

Guidance on the commissioning of wheelchair services

1. Background

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.¹ The report concluded that assistive technology provides the gateway to the independence, dignity and self-esteem of some 4 million older or disabled people and for 1.7 million informal carers. But the current services were found to be unsatisfactory:

- there were unexplained variations in all aspects of service provision, bearing little relation to underlying levels of need;
- the quality of services owed more to custom and practice, rather than to a considered view of the contribution that equipment services could make to the overall needs of the population; and
- eligibility criteria were often unclear to users, carers, voluntary organisations and staff, and they were often applied inconsistently.

In June 2002, the Audit Commission reviewed progress in a follow-up report, *Assisting Independence - Fully Equipped 2002*.² It found that while there had been significant progress in some assistive technology services, progress in improving the wheelchair service was disappointing.

2. Why is a need to improve the commissioning of wheelchair services?

The Government has introduced a number of policies and initiatives that require improvements to wheelchair services. These include:

- the National Service Framework for Older People(NSF(OP)), which details the Government's expectations of the services that should be available to older people, and the manner of their delivery as part of the NHS Plan³
- the Fair Access to Care Services (FACS) initiative, which aims to make eligibility for services dependent on needs and circumstances, not on where people live and where they first access services. Primary Care Trusts (PCTs), working closely with local councils were required to ensure continuing NHS health care policies comply with the guidance set out in HSC 2001/015: LAC (2001)18 by 1st October 2001; and agree joint eligibility criteria, setting out their respective responsibilities for meeting continuing health and social care needs by 1st March 2002. Over time, the Strategic Health Authorities (StHAs) are to align the continuing NHS health care criteria they have inherited and establish common criteria across each health economy.

The direction set by these policies places great emphasis on supporting independence by improving services for older or disabled people. The Government's spending plans for 2003/06 included a Public Service Agreement between the Treasury and the Department of Health to 'improve the quality of life and independence of older people so that they can live at home wherever possible, by increasing by March 2006 the number of those supported intensively in their own homes to 30% of the total being supported by social services. This has been reflected in the NHS Priorities and Planning Framework.

¹ Audit Commission, *Fully Equipped – The provision of disability equipment services to older or disabled people by the NHS and social services in England and Wales*. 2000, Audit Commission

² Audit Commission, *Assisting Independence - Fully Equipped 2002*. 2002, Audit Commission

³ <http://www.doh.gov.uk/nhsplan/contents.htm> and <http://www.doh.gov.uk/nsf/olderpeople.htm>

3. Commissioning guidance

The Audit Commission's report *Assisting Independence* identified the commissioning of all assistive technology services, including wheelchair services, as a key weakness.

This guidance has been prepared to help address this shortcoming. It tries to describe how PCTs should commission wheelchair services as part of wider strategies to support independence.⁴ PCTs are the main commissioners of wheelchair services but they also have to work closely with other agencies to deliver integrated services. These other agencies include: social services, housing, education and both voluntary and private sector providers.

It is hoped that this guidance will be relevant to them all, and used in the absence of locally agreed standards. It is also intended that service commissioners and providers will use the guidance to examine and audit their current performance against the standards and best practice/innovation set out below. The guidance may also be used as a resource to help develop commissioning standards and business cases to support the delivery of Government targets for the improvement of wheelchair services. The guidance will be particularly relevant to those wheelchair services that are taking part in a current initiative by the Modernisation Agency, which has established a collaborative programme to support the improvement of wheelchair services.

4. Structure of the guidance

The structure of the guidance is:

1. Policy (What we plan to do and why)

- Overall objectives
- How wheelchair services contribute to wider healthcare objectives
- Health economics arguments
- Likely future developments for which commissioners need to prepare

2. Strategy (How we plan to do it)

- Understanding the underlying level of demand in the community
- Service description
- Statement of work to be performed

3. Delivering the service (Implementation and review)

- Method of working
- Performance management

⁴ The terms, commissioning, and, purchasing, by health authorities are often used interchangeably. In this guide, commissioning is used as it includes wider responsibilities for assessing health needs and for strategic planning of services, rather than the term, purchasing, which has a narrower focus on contracting processes.

Policy

Overall objectives		
Matters to address	Key issues to consider	AC comment on the issues
Service aims and underlying principles	<ul style="list-style-type: none"> • Meeting the needs of people of all ages, including children, and responding whenever changes in their type or level of disability occur • 	<p>The aim of the wheelchair service is to:</p> <ul style="list-style-type: none"> ▪ provide suitable wheelchairs for all those with a permanent condition that impairs their ability to walk; ▪ provide a comprehensive service that includes consideration of comfort, posture, function, pressure relief and cosmesis; ▪ maintain and repair wheelchair equipment in a responsive, rapid and effective manner; ▪ respond to changing medical and social needs of wheelchair users with provision of different wheelchairs when necessary. <p>Wheelchairs range from highly sophisticated pieces of equipment with integrated micro-technology to basic chairs for occasional use (Appendix 2). The majority of users are in the latter category and are usually over age 65.</p> <p>Wheelchair need to be commissioned around care pathways, which describe an agreed and explicit route that a service user takes through health and social care services. Agreements between the various professionals involved will typically cover the type of care and treatment to be provided, the professionals involved, and the place where treatment or care will take place.</p> <p>Effective commissioning requires a baseline audit and analysis to establish an understanding of:</p> <ol style="list-style-type: none"> i. the number of people currently needing services, and the likely future trends ii. the type of services they require as part of the comprehensive support of independence iii. the type, volume and quality of existing services iv. the gap between (ii) and (iii); and plans to fill the gap v. using information to monitor progress in delivering commissioning objectives <p>The wheelchair service covers many different categories of users (Appendix 1), though each service user will have his or her own individual needs.</p>
	<ul style="list-style-type: none"> • Meeting the requirements and standards of the NHS Plan and NSF for Older People 	<p>The NSF for Older People also specifies that commissioners must have a established an integrated 'falls prevention strategy by April 2005.</p>

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Provision of services	<ul style="list-style-type: none"> Involving users and carers in planning the service and monitoring its delivery 	<p>A central theme of the NHS Plan, the work of the Modernisation Agency and one of the key components of clinical governance is the engagement of users and carers in service provision. Seeing the service through the user's eyes is vital. However, research by the Audit Commission has found that only one-third of wheelchair services are currently running user groups.</p> <p>Commissioners must engage users in planning and specification of local wheelchair services, and require that service providers develop and maintain continuing engagement with users and carers to support the operational review of the service. Better and more user engagement should in theory support a move away from the traditional medical model of care to the more acceptable social model with the aim of transferring power from the professional to the individual and concentrating on individual needs, allowing people to make their own decisions.</p> <p>Guidance on user engagement is available in <i>How to Consult your Users – An Introductory Guide</i>. Service First Unit 020 7270 1838 or www.servicefirst.gov.uk.</p> <p>The techniques for engaging users with special needs are also described in the RNIB's <i>See it Right</i> pack for advice on meeting information needs of people with visual impairments. www.rnib.org.uk.</p> <p>Obtaining the views of children and their carers is described in <i>Can You Hear Us</i> from Save the Children www.savethechildren.org.uk.</p>
	<ul style="list-style-type: none"> Integrating wheelchair services into wider rehabilitation services 	<p>The commissioning philosophy should be informed by an understanding of the needs of the service user and the considerable significance the average user will attach to their wheelchair as essential to their independence. A wheelchair is often an indispensable kit, making the difference between dependence and a reasonable quality of life; it is not simply a prescription item. Commissioners should set standards based on users' needs, not on referring to types and numbers of wheelchairs.</p>
	<ul style="list-style-type: none"> Promoting independence 	<p>Wheelchair services should be tailored to achieve maximum self-reliance and independence for the user. There is a need to tailor wheelchairs to suit individuals' needs. Work by the King's Fund has demonstrated how wheelchair services should be mapped to meet an individual's aspirations.⁵</p>
	<ul style="list-style-type: none"> Use of direct payments and voucher schemes 	<p>The use of direct payment or voucher schemes also needs to be considered in the overall commissioning strategy (Appendix 4). The clear direction of Government policy is towards increased choices for service users - direct payments allow service users to make their own decisions about the care they need.</p>

