



Local innovations in wheelchair and seating services

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Local innovations in wheelchair and seating services

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Purpose

This document aims to support PCTs and local wheelchair service managers in their commissioning and delivery of wheelchair and seating services by capturing current examples of local innovations that improve quality in this area.

The innovations and service improvements captured here will continue to be relevant as the proposals in *Equity and Excellence: Liberating the NHS* are implemented, and GP consortia begin to commission the majority of NHS services.

Background

Completed in early 2008, the findings of a Wheelchair Services review revealed a complex landscape of services with no consistent approach to commissioning. Assessment, procurement and delivery approaches differed considerably, leading to significant inefficiencies and a poor record of service delivery nationally.

In 2009, the Department of Health launched a new programme of work to refine the review's proposals in partnership with the NHS, service users and other stakeholders. The aim is to develop a commissioning approach that will facilitate timely provision of wheelchair and seating services focused on the health, social and lifestyle needs of the service user.

There are number of key policy drivers underpinning this work. Firstly, *Quality, Innovation, Productivity, Prevention* (QIPP) (2009), which sets out one of the most important financial challenges facing the NHS for the foreseeable future. QIPP supports clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested in the service to deliver year on year quality improvements

Secondly, the White Paper *Equity and Excellence: Liberating the NHS* (July 2010), which proposes that groups of GP practices – GP consortia – will be responsible for commissioning the majority of NHS services, supported by a new national NHS Commissioning Board. The way that wheelchair services are commissioned is likely to change. During the transition period, it is important that current examples of best practice are continued and built upon.

This document has also been informed by a number of previous publications that commissioners should consider when planning and developing their services. These include:

- *Out and about: wheelchairs as part of a whole system approach to independence* (2006), Department of Health; conducted by the Care Service Improvement Partnership
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139932
- The Audit Commission reviewed progress in a report, *Assisting Independence – Fully Equipped* (2002). It found that while there had been significant progress in some assistive technology services, progress in improving the wheelchair service was disappointing
<http://www.audit-commission.gov.uk/nationalstudies/health/socialcare/Pages/fullyequipped2002.aspx>

Don't Push Me Around (Whizz-Kidz and Barnados 2006) – a campaign to improve the provision of NHS Wheelchair services for children in the UK
www.whizz-kidz.org.uk/wp-content/uploads/.../dont_push_me_around.pdf

Reviews of wheelchair services are also taking place in Scotland, Wales and Northern Ireland, and provide further information on which to draw.

Key Facts

- Disability (as defined by the Disability Discrimination Act 1995 and 2005 definition of disability) is strongly related to age: 2.1% of those 16-19 years are recorded as having a disability, compared with 78% of those aged 85 or over
- Only 17% of disabled people were born with disabilities. Acquired Brain Injury is the largest cause of disability among the working age population¹
- Approximately 69% of wheelchair users are over 60²
- It is estimated that there are 1.2 million wheelchair users in England (just over 2% of the population). Some 825,000 are regular users of NHS services with others needing services for a limited time only³

¹ Disability in the United Kingdom – Facts and Figures, www.papworth.org

² Empower, NHS wheelchair and seating services mapping project – final report, January 2004

³ Empower, NHS wheelchair and seating services mapping project – final report, January 2004

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- The wheelchair service costs approximately £125.8m a year to operate and is receiving around 184,230 referrals per annum of which 40% are already known to the service. The referrals are split between adults (89%) and children (11%) – 2006/7 figures
- There are approximately 570,000 disabled children in England, around 100,000 of whom have complex care needs⁴. In the past ten years the prevalence of severe disability and complex needs has risen. This is due to a number of factors, including increased survival of pre-term babies and children who suffer severe trauma or illness. There are up to 6,000 children living at home who are dependent on assistive technology⁵

⁴ Aiming High for disabled children, 2007

⁵ National Service Framework for Children, Standard Eight, page 7

The case studies

The following case studies highlight pockets of good practice around quality and innovation in wheelchair commissioning and service delivery. Although not all of the examples below will be applicable to all areas, they should serve to inspire improvements and new thinking in wheelchair services.

Some common threads are evident from these case studies:

- Services must put the user at the heart of everything they do and aim to address the holistic needs of users – the service must be tailored to individual needs
- Consider how the service can be delivered in a way that better suits users' needs and avoids long travel times – mobile vehicles, assessments in local town halls or churches, or talking with families and carers to identify barriers to attendance and arrange suitable appointment times can all reduce non-attendance rates and increase user satisfaction
- Joint working – with charities, children's services or local authorities can deliver real benefits to users, and savings to the service
- Communicate clearly with assessment staff, suppliers and maintenance teams in order to ensure that information can be passed quickly and accurately through the system, reducing unnecessary delays
- Patient engagement is crucial – every service should have a user group that allows the service managers to identify problems, test ideas and communicate effectively with users
- Although children only make up a relatively small proportion of wheelchair users, it is important to get the service right for them as they will often be lifelong users – working closely with other services, the child's family and looking at how a wheelchair could address the child's holistic needs are all important

Case Study 1: Evidence based commissioning – assessing need

The challenge

Faced with evidence of increasing demands on the wheelchair service, NHS Ealing wanted a greater understanding of the need for wheelchair services and how this might change in the next few years.

What did they do?

The PCT commissioner requested that Public Health colleagues conduct a detailed needs assessment.

How did they do it?

