

# briefing

JUNE 2002

## Fully Equipped 2002 Assisting Independence

The Audit Commission's March 2000 report *Fully Equipped* concluded that the organisation of equipment services was a recipe for confusion, inequality and inefficiency.

- service users did not always get equipment of a reasonable quality
- poor clinical outcomes combined with a waste of money when services did not meet users' needs first time
- many equipment services were small and fragmented
- equipment services were characterised by a lack of clinical leadership and senior management involvement
- equipment services failed to meet the basic demands of clinical governance

There have been some achievements in the last two years...

- audiology services have seen progress through the introduction of hearing screening for new-born babies
- digital hearing aids are becoming more widely available
- the Government has set targets for the integration and improvement of community equipment services, supported by a national implementation team

...but, for the most part, equipment services remain in a parlous state.

- users continue to report long delays for equipment of dubious quality
- many who could benefit from equipment services are excluded by stringent eligibility criteria



- waiting times for some equipment is up to six years – a period of time that would be unacceptable for other NHS services
- very little of the £220 million 'new' money provided for equipment services has been spent in accordance with Ministers' stated wishes
- a mood of despondency is common among managers running equipment services
- no progress has been made in integrating mobility services, leaving the wheelchair and orthotics services marginalised

Ineffectual service commissioning is at the heart of the problems facing equipment services

- service commissioning is not integrated with wider healthcare and social objectives
- services are often measured in terms of pieces of equipment, not people

- equipment services are commissioned to match a limited budget, rather than to meet need

Commissioners neglect the vital contribution that equipment services could make to wider health care and social policy objectives.

- equipment is a vital ingredient to policies that aim to promote social inclusion and independence
- better equipment services would reduce admission to, and facilitate prompt and appropriate discharge from, acute hospital services which would in turn have a major impact on bed capacity
- equipment services reduce morbidity at costs that are very low when compared to other forms of healthcare
- if the targets in the National Service Framework for Older People are to be achieved, improvement in equipment services is vital, especially to help to reduce the number of falls in the home

Over the next year, the Audit Commission will continue to work with stakeholders to examine best practice in the commissioning of equipment services; and the potential for Public Private Partnership initiatives to improve services.

## Introduction

1. In March 2000, the Audit Commission published *Fully Equipped*, a report on the provision of some forms of equipment to older or disabled people by the NHS or social services in England and Wales. It concluded that the organisation of equipment services was a recipe for confusion, inequality and inefficiency. Many equipment services were found to be small and fragmented. They were characterised by a lack of clinical leadership and senior management involvement, and as a result failed to meet basic clinical governance standards. Users did not always get equipment of a reasonable quality meaning that some of the money spent was being wasted.

2. The Commission called for urgent action to improve standards, provide a fairer service

and make equipment services an important component of strategies designed to promote independence.

3. The Government expressed strong support for the report's main recommendations. But *Fully Equipped* was published at a time of great change in the NHS in terms of new commissioning structures, a large number of organisational mergers, and the imperative to deliver the NHS Plan and the associated National Service Frameworks. Not surprisingly, equipment services have continued to struggle to attract the attention of senior policy-makers and managers.

4. The NHS Plan (Ref.1) included the Government's intention to achieve a single, integrated community equipment service by 2004. Specific guidance on the integration was issued to the NHS

