through the contact centre.

Collectively, these system changes deliver significant enhancements in quality for people who use services as well as significant increases in efficiency of operations. This is a system designed for the next 15 – 20 years.

Improving the service user experience

The benefits of implementing the wheelchair and seating services model include the incentivisation of improved care across all care management pathways. This approach supports and empowers service users to effectively self-manage their needs.

Feedback from service users is essential to developing quality wheelchair and seating services. The new model aims to ensure that feedback from service user, together with other information, is used to assist performance management and improve service delivery

There should be a culture of getting it right first time including

* Quality and accessibility of information available to support user choice - of provider, appointments, treatments, equipment solutions, links to other services etc
* Standard data captured throughout the referral process
* Assessment using a validated assessment tool
* Measuring improvement using a validated assessment tool
* Obtaining feedback from service users via forums, web feedback, questionnaires etc about their experience, reviews and ratings on products and services, etc

By analysing the output it will be possible to identify areas of underperformance and take the necessary actions to foster improvements.

This section describes how different people who require wheelchairs and specialised seating will experience the new system.

The aim is to ensure individuals with posture and mobility needs are

* Able to access an assessment and wheelchair or specialised seating provision through appropriate professionals or by directly through a contact centre where trained personnel will be available
* Given an initial assessment which will consider their wider enablement needs across a range of services looking at the requirements to assist them to live independently
* Only having to give their information once during this assessment as information will be collected for all the services
* Offered options of the ranges of equipment that meets their needs, receive product information and advice and know what funding is available to them irrespective of their basic or specialised requirements
* Offered the choice of a personalised budget with advice and support to manage this budget available from or signposted by the assessors in the community or from the contact centre
* Offered flexibility to pool personalised budgets from a number of services and reapportion them in a way that best suits them to maximise the impact on their daily lives
* Able to have multiple interventions or deliveries coordinated to minimise disruption to their daily life
* Able to access 24 hour repair and maintenance services
* Able to provide feedback to the contact centre to drive future improvements

The diagrams below describe the ‘journeys’ through the new service of three people with very different sets of needs and degrees of eligibility for state support. Two of the journeys have been taken from case studies in the 2008 DH report, ‘Out and About.’

The overarching aims of the new system are summarised after the following case study ‘journeys.’

Self-supported care case study

Enid is an older person with Parkinson’s disease. She is finding it difficult now to retain her mobility and fell recently doing her weekly shopping when out with her daughter. She would benefit from a wheelchair.

Figure 9: Self-supported care case study

User journey 3

Self-supported care case study benefits

* Readily available information, in this case through the decision support tool used by the Parkinson’s Nurse who is well known to Enid and her family
* The assessment can be undertaken there and then in the comfort of her home
* The Parkinson’s Nurse has access to more specialist advice through a phone call to the Contact Centre or through online links via the decision support tool
* She can have other needs assessed at the same time, for example she is also having difficulty moving within her home so some daily living aids may be beneficial
* If Enid is eligible to receive a state funded wheelchair she can look at what is available from the information in the decision support tool
* She can top-up if she chooses to purchase additional features
* Her choice can be ordered there and then, or she can receive a prescription to the state funded value and visit an accredited provider outlet to see them
* There Enid is able to try a range of products and be further guided in her choice by staff who are trained and competent as required to obtain accreditation
* She may decide to purchase additional products that may be helpful
* Enid and her daughter can take the products immediately or she can arrange delivery (and installation as required for daily living products) when it is convenient for her
* She can return daily living products with the same protections offered by consumer legislation

Disease management case study

Arif, a young man of 20 with spastic quadriplegia, weighs about 18 stone and is cared for by his parents who are in their late fifties/sixties. He has severe postural problems. His father already is suffering from back problems and his mother has arthritis in her hands.

Figure 10: Disease management case study

User journey 1

Disease management case study benefits

* Readily accessible information, in this case through the Contact Centre, who can capture any additional information about Arif and his carers at this first point of contact
* Arif’s parents can book an appointment to see a specialist assessor at a place and time of their choosing, e.g at home or at a wheelchair service clinic.
* The specialist assessor’s role is to carry out a full assessment of Arif’s needs and those of his parents who care for him, without being constrained about considering only Arif’s posture and mobility needs
* The family can decide if they wish to take up re-abling or rehabilitative services which are also offered to the parents as well as Arif, particularly in light of their back and arthritis problems
* The family can discuss the range of options that are available and consider which option may be the most flexible solution for them
* There may be contributions required through other agencies, such as social care or access to work, but this will be seamless to Arif and his family
* They may well benefit from a personal budget and be advised of the budget allocation
* They are then in the best position to understand what option they wish to decide upon and if they are to contribute any financial contribution to obtain all the features they wish
* They are able to access and Accredited Provider
* They are able to try the product suggested by the practitioner and see what else they accredited provider offers that might be of use. The family are served by qualified and knowledgeable staff who have the training and competencies required to obtain accreditation
* The family can arrange for delivery and handover of the new wheelchair when it is convenient for them

Case management case study

Sarah, a quadriplegic and a full-time wheelchair user, has a number of carers to assist with particular daily activities.

Figure 11: Case management case study

User journey 2

Case management case study benefits

* Sarah has complex needs and her PCT/local authority are still responsible for ensuring her needs are assessed and met
* By jointly commissioning services they have agreed local systems and protocols to ensure the most flexible solutions are available to individuals with exceptional needs
* By understanding how a specialist chair could improve health outcomes for Sarah by
* Reducing the risk of autonomic dysreflexia, which can lead to a sudden increase in blood pressure – life threatening if it remains unchecked
* improved bowel and bladder management
* the production of normal bone density and joint and tendon flexibility and tone control
* improved chest/respiration/infection management due to optimum changes in posture influencing chest drainage
* no need for a separate tilt table and use of three trained staff to operate the table £1,295 + VAT for the tilt table alone, plus staff costs)
* Positioning controls which enable Sarah to perform physiotherapy exercises in her chair, as opposed to being hoisted into bed to perform the same exercises. This would help manage Sarah’s blood pressure and reduce the number of carers required throughout the day
* Powered leg rest elevation reduces the risk of carers suffering back injury.

