SCOTTISH GOVERNMENT HEALTH AND SOCIAL CARE DIRECTORATES
THE QUALITY UNIT
HEALTHCARE PLANNING DIVISION

NHS Scotland Wheelchair Modernisation Delivery Group

WHEELCHAIR & SEATING SERVICES QUALITY IMPROVEMENT FRAMEWORK

Background

1. NHS Scotland Wheelchair and Seating Services (WSSs) provide a broad range of wheelchairs and postural support equipment for people with widely varying complexities of need. They aim to provide a comprehensive service to people who have mobility impairments, including the consideration of function, posture, pressure relief and comfort. They support people's mobility and independent living in their own home to help enhance their and their carers' quality of life. They provide not only initial provision of the equipment, but ongoing support; in most cases for the lifetime of the user. Seating is provided to those who need additional support in their wheelchair due to postural instability or irregular body shape. Many wheelchair users, and especially those with special seating requirements, are effectively in a continuum of care that is punctuated by specific episodes of intervention.

2. To maintain momentum and continue improvement in these services, following the £16m modernisation programme, NHS Boards will wish to be assured that ongoing care is of the highest quality possible and sustainable. In that context these services (and the wider re-enablement services) are particularly relevant to delivering the 20:20 Vision (Annex A) by supporting people in living longer, healthier lives at home or in a homely setting[1].

Development of Clinical Healthcare Quality Standards

3. As part of the WSS modernisation project quality standards were developed by a group with clinical, user and carer and third sector involvement. The Wheelchair Modernisation Delivery Group welcomed the Clinical Healthcare Quality Standards (CHQS) (Annex B) as a useful tool for local service improvement but noted concern that measuring all criteria may place an undue burden on WSS and detracts from time for clinical care. In order to recognise the importance of the CHQS and measuring improvement it was suggested that a Quality Improvement Framework be developed. The CHQS underpinned the development of this Quality Improvement Framework which is designed to support the delivery of WSSs in accordance with NHS Scotland's *Healthcare Quality Strategy*[2]. It is therefore envisaged that NHS Board WSSs will work towards delivering this vision through the five overarching objectives in the CHQS (Annex B).

4. It will be a matter for NHS Boards to determine the extent to which it is possible and beneficial to self assess services against all of the criteria set out in the CHQS. This may be the aim over time as, for example, data capture systems are developed and/or improved to ease the burden of data collection and analysis on front line staff and release as much time as possible for clinical care.

[1] Achieving Sustainable Quality in Scotland's Healthcare, a 20:20 vision, Edinburgh, 2011 (see appendix A)
[2] *The Healthcare Quality Strategy for NHS Scotland*, Edinburgh, 2010.

5. The Quality Improvement Framework contains 9 Quality Ambitions for Wheelchair Services statements which represent key elements of a quality service. The Quality Ambitions for Wheelchair Services will be challenging to achieve in their entirety but the most important outcome of measurement against these ambitions will be the demonstration of continual quality improvement and commitment to providing excellence in care to users of the service.

Healthcare Scrutiny Model

6. The Quality Improvement Framework uses a Healthcare Scrutiny Model to provide risk-based and proportionate scrutiny to recognise and learn from good practice and effective systems and to focus on key improvement areas. In the context of WSSs, the model has three key elements:

- The Quality Improvement Framework
- The Clinical Healthcare Quality Standards (CHQS)
- The Clinical Healthcare Quality Standards (CHQS) Evaluation Tool

7. The Quality Ambitions for Wheelchair Services bring together information about performance that can be used to prompt any necessary scrutiny activity. In this way they present an estimate of risk that expected service levels may not be consistently achieved and guide toward scrutiny and inspection.

8. The CHQS consists of person-focused and evidence-based standards that set out the best practise requirements for WSSs. The CHQS Evaluation Tool (Annex C) can be used for self-assessment by services to identify priority areas for improvement, highlight areas of good practise, and determine if further quality improvement activity is required.

9. It is recognised that WSSs should also adhere to national and local strategies and targets that will support and assist these services as they seek to achieve the Quality Ambitions for Wheelchair Services and the wider NHS Scotland Quality Ambitions. Each WSS may therefore wish to add their own supplementary Quality Ambitions for Wheelchair Services to the annual assessment on an ongoing basis or for short periods to support specific developments.

Quality Ambitions for Wheelchair Services

10. Nine Quality Ambitions for Wheelchair Services have been developed, based on the criteria within the CHQS and are noted below.

11. These Quality Ambitions for Wheelchair Services support the three NHS Scotland Quality Ambitions[3] (Annex D) that provide the focus for everything NHS Scotland does in its aim to deliver the best quality healthcare to the people of Scotland and, through this, make NHS Scotland a world leader in healthcare quality.

12. The Quality Ambitions for Wheelchair Services have been aligned to the NHS Scotland Quality Strategy and to the relevant CHQS Standard(s), however, as CHQS Standard 1 relates to pre-referral to WSS it is not currently possible for services to self assess against it. However, over time, as further integration of health and social care services progresses and opportunities for collaborative working and joint consideration of patients' mobility needs develop it should hopefully be possible to do so.

[3] NHS Scotland Healthcare Quality Strategy: The Quality Ambitions, Edinburgh, 2010

Quality Ambitions for Wheelchair Services

Person Centred

13. NHS Scotland Quality Ambition - There will be mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

Quality Ambition for Wheelchair Services		**May wish to evidence by**	**Related CHQS**
1	Specialist assessments are person-centred and anticipatory, and based on the factors detailed in the CHQS, annex B	User/ carer engagement and random sampling of patient notes	2
2	Specialist assessments are conducted within 4 weeks of referral in at least 95% of cases and within 8 weeks for 100% of cases.	Figures recorded in local IT system	2
3	85% of clinical appointments should be conducted in user's own NHS Board area where it is possible to do so.	Figures recorded in local IT system	2
4	Accessible information about services should be readily available to disabled people, their families and carers, and other interested stakeholders.	Copies of documents, etc. and user/ carer engagement	4

Effective

14. NHS Scotland Quality Ambition - The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

Quality Ambition for Wheelchair Services		**May wish to evidence by**	**Related CHQS**
5	All patients should be contacted at least once a year and planned clinical reviews scheduled where appropriate. Users and carers should also be made aware of how to request a review at other times if they feel it appropriate.	Figures recorded in local IT system and User/ carer engagement and random sampling of patient notes	3 & 4
6	Standard provision, for which a specialist assessment was not required, is provided within 2 weeks of referral in at least 95% of cases and within 3 weeks for 100% of cases	Figures recorded in local IT system	4

7	Following a specialist assessment, provision is within 14 weeks of referral in at least 95% of cases and within 18 weeks for 100% of cases.	Figures recorded in local IT system	4

Safe

15. NHS Scotland Quality Ambition - There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

Quality Ambition for Wheelchair Services		**May wish to evidence by**	**Related CHQS**
8	Centres should be aware of the percentage of currently issued wheelchairs over 5 years old and the percentage of stock wheelchairs over 5 years old. A model of equipment renewal is in place that responds to technological advances and involves users and carers	Figures recorded in local IT system and procurement plans	4
9	75% of urgent repairs completed within one day and 90% of routine repairs completed within five days.	Figures recorded in local IT system	4

Notes
All times are from the point of receipt of a referral by the WSS that contains all essential information in accordance with the CHQS.
The targets given are calendar days, not working days.
For definitions of terminology see the full CHQS.

Assessment of Quality Ambitions for Wheelchair Services

16. To provide local (NHS Board) assurance of the quality of services, it is recommended that WSS should aim to self assess performance against the Quality Ambitions for Wheelchair Services at least annually (following establishment of an initial baseline). The outcome of this assessment should be reported through routine channels to the Health Board Governance committee or other appropriate forum as agreed locally.

17. NHS Boards/services may wish to measure performance on a more regular basis throughout the year to ensure ongoing quality improvement locally. Boards/ services may also find it helpful to utilise measures from the full CHQS, as appropriate, in conjunction with the assessment of the Quality Ambitions for Wheelchair Services, to provide evidence of quality improvement and underpin benchmarking across Scotland.

18. It is also recommended that services should engage with users at least once every two years to check their and their carers' satisfaction with the service provided and how well their equipment meets their needs. This engagement could be in the form of a survey of users.

Annexes

A. Achieving Sustainable Quality in Scotland's Healthcare, a 20:20 vision
B. Clinical Healthcare Quality Standards (CHQS)
C. CHQS Evaluation Tool
D. NHS Scotland Healthcare Quality Strategy: The Quality ambitions

Annex A

ACHIEVING SUSTAINABLE QUALITY IN SCOTLAND'S HEALTHCARE

A '20:20' Vision

Introduction

During the first month of the new Parliament, the Cabinet Secretary for Health, Wellbeing and Cities set out her strategic narrative and vision for achieving sustainable quality in the delivery of healthcare services across Scotland. The key messages contained in this narrative were discussed and agreed with NHS Scotland Board Chief Executives and Chairs and with Scottish Government Health and Social Care Management Board, and are set out in this document.

This strategic narrative now provides the context for taking forward the implementation of the Quality Strategy, and the required actions to improve efficiency and achieve financial sustainability. It is agreed that many of the actions required are urgent in order to respond to the immediate challenges and the need to simultaneously protect and improve quality. Everyone involved in the delivery of healthcare in Scotland is now asked to play their part in turning the vision into a reality.

Recent Progress in improving Quality

Significant progress has been made in recent years through impressive improvements in waiting times for access to high quality healthcare services and treatments. We have a world leading patient safety programme which is making a real difference to standards of care and to hospital mortality. We have made substantial progress on issues as varied as access to GPs and dentistry, support for people with long term conditions, outcomes for cancer, stroke and heart disease. We are producing improved outcomes for people in terms of reduced need for hospitalisation, shorter stays, faster recovery and longer life expectancy.

Through our Quality Strategy we have set ourselves three clearly articulated and widely accepted ambitions based on what people have told us they want from their NHS: care which is person-centred, safe and effective. We are already seeing real progress in terms of positive impacts for patients.

For example:

- Improvements in care for people with long term conditions have resulted in the avoidance in 2009/10 of over 125,000 bed days for people aged over 65.
- Improvements in safety in our hospitals have resulted in a 7% reduction in hospital standardised mortality rates since 2007.
- A reduction in the rates of Clostridium Difficile of over 70% since 2007.

Looking ahead – the Challenges

We all know that the demands for healthcare and the circumstances in which it will be delivered will be radically different in future years.
Over the next few years we must ensure that - in the face of these demands and changing circumstances - we can continue to provide the high quality health service the people of Scotland expect and deserve into the future.

In order to achieve this, we must collectively recognise and respond to the most immediate and significant challenges we face - which include Scotland's public health record, our changing demography and the economic environment.

Over the next 10 years the proportion of over 75s in Scotland's population – who are the highest users of NHS services - will increase by over 25%. By 2033 the number of people over 75 is likely to have increased by almost 60%. There will be a continuing shift in the pattern of disease towards long-term conditions, particularly with growing numbers of older people with multiple conditions and complex needs such as dementia. Over the next 20 years demography alone could increase expenditure on health and social care by over 70%.

Scottish public expenditure will fall in real terms in the period to 2014/15. The revenue position for the NHS has been relatively protected. However that vital protection needs to be seen in the context of the global pressures on health spending. To meet those pressures, health boards are working this year to release cash savings of £300 million to be retained locally.

We must be bold enough to visualise the NHS that will best meet the needs of the future in a way that is sustainable, and then make the changes necessary to turn that vision into reality.

Our Values

We remain committed to the values of NHSScotland: the values of collaboration and cooperation partnership working across NHSScotland, with patients and with the voluntary sector; of continued investment in the public sector rather than the private sector; of increased flexibility, provision of local services and of openness and accountability to the public. We oppose the route being considered in NHS England as their response to the global challenges.

Our '2020 Vision'

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Action Required

- We need a shared understanding with everyone involved in delivering healthcare services which sets out what they should expect in terms of support, involvement and reward alongside their commitment to strong visible and effective engagement and leadership which ensures a real shared ownership of the challenges and solutions.

- We need to develop a shared understanding with the people of Scotland which sets out what they should expect in terms of high quality healthcare services alongside their shared responsibility for prevention, anticipation, self management and appropriate use of both planned and unscheduled/ emergency healthcare services, ensuring that they are able to stay healthy, at home, or in a community setting as long as possible and appropriate.

- We need to secure integrated working between health and social care, and more effective working with other agencies and with the Third and Independent Sectors.

- We need to prioritise anticipatory care and preventative spend e.g. support for parenting and early years.

- We need to prioritise support for people to stay at home/in a homely setting as long as this is appropriate, and avoid the need for unplanned or emergency admission to hospital wherever possible.

- We need to make sure people are admitted to hospital only when it is not possible or appropriate to treat them in the community - and where someone does have to go to hospital, it should be as a day case where possible.

- Caring for more people in the community and doing more procedures as day cases where appropriate will result in a shift from acute to community-based care. This shift will be recognised as a positive improvement in the quality of our healthcare services, progress towards our vision and therefore the kind of service change we expect to see.

Scottish Government
NHSScotland
SEPTEMBER 2011

Annex B

Wheelchair & Seating Services Modernisation Project

Standards and Eligibility Working Group

CLINICAL HEALTHCARE QUALITY STANDARDS FOR WHEELCHAIR & SEATING SERVICES

These standards were developed by the Wheelchair & Seating Services Eligibility and Standards Working Group as part of a modernisation project. The standards were developed in line with the principles used by Quality Improvement Scotland (QIS):

- adopt an open and inclusive process involving a wide range of both members of the public and professional people through a variety of mechanisms;
- work within NHS QIS policies and procedures; and
- test standards through undertaking pilot reviews to ensure that they meet the principles of NHS QIS.

It should be noted, however, that these standards are being issued as good practice recommendations rather than mandatory guidelines and should be used appropriately to support NHS Boards in improving services locally.

The Clinical Healthcare Quality Standards for Wheelchair & Seating Services should be read in conjunction with the Wheelchair & Seating Services Quality Improvement Framework

Annex B

CLINICAL HEALTHCARE QUALITY STANDARDS

Contents

1. Introduction

Wheelchair and seating provision affects quality of life, health and well-being and is important in facilitating social inclusion and improving life chances. Changes to mobility and posture bring challenges to people living with a variety of conditions and these can be life-long and life-limiting. These impairments impact on people's ability to lead active and full lives with dignity and autonomy. Wheelchairs and seating can enable greater activity, including wider participation in work, education and society as a whole, and produce health benefits (for both wheelchair users and their carers).

Wheelchair users are not a homogeneous group. They have a great variety of physical and sensory impairments, which along with other needs and expectations can be either stable or subject to change over time. They include:

- children who often need better integration between education, health and social work services,
- young people who make the transition out of children's services at a time when their wheelchair and seating becomes increasingly important for further education and employment,
- people who have an accident or who develop a progressive condition that now affects their mobility,
- people whose medical condition makes them vulnerable to skin damage and pressure sores, and
- older people who develop the need to use a wheelchair to provide mobility for longer distances, e.g. when outside the home.

Wheelchair users also have a wide variety of carers with different needs, capabilities and involvement, from parents and other family members to friends and neighbours.

NHS Scotland Wheelchair and Seating Services (WSSs) provide a broad range of wheelchairs and postural support equipment for people with widely varying complexities of need. They aim to provide a comprehensive service to people who have mobility impairments, including the consideration of function, posture, pressure relief and comfort. They support people's mobility and independent living to help enhance their and their carers' quality of life. They offer not only initial provision of the equipment, but ongoing support; in most cases for the lifetime of the user. Seating is provided to those who need additional support in their wheelchair due to postural instability or irregular body shape. Many wheelchair users, and especially those with special seating requirements, are effectively in a continuum of care that is punctuated by specific episodes of intervention.

WSSs work in collaboration with other, health and social work based, rehabilitation services to ensure that wheelchair mobility and postural needs are managed effectively as part of an integrated care management approach. It is essential that these services form an integral part of care pathways within and between agencies, to ensure the support they provide offers smooth and seamless provision for users and their carers.

In Scotland there are currently five WSS centres. These are located in Aberdeen (NHS Grampian), Dundee (NHS Tayside), Edinburgh (NHS Lothian), Glasgow (NHS Greater Glasgow and Clyde) and Inverness (NHS Highland). They provide specialist, integrated services for children and adults that includes specialist assessments, review, provision, follow up, maintenance and repairs, to people living in their own NHS Board area. Four of the centres also provide specialist services to other territorial NHS Boards.

2. Development

Background

The development of clinical healthcare quality standards for WSSs builds on the Scottish Government's (SG) previous work in this area. In 2005, a Steering Group was established, supported by the Scottish Executive Health Department and NHS Quality Improvement Scotland (QIS), to conduct an independent review of WSSs in Scotland. This cumulated in the publication of the *Moving Forward* report in 2006 [1]. The report highlighted a chronic lack of profile and under-resourcing, set against a background of an increasing wheelchair user population and greater expectations. A situation reflected in other parts of the UK [2]. In response, the Scottish Government (SG) established the WSS Project Board to take forward the review's recommendations [3]. In 2009, the *Wheelchair and Seating Services Modernisation Action Plan* was published [4]. The *Action Plan* set out the direction of travel for the WSSs in Scotland over a 3-year period, forming a programme of service modernisation, intended to introduce service and practice change in keeping with the person-centred approach that is core to the SG's commitment to developing health services with users as partners.

Working Group

A Working Group was convened in January 2010 to develop the standards. When establishing the Working Group, the WSS Project Board ensured, where possible, representation was drawn from across Scotland and included as many healthcare professions as necessary. The group also included user, carer and voluntary sector representatives. All members were obliged to liaise regularly with the group(s) and/or organisation(s) that they represented; communicating updates, discussing points, canvassing views and feeding these back to the Working Group.

Dr Michael J. Dolan was recruited as a Clinical Advisor to lead the work of the group. Dr Dolan, a clinical scientist based in NHS Lothian, took up his post in February 2010. Mr Richard Hamer, Director of External Affairs, Capability Scotland, was appointed as Chair of the Working Group.

To support the Working Group and provide input from people with a broader range of knowledge and experience from across the UK, a Reference Group was recruited. Their remit was to sense check the standards and evaluation tool before publication.

The methodology employed to develop the standards is set out in Appendix A. The Working Group membership is set out in Appendix B.

Context

It was recognised that the development of clinical healthcare quality standards that are evidence-based and person-centred must be set within the context of the wider desire to provide a health service that is "safer, more reliable, more anticipatory and more integrated, as well as being quicker still" [5]. The SG's *Better Health, Better Care* report proposed the adoption of the Institute of Medicine's six *Dimensions of Quality* [6] as key to the systematic improvement of services. The dimensions are:

- **Person-centred**: providing care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions
- **Safe**: avoiding injuries to patients from care that is intended to help them
- **Effective**: providing services based on scientific knowledge

- **Efficient**: avoiding waste, including waste of equipment, supplies, ideas, and energy
- **Equitable**: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socioeconomic status
- **Timely**: reducing waits and sometimes harmful delays for both those who receive care and those who give care

Each criterion within the standards is applicable to at least one of these quality dimensions.

The SG's new *The Healthcare Quality Strategy for NHSScotland* [7] sets out the need to concentrate action and interventions on three of these dimensions:

- Put **people at the centre** of care and ensure that all staff, patients and carers can report that they are supported to work together in a relationship which recognises their needs and plans to deliver care to meet those needs
- Improve **clinical effectiveness**, with a focus on reducing unnecessary and harmful variation in the models and methods of delivering care and treatment, and on the standards of care for long-term conditions
- Improve **safety** throughout primary, community, and acute services, achieving significant reductions in mortality and adverse events

The SG's focus for action will be on these three key drivers, but there is a commitment to pursuing these in a way which ensures equity, efficiency and timely access.

Within the context of WSSs, the independent report, *Moving Forward* [1], established the need for improvements in services. The *Action Plan* [4] for service modernisation is being implemented by NHS Boards to ensure more integrated services are in place to meet the needs of wheelchair users and their carers. It identifies those areas of service delivery where improvement is needed and charges accountable NHS personnel with delivering the required changes. The standards are critical to supporting change and ensuring that improvements are sustained.

The Development of the Draft Clinical Standards and Evaluation Tool

Between February and April 2010, a scoping exercise was led by Dr Dolan. The purpose of this was to identify any quality gaps and make recommendations on how the process could be taken forward. The scoping exercise consisted of a review of the current research and clinical literature and other available evidence, including the *Moving Forward* report [1] and the *Wheelchair and Seating Services Modernisation Action Plan* [4]. Both these documents were produced following extensive consultation with wheelchair users and their carers, the voluntary sector and the wider public in Scotland.

The overall aim of the Working Group was to develop evidence-based standards that quality assure NHS Scotland WSSs. When developing the standards, the Working Group made the decision to focus on areas that would help improve the WSSs the most. A person-centred approach was used to identify themes and areas of concern. In particular the disabled person's journey through and with the service was employed and the supporting structures were considered.

An internal report summarising the scoping process and findings, was produced to inform the development of relevant standards and associated project management

processes. The report identified a number of areas for consideration and emerging themes. The report was used as a basis for the Working Group to develop the draft standards and the draft evaluation tool. During this time, members of the Reference Group were recruited to sense check the drafts before their publication.

Consultation and piloting

The Draft Clinical Standards and Evaluation Tool were published on 3rd December 2010 at the start of a 12 week long public consultation [8]. The purpose of this consultation was to secure the views of stakeholders and members of the public in advance of the final publication of the Standards and Evaluation Tool and to afford them the opportunity to influence the detail of the documents.

In addition, two NHS Boards (NHS Grampian and NHS Highland) were peer reviewed against the Draft Evaluation Tool in a pilot exercise in January 2011. The purpose of this was to test the measurability of the standards and identify possible sources of evidence to support compliance and to check how a review might work in practice (e.g. whether the right questions are being asked to the appropriate people).

Finalising the Standards and Evaluation Tool

A wide range of organisations and individuals responded to the Scottish Government consultation on the Draft Clinical Standards and Evaluation Tool for NHS Scotland WSSs. The majority of the responses were supportive, recognising the need to encourage and measure improvements, and highlighted the need for a consistent approach to the delivery of these services across Scotland. The consultation responses and a consultation analysis report have been published [9, 10].

The consultation responses were considered, along with the outcomes from the piloting of the Evaluation Tool, by the Working Group and, where appropriate, used to develop the final versions.

The final versions have been tailored to fit with a Healthcare Scrutiny Model that provides risk-based and proportionate scrutiny.

3. Scope

The standards apply to all territorial NHS Boards in Scotland, regardless of whether or not the board hosts a WSS centre. They apply to any care setting within an NHS Board where wheelchair services are provided including primary, secondary and tertiary care, and to anyone using the services regardless of a person's background or personal circumstances.

The following special health boards and non department public bodies will not be directly reviewed against the standards, but the development of the standards may have implications for them:

- Healthcare Improvement Scotland
- NHS 24
- NHS Education for Scotland
- NHS Health Scotland
- NHS National Services Scotland (in particular National Procurement and Information Services Division)

The standards are intended to support equity of service provision across the NHS in Scotland and the delivery of quality services for users and their carers. The standards are not intended to tell NHS Boards how to arrange services as each board will develop solutions according to its local circumstances. The standards, therefore, focus on outcomes rather than processes.

Clinical professions

The standards apply to all clinical professions involved in the care of people with mobility impairments that require the use a wheelchair within the NHS Boards specified above, but also those that may be employed in local authority social services or in the voluntary sector. This includes general practitioners, physicians, nurses, allied health professionals (AHPs) and healthcare scientists (HCSs).

Wider applicability

The standards have been developed for NHS Scotland WSSs within the context set out in Section 2. It is recognised that aspects of these standards may be applicable to services based in other parts of the UK and elsewhere. However, these standards are developed to apply to the policy context, model of service delivery and national healthcare in Scotland.

4. Clinical Healthcare Quality Standards

The first four standards relate to the disabled person's journey through and with the NHS WSS, whilst the latter one is concerned with the supporting mechanisms and structures that underpin their journey. The relationship between the first four standards and the clinical decision making and provision processes is illustrated in the diagram in Appendix C. High level pathways with the target times set out in the standards are given in Appendix D.

Standard 1: Assessment of mobility and mobility needs

Standard Statement
The clinical assessment of mobility and mobility needs should be person-centred.
Rationale
The population of disabled people with mobility impairments that require wheelchairs is highly diverse with a great variety of physical and sensory impairments, which along with other needs and expectations can be either stable or subject to change over time. Mobility impairments are varied and wide-ranging in their complexity and associated issues and a wheelchair may only be part of a solution. A timely, person-centred assessment that is responsive to clinical needs and made within a framework of the Social Model of Disability is fundamental to ensuring that an individual's mobility needs are addressed. Disabled people may have carers who have different needs, capabilities and level of involvement. Assessments should cover the needs of carers with regular or substantial caring responsibility. Registered healthcare professionals assess mobility needs and identify or confirm the need for wheelchair assisted mobility, or a change to existing need. The initial assessment includes taking measurements and submitting a request for a wheelchair to be issued or for a specialist assessment. The initial assessor must be skilled in the assessment of mobility and mobility needs and aware of the range and type of wheelchair equipment available to meet the specific needs of the disabled person. Wheelchair need and provision should be recorded as part of the mobility assessment within the Single Shared Assessment (SSA) when the latter assessment is used. Children and young people are physically, mentally and socially distinct from their adult counterparts. The mobility impairments that they experience and the ways that certain illnesses and conditions can affect them are significantly different. Assessments of children and young people must be conducted by people trained in child development, employ multidisciplinary approaches and consider age-related transitions and educational needs. Accurate and clear information needs to be provided when wheelchair requests are made to ensure optimum outcomes and reduce unnecessary delays. Information governance and data protection standards, procedures and practises must be employed.
References[4]: 1, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20

Essential Criteria	
No.	Criteria statement
1.1	Clinical assessments of mobility and mobility needs are person-centred and anticipatory.
1.2	Assessments are conducted in accordance with evidence-based national or local good practice guidelines, where these exist.

[4] See numbered references listed in Appendix I.

1.3	Assessments are conducted by competent, registered clinical staff[5].
1.4	Assessments of children and young people should also: • address physical and social development • consider age-related transitions from pre-school to school, primary to secondary education, youth to adult services.
1.5	Assessments should consider the needs of primary carers[6].
1.6	Wheelchair need is recorded within the mobility section of the SSA when this assessment is used.
1.7	Referral forms (and supporting guidance) should conform to the recommended content and format (Appendix E) and be readily available.
1.8	Referral forms (and prescription forms if in use) can be submitted in a variety of formats, including electronically.

Desirable Criteria	
No.	Criteria statement
1.9	Any unmet mobility needs and/or any unresolved disagreements should be recorded.
1.10	Non-WSS Centre staff trained to an agreed level of competence should be able to directly prescribe from an agreed list of equipment.
1.11	Prescription forms (and supporting guidance) for use by non-WSS Centre staff should conform to the recommended content and format (Appendix E) and be readily available.

[5] Staff should have the level of knowledge, skills and experience appropriate to their role and be registered with the GMC, HPC or NMC.
[6] Under the Community Care & Health (Scotland) Act 2002, carers have a legal right to a carer's assessment from their local authority and the NHS and local authorities have a duty to inform carers of their rights.

Standard 2: Specialist assessment

Standard Statement

The specialist assessment of wheelchair and seating needs should be person-centred, anticipatory and conducted in the context of a multidisciplinary team.

Rationale

Disabled people's mobility needs can be complex and diverse and referrals for specialist assessment need to be screened by registered healthcare staff trained to an agreed level of competence. To minimise adverse effects resulting from delays to assessment and subsequent provision, referrals should be screened, prioritised and subsequently actioned within reasonable timescales. If delays are anticipated, referrers and those referred should be advised so that they may take steps to take mitigating action.

A timely, comprehensive and person-centred assessment is fundamental to ensuring that outcomes are improved. Specialist assessments should be conducted in accordance with evidence-based good practice guidelines by competent, registered clinical staff in the context of a Multidisciplinary Team (MDT) approach. Specialist knowledge and skills are required to assess disabled people who have complex clinical needs and/or require additional or complex technological solutions to address their mobility and associated seating needs effectively.

Assessments must be outcome-focused with goals agreed with the disabled person, and, if relevant, a primary carer. These should be recorded and shared, and appropriate measures administered to evaluate the effectiveness of intervention.

Healthcare clinical staff who assess for wheelchair mobility must have access to the necessary equipment. This may include portable investigative resources to support assessment at home or in other community settings. Disabled people with specific and complex needs should be seen in suitable clinic facilities with access to appropriate assessment resources and skills.

People requiring complex equipment solutions and/or have complex needs should be managed collaboratively by relevant health and social care services using case management approaches. This ensures that an individual's wheelchair mobility and their carer's needs are managed appropriately in the most clinically effective and efficient way.

References: 2, 11, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31

Essential Criteria	
No.	Criteria statement
2.1	Referrals for specialist assessment are screened by competent, registered clinical staff[7].
2.2	Referrals for specialist assessment are prioritised in accordance with publicly available criteria based on clinical need.
2.3	Referrers and those referred are advised if a specialist assessment will not occur within 4 weeks of receipt of a referral.
2.4	Specialist assessments are conducted within 4 weeks of referral in at least 95% of cases and within 8 weeks for 100% of cases, in each major pathway through the services[8].

[7] Staff should have the level of knowledge, skills and experience appropriate to their role and be registered with the GMC, HPC or NMC.

[8] All urgent cases should be within the lower target time. Times are from the point of receipt of a referral by the WSS that contains all essential information in accordance with Appendix E.

2.5	Specialist assessments are person-centred and anticipatory, and based on the factors listed in Appendix F.
2.6	Specialist assessments are conducted in accordance with evidence-based national or local good practice guidelines, where these exist.
2.7	Specialist assessments are conducted by competent, registered clinical staff[9].
2.8	Appropriate measures[10] should be administered to evaluate the outcome of each intervention, covering both service users' and carers' needs.
2.9	Any unmet mobility needs and/or any unresolved disagreements should be recorded.
2.10	A written summary of the agreed specialist assessment outcome and prescription should be shared with users and, with their agreement, carers and other appropriate, interested parties[11].
2.11	Clinic facilities should comply with the minimum requirements set out in Appendix G.
2.12	At least 85% of users should be seen within their own local NHS Board area subject to the availability of suitable clinic facilities (as set out in Appendix G).

[9] Staff should have the level of knowledge, skills and experience appropriate to their role and be registered with the GMC, HPC or NMC.
[10] Any outcome measures administered should be proportionate to the complexity of need and intervention.
[11] For example, case/care manager, primary care services, paediatric and education services.

Standard 3: Clinical follow up and planned review

Standard Statement

Service users should be followed up after each significant clinical intervention and planned clinical reviews are offered to those who need one.

Rationale

To ensure that any significant clinical intervention meets the needs identified at an initial or specialist assessment, a follow up should be undertaken. This should be done as soon as the user and/or carer(s) have had adequate time to assess whether or not the equipment provided meets the agreed assessment outcome. This is the responsibility of the initial assessor who identified or confirmed the need for wheelchair assisted mobility or, when a specialist assessment has been undertaken, the specialist clinician responsible.

Wheelchair users have complex and changing needs caused by their underlying medical condition(s) and other health or social factors. Some users may require periodic, planned reviews to ensure that any changes in their impairment(s) or circumstances, that could be reasonably anticipated, can be addressed in a timely manner.

Children also have rapidly changing needs as they grow and develop, both physically and cognitively. Developmental needs can be adversely affected if a child does not have the right wheelchair and seating provision. Services need to anticipate and plan for growth and changes in body shape, as well as transitions through the education, health and social care systems.

The frequency of review should be determined individually to minimise any potential negative impact on user's educational, vocational, health or social care arrangements. The progressive nature of their underlying medical condition(s), planned medical or surgical interventions, child development and growth, planned transitions or changes to domestic, vocational or social care arrangements should be taken into account when determining review periods.

Existing users, and/or their family and carers, should be aware of how they can request a clinical review should their current wheelchair and/or seating provision no longer meet their mobility or postural support needs.

References: 1, 7, 11, 12, 14, 18, 25, 26, 31, 32, 33

Essential Criteria	
No.	Criteria statement
3.1	Significant clinical interventions are followed up to ensure that these meet the agreed outcomes identified at an initial or subsequent assessment.
3.2	Planned clinical reviews are offered to all users identified as having complex and changing needs, including: • those with progressive conditions • children (< 16 years old) • those with anticipated transitions • those with anticipated changes to their domestic, vocational or social care arrangements.

3.3	The frequency of review will be agreed with the user taking into account, where appropriate: • progression of condition • children's physical and social development • planned transitions or changes to domestic, vocational or social care arrangements.
3.4	Existing NHS wheelchair users, family and carers (where appropriate), are aware of how they can request a clinical review.

Standard 4: Equipment provision and management

Standard Statement

Wheelchairs, seating and associated equipment are medical devices and should be safe and fit for purpose and provided in a timely manner in accordance with risk management principles.

Rationale

Wheelchairs, seating and associated equipment are Class I medical devices and must comply with the Medical Devices Regulations (MDR) (2002) as regulated by the Medicines and Healthcare products Regulatory Agency (MHRA). Any risks associated with the equipment provision should be minimised. Adverse incidents, problems (or the potential for problems) should be managed in accordance with Medical Device Alert (MDA) recommendations.

Provision should be conducted by or overseen by a competent, registered clinical staff member who is responsible for managing the case and acts as the contact person for the disabled person and/or their carers. The time from assessment to provision should be minimised to avoid the need for reassessment should needs change in the meantime (e.g. due to children growing).

The introduction of new product lines and technologies to NHS provision must involve wheelchair users and be objectively evaluated to ensure that they fulfil their intended purpose from both clinical and device management perspectives. Their introduction should be managed to ensure that adequate spares are stocked and that they can be maintained and repaired. A planned approach to ensuring wheelchair and seating equipment responds to user needs and advancing technology must be in place.

The modification of CE-marked medical devices, in-house manufacturing and off-label use of devices to meet particularly needs are subject to the requirements of the MDR. A risk assessment, which is necessary to minimise any potential hazards, should be conducted in accordance with the International Standards Organization's (ISO) risk management standard (ISO14971).

The provision, and updating, of instructions, and if necessary training, that takes into account the knowledge and training of the intended user(s), is crucial to the safe and effective use of equipment. Adequate instructions, and if necessary training, should be provided to new and existing users and/or carers. These should, as a minimum, cover how to report faults and adverse incidents, how to carry out routine checks and basic maintenance, and general wheelchair management, such as how to negotiate kerbs.

Maintenance and repair policies and procedures should ensure user safety and continuity of care using a risk management approach. The frequency and type of planned preventive maintenance (PPM) should be specified, taking account of the manufacturer's instructions, the expected usage and the environment in which the equipment is to be used.

References: 11, 12, 25, 26, 34, 35, 36, 37, 38, 39, 40, 41

Essential Criteria	
No.	Criteria statement
4.1	Provision of devices to individuals is conducted by or overseen by competent, registered clinical staff[12].
4.2	Standard provision, for which a specialist assessment was not required, is provided within 2 weeks of referral in at least 95% of cases and within 3 weeks for 100% of cases.

[12] Staff should have the level of knowledge, skills and experience appropriate to their role and be registered with the GMC, HPC or NMC.

4.3	Standard provision, for which a specialist assessment was undertaken, is provided within 6 weeks of referral in at least 95% of cases and within 11 weeks for 100% of cases.
4.4	Specialist provision is provided within 14 weeks of referral in at least 95% of cases and within 18 weeks for 100% of cases.
4.5	Services should adhere to local equipment management policies and procedures that are based on a risk management approach and conform to MHRA guidance.
4.6	In-house manufacturing and off-label use of devices should be in accordance with the MDR, including design and risk assessments records.
4.7	NHS wheelchairs are provided from national contract in accordance with policy and legislative requirements.
4.8	A model of equipment renewal is in place that responds to technological advances and involves users and carers.
4.9	New product lines should only be introduced with adequate staff training.
4.10	Adequate instructions, and if necessary training, should be provided for all devices in accordance with MHRA guidance.
4.11	Adequate instructions, and if necessary training, should be provided on using wheelchairs and/or equipment for new and existing users and/or carers.
4.12	Users and carers have information on how to report faults and adverse incidents, carry out routine checks and basic maintenance, and on the potential danger of inappropriate modifications or adjustments.
4.13	Repairs are prioritised and completed in accordance with publicly available criteria and targets.
4.14	Planned Preventative Maintenance (PPM) is undertaken based on a risk management approach that conforms to MHRA guidance.
4.15	Services should adhere to MHRA adverse incident guidance on the reporting of incidents and responding to alerts.
4.16	All service users with equipment on issue are contacted at least annually.
4.17	Urgent[13] repairs should be completed within one day in at least 75% of cases.
4.18	Routine repairs should be completed within five days in at least 90% of cases.
4.19	Deliveries, repairs and PPM appointments are arranged at times to suit user's lifestyles as far as it is practical.

Note on Criteria 4.2, 4.3 & 4.4

All urgent cases should be within the lower target time. Times are from the point of receipt of a referral by the WSS that contains all essential information in accordance with Appendix E.

Note on Criteria 4.17 & 4.18

The targets given are calendar days, not working days.

[13] Defined in Appendix J.

Standard 5: Quality management and service improvement

Standard Statement

Services should, in partnership with all stakeholders, create and sustain a culture of continuous quality improvement to deliver a person-centred, clinically effective and safe service.

Rationale

Better outcomes are achieved when services are provided in partnership with users, carers and staff. Clinical governance, evidence-based practice and quality assurance underpin person-centre, safe and effective service provision. Surveys of user and carer satisfaction can provide valuable insights to improve provision and outcomes.

Quality Management Systems (QMSs) imbed quality assurance and encourage service improvement. These should conform to an internationally recognised standard for the providers of medical devices, for example, ISO13485. QMSs should to be integral to the day to-day policies and procedures and culture of the service. This ensures that services are safe and effective and able to respond to the ever changing and challenging external environment.

Leadership, user, carer and staff involvement and on-going, focused initiatives are critical to achieving and sustaining service and quality improvements. Staff training and education and adherence to evidence-based clinical practice are an underlying necessity. Research and development not only furthers the knowledge of the field, but is also a means of motivating and developing staff. Safety is a key driver of service change and development.

The recording and sharing of outcomes from quality improvement, product evaluation and research and development activities promote further improvements and spreading of best practice. Collating and reporting unmet needs supports this endeavour.

References: 1, 7, 15, 39, 42, 43, 44, 45, 46, 47, 48

Essential Criteria	
No.	Criteria statement
5.1	NHS Boards should integrate or link their local wheelchair user and carer groups or networks with their Patient Focus Public Involvement (PFPI) structures and processes.
5.2	Services should commission an independent survey of users at least once every two years to check their and their carers' satisfaction with the service provided and how well their equipment meets their needs.
5.3	Information made available to users and carers should comply with the Scottish Accessible Information Forum's (SAIF) standards and be provided in alternative formats consistent with equality and diversity duties.
5.4	Information (as outlined in Appendix H) should be readily available to disabled people, their families and carers, and other interested stakeholders.
5.5	Each territorial NHS Board should have an identified and active strategic lead with a responsibility for WSSs.
5.6	A comprehensive QMS should be in place that drives continuous service improvement.
5.7	Each WSS should identify lead roles for quality and service improvement.
5.8	Each WSS should identify lead roles for product evaluation, research and development.
5.9	WSSs should report on their quality improvement, product evaluation and research and development activity.

5.10	Records of unmet needs should be collated and reported on annually.
5.11	All staff should undergo wheelchair and seating specific induction training appropriate to their role.

Desirable Criteria	
No.	Criteria statement
5.12	QMSs should conform to an internationally recognised standard.
5.13	Outcomes from quality improvement, product evaluation and research and development events and activities should be shared with other Scottish services and the wider field.

Appendix A: Standards development methodology

The methodology employed by the WSS Standards & Eligibility Working Group to develop these standards was based on that developed by NHS QIS[14]. The NHS QIS methodology has been developed over a number of years and has resulted in the publication of clinical standards covering many different aspects of healthcare in Scotland. It was adapted to suit the purposes and timescales of the project.

Basic principles

The standards have been developed in partnership with healthcare professionals, the voluntary sector and users and carers. The Working Group has endeavoured to ensure that consideration of equality and diversity issues featured prominently in the development of the standards and that they were developed in accordance with the commitments of the *National Health Service Reform (Scotland) Act (2004)* that states that 'individual patients receive the service they need in the way most appropriate to their personal circumstances and all policy and service developments are shown not to disadvantage any of the people they serve'.

Standards format and definition of terminology

The standards are designed to be clear and measurable, based on appropriate evidence, and written to take into account other recognised standards and clinical guidelines. Each standard has a title that summarises the area on which that standard focuses. This is followed by the standard statement, which explains the level of performance to be achieved. The rationale section provides the reasons why the standard is considered to be important. The references are listed in order of citation and year of publication. The numbers refer to the listing in Appendix I.

The standard statement is expanded in the section headed criteria that states exactly what must be achieved for the standard to be reached. Some criteria are essential, in that it is expected that they will be met wherever a service is provided. Other criteria are desirable in that they are being met in some parts of the service, and demonstrate levels of quality that other providers of a similar service should strive to achieve. The criteria are numbered for the sole reason of making the document easier to work with, particularly for the assessment process. The numbering is not a reflection of priority.

Evaluation tool

The Evaluation Tool has been developed in parallel with the standards and consulted upon as part of the standards development process. It includes guidance on how it can be completed. By completing all areas of the tool, service providers will be able to identify priority areas for improvement and development, highlight areas of good practise, and determine if the standards have been met.

Clinical governance and risk management standards

Every individual using healthcare services should expect these to be safe and effective. There are existing NHS QIS Standards for Clinical Governance and Risk Management [15] to ensure NHS Boards can provide assurance that clinical governance and risk management arrangements are in place, and that they are supporting the delivery of safe, effective, person-centred care and services. These standards underpin all care and services delivered by the NHS in Scotland and provide the context within which NHS QIS service and condition-specific standards apply.

[14] NHS QIS is now part of Healthcare Improvement Scotland.

Annex B

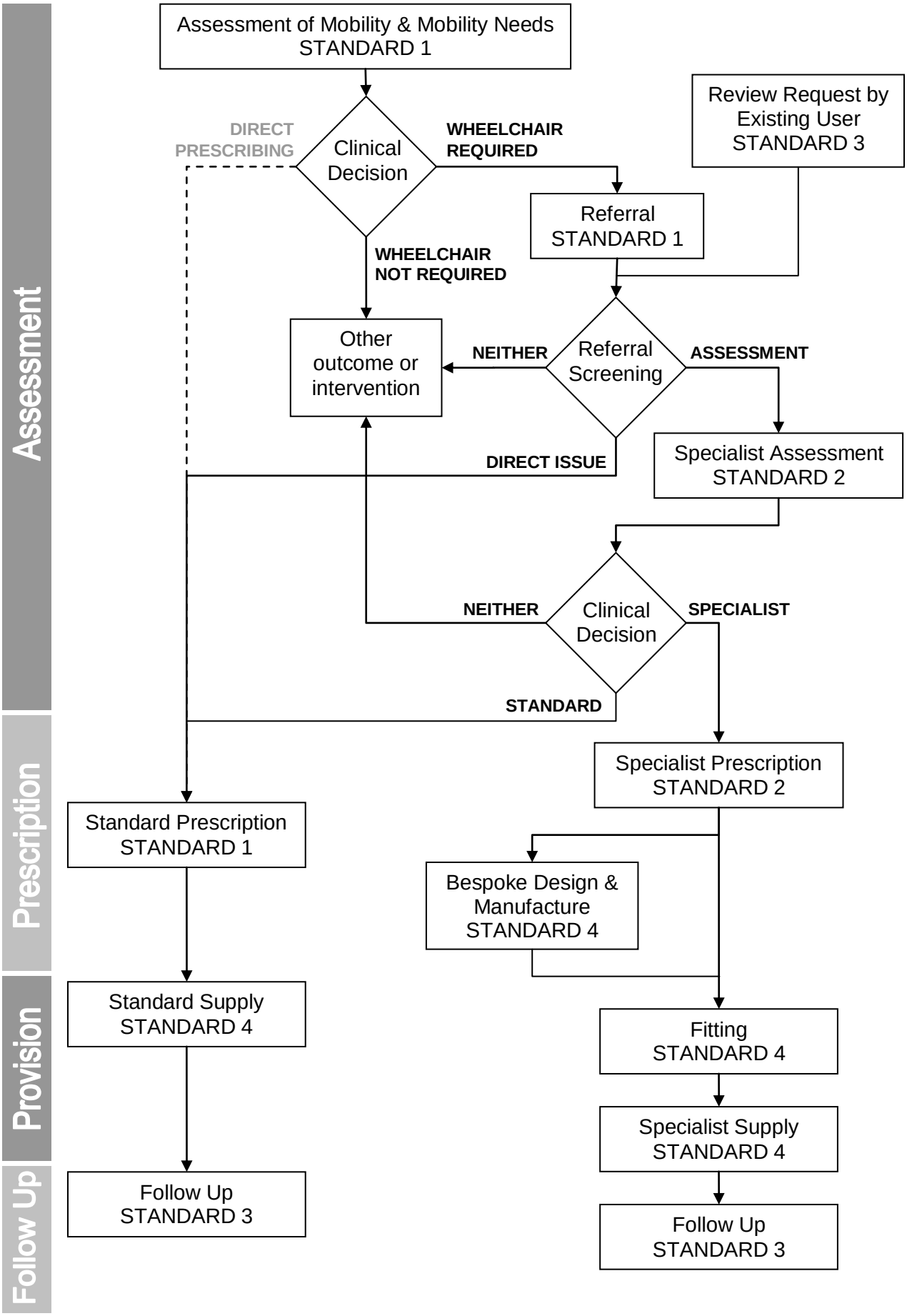
Appendix B: Working Group membership

The members of the WSS Standards & Eligibility Working Group during the development of the standards were as follows.

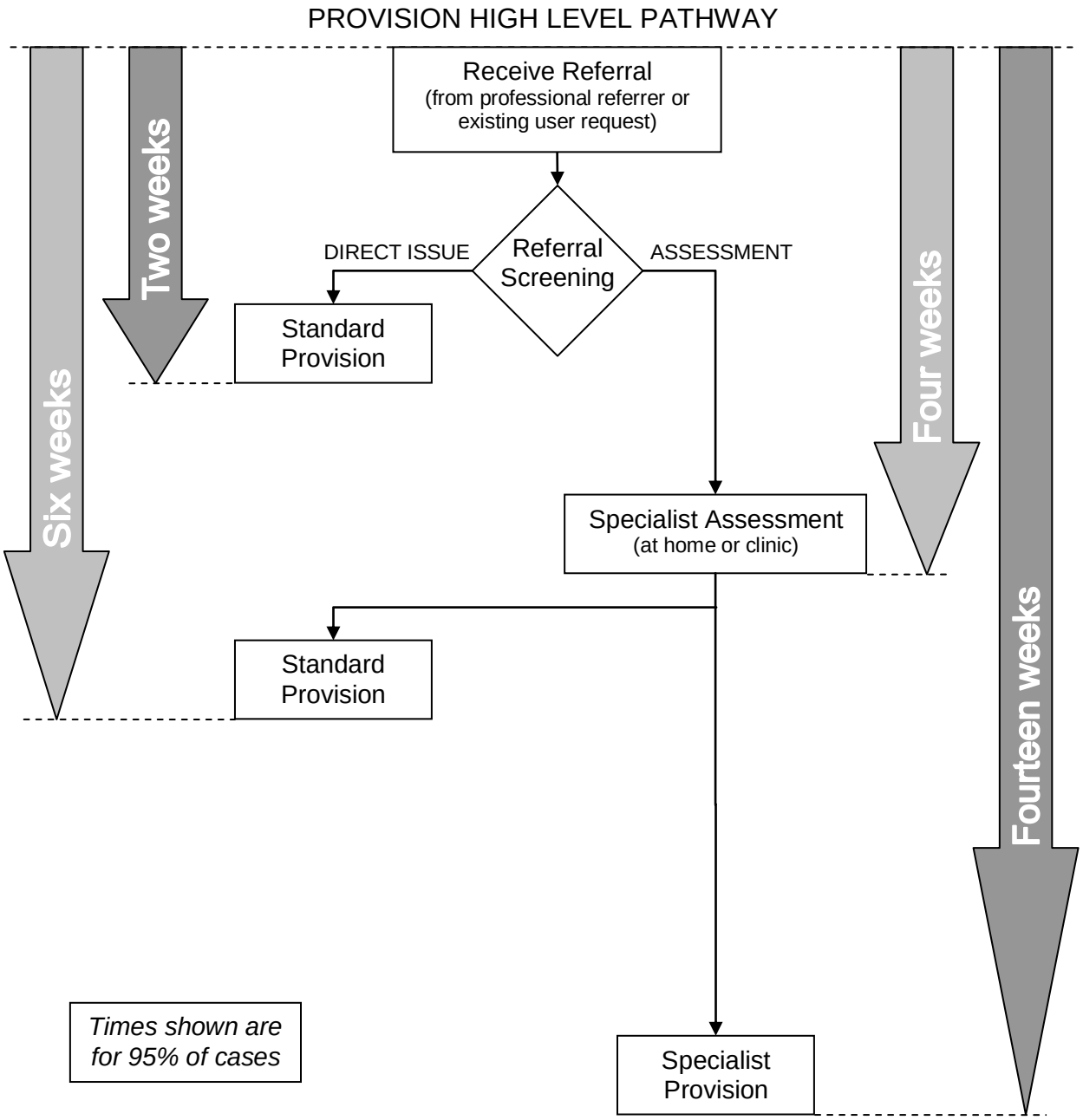
Mr Richard Hamer	Director of External Affairs, Capability Scotland - *Chair*
Dr Michael Dolan	WSS Clinical Advisor, Health & Healthcare Improvement Directorate, Scottish Government
Mrs Isobel Allan	*Representing users and carers [from June 2010]*
Ms Jane Arroll	Lead on Shared Assessment & Review, Equipment and Adaptations, Health & Healthcare Improvement Directorate, Scottish Government *[until August 2010]*
Mrs Amanda Beech	*Representing users and carers*
Mr John Colvin	Head of Service, WestMARC, NHS Greater Glasgow and Clyde - *Representing the Scottish Health Sciences Forum*
Mrs Catherine Dowell	Head of Mobility, SMART Centre, NHS Lothian - *Representing Centre Managers*
Ms Hazel Dykes	Associate Director AHP, NHS Dumfries and Galloway - *Representing the WSS Project Board*
Ms Clare Echlin	Acting Head of Standards Development, NHS Quality Improvement Scotland
Mr Steven Fenocchi	Policy Manager, Health & Healthcare Improvement Directorate, Scottish Government [*from April to August 2010]*
Janet Garcia	WSS National Project Manager, Health & Healthcare Improvement Directorate, Scottish Government
Ms Susan Gold	Head Occupational Therapist, WestMARC, NHS Greater Glasgow and Clyde - *Representing the Allied Health Professions Forum*
Ms Dawn Kofie	Policy Manager, Health & Healthcare Improvement Directorate, Scottish Government *[until March 2010]*
Mrs Elizabeth Porterfield	Head of Strategy and Planning, Health & Healthcare Improvement Directorate, Scottish Government *[from April 2010]*
Ms Jessie Roberts	Senior Co-ordinator, PAMIS
Mrs Muriel Williams	*Representing users and carers*
Mr Graham Wood	WSS Project Officer, Health & Healthcare Improvement Directorate, Scottish Government *[until March 2011]*

The Working Group acknowledges the input from the members of the Reference Group who commented on the draft versions. It particular, the group would like to thank Professor Andrew Frank, Kevin McGoldrick and Dr Chris Roy.

Appendix C: Relationship between standards and clinical decision making and provision processes



Appendix D: High level pathways with target times

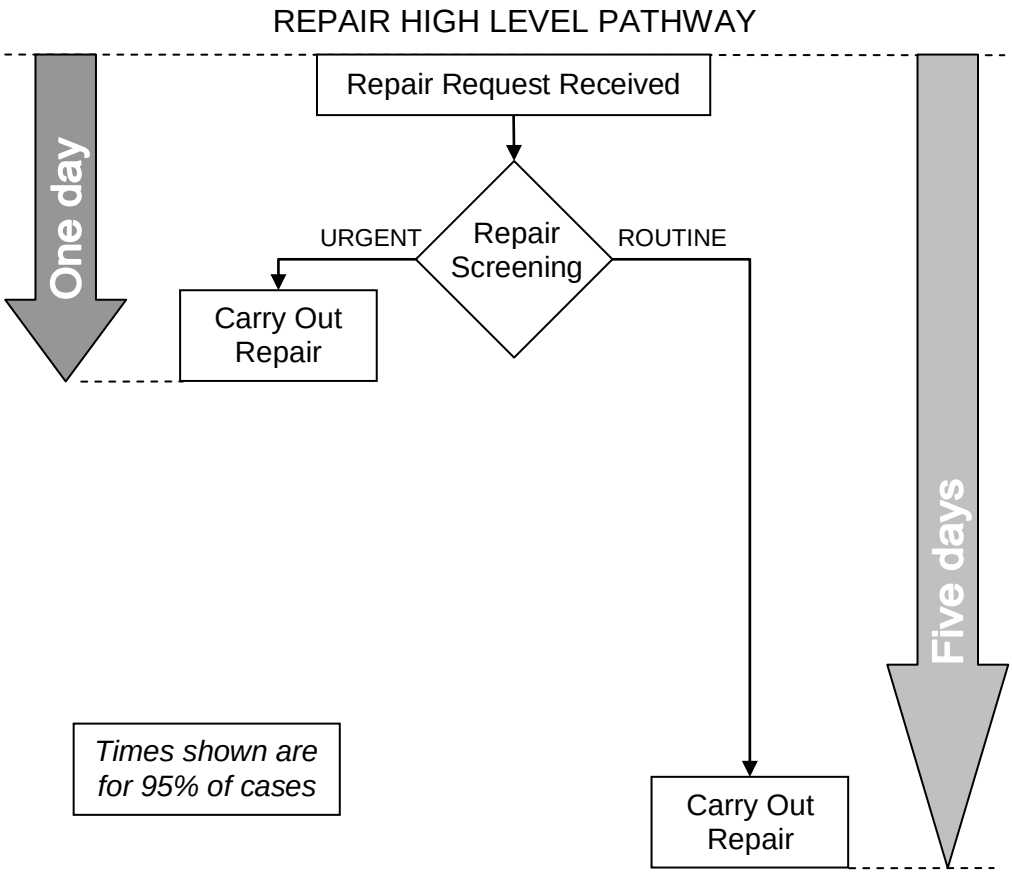


Essential Criteria	
No.	Criteria statement
2.4	Specialist assessments are conducted within **4 weeks of referral in at least 95% of cases** and within 8 weeks for 100% of cases, in each major pathway through the services.
4.2	Standard provision, for which a specialist assessment was not required, is provided within **2 weeks of referral in 95% of cases** and within 3 weeks for 100% of cases.
4.3	Standard provision, for which a specialist assessment was undertaken, is provided within **6 weeks of referral in at least 95% of cases** and within 11 weeks for 100% of cases.
4.4	Specialist provision is provided within **14 weeks of referral in at least 95% of cases** and within 18 weeks for 100% of cases.

Annex B

Note on Criteria 2.4, 4.2, 4.3 & 4.4

All urgent cases should be within the lower target time. Times are from the point of receipt of a referral by the WSS that contains all essential information in accordance with Appendix E.



Essential Criteria	
No.	Criteria statement
4.17	Urgent repairs should be completed within **one day** in at least 75% of cases.
4.18	Routine repairs should be completed within **five days** in at least 90% of cases.

Note on Criteria 4.17 & 4.18

The targets given are calendar days, not working days.
See 'Repair' definition in Appendix J for the distinction between routine and urgent repairs.

Appendix E: Referral and prescription form requirements

Referral and prescription forms should request the following, essential information:

- patient's full name
- Community Health Index (CHI) number or, if not available, date of birth (DOB)
- sex
- diagnosis and other relevant clinical information[15]
- residential address[16] and telephone number(s)
- name and contact details[17] of GP/GP practice
- name, profession and contact details of referrer
- reason for referral and summary of mobility needs
- weight, height and other anthropomorphic measurements
- environmental and life-style considerations

Forms received that do not have all the essential information provided may result in delays to assessment and/or provision.

Referral and prescription forms should request the following, desirable information:

- name, profession and contact details of any other relevant professionals involved
- name and contact details of case/care manager
- name and contacts details of day centre/residential centre/work
- name, contact details and relevant needs of main carer(s)
- parental and/or caring responsibilities
- transfer requirements
- anticipated changes/transitions
- details of requested equipment
- delivery preferences for equipment (e.g. alternative address)
- assessment preferences (e.g. location and availability)
- any prioritising factors, whether clinical or social/personal
- whether or not patient is aware of referral
- whether or not patient has agreed that referral information can be passed to other agencies

Format and other guidance

1. Referral and prescription forms should be clear and specific.
2. Essential information should be highlighted.
3. Supporting guidance should be readily available to referrers/prescribers to enable them to complete the forms correctly.
4. All forms and supporting information should clearly state that referrers/prescribers will be responsible for any delays resulting from incomplete and/or incorrectly completed forms, and not the supplier of the equipment or specialist centre/service.
5. All data collected and recorded should be consistent with the data definitions and standards set out in the national *Health and Social Care Data Dictionary* [49].

[15] For example, hearing/visual/communication ability, previous/planned medical or surgical information, medication, alcohol and drug use, skin care/pressure sore problems, descriptions of fixed deformities, limitations in ranges of joint motion and abnormal muscle tone.
[16] Including postcode for all required addresses.
[17] Including full address and telephone number(s).

Appendix F: Specialist assessment factors

The following factors should be considered during specialist assessments:

- diagnosis, status and progression of condition(s)
- any planned medical intervention(s)
- physical function and posture
- cognitive and sensory abilities
- pressure care and tissue viability
- challenging behaviour if relevant
- relevant daily living activities[18]
- Augmentative and Alternative Communication (AAC) needs[19]
- Electronic Assistive Technology (EAT)[20] needs
- parental and/or caring responsibilities of the person being assessed
- domestic and other accessed environments
- transfer needs in the different settings where the wheelchair will be used
- impact of the wheelchair on continence care routines or management
- continuity of healthcare during health and/or social service transitions
- vehicular transport arrangements
- level of dependency on others in daily living
- care package
- carer profile and requirements
- strengths, goals and aspirations
- need for informed consent

In addition, for children and young people, the following factors should also be considered:

- physical and social development
- age-related transitions from pre-school to school, primary to secondary education, and youth to adult health and social services

[18] Such as getting out of and in to bed, dressing, toileting, washing, eating, operating household appliances, etc.
[19] For example, use of communication aids.
[20] For example, the use of special switches to control a powered wheelchair, or the need for integrated control systems.

Appendix G: Clinic facilities

All clinic facilities should be fully accessible to people with mobility and/or sensory impairments and provided in accordance with the Disability Discrimination Act 2005, the Disability Equality Duty and current Building Regulations. Further information on ensuring that premises are accessible for disabled people can be found in the SAIF's *Standards for Disability Information and Advice Provision in Scotland* [50] and the British Standards Institution's (BSI) Code of Practice on the *Design of Buildings and their Approaches to Meet the Needs of Disabled People* [51].

The minimum facilities and/or equipment that should be available at each type of clinic location are listed below.

Temporary clinics held in schools, day centres or similar:

- private, dedicated space for the duration of the clinic
- a separate reception/waiting area
- a wheelchair accessible toilet
- patient handling equipment (e.g. hoists, slings and plinths)
- a pressure mapping kit*
- wheelchair accessible weighing scales*

Satellite clinics, in addition to that listed above:

- space to accommodate 6 people and equipment
- access to local transportation systems
- designated disabled parking nearby
- available ambulance transportation
- access to food and beverages
- information on the service available to take away
- a range of assessment wheelchairs
- a range of assessment base cushions
- a range of postural supports and seating systems
- access to workshop space to allow for simple repair and modification of equipment

Main centres, in addition to that listed above:

- nursing cover
- wheelchair accessible toilet with changing facilities[21]
- child friendly facilities, including a safe play area for waiting children
- access to a range of ground surfaces, ramps, kerbs, floorings
- access to a workshop for modifying and repairing equipment with technical staff available

* Investigative resources may be kept at a clinic location or portable devices taken to the clinic when in use.

[21] For example, in accordance with the 'Changing Places' standards [52].

Appendix H: Public information requirements

The following information, as a minimum, should be made be readily available to disabled people, their families and carers, and other interested stakeholders (in accordance with Criterion 5.4):

- opening times for services and clinic facilities
- how to contact services
- how to request a clinical review (as Criterion 3.4)
- how to request a repair
- how to make a complaint or appeal a decision
- directions and public transport links to clinic facilities
- how to contact local wheelchair user and/or carer groups and/or networks
- timescales for assessments and repairs
- referral forms and supporting guidance (as Criterion 1.7)
- the criteria used to prioritise referrals for specialist assessment (as Criterion 2.2)
- how to report faults and adverse incidents (as Criterion 4.12)
- how to carry out routine checks and basic maintenance (as Criterion 4.12)
- the potential danger of inappropriate modifications or adjustments (as Criterion 4.12)
- the criteria used to prioritise repairs (as Criterion 4.13)
- the procedures for PPM
- the service's performance against the Essential Criterion 2.4, 4.2, 4.3, 4.4, 4.17 and 4.18

This information should comply with the Scottish Accessible Information Forum's (SAIF) standards and be provided in alternative formats consistent with equality and diversity duties (in accordance with Criterion 5.3).

Appendix I: Evidence base

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Annex B

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Appendix J: Glossary

Anticipatory approach
Identifying and addressing potential problems before they occur.

Assessment
The process of measuring a person's needs or the quality of an activity, service or organisation.

Carer
A person who looks after relatives, partners or friends in need of help because of age, physical or learning disabilities or illness on a voluntary, unpaid basis.

Case management
A collaborative process of assessment, planning, facilitation and advocacy to meet individual needs to promote quality cost-effective outcomes.

Clinical effectiveness
The extent to which specific clinical interventions do what they are intended to do, i.e. maintain and improve health, securing the greatest possible health gain from the available resources.

Clinical follow up
The task of checking that a significant clinical intervention resulted in the outcome expected. This task may be delegated to non-clinical staff who are able to pass on issues that require clinical knowledge to the clinician responsible.

Clinical intervention
An intervention carried out to improve, maintain or assess the health and/or needs of a person in a clinical situation. A significant clinical intervention in the context of clinical follow up (Standard 3) is one that would be reasonably expected to have the potential for consequences that are not immediately apparent at the time of the intervention and for which further intervention might be required.

Clinical governance
The system through which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services and safeguarding high standards of care and services.

Clinical review
Any assessment undertaken after a first assessment. These can be planned or unplanned.

Clinician
Any healthcare member of staff, e.g. doctor, HCS, nurse, AHP, who is involved in diagnosing and/or treating patients.

Equipment
Any device, whether acquired commercially off-the-shelf, modified or customised. Standard equipment can be used to meet non-complex needs and does not need to be

adapted for the individual, though there may need to be slight adjustments (e.g. the height of wheelchair footplates). Specialist equipment will usually require a specialist assessment and will need to be uniquely specified and sourced for an individual. Specialist equipment may need to be individually adjusted and modified and/or designed and manufactured.

Initial assessor

The person who undertakes the initial assessment that identifies or confirms the need for wheelchair mobility. They must be skilled in the assessment of mobility and mobility needs and aware of the range and type of wheelchair equipment available to meet the specific needs of the disabled person. The initial assessment includes taking measurements and submitting a request for a wheelchair to be issued or for a specialist assessment.

Medical device

An instrument, apparatus, appliance, material or other article, whether used alone or in combination, together with any software necessary for its proper application, which is intended by the manufacturer to be used for medical purposes, such as the diagnosis, monitoring, treatment, alleviation of, or compensation for, an injury or physical impairment.

Multidisciplinary Team (MDT)

A group of people, including NHS, community care and local authority staff, who work together to provide care for patients.

Outcome

The end result of a system, process or care, treatment and/or rehabilitation.

Outcome measure

A measure of the quality of healthcare. It is a measure of change, the difference from one point in time (usually before an intervention) to another point in time (usually following an intervention). An outcome measure should be standardised, with explicit instructions for administration and scoring.

Planned Preventive Maintenance (PPM)

The correction or prevention of faults by a programme of servicing, inspection and replacement of parts carried out at fixed intervals by appropriately trained and qualified staff, in order to keep a medical device performing as intended by the manufacturer.

Provision

The supply of a wheelchair and/or seating equipment. Standard provision is the supply of standard equipment that does not require clinical involvement beyond the prescription stage. This can occur after referral screening (direct issue) or, occasionally, after a specialist assessment. Specialist provision is the supply of specialist equipment usually after a specialist assessment. It will require additional clinical involvement beyond the prescription stage, e.g. a fitting appointment. Depending on individual's needs, an identical piece of standard equipment could be supplied via either route.

Repair

The restoration of a device to correct working order, after it has either broken down or stopped working properly. In the context of this document, repairs are classified as

being either urgent or routine. A repair is urgent when a wheelchair and/or seating is/are not safe to use and the user is dependent on it. Any other repair is routine. A repair that would normally be classified as urgent may be classified as routine when the user needs their device only occasionally. An urgent repair may result in a follow up routine repair or provision, when a temporary alternative device is provided that is safe to use.

Risk management

The systematic identification, evaluation and treatment of risk. It is a continuous process with the aim of reducing risk to organisations and individuals alike.

Single Shared Assessment (SSA)

The SSA is for people with community care needs seeking help from social work, health or housing authorities, and who may require the services of more than one professional discipline or agency.

Seating

Seating provides postural support to a wheelchair occupant who, due to irregular body shape or instability, needs additional support in order to function. Seating is made up of postural support devices that are attached to a wheelchair, which have surfaces that are in contact the occupant's body and are used to either modify or accommodate the occupant's sitting posture. For example, a seat, back support, lateral trunk support, and head support are all postural support devices. In the context of this document, seating refers only to that provided in a wheelchair and does not cover seating provided in static chairs.

Social Model of Disability (SMD)

The SMD provides a framework for assessment of mobility and makes an important distinction between 'impairment' and 'disability'. It suggests that many problems faced by people with impairments are caused by the way society is organised rather than the impairments themselves. It provides an alternate way of understanding access issues and social exclusion and sees the problem as a 'disabling world'. The model explores why society does not treat all its members as equal. The International Classification of Function developed by the World Health Organisation uses the distinctions identified in the SMD as its base.