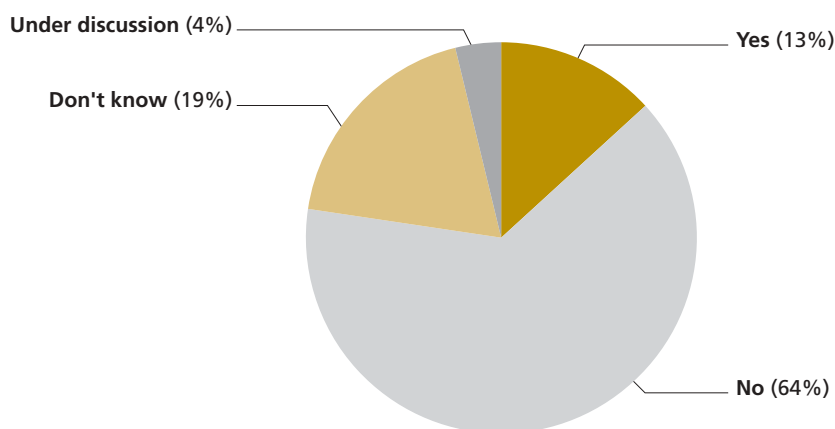
and local councils in March 2001 (Ref. 2). It set ambitious targets to increase by 50 per cent the number of people benefiting from these services and to improve the quality of the equipment issued. The Department of Health (DH) also established a national implementation team with responsibility for helping trusts and social services to implement the guidance by the target date of April 2004.

5. Additional NHS funding of £105 million over three years for community equipment services was announced, together with extra Government grant to local authorities to enable them to make a similar contribution. However, little of the first-year 'new' money has reached frontline services (EXHIBIT 1). Similar problems are reported in Wales.

### EXHIBIT 1

#### 'Additional money' provided to community equipment services in 2000/2001

Very few equipment services have received additional money.



Source: Audit Commission survey of 65 equipment services in England and Wales

6. But some progress has been made. In June 2000, the Government announced the introduction of the hearing screening programme for all new born babies (Ref. 3). There is strong evidence that neonatal hearing screening is more effective than health visitors using infant distraction tests when babies are six to nine months old. Early identification and appropriate management will lessen the impact of deafness on the child, his or her family, and on society (Ref. 4). Investment in this area is strongly justified on health economics grounds.

7. More promise of progress was found in the National Institute of Clinical Excellence's (NICE's) guidance on hearing aid technology, issued in July 2000 (Ref. 5). The review stopped short of recommending the immediate replacement of analogue with digital hearing aids, as recommended in *Fully Equipped*. However, NICE accepted that the NHS had been very conservative in its prescribing, typically offering only the most basic hearing aids. NICE concluded that the full range of analogue aids should be offered while a fuller evaluation of digital aids is undertaken.

8. The Modernising NHS Hearing Aid Services Project is anticipating the widespread introduction of digital hearing aids across the NHS. In May 2000, the Government announced a first wave of modernisation at 20 trusts, with central funding of £11 million for extra staff, training, IT support and facilities. In December 2001, a further £20 million was announced to create a second wave of 30 trusts in 2002/03.

## Overall assessment of progress

9. A stocktake of the current position reveals that progress in improving equipment services is patchy (BOX A, overleaf). The partial progress seen in audiology services and in community equipment services has not been matched in mobility services, where little has been achieved. Concerted action at both a national and local level is still needed in order to improve services which affect the lives of one in ten of the population.

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## BOX A

## Summary of the current position of equipment services

	Audiology	Community equipment	Mobility
<b>Strategy</b>	<ul style="list-style-type: none"> <li>✓ Introduction of hearing screening for newborn babies.</li> <li>✓ Modernising Hearing Aid Services Project.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Clear Government support.</li> <li>✓ Establishment of implementation team.</li> </ul>	<ul style="list-style-type: none"> <li>✗ Commissioning structures not in place.</li> <li>✗ The Artificial Limb and Appliance Services in Wales is affected by a re-assessment currently taking place – in consequence little progress has been made in respect of wheelchair and prosthetics services.</li> </ul>
<b>Operational delivery</b>	<ul style="list-style-type: none"> <li>• Roll-out of digital hearing aids across the NHS required.</li> <li>✗ Evidence of long waiting times.</li> <li>✗ Some problems with local delivery.</li> </ul>	<ul style="list-style-type: none"> <li>✗ Little of the first-year funding has reached front-line services.</li> <li>✗ Concerns regarding effectiveness of risk management.</li> </ul>	<ul style="list-style-type: none"> <li>✗ Limited local improvement.</li> </ul>
<b>Future challenges</b>	<ul style="list-style-type: none"> <li>• Upgrading of premises.</li> <li>• Reduction in waiting times.</li> </ul>	<ul style="list-style-type: none"> <li>• The DH should require that new money is spent in accordance with Ministers' wishes.</li> </ul>	<ul style="list-style-type: none"> <li>• Commissioning needs to support hub-and-spoke arrangements.</li> </ul>

Source: Audit Commission

## Continuing problems in equipment services

10. During 2000 and 2001, the Commission's auditors or inspectors undertook reviews in about half of all the NHS trusts and local authorities that provide equipment services. The main messages are summarised in this briefing.

