

Community
Equipment
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Transforming Community Equipment Services The Retail Model (England)



“It would be the height of folly to risk the welfare of the most vulnerable members in our society by adopting the Retail Model without appropriate safeguards in place.”

Brian Donnelly

The need for Standards

Brian Donnelly MSc
January 2011

About the author

This paper was written by Brian Donnelly, director of Community Equipment Solutions Ltd and founder and chair of the UK Community Equipment Standards Adoption Group. Brian has a wealth of experience in the community equipment industry. He has recently finished a 3 year contract as the National Development Officer for community equipment provision within the Welsh Assembly Government. Prior to that he was head of an integrated service in England, and has also worked as an ICES project manager across various services.

Brian is well known for his authoritative and sobering paper calling on the need for national minimum standards for equipment provision in England and Wales. As a result of his paper Brian has since written Standards for the Welsh Assembly Government. He also set up and now chairs a UK-wide group which aims to see Standards introduced across the UK. Many of the leading community equipment stakeholders sit on this group, and Brian is currently leading their campaign.

Such is Brian's conviction and concerns about the safety and quality of community equipment provision, understanding the impact poor provision has upon service users, he has written his best known documents in a personal and voluntary capacity. This includes, for example, 'The Need for National Minimum Standards', his work for the Standards Adoption Group, as well as this paper. Brian believes that without having appropriate safeguards in place, especially in a time of unparalleled change and deep financial cuts, service users could be exposed to unsafe and poor quality service provision – especially the most vulnerable.

Brian is well placed to address these issues, having great experience of the industry, as well as being qualified in purchasing & supply, and holding an MSc in Health & Social Care.

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Executive Summary

It is now widely known that Standards for community equipment provision are due to be issued in England early 2011 (in the form of Best Practice Guidelines). This is supported by The UK Community Equipment Standards Adoption Group. The Guidelines will cover the provision of community equipment in its entirety, including the Transforming Community Equipment Services (TCES) Retail Model.

This summary paper has been written to make it clear why Standards for England are required to cover the Retail Model, as well as other methods of provision. The paper examines the main issues and concerns relating to the Retail Model. It should be read in conjunction with our original paper calling on [The Need for National Minimum Standards](#)¹, as this provides the overall context.

It is often assumed that the Retail Model, as a Government backed scheme, includes safeguards and standards within its design; this is not the case. Local Authorities and NHS organisations are responsible themselves for ensuring service provision is safe, legal and of acceptable quality. Some aspects of the Retail Model increase the risks borne by these organisations.

Many of the concerns raised in the past about the Retail Model e.g. governance, finance and legal issues, have still not been sufficiently addressed. Recent evidence has proved that some of the longstanding concerns around the safety and quality of the Model still exist.

Assessing overall performance of community equipment provision is also difficult where the Retail Model is adopted, especially where service users have multiple and complex needs.

There is evidence that in many cases adopting the Retail Model could cost much more than traditional methods of provision. In some areas where the Model has been adopted hidden costs are beginning to emerge. For example, it is reported that in some cases up to 45 per cent of prescriptions are not redeemed; this may seem like a saving, but it usually results in further episodes of care such as costly hospital admissions. In addition, a high number of clinical professionals are collecting

¹ <http://www.communityequipment.org.uk/>

prescriptions on behalf of service users, which is both costly and an inefficient use of valuable professional expertise.

The DH has discouraged contractual arrangements with retailers, a lack of appropriate governance which leaves organizations exposed to a high level of risk. Their withdrawal from supporting the highly regarded accreditation scheme (CEDAB) could also be exposing service users to high-pressure selling and unmet needs, from less professional and ungoverned retailers.

Although it is not possible for Standards to resolve all of the concerns relating to the Retail Model, their application will help to mitigate the effects and provide a level of protection and assurance for those organisations which have chosen, or are considering whether, to adopt the Retail Model. They would be beneficial to all commissioners, providers, retailers, service users and regulators.

It is essential to remember that community equipment is provided to some of the most vulnerable members of our society e.g. disabled, elderly, sick and in some cases dying; it is therefore our legal duty, if not moral obligation, to ensure appropriate safeguards are in place so that these service users are in receipt of a safe and good quality service.

1. Introduction

Many people will now be aware that Standards are soon to be issued in England for the provision of community equipment. Standards will cover all aspects of community equipment e.g. commissioning, provision and clinical interface. These will be similar to the Standards recently launched in Wales, but will also incorporate the Department of Health's (DH) Transforming Community Equipment Services (TCES) Retail Model.



The Standards will be issued in England as Best Practice Guidelines. It is expected that they will be endorsed by all of the stakeholder organisations currently forming the [UK Community Equipment Standards Adoption Group](#)².

This summary paper has been written to make it clear why Standards for England are required to cover the Retail Model, as well as other methods of provision. This paper is to be read in conjunction with our original paper calling on [The Need for National Minimum Standards](#)³, as this provides the overall context.

Many people assume that the Retail Model, as a Government backed scheme, must include safeguards and standards within its design. However this is not the case, and the DH have stated that Local Authorities and NHS organisations are responsible themselves for ensuring service provision is safe, legal and of acceptable quality. In fact, some aspects of the Retail Model increase the risks borne by these organisations, as will be explained.

This summary paper examines some of the main reasons why Standards are needed for the Retail Model. It also examines the main concerns – both past and present - which have been raised about the Retail Model from across the industry. The paper also explains how Standards can help to ensure all parties concerned are protected and that they are operating safely, legally and efficiently, so far as is possible within the constraints of the Retail Model.

² <http://tinyurl.com/28hxyap>

³ <http://www.communityequipment.org.uk/>

Although it is not possible for Standards to resolve all of the concerns relating to the Retail Model, their application will help to mitigate the effects and provide a level of protection and assurance for those organisations which have chosen, or are considering whether, to adopt the Retail Model.

It is essential to remember that community equipment is provided to some of the most vulnerable members of our society e.g. disabled, elderly, sick and in some cases dying; it is therefore our legal duty, if not moral obligation, to ensure appropriate safeguards are in place so that these service users are in receipt of a safe and good quality service.

This paper is not to be viewed as a direct criticism of the Retail Model, just as our original paper calling on the need for Standards was not a criticism of all other community equipment provision. Rather it has been written with a view to increasing awareness both of the risks inherent in the Retail Model, and of the role Standards have in reducing these risks, and safeguarding individuals and organisations.

2. The Need for National Minimum Standards – England and Wales



In view of the wider concerns about community equipment provision in general, we wrote an independent paper in 2009 calling on the need for National Minimum Standards for community equipment services in England and Wales⁴. The paper also included some of the main concerns about the TCES Retail Model, and why this area of provision should also have Standards.

The independent review looked at equipment provision in its entirety including, for example, commissioning, provision, the clinical interface and peripheral issues. The paper set the services in their legal and regulatory context, and highlighted where breaches of these obligations were occurring. As well as focusing largely on wider

⁴ <http://www.communityequipment.org.uk/>

community equipment issues the paper also exposed the weakness of the Retail Model in terms of performance assessment, and the difficulty this presented.

As a result of the paper Standards have been written for the Welsh Assembly Government. Many of the key stakeholders in the industry also want Standards to cover England; these are currently being written, and should be available early 2011.

The Standards are intended to protect service users and organizations alike. They basically provide a 'framework of understanding' for everyone operating in the community equipment space, and are in keeping with current legal and welfare duties and obligations. They are not intended to fetter provision, but rather to ensure provision is made with appropriate safeguards in place. They also allow services to be measured so that performance and quality levels can be ascertained. The original paper arguing for the introduction of Standards also highlighted the financial benefits of getting service provision right.

2.1 Support for Standards

Key stakeholders and organizations⁵ from across the industry have come together, including Assist UK, British Health Trade Association (BHTA), Chartered Society of Physiotherapy (CSP), College of Occupational Therapists (COT), Disabled Living Foundation (DLF), Health and Safety Executive (HSE), Medicines and Healthcare Regulatory Agency (MHRA), National Association of Equipment Providers (NAEP), Royal College of Nursing (RCN), and SCOPE, amongst many others, and have provisionally agreed that Standards should be introduced and should cover the entire community equipment industry. This obviously includes retail provision. Many of these members recently sat on a reference group in Wales and contributed to the Standards issued there.

Where organizations have opted for the Retail Model (or a 'hybrid' version) the Standards (England) will help to ensure that they are operating safely and legally. They will also, and most importantly, ensure that safeguards are in place to protect vulnerable service users.

⁵ Some organisations can only show support for the parts of the Standards which relate specifically to them e.g. MHRA for medical devices. Also, although provisional support is shown from the member organisations, some of the professional associations have a formal process to go through before official endorsement can be given. This obviously is only possible after the Standards are complete.

3. About the Transforming Community Equipment Services (TCES) Retail Model



The Retail Model⁶ for community equipment was announced in June 2006 by the DH TCES team. It was originally intended to cover all aspects of community equipment provision including simple and complex aids. It was also intended to eventually cover Wheelchair provision.

3.1 Background issues

When the Transforming Community Equipment Services initiative was first announced the DH TCES team⁷ was quite scathing about the capabilities of statutory services. They claimed there were 'real and growing problems with the existing way this service is provided to users.' They added that the issues with (then) current service provision were:

- 'Struggles to meet the needs of the population who would benefit from equipment
- Does not meet the needs of the whole population
- Will not meet the needs of increased demographics
- Is at risk where local budgets are under pressure
- May not promote independence, choice and control for all'

However it was soon noticed that in attempting to resolve these issues, the TCES team primarily focussed on the provision of services and failed to recognise the more fundamental issue of the role commissioning had upon provision i.e. by better commissioning, services would be in a position to overcome the issues highlighted above, and could reduce the likelihood of secondary episodes of care occurring.

Besides many providers from across the industry feeling insulted, especially having just come out of a previous 4 year DH-led initiative (Integrating Community Equipment Services), this significant oversight caused some concern about the whole

⁶ www.csed.dh.gov.uk/TCES/

⁷ This was part of the Care Services Efficiency Delivery (CSED) branch.

TCES team approach to service improvements. To date the Retail Model still hasn't addressed the commissioning of services; because of this it cannot really be said that the Retail Model has in fact resolved the issues which the TCES team originally set out to address.

The Retail Model was originally intended to also cover complex equipment e.g. beds and hoists, and wheelchair provision, but these have not been addressed to date. The services and stores criticized by the DH are still in place to provide these types of equipment. Even though the DH TCES team originally envisaged closing stores across the country, the success of the Retail Model very much relies upon these stores being operational to provide the equipment the Retail Model doesn't cover. This in effect has produced a two tier system for provision.

3.2 How the Retail Model works

The current retail prescription model is only for simple aids to daily living (SADLs) such as aids for moving, eating and toileting. Generally the DH considers an item costing less than £100 to be a SADL. The current prescribers e.g. therapists and nurses, assess and identify equipment needed for the service user. The Model originally hoped that independent assessors would be introduced, but to date most areas have kept current assessment processes. The prescriber will write a prescription which the client will take to the retailer. Service users requiring equipment not on the prescription list, such as complex aids to daily living (CADLs) e.g. beds and hoists, or specialist equipment, will still receive it from the current equipment providers/contractors.

Accreditation of retailers is agreed locally and will include, for example, the capacity to deliver, fit and instruct the client in the use of the equipment where necessary. Anyone can collect the equipment from the retailer e.g. the service user, their carer, relative, volunteer, therapists or nurses.

Where possible the retail provider will be expected to deliver, fit and explain the use of the equipment to the service user. Additional costs may apply for delivery and fitting.

Unlike statutory arrangements, where equipment is recycled when the service user is finished with it, the service users are expected to dispose of equipment themselves, when it is no longer required.

Retailers may offer a wider range of choice other than the standard catalogue items. It is hoped that retailers will benefit from the additional 'footfall' to their premises, and will be able to market to self-funders by up-selling products to service users.

The benefits which the Retail Model purports to achieve include:

- Helps deliver independence, choice and control for the whole population - and puts users at the heart of the service
- Improves access to products that aid daily living, via the normal retail environment
- Improves delivery mechanisms - products available immediately
- Increases flexibility - state supported users can 'top up' to a product more suited to their lifestyle
- Allows easier access to information and advice
- Enables state practitioners to refocus on re-ablement and rehabilitation activities
- Creates capacity to meet demands of demographic growth via a dynamic retail market
- Provides better access to assessment outside the state, i.e. independent needs assessors, self-assessment tools

Although the Model is not mandatory it is aimed at local adoption and implementation by local authorities and their health partners.

Since the announcement in 2006 there have been some concerns about the retail initiative e.g. fragmenting provision, inequity of provision, the financial soundness, governance, legal issues and safety.

Today's version of the Model is very much different from what was originally intended; in particular, it has only addressed simple aids, and has to date left complex, children's and wheelchair provision to local services.

Although the Retail Model was originally intended for both Local Authorities and their health partners the roll out so far is very much weighted toward Local Authority provision.

Currently the Model has had relatively little take up. Where the Retail Model has been adopted it is reported that there are currently eleven different ('hybrid') versions in place. Because of the many variations it is difficult to ascertain what the true 'Retail Model' looks like.

4. General issues and concerns about the Retail Model

This large section summarizes the concerns that have been voiced about the Retail Model, drawing from various documents and other sources across the industry, both past and present. It also points to where Standards could help to mitigate these concerns.

When considering the Retail Model it is important to remember that it is not to be detached from the wider context of statutory community equipment provision, neither is it to be viewed as a cop out from existing duty of care by funding and commissioning authorities. The Retail Model forms an integral part of the overall statutory provision of community equipment, especially where the duty to meet assessed need is concerned.

Furthermore, approximately 80% of service users requiring beds and hoists etc. (CADLs), still provided by existing equipment services, will also require simple aids, which they will have to obtain from a retailer under the Retail Model. Also, something as simple as a commode, provided by retailers under the Model, is a fundamental part of hospital discharge. It is a misunderstanding therefore to think that the retail aspect of provision can be separated out as a different service, or that SADLs are simple to administer; often they are a small but crucial part of a much bigger and more complex package of client care.

To date **there have been no legislative changes to support retail provision**, so funding and commissioning authorities are still required to fulfil existing legal and welfare related duties and obligations.

The following list details the issues and concerns about the Retail Model which in effect stress the need for Standards to be applied to this area of service provision.

4.1 Lack of governance and resultant exposure of organizations and service users.

The Retail Model lacks in-built governance procedures and passes a lot of responsibility to local organisations. This is evidenced as follows:

4.1.1 DH withdrawal from national retail accreditation scheme (CEDAB)⁸



One of the longstanding issues about the Retail Model was the ability to have retailers accredited. Early on in the process the DH worked alongside BHTA and National Association Equipment Providers (NAEP) to develop the Community Equipment Dispenser Accreditation Body (CEDAB)⁹.

The key objectives of the CEDAB Accreditation Body were as follows:

The body established to carry out the accreditation function will:

1. Set a national minimum standard of competency and review and develop it to ensure that it remains responsive to user needs over time
2. Hold a register of Accredited Individuals who have reached the competency requirement and ensure that the register is regularly maintained and updated
3. Hold a register of Accredited Retailers and ensure that the register is regularly updated
4. Investigate complaints relating to:
 - Individual competency
 - Accreditation status of Retailers or Individuals
5. Remove from the register of Accredited Individuals and/or Accredited

⁸ <http://www.cedonline.org.uk/>

⁹ CEDAB was formed in 2007 to establish the first registration scheme and accreditation body to champion the provision of a quality assured prescription based dispensing service for the Community Equipment Services Retail Model and all Retail establishments throughout the United Kingdom.

Retailers those who have:

- Failed to maintain accreditation requirements
- Failed to maintain competency requirements
- Used the Accreditation logo without compliance with accreditation, competency or other requirements

6. Act as a referral point for other regulatory bodies i.e. refer miss-selling complaints to Consumer Direct or Office of Fair Trading.

These objectives very much supported the ambitions of the Retail Model, and in many ways served to reduce and mitigate many of the inherent risks of the Model, where the retailer was concerned. However the DH later dropped their support for this, stating, ‘...organisations adopting the prescription scheme for simple community equipment will manage their retailer accreditation scheme locally, based on core operating requirements and competencies for Assistive Technology.’

The CEDAB accreditation system is still available and fully operational for retailers. CEDAB is ‘an independent body set up to facilitate a national standard of prescription fulfilment for Local Authorities/PCTs, to safeguard users of the service, and self-funders, by creating a high level of training and ethics in equipment provision via retailