

## **ScotRET Wheelchair Group**

### **Response to the consultation on the Wheelchair and Seating Service Modernisation Draft Action Plan**

**29<sup>th</sup> October 2008**

#### **General Comments**

At times the wording of the Action Plan implies that the services are starting from scratch and that many fundamental requirements of a clinical service are not already in place. On the contrary, staff members have over many years strived to provide a patient centred and professional service which is as efficient, effective and equitable as possible given the resources available.

We have found that many of the actions are open to interpretation and have, therefore, found it difficult to provide pertinent comment.

Overall, we think that greater urgency should be applied to all actions that have an impact on staff recruitment, retention and training. In this regard we draw your attention to the following quote from *Moving Forward* (page 137):

*“Attracting and retaining staff is a key issue, which will undoubtedly constrain some of the development outlined in this paper; indeed, it could prevent some improvements not merely delay them. The status of the service and lack of training and career progression are key issues. Unless this is addressed, NHS service providers will not be able to make the changes both they and service user want.”*

**Patient and User Involvement**

<b>Action</b>		<b>Who</b>	<b>By When</b>	<b>ScotRET Wheelchair Group Response</b>
1.	Each NHS Board must establish a wheelchair user and carer group as part of their PFPI structures and processes	NHS PFPI Leads; wheelchair users and their carers	June 2009	One group per centre (as Moving Forward recommendation 18) would be more practical and sustainable.
2.	National Procurement, as part of NSS will include wheelchair users views and feedback to inform product selection in accordance with PFPI	NHS, NSS, National Procurement	September 2009	Needs to be clearer that this refers to product selection for the national contracts rather than for individual patient's requirements.
3.	Each CHP will ensure that wheelchair users and their carers are appropriately represented in their local partnership forum to inform local service planning and development	CHPs	June 2009	Agree.

## Partnerships and Collaborations

Action	Who	By When	ScotRET Wheelchair Group Response
4. Professional leadership will be provided in each NHS Board for wheelchair mobility and associated postural management	NHS Boards; AHP Directors	March 2009	<p>Each centre manager already provides professional leadership for wheelchair mobility. Having this responsibility diluted amongst each Health Board and physical remote from the professional staff actually delivering the service would be detrimental to aims of the Action Plan.</p> <p>Having an interested “sponsor” at board level may be of benefit for each of the host Health Boards. This, however, need not be the AHP Director but could very well be the Director with responsibility for Healthcare Science or rehabilitation services.</p> <p>This appears to be a repeat of action 19 (Building Capacity).</p>
5. WSS centres will be part of the rehabilitation structure	NHS Boards	March 2009	Not sure what this means. Some centres' host Health Boards do not have a rehab. structure. Services need to be clinically aligned but not necessarily part of the same management structure.
6. WSS centres will develop referral pathways and protocols in partnership with other rehabilitation service providers to enhance MDT working	WSS Centres; Rehabilitation Services; Education providers	January 2010	This is part of ongoing continuous improvement and can not be considered to be time limited.
7. WSS centres will form partnerships with local health, education and social care services with a view to establishing case management approaches	WSS Centres; CHPs; local authority partners; Rehabilitation Coordinators	June 2010	This is part of ongoing continuous improvement and can not be considered to be time limited.

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8.	Opportunities for joint working between health and social care equipment services to develop capacity locally for managing wheelchair storage, decontamination and uplift of equipment should be explored	WSS Centres; CHPs; Local Authority Partners; Joint Equipment Stores	December 2009	It is sensible to explore the working relationships with joint equipment stores, but other opportunities, such as commercial, should also be looked at. Joint equipment stores do not exist everywhere, particularly in remote areas.
9.	Patient information will be developed in partnership with service users and other providers	WSS Centres; wheelchair users; voluntary organisations	December 2009	This is already in place, but there will always be a need to review information as services developed and as such can not be time limited.

### Service Redesign

Action		Who	By When	ScotRET Wheelchair Group Response
10.	Each WSS centre will have completed a rapid improvement event in one area of their service	WSS Project Manager; NHS Redesign Teams; WSS Centres	December 2008	Single one of rapid improvement events are of value but there needs to be support for an on-going process of continuous improvement.
11.	Learning and outcomes of the rapid improvement events will be shared between centres and teams	WSS HoS; NHS Redesign Teams; WSS Project Manager	January 2009	Agree and consider that there is a good case for a national conference to achieve this.

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12.	A learning needs analysis for staff development in improvement tools and techniques will be developed by each centre	WS HoS	March 2009	This is a host NHS Board responsibility rather than a HoS one.
13.	To support development and behavioural change, each WSS centre will develop a local action plan	WS HoS	March 2009	Unclear as whose behaviour needs to be changed and what is the evidence for changing behaviour. Staff have already demonstrated their willingness, capability and commitment to continuous improvement but have often been thwarted by more immediate service pressures and the lack of senior management support. We would expect each service to have a business case that addresses this and do not see the need for a separate local action plan.
14.	Improvement outcomes must be spread across and between services	NHS Boards, CEOs supported by WSS Project Manager	2011	Agree, but not every improvement outcome will be transferable. This should, like other actions, be imbedded in local sustainable continuous improvement programmes. Action should also be the responsibility of centre managers.
15.	A skill mix review to be carried out in each WSS centre to include medical, technical, therapy, administrative and scientific staff.	WS HoS; NES	March 2009	We would have expected each centre to have considered their staff mix as they have developed their business cases. We would also consider that the staff skill mix should be reviewed continuously.
16.	Outcomes will be measured using improvement measuring tools	WSS Centres supported by WSS Project Manager	2009	We would positively support the increased use of SMART outcome measures that can be demonstrated to add value for patients.
17.	NHS Boards will seek to optimize their rehabilitation technology services through shared use of resources across all rehabilitation technology services	NHS Boards	December 2009	We consider this to be more applicable to infrastructure than other resources. The integrated model supports this (see comments on Building Capacity).

18.	As part of the patient journey, WSS centres will work towards meeting the overall RTT of 18 weeks	WSS Centres; NHS Boards	2011	We consider this to be an important target, but that it will require the overcoming of many practical challenges particular in relation to provision of special seating.
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## Building Capacity

We are particularly concerned that the proposed tiered model of service (page 12) is open to the interpretation that the current services should be dismantled and replaced, for the most part, by community-based, non-centre staff and facilities. We consider that the best model is an integrated one with assessment and provision predominantly by staff employed within the existing services, with the support of non-centre referrers at Tier I and prescription by trained, authorized, non-centre staff for a proportion of patients at in Tiers I and II (see Figure 1).

Over recent years, all the services have been moving towards a more integrated model of service delivery. This includes assessment, prescription, purchasing, fabrication, delivery, repairs and refurbishment. It also extends to other Rehabilitation Technology Services such as Prosthetics and Orthotics and particularly to Electronic Assistive Technology where there is considerable overlap of provision. This is in line with Action 17 (NHS Boards will seek to optimize their rehabilitation technology services through shared use of resources across all rehabilitation technology services). This level of integration appears to minimise discontinuities, duplications and bureaucracy in the service making it more efficient and user friendly. Any plans to change the way wheelchair and seating services are planned and provided would need to take account of the effect on other rehabilitation technology services.

There are many different examples of fragmented services in the UK including the fragmentation of wheelchairs from seating, children's services from adult services, powered wheelchairs from manual, assessment from provision, purchasing decisions from maintenance responsibilities. In many of these services one part may work very well but there is no evidence to support the case that any of these fragmented services provide a more efficient or user friendly service than the integrated model. Most of the services in Scotland have found it beneficial to move towards greater integration with facilities and expertise being shared across services. Indeed, Edinburgh has just made a significant investment in accommodation and time to bring the various parts of its service together.

Wheelchair services currently see only 25 to 50% of the people referred to them, typically the more complex cases. Depending on the centre, 50 to 75% of referrals are assessed and provided with equipment based on the information submitted by community staff. Additionally, some services authorize some experienced hospital and community-based nurses and therapists to prescribe a limited range of wheelchairs. This approach has clear attractions of reducing the demand on clinical staff, speeds up provision and integrates

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the different agencies involved with these patients. The approach is, however, limited by the skills and experience of the referrers. Currently, centre staff need to screen carefully all referrals in view of the frequency of incorrect or incompatible information. Expanding the scope of non-centre staff may be beneficial, but will require additional training for referring staff and authorized prescribers. This issue would be partly address by Action 13 (WSS centres will develop training for referrers to the service in partnership with them). Ideally the relevant centre staff should carry out this training to ensure it is consistent with local practices. However, this will require extra staff for this purpose. It may also have staffing implications for the Local Authorities and Health Boards as they may require further staff to carry out these referring/prescribing roles.

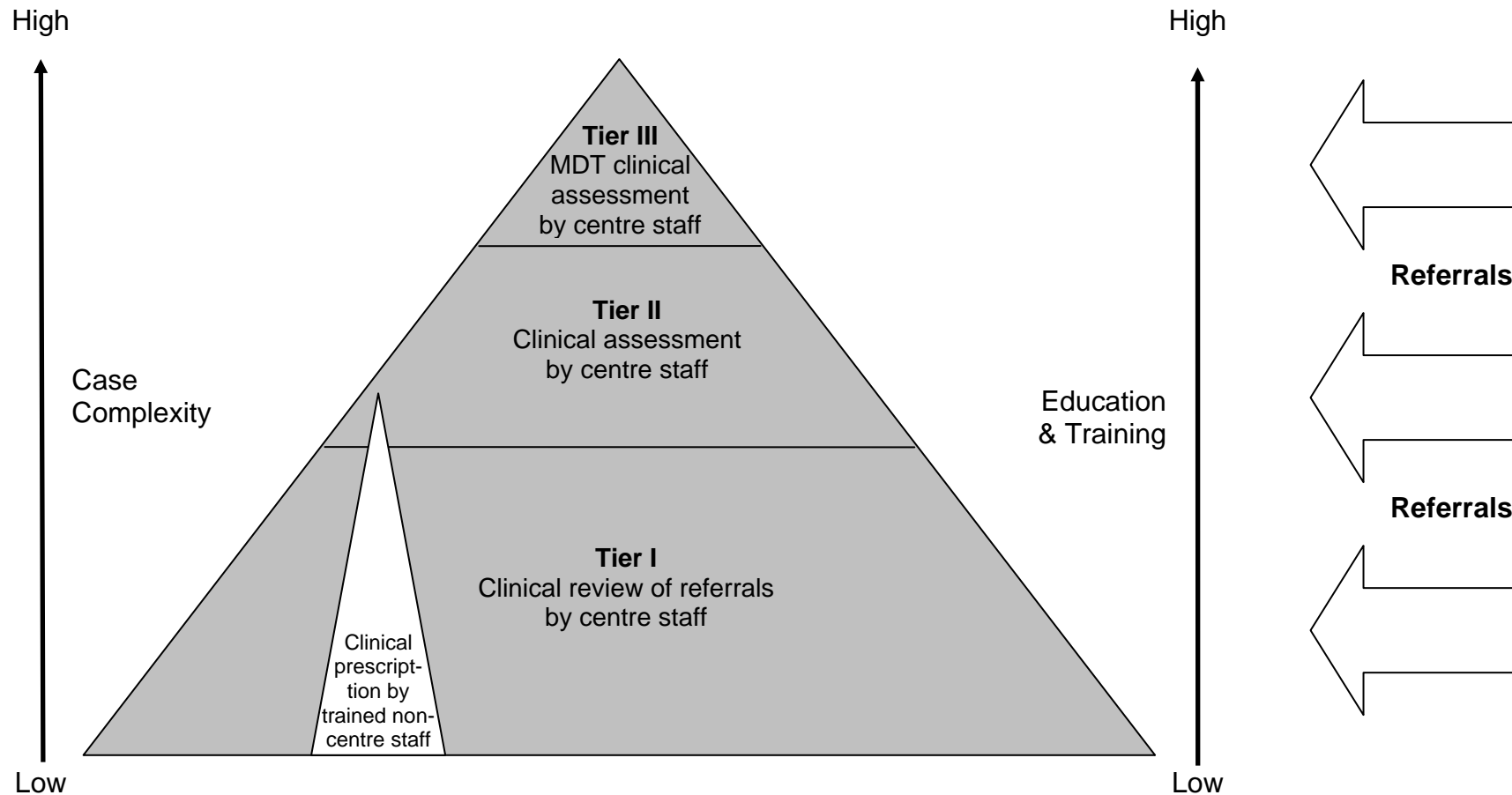


Figure 1 - Integrated Tiered Model.