*Source: Yorkshire Spinal Injury Centre*

* By undertaking a whole system approach to the evaluation of wheelchair provision and investment opportunities, the payback period for the more costly wheelchair was three months through reductions in nursing and care costs
* The risk of emergency hospital admission is also greatly reduced by the selection of the more efficient chair, providing further potential significant savings.
* Sarah is a strong candidate for a personal budget to self-direct her support

Wider population

Colin is in his late 70’s and is finding he needs to stop and sit down for a while when he is out for the day. He has used a stick for some months but thinks he would like to see about a lightweight chair that he can pop into the boot of the car.

Figure 12: Wider population

user 4

Wider population benefits

* Readily available products and information through a normal retail outlet experience
* The ‘assessment’ can be undertaken there and then
* Should more specialist advice be required the retailer is trained to signpost individuals to the relevant service, e.g. GP; NHS wheelchair provider; social care services
* Colin and his wife can see products demonstrated and consider all the features that are important to them.
* They can take away information and discuss with their family, or just take the time they need to think about what they wish to purchase
* Their choice can be purchased there and then and they may decide to purchase additional products that may be helpful
* Colin can take the products immediately or he can arrange delivery (and installation as required for daily living products) when it is convenient for him
* He can return the products with the same protections offered by consumer legislation.

Developing high quality services

There are a number of other components that Commissioners may choose to develop with other organisations and/or providers to deliver integrated services. These could include:

Virtual funding mechanisms

Cross sharing across agencies facilitates patient choice. Establishing ways of working that ensure the seamless funding across health, social care, work and education to underpin the whole life assessment process without onerous or delaying authorisation processes. There are a number of options available which are summarised in Annex 7.4.

Single Point of Contact

Users, carers and professionals will be able to contact a single point for a wide range of services. Utilising ‘Choose and Book’ or similar applications, individuals would benefit from improvements in referral processing and appointment booking being able to choose the assessment location of their choice and the date and time of their assessment. This delivers improved referral to treatment (in this case provision) timelines.

A single point of contact should be able to triage and act as a knowledge resource that provides advice relating to a wider range of equipment and services and not just relating to posture and mobility It is envisaged that specialist assessors based in wheelchair centres will also provide expert advice that complements that of local assessors.

A single point of contact could offer the facility to arrange maintenance and repairs for all people who use wheelchairs or special seating and may initially deal with breakdown requests. This will negate the need for users to have a range of contact numbers for chair repairs and deal with a single point of contact.

There will be a strong emphasis on customer services, actively seeking feedback to help drive choice and areas for improvement. This feedback could be broadened from just consideration of wheelchairs to their enablement needs and will be based on measuring outcomes to maximise their effectiveness and will be used to assist user choice.

Currently data on services is minimal, inconsistently collected and defined. A consequence of the new model for wheelchair services will be that a wealth of standardised data will be available for commissioners and accredited providers to drive a culture of continuous improvement. A single point of contact should also be the conduit for transfer charges back to originating budget holders.

The NHS contract and Better Standards for Health require providers to provide interpretation services, information in a range of accessible formats, service user influence in the management of the service and brokerage for individuals. Service user feedback showed 24 hour support lines were a key requirement for wheelchair services.

There is a number of NHS support lines operated that could be developed to provide single point of contact functions without each provider having to do so.

Commissioners should look to where these services are currently well provided and support providers to utilise and partner with other organisations wherever possible.

Common Eligibility Criteria

Establishing common eligibility criteria across wider localities including health, social care, Department of Works and Pensions and education criteria means that anyone ineligible for state funded services can be informed at the beginning of the process. Individuals can be given information relating to the services provided by the State, options for self-funding of equipment and signposting to the accredited marketplace where they can have their needs met. The criteria in the new cross-service model will in due course effectively act as a budget setting mechanism rather than access criteria.

Increasing the range of services offered through an independent living service

Examples of services could include rehabilitation services, aids to daily living, assistive technology services including orthotics, prosthetics, electronic assistive technology services, podiatry services, transport solutions, equipment for school or work and care packages to enable them to live life as independently as possible

Inventory management and recycling

It is expected that equipment solution providers will be effective in managing inventory, especially if it is owned by them and not the NHS. This may include refurbishing and reusing equipment provided it performs at an acceptable level.

Commissioners may decide they wish to continue to provide recycled equipment as part of their service offering. Service users should be given this information. Service users may choose to top up to new equipment if they do not wish recycled equipment. This is about being open and transparent, not about stopping economically viable and performance acceptable refurbishment and reuse.

Validated assessment/decision support tools

It is proposed that existing community based staff across health and social care, who currently refer individuals to wheelchair services, will be trained and provided with validated assessment/ decision support tools to undertake the initial assessment for self supporting needs which will include obtaining physical and environmental measurements as required.

It is proposed that through the deployment of validated assessment/decision support tools, accredited assessors will be able to carry out whole life assessments. The systemisation of the assessment process minimises rework, applies requirements across services and establishes baseline financial allocations for categories of assessment.

The benefits of the new system

Quality Improvements

Whole life assessments

In the new system, people will be given an initial assessment, which will consider their wider enablement needs across a range of services looking at the requirements to assist them to live independently. Common and transparent eligibility criteria across the region should help people know where they stand at the outset.

Greater choice and flexibility to fit a enablement package to user needs

This will give people choices of options and ranges of equipment that meets their needs, receive product information and advice and know what funding is available to them irrespective of their basic or specialised requirements. People will be offered flexibility to pool personalised budgets from a number of services and reapportion them in a way that best suits them to maximise the impact on their daily lives.

Service improvement driven by patient feedback mechanism

A strong emphasis is placed in the new system for capturing consumer feedback to measure provider performance. Commissioners should include this in outcome specifications and contracts to ensure providers are accountable for achieving the contracted targets and rewarded for innovative practices.