⁵ Mitchell J et.al., *Choosing a wheelchair by mapping your life*, Sheffield Hallam University, 1998

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Access to services	<ul style="list-style-type: none"> Referral from a health or social care professional 	There are a number of ways that users gain access to the wheelchair service. The traditional route is via referral by a health or social care professional.
	<ul style="list-style-type: none"> Self-referral 	Progressive commissioners support self-referral from potential users/carers, as well as telephone requests from GPs.
	<ul style="list-style-type: none"> 'Blind' provision 	<p>In most services, provision is usually made following receipt of a written request which is checked by a wheelchair service co-ordinator: if there are no indications of non-standard requirements or medical problems requiring an assessment, delivery is arranged directly, either from an in-house service or from the private sector (usually called the 'Approved Repairer'. Commissioners need to pay particular regard to the question of who has the responsibility for providing training and handling instructions to the user and carer.</p> <p>Commissioners also need to consider the amount of 'blind provision' that will be made under the contract. Policies currently differ widely between wheelchair services. A few services routinely assess all new users: whilst this approach offers a high quality assessment, it can lead to delays in provision which leave people at risk and without a chair whilst they wait. Conversely, allowing blind referral increases the risk of inappropriate provision. In a clinical audit of 160 cases in the North-West Wales, 55% of referrals were considered inadequate with blind referral.</p>
Eligibility criteria	<ul style="list-style-type: none"> Assessment needs to be based on an individual's needs - not used as a means of rationing / containing costs 	There is a general view that eligibility criteria are used to exclude people, rather than include them, from receiving equipment services. 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 of spending their time 'managing rationing' rather than providing direct care. ⁶ This is because eligibility criteria are generally set by provider organisations with a view to their meeting the available annual budget: thus 'need' is equated with 'money available', not with long-term healthcare and social needs. This creates significant tension between staff and service users and it is demoralising for both. Assessment therefore needs to be based on an individual's needs.
	<ul style="list-style-type: none"> Provision of help and advice to people outside the stated criteria who would benefit from purchasing privately 	Ideally, the only acceptable eligibility criteria are clinical and lifestyle needs and the ability to use the wheelchair safely. Exclusion on the grounds of age or prognosis alone is unacceptable and discriminatory. The current rationing regime applied by many wheelchair services would be unacceptable in most other services provided by the NHS. However, eligibility criteria will continue to be applied in the case of more expensive or powered wheelchairs. Commissioners should ensure those wheelchair users who fall outside eligibility criteria are given the contact details of organisations, such as DLCs and SCOPE, who may be able to advise them.

⁶ The Department of Health's guidance on Fair Access to Care Services seeks to address this issue.

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Longer term considerations	<ul style="list-style-type: none"> Financial planning 	<p>Commissioning decisions are made annually through the local delivery plan. (The first LDPs run from 2003-06). It is particularly important that different demands by different age groups need to be factored into the equation. Thus, whilst three quarters of wheelchairs are supplied to older people, the extra costs of meeting the more complex equipment needs of the younger age group – and the fact it is increasing in number – needs to be anticipated. The average cost of supply is considerably lower than the cost of the younger age group who often have more complex needs and whose numbers also increasing at a rate of about 2 per cent per annum.⁷</p>
	<ul style="list-style-type: none"> Future service demands 	<p>Commissioning of services should reflect the future growth in demand for the wheelchair service. There are currently about 700,000 wheelchair users in England.⁸ It is estimated that the number of wheelchair users will rise by 15 per cent per annum because of the increasing average age of the population.⁹ The demand for wheelchair services is also influenced by:</p> <ul style="list-style-type: none"> Improvements in medical techniques and treatment resulting in the survival of many severely disabled people Wheelchair users' increased aspirations and expectations of mobility and independence, especially among the younger age group Accelerated discharge from hospital Improvements in access to public transport and air travel as a result of campaigning by disabled people Changing attitudes towards, and increased acceptance of, disability by the general public Greater expectations of wheelchairs and their use
	<ul style="list-style-type: none"> Providing support for carers based on the national strategy for carers 	<p>The formal care system cannot begin to deliver the range, volume, flexibility of care and support for users of equipment that is provided by unpaid carers. Relatives and friends are the major deliverers of care and act as partners with service providers, while also monitoring the quality of services. The philosophy of support behind the NSF for Older People is equally relevant to those unpaid carers, who are increasingly becoming old themselves.¹⁰</p> <p>In many organisations, there is still a difficulty turning recognition of the pivotal role that unpaid carers play into practical forms of support. Significant progress is needed to deliver the vision that is set out in the National Strategy for Carers.¹¹</p>

⁷ Department of Health and College of Occupational Therapists, *National Prosthetic and Wheelchair Services Report*, Department of Health, 1997.

⁸ Department of Health and College of Occupational Therapists, *National Prosthetic and Wheelchair Services Report*, Department of Health, 1997.

⁹ Stewart C, 1992. Wheelchair evaluation and prescription. *Nursing Standard* 7; 1:27-30.

¹⁰ Government Actuary Department. *Mid-2000 UK population estimates – United Kingdom: projected populations in 5 year age groups 2018-2038*. London: The Stationery Office, 2000

¹¹ HM Government, *Caring about Carers – A National Strategy for Carers*, 1999, The Stationery Office

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Choice	<ul style="list-style-type: none"> • Providing individuals with choice 	<p>Commissioning policy should reflect The National Service Framework for Older People (Ref.¹²). Standard 2 of the NSF requires that: <i>NHS and social care services treat older people as individuals and enable them to make choices about their care.</i> Pressures on the service will also grow from implementing the stated government policy of providing more choice to users of the service. To comply with this policy, commissioners will need to specify the provision of a wider range of wheelchairs than have typically be supplied in the past.</p>
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How wheelchair services contribute to wider healthcare objectives		
<i>Matters to address</i>	<i>Key issues to consider</i>	<i>AC comment on the issues</i>
Joined-up commissioning	<ul style="list-style-type: none"> • The contribution of wheelchair services to other health and social care priorities 	<p>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. Access to individually appropriate assistive technology, such as wheelchairs, is key to this.</p> <p>Good pressure distribution products (for example, cushions) and supportive seating is an important element of the service. They can both improve independence, but reduce pressure sore problems and acquired disability later in the healthcare cycle for an individual.</p> <p>Commissioners should also require wheelchair service providers to demonstrate work on clinical audit and clinical effectiveness, particularly around the issue of the contribution that the service makes to these wider health and social care priorities.</p>
Establishing partnerships	<ul style="list-style-type: none"> • Working with other agencies 	<p>Commissioners' service specifications should include the need for multi-agency working to meet the totality of users' needs. This will require liaison arrangements with the housing service for minor adaptations, the education department for special needs, and other mobility services, for example prosthetic, orthotic and community equipment services.</p> <p>The Health and Social Care Act 2001 introduces a statutory duty on NHS bodies to involve the public in service planning; and engage local councils via the work of their scrutiny committees. A range of agencies also need to be engaged in plans to develop wheelchair services: for example, social services, housing, education and the wider voluntary sector, including Independent Living Centres.</p>

¹²

Department of Health, National Service Framework for Older People, 2001

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Health economics		
<i>Matters to address</i>	<i>Key issues to consider</i>	<i>AC comment on the issues</i>
Meeting the needs of the local population for wheelchair services	<ul style="list-style-type: none"> • Implications of not meeting current demand, for example the impact on community care policies and institutional care 	<p>Commissioners need to consider the extent to which the service they specify meets the underlying levels of demand in the community. They need to assess the current level of service coverage; the level of service it should ideally provide; and establish plans to bridge the gap between the two. Current age-specific prevalence of wheelchair use shows demand rising steeply with age. However, it is important to recognise the often complex needs of wheelchair users who are younger adults and children.</p> <p>Investment in wheelchair and associated equipment services delivers high quality at low cost. Enabling people to remain independent in the community through the use of appropriate equipment is always preferable to admitting them for treatment into other parts of the healthcare system. Accordingly, commissioners will wish to have regard to the benefits to other parts of their commissioning responsibilities. For example, wheelchair services are central to strategies to promote independence and prevent accidents. Standard Six of the NSF(OP) aims to reduce the number of falls which result in serious injury. Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK.¹³ Preventing falls in older people depends on identifying those most at risk of falling and co-ordinating appropriate preventative action.¹⁴ Public Health strategies should aim to reduce the incidence and impact of falls.¹⁵ Over 400,000¹⁶ older people in England attend A&E departments following an accident¹⁷ and up to 14,000 people a year die in the UK as a result of an osteoporotic hip fracture.¹⁸</p> <p>Moreover, assistive technology has been demonstrated to be central to effective rehabilitation¹⁹; it improves quality of life²⁰; it obviously enhances people's life chances through education and employment. And it reduces morbidity at costs that are very low compared to other forms of healthcare²¹.</p>

¹³ Health Education Authority (1999), Older People and Accidents; Fact Sheet 2. London: HEA.

¹⁴ Nuffield Institute of Health and NHS Centre for Reviews and Dissemination (1996), Preventing falls and subsequent injury in older people. *Effective Healthcare Bulletin* 2(4), 1-16.

¹⁵ Health Education Authority (1998), *Accident Prevention among older people: approaches in practice, a series of case studies*. London: HEA.

¹⁶ O'Loughlin JL et al. 1993, Incidence of and risk factors for falls and injurious falls among the community dwelling elderly. *American Journal of Epidemiology*; 137:342-354.

¹⁷ DTI (1997), Home accident surveillance system data. London. DTI.

¹⁸ Melton LJ III 1988, Epidemiology of fractures. In Riggs BL and Melton LJ III (eds.) *Osteoporosis: Etiology, Diagnosis and Management*: 133-154. New York.

¹⁹ Enderby P et al , *Action Towards Improved Rehabilitation in Sheffield*, February 1998.

²⁰ Ohlin, P et al *Technology Assisting disabled and Older People in Europe : The HEART Study.*: Swedish Handicap Institute for European Commission Directorate General XIII, *Stockholm*, 1995.

²¹ Mann W C et al , 'Effectiveness of Assistive Technology and Environmental Controls in Maintaining Independence and Reducing Home Care Costs for the Frail Elderly', *Archive of Family Medicine*, Vol. 8, May / June 1999.

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Wider contribution to health and social care	<ul style="list-style-type: none"> Promoting independence 	<p>The additional cost of good hardware...and decreased dependence for the users. When seen as a total package of care, it represents a good investment that improves mobility, independence, and children's life chances and improves quality of life for users and their families.</p> <p>Younger wheelchair users are most likely to have changing equipment needs if they suffer from neurological deteriorating conditions, such as muscular dystrophy. This younger group tends to be the most severely disabled, and failure to supply appropriate equipment can result in severe fixed deformities in later life that require surgical interventions, affecting health, respiration, digestion and care. These children will have a lifelong need for the highest quality of care, and the relatively high levels of deprivation associated with the disease may restrict availability of the sustained, high quality, specialised support needed.²²</p>
	<ul style="list-style-type: none"> Minimising in-patient stays and reducing delayed discharge 	<p>Government has set specific targets to reduce the number of patients who experience delayed discharge by 20 per cent by March 2003, compared with April 2002. Social services received earmarked funding of £100m in 2001/02 (LAC (2001)34) and £200m in 2002/03 to reduce delayed discharges. Wheelchair services are a part of any strategy to achieve this target.</p> <p>The extra money is intended to be used to increase capacity in residential and nursing homes (by increasing the rates paid). But the funds can also be used to buy wheelchairs and other equipment. The whole thrust of the NSF for Older People is to keep more people living in their own homes, not in residential accommodation.</p>
	<ul style="list-style-type: none"> Systematic re-assessment 	<p><i>Fully Equipped</i> argued that wheelchair service centres should introduce systematic re-assessment programmes for all users instead of relying on users to present themselves to their GP or put up with equipment that they find hard to use. This approach is likely to meet users' needs at an earlier stage, support user independence and reduce cost transference that could lead to more expensive care at a later stage in the acute and social services sectors. The frequency of the reviews should be consistent with the user's needs.</p> <p>Such systematic reassessment programmes provide the basis for learning and should be used as a way of measuring clinical effectiveness as a part of clinical audit.</p>

²²

Bushby K, et.al. Social deprivation in Duchenne muscular dystrophy: population based study. *British Medical Journal*, 2001; 323: 1035-36.

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Likely future developments for which commissioners need to prepare		
<i>Matters to address</i>	<i>Key issues to consider</i>	<i>AC comment on the issues</i>
Equipment developments	<ul style="list-style-type: none"> Planning for the introduction of better wheelchairs 	<p>Research into materials, science, ergonomics, and biomechanics is producing new techniques applicable to wheelchair manufacture. These include the production of lightweight alloy and carbon fibre frames, pressure relieving systems and interfaces, wheel and castor design and postural mechanics. As a result, significantly improved models are now available. This applies especially to:</p> <ul style="list-style-type: none"> Lightweight chairs (good for people with weak upper limbs for example, people with multiple sclerosis, muscular dystrophy and tetraplegic patients and people who need to lift the chair into a car.) Active-user wheelchairs (high performance chairs allowing a full range of activities at work, travel and sport). Indoor-outdoor electric chairs – most services provide only indoor chairs but more expensive indoor/outdoor chairs can greatly improve independence. Outdoor attendant-controlled electric chairs – helpful where the wheelchair user is heavy and/or the local terrain is hilly Children's chairs and buggies – physically disabled children and parents need a range of smart, modern equipment Pressure relieving surfaces – should be available to all users and prescribed pro-actively Use of gel batteries reduces maintenance to a minimum New materials will offer scope for lighter chairs, improved appearance and greater durability Greater use of modular chairs will enable better adaptation to user's specific needs.
Clinical audit, effectiveness and training	<ul style="list-style-type: none"> Commissioners need to provide guidelines for the involvement and education of professional staff in the field of wheelchairs and associated posture and pressure management. 	<p>Commissioners should specify the need for providers to provide proper clinical audit and clinical effectiveness reviews. Particular attention should be paid to user satisfaction and the risk of developing pressure sores.</p> <p>Commissioners should also require that all service users have an explicit pathway of care. This needs to be agreed between service provider and service users and state clear mile-stones towards achieving the agreed goals. Protocols of care for treating common conditions should be a commissioner requirement.</p> <p>Commissioners should also require that all service staff are adequately qualified (Appendix 3) and have a programme for continuing professional development.</p>

Strategy

Understanding the underlying level of demand in the community		
<i>Matters to address</i>	<i>Key issues to consider</i>	<i>AC comment on the issues</i>
Current and projected levels of demand	<ul style="list-style-type: none"> Use of accurate data on the current and future levels of demand for the various types of equipment 	<p>Many wheelchair services lack accurate information about their workload, impeding proper management. Few have an accurate picture of the:</p> <ul style="list-style-type: none"> numbers of active patients/users (equipment services need regular review to ensure that records reflect real patients with real needs); background-specific needs of individual users, e.g. a demanding job that makes availability for wheelchair service-based repair of equipment difficult and therefore necessitates out-of-hours emergency repair cover; numbers on waiting lists; cross-boundary flows; use of smaller items of equipment – for example, cushions/seating components; and allocation of costs and overheads to each component part of the service.
Knowledge about the underlying level of need	<ul style="list-style-type: none"> Use of national and local public health data on identified need 	<p>Commissioners need to establish systems for the identification of unmet need. The Director of Public Health's annual report should be a useful source of information. Community Care Plans tend to rely heavily on broad prevalence data to inform commissioning, but there is currently little use by commissioners of their own data on unmet need, or data from other local sources.</p> <p>Public health staff have a role in the effective commissioning of wheelchair services. They provide clinical knowledge, as well as the ability to assess population needs and interpret information on the effectiveness of treatments.</p>