The Public Health Specialty Registrar conducted a four-month needs assessment. Three approaches were taken:

- An **epidemiological approach**. Current estimates of prevalence of wheelchair use were not available. A lack of current and complete service data, for example regarding case-mix (i.e. reason for wheelchair need), hampered estimation of unmet and future need. Evidence of effectiveness of wheelchair provision was collected using a comprehensive literature search
- A **corporate approach**. Stakeholder views (collected at interviews and wheelchair users forums) were synthesised. This included views of wheelchair users, carers, service staff and clinicians
- A **comparative approach**. This approach was impeded by either limited response from other wheelchair services or for those who did respond, an inability to provide comparative data due to technical and/or resource issues

Outcomes and Impacts

The local wheelchair service was already in the process of planned change:

- The contract with the existing Approved Wheelchair Repairer company was renewed in December 2009 and was negotiated by a consortium of seven rather than two PCTs (with service users on the panel)
- The new contract is activity-based rather than block contract with management overhead. Supply chain is now included (in addition to maintenance) to address service bottlenecks previously experienced by users. The Approved Repairer has a financial incentive to recycle equipment no longer needed (hence reducing overall costs to the service)
- The consortium has procured a new data management system for the service to manage customer relations and some aspects of workflow
- The service has a regular Wheelchair Service User Forum held quarterly, user representation on the Wheelchair Service Partnership Board and a User Reference Group to advise and support the Commissioner
- The direct outcome of the needs assessment study was a set of recommendations to be considered for future commissioning models

Key Lessons Learned

- **Ensure a suitable range of equipment is procured** – Ensure local wheelchair service has a standard range of equipment, which can meet the needs of the vast majority of users. Consider use of new technology e.g. systems to minimise vibration exposure and minimise disc degeneration, lower back pain etc
- **Maximise likelihood of equipment use** – In one reference study⁶ only 7.4% of chairs provided were in regular use. Encouragement and reasons to use the equipment are key, as are suitable housing, environment and accessible local transport. In addition, physical and skills-based training programmes may help to reduce fatigue and pain
- **Work to increase safety of intervention and reduce risk** – using:
 - technology (e.g. braking systems can reduce transfer-related fall rates);
 - patient education (recognition of 'red-flag' symptoms necessitating urgent review);
 - exercise interventions; and
 - proactive surveillance for problems associated with use of wheelchairs e.g. regarding pressure ulcers (as per NICE guidance) and shoulder pain.

⁶ Wheelchair charity: a useless benevolence in community-based rehabilitation. Mukherjee et al. Disability & Rehabilitation, May 2005, vol./is. 27/10(591-6), 0963-8288

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- **Plan for service evaluation and act on findings** – Commissioners are encouraged to ensure that appropriate data and quality indicators are collected and acted upon. Good quality data facilitates audit (equity, response time etc) and sensitive handling of clients and carers
- **Ensure eligibility criteria are fit for purpose and evidence based** – Existing validated criteria should be used where possible. Criteria should be consistent between comparable services but take into account local need and priorities. 'Ineligibility' should not preclude advice or sign-posting
- **Predict future capacity requirements** – In addition to stakeholder involvement, good quality case mix data is essential to understand the determinants of wheelchair need and for analysing trends. Research is needed to develop predictive models of future demand and resulting demands on service capacity. Such modelling could also be used to allocate funding to wheelchair services year on year
- **Consider joint investment** – for example between healthcare, local authority, education sector, charities and employers
- **Recognise synergies between services and sectors** – Long term savings in community and social care (together with increased well-being) may be realised if discharge services and wheelchair services collaborate
- **Recognise the need for other related services** – wheelchairs do not remove certain needs e.g. for assistance with transfers. Mental well-being issues may need to be addressed in certain patient groups who over-estimate their rate of progression to complete dependency on wheelchair use

Contacts

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Case Study 2: Building partnerships to improve children's services

Lord Darzi's NHS next stage review (June 2008) placed a duty on the NHS to build partnerships with local authorities and third party organisations that would provide greater economies of scale and benefit patient services. NHS Tower Hamlets have done just that with the charity Whizz-Kidz

The challenge

NHS Tower Hamlets had limited funding to purchase high quality electric wheelchairs, and budget restrictions contributed to waits of up to 18 months for children's powered wheelchairs. The PCT was also unable to spend sufficient time on teaching wheelchair skills meaning children remained isolated at home and failed to use community resources as local accessibility improved. Provision was also restricted by eligibility criteria as equipment only met mobility needs and didn't treat children holistically.

What did they do?

NHS Tower Hamlets commissioned the charity Whizz-Kidz to deliver wheelchair services for children and young people.

How did they do it?

Tower Hamlets were already working with Whizz-Kidz on a case by case basis as individual children's needs arose. Originally the service started as a partnership arrangement whereby Whizz-Kidz provided funding for additional wheelchair accessories or topped up costs of more expensive electric wheelchairs. From 1st April 2008, Whizz Kidz was contracted to meet the seating and mobility needs of all children and young people with disabilities in Tower Hamlets.

Once the service was established, regular meetings were set up to look at processes and resolve identified problems. Meetings gradually reduced over time and now a small team meets on a quarterly basis.

Under the service, Whizz-Kidz therapists – experts in paediatric mobility – assess all children and young people referred to the service and prescribe mobility equipment that takes account of their educational, social and clinical needs. Whizz-Kidz also runs regular clinics with the three main special educational needs schools in Tower Hamlets – this reduces the amount of time that children and young people are out of school for appointments. The charity also arranges Wheelchairs Skills Training Courses and recruits ambassadors for its wheelchair services from its user-base – offering them life skills training and work experience.