Enhanced data quality and analysis to identify and resolve service issues

By capturing information through simplified processes and improved systems through the contact centre, Commissioners will have robust data to understand the activity, case mix and spend against plan. This, combined with the procurement hub developing a supplier relationship management approach, will enable any service issues to identified quickly and be resolved at the earliest opportunity.

Reduced referral to treatment waits

In the new system, accredited assessors, using an evaluated decision support tool, can undertake an increased range of low to moderate needs assessments instead of completing a referral form to send to the Wheelchair & Seating Service. This is estimated at 55% of current referral patterns

Figure 13: Needs assessment

optimal timeline

* The remaining moderate to complex needs assessments are referred for more specialist assessment
* This timeline can be improved to 21 days maximum waiting time based on current average priority waiting time from referral to assessment
* The maximum time from agreeing equipment package to equipment handover should not exceed 6 weeks based on manufacturers feedback
* Total timeline maximum of 9 weeks

Innovation

Joint personalised budget approaches to maximise patient choice

In the new approach, the development and roll-out of personal health budgets for people who use wheelchair services will provide a new dynamic in the marketplace. The removal of the ‘State’s’ disproportionate influence over product specification will create a direct and dynamic relationship between the individual and suppliers. Greater competition will drive innovation as suppliers vie to attract customers.

Cost and savings sharing mechanism to drive cross sector working

The new system proposes virtual funding mechanisms that include an allocation system. Cross sector, working can be encouraged by understanding the percentage contributions from agencies and allocating this to overall savings and eliminating the arguments over contributions and benefits that occur through the current silo funding arrangements.

Packages of product and service commissioned to deliver effective patient outcomes

Commissioners will source provision of both equipment and service solutions from providers who are best able to improve quality and productivity. Packages of wheelchair equipment and support will normally be for 5 years and include all equipment, modification, servicing and maintenance requirements. The packages can be tailored to achieve individual outcomes.

Sustainable alternative to state provision

Stimulating and accrediting the marketplace to innovate, provide solutions and increase visibility and accessibility of products for all wheelchair users, not just those whom the state supports, is critically important to the development of the new system. This normalisation of the marketplace caters for individuals with personal budgets to choose from a marketplace that is starting to operate like any other consumer marketplace. It will also enable those with low-level needs to purchase their own equipment in the future knowing, as with spectacles, if their condition deteriorates they will be supported by the state.

Ability to measure improvements in innovation

By working together to regularly review packages of solutions to include new products, commissioners can provide the incentive for providers to innovate.  Commissioners will be able to establish a baseline and measure annual improvements in innovation through a basket of indicators (no of new products, services and process improvements introduced per annum; average turnover accounted for by new or significantly improved products and services) as well as track Providers investment in innovation-directed activities, including Research & Development, as a percentage of business turnover.

Prevention

Potential for greater individual enablement which reduces the rate of their deterioration

Focussing on an individual and supporting them to meet their desired outcomes with the most appropriate wheelchair and associated equipment has a range of benefits. These include obtaining features such as angled seatbacks that improve breathing and lung function that reduces admission into hospital; having the freedom to use equipment where and when they want not tied to conditions of use restricting how and where they use the equipment (currently restrictions tying equipment use to a school or workplace)

Reduction in consequential costs

There is considerable evidence from the DH[[4]](#footnote-5) about the significant financial impacts on other agencies, such as housing, social care and acute hospital care, resulting from the consequences of poor decision making and limiting eligibility criteria away from wheelchair models, functionality and accessories that meets lifestyle needs rather than purely clinical needs.

Productivity

Reduction in duplication

Duplication exists across agencies and within services where the same information is collected about an individual many times. By driving common approaches much of this duplication can be removed. There is also considerable evidence that duplication of issue between services occurs with a number of users commenting on the provision of multiple number of chairs, with greater join up this will be minimised.

Improved purchasing effectiveness

Developing packages of wheelchair equipment and support, underpinned by currency and tariff establishing visibility of how the budget is being spent. Driving consistency across provider activities which will enable greater purchasing power and more effective procurement activity.

Improved work rate through booking effectiveness and benchmarking

Booking will be able to be made by the accredited assessor via choose and book through the contact centre this will also populate all relevant details. Greater understanding of best practice through benchmarking will improve productivity this will be made possible by effective information collation through a regionalised approach.

Reduced administration costs

The administration will be reduced by improving the effectiveness of the referral process thereby preventing the need for follow up. The contact centre will act as a collation point for ordering which will occur by EDI reducing the administration burden.

Allocating cases effectively to staff with the appropriate skill set

Up-skilling of accredited assessors will enable a greater level of direct issue, improving the provision timeline for user and reduce the overall cost base. With more straightforward cases being dealt with by accredited assessors, the more specialised clinicians within the wheelchair service will have more capacity to assess complex patients and this will reduce waiting times for appointments.

Annex

Personal health budgets – Key Learning from In Control

Individual resource allocation system (RAS) for Wheelchair services

Table 23: Key design criteria

| The resource allocation system should provide: | |
| --- | --- |
| **Consistency** | One consistent framework for allocation of resources to individuals across the region. |
| **Outcomes** | a system based on outcomes achieved rather than activity undertaken or equipment purchased |
| **Transparency** | a transparent framework that is understood by those allocating and receiving resources. |
| **Transactional efficiency** | An assessment based allocation that is low on transaction cost. |
| **Needs** | a system that ensures allocations are better attuned to the distribution of needs, addresses historic imbalance in the distribution of costs, where access to low cost equipment is effectively universal whilst more specialist higher cost equipment is overly constrained. |
| **Innovation** | The best conditions for the innovative use of resources. |
| **Dynamic** | A system where individual allocations are based on the actual cost of achieving agreed outcomes (these will change over time) |
| **Integration** | Compliment and supplement the resources individuals are able to call upon from elsewhere (personal or from other services) |

Given the design criteria the system, will have key component

* A single defined outcome
* A simple framework of need
* Costing initially based upon existing unit costs attuned over time as the system is operated

**Methodology**

For the RAS to allow people genuine choice and control it is essential they are equipped early on with key information. They should be told, how much money they can control, what outcome should be achieved with the money and what if any constraints are to be placed on the way money can be spent.

