



NHS Review of Wheelchair and Special Seating Services in Scotland

NHS Quality Improvement Scotland
November 2005

Sense Scotland Response
23rd January 2006

Introduction

Sense Scotland is a leader in the field of communication and innovative support services for people who are marginalised because of challenging behaviour, health care issues and the complexity of their support needs. The organisation offers a range of services for children, young people and adults whose complex support needs are caused by deafblindness or sensory impairment, physical, learning or communication difficulties. Our services are designed to provide continuity across age groups and we work closely with families and colleagues from health, education and social work. This breadth and depth of approach to service delivery helps us take a wider perspective on the direction and implementation of new policies.

General comments

We welcome the review of wheelchair service provision across Scotland. Below we set out specific comments relating to each of the eight sections. Here we raise more general points. An electronic source document and response form would have made it much easier to provide comments. Not only would this have saved paper and increased efficiency by allowing direct transfer of responses for public scrutiny, it would also have improved the accessibility of the consultation process.

The areas covered by the consultation document are important. Nonetheless, in our view a key area is omitted. Where any major structural change is being considered it is always helpful to return to first principles and, in this case, to ask if a 'wheelchair and seating' service is the optimum way to structure the service.

From a user perspective an integrated approach to service delivery is needed. One example of this integrated approach is when considering the various other aids and equipment a user may require. For example, some wheelchair users require a communication aid, a switch system to operate a laptop or desktop computer, an environmental control system, or a combination of all three. What happens currently? Assessment for seating and wheelchair will be carried out at one centre; for communication aid assessment the person will attend a different centre: which may be joint agency funded, or may be specific to education or to health.

A more integrated systems-approach is also required to funding, as for example is the case with riser or elevating chairs, which are difficult to obtain through NHS Scotland. Consider the example of a child who uses a wheelchair at school. Wheelchair and seating assessment will not pay for the supply a chair with an elevating seat. Instead the child will be supplied with a standard wheelchair (perhaps powered). In parallel, a referral is made to improve accessibility of the school's physical environment and the curriculum. Occupational therapy assessment takes place and identifies the need for adjustable computer trolley; adapted workbenches and desks, tables and other equipment. At secondary school similar consideration has to be made, for each subject. Because education will pay for adaptations to the school environment, and NHS Scotland pays for the wheelchair each operates separately, and satisfies, also separately, criteria for best value. At the same time, no consideration is made of the opportunity cost of having not provided a chair with elevating seat under the NHS and thus avoided having to pay for adaptations to equipment. Nor has the user perspective been taken of being able to participate in discussions, meetings and interact socially with their peers.

It would have been helpful if the consultation paper had considered such issues. We hope that the Executive will look at these issues again in the light of our comments.

1. Structuring the service, making it local

Comments on options listed follow. In summary, we favour a move toward Option 1B in the medium term, followed by a move to Option 1C. The tick box response format used in the questionnaire does not allow for this type of response.

Option 1A

While increasing the number of outreach clinics would improve access and reduce the 'emotional distance' inherent in a very large service, this option would not address the issues of complex data management as the 'hub' (e.g. WESTMARC) arrangement would continue. Indeed if outreach centres are not given a high level of autonomy then the 'hub' would have to spend even more time in managing the centres, designing database systems for tracking and so on.

As the paper does not state specifically what would constitute an 'outreach' service, it is difficult to evaluate how different the option would be from current service delivery. Specifically, an outreach centre that depended on its 'hub' for referral pattern and tracking, parts and maintenance, management and control of decision making would retain many of the existing difficulties of service delivery.

Option 1B

We agree that this is the most pragmatic option, addressing the need for a greater level of independence for centres than is proposed in Option 1A. At the same time it does not go as far as Option 1C which would encounter major difficulties in the medium term.

We would suggest two additional considerations when taking forward this option.

First, when identifying locations for the additional two or perhaps three regional centres, consideration should be given to what an optimum service functioning under Option 1C would look like.