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It would be expected that allowing community-based staff to prescribe wheelchairs would have a significant impact on the cost of the service and may have a catastrophic effect on service provision to the more clinically complex patients. There may also be additional problems of the safety and performance of repairer services and fleet management issues to be addressed.

The tiered model with existing centres providing only Tier 3 (as Action Plan model) would run counter to the desire to offer a smooth and seamless provision for users and carers. This is illustrated by the comparison this model and the integrated model against the six dimensions of quality in the table below.

<b>Six Dimensions of Quality</b>	<b>Tiered Model as Action Plan (with existing centres providing only Tier 3)</b>	<b>Integrated Tiered Model as Figure 1 (with integrated provision by centres)</b>
<b>Patient centred</b> Providing care that is responsive to individual patient preferences, needs and values and assuring that patient values guide all clinical decisions.	Service standards would be highly variable depending on the knowledge, experience, interests and continuity of community staff. As patients needs change they would not have a single point of contact leading to delays.	Service standards would be controlled and delivered in an easily accessible and efficient manner directly to patients.
<b>Safe</b> Avoiding injury to patients from care that is intended to help them.	Frequent changes in community staff and their lack of in depth understanding of changing needs in relation to the whole gamut of pathologies could result in highly risky prescribing. Community staff would not have the capacity to keep up to date with MHRA action notices and rapidly changing equipment.	Centres operate within risk management frameworks guided by and meeting the requirements of the legally binding requirements of the Medical Devices Directive and MHRA action notices to minimise the possibility of injury.
<b>Effective</b> Providing services based on scientific knowledge.	Ensuring that thousands of community based staff are suitably up to date would be near impossible and would be detrimental to ensuring that equipment prescribed remains up to date.	The integrated model allows for staff to gain and maintain knowledge of evidence based practise.
<b>Efficient</b> Avoiding waste, including waste of equipment, supplies, ideas and energy.	Resources and expertise would be diluted resulting in inefficient and incorrect prescribing of equipment.	The integrated model allows for the efficient use of resources (drawing on economies of scale) and the harnessing of ideas and expertise with peer support.

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<p><b>Equitable</b> Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status.</p>	<p>Service standards could be developed but centres would not be in a position to monitor or even be aware of inequitable care.</p>	<p>Service standards and the monitoring of these standards would ensure equity of care.</p>
<p><b>Timely</b> Reducing waits and sometimes harmful delays for both those who receive care and those who give care.</p>	<p>Creating artificial barriers between levels of need would result in delays and patients becoming lost in the community with community staff not recognising when patients progressive conditions need to be escalated up to more specialist staff until after harm has been done.</p>	<p>Integrated case management approach of the centres would ensure that delays are minimised and that those with progressive conditions can be offered clinical reviews. Pooled expertise at the centres would ensure that changing demands can be met and that staff can be redeployed to cover for absences.</p>

Action	Who	By When	ScotRET Wheelchair Group Response
19.	Professional leadership responsibility for wheelchair and seating services will be provided by an AHP Director in each NHS Board.	NHS Boards	<p>June 2009</p> <p>Each centre manager already provides professional leadership for wheelchair mobility. Having this responsibility diluted amongst each Health Board and physical remote from the professional staff actually delivering the service would be detrimental to aims of the Action Plan.</p> <p>Having an interested “sponsor” at board level may be of benefit for each of the host Health Boards. This, however, need not be the AHP Director but could very well be the Director with responsibility for Healthcare Science or rehabilitation services.</p> <p>This appears to be a repeat of Action 4 (Partnerships and Collaborations).</p>