To set these conditions it will be necessary to engage with a range of stake holders locally and agree outcome and constraints to be adopted.

Suggested outcomes and conditions are set out below.

**Outcome:** The person’s mobility is enhanced.

**Conditions:** Allocations should:

* Be used to enhance mobility.
* Be legal.
* Not expose the individual or others to unmanaged or un-assessed risk.

**Defining a simple needs framework**

The needs framework is required to provide a broad indication of a person’s need. It is not necessary to gather all the information used to determine how best to meet a person’s needs as this will take place once the initial budget has been set.

The overriding factor for the needs framework should be; simplicity, transparency and transactional efficiency. It is proposed that a matrix of needs indicating 4 broad levels of needs would provide sufficiently sensitive measurement of needs.

It is likely that existing eligibility criteria already in use across the region could be used to inform this framework of needs, and so it is recommended that a scoping exercise be undertaken to inform the development of a framework need. To illustrate the model and stimulate development, an initial draft is set out bellow.

Table 24: Model and stimulate development initial draft

| Level | Typical Descriptors of need |
| --- | --- |
| Non eligible | Person is ambulant and not eligible for wheel chair service |
| Low | Person has some difficulty with mobility and can only walk only very short distances. Needs are likely to be met by the provision of a standard wheelchair. |
| Medium | Person cannot walk unaided, mobility significantly impacts upon their lifestyle. |
| High | Person cannot walk, their independence and lifestyle are likely to be significantly enhanced by access to more specialist equipment. |
| Very high | Person has complex multiple disabilities likely to require highly specialised and costly equipment |

The framework of need will need to be further refined and agreed with key stakeholders, including appropriate clinical professions and disabled people.

Calculating individual allocation levels

An initial figure will need to be set for each level of need. At this point of development it is proposed that the figure be broadly equivalent to the cost to the NHS of providing refurbished equipment to individuals in each level of need.

Table 25: Refurbished equipment levels of need.

| Level | Allocation |
| --- | --- |
| Non eligible |  |
| Low |  |
| Medium |  |
| High |  |
| Very high |  |

7.1.5 Initial financial modelling

The allocation levels will need to be refined and checked by some simple predictive financial modelling that includes;

* Total equipment budget expenditure
* Total number of patients receiving equipment at each need level.

Calibrating the system

As the system is implemented and ranges of people take control of personal budgets, it will be possible to fine-tune the allocations at each level. It will be clear how many people at each level of need are being allocated funds.

Once the system has been operational for some time, it will be possible to recalibrate the allocation levels using information from people who have control of personal budgets.

Figure 14: Calibrating the system

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Indicators of Level of Care Management Framework

The Posture & Mobility Group (PMG) shared the following information they have developed to support clinicians working with the Care Management Framework

Table 26: Indicators of Level of Care Management Framework

| Description of Indicator: | Level |
| --- | --- |
| **Time** | |
| Wheelchair is a mobility option but used <1hr /day | 1 |
| Wheelchair is main means of mobility, used every day but not all day | 1 or 2 |
| Totally dependent on wheelchair for mobility and in it all day | 2 or 3 |
| **Posture** | |
| No specific postural issues | 1 |
| Requires a single commercial postural support e.g. backrest, cushion, wedge, lateral supports | 1 or 2 |
| Requires 2 or more postural elements which can be commercial or bespoke | 2 or 3 |
| Needs complete postural support requiring bespoke prescription | 2 or 3 |
| **Ability to establish, maintains, and change position** | |
| Can change position independently | 1 |
| Can change position with occasional assistance/prompting/supervision | 1 or 2 |
| Can change position with regular assistance of one person | 2 or 3 |
| Poor ability to establish a good sitting position, even with assistance | 2 or 3 |
| Totally dependent on one or more people in order to change position | 2 or 3 |
| Spasticity and/or involuntary movements are present, causing difficulties with establishing and maintaining a good sitting position, even with assistance | 2 or 3 |
| Recurrent issues with pressure ulceration | 3 |
| **Need for assistive technology** | |
| Requires basic manual chair (attendant or self-propelled) only | 1 |
| Requires powered chair for mobility | 2 or 3 |
| Requires lightweight, active user chair | 2 or 3 |
| Requires powered chair and one or more additional assistive technology (AT) devices to enhance independence and quality of life | 2 or 3 |
| Totally dependent on powered chair with multiple integrated AT devices, to maintain quality of life | 3 |
| **Changing needs** | |
| Static condition | 1 |
| Anticipated, predictable change requiring regular monitoring and adjustment e.g. as a result of growth, injury, surgery, lifestyle change | 2 or 3 |
| Single anticipated change but with unpredictable needs e.g. surgery | 2 or 3 |
| Continual anticipated changes, with unpredictable needs e.g. deteriorating conditions | 3 |

Additional specific indicators of Level 3

The Posture & Mobility Group (PMG) shared further detail to support clinicians working within the Care Management Framework.

* Clients with specific diagnoses who are totally dependent: cerebral palsy, muscular dystrophy, motor neurone disease, multiple sclerosis, and other progressive, deteriorating neurological conditions
* A person with a progressive neurological condition with moderate postural need who would ideally be prescribed a tilting powered wheelchair but who is unable to drive safely.  Since they need to maintain independence in the day time while their spouse is out at work, a normal self-propelling manual wheelchair with customised supports is prescribed.  This example highlights the need of the clinician to make judgements where a number of conflicting factors exist but where, ultimately, the equipment prescribed is, on the face of it, non-complex.
* A person having a movement disorder where there are significant amounts of involuntary movement causing premature failure of “off the shelf” equipment.  This sort of prescription requires very careful consideration and experience in determining what equipment has sufficient strength and function to meet the requirements.
* A person who has a very high level of postural need normally leading to the prescription of custom contoured seating but who chooses to use “off the shelf” equipment for functional reasons.  This sort of assessment should be equally as thorough as an assessment in which the person is prescribed custom contoured seating in order to provide sufficient information for a sound, clinical decision to be made.
* A person with a moderate to low postural requirement but who has a highly complex and intricate combination of functional, environmental, and social factors for whom only a very specific piece of “off the shelf” equipment will be appropriate, i.e. the person carrying out the assessment should be able to appraise a wide variety of options, including custom made equipment, before deciding on a prescription.
* A person having recurrent issues with pressure ulceration should be referred to the specialist service because, usually, the problems are not isolated to the wheelchair and may require changes in routine, other equipment, and nursing input.
* A person who would be adequately supported by “off the shelf” equipment but who continues to experience significant and chronic pain.
* A person having “challenging behaviour” where there are significant issues balancing the need for safety with the risk of applying restraint.