Wheelchair

A wheelchair is a medical device with a seating support surface and wheels that provides wheeled mobility for people with impaired mobility. A walker with wheels is not a wheelchair as it does not provide wheeled mobility, but provides support to a person while walking. In the context of this document, wheelchairs are also deemed to include children's buggies/pushchairs. A manual wheelchair requires the occupant or an attendant to propel the wheelchair. A powerchair (or electrically powered wheelchair) generally has an electric motor that propels the wheelchair and is controlled by the occupant or an attendant.

WSS Centre

A WSS Centre is a central NHS resource where people can have specialist assessment and fitting for wheelchairs and wheelchair seating systems. These centres also manage the provision and delivery of the equipment and operate repairs and maintenance services for the NHS wheelchairs they provide.

Appendix K: Abbreviations

AAC	Augmentative and Alternative Communication
AHP	Allied Health Professional
BS	British Standard
BSI	British Standard Institution
CHI	Community Health Index
CHQS	Clinical Healthcare Quality Standards
DOB	Date of Birth
EAT	Electronic Assistive Technology
GMC	General Medical Council
GP	General Practitioner
HCS	Healthcare Scientist
HPC	Health Professions Council
ISO	International Standards Organization
MDA	Medical Device Alert
MDR	Medical Devices Regulations
MDT	Multidisciplinary Team
MHRA	Medicines and Healthcare products Regulatory Agency
NES	NHS Education for Scotland
NHS	National Health Service
NMC	Nursing and Midwifery Council
NP	National Procurement
NSS	National Services Scotland
PCR	Planned Clinical Review
PFPI	Patient Focus Public Involvement
PPM	Planned Preventive Maintenance
QIS	Quality Improvement Scotland
QMS	Quality Management System
SAIF	Scottish Accessible Information Forum
SG	Scottish Government
SSA	Single Shared Assessment
WSS	Wheelchair and Seating Service

Annex C

NHS Scotland Wheelchair & Seating Services

CHQS EVALUATION TOOL

Contents

1. Introduction

This Evaluation Tool accompanies the Clinical Healthcare Quality Standards (CHQS) for Wheelchair and Seating Services in NHS Scotland. The standards apply to all territorial NHS Boards in Scotland, regardless of whether or not the board hosts a WSS centre. They apply to any care setting within an NHS Board where wheelchair services are provided including primary, secondary and tertiary care, and to anyone using the services regardless of a person's background or personal circumstances.

The questions in the Evaluation Tool are designed to help service providers gain a better understanding of the services they provide. For the most part, service providers will be NHS Boards, but other organisations may employ staff that undertake assessments of mobility and mobility needs[22]. Providing detailed answers for each question will allow each NHS Board[23] to highlight areas of good practice, as well as determining if the standards have been met.

In the Evaluation Tool, some examples are given of evidence that could be provided to demonstrate that the standard is being met. These are not exhaustive and there may be other examples of evidence that the NHS Board can provide to show it is meeting a standard.

The Evaluation Tool can be used by NHS Boards to self-assess their service's performance and identify areas for development and improvement. It can also be used by other organisations to scrutinise services. NHS Boards that are part of a consortium may find that it is more efficient to undertaken self-assessment at the same time as other consortium members.

[22] For further details see the Scope section in the Clinical Standards.
[23] Board will be used throughout the document to cover all service providers.

2. Guidance Notes

This guidance has been developed to help NHS Boards complete the Evaluation Tool.

Layout of the evaluation tool
Each standard is clearly stated, along with its rationale[24]. Below each standard the response section of the tool is divided into two tables, one for essential criteria and one for desirable criteria. Each table consists of:

Criteria	Statements of what needs to be achieved for the standard to be met.
Evaluation questions/ information request	Outlines the evaluation questions or requested information that corresponds to the criterion.
Example evidence	Outlines examples of evidence that can be provided.
Evidence/progress	Provides space for the NHS Board to provide evidence or report on it's progress towards meeting the criterion.

Guidance

1. The Evaluation Tool is available in PDF and Microsoft Word 2003 format.

2. It is helpful to determine whether each criterion is met, not met or not applicable. For a standard to be met, all applicable essential criteria must be met. To help develop services, NHS Boards should include information of how unmet criterion will be met in the future and are encouraged to collate these into an Action Plan with timescales identified.

3. Information or data (text, figure, percentage etc) and, where appropriate, an explanation of what this information relates to, or how it was captured, should be included in the NHS Board's evidence/progress cell.

   Where an NHS Board refers to a separate piece of supporting information (for example a copy of a protocol/policy or an example of a care plan) a reference number should be noted in the evidence/progress box.

   Similarly, all additional written evidence/data should be referenced with an appendix number that corresponds to the criterion number to which it applies (e.g. policies provided in support of criterion 1.1 should be labelled appendix 1.1). Evidence which relates to multiple criteria can be cross-referenced rather than re-listed.

4. To ensure a true reflection of the current provision of services, it should be noted where no data/evidence is available.

5. In order to comply with information governance, all personal information should be anonymised or, where appropriate, blank examples of hospital forms, care plans, letters, etc should be provided.

6. For most simple audits, e.g. measuring whether processes are being followed as per the standards, a sample size of between 20 and 50 is considered sufficient.

[24] The evidence base upon which the rationale is based can be found in the Clinical Standards.

7. When evidence cross-refers to a different criterion with multiple questions, it is helpful to consider all questions in the response.

8. Where a question asks for data for a specific group of patients over a specific time period, NHS Board's local data capture and audit processes need to support this.

9. To help ensure accuracy, incomplete and missing data must be included when calculating the total percentage. The number of patients whose data are missing or incomplete should be specified. For example:

   Time period = April 2010 to March 2011 inclusive
   - number of patients = 100
   - data incomplete or missing for 10 patients
   - 50 patients meet the criterion
   - 40 patients do not meet the criterion
   Therefore 50% of patients are known to meet the criterion for this time period.

10. Data provided to supporting waiting or provision time targets should include, as a minimum:
    - number and percentage of cases below and above target
    - minimum, maximum and mean times

11. The value of including data produced from a historical audit if this audit was conducted more than 2 years ago should be considered. However, it is acceptable to supply trend data covering up to 5 years.

12. When complete, the Evaluation Tool (with all necessary attachments and appendices) should be reviewed through the NHS Board's relevant quality and governance processes to gain an understanding of current provision and identify areas for improvement and development. To encourage sustained improvement, any identified strengths should be highlighted.

13. Regular use of the Evaluation Tool for self-assessment[25] will not only help service providers to monitor and measure progress, but will also support any future assessments undertaken by external organisations. It is recommended that the Evaluation Tool be completed at least once every two years.

[25] Self-assessment is also in keeping with Standard 5.

4. Evaluation Tool

Standard 1: Assessment of mobility and mobility needs

Standard Statement
The clinical assessment of mobility and mobility needs should be person-centred.
Rationale
The population of disabled people with mobility impairments that require wheelchairs is highly diverse with a great variety of physical and sensory impairments, which along with other needs and expectations can be either stable or subject to change over time. Mobility impairments are varied and wide-ranging in their complexity and associated issues and a wheelchair may only be part of a solution. A timely, person-centred assessment that is responsive to clinical needs and made within a framework of the Social Model of Disability is fundamental to ensuring that an individual's mobility needs are addressed. Disabled people may have carers who have different needs, capabilities and level of involvement. Assessments should cover the needs of carers with regular or substantial caring responsibility. Registered healthcare professionals assess mobility needs and identify or confirm the need for wheelchair assisted mobility, or a change to existing need. The initial assessment includes taking measurements and submitting a request for a wheelchair to be issued or for a specialist assessment. The initial assessor must be skilled in the assessment of mobility and mobility needs and aware of the range and type of wheelchair equipment available to meet the specific needs of the disabled person. Wheelchair need and provision should be recorded as part of the mobility assessment within the Single Shared Assessment (SSA) when the latter assessment is used. Children and young people are physically, mentally and socially distinct from their adult counterparts. The mobility impairments that they experience and the ways that certain illnesses and conditions can affect them are significantly different. Assessments of children and young people must be conducted by people trained in child development, employ multidisciplinary approaches and consider age-related transitions and educational needs. Accurate and clear information needs to be provided when wheelchair requests are made to ensure optimum outcomes and reduce unnecessary delays. Information governance and data protection standards, procedures and practises must be employed.
Status: Met / Not Met / Not Applicable

Essential Criteria			
No.	Criteria statement		
1.1	Clinical assessments of mobility and mobility needs are person-centred and anticipatory.		
	Evaluation questions / information request		
	1.1.1	Please provide all assessment forms in use outside the specialist WSS centres.	
		Example evidence	Single Shared Assessment form with applicable parts highlighted.
		Evidence /progress	
	1.1.2	Please provide data from a case note audit to demonstrate a person-centred and anticipatory approach.	
		Example evidence	
		Evidence /progress	

1.2	Assessments are conducted in accordance with evidence-based national or local good practice guidelines, where these exist.		
	Evaluation questions / information request		
	1.2.1	Please provide copies of all good practice guidelines in use.	
		Example evidence	Copies of guidelines or links to those available on internet.
		Evidence /progress	
	1.2.2	Please provide data from a case note audit that addresses this criterion.	
		Example evidence	
		Evidence /progress	
1.3	Assessments are conducted by competent, registered clinical staff.		
	Evaluation questions / information request		
	1.3.1	Please provide evidence of a random check of referrers against HPC/GMC/NMA databases.	
		Example evidence	
		Evidence /progress	
	1.3.2	Please provide evidence of how referrers are kept up to date with WSS practices.	
		Example evidence	
		Evidence /progress	
1.4	Assessments of children and young people should also: ▪ address physical and social development ▪ consider age-related transitions from pre-school to school, primary to secondary education, youth to adult services.		
	Evaluation questions / information request		
	1.4.1	Please provide copies of good practice guidelines in use for children and young people.	
		Example evidence	Copies of guidelines or links to those available on internet.
		Evidence /progress	
	1.4.2	Please provide all assessment forms in use for children and young people.	
		Example evidence	Forms with applicable areas highlighted.
		Evidence /progress	
1.5	Assessments should consider the needs of primary carers.		
	Evaluation questions / information request		
	1.5.1	Please provide copies of good practice guidelines in use for carers.	
		Example evidence	Copies of guidelines or links to those available on internet.
		Evidence /progress	
1.6	Wheelchair need is recorded within the mobility section of the SSA when this assessment is used.		
	Evaluation questions / information request		

	1.6.1	Please provide data from a case note audit that addresses this criterion.	
		Example evidence	
		Evidence /progress	
1.7	Referral forms (and supporting guidance) should conform to the recommended content and format and be readily available.		
	Evaluation questions / information request		
	1.7.1	Please provide evidence that all essential data and format requirements listed in Appendix E (of the CHQS) are met.	
		Example evidence	Copies of forms or links to those available on internet.
		Evidence /progress	
	1.7.2	Please provide copies of all supporting guidance for all prescription and referral forms in use.	
		Example evidence	Copies of guidance or links to those available on internet.
		Evidence /progress	
	1.7.3	Please provide evidence of how the supporting guidance is made available to referrers.	
		Example evidence	Intranet or internet address if available online.
		Evidence /progress	
1.8	Referral forms (and prescription forms if in use) can be submitted in a variety of formats, including electronically.		
	Evaluation questions / information request		
	1.8.1	Please outline in what formats prescriptions and/or referrals can be submitted.	
		Example evidence	
		Evidence /progress	

Desirable Criteria			
No.	Criteria statement		
1.9	Any unmet mobility needs and/or any unresolved disagreements should be recorded.		
	Evaluation questions / information request		
	1.9.1	Please provide data from a case note audit that addresses this criterion.	
		Example evidence	
		Evidence /progress	
1.10	Non-WSS Centre staff trained to an agreed level of competence should be able to directly prescribe from an agreed list of equipment.		
	Evaluation questions / information request		
	1.10.1	Please describe what training is made available to staff who undertake assessments of mobility and mobility needs to allow them to prescribe more specialist equipment.	
		Example evidence	

		Evidence /progress	
	1.10.2	How is the ongoing competence of staff assessed and recorded?	
		Example evidence	Protocol for, and anonymised records of, staff training.
		Evidence /progress	
	1.10.3	Please provide a copy of the agreed list of more specialist equipment available to competent, non-specialist staff.	
		Example evidence	
		Evidence /progress	
	1.10.4	Please provide a breakdown of the numbers of non-specialist staff that are able to access specialist equipment with their level of prescribing rights, including their professional background and work locations.	
		Example evidence	
		Evidence /progress	
1.11	Prescription forms (and supporting guidance) for use by non-WSS Centre staff should conform to the recommended content and format (Appendix E of the CHQS) and be readily available.		
	Evaluation questions / information request		
	1.11.1	Please provide evidence that all essential data and format requirements listed in Appendix E (of the CHQS) are met.	
		Example evidence	Copies of forms or links to those available on internet.
		Evidence /progress	
	1.11.2	Please provide copies of all supporting guidance for all prescription forms in use.	
		Example evidence	Copies of guidance or links to those available on internet.
		Evidence /progress	
	1.11.3	Please provide evidence of how the supporting guidance is made available to prescribers.	
		Example evidence	Intranet or internet address if available online.
		Evidence /progress	

Standard 2: Specialist assessment

Standard Statement
The specialist assessment of wheelchair and seating needs should be person-centred, anticipatory and conducted in the context of a multidisciplinary team.
Rationale
Disabled people's mobility needs can be complex and diverse and referrals for specialist assessment need to be screened by registered healthcare staff trained to an agreed level of competence. To minimise adverse effects resulting from delays to assessment and subsequent provision, referrals should be screened, prioritised and subsequently actioned within reasonable timescales. If delays are anticipated, referrers and those referred should be advised so that they may take steps to take mitigating action. A timely, comprehensive and person-centred assessment is fundamental to ensuring that outcomes are improved. Specialist assessments should be conducted in accordance with evidence-based good practice guidelines by competent, registered clinical staff in the context of a Multidisciplinary Team (MDT) approach. Specialist knowledge and skills are required to assess disabled people who have complex clinical needs and/or require additional or complex technological solutions to address their mobility and associated seating needs effectively. Assessments must be outcome-focused with goals agreed with the disabled person, and, if relevant, a primary carer. These should be recorded and shared, and appropriate measures administered to evaluate the effectiveness of intervention. Healthcare clinical staff who assess for wheelchair mobility must have access to the necessary equipment. This may include portable investigative resources to support assessment at home or in other community settings. Disabled people with specific and complex needs should be seen in suitable clinic facilities with access to appropriate assessment resources and skills. People requiring complex equipment solutions and/or have complex needs should be managed collaboratively by relevant health and social care services using case management approaches. This ensures that an individual's wheelchair mobility and their carer's needs are managed appropriately in the most clinically effective and efficient way.
Status: Met / Not Met / Not Applicable

Essential Criteria			
No.	Criteria statement		
2.1	Referrals for specialist assessment are screened by competent, registered clinical staff.		
	Evaluation questions / information request		
	2.1.1	Please provide a list of the names of clinical staff who undertake screening and their professions and registration numbers.	
		Example evidence	
		Evidence /progress	
	2.1.2	How is the ongoing competence of staff assessed and recorded?	
		Example evidence	Protocol for, and anonymised records of, staff training.
		Evidence /progress	
2.2	Referrals for specialist assessment are prioritised in accordance with publicly available criteria based on clinical need.		