Outcomes and Impacts

- Whizz-Kidz conducted a survey that showed the satisfaction rate for equipment provided by Whizz-Kidz in Tower Hamlets was 100%⁷
- Since Whizz-Kidz took over the service, there has only been one formal complaint in three years – a significant reduction on previous levels
- Of the 115 users provided by equipment by Whizz-Kidz, 74 (64%) received their equipment within 18 weeks from the date of initial referral
- Regional winners 'Health and Social Care Awards' NHS Institute for Innovation and Improvement
- Improved efficiency of children's service has freed up capacity to dedicate to adults
- Waiting time from referral to provision is six weeks⁸
- Whizz-Kidz provided a service that meets needs rather than being restricted by eligibility criteria, using health and charitable funding to ensure the user gets the best possible outcome
- Children are now able to access the school environment and the burden of raising funds by therapists and education staff has been removed
- Whizz-Kidz has extended its reach and now provides services in four other areas of the South East England

Key Lessons Learned

- Seek mutually beneficial partnerships and be clear what you wish to achieve
- Share your vision and engage users and carers in the planning and delivery of the service – ensure children's voices are heard too
- Look at the QIPP challenge and then go for it – the benefits, both quantitative and qualitative are enormous and can be life changing for a service user

⁷ Survey was carried out using the 'Quebec User Evaluation of Satisfaction with Assertive Technology (QUEST 2.0) in 2008

⁸ As of April 2009

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- Collaborative working brings greater benefits for service users – explore all options for partnerships; no one service has all the answers

Contacts

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Case Study 3: Improving the pathway by valuing staff

The challenge

Preston Specialist Mobility Rehabilitation Centres (SMRC) conducted a survey in the mid to late 90's following numerous complaints to the commissioners. The issues related to long waits for equipment, lack of understanding as to access criteria, multiple levels of priority, abuse of those priorities and lack of familiarity with the equipment. The survey found that no one entity was coordinating wheelchair service provision across the service footprint. Community staff in a variety of locations had differing perceptions of their role, effectiveness of the service and complexity of provision. This also meant there was no real understanding of costs or added value to the service. Poor communication was resulting in mixed messages to staff.

What did they do?

The SMRC implemented a quarterly newsletter, which informs the community staff of referral / activity levels, clinical updates, training availability and product recalls. To underpin the newsletter, community staff user meetings were organised to discuss service delivery and any issues arising. Community staff training was also developed and delivered by SMRC.

How did they do it?

Preston SMRC took the lead on improving communication and training.

Outcomes and Impacts

- Prior to the survey a high proportion of referrals could not be processed due to omissions or errors by the referrers. Now over 99% are processed in under 2 working days
- Valuable clinical assessment time and venues are utilized to see the most appropriate patients as speedily as possible
- Prompt hospital discharge
- Improved openness has stopped the abuse of the 'priority' type referral
- The need to replace newly provided equipment due to referrer/prescription error has dropped hugely

Key Lessons Learned

- Encourage communication across the service pathway and its key stakeholders
- Listen to community/ service staff opinions and encourage partnership working
- Develop a minimum information set that allows easy prescription/ product selection
- Consider the community staff member, not just patients as a service user
- Ensure feedback to community staff is effective to ensure they feel part of the service team

Contacts

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Case Study 4: Partnerships putting patients first

The charity Motor Neurone Disease Association has been working with a number of NHS organisations across the country and in particular NHS Oxford to deliver a service model, which they regard as the 'gold standard'

The challenge

There are 500 people with Motor Neurone Disease (MND) waiting for an NHS wheelchair at any one time, and wheelchairs will be required in 80% of MND cases. People with MND in 30 counties across England have experienced, or are currently experiencing unacceptable challenges in access to wheelchairs.

What did they do?

The David Carleton Paget (DCP) Wheelchair service for people with MND was established to address this issue. It operates out of the Oxford MND care centre, funded by the MND association.

How did they do it?

The DCP Wheelchair service enables the MND Association to leverage local NHS resources for the benefit of people with MND. Arrangements were reached with local NHS services mainly via direct approaches to wheelchair service managers from the MND Association. Under these agreements the local NHS service takes responsibility for maintenance, storage, delivery and insurance costs of DCP wheelchair services. The MND Association funds an occupational therapist (OT) at the Oxford MND care centre full-time.

Outcomes and Impacts

Any client seen in the Oxford MND Centre can have access to wheelchairs owned by the centre and have an assessment by an OT there. If the Care Centre has an appropriate wheelchair in stock and local NHS provision will entail a delay in comparison to the time scales offered by the Care Centre, then the Care Centre chair is provided and the NHS wheelchair service is informed.

- The result is that many users receive wheelchairs faster than they otherwise would
- The aim of the DCP Wheelchair service is to ensure that every person with MND can access a wheelchair when they need one. This means timely assessment by an occupational therapist of individual needs, and delivery of a suitable wheelchair within 7 to 10 days of assessment – this target has not yet been reached for all users, but the vast majority of users receive a suitable chair within a week
- As of January 2010, five-year agreements have been formalised with seven local services in the South East

Key Lessons Learned

- A good reliable rehabilitation engineering service is essential to maintain the chairs and ensure they fit the clients needs as they evolve
- There must be a balance between available equipment and therapist time in order to deliver 'right time and right place' services
- Beware of lead times from manufacturers, negotiate clear delivery times and monitor them
- Good communication and relationship with local NHS wheelchair services is essential
- Commissioners need to have a better understanding of needs on the ground – especially in rapidly progressing diseases such as MND – future needs should be anticipated

Contacts

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Case Study 5: Delivering care closer to home

The challenge

Users may find it difficult to travel to external venues to have their wheelchair and seating needs addressed, and there was poor attendance at wheelchair clinics due to patient health problems. The service provider was also keen to ensure that wheelchairs and seating provided to users are appropriate to their home environment.