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20.	Each NHS Board will put in place separate local wheelchair and seating clinics for children and for adults. Local clinics will be supported by WSS Centres	NHS Boards; WSS Centres	January 2010	We support this principle and services are already delivering separate clinics. Local children's clinics need to be supported, where appropriate, by schools. Also, each local clinic needs to be supported by sufficient demand and local facilities to ensure its viability and that do not run in conflict with other objectives (e.g. 18 week RTT target).
21.	NHS Boards will work in partnership with transport providers to ensure adequate transport arrangements are in place for access to wheelchair clinics	NHS Boards; WSS Centres; SAS	January 2010	We welcome this aspiration, but extensive discussions in the past have led to little, if any, improvement in transportation services. It is our understanding that SAS classify our services as the lowest priority leading to frequent cancellations and delays.
22.	Protocols for assessment and issue of wheelchairs will be developed to support the delivery of local wheelchair and seating clinics	NHS Boards; WSS HoS	December 2009	Whilst this concept is admirable it will depend on the overall operational model of service.
23.	Protocols for assessment and issue of wheelchairs will be developed with a specific view to reduce waiting times for users with progressive conditions	NHS Boards; WSS Centres	December 2009	We are working towards protocols that reduce waiting times for all users (i.e. RTT 18 weeks). For patients with progressive conditions there needs to be a commitment to provide scheduled clinical reviews to ensure that their changing needs are correctly anticipated and addressed.
24.	Practitioners with a special interest will be trained and developed to provide clinical expertise locally	NHS Boards; AHP Directors	January 2010	We are concerned that this would not be sustainable due to the volume and turnover of local staff. We consider that it would be more effective and efficient to employ staff within the centres to provide local expertise.

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25.	The education and training needs of technical and scientific support staff in wheelchair services will be identified and developments linked to support worker and assistant practitioners in health care science	CHPO; NES	December 2010	Agree, but we see this as being a more urgent priority as staff are needed to deliver the actions with deadlines prior to December 2010.
26.	Training needs for registered clinical and scientific staff will be identified and education programmes developed in line with the national agenda for Healthcare Scientist education and training	CHPO; NES; WSS Centres	December 2010	Agree, but we see this as being a more urgent priority as staff are needed to deliver the actions with deadlines prior to December 2010.
27.	Training and education will support the development of career paths for wheelchair and seating service and related staff within the NHS Scotland Career Framework	CHPO; NES	June 2011	Agree, but we see this as being a more urgent priority as staff are needed to deliver the actions with deadlines prior to June 2011.

**Referral**

<b>Action</b>	<b>Who</b>	<b>By When</b>	<b>ScotRET Wheelchair Group Response</b>
28. WSS will accept referrals from registered health care professionals and Occupational Therapists in social care without approval from a medical doctor	WSS Centres; Local Authorities	March 2009	Agree that referrals should be accepted from currently registered healthcare professionals, but first referrals should be acknowledge to GPs. Please note that this wording implies wrongly that social work OTs are not registered.

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29.	Onward referral pathways to other health and social care services will be developed for those who need them.	WSS Centres; CHPs; Health, Education and Social Care providers	2010	Agree.
30.	Existing wheelchair users shall self refer directly to the WSS centres for review and re-assessment	WSS Centres	January 2009	Already existing practice.
31.	WSS centres will develop training for referrers to the service in partnership with them	WSS Centres; CHPs; Local Authorities	March 2009	Agree and partly in place but need increasing in frequency and scope.

### Assessment

Action	Who	By When	ScotRET Wheelchair Group Response
32. Wheelchair and seating services will develop a standard assessment tool	WSS Centres; Professional Bodies	2010	We are not convinced that a single blanket approach can capture the needs of patients with widely varying conditions and requirements. Different assessment tools may be required to be developed locally to suit different staff skill mixes and individual patient requirements, particularly in new areas of service. Experience has shown that generic assessment tools are often cumbersome and can quickly become outdated.

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33.	MDT approaches to assessment and care planning should be introduced in partnership with health and social care teams	WSS Centres, Health, Social Care and Education Services	March 2010	Already in place but may require further development.
34.	Alternative pathways for provision of standard issue equipment should be explored with other health and social care equipment providers	CHPs; WSS Centres	2010	We believe this action is already well addressed. The main text says “established” not “explored”; which is correct? Alternatives should only be adopted if there is clear evidence that there are beneficial. Commercial alternatives should not be overlooked.
35.	Carer needs must be identified and solutions found through case management and partnership approaches to provision	WSS Centres, CHPs; Health, Education and Social Care providers	2010	Agree that carers’ needs need to be addressed, but not when these conflict with patients’ needs. Action unclear as to who would be responsible to meet the identified need.

**Provision**

<b>Action</b>	<b>Who</b>	<b>By When</b>	<b>ScotRET Wheelchair Group Response</b>
36. New national eligibility criteria within context of other health and social care equipment provision must be developed	Scottish Government; NHS Boards	October 2010	Agree but patients will feel that this should be looked at more urgently, i.e. April 2009 to ensure that addressed with the increased funding in 2009/10. There should be consideration to replacing the criteria with a risk assessment. Once decided upon there needs to be a commitment to finance the outcome.

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37.	Service level agreements with local nursing and care home providers for non specific use transit chairs should be developed	WSS Centres, Nursing and Care Home providers	June 2009	Care Commission and Scottish Government needs to be added to Who. There is a need for national guidance on what the remit of the wheelchair services are in this regard to ensure that provision is equitable across Scotland.
38.	Decision making for the provision and supply of wheelchairs will be supported by evidence of non financial aspects of equipment provision.	NHS NSS, National Procurement; WSS Centres	December 2009	We are unsure how this defers from current practice. The national contracts are not awarded solely on financial criteria. Services and staff would welcome the opportunity to improve the decision making process but have struggled to release staff to participate more fully.

**Delivery**

<b>Action</b>		<b>Who</b>	<b>By When</b>	<b>ScotRET Wheelchair Group Response</b>
39.	Written information must be provided to users on delivery of equipment and must comply with SAIF	WSS Centres	December 2009	Agree.
40.	Information and demonstration of equipment use must be provided on delivery	WSS Centres	December 2009	Agree.

## Equipment, Repairs and Maintenance

Action		Who	By When	ScotRET Wheelchair Group Response
41.	WSS Centres will modernise equipment and renew the wheelchair fleet in relation to current demand and technological advances	NHS Boards; WSS Centres	December 2010	Agree but think there should be national guidance or standards to ensure equitable provision across Scotland.
42.	A model of fleet renewal will be developed that is responsive to new technology and changes in demand	NHS Boards; WSS Centres	March 2011	Agree but think there should be national guidance or standards to ensure equitable provision across Scotland.
43.	Planned Preventative Maintenance programmes will be introduced to all centres for power chairs, heavy users and active users in the first instance	WSS Centres	December 2009	Agree but think there should be national guidance or standards to ensure equitable provision across Scotland. It will be necessary to define what is meant by heavy and active users. A separate action should be added to expand PPM to other users, by say December 2010.
44.	NHS wheelchair repair and maintenance services should explore providing an extended hours service in response to local need	WSS Centres	December 2009	Agree but think there should be national guidance or standards to ensure equitable provision across Scotland.

## IT and Information Management

Action		Who	By When	ScotRET Wheelchair Group Response
45.	An options appraisal of IT support needs will be carried out	NSS NISG	January 2009	Agree.

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46.	A national eHealth action plan needs to be agreed with eHealth Leads to take forward work identified in the options appraisal.	CHPO; WSS Project Manager ISD; NHS eHealth Leads; WSS Centres	March 2009	Agree.
47.	Clinical data standards and data definitions will be developed for wheelchair and seating services	CHPO; ISD; WSS Project Manager; eHealth Leads	December 2009	Agree but need to involve WSS Centres.

**Quality and Governance**

<b>Action</b>		<b>Who</b>	<b>By When</b>	<b>ScotRET Wheelchair Group Response</b>
48.	National service and clinical standards will be developed for WSS	WSS Centres; WSS Project Manager	December 2010	Agree but should be achieved earlier.
49.	Each WSS centre will identify a clinical lead for quality to support standards development and implementation	WSS HoS	March 2009	Agree.
50.	Detailed service level agreements for wheelchair and associated seating provision from each WSS centre must be in place	NHS Board; NHS Finance Directors	June 2010	Need NHS Board consortium level agreements to avoid postcode lottery.