	Evaluation questions / information request		
	2.2.1	Please provide a copy of guidance used to prioritise referrals.	
		Example evidence	Copies of guidance or links to those available on internet.
		Evidence /progress	
	2.2.2	Please provide data on the numbers and proportions of referrals during that most recently completed quarter broken down by priority and major pathways.	
		Example evidence	
		Evidence /progress	
	2.2.3	Please provide evidence of how the criteria used to prioritise referrals is made publicly available.	
		Example evidence	
		Evidence /progress	
2.3	Referrers and those referred are advised if a specialist assessment will not occur within 4 weeks of receipt of a referral.		
	Evaluation questions / information request		
	2.3.1	Please provide data on all specialist assessments that did not occur within four weeks of receipt of referral in the most recently completed quarter including how and when the referrers and those referred were contacted.	
		Example evidence	
		Evidence /progress	
2.4	Specialist assessments are conducted within 4 weeks of referral in at least 95% of cases and within 8 weeks for 100% of cases, in each major pathway through the services.		
	Evaluation questions / information request		
	2.4.1	Please report the percentage of assessments conducted within 4 weeks and within 8 weeks for the most recently completed quarter, broken down by priority and major pathways.	
		Example evidence	
		Evidence /progress	
2.5	Specialist assessments are person-centred and anticipatory, and based on the factors listed in Appendix F (of the CHQS).		
	Evaluation questions / information request		
	2.5.1	Please provide all assessment forms in use.	
		Example evidence	
		Evidence /progress	
	2.5.2	Please provide data from a case note audit mapped against the assessment factors listed in Appendix F.	
		Example evidence	
		Evidence /progress	

2.6	Specialist assessments are conducted in accordance with evidence-based national or local good practice guidelines, where these exist.		
	Evaluation questions / information request		
	2.6.1	Please provide copies of all good practice guidelines in use.	
		Example evidence	Copies of guidelines or links to those available on internet.
		Evidence /progress	
	2.6.2	Please provide data from a case note audit that addresses this criterion.	
		Example evidence	
		Evidence /progress	
2.7	Specialist assessments are conducted by competent, registered clinical staff.		
	Evaluation questions / information request		
	2.7.1	Please provide a list of the names of clinical staff who undertake specialist assessments and their professions and registration numbers.	
		Example evidence	
		Evidence /progress	
	2.7.2	How is the ongoing competence of staff assessed and recorded?	
		Example evidence	Protocol for, and anonymised records of, staff training.
		Evidence /progress	
2.8	Appropriate measures should be administered to evaluate the outcome of each intervention, covering both service users' and carers' needs.		
	Evaluation questions / information request		
	2.8.1	Please provide a copy of all the documentation used to support the outcome measure(s) employed.	
		Example evidence	
		Evidence /progress	
	2.8.2	Please provide data from a case note audit that addresses this criterion.	
		Example evidence	
		Evidence /progress	
2.9	Any unmet mobility needs and/or any unresolved disagreements should be recorded.		
	Evaluation questions / information request		
	2.9.1	Please explain how unmet mobility needs and/or any unresolved disagreements are recorded.	
		Example evidence	
		Evidence /progress	
	2.9.2	Please provide data from a case note audit that addresses this criterion.	
		Example evidence	

		Evidence /progress	
2.10	A written summary of the agreed specialist assessment outcome and prescription should be shared with users and, with their agreement, carers and other appropriate, interested parties.		
	Evaluation questions / information request		
	2.10.1	Please outline how agreed outcomes and prescriptions are shared.	
		Example evidence	Copy of template form/letter.
		Evidence /progress	
	2.10.2	Please provide anonymised copies of at least five written summaries issued within the past three months.	
		Example evidence	
		Evidence /progress	
2.11	Clinic facilities should comply with the minimum requirements set out in Appendix G (of the CHQS).		
	Evaluation questions / information request		
	2.11.1	Please provide a list of all locations used for clinical events with a list of investigative resources available and type of activity undertaken at each location.	
		Example evidence	
		Evidence /progress	
2.12	At least 85% of users should be seen within their own local NHS Board area subject to the availability of suitable clinic facilities.		
	Evaluation questions / information request		
	2.12.1	Please provide a list of all locations used for clinical events by NHS board area.	
		Example evidence	
		Evidence /progress	
	2.12.2	Please provide data on the proportion of clinical events conducted outside of users' own local NHS Board area for the most recently completed quarter.	
		Example evidence	
		Evidence /progress	
	2.12.3	Please provide reasons for the clinical events conducted outside of users' own local NHS board area for the most recently completed month.	
		Example evidence	
		Evidence /progress	

Standard 3: Clinical follow up and planned review

Standard Statement
Service users should be followed up after each significant clinical intervention and planned clinical reviews are offered to those who need one.
Rationale
To ensure that any significant clinical intervention meets the needs identified at an initial or specialist assessment, a follow up should be undertaken. This should be done as soon as the user and/or carer(s) have had adequate time to assess whether or not the equipment provided meets the agreed assessment outcome. This is the responsibility of the initial assessor who identified or confirmed the need for wheelchair assisted mobility or, when a specialist assessment has been undertaken, the specialist clinician responsible. Wheelchair users have complex and changing needs caused by their underlying medical condition(s) and other health or social factors. Some users may require periodic, planned reviews to ensure that any changes in their impairment(s) or circumstances, that could be reasonably anticipated, can be addressed in a timely manner. Children also have rapidly changing needs as they grow and develop, both physically and cognitively. Developmental needs can be adversely affected if a child does not have the right wheelchair and seating provision. Services need to anticipate and plan for growth and changes in body shape, as well as transitions through the education, health and social care systems. The frequency of review should be determined individually to minimise any potential negative impact on user's educational, vocational, health or social care arrangements. The progressive nature of their underlying medical condition(s), planned medical or surgical interventions, child development and growth, planned transitions or changes to domestic, vocational or social care arrangements should be taken into account when determining review periods. Existing users, and/or their family and carers, should be aware of how they can request a clinical review should their current wheelchair and/or seating provision no longer meet their mobility or postural support needs.
Status: Met / Not Met / Not Applicable

Essential Criteria			
No.	Criteria statement		
3.1	Significant clinical interventions are followed up to ensure that these meet the agreed outcomes identified at an initial or subsequent assessment.		
	Evaluation questions / information request		
	3.1.1	Please provide evidence from a case note audit that demonstrates that this criterion is being met by initial assessors.	
		Example evidence	
		Evidence /progress	
	3.1.2	Please provide evidence from a case note audit that demonstrates that this criterion is being met by specialist clinicians.	
		Example evidence	
		Evidence /progress	

3.2	Planned clinical reviews are offered to all users identified as having complex and changing needs, including: ▪ those with progressive conditions ▪ children (< 16 years old) ▪ those with anticipated transitions ▪ those with anticipated changes to their domestic, vocational or social care arrangements.		
	Evaluation questions / information request		
	3.2.1	Please provide copies of guidelines or other documents used to determine if users require a specialist clinical review.	
		Example evidence	
		Evidence /progress	
	3.2.2	Please provide number of users offered a clinical review in the most recently completed quarter and the percentage of total users that this represents.	
		Example evidence	
		Evidence /progress	
	3.2.3	Please provide details from a case note audit of users offered a specialist clinical review in the past year, including primary diagnosis, age, and clinical reasoning.	
		Example evidence	
		Evidence /progress	
3.3	The frequency of review will be agreed with the user taking into account, where appropriate: ▪ progression of condition ▪ children's physical and social development ▪ planned transitions or changes to domestic, vocational or social care arrangements.		
	Evaluation questions / information request		
	3.3.1	Please provide copies of guidelines used to help determine the frequency of a review.	
		Example evidence	
		Evidence /progress	
	3.3.2	As 3.2.3 including details of review frequency.	
		Example evidence	
		Evidence /progress	
3.4	Existing NHS wheelchair users, family and carers (where appropriate), are aware of how they can request a clinical review.		
	Evaluation questions / information request		
	3.4.1	Please provide copies of the information provided.	
		Example evidence	
		Evidence /progress	

	3.4.2	Please provide evidence of how this information is made available to these groups.	
		Example evidence	
		Evidence /progress	

Standard 4: Equipment provision and management

Standard Statement
Wheelchairs, seating and associated equipment are medical devices and should be safe and fit for purpose and provided in a timely manner in accordance with risk management principles.
Rationale
Wheelchairs, seating and associated equipment are Class I medical devices and must comply with the Medical Devices Regulations (MDR) (2002) as regulated by the Medicines and Healthcare products Regulatory Agency (MHRA). Any risks associated with the equipment provision should be minimised. Adverse incidents, problems (or the potential for problems) should be managed in accordance with Medical Device Alert (MDA) recommendations. Provision should be conducted by or overseen by a competent, registered clinical staff member who is responsible for managing the case and acts as the contact person for the disabled person and/or their carers. The time from assessment to provision should be minimised to avoid the need for reassessment should needs change in the meantime (e.g. due to children growing). The introduction of new product lines and technologies to NHS provision must involve wheelchair users and be objectively evaluated to ensure that they fulfil their intended purpose from both clinical and device management perspectives. Their introduction should be managed to ensure that adequate spares are stocked and that they can be maintained and repaired. A planned approach to ensuring wheelchair and seating equipment responds to user needs and advancing technology must be in place. The modification of CE-marked medical devices, in-house manufacturing and off-label use of devices to meet particularly needs are subject to the requirements of the MDR. A risk assessment, which is necessary to minimise any potential hazards, should be conducted in accordance with the International Standards Organization's (ISO) risk management standard (ISO14971). The provision, and updating, of instructions, and if necessary training, that takes into account the knowledge and training of the intended user(s), is crucial to the safe and effective use of equipment. Adequate instructions, and if necessary training, should be provided to new and existing users and/or carers. These should, as a minimum, cover how to report faults and adverse incidents, how to carry out routine checks and basic maintenance, and general wheelchair management, such as how to negotiate kerbs. Maintenance and repair policies and procedures should ensure user safety and continuity of care using a risk management approach. The frequency and type of planned preventive maintenance (PPM) should be specified, taking account of the manufacturer's instructions, the expected usage and the environment in which the equipment is to be used.
Status: Met / Not Met / Not Applicable

Essential Criteria			
No.	Criteria statement		
4.1	Provision of devices to individuals is conducted by or overseen by competent, registered clinical staff.		
	Evaluation questions / information request		
	4.1.1	Please provide a list of the names of clinical staff who conduct or oversee assessments and their professions and registration numbers.	
		Example evidence	

		Evidence /progress	
	4.1.2	Please provide evidence of supervisory arrangements for elements of the service delivered by non-clinical staff in relation to device provision to individuals.	
		Example evidence	
		Evidence /progress	
	4.1.3	How is the ongoing competence of staff assessed and recorded?	
		Example evidence	Protocol for, and anonymised records of, staff training.
		Evidence /progress	
4.2	Standard provision, for which a specialist assessment was not required, is provided within 2 weeks of referral in at least 95% of cases and within 3 weeks for 100% of cases.		
	Evaluation questions / information request		
	4.2.1	Please provide data of time (in days) between referral and provision for all standard provisions not requiring a specialised assessment in the most recently completed quarter.	
		Example evidence	
		Evidence /progress	
	4.2.2	Please report the percentages achieved within 2 weeks and within 3 weeks.	
		Example evidence	
		Evidence /progress	
4.3	Standard provision, for which a specialist assessment was undertaken, is provided within 6 weeks of referral in at least 95% of cases and within 11 weeks for 100% of cases.		
	Evaluation questions / information request		
	4.3.1	Please provide data of time (in days) between referral and provision for all standard provisions following a specialised assessment in the most recently completed quarter.	
		Example evidence	
		Evidence /progress	
	4.3.2	Please report the percentages achieved within 6 weeks and within 11 weeks.	
		Example evidence	
		Evidence /progress	
4.4	Specialist provision is provided within 14 weeks of referral in at least 95% of cases and within 18 weeks for 100% of cases.		
	Evaluation questions / information request		
	4.4.1	Please provide data of time (in days) between referral and provision for all specialist provisions in the most recently completed quarter.	
		Example evidence	