What did they do?

The Disablement Services Centre at University Hospitals South Manchester NHS Foundation Trust introduced a Mobile Assessment Vehicle (known as MAVIS) in order to take specialised services direct to the patient.

How did they do it?

The Mobile Assessment Unit is driven by a member of the multi-disciplinary team which normally consists of a combination of Rehabilitation Engineer/Engineering Technician/Posture & Mobility Therapist depending on the type of assessment/work to be undertaken.

Assessment is carried out within the patient's home/nursing home/day centre/school, including EPIC/EPIOC assessment, casting for a new bespoke seating system, adjustments to equipment (the unit is fitted out with a small work bench) or ordering a new wheelchair if necessary. Instructions and advice can be given to the user and/ or carers on how best to use the equipment

Outcomes and Impacts

- Enhanced patient experience
- Access to the service improved
- Prompt adjustment of seating equipment – especially complex seating systems
- Ensures wheelchair and seating provision is provided at point of need
- Assessment of home environment in relation to proposed equipment supply is undertaken at the same time resulting in faster delivery of appropriate equipment
- The MAVIS service won an award for innovation at the Trust

Key Lessons Learned

- Holistic team approach with patient-centred assessment and provision
- Use of portable pressure monitoring equipment can show how correct positioning affects pressure distribution and be used to help reduce pressure sores.
- Provision of detailed information including user manual and demonstration of equipment enables users to get the most out of their equipment

Contacts

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Case study 6: Public sector / private sector partnerships

The challenge

Users may find it difficult to travel to external venues to have their wheelchair and seating needs addressed, and many users were experiencing a lag in time to access equipment once needs were assessed.

The agreed action / solution (what did they do)

A mobile unit and Call Centre was set up and run through a public / private partnership. The Unit brings wheelchair services closer to users' homes by using pre-booked rooms in Leisure Centres and Sports studios and increased home, work and school visits. Patient data, manufacturers' specifications and real time stock data is accessed remotely using laptops in the clinic situation.

The process (how did they do it)

The partnership is between Central Essex Community Services and DGT Services, Chelmsford. DGT services is a trusted partner with many years of track record in providing wheelchair service support. It was therefore the natural first contact with whom to explore a new type of working. The idea of the mobile service was a local response to the service specification being tendered by the PCT (taking the service to the clients). The contract has clearly defined areas and responsibilities. The van, driver and logistics responsibilities are managed by the private sector. Other staff, call centre and other aspects of the service are the responsibility of the Healthcare Provider (CECS).

Regular, (weekly) meetings with all stakeholders were needed in the first couple of months. This has continued with monthly stakeholder meetings and regular (daily) communication using all available channels.

The mobile unit is fully equipped with plinth, pressure monitor, scales, hoist, assessment wheelchairs / buggies, powerchairs and cushion range. The unit driver is a skilled engineer and acts as receptionist at clinics, a carer, helper and low needs assessor, Call centre staff are trained to carry out telephone assessments of low needs clients and to triage the more complex cases.

Outcomes and Impacts (particularly on user outcomes)

- Faster client access to equipment and help through triaging – all clients, even complex, served within 18 weeks
- Huge reduction in complaints compared to previous provider model leading to greater satisfaction

Key Lessons Learned

- Economical use of estate – only pay for the accommodation for the time you need it
- Move the service around to where the people are
- Remote connectivity to client data allows staff to access the notes where they need them without carrying heavy confidential files
- Real time electronic access to stock allows equipment to be allocated in the clinic – this speeds up delivery times
- Partnership brings together the best of both organisations. Private sector logistics and engineering skills with public sector healthcare and assessment skills

Contact

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Case study 7: Patient engagement – the virtual user group

The challenge

NHS Leicester wished to engage with users and use their views to shape the service. However, when the user group met in person this excluded wheelchair users who had limited access to transport or were unable to resource wheelchair taxis to and from meetings. In addition, parents of young children requiring mobility seating often could not attend due to need to pay for childcare and lack of time.

What did they do?

In order to ensure users' views were heard, a virtual user group was set up.

How did they do it?

The group was publicised by placing posters around the building. Once a user signs up as a member of the wheelchair user group, NHS Leicester communicates with that member via their selected communication route – telephone, email or post. Two way communication is actively encouraged by posing important questions about future provision, processes, access, quality metrics etc.