### Commissioning

- **The commissioning of equipment services is exceptionally weak.** Service commissioners and providers generally have no idea about the underlying level of demand for equipment services. Unmet need represents a major cause of social exclusion.
- **Equipment services do not contribute to wider strategies**

**to promote independence.**

Many commissioners appear to plan services beginning at an acute hospital's front door. Their plans fail to place value on the ability of community support to prevent admission in the first place and then to facilitate prompt and appropriate discharge from hospital. Preventative measures appeared to receive inadequate funding.

- **Equipment services are not explicitly linked to other healthcare objectives.** For example, increases in the prevalence of diabetes will put significant demands on orthotics and prosthetic services in future years. Despite this, auditors found no evidence of commissioners considering how strategies to invest in therapy or equipment could reduce the long-term incidence of surgery.
- **Short-term thinking in commissioning.** Auditors found that commissioning decisions made through the annual Service and Financial Frameworks did not reflect the longer-term Health Improvement and Modernisation Programme

objectives. As a result, the long-term health and cost implications of providing less than optimal solutions were not properly considered.

### Eligibility criteria

- **Eligibility criteria are not set by commissioners with a view to meeting long-term healthcare and social needs.** Instead, criteria are set to meet the available annual budget: thus ‘need’ is equated with ‘money available’. Users sometimes perceive that staff invest enormous energy in putting up obstacles, rather than thinking creatively about how to meet their needs; while many practitioners complain about spending their time

‘managing rationing’ rather than providing direct care.

- **Eligibility criteria are getting tighter.** Many people have experienced reductions in community services at a time when there is an expectation that these services need to be expanded in order to meet stated Government objectives.

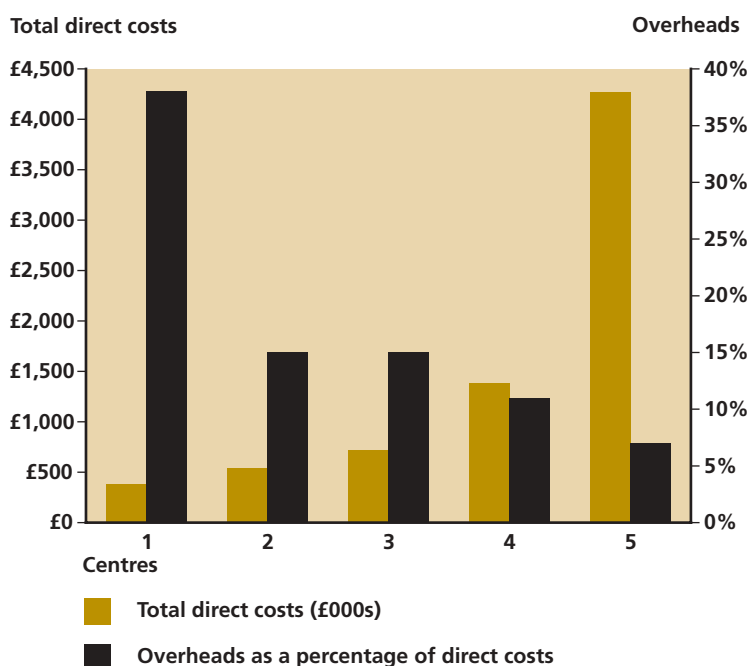
### Operational management

- **Small-scale equipment services are comparatively expensive.** The high overheads associated with small-scale operations supports the development of larger-scale, integrated rehabilitation services that would be able to spread fixed overhead costs over a greater volume of activity (EXHIBIT 2).