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Service description														
Matters to address	Key issues to consider	AC comment on the issues												
Service configuration	<ul style="list-style-type: none"> • Integration of wheelchair services with other assistive technology services and rehabilitation services 	<p>The reports <i>Fully Equipped</i> and <i>Assisting Independence</i> both proposed the development of a 'hub and spoke' arrangement across regions with specialist services at the centre supporting local services. The model of care has endorsement from Government and most professional organisations.</p> <p>Integration of community equipment services is an ideal time to consider the likely benefits of scale and service delivery that can be achieved by amalgamation of the wheelchair service with other related services - there should be close links to enable the delivery of 'packages of equipment'.</p>												
Service standards	<p>Commissioners should specify that the following minimum standards are achieved:</p> <ul style="list-style-type: none"> • Assessment process 	<p>Following the initial 'paper' assessment and prioritisation, the clinical and lifestyle needs of the service user should be fully assessed. The full assessment must provide compatibility with other transport modes of the service user, for example their private car or wheelchair accessible vehicle.</p> <p>Except for 'only occasional' or 'casual' users, all assessments should include at minimum guidance from a physiotherapist or from an occupational therapist.</p> <p>The service user and, where appropriate, his or her carers or enablers, must be fully consulted and meaningfully involved throughout the assessment process. Assessors must arrive at optimum recommended solutions to needs. Inability to provide must not be presumed, for whatever reason, and must not compromise or diminish the optimum assessment of what the clinical and lifestyle needs of the applicant require.</p> <p>Commissioners will wish to state that the least expensive solution should be prescribed provided that it will meet the service user's assessed clinical and lifestyle needs.</p>												
	<ul style="list-style-type: none"> • Waiting times 	<table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 70%; padding: 5px;">Process</th> <th style="width: 30%; padding: 5px;">Maximum waiting time (days)</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">Referral to assessment</td> <td style="text-align: center; padding: 5px;">10</td> </tr> <tr> <td style="padding: 5px;">Assessment to delivery (non-powered)</td> <td style="text-align: center; padding: 5px;">12</td> </tr> <tr> <td style="padding: 5px;">Assessment to delivery (powered)</td> <td style="text-align: center; padding: 5px;">12</td> </tr> <tr> <td style="padding: 5px;">Assessment to delivery (non-powered, with complex posture/pressure needs)</td> <td style="text-align: center; padding: 5px;">12</td> </tr> <tr> <td style="padding: 5px;">Assessment to delivery (powered, with complex</td> <td style="text-align: center; padding: 5px;">30</td> </tr> </tbody> </table>	Process	Maximum waiting time (days)	Referral to assessment	10	Assessment to delivery (non-powered)	12	Assessment to delivery (powered)	12	Assessment to delivery (non-powered, with complex posture/pressure needs)	12	Assessment to delivery (powered, with complex	30
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Assessment to delivery (powered, with complex	30													

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		Waiting time for repairs <i>Source: Ref.²³</i>	1 or replacement with similar chair
	<ul style="list-style-type: none"> Levels of postural support 	Some wheelchair users will require postural support. Additional assessment and modifications of special equipment will be required for complex needs.	
		1	Minimum support Good head control Good to fair trunk control Maybe unstable while sitting unsupported Good functional ability when seated on stable base with minimal support
		2	Medium support Moderate disability Variable head control Poor trunk control Requires support to maintain stable posture Limited hand function Modular system supporting hip and trunk possibly appropriate
		3	Maximum support Severe disability Poor head and trunk control Unable to sit without support Limited upper limb function Possibly upper limb function Possibly spinal curvature and joint contractures Custom-made seating required to provide maximum support
		<i>Source: Ref.²⁴</i>	
	<ul style="list-style-type: none"> Pressure care risk grades 	Assessed risk of pressure breakdown is divided into three categories. Recognised risk assessment charts (for example, Waterlow or Norton) can be used as indicators of risk, bearing in mind: <ul style="list-style-type: none"> these are not specifically targeted at wheelchair users they are only one part of the assessment procedure consideration must be given to time spent in the wheelchair and ability to relieve pressure 	

²³ Department of Health and College of Occupational Therapists, *National Prosthetic and Wheelchair Services Report*, Department of Health, 1997.

²⁴ Department of Health and College of Occupational Therapists, *National Prosthetic and Wheelchair Services Report*, Department of Health, 1997.

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		1	Low risk	Some part-time users Full-time users with ability to change position and transfer. Good general health with no previous history of pressure sores
		2	Medium risk	Less able part-time user Full-time users with signs of redness or tissue breakdown Incontinent Tendency to sweat General health variable Possibly asymmetrical sitting position
		3	High risk	Immobile Long periods of sitting Weight loss Poor health Previous history of pressure sores Asymmetrical posture Possibly fixed deformities or previous low-medium risk but sudden illness or deterioration in health
		Source: Ref. ²⁵		
	<ul style="list-style-type: none"> Provision of technical support services 	<p>The provision of technical services can contribute to the overall cost and efficiency of the equipment service, for example, servicing and maintenance of equipment / equipment and electrical testing.</p> <p>Commissioners need to consider the range of wheelchair service users' needs that the service is to provide. For example, it is necessary to consider whether short-term loan chairs are to be included in the service specification.</p> <ul style="list-style-type: none"> Location and frequency of service Screening services Assessment Treatment Repairs <p>A fast repair service is important but commissioners' focus should be on preventive inspection and preventative maintenance which would reduce the requirement for repairs. Planned maintenance visits would give contractors</p>		

²⁵

Department of Health and College of Occupational Therapists, *National Prosthetic and Wheelchair Services Report*, Department of Health, 1997.

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		<p>or others an opportunity to plan their workload much better and to incorporate the needs of the users (for example, timed appointments to suit them) and leave the emergency response for repairs to a small number.</p>
	<ul style="list-style-type: none"> Review, maintenance and inspections 	<p>The general guidance from the Medicines and Healthcare Regulatory Agency and within the DH's Controls Assurance Framework is that manufacturers' guidance should be followed. Local services therefore need to work with manufacturers' guidance as a starting point and then apply their risk analysis and risk management arrangements to the expected usage of the product by an individual.</p> <p>For reconditioned or reissued chairs, commissioners should specify that there is to be an absolute maximum of a three-yearly inspection of non-powered wheelchairs to provide safety to users and carers; and help the user get the best use from their chair. The non-powered chairs of active users will require more frequent maintenance.</p> <p>Annual inspections of powered wheelchairs are necessary for these reasons and for planned preventive maintenance.²⁶ This is also required to meet the requirements of legislation relating to the HASAWA, which states that all portable appliances (electrical) used in a place of work should be tested annually. This applies to medium voltage equipment such as the charger for a powered wheelchair.</p>

²⁶ HS (G) 107; HSE 1994. ISBN 07176 0715 1.