Outcomes and Impacts (particularly on user outcomes)

- There was a positive response to requests to join the group – there are currently 15 active members with ages ranging from 5 to users in their late 80s, and the membership is steadily growing
- Having a virtual group means there are no limitations to the numbers of people who may wish to be involved or their ability to attend the centre
- Feedback from the user group has a real impact on how the service is delivered – for example, comments from the group led to changes in how wheelchairs were reclaimed from deceased users – the group agreed a wait of two weeks (rather than six) before contacting the family would be reasonable in order to limit wheelchair wastage

Key Lessons Learned

- Identify gaps in engagement and speak with patient advisors and existing user groups to ensure there is a good cross section of the local community able to attend meetings and venues
- Communicate regularly, promote any changes in advance of carrying them out
- Engage support both internally and externally from the NHS e.g. communication team, general practice, community services – maximise those who can be involved
- Keep membership details up to date – validate the list regularly to maintain an active user group
- Keep communication channels current – explore the use of texting for younger members

Contacts

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Case study 8: Specialist commissioning for children

The challenge

It is a national and Kent priority to develop integrated processes for vulnerable groups of children and their families, and to promote the co-location of staff. Stakeholders were also aware of the need to align commissioning intentions within the various bodies in Kent who care for disabled children.

What did they do?

Create multi-agency specialist hubs to provide services to disabled children and young people.

The hubs offer:

- Reviews of children's needs in a multi-disciplinary environment leading to (among other things) the provision of wheelchairs and specialist seating systems
- A single base for Kent County Council (KCC), NHS and Third Sector staff
- A multi-agency approach to providing advice, training and outreach support for early years settings, schools and leisure providers on including disabled children and young people in their activities
- Joined up approach to providing assessments, interventions and reviews
- Specialist centre to enable severely disabled children and young people to be able to access a short break during the day and evening
- Local community venue for providing training, advice and support for parents and carers

How did they do it?

An agreement was made between Eastern and Coastal Kent PCT and Kent County Council (KCC) whereby KCC leads on the construction of a new multi-agency specialist hub building.

Following further needs analysis, the Directorate of Commissioning, Child Health made applications to the Department for Children Schools and Families to construct four additional multi-agency specialist hubs – funding for three was secured, and additional funding was secured for a fourth, smaller building from the NHS. The new buildings will operate within a hub and spoke model of service delivery, maximising the efficient use of capital estate e.g. space within a special school or children's centre.

Outcomes and Impacts

- 'One stop shop' for disabled children, young people and their families enabling them to receive the right information and support at the right time, in the right place
- Three large multi-agency specialist hubs will be completed by September 2011, with a smaller building completed by December 2010
- Professionals, parents and disabled children have actively participated in the development of the multi-agency specialist hub model over the last 6 years meaning that a number of changes have already taken place including:
 - NHS and Kent County Council staff have come together to develop new models of working and will maximise the opportunities of being co-located in the same building
 - All disabled children aged between 0-7 with highly complex needs are allocated a Key Worker, having access to a multi-agency family plan
 - A range of training courses for promoting the inclusion of disabled children in early years settings and schools has been developed

Key Lessons Learned

- By promoting the active participation of disabled children, young people and their carers in the development of the service, creative ideas can be established
- Involve as broad a range of professionals in the development of the model as possible
- Develop shadow multi-agency locality operational groups to support the service transformation agenda
- Start early on resolving the big challenges e.g. IT
- Ensure there is an overarching multi-agency strategy to provide the vision and direction on how a range of strategic initiatives can come together to form an overarching model of intervention

Contact

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Case study 9: Joint agreement between children's services and the NHS on wheelchair provision

The challenge

Provision of wheelchairs and seating equipment for solely educational use has always been a problem in terms of who is the responsible budget holder and the wheelchair service remit to provide an equitable service across all age groups.

Under the current scope of service provision eligibility criteria mean that users often do not get wheelchairs they require i.e. a child may be able to walk but the distances and speed to access lessons requires a powered wheelchair which they are not provided with. Generally, problems are encountered in secondary schools due to distances required to get to classrooms and work table accessibility. On occasions, money was being wasted by providing two or three pieces of equipment to solve access issues, (i.e. variable height tables in a number of classrooms) when a joint investment in a sophisticated wheelchair would be more cost-effective and better for the young person.

What did they do?

A service level agreement (SLA) was drawn up between Telford & Wrekin Council, Education and NHS Telford & Wrekin in order to enhance wheelchair provision for children and young people attending secondary school.

How did they do it?

A meeting was arranged between the Education Officer responsible for access funding and the Wheelchair Services Manager for Telford and Wrekin PCT, to negotiate an SLA. This involves a virtual allocation of £8,000 from education access budget to enhance wheelchair provision. This largely replicated the voucher scheme – the wheelchair service assesses as usual with the input of the paediatric occupational therapist responsible for special educational needs and we agree provision. Where an addition is required above what would have been supplied by the service, Education pays that 'top-up' element (the 'enhancement'). The wheelchair service retains the ownership of the wheelchair and is responsible for repairs.

Outcomes and Impacts

This agreement is now in its third year and nine children have benefited so far

- The assessment process and provision is clearer and thus more timely, reducing waiting times
- Equipment previously not accessible through the NHS can be considered and loaned under this agreement
- The children involved have benefited from increased independence, socialisation and learning opportunities
- The enhancements are dependent on the needs of the child i.e. joint funding was agreed to provide a child with a higher performance self propelling wheelchair for him to participate in sports. Therefore, imaginative solutions can be considered to improve the child's access in the broadest terms

Key Lessons Learned

- Joint working between different bodies responsible for children/adults requiring wheelchair provision can reduce waste and deliver a better service for users
- An appreciation of each other's roles, responsibilities and limitations enhances the holistic approach to providing meaningful services in addressing people's needs
- The initial stages required a lot of discussion in explaining the role of wheelchair services in the NHS and the support we can offer, which highlighted the lack of knowledge around this service
- A knowledgeable commissioner and open-minded education officers was key to moving the discussion forward
- The provision of maintenance and future disposal by the wheelchair service of any equipment purchased resolved many of the concerns in education

Contact

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Case study 10: Provision of powerpacks

The challenge

One of the main and recurring issues highlighted during assessments is that many carers have difficulty pushing the wheelchair assigned to the individual they care for. For example, the carer may be elderly, have a chronic medical problem or disability themselves, the wheelchair user may be heavy, or the area where they live may be particularly hilly.