EXHIBIT 2

#### Overheads allocated to wheelchair service centres

There are high overheads associated with small-scale operations.



Source: Audit findings at five wheelchair services

- **The tracking of equipment needs improvement.** The equipment issued to users needs to be reviewed regularly to check that it meets, and continues to meet, their needs. In the case of wheelchair and community equipment services, systems also need to track equipment for recycling. A typical community equipment service has an annual turnover of £400,000; a typical system to enable tracking costs £20,000. So recycling only has to be increased by 5 per cent of the annual turnover in order to save the cost of the system. The audits found that introducing IT systems increased recycling rates from 20–30 per cent to 60–70 per cent, thus forming a strong business case.
- **Compliance with manual handling regulations and the Health and Safety at Work Act.** All equipment, including that in people's homes, must be checked regularly. But auditors found that hardly any trusts or councils had made provision for the significant costs, in terms of staff time and vehicles, to enable them to introduce such procedures.
- **The Controls Assurance Standards for Medical Devices is often not applied to community equipment.** DH guidance states 'the term *medical device* covers a broad range of products, including

those used every day for the treatment, or alleviation of an injury or handicap.' However, in the case of equipment services, the application of the Controls Assurance Framework has either fallen into disuse or was never properly applied in the first place.

- **Most community equipment services fail to meet the needs of people with sight-loss.** Low vision is one of the most significant factors restricting an older person's ability to undertake everyday activities. It also leads to disability and loss of independence (Ref. 6). Thus inadequate low vision services mean poor services for many people and more residential care and attendance costs for local authorities. And the cost of shortcomings in these services is felt in other parts of the NHS. In 1999 there were 190,000 A&E attendances, as a result of falls by people with a visual impairment, which cost hospitals £270 million. Nearly half of the falls (90,000) were as a direct result of visual impairment, at a cost of £130 million (Ref. 7). Targeting the three-quarters of the visually impaired population whose condition is treatable needs to form a key element of strategies to achieve the targets for reducing falls set out in the National Service Framework for Older People.

## Information

- **The quality of user and management information is generally poor.** One auditor reported: 'The poverty of information and absence of standards means that patients are not assessed in accordance with the health authority's wishes, the staff employed ... do not receive updates on new products and training opportunities, and users do not know how to register complaints or provide useful feedback on the services provided.'
- **Clinical note-taking and patient activity information systems need to be improved.** In most equipment services, information systems were not conducive to meaningful clinical audit. Urgent improvement in record keeping and the introduction of better information systems is essential in order to achieve adequate management of resources and to conduct clinical audit across all services. This shortcoming is recognised by many clinicians and will be addressed by the introduction of new professional standards, but taking contemporaneous notes will have an impact on time and costs.

## User and carer satisfaction

- **Many, usually older, users have low expectations.** Auditors conducted surveys in many organisations as part of their investigations. Across all five services, a common theme emerged: as a group, users were significantly more satisfied than were healthcare professionals with the quality of the service provided to them

(BOX B). This is explained by the reluctance of users to criticise a service upon which they are likely to depend for the rest of their lives; and also by the absence of clear publicised quality standards with which users can judge the quality of the service which they received.

- **Large variations in waiting times within the same organisation.** A common

characteristic is the unpredictability of the services that are provided: two individuals who have the same needs and who are served by the same provider are likely to have completely different experiences of waiting times.

### BOX B

#### Findings of user surveys

- 22 per cent of patients reported that their orthoses were uncomfortable; average waiting times exceeded ten weeks from measurement to the supply of the orthosis; and 50 per cent of patients received no information about the use, care and repair of their orthosis. Nevertheless, 90 per cent of users reported that they were satisfied;
- 82 per cent of wheelchair users in surveys at six centres felt that the average six-weeks wait for a conventional wheelchair was reasonable;
- surveys across five prosthetics services found that, on average, 20 per cent of users did not use their artificial limbs, but only 10 per cent reported that they were dissatisfied.

## Conclusions and next steps

11. The value of any study is not the publicity that it generates but the action that results. So *Fully Equipped* has been of limited value to the users of equipment services. Its recommendations remain to be implemented, leaving many equipment services locked in a vicious circle (EXHIBIT 3).

12. While there are some signs of improvement in audiology and community equipment services, there has been only faltering progress in improving mobility services. In particular, the hub-and-spoke model of service provision recommended by the

British Society for Rehabilitation Medicine has not developed; nor has there been any progress towards the integration of the orthotics and prosthetics service, recommended by the 1992 Bowker report (Ref. 8) and reiterated in *Fully Equipped*.

13. It is hard to compare and contrast systematically the three mobility services (orthotics, prosthetics and wheelchair services) that were examined in the performance audits. Nevertheless, the overall impression of the audits is that the prosthetics service emerged as the most effective of

the three. In general terms, prosthetics services had the clearest sense of organisational direction, reasonable management information and the necessary scale of operation.

14. These impressions, however subjective, confirm the view expressed in *Fully Equipped* that the prosthetics services should be established as the hubs of a hub-and-spoke model wherever that is practically possible. They should be commissioned to provide support to local orthotics and wheelchair services. These larger centres could become centres of

### EXHIBIT 3

#### The vicious circle of equipment services

Equipment services are locked in a vicious circle.



Source: Audit Commission

excellence and develop university affiliations with access to academic and technical facilities. The DH and commissioners should specify services that drive such a reorganisation forward, taking full advantage of the opportunities afforded by information technology, telecare opportunities, and clinical networks.

15. A further general conclusion concerns scale: the least critical audit reports were made in the larger centres of operation, whether in mobility or community equipment services. Community equipment services that serve whole counties appear to have the scale to provide the necessary leadership, management information and logistics capability. Larger rehabilitation centres were also found to deliver increased efficiency and economy of scale.

16. The audits confirmed that the commissioning of services is a key weakness which needs to be tackled if equipment services are to break out of the vicious circle. The Audit Commission proposes further work in this area to provide guidance on the commissioning of equipment services to social services, primary care trusts and strategic health authorities. The work will examine how the commissioning of equipment services fits into wider healthcare and social policy objectives; and will emphasise the

health economics case for investing in them. The work will also explore options for developing alternative models of service delivery, including making better use of Public Private Partnerships and direct payments schemes.

17. In addition to the outstanding recommendations of *Fully Equipped*, further action is required. A major review of current policy, strategy and operational delivery is needed, both centrally and locally to reinvigorate the wider independence agenda (EXHIBIT 4, overleaf).

*While there are some signs of improvement in audiology and community equipment services, there has been only faltering progress in improving mobility services*

## EXHIBIT 4

**Recommendations of this report**

A major review of current policy, strategy and operational delivery is needed to energise the wider independence agenda.

**P O L I C Y**

Promote independence as a means of delivering important healthcare and social priorities:

- promoting social inclusion
- relieving pressure on acute hospitals
- complying with the Disability Discrimination Act

**S T R A T E G Y**

- Link policy to NSF for older people targets, for example, on preventing falls
- Develop health economics arguments for investment in equipment
- Integrate policy with other strategies, for example, home adaptations; disabled facilities grants; direct payments; voucher schemes
- Examine the potential of Public : Private Partnerships
- Devise performance measures that encourage independence and establish national minimum standards
- Devise a human resource strategy to support service development
- Evaluate the alternative models for meeting childrens' needs

**T A C T I C S**

- Ensure that additional funding for equipment is spent as intended
- Establish a national centre or forum to deliver the strategy
- Commission integrated services through hub-and-spoke models
- Integrate low-vision services with community equipment services

Source: Audit Commission

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*If you want to know more: the full update, Fully Equipped 2002: Assisting Independence looks at all of these issues in more detail and includes background information, case studies and specific guidance.*

Audit Commission,  
**Fully Equipped 2002: Assisting Independence** (update)  
 ISBN 1 86240 367 8  
**£12.00**

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