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	<ul style="list-style-type: none"> • Provision of demonstration facilities 	<p>Commissioners should require that facilities should be provided to enable service users have the opportunity to try out wheelchairs. For example, an independent living centre can be supported where the user can receive advice and assessment.</p>
	<ul style="list-style-type: none"> • Roles and responsibilities 	<p>Any contract arrangement or service level agreement should make clear respective roles and responsibilities. For example, the contractor's roles may be described as: 'to receive and process all service demands raised by the authority the main features of which include: stock purchase; storage; service user and prescriber liaison, delivery, installation and commissioning, technical and bespoke services, in-situ maintenance, collection, cleaning, renovation, recycling, disposal of goods.'</p>
	<ul style="list-style-type: none"> • Procurement arrangements 	<p>It is important to consider the risk of perverse incentive within contracts: if the contractor sources new wheelchairs, there may be an incentive not to strive to recycle equipment. This can be avoided by specifying a list of preferred suppliers of the agreed product range.</p>

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Risk management	<ul style="list-style-type: none"> Legal requirements 	<p>Commissioners should specify that wheelchair services must comply with manual handling regulations and with the Health and Safety at Work Act (HASAWA) 1974. These require that all equipment, including that in people's homes, must be checked regularly. However, hardly any services have made any provision for the significant costs involved in terms of staff time and vehicles, in implementing such procedures. In addition, all NHS organisations are subject to legal and statutory requirements relating to 'the duty of care' that requires employers to provide competent and safe fellow employees, safe equipment and place of work, and a safe system of work.</p>
	<ul style="list-style-type: none"> Controls assurance standards 	<p>Wheelchairs services commonly fail to apply the DH's Controls Assurance Standards for Medical Devices to their equipment. DH guidance states that 'the term <i>medical device</i> covers a broad range of products, including those used every day for the treatment, or alleviation of an injury or handicap.' Wheelchairs services are clearly included in this definition.</p>
	<ul style="list-style-type: none"> Devise management procedures 	<p>There is also a general absence of devise management procedures that included policies for the purchase, acceptance, decontamination, maintenance, repair, monitoring and replacement of wheelchairs, and for the training of users and staff. Equipment purchasers and providers need to develop and implement suitable devise management procedures to ensure that whenever equipment is used, it should be:</p> <ul style="list-style-type: none"> - suitable for its intended purpose; - properly understood by the professional user; and - maintained in a safe and reliable condition. <p>In addition to these concerns, there are:</p> <ul style="list-style-type: none"> - few examples of planned preventative maintenance that followed manufacturer's guidance - there were also doubts about whether properly trained technicians checked that devices were safe and reliable; - several examples of inadequate washing and decontamination facilities - where appropriate, all medical devices should be cleaned, disinfected and/or sterilised in accordance with the latest decontamination guidance; and - poor facilities and cramped working conditions. <p>Planned maintenance should concentrate initially on mechanical and electrical goods, but ultimately needs to include a performance life expectancy of all items of equipment issued by the wheelchair service.</p> <p>Proper documented procedures are needed in all these areas to achieve compliance with the higher CNST standards.</p> <p>Further information is provided in Appendix 5.</p>

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Information	<ul style="list-style-type: none"> Standard of information provided to service users 	<p>Commissioners should specify arrangements that provide information to service users at each step in the process from assessment to supply. Information about the chair and the clinical and technical support is important. Manufacturers usually provide information about chairs to users, but in many cases the tone tends to be rather technical and legalistic, and tends to neglect the training of and provision of information to the user. Wheelchair services need to provide information to users and carers in an accessible format, providing a helpline number (preferably a free-phone number.) One approach is to provide information on the day that the chair is delivered, and revisit the user within a week once initial familiarisation has taken place for a programme of formal training in how to use the chair. Support should also be provided to 'expert' / established patients.</p> <p>Wheelchair Services also need to provide information to users about their specific services, not only in the terms of repairs but also in the terms of how users can access the service to be reviewed or to register their changing circumstances, or even how to register a complaint.</p>
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Statement of work to be performed		
<i>Matters to address</i>	<i>Key issues to consider</i>	<i>AC comment on the issues</i>
Duration of contract or service level agreement	<ul style="list-style-type: none"> Length of contracts or service level agreement 	<p>Best value is likely to be delivered by establishing long-term relationships with suppliers, albeit with appropriate break clauses that should be applied as necessary. Contracts of up to seven years have been established to good effect in other fields of assistive technology provision (for example, prosthetics) and the practice should be applied with wheelchair services.</p> <p>Either party may terminate the contract even though the other party is not in default by giving six months written notice, or such other shorter period of notice as may be agreed between the parties. During the period of notice, both parties shall co-operate to ensure that the interests and needs of users may be met under whatever new arrangements are proposed.</p> <p>Wheelchair services with in-house suppliers operating service level agreements are not in a contractual relationship in law but it is nevertheless valuable to place the arrangement on a quasi-legal footing with formal time periods for the relationship. This provides senior management with the opportunity to review the arrangement.</p>
Management of the SLA/contract	<ul style="list-style-type: none"> Meaningful data on patient numbers and throughput needs to be linked to actual performance, for example, delivery targets met; logistics costs per £ value of equipment delivered. 	<p>There is currently a marked absence of penalties under external contracts. There is an incentive for the contractor insofar as they won't be paid until they deliver, but there are no examples of contract penalties for failing to achieve performance standards.</p>

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Range of equipment / standardisation	<ul style="list-style-type: none"> Commissioners need to establish a common range of standard equipment, agreed with service prescribers, with input from user representatives. 	<p>There is a difficult tension between the desire, on the one hand, to reduce costs by aggregating demand across a standardised equipment range; and, on the other hand, to meet users' demands for greater choice and variety of equipment. This tension is not clearly expressed or adequately resolved in many organisations. The establishment of a product selection group is a useful way to review and address service and budget performance and professional training.</p> <p>Clearly, if only a restricted choice of equipment is available to assessors or prescribers the poor suitability of the present equipment when compared with the actual needs of individuals will continue.</p>
Roles and responsibilities	<ul style="list-style-type: none"> Specifying clear roles and responsibilities 	<p>Commissioning standards need to specify arrangements for:</p> <ul style="list-style-type: none"> Assessment Authority to place orders/requisition equipment Installation of the equipment (where appropriate) Instructions for use of the equipment Demonstrating equipment to users Short / long term review of use / suitability <p>With many contracts, it is unclear whether providing information about how to use the equipment is the responsibility of clinical professionals (for example, occupational therapists (OTs) and district nurses) or the staff who deliver the equipment.</p>
Records to be maintained	<ul style="list-style-type: none"> Client records 	<p>Commissioning standards need to specify arrangements for maintaining documentation and complying with Caldicott standards on the confidentiality of patient records, especially where these are shared with social services/education department.</p>
	<ul style="list-style-type: none"> Stock records and equipment tracking 	<p>Service providers should be required to maintain a database on behalf of commissioners which contains all client, staff and equipment data required operating the contract or service level agreement.</p>
Hours of service	<ul style="list-style-type: none"> Opening hours and emergency arrangements 	<p>Service contractors are commonly required to provide a daily Monday to Friday weekday service during the normal operational period of 0800-1700 hours; a call-out emergency service during the defined normal operational period; a call-out emergency service outside the defined normal operational period (including weekends and bank holidays).</p> <p>There should be a requirement that emergency requests be dealt with within one working day.</p>

Delivering the service

Method of working		
<i>Matters to address</i>	<i>Key issues to consider</i>	<i>AC comment on the issues</i>
Resources	<ul style="list-style-type: none"> Organisational arrangements 	<p>The British Society of Rehabilitation Medicine is of the view that hub and spoke arrangements for the delivery of wheelchair services is likely to offer the best combination of local delivery while providing a concentration of the necessary clinical expertise. Complex cases are to be referred for multi-disciplinary assessment at the hub of a hub-and-spoke model.</p> <p>Each spoke service should have:</p> <ul style="list-style-type: none"> A manager (usually the budget-holder) Wheelchair therapists Rehabilitation engineers A nurse A therapy helper Access to a consultant in rehabilitation medicine Administrative staff <p>Each hub service should have:</p> <ul style="list-style-type: none"> Consultant in rehabilitation medicine Therapists Clinical bioengineer Orthotists Prosthetists Access to a consultant in orthopaedics A manager (usually the budget-holder) Wheelchair therapists Rehabilitation engineers A nurse A therapy helper Administrative staff A trained counsellor

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	<ul style="list-style-type: none"> Staff required to deliver the service 	<p>The number of staff employed is a matter for the provider of the services. However, commissioners will wish to specify certain minimum competencies and skills. Commissioners should also encourage job-redesign or job-enlargement within the clinical team. For example, it is worth considering the opportunity to increase the role of rehabilitation engineers in therapy work and vice-versa.</p>
	<ul style="list-style-type: none"> Physical resources 	<p>The service should have adequate demonstration stock which can be used for assessment either at the clinic or in the patient's home.</p> <p>Delivery, modification, repairs, maintenance and reconditioning are usually contracted to an approved repairer, a commercial firm with its own workshop facilities and staff. Their performance is monitored by rehabilitation engineers.</p>
Assessment	<ul style="list-style-type: none"> Streamlining the assessment process to improve response times 	<p>Commissioning standards should specify the routes by which the user is referred into the service. Requests for the local wheelchair service should be allowed from any health services, social services, or voluntary agency; and more services are encouraging self-referral.</p> <p>Flexible appointments should be offered and provision should be made for home assessments, workplace assessments or school assessment if appropriate.</p> <p>The number of reviews of equipment currently exceeds the number of reviews of users by six to one. There is therefore an opportunity for those (whether approved repairers or NHS staff) assessing the equipment to be trained to identify possible clinical problems.) Concerns may be reported to clinicians as a way of triggering a review.</p>
Facilities	<ul style="list-style-type: none"> Secure, well ventilated and well organised storage facilities 	<p>The service contractor needs to make provision for a store and all the resources needed to undertake the full requirements of the contract, including a technical workshop and custom-designed cleaning facilities.</p> <p>In awarding contracts, commissioners should be satisfied as to the contractor's standing in respect of:</p> <ul style="list-style-type: none"> - Control of Substances Hazardous to Health regulations - Health and Safety procedures under the Health and Safety at Work Regulations 1974 - Minimum standards and the management of equipment provision for Hospital and Community-based Organisations are set out in MDA DB 9801, January 1998. - quality control procedures, practice and training - ability and technical capacity - recruitment procedures (particularly character references of staff who will have direct contact with service users) - personnel procedures (particularly training) - customer care procedures

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	<ul style="list-style-type: none"> • Waiting areas 	<p>Assessment environments should have adequate waiting areas including suitable toilets for people with disabilities and transfer techniques that comply with best practice in manual handling (HSE code of practice L23).</p>
	<ul style="list-style-type: none"> • Decontamination in accordance with official guidelines • 	<p>The contract should specify the need for decontamination facilities within the store, including, ideally, the need for separate entrances in store to separate clean and unclean items.</p> <p>Cleaning/decontamination should comply with requirements agreed by clinical professionals and health and safety policy. Commissioners should specify that service providers will clean and refurbish all equipment to a standard to meet Health & Safety and manufacturer's requirements, and return it to stock. Items requiring mandatory testing to be identified. Cleaning and decontamination guidelines are currently being drawn-up by the Medicines and Healthcare Regulatory Agency (MHRA). Commissioners need to consider whether they wish to specify that separate deliver and collection vehicles are to be used (recommended); or whether they adopt a 'one-stop' approach. In the case of the latter, there is a need for proper segregation of clean and dirty equipment to prevent cross-infection if vehicles are used for both collection and delivery.</p>
Procurement	<ul style="list-style-type: none"> • Commissioners need to specify that there shall be adequate standards for procurement with responsibility/arrangements for purchasing equipment needs to be specified in the contract 	<p>Commissioner specifications should require that:</p> <ul style="list-style-type: none"> • all equipment purchased meets the requirements of the Medical Devices Directive • there is feedback on supplier performance to the NHS Purchasing and Supplies Agency • there is feedback on adverse incidents to the Medical Devices Agency <p>The purchase of equipment should ideally be undertaken through a consortium of service providers or by using NHS PASA national contracts.</p>
Stock and equipment	<ul style="list-style-type: none"> • Commissioners need to specify a catalogue of equipment including the range, types and specification of standard equipment 	<p>Stock should be maintained at levels sufficient to meet demand – this will vary over time and should be monitored on a regular basis. Commissioners need to specify that there shall be adequate rates of recycling of equipment. A common target is that at least 70% of the value of wheelchairs is recycled.</p>
Ordering and requisitions	<ul style="list-style-type: none"> • Procedure for ordering/requisitioning equipment from store 	<p>The service contract should include the requirement to provide a computer system to receive and process service demands, support stock control and accounting arrangements to the authority to a standard that satisfies audit requirements.</p>
Retrieval and recycling	<ul style="list-style-type: none"> • Arrangements for the tracking, collection and recycling of equipment 	<p>Bar coding of individual items of equipment will help with all aspects of stock handling/issues and should be specified in SLAs/contracts.</p> <p>A common target is for 70% of the value of equipment to be recycled.</p> <p>Retrieval may also be required when a manufacturer recalls a device due to safety problems or wishes to arrange</p>

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		for the update of a devise to remove a safety problem. Hence arrangements for tracking are also a safety/risk/liability issue.
Write-off and scrapping	<ul style="list-style-type: none"> • Agreed procedure 	<p>The more expensive items of equipment that require repair at a cost greater than the cost of replacement shall be identified by the contractor for write-off approval. Two alternative approaches are then possible:</p> <ol style="list-style-type: none"> i. Goods selected for write-off approval should be held with collection notes in a designated warehouse, pending inspection. Over time, as the contract matures, the amount of checking should reduce to ever-smaller samples. The overall value of 'lesser value items' written-off by the contractor should be monitored on a regular basis. ii. Alternatively, the contractor may be given delegated authority to write off items that are no longer serviceable or economic to repair and keep records of such items. Quarterly reports to be produced highlighting all items and the total value of scrapped items for that quarter. <p>Goods authorised for write-off should be disposed of in accordance with clinical waste regulations.</p>
Peripheral stores/stocks	<ul style="list-style-type: none"> • Supply of equipment to peripheral stores, for example hospital sites (where appropriate) 	<p>Commissioners should consider whether peripheral stores are to be included in the contract. If they are included, the specification needs to consider the stock items and stock levels in each store, the arrangements for ordering, replenishment, cleaning and servicing, and the records to be maintained.</p> <p>It is recommended that peripheral stores/stocks be kept to a minimum.</p>