What did they do?

The Sandwell wheelchair service decided to introduce power packs into their equipment range in 1997.

The power pack is a detachable unit that consists of a wheeled motor and battery pack which is fitted to the rear of the wheelchair. It is controlled by the attendant using a control fitted to the push handles. It can help carers to push a wheelchair when they would have difficulty doing so using their own strength alone.

How did they do it?

The decision was made to introduce the packs following agreement from the regional rehabilitation centre. Each pack costs in excess of £400, although refurbished units are considerably cheaper. Used packs are put back into stock if they are in good condition. The money is not ring fenced and comes from main budget.

The service carried out a project to see who was gaining most benefit for the packs. This enabled them to consult users and gain valuable feedback on the usefulness of this piece of equipment. This feedback was then used to develop guidelines for issue. Users will only be issued with the power pack if they meet these guidelines.

Outcomes and Impacts

- Feedback from users indicate that power packs are a valuable piece of equipment, either increasing outdoor mobility or making existing journeys easier
- Users also report that they worry less about the strain placed on the carers expected to push them

Key Lessons Learned

- To provide a truly holistic assessment the carers needs must be recognised and taken into consideration during the assessment process
- Power packs not suitable for all carers as they need to be removed for transportation, the power packs are heavy so not all carers will have the capability to do this
- It is important to carry out regular reviews to ensure the power packs have met need and have continued to be useful
- Being able to refurbish and reuse power packs enables costs to be kept down

Contact

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Case study 11: Increasing social inclusion for children through timely wheelchair provision

The Allied health professions (AHP) Service Improvement Project (SIP) commenced in September 2009 when thirty services were selected to deliver sustainable reductions in waiting times for AHP services whilst maintaining or improving the quality of care received by patients and the public. The project will end in March 2011 recognising the local benefits.

AHP services are involving patients in decisions about their care and in service redesign to deliver better outcomes by improving quality and access to services. They are delivering local, clinically-led service improvement; collaborating across health economies and extending best practice across health, social care and independent partners to promote a culture of continuous improvement. Improved AHP services are pro-actively engaging with commissioners to benefit patients and reduce cost informed by improved outcomes.

The challenge

High waiting times for children's wheelchairs (around 40 weeks) in HMR Posture and Mobility centre that supports Bury and Rochdale Populations

What did they do?

Action was taken to improve the service as part of the Allied Health Professional Service Improvement Programme. This included exploring all the barriers to fast delivery of chairs both from a service and user perspective (e.g. Non attendance rates)

The solution covered two main areas:

Equipment

1. Install an improved database that stores relevant information e.g. waiting times
2. Track individual progress of client and equipment through database
3. Pilot electronic ordering and supply of chair and commitment from suppliers to deliver to a guaranteed ETA (Estimated time of arrival) of equipment.

Clients

1. Explore barriers to clients attending appointments
2. Explore possibility of reducing appointments

How did they do it?

Equipment

The programme was able to reduce waiting times and implement the changes within current resources through reorganisation. One-off additional costs included the IT database system which was funded by the Approved Repairer as part of partnership working and the pressure-mapping system through a capital bid.

Clients

The service broke down non-attendance rates, including same-day cancellations, to look at the reasons behind them, and found that complex family reasons such as childcare for other children, often played a part. The service identified a range of solutions to improve the non-attendance rate including use of an advocate who works with the family closely around the issues that may cause non attendance, and the purchase of a pressure mapping system in order to halve the number of appointments required for assessment

Outcomes and Impacts

- Early provision of equipment promotes social inclusion for children
- Non-attendance record reduced
- Waiting times reduced from an average of 40 weeks to 25 weeks and continuing to improve to target of 18

Key Lessons Learned

- Treat the family holistically
- Look at the child's holistic needs – what is the impact on their education, social life and wider health if wheelchairs are delayed or do not fully meet their needs
- Value of IT in supporting change

Contact

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Case study 12: Sustaining improvements in wheelchair services

The challenge

In 2001, Barnet wheelchair service was facing a number of significant problems. Users faced long waiting times before they were assessed, and were not happy with the service as a whole, leading to many complaints. The poor state of the service contributed to stressed staff with low morale.

What did they do?

The service worked with The Access Partnership – an NHS based healthcare consultancy – to reduce waiting times and improve the service. Workshops were set up involving whole team including service users looking in detail at process mapping. The team initially felt that more staffing and financial resources would be required to improve the service. However, a two week time analysis audit showed that work was being duplicated – a change in process was required.

A clear strategic objective was formulated by the whole team. Expectations of referrers and clients were managed by setting up a user group, logging all referrers and targeting training appropriately.

Following the initial success of the project, the service continued to push for improvements. The number of clients coming to clinic increased following an audit of home visits by therapists, re-design of referral forms and an information leaflet being sent to clients. A comprehensive data collection system was also designed, and administration processes were standardised to streamline the system. Targeted business cases in 2004 and 2006 led to the introduction of a dedicated assessment centre, and a more suitable skill mix among staff, including a full time Planned Preventative Maintenance Engineer.