Virtual Funding Mechanism Options

Table 27: Virtual Funding Mechanism Options

| Arrangement | Description | Legislative basis: 2006 Act | Further detail |
| --- | --- | --- | --- |
| Lead commissioning | One partner takes the lead (and acts as the host) in commissioning services on behalf of another to achieve a jointly agreed set of aims | Section 75 | Suitable option depending on size and make-up of the service to be commissioned |
| Integrated management or provision | One partner delegates their duties to another to jointly manage service provision; or partners combine (pool) resources, staff and management structures to help integrate provision of a service from managerial level to the frontline. One partner acts as the host to undertake the other’s functions | Section 75 | Helps to ensure cooperation and prevent duplication where the same person is responsible for services for both bodies |
| Pooled funds | Each partner makes contributions to a common fund to be spent on pooled functions or agreed NHS or health-related council services under the management of a host partner organisation | Section 75 | Shared resources and responsibility to meet specific local needs is acknowledged.  Flexibility, as expenditure and service response is based on users’ needs rather than financial contributions, helping to prevent disputes over funding responsibilities.  Essential where a service is, or moving towards being, fully integrated.  Associated processes, e.g. financial management and technical requirements of the pool seen to be bureaucratic |
| Combination of section 75 flexibilities | Combination of any or all of the above, for example, pooled funds with lead commissioning arrangements, pooled fund with integrated provision or delegated (or lead) funds with pooled funds | Section 75 | Allows flexibility and seamless provision of care |
| Aligned budgets | Partners align resources (identifying their own contributions) to meet agreed aims for a particular service, with jointly monitored spending and performance but separate management of, and accountability for, NHS and council funding streams | Non-statutory | Flexibility around the use and monitoring of funds  Retained ownership of funds and responsibility of budget management  Interim step to pooling  Not ideal where a service is already integrated |
| Aligned budgets with section 75 flexibilities | One partner takes the lead in the management of jointly commissioned or provided services, but NHS and council funds are not pooled | Section 75 | Flexibility around the use and monitoring of funds against a jointly agreed set of aims  Retention of specialist knowledge by lead partner about specific service area |
| Care trusts | NHS and council health-related responsibilities are combined (via council delegation) within an NHS body under a single management. Can be formed from an existing NHS trust or PCT (in the latter case, the PCT is both a commissioner and provider) | Section 75  Section 77 | Joint planning, commissioning and delivery of health and social care services across a local area |
| PCT grants to councils | PCTs make transfer payments (service revenue or capital contributions) to councils to support or enhance a particular council service. This is not a partnership and there is no delegation or pooling of functions | Section 256 | Can be used to provide funding from one partner to another in order to offer a more effective use of resources and provide a greater level of care where necessary |
| Council grants to PCTs | As above, but for council transfers to PCTs | Section 76 |  |

**(Local Innovations in wheelchair and seating services, DH, Dec2010)**

1. Core Delivery Team / Acknowledgements

**Annex 1: Core Delivery Team / Acknowledgments**

**AQP Wheelchair Programme Team**

| AQP Role | Name | Role |
| --- | --- | --- |
| Cluster Lead Contact | Barry Day | QIPP Procurement Programme Manager |
| DH Account Manager | Alexander Kamadu | AQP Planning & Service Development Manager |
| SHA AQP SRO | Steve Clarke | Director of Finance |
| Buddy SHA AQP Contact | Helen Cameron |  |
| Buddy Cluster Contact | Will Huxter | Director of Procurement, Contracting and Performance |
| Buddy Cluster Contact | David Bearman | NHS South West Project Lead |
| PBR Lead | Lorna Sinclair | Principal Operational Research Analyst |
| Policy Lead | Stephen Pigeon | Policy Manager |

| AQP Delivery Team |
| --- |
| Barry Day |
| Lesley Cave |
| Paul Ruthven |
| Many Hall |
| Lynne Horn |
| David Bearman |
| Alan Warren |
| Gemma Leavens |

**Acknowledgements**

| Organisation | Name | Role |
| --- | --- | --- |
| Assist UK | Alan Norton | Chief Executive & User & Advocate |
| NHS Suffolk | Alex Winterbone | Independent Living Manager |
| Local Stakeholder Groups | Alison Coppen | Highly Specialist Occupational Therapist |
| NHS Hertfordshire | Andrew Boasman | Commissioner |
| NHS West Kent | Angela Broomby | Lead Commissioner WCS NHS West Kent |
| NHS Cambridgeshire | Anne Heath | Commissioner NHS Cambridge |
| Local Stakeholder Groups | Asim Niaz | Rehabilitation Medicine Consultant |
| Nat Stakeholder Groups | Barend ter Haar | Director BES Rehab, ex treasurer of PMG |
| Disability and Carers' Organisations | Beverley Davies | Royal British Legion |
| Disability and Carers' Organisations | Beverley Dawkins | Mencap |
| Nat Stakeholder Groups | Carolyn Nichols | Editor, journal of the Posture and Mobility Group |
| British Association of Occupational Therapists | Catriona Ogilvy | Chair, Specialist Group - Children and Young People |
| Local Stakeholder Groups | Chas Banks | Chair NWWUG Manchester User Group |
| NHS South Central | Chris Gwyther | Head of Learning Disability and Physical Health, NHS Hampshire |
| Local Stakeholder Groups | Chris King | Development Director Sun Medical |
| Bedford Cluster PMO | Chris Myers | Deputy Chief Operating Officer- Children, Young People & Specialist Services |
| Disability and Carers' Organisations | Christine Lenehan | Council for Disabled Children |
| Local Stakeholder Groups | Christine Lenehan | The Council for Disabled Children |
| Department of Health | Claire Aldiss | Stephen Pidgeon’s Line Mgr |
| Department of Health | Claire Aldiss | Acting Director of Commissioning |
| Local Stakeholder Groups | Clare Leckey | Chair of the Posture and Mobility Group |
| Service User Group | Cliff Bush | North West Surrey Association of Disabled People |
| Service User Group | Clive Lock | Croydon Wheelchair Service User Group |
| Local Stakeholder Groups | Colin Plumb | Plymouth DSC Wheelchair and Special Seating Services Manager 2002-2011 |
| Organisation | Name | Role |
| NHS Norfolk | Colleen Hubbard | NHS Norfolk Commissioning WCS |
| Bedford Cluster PMO | Corinna Welbourn | Bedfordshire PCT QIPP PMO |
| Local Stakeholder Groups | Corinnne Edwards | NHS Banes Commissioner |
| Spinal Injuries Association | Dan Burden | Head of Public Affairs |
| Local Stakeholder Groups | Dan Steedman | Parent of 12 year with Postural Needs and M.D.of  Activate |
| Camden Children's Services | Daphne Turner | Commissioning Manager Complex Needs Service Improvement |
| Local Stakeholder Groups | Dave Harrison | Royal Borough of Kensington and Chelsea |
| Department of Health | David Colin-Thomé | National Director for Primary Care |
| Local Stakeholder Groups | David Griffiths | Managing Director - Medequip |
| Local Stakeholder Groups | David Lock | Operations Director Millbrook Healthcare Centre |
| NHS London | Deborah Russell | Flexible Resource Team Member |
| Local Stakeholder Groups | Declan O`Mally | CEO Mobility |
| Bedford Cluster PMO | Dianne Meddick | Change Manager for Long Term Conditions |
| Local Stakeholder Groups | Donald Harrison | General Manager Business and Performance,  West Midlands Rehabilitation Centre |
| Ministry of Defence | Dr Anne Braidwood | Senior Medical Advisor |
| SHA | Ed Garratt | SHA Cluster Development - Deputy Director of Commissioning |
| Local Stakeholder Groups | Elaine Fitzsimmons | NHS Plymouth Commissioner |
| NHS Bedforshire | Esther Bolton | Commissioner |
| Disability and Carers' Organisations | Farah Nazeer | Motor Neurone Disease Association |
| Local Stakeholder Groups | Fiona Bell | Exeter Wheelchair Manager |
| Bedford Borough Council | Frank Toner | Director Adult Services |
| Local Stakeholder Groups | Giles Gardiner | Devon County Council |
| Local Stakeholder Groups | Gina Joslin | The British Association and College of Occupational Therapists member |
| Disability and Carers' Organisations | Heather Nicholson | British Limbless Ex Servicemen Association |
| Buddy | Helen Cameron | Links with Will Huxter |
| Organisation | Name | Role |
| Clinical Groups | Henry Lumley | Posture and Mobility Group |
| Whizz Kidz | Ian Legrand | Strategic Advisor |
| Luton PCT | Ian Rosser | QIPP Lead |
| Local Stakeholder Groups | Irene Hart | North Staffs Wheelchair User Group (main contact) |
| Department of Health | Jacqueline Naylor | Head - Ill and Disabled Child |
| North Linc & Goole HNHST | Jacqui Twomey | WCS Manager, Brumby, Scunthorpe |
| Local Stakeholder Groups | James Brown | Swindon Wheelchair Focus Group ( Engagement Officer) |
| QIPP | Jan Filochowski | West Herts CEO |
| Local Stakeholder Groups | Jane Howard-White | Representative of user groups |
| Local Stakeholder Groups | Jane Thurlow | Wheelchair Manager - York |
| NHS Supply Chain | Janet Booth | Senior Buyer - Primary Care |
| NHS Supply Chain | Janice O'Connell | Buyer - Rehabilitation |
| NHS Devon | Jayne Carroll | Director of Strategic Commissioning |
| National Association Equipment Providers (NAEP) | Jean Hutfield | Chair |
| Local Stakeholder Groups | Jenny Stanford | Service manager of the Worcestershire Wheelchair & Seating Service |
| Disability and Carers' Organisations | Joanne Carr | Council for Disabled Children |
| Local Stakeholder Groups | John Bruce | Liverpool Wheelchair User Group ( Secretary) |
| ADASS | John Nawrockyi | Disability Network Joint Chair |
| Cluster CCG SRO | John Rooke | COO CCG 1 |
| Solihul Care Trust | Judith Davis | Interim Deputy Director of Commissioning |
| British Association of Occupational Therapists | Judith Taylor-Cookson | Specialist Group - Children and Young People |
| Local Stakeholder Groups | Julia Kinsela | Dorset Wheelchair Manager |
| Bedford Cluster PMO | Julia Morgan | Provider Business Lead |
| Department of Health | Julie Chapman | Policy Officer |
| Central Bedford Council | Julie Ogley | Director Adult Services |
| NHS North East | Julie Ross | Strategic Head of Commissioning & Primary Care |
| NHS South Central | Karen Ashton | Associate Director of Programme, Long Term Conditions |
| NHS West Sussex | Karen Coley | Service User |
| Organisation | Name | Role |
| Disability and Carers' Organisations | Karyn Galloway | Veterans UK (London Region) |
| Department of Health | Kate Dixon | Commissioning Capabilities Branch Head |
| British Association of Occupational Therapists | Katie Waghorn | Specialist Group - Children and Young People |
| Accenture | Keith Stewart | Consultant, Health & Public Service |
| Disability and Carers' Organisations | Kirstine Knox | Motor Neurone Disease Association |
| Clinical Groups | Kirsty-Anne Cutler | Posture and Mobility Group |
| Nat Stakeholder Groups | Krys Jarvis | Nat WC Mgrs Forum |
| NHS Eastern and Coastal Kent | Laura Counter | Commissioning Support Officer Community Equipment and Wheelchair Services |
| Disability and Carers' Organisations | Liam Dwyer | Motor Neurone Disease Association |
| Local Stakeholder Groups | Linda Fermont | Retired Consultant in Rehabilitation Medicine, and National Advisor to PMG |
| Nat Stakeholder Groups | Linda Marks | Retired consultant in rehabilitation medicine, external adviser to PMG |
| Cluster Delegated SRO | Linda Willis | Deputy Director of Commissioning at NHS Bedfordshire |
| Ministry of Defence | Lisa Dunthorne | Occupational Therapy Professional Lead Advisor - DMRC Headley Court |
| Local Stakeholder Groups | Lorraine Long | NHS Cornwall Commissioner |
| Disability and Carers' Organisations | Louise Munden | Contact a Family |
| Local Stakeholder Groups | Lyn Alesbury | NHS Somerset Commissioner |
| Local Stakeholder Groups | Lyn Rowney | North Essex Wheelchair User Forum ( Secretary) |
| Local Stakeholder Groups | Maddy Ferrari | NHS Wiltshire Commissioner |
| Bedford Cluster PMO | Maggie Layton | Carer |
| Local Stakeholder Groups | Mark Prosser | Managing Director - Inva Care |
| Local Stakeholder Groups | Mark Robertson | Wizz Kidz Director of Comms re childs user group |
| Kent Children’s Trust | Martin Cunnington | Senior Commissioning Manager - Disabled Children and Long Term Conditions |
| Office of Disability Issues (DWP) | Mary Helson | Deputy Director, Right to Control |
| Organisation | Name | Role |
| Local Stakeholder Groups | Meg Bodycoat | Clinical Lead at Bowley Close Rehabilitation Centre |
| Bedford Cluster PMO | Mick Dillon | Wheelchair User / Disability Resource Centre |
| Local Stakeholder Groups | Mike Griffin | BAOT ( British Association of Occupational Therapists) representative |
| Local Stakeholder Groups | Mike Hearn | Chairman - Seacroft Hospital ( User group) |
| Service User Group | Mo Reece | South East Coast People's Engagement and Development Network |
| Disability and Carers' Organisations | Nick Bungay | Muscular Dystrophy Campaign |
| Local Stakeholder Groups | Nicola Aburto | Wheelchair Manager |
| NHS North East | Nicola Hair | Senior Team Secretary for Primary Care and Commissioning - PA Julie Ross |
| NHS Devon | Nikki Coombes | Strategic Commissioning Business Support Manager/ PA to Jayne Carroll |
| Posture and Mobility Group | Olwen Ellis | Secretary |
| SME | Pam Green | NE Essex PCT Acute Commissioner |
| Local Stakeholder Groups | Pat Newton | East Sussex Wheelchair Service Group (Chair) |
| Local Stakeholder Groups | Paul Dryer | Head of Rehabilitation Engineering at Kings College Hospital |
| SME | Peter Gage | Links with Nat WC Mgrs & SEPT - Wheelchair Manager |
| Local Stakeholder Groups | Peter Lane | Senior Rehabilitation Engineer |
| Nat Stakeholder Groups | Peter Rowell | PMG member, rehabilitation engineer at Worcester Wheelchair Service |
| Nat Stakeholder Groups | Ray Hodgkinson | Director of BHTA (British Healthcare Trades Association) |
| Department of Health | Rebecca Molyneaux | ex DH Adviser and Wheelchair Policy Manager |
| Service User Group | Richard (plus Tom - wheelchair user partner) | Milton Keynes user group |
| Norfolk CHC | Richard Goodhew | Wheelchair Services Manager Norwich |
| Local Stakeholder Groups | Richard Wallace | Milton Keynes Wheelchair User Group |
| Bedford Provider | Richard Winters | Chief Operating Officer Bedfordshire Community Provider |
| Local StakeholderGroups | Rob Hayday | Wiltshire Wheelchair Manager |
| Organisation | Name | Role |
| Local Stakeholder Groups | Rob Hood | Shropshire Wheelchair User Group (Secretary) |
| Local Stakeholder Groups | Rosalind Ham | Clinical Specialist ( recommended by AK) |
| Whizz Kidz | Ruth Owen | Chief Executive |
| Disability and Carers' Organisations | Ryan Thompson | Whizz Kidz |
| Nat Stakeholder Groups | Sam Gallop | emPower |
| SHA | Sam Hepplewhite | Midlands & East SHA liaison |
| NHS West Sussex | Sarah Roberts | Senior Community Contracts Manager |
| Bedford Cluster PMO | Sarah Sherwood | Provider WC Services Manager & Bedford Local User Group - Bedfordshire Wheelchair Service Manager |
| Association of Chartered Physiotherapists | Sarah Vines | Committee Member, Community Physiotherapists Group |
| Local Stakeholder Groups | Sharon Tuppeny | Professional Affairs Officer College of Occupational Therapists |
| Local Stakeholder Groups | Sherry Pugh | Bedford Local User Group |
| Local Stakeholder Groups | Sidney Chu | The British Association and College of Occupational Therapists member |
| Bedford Borough Council | Simon White | AD Adult Services |
| QIPP | Simon Wood | Beds Cluster Director of Com Development |
| Disability and Carers' Organisations | Srabani Sen | Contact a Family |
| Disability and Carers' Organisations | Stephen Duckworth |  |
| Disability and Carers' Organisations | Stephen Springer | RADAR |
| Disability and Carers' Organisations | Sue Bott | National Centre for Independent Living - Director |
| NHS East Midlands | Sue Dryden | Lead for Children |
| Local Stakeholder Groups | Sue Line | Coventry Wheelchair Service User Group (Secretary)  Chair person and trustee of National Association of Patient Participation |
| Local Stakeholder Groups | Sue Pimentel | Isle of Wight Wheelchair User Group (Main contact) |
| Kent Children’s Trust | Suzanne Wilkins | Specialist Teaching Service Manager |
| Local Stakeholder Groups | Terrance Nicholls | Bedford Local User Group |
| Organisation | Name | Role |
| NHS Sheffield | Tim Furness | Deputy Director of Strategy |
| Bedford Cluster PMO | Tracey Brightman | Wheelchair User |
| SME | Tracy Freeman | Specialist occupational therapist & Wheelchair service Lead |
| Local Stakeholder Groups | Tracy Steve | Bedford Local User Group |
| Local Stakeholder Groups | Trudy Ward | Representative of Royal College of Nursing |
| Buddy | Will Huxter | Managing Director, East London & the City Sector Acute Commissioning Unit at NHS Tower Hamlets |
| Disability and Carers' Organisations | Zara Todd |  |