Second, if at all possible, one of the new centres should act as a pilot with a clear remit to operate within an integrated systems environment. It would then be possible to compare processes and outcomes, allowing evidence based conclusions to be reached.

Option 1C

We are attracted to this option particularly because it would help pave the way for a more integrated approach to service delivery, one that is based around the user rather than on the structure of services being offered.

We agree that in the medium term – 2 to 5 years – significant challenges would be presented that would be difficult to overcome, especially recruitment, training and retention of staff with specialist skills.

As we have outlined in Option 1B, we can see advantages of moving to Option 1B for the medium term, meanwhile building capacity to move towards Option 1C in the longer term.

Option 1D

The status quo is not an effective option. In particular, the evidence that no other country has a single centre serving such a large population (2.5 million WESTMARC;

1.5 million Edinburgh Mobility Centre) would caution against retaining this option. The current system is unworkable.

2. Making the service accountable

Option 2A Maintain a regionally managed service, but introduce nationally agreed standards and performance targets to ensure equity of services

We are aware of the current debate across NHS and NHS Scotland of the inappropriateness of target setting. In particular, difficulties arise where services follow targets rather than concentrating on delivering better outcomes for service users.

In the case of wheelchair services specifically, targets would be most easily met by addressing wheelchair provision for those with the least complex support needs at the expense of those with the most complex support needs. As a result waiting lists could be addressed most easily while making it more difficult for those with the most complex support needs.

Option 2B Have a single wheelchair service co-ordinating body for Scotland, responsible for all wheelchair centres, and funded directly by the Scottish Executive Health Department

Preferred option with reservation. We could support this model if a significant change was made to the focus of that specialist service. As we have already noted we favour a more integrated approach to services for users. A co-ordinating body for wheelchair services might improve services for some wheelchair users but would cement into place a non-integrated model of service delivery that would not advance the needs of those with more complex support needs.

Option 2C No change to the current accountability of the service

No.

3. Assessment

We would welcome a commitment being made to a more holistic view of assessment and, as our comments in the General comments section indicate, we would like to see 'holistic' meaning better integrated with other functions such as communication aids.

Option 3.3A The NHS wheelchair service continues as the sole assessor of wheelchairs and special seating but with assessment separated from provision of equipment

We cannot see how this would offer an improvement to service for users. Prescribers would inevitably check and re-check with assessors. Assessors would have to be even more precise in their reporting.

In practice this arrangement would be unworkable for those with more complex support needs. On delivery, it is rare for wheelchairs used by those with complex needs not to need adjustment. The chair would have to be delivered to the assessment centre which would then have to contact the purchasing centre to say

Part X or Y was needed, or was missing, with inevitable delays. Paper trails would increase with no improvement in effectiveness of service or outcomes for the user.

Moreover, if there are gaps due to funding shortfalls then the assessor / provider split would do little to improve this.

Option 3.3B The NHS regional centres assess complex cases only, while users with less complex needs are assessed in the community and by community based professionals, whether employed by the NHS or by local authorities

Preferred option. It would be important to ensure that referral criteria were clearly stated and consistently applied across centres.

Option 3.3C No change to the current assessment process

See above.

3.4 Follow up and Reassessment

Option 3.4A Initial assessment process includes a date for next planned assessment

Preferred option. As it is likely that re-assessment would for most people be annual the number of appointments not being kept is likely to be high. Email and text messaging reminders should be built in to the service.

Option 3.4B No change to the current follow and reassessment process

No.

4. Provision of equipment

Option 4A The NHS continues to provide all wheelchairs following assessment

Preferred option.

Option 4B Provision of wheelchairs is devolved to a multiplicity of providers, including the NHS where appropriate (for example for every complex provision)

Any cost reduction through competition is likely to be offset by the loss of bulk purchasing power by the NHS.

Option 4C No change to the current method of providing equipment

See above.