The service undertook a pilot project to providing assessment and issuing of Electric Powered Indoor Outdoor Chairs (EPIOC) locally. This has reduced waits for these clients from 104 weeks at the start of the work in 2001 to only 12 weeks.

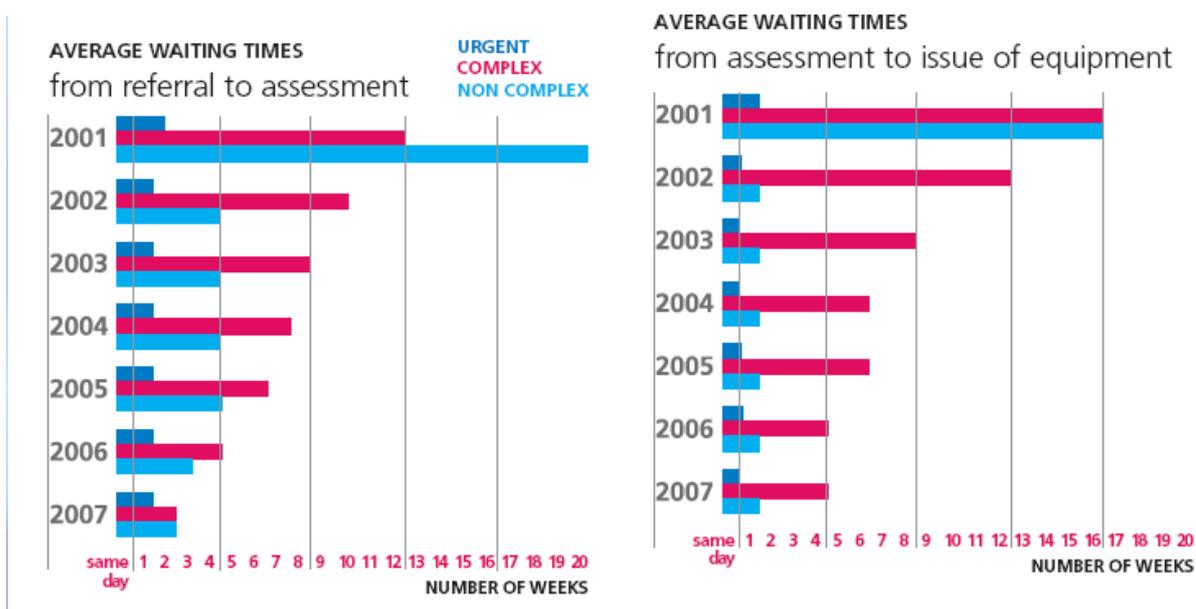
The process (how did they do it)

To prevent delay of wheelchair issue due to external factors, the service worked with a new Approved Repairer to issue wheelchairs at assessment via Drop-In Clinic.

The changes meant that more standard wheelchairs were prescribed by external therapists, which allowed the service to concentrate on the assessment and prescription for more complex clients.

Outcomes and Impacts (particularly on user outcomes)

- No increase in staff to deal with increase in demand of 30%.
- 83% of clients issued with wheelchairs at Drop-In Clinics
- 58% of clients issued with wheelchairs at time of assessment at regular clinics
- Less time spent dealing with complaints
- Waiting times were reduced (see tables below)



Local innovations in wheelchair and seating services

Key Lessons Learned

- Process mapping can identify efficiencies that could be made in a service

Contacts

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Case study 13: In-house Repair and Maintenance Workshop

The challenge

The Doncaster wheelchair service was facing delays in response times for delivery and repairs of wheelchairs, and users expressed a wish to have a local repair service (the service at the time was 15 miles away). Service managers believed that the previous repairer was inefficient and that its staff lacked training in customer care and disability issues. The service also wished to deliver a seamless service, with a single point of contact for users, and a holistic assessment that considered users' overall needs.

What did they do?

The service introduced an in-house repair and maintenance workshop – this carries out repairs on-site and in users' homes.

How did they do it?

The service utilised existing buildings on hospital site and converted them to workshop and storage space for wheelchair repairs. It directly employed technicians in various grades, and purchased and converted vans for delivery, collection and repairs. They also introduced a database for stock control and patient information. There was an initial cost to set up the in-house service, but it has proved cost-effective overall, and bringing the repair budget in-house has enabled them to gain greater control over how it was spent.

Outcomes and impacts

- **Faster response times** for deliveries and repair of wheelchairs – In case of urgent hospital discharges, an appropriate wheelchair can be picked up by the client on the way home
- **Ability to change and improve working practices** without reliance on external suppliers
- Greater customer satisfaction
- **Greater satisfaction for the Technicians** and ownership of work carried out by them. **Technicians are also able to ask the advice of Therapist** involved with particular client
- **One stop shop** for wheelchair users and carers means that wheelchair users know who to contact
- **Appropriate wheelchairs to meet clients' needs every time** - Technicians on hand to assist the Therapists in clinics eliminate the need for multiple visits. Wheelchairs can be configured in the clinic to meet the client's needs. Any bespoke accessories or modifications can be accessed from the workshop.
- **Multi-disciplinary approach** - Workshop not seen as a separate entity to the rest of the Service and is very much part of a multi-disciplinary team of O.T. Manager, Administration staff and Posture and Mobility Therapists
- **Reduction of wastage** and some costs by recycling reusable parts
- **Introduction of new range of equipment** without extra cost for maintenance

Key lessons learned

- All aspects of the service benefit when it is provided by one provider, as opposed to fragmented service provision by various providers
- Bringing services in house leads to better control of expenditure
- All manufacturers and suppliers are willing to assist and give advice and training relating to their products.
- Multi-skilling and sharing of job responsibilities improves staff morale
- Consultation of service users is vital to making any changes to the service delivery

Contact

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Case study 14 – specialised seating service

The challenge

In the late 1980s when wheelchair services were being devolved into the NHS, it was decided in South London to maintain specialised seating as a centralised service, serving a number of outlying wheelchair services. It was thought that a specialist centre would attract a critical mass of clients with rarer conditions and this in turn would lead to the acquisition of the expertise and knowledge base required to treat this client group. This model of delivery was later recommended by the Audit Commission in their report *Fully Equipped*.