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<p>Maintenance and repair</p>	<ul style="list-style-type: none"> • Arrangements for maintenance/servicing 	<p>The wheelchair service is responsible for the equipment on loan because they retain ownership. Maintenance is required under Health and Safety legislation.</p> <p>Planned preventive maintenance of different categories of wheelchair should be undertaken, based on a systematic risk assessment, starting with the most complex equipment.</p> <p>The Medical Devices Agency standards require that all equipment is regularly tested. Any deviations from this standard should be audited and documented.</p> <p>Bar coding of individual items of equipment will help with all aspects of equipment servicing/maintenance and should be specified in SLAs/contracts. In the longer term, services should look to the potential for keeping appropriate information on the wheelchair on a microchip (for example, through a data tag system) where the history of the item could be kept with the item rather than on a separate set of records held elsewhere.</p> <p>Commissioner and contractor should agree a replacement policy for major items of equipment and who will be responsible for implementation. The policy should differentiate between 'shelf life' and replacement of broken/damaged items of equipment.</p> <p>Maintenance and servicing of equipment must meet manufacturers requirements and be clearly documented to provide an 'audit trail'.</p> <p>It is a significant source of irritation to many users that many wheelchair services will not maintain or repair chairs that have been purchased privately or by charities. There are often haphazard arrangements around this and commissioners need to be clear about their policies. The dilemma is clear: users may be excluded from obtaining a wheelchair by virtue of restrictive eligibility criteria. They may then buy a chair privately or obtain a chair via a charity, but may see themselves as being doubly penalised because the NHS will then not maintain the chair for them.</p> <p>On the other hand, it is understandable that the NHS may not have the expertise in maintaining a particular piece of equipment, or be concerned that they will incur liability in the event of litigation.</p> <p>Commissioners should consider whether the service specification should include:</p> <ul style="list-style-type: none"> (i) provision of advice to users about their choice of privately purchased or charity supplied wheelchair; (ii) maintenance and repair of such chairs.
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Continuous improvement	<ul style="list-style-type: none"> The service specification needs to include provision for mutually beneficial service improvements. 	<p>There should be an expectation in the contract or SLA that the wheelchair service and the authority will work together to deliver incremental improvements to the service.</p>
	<ul style="list-style-type: none"> The service specification needs to include arrangements to improve service quality 	<p>The service specification needs to state whether the contractor or the authority will be responsible for the monitoring of complaints. In most circumstances, it will make sense for the authority to receive and monitor complaints, as a means of checking on performance under the contract.</p> <p>The service provider should be required to establish a system for incident and near miss reporting and monitoring that complies with (i) the Clinical Negligence Scheme for Trusts; and (ii) with Medical Devices Agency equipment hazard warnings and reporting systems. The service provider should also be required to review all equipment incidents in liaison with the commissioners or with, for example, the equipment professional advisory group.</p>
Sub-contracting	<ul style="list-style-type: none"> Arrangements for sub-contracting parts of the service 	<p>Sub-contracting of any of the service provider's responsibilities should not be allowed without prior written consent of the other parties, except for the hiring of agency staff in cases of emergency and other planned absence.</p>

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Performance management		
<i>Matters to address</i>	<i>Key issues to consider</i>	<i>AC comment on the issues</i>
Monitoring and reporting system / performance measures	<p>The contract should specify a range of key performance indicators, for example:</p> <ul style="list-style-type: none"> • activity levels/throughput • waiting time from referral to assessment • waiting time from assessment to order • waiting time from order to delivery / use • clinical effectiveness • recycling rate(s) • Regular management reports 	<p>Suggested key indicators</p> <p>Prescription of the wheelchair</p> <p>Percentage referral forms containing adequate data.</p> <p>Services should acknowledge that they have received a referral – copy to the referer and to the user.</p> <p>User should be given a named contact.</p> <p>Need to monitor the proportion of users who receive a MDT assessment; and how many receive a paper assessment. (Need to audio that people are going down the right route.</p> <p>Target: 90% of all 'blind referral' users should receive a standard chair in 10 days; and all in 20 days.</p> <p>Target: Referral to clinical assessment: 80% seen in 30 days; and all in 50 days.</p> <p>Appropriateness of the prescription</p> <p>Blind referrals are still to have proper objectives set on the documentation.</p> <p>Delivery and maintenance of the wheelchair</p> <p>All service users/carers are to receive information and a users' manual when their chair is delivered.</p> <p>All users are to receive a placed on a tailored pathway of care with clinical review at three months.</p> <p>All equipment will be reviewed on the basis of planned maintenance programme.</p> <p>The number and proportion of users whose care deviates from the agreed pathway of care is to be reported and monitored.</p> <p>Regular audit is to undertaken, measuring the number of people who report that they are comfortable in their</p>

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		<p>chair.</p> <p>A multi-professional care plan is to be prepared for each individual, to reflect their own goals and objectives of care. The proportion of people who report that they have achieved their goals is to be reported.</p> <p>Maintenance and repair standards are to meet the minimum standards set out in the DH Controls Assurance Framework for medical devices.</p> <p>Repair response times are to be agreed with providers, service commissioners and users' groups.</p> <p>The underlying level of unmet need and the eligibility criteria that will be applied are to be estimated with reference to local data for example, the annual report of the director of public health.</p> <p>Inappropriate referrals are to be monitored.</p>
User/carer satisfaction	<ul style="list-style-type: none"> • Undertaking surveys 	<p>The service provider should be required to interview service users and referrers in random samples, in order to gain their views on the service. One approach is to undertake a one-week every six months, of all clients delivered to and referrers placing orders. A written report on the outcome of the survey should be sent to commissioners.</p>
	<ul style="list-style-type: none"> • Dealing with and monitoring complaints 	<p>The service provider shall set out clear written procedures for dealing with the service users or their relatives', carers' or their advocates' complaints. These procedures should include but not be limited to, a written record of all complaints and action taken to deal with that complaint.</p> <p>If the service users or their relatives, carers or their advocates are not satisfied after following the service provider's procedure for dealing with complaints, the service provider must refer them to the commissioner of the service.</p>

Appendices

Appendix 1 Categories of wheelchair users

	Description of user	Equipment needs
Long-term full-time users		
	Description of user	Equipment needs
6	High activity Independent mobility and lifestyle	Self-propelling Standard or high performance Postural support Pressure relief
5	Restricted activity	Indoor powered + transit or outdoor powered depending on ability / environment and motivation Transit for travel Postural support Pressure relief
4	Low activity Limited or nil ability Degree of independence in basic daily needs	Pushed or self-propelling standard model or buggy Outdoor powered Specialist chassis for custom made seat Postural support Pressure relief
Long-term occasional users		
	Description of user	Equipment needs
3	Variable walking ability due to fluctuating condition. High degree of independence but requires wheelchair to maintain quality of life and independence	Self-propelling standard or high performance model Outdoor powered Postural support Pressure relief
2	Ability to walk short distance Requires wheelchair on regular basis for outdoor use or to enhance lifestyle of carer or user	Pushed or self-propelling standard or outdoor powered Buggies for children Postural support Pressure relief
1	Temporary users Normally independently mobile Immobile due to operation or accident (may include terminal care)	Attendant pushed or self-propelling model Standard model Special chair may be required for example, recliner for full length plaster/child/hip spica Short-term loan is not normally available from the wheelchair service.
Short-term temporary users		
	Description of user	Equipment needs
1	Normally independently mobile; immobile due to accident or operation (may include terminal care)	Attendant pushed or self propelling standard model. Special chair may be needed (for example, recliner for full-leg plaster.)

Source: Ref.²⁷

²⁷ Department of Health and College of Occupational Therapists, *National Prosthetic and Wheelchair Services Report*, Department of Health, 1997.

Appendix 2 NHS Purchasing and Supply Agency wheelchair categories

A) Manual/Non-powered Wheelchairs (Categories)

1. **Basic chair – user propelled**
2. **Basic chair – attendant pushed**
3. **Basic chair – modular**
4. Heavy duty chair
5. Lightweight chair – user propelled
6. Lightweight chair – attendant pushed
7. Lightweight chair – modular
8. Compact chair
9. Active chair
10. Children's chair
11. Comfort chair
12. Tilt in space chair or chassis unit

B) Powered Wheelchairs (Categories)

1. Indoor powered chair
2. Heavy duty indoor powered chair
3. Indoor/outdoor powered chair
4. Heavy-duty indoor/outdoor powered chair
5. Comfort powered chair

Tilt in space powered chair or powered chassis unit

Appendix 3 Qualification of assessor

Team member	Role
Primary care team (GP, district nurse, social worker) with additional training, information and guidelines from the local wheelchair service.	Assess part time/occasional users with standard attendant pushed wheelchair requirements
Occupational therapist/Physiotherapist with additional training, information and guidelines from the local wheelchair service; and specialist paediatric experience for children's needs	Assess for standard equipment and initial assessment of non-standard requirements
Wheelchair therapist. Occupational therapist/Physiotherapist with additional wheelchair training or minimum of 6 months experience in the wheelchair service	Assess for all grades with additional expert support for specialist needs.
Rehabilitation engineer with wheelchair training	Provide technical advice on non-standard requirements
Specialist team for complex disabilities	Specialist team may include consultant in rehabilitation medicine; senior therapist; paediatric therapist; rehabilitation/clinical engineer; orthotist; tissue viability nurse specialist
Specialist assessor/trainer	Assessment and training is required for users of outdoor powered and high performance wheelchairs. Additional advice may be required from a centre specialising in this type of equipment.