1. Considerations

**Annex 2: Considerations (to be completed)**

**Please note Annex 2 is being updated - the following link will take you to the latest version of this document.**

<http://www.supply2health.nhs.uk/AQPResourceCentre/Pages/Annex2.aspx>

1. Public Sector Equality Duty

**Annex 3: Public Sector Equality Duty**

The Equality Act 2010 replaces the previous anti-discrimination laws with a single Act making it easier for people to understand. It also strengthens the law in important ways, to help tackle discrimination and inequality. The Public Sector Equality Duty, which came into effect on 5 April 2011, sets out the responsibilities a public authority must undertake in order to ensure an environment that fosters good relations between persons of differing protected characteristics. Protected characteristics under the Equalities Act 2010 are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation. The Equality Duty has three aims. it requires public bodies to have due regard to the need to:

* eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
* advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
* foster good relations between people who share a protected characteristic and people who do not share it.

Commissioners should have regard to the Public Sector Equality Duty when commissioning services for patients. For more information please visit the Department of Health website and search for 'Equality and Diversity'.

1. Glossary

**Annex 4 – Glossary**

| Term | Definition |
| --- | --- |
| Commissioner | Commissioners have a responsibility to purchase a range of healthcare and/or social care services from Providers to meet the needs of the populations for which they are responsible. These are subject to formal agreements and relate to a specified range of services. |
| Provider | Providers supply services to the Commissioners to meet the specification and against the terms of an agreement. |
| AQP | Any Qualified Provider |
| Referrer | This is a person who is authorised by the commissioner and can refer an individual to a wheelchair service (e.g. GP, community nurse etc; and possibly Self-Referral) |
| Assessor | This is a person who has been trained to undertake assessments for standard wheelchair equipment solutions including the preparation of the prescription form. |
| Referral | This is the process for entry to an appropriate service. It usually requires information to be provided in a format that gives sufficient information to triage the individual.  Referrals can be made by the individual (self referral) or by a referrer on behalf of the individual |
| Triage | This is the process of prioritising people for assessment and/or treatment according to the seriousness of their condition or injury. Using the information provided in the referral form, or via additional contact with the individual or the person who referred them. |
| Assessment | This is the discussion, examination and measurement of the individual to understand what is the most appropriate equipment solution to meet the individual’s healthcare outcomes and meets the individuals’ goals (recognising that the NHS funded solution may not be sufficient.) |
| Prescription | This is the document that provides the detail required to ensure that an appropriate equipment solution can be provided. |
| Prescription Solutions Review | This is the discussion that takes place after assessment between the individual who has been issued with a prescription and the provider of the equipment solution. It is not a clinical review of the individual, but a review of the equipment options available. |
| Standard equipment solutions (used interchangeably as wheelchair equipment) | These are unmodified, ‘off the shelf’ wheelchairs, backrests, cushions and accessories |
| Modifications | This involves either the alteration of a piece of equipment for use in a different way or the manufacture of bespoke items for a specific clinical need. Modifications must be specified, including the preparation of technical drawings as necessary, by appropriately qualified individuals.  There is a requirement for bespoke engineering solutions to be fully documented in a technical file, as required by the EEC Medical Devices Directive, 93/42/EEC. |
| Handover | This refers to the activities undertaken to handover the equipment solution to the individual. These activities could include assembly and demonstration of the equipment, ensuring the individual, their family and carers understand how to operate the equipment safely, the handing over of written instruction manuals and information relating to aftercare (maintenance, servicing, access to breakdown services, customer support contact details). It is likely to involve the individual signing for receipt of the equipment and confirming their understanding and acceptance of the information provided. |
| Specialised wheelchair services | This is defined by the SPECIALISED SERVICES NATIONAL DEFINITIONS SET (3rd Edition):  ‘Assessment and Provision of Equipment for People with Complex Physical Disabilities (all ages) - Definition no. 5’.  THIS IS EXCLUDED FROM AQP WHEELCHAIR SERVICES |
| Recall (clinical) | In clinical terms this refers to the service user being requested to attend a further appointment |
| Review | This is an appointment after an agreed period of time when the individual has a follow up discussion, which may include checking the fit or continued suitability of equipment, with the assessor(s) involved in agreeing their care plan and prescription. The main aim is to support the individual to achieve the health outcomes agreed. |
| Re referral | An individual’s condition may change over time and they may be re referred into the service. This can be a self re referral. |
| Recall (equipment solution) | This refers to the process that is followed when a problem is identified with a product. As a Wheelchair is classified as a Medical Device this is coordinated through the Medicines and Healthcare products Regulatory Agency (MHRA) and  If an issue is identified with a medical device the manufacturer is responsible for alerting their customers including providers and retailers |
| Provider Uplift | In supply chain terms this refers to picking up equipment at an individual’s home or other agreed location (school, work etc) |
| Customer Collection | In supply chain terms this refers to customers collecting equipment from the providers premises |

1. The AQP impact assessment shows that the cost of procuring services per project under AQP is lower than existing arrangements:

   <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_128457> [↑](#footnote-ref-2)
2. The on-line standard template on the website of the NHS Institute for Innovation and Improvement contains some additional fields to assist its automated functions. Parties may include these additional fields in the completed version of the scheme included in the contract [↑](#footnote-ref-3)
3. There may be several indicators for each goal [↑](#footnote-ref-4)
4. ‘Out and About,’ Care Services Improvement Partnership, DH, October 2006

   Transforming Community Equipment and Wheelchair Services Outline Business Case, DH, March 2008 [↑](#footnote-ref-5)