What did they do?

Established a specialised seating service based at Queen Mary's Hospital in Roehampton. Facilities consist of an office, a clinic room and a workshop.

How did they do it?

Thirteen wheelchair services refer patients to the service via a detailed referral form.

Depending on the complexity of the client's situation, the initial appointment will normally be attended by the Special Seating team, the client and his or her parents and or carers, and the clients treating therapist. It is important that key personnel be present at initial appointments in order that a complete picture of the client and his or her lifestyle can be put together. At times the team may need to include the clients wheelchair service therapist, speech and language therapist and class teacher.

A prescription is sent to the referring Wheelchair Service and a technical specification is prepared to enable to equipment to be manufactured in the workshop. Once agreement has been received from the referring Wheelchair Service the piece of equipment is either manufactured in the workshop or ordered from a commercial company. The client is then invited to attend another appointment to take delivery of the equipment.

The clinical team have direct access to the Engineers who manufacture the Special Seating equipment. That way instructions are not lost in translation and the client actually gets the equipment that was prescribed and specified by the team. This collaborative approach has proved extremely successful.

The team currently undertakes approximately 750 face-to-face contact appointments per year, at Roehampton or one of six other satellite sites. Of these 750 contacts, approximately 25% will be new to the service with the clients attending initial appointments. The other 75% of appointments are made up of reviews, casting for custom-made systems, fittings and deliveries. Charging PCTs for each individual face-to-face contact funds the whole of the Special Seating Service.

The team will often refer on to Orthopaedic Surgeons, Orthotists and Neurologists. The service will then work with these professionals in a co-ordinated way to ensure a successful outcome for clients.

Outcomes and Impacts

- Anecdotally there has been a reduction in fixed postural deformity as a result of the early introduction of 24 hour postural management
- Improved seating and postural management generally increases overall health and well-being, assisting in the management of eating, digestion, breathing and elimination. It also reduces the incidence of chest infection and pressure problems
- Greater level of client satisfaction

Key lessons learned

- Comprehensive information gathering is essential in order that every aspect of a client's condition and lifestyle can be taken into account prior to making a prescription
- The client's views and opinions should guide any decisions made
- Key personnel must attend every appointment throughout the length of the whole of the episode of care. The consistency of this team is paramount
- Clients, carers and all professionals involved must fully understand the reasons why a specific piece of equipment has been prescribed. The benefits to the client need to be fully explained and documented.
- The clinical team need to work seamlessly with the workshop team in order to produce a piece of equipment that fully meets the client's needs

Local innovations in wheelchair and seating services

- Comprehensive instructions should be issued to carers and other professionals explaining how a piece of equipment should be used. Positive reinforcement and on-going training may also be required in order that the equipment achieves maximum benefit for the client

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The future direction of wheelchair and seating services

Advisory Group

In December 2009 an Advisory Group of commissioners, third sector organisations, providers, clinicians and service users was established to review the model of wheelchair and seating services and to inform the future direction for commissioners across the NHS

The group identified a number of emerging themes for wheelchair and seating services that they believe commissioners should build in to any future model

- **Focus on the needs of the user** – wheelchair services should employ a holistic approach to assessment that considers the social, environmental and lifestyle needs of the individual alongside their clinical requirements
- **Achieve timely access** – providers should work with service users to identify and eliminate unnecessary delays in the assessment for and delivery of wheelchairs
- **Ensure equity of provision** – institute eligibility criteria that are transparent and evidence-based
- **Improve outcomes for service users** – providers should have clear and responsive processes for listening to and acting upon user feedback. Commissioners should use robust metrics to measure the quality of service provision from both a commissioner and service user perspective, including waiting times and product suitability
- **Adopt a preventative approach to service provision** – services should look forward to the medium and longer term clinical and social needs of the user when providing a wheelchair
- **Shift the balance of resources from service management to wheelchair provision** – commissioners, providers and service users should work closely to identify areas where productivity can be improved. Improvements should be quantified and re-invested into wheelchair and seating provision
- **Encourages innovation** – commissioners should encourage and empower providers to seek product innovation and procurement opportunities

Conclusion

The examples in this document provide a foundation on which to build, but most reflect only pockets of good practice. There is still more to be done to improve wheelchair services across the country. The two regional pilot projects in the East of England and the South West will also offer significant opportunities for systematic service reform addressing the QIPP agenda.

Over the coming months, the Wheelchair and Seating services Programme will work with these pilots learning lessons and testing out new approaches that will be shared nationally

The Wheelchair and Seating Services Programme would also like to hear from any other commissioners or providers are collaborating to review their wheelchair and seating services. Please email:

wheelchair.services@dh.gsi.gov.uk