		Evidence /progress	
	4.4.2	Please report the percentage achieved within 14 weeks and within 18 weeks.	
		Example evidence	
		Evidence /progress	
4.5	Services should adhere to local equipment management policies and procedures that are based on a risk management approach and conform to MHRA guidance.		
	Evaluation questions / information request		
	4.5.1	Please provide a copy of the local device management polices and procedures.	
		Example evidence	
		Evidence /progress	
	4.5.2	Please map local polices and procedures against MHRA guidance.	
		Example evidence	
		Evidence /progress	
	4.5.3	Please provide copies of all pre-handover checks lists currently in use.	
		Example evidence	
		Evidence /progress	
	4.5.4	Please provide evidence that pre-handover checks are completed for all devices issued during the most recently completed calendar month.	
		Example evidence	
		Evidence /progress	
4.6	In-house manufacturing and off-label use of devices should be in accordance with the MDR, including design and risk assessments records.		
	Evaluation questions / information request		
	4.6.1	Please provide a copy of procedures and other documentation used to ensure compliance with the MDR for the in-house manufacture and off-label use of devices.	
		Example evidence	
		Evidence /progress	
	4.6.2	Please provide copies of the design records and risk assessments of all in-house manufactured and off-label use devices issued in the most recently completed quarter.	
		Example evidence	
		Evidence /progress	
4.7	NHS wheelchairs are provided from national contract in accordance with policy and legislative requirements.		
	Evaluation questions / information request		

	4.7.1	Please provide the percentage of wheelchairs purchased in the most recent complete year bought from the NHS National Procurement contract.	
		Example evidence	
		Evidence /progress	
4.8	A model of equipment renewal is in place that responds to technological advances and involves users and carers.		
	Evaluation questions / information request		
	4.8.1	Please provide details of the equipment/fleet renewal strategy and evidence that the strategy is in place.	
		Example evidence	
		Evidence /progress	
	4.8.2	Please provide the percentage of wheelchairs that are over 5 years old in the fleet, that currently are on issue and that are in stock awaiting issue.	
		Example evidence	
		Evidence /progress	
	4.8.3	Please provide details of how users and carers are involved in this area.	
		Example evidence	Minutes/agendas of meetings/events.
		Evidence /progress	
4.9	New product lines should only be introduced with adequate staff training.		
	Evaluation questions / information request		
	4.9.1	Please provide evidence of the staff training undertaken when new wheelchairs and seating are introduced.	
		Example evidence	
		Evidence /progress	
4.10	Adequate instructions, and if necessary training, should be provided for all devices in accordance with MHRA guidance.		
	Evaluation questions / information request		
	4.10.1	Please provide evidence that conditions of supply and instructions and, if necessary, training are provided.	
		Example evidence	
		Evidence /progress	
	4.10.2	Please provide copies of the instructions accompanying all in-house manufactured and off-label use devices that were issued in the most recently completed quarter.	
		Example evidence	
		Evidence /progress	
	4.10.3	Please provide evidence that there are processes in place for recording, tracking and issuing updated instructions.	
		Example evidence	Copy of standard operating procedures/equipment management policy.

		Evidence /progress	
4.11	Adequate instructions, and if necessary training, should be provided on using wheelchairs and/or equipment for new and existing users and/or carers.		
	Evaluation questions / information request		
	4.11.1	Please provide evidence that adequate instructions and, if necessary, training are provided to users and/or carers on general wheelchair and equipment management.	
		Example evidence	
		Evidence /progress	
4.12	Users and carers have information on how to report faults and adverse incidents, carry out routine checks and basic maintenance, and on the potential danger of inappropriate modifications or adjustments.		
	Evaluation questions / information request		
	4.12.1	Please provide copies of this information.	
		Example evidence	
		Evidence /progress	
	4.12.2	Please provide evidence of how this information is made available to users and carers.	
		Example evidence	
		Evidence /progress	
4.13	Repairs are prioritised and completed in accordance with publicly available criteria and targets.		
	Evaluation questions / information request		
	4.13.1	Please provide a copy of the locally agreed categories used to prioritise repairs.	
		Example evidence	
		Evidence /progress	
	4.13.2	Please provide evidence of how the criteria used to prioritise referrals is made publicly available.	
		Example evidence	
		Evidence /progress	
4.14	Planned Preventative Maintenance (PPM) is undertaken based on a risk management approach that conforms to MHRA guidance.		
	Evaluation questions / information request		
	4.14.1	Please provide a copy of procedures and other documentation used to ensure compliance with the MHRA guidance on PPM.	
		Example evidence	
		Evidence /progress	
	4.14.2	Please provide evidence to demonstrate PPM is being completed.	
		Example evidence	

		Evidence /progress	
4.15	Services should adhere to MHRA adverse incident guidance on the reporting of incidents and responding to alerts.		
	Evaluation questions / information request		
	4.15.1	Please evidence that this criterion is being met.	
		Example evidence	Any documented service procedures.
		Evidence /progress	
	4.15.2	Please supply a list of all applicable adverse incidents reported to MHRA by the service in past year.	
		Example evidence	
		Evidence /progress	
	4.15.3	Please supply a list of all applicable MHRA device alerts and details of the service's response.	
		Example evidence	
		Evidence /progress	
4.16	All service users with equipment on issue are contacted at least annually.		
	Evaluation questions / information request		
	4.16.1	Please provide evidence of the procedures for contacting users at least annually and copies of any standard letters in use.	
		Example evidence	
		Evidence /progress	
	4.16.2	Please provide data on the number of patients contacted the past year and what proportion of the overall user number they represent.	
		Example evidence	
		Evidence /progress	
4.17	Urgent repairs should be completed within one day in at least 75% of cases.		
	Evaluation questions / information request		
	4.17.1	Please provide the percentage of urgent repairs completed with one day during the most recently completed quarter.	
		Example evidence	
		Evidence /progress	
4.18	Routine repairs should be completed within five days in at least 90% of cases.		
	Evaluation questions / information request		
	4.18.1	Please provide the percentage of routine repairs completed with five days during the most recently completed quarter.	
		Example evidence	
		Evidence /progress	

4.19	Deliveries, repairs and PPM appointments are arranged at times to suit user's lifestyles as far as it is practical.		
	Evaluation questions / information request		
	4.19.1	Please provide a copy of procedures and other documentation used to ensure compliance with this criterion.	
		Example evidence	
		Evidence /progress	
	4.19.2	Please provide evidence that this criterion is being met.	
		Example evidence	Outcomes from an independent survey of users and their carers' satisfaction.
		Evidence /progress	

Standard 5: Quality management and service improvement

Standard Statement
Services should, in partnership with all stakeholders, create and sustain a culture of continuous quality improvement to deliver a person-centred, clinically effective and safe service.
Rationale
Better outcomes are achieved when services are provided in partnership with users, carers and staff. Clinical governance, evidence-based practice and quality assurance underpin person-centre, safe and effective service provision. Surveys of user and carer satisfaction can provide valuable insights to improve provision and outcomes. Quality Management Systems (QMSs) imbed quality assurance and encourage service improvement. These should conform to an internationally recognised standard for the providers of medical devices, for example, ISO13485. QMSs should to be integral to the day to-day policies and procedures and culture of the service. This ensures that services are safe and effective and able to respond to the ever changing and challenging external environment. Leadership, user, carer and staff involvement and on-going, focused initiatives are critical to achieving and sustaining service and quality improvements. Staff training and education and adherence to evidence-based clinical practice are an underlying necessity. Research and development not only furthers the knowledge of the field, but is also a means of motivating and developing staff. Safety is a key driver of service change and development. The recording and sharing of outcomes from quality improvement, product evaluation and research and development activities promote further improvements and spreading of best practice. Collating and reporting unmet needs supports this endeavour.
Status: Met / Not Met / Not Applicable

Essential Criteria			
No.	Criteria statement		
5.1	NHS Boards should integrate or link their local wheelchair user and carer groups or networks with their Patient Focus Public Involvement (PFPI) structures and processes.		
	Evaluation questions / information request		
	5.1.1	Please provide details of the remit, membership, meetings, etc. of these local groups and/or networks.	
		Example evidence	Terms of Reference, Minutes of Meetings.
		Evidence /progress	
	5.1.2	Please provide evidence of how these groups and/or networks are supported.	
		Example evidence	
		Evidence /progress	
5.2	Services should commission an independent survey of users at least once every two years to check their and their carers' satisfaction with the service provided and how well their equipment meets their needs.		
	Evaluation questions / information request		
	5.2.1	Please provide evidence to support this criterion.	
		Example evidence	Survey report, Survey questionnaire.

		Evidence /progress	
5.3	Information made available to users and carers should comply with the Scottish Accessible Information Forum's (SAIF) standards and be provided in alternative formats consistent with equality and diversity duties.		
	Evaluation questions / information request		
	5.3.1	Please provide a copy of policies relating to this issue.	
		Example evidence	
		Evidence /progress	
	5.3.2	Please provide evidence of how any requests made for alternative formats have been dealt with in the past two years.	
		Example evidence	Details of requests with time taken to supply requested format.
		Evidence /progress	
5.4	Information (as outlined in Appendix H of the CHQS) should be readily available to disabled people, their families and carers, and other interested stakeholders.		
	Evaluation questions / information request		
	5.4.1	Please provide copies of this information.	
		Example evidence	Copies of documents or links to those available on internet.
		Evidence /progress	
	5.4.2	Please provide evidence of how this information is made available to these groups.	
		Example evidence	List of physical locations and internet addresses.
		Evidence /progress	
5.5	Each territorial NHS Board should have an identified and active strategic lead with a responsibility for WSSs.		
	Evaluation questions / information request		
	5.5.1	Please provide the name, post-held and profession of the lead.	
		Example evidence	
		Evidence /progress	
	5.5.2	Please provide evidence of their active involvement in the provision of WSSs over the past two years.	
		Example evidence	Minutes of meetings.
		Evidence /progress	
5.6	A comprehensive QMS should be in place that drives continuous service improvement.		
	Evaluation questions / information request		
	5.6.1	Please provide copies of Quality Manual or other similar documents.	
		Example evidence	
		Evidence /progress	

	5.6.2	Please provide evidence to demonstrate that system encourages service improvement.	
		Example evidence	
		Evidence /progress	
5.7	Each WSS should identify lead roles for quality and service improvement.		
	Evaluation questions / information request		
	5.7.1	Please provide the name, post-held and profession of the leads.	
		Example evidence	
		Evidence /progress	
5.8	Each WSS should identify lead roles for product evaluation, research and development.		
	Evaluation questions / information request		
	5.8.1	Please provide the name, post-held and profession of the leads.	
		Example evidence	
		Evidence /progress	
5.9	WSSs should report on their quality improvement, product evaluation and research and development activity.		
	Evaluation questions / information request		
	5.9.1	Please provide a copy of the most recent report(s) or other documents that are less than two years old.	
		Example evidence	
		Evidence /progress	
5.10	Records of unmet needs should be collated and reported on annually.		
	Evaluation questions / information request		
	5.10.1	Please provide a copy of the latest annual report.	
		Example evidence	
		Evidence /progress	
5.11	All staff should undergo wheelchair and seating specific induction training appropriate to their role.		
	Evaluation questions / information request		
	5.11.1	Please provide details of the content on the service's WSS specific induction training.	
		Example evidence	
		Evidence /progress	
	5.11.2	Please provide details of the percentage of staff who have joined the service in the past year who have undertaken WSS specific induction training broken down by professional groupings.	
		Example evidence	

		Evidence /progress	

Desirable Criteria			
No.	Criteria statement		
5.12	QMSs should conform to an internationally recognised standard.		
	Evaluation questions / information request		
	5.12.1	Please state the internationally recognised standard that the quality management system conforms to.	
		Example evidence	
		Evidence /progress	
5.13	Outcomes from quality improvement, product evaluation and research and development events and activities should be shared with other Scottish services and the wider field.		
	Evaluation questions / information request		
	5.13.1	Please provide copies of the information shared.	
		Example evidence	
		Evidence /progress	
	5.13.2	Please provide details of how this information was shared.	
		Example evidence	
		Evidence /progress	

The Quality Ambitions

Three Quality Ambitions provide the focus for everything NHSScotland does in its aim to deliver the best quality healthcare to the people of Scotland and, through this, make NHSScotland a world leader in healthcare quality.

Person-Centred

There will be mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

The aims are:

- to improve and embed patient-reported outcomes and experience across all NHSScotland services
- to support staff, patients and carers to create partnerships which result in shared decision-making
- to inform and support people to manage and maintain their health, and to manage ill-health

Safe

There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

The aims are:

- to secure the improvements which have been delivered through the success of the Scottish Patient Safety Programme, and roll out across other areas of NHSScotland activity
- to support integrated programme of action to reduce occurrence of Healthcare Associated Infection (HAI)

Effective

The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

The aims are:

- to ensure continuity in all care pathways through implementation of long-term conditions action plan
- to apply information from quality data to drive consistently better care across NHSScotland
- to increase focus on preventative and anticipatory care and intervention