Appendix 4

The voucher scheme

In 1996, the Government of the day introduced a NHS voucher scheme to give wheelchair users more choice when being issued with a wheelchair. The scheme enables a user to take one of three options:

Option 1: Standard option

Following assessment, the user may choose to accept a wheelchair, free of charge, which will meet his or her clinical need. This is called a 'standard' wheelchair. The chair is loaned to the user for as long as it is needed. All repair and maintenance costs will be met by the wheelchair service.

Option 2: Partnership option

If, following assessment, the user wishes to have the security of NHS maintenance and repair service but does not wish to have a 'standard' wheelchair, he or she can choose to contribute to the cost of a wheelchair from a range selected by the wheelchair service. The service will own the wheelchair. The range available will be dependent on the wheelchair service being able to include the maintenance and repair services and also secure value for money. The chair is loaned to the user for as long as it is needed. All repair and maintenance costs will be met by the wheelchair service.

Option 3: Independent option

If, following assessment, the user wishes to have a 'standard' wheelchair, or a voucher under the Partnership option, he or she can choose to contribute to the cost of the wheelchair they would like and which would be available via an agreed supplier. If the wheelchair service is satisfied that the wheelchair would meet the users' clinical needs and it is safe and suitable, an agreement is drawn up between the wheelchair service and the user. The user will become the owner of the chair and will be responsible for all repair and maintenance costs.

Voucher period

The voucher period is the length of time that the user will be expected to have use of the wheelchair supplied under the voucher scheme. The average length of time that the voucher period will last is five years. However, when deciding on the actual voucher period, account will be taken of individual circumstances under which the wheelchair is used. The user's circumstances may change and he or she may ask at any time for a reassessment.

£50 million was made available over four years to enable the introduction of the voucher scheme and for the provision of more powered wheelchairs, though it was not intended that vouchers would be used for powered wheelchairs.

Local services set their own eligibility criteria for powered wheelchairs.

Appendix 5 Risk management regulations

Controls Assurance Standards

All controls assurance standards conform to a common framework model for internal control. Of the 21 standards, the following have a direct influence on wheelchair services:

Standard 3 Decontamination of reusable medical equipment

Requires a system to be in place which requires that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are adequately managed.

Standard 8 Governance

The framework for all the standards, it aims to deliver assurance to stakeholders in relation to meeting an organisation's objectives. Assurance can be given with reference to independent assurance processes (internally and external) and achievement of satisfactory outcomes, or results.

Standard 9 Health and safety

Requires a managed environment which provides for the health, safety and welfare of patients, staff, visitors, contractors and all others who are affected by the activity of the organisation. Whilst most of this standard addresses occupational health and safety, the Health and Safety at Work Act covers non-employees, for example patients and visitors. Thus the spirit of the standard involves a commitment to public safety.

Standard 11 Infection control

Requires that there is a managed environment which minimises the risk of infection, to patients, staff and visitors. HSC 1999/049 (Infection Control) sets out the key activities that should be undertaken by all NHS organisations in respect of infection control.

Standard 13 Managing and purchasing supply

Requires there to be an environment whereby purchasing and supply activity is managed to meet the needs of the organisation through the consistent delivery of best value and the appropriate management of risk, and that it complies with relevant statutory requirements.

Standard 14 Medical equipment and devices management

Requires a system to be in place to minimise all risks associated with acquisition and use of medical devices. The term 'medical device' covers a broad range of products including those used every day in most health care settings and can be defined as any instrument, apparatus, appliance, material or healthcare product, excluding drugs, used by a patient or client.

Standard 16 Professional and product liability

Requires all goods and services, including professional advice, supplied by the organisation are properly managed to minimise potential liability risks.

Standard 17 Records Management

Requires a systematic and planned approach to managing records from the moment a record is created until its ultimate disposal. The organisation must be able to control both the quality and quantity of information it generates, can maintain that information in a manner that effectively services its needs and those of its stakeholders, and can dispose of the information appropriately when no longer required.

Standard 18 Risk management (core standard)

Requires a risk management system in place which conforms with the generic principles contained in the Australian Risk Management Standard AS/NZS 4360:1999 and meets NHS and other requirements in respect of managing risks, hazards, incidents, complaints and claims.

Standard 20 Transport:

Requires the organisation to demonstrate improvement in reducing environmental and other risks associated with transport.

Standard 21 Waste management:

Requires that segregation, handling, transport and disposal of waste is properly managed to minimise the risk to the health and safety of staff, patients, the public, and the environment. Unless properly managed, clinical waste can present significant risk to the health and safety of staff, patients, the public and the environment, and hence can pose potentially significant risk to the organisation.

Manual Handling Operations Regulations 1992

The main points to consider for wheelchair services are:

There is a need for risk assessments to be carried out at all stages of the process of handling equipment.

Staff need to receive regular, appropriate training in moving and handling issues and be involved in planning process.

Consideration needs to be given to the use of equipment to minimise risk, for example trolleys, forklifts, steps.

Consideration should be given to the appropriateness of vehicles used for the purpose of transporting equipment. For example, does the internal height of the van floor need adjustment? Could tail lifts reduce the need for lifting?

Consideration should be given to safe storage systems, e.g. racking at the correct height and that systems are in place to reduce the weight of loads being managed.

Those involved in purchasing equipment for use by patients, clients, carers and staff need to use equipment to reduce the need for moving and handling whenever and wherever possible. Health and Safety at Work Act 1974 and Management of Health and Safety at Work Act Regulations 1992 requires that employees are not exposed to a foreseeable risk of injury from manual handling and they take reasonable care for their own safety and for that of colleagues and clients when handling people or loads. Lifting Operations and Lifting Equipment Regulations (LOLER) 1998 Provision and Use of Work Equipment Regulations (PUWER) 1998 The principal aim of both LOLER and PUWER is a change of emphasis from a prescriptive approach, to one based more on the consideration and management of risk.

Each service should ensure that:

A system is established for training all staff in health and safety issues including in particular moving and handling.

Risk assessments are carried in all areas of activity and that records are maintained, ensuring that all staff are aware of the information and that records are readily available.

Risks are reduced wherever possible to the lowest level by the introduction of safe working systems, training and appropriate equipment to do the job.

Sound communication systems are in place and that health and safety awareness issues are given a high priority at all levels of the organisation. Maintenance and repair schedules The main issues for equipment are:

All electrical devices need annual PAT testing

All mechanical equipment which needs regular servicing needs to be identified to meet the requirements of Lifting Operations and Lifting Equipment Regulations (LOLER) and Provision and Use of Work Equipment Regulations (PUWER).

Services need to have clearly written procedures for maintenance and inspection of all items returned to the store for reuse.

Establish and publish a local system for reporting adverse incidents to the Medicines and Healthcare Regulatory Agency as per MDA SN2002(01) Medical Devices Reporting Adverse Incidents and Disseminating Safety Warnings.

Services should have a system in place which enables the recall of equipment if required.

Infection and decontamination issues

The main issues for equipment services are:

Systems for collection do not allow for cross contamination. All used equipment must be collected in vehicles dedicated for that purpose or in separate compartments of the vehicle from clean/new equipment

Systems for cleansing/decontamination for purposes of recycling must meet relevant standards. Clear written procedures and protocols must be in place for each line of equipment.

Control of Substances Hazardous to Health

COSHH regulations should be applied to all staff working within the decontamination area.

- Staff should have access to appropriate clothing.
- Investment should be made in appropriate machinery.
- Regular inspection and audits should be conducted to ensure infection and decontamination procedures are effective.