5. Maintenance of equipment

Option 5A Wheelchair centres continue to run the maintenance and repair system, but with a programme of planned preventive maintenance (PPM) introduced in all centres

PPM would be an important development that would also maintain contact with the user and allow minor difficulties to be resolved before they escalated. With an appropriate tracking system it may be possible to combine this with Option 3.4A, improved follow-ups.

Option 5B NHS contracts out all minor repairs to accredited local providers for example, garages and bicycle repair shops. This could be combined with PPM run by wheelchair centres

This would be helpful – minor repairs could be carried out locally. We know of many examples where a wheelchair or wheelchair mounting repair has to wait for many months for a wheelchair service representative. In some cases, repair was a relatively simple job.

Users could be encouraged to give a rating of how they find a local repair service. The information could then be used as a simple and direct way of monitoring performance.

Option 5C The entire maintenance and repair service is contracted out to external providers

It is difficult to see how an external service could be more efficient and effective when profits still have to be made by that company. An important consideration is that if this route is adopted, and it fails, it will be more difficult to return to the present position or to improve on the present position. Also, such companies will be subject to market forces and subject to take over.

Option 5D No change to the current method of maintaining equipment

See above. The comments below would caution against the status quo.

Getting parts that were required for a wheelchair took ages, it was quicker to go to an external resource though this would cost the family additional cost.

Who fixes electric chairs if bought privately, be good to have contacts list of local fix-it places, e.g. so not left stranded. Days or weeks without a chair are unacceptable.

6. Gap analysis of equipment provision

We agree with the areas listed on page 20.

Additional gaps

As described in our general comments section, there is a need to take a more integrated systems approach. While this may appear to be identical with taking a more holistic approach, in our view the term 'holistic' is used in a rather narrower sense in the consultation report..

7. Staffing

Option 7.1A NHS Education for Scotland should conduct a Training Needs Analysis for wheelchair services

Preferred option. We also suggest that it would be helpful to include the option of secondments for training. This could for example help to drive a more inter-agency, better integrated system of service delivery.

Option 7.1B No change to the current staff training opportunities

See above.

Option 7.2A Staffing based on national agreement while allowing flexibility

Preferred option.

Option 7.2B No change to the current staffing skill mix

See above.

8. Funding

We agree that increasing funding resources will need to be earmarked as population needs are changing. The principle of providing wheelchairs according to need should, however, remain the basis of funding.

8.1 Flexible funding

While flexible funding sounds attractive, encouraging a more integrated approach, it is difficult to appreciate the impact as 'flexible' could mean anything from means testing through to arguments over which particular service should pay for the additional component.

We are not in favour of a voucher scheme for a number of reasons. First, it would favour those who are better off, allowing them to subsidise the cost of more expensive wheelchairs. Second, the value of vouchers would remain static with an increasing proportion of the true cost passed on to the individual.

8.2 Leasing schemes

It is difficult to assess this option as, unlike Option 8.3 no indication is given of how a leased wheelchair would be funded. Currently a wheelchair is provided free through the NHS and remains its property. A proposal for a leasing scheme implies that additional cost would be borne by the individual. We would be against this as DLA / higher mobility component covers only basic car expense.

8.3 Hire purchase

With deductions at source, this proposal represents an additional tax on the user. We do not favour it as there is already strong evidence that the income of disabled people is far lower than that of the general population.

Scottish Executive Consultation responsee information form

Please detach, complete and submit with your response. This will help ensure that we handle your response appropriately:

Title of: NHS Review of Wheelchair and
consultation Special Seating Services in Scotland

Name: Dr Stuart Aitken

Address: **Sense Scotland**
5th Floor, 45 Finnieston Street, Glasgow G3 8JU

Responding as: an individual on behalf of a group or organisation?
Do you agree to your response being made public in Scottish Executive library
and/or on the Scottish Executive website)?
Yes No

Where confidentiality is not requested, we will publish your full response including
your name (and address, where provided). **If you do not wish for these personal
details to be published, please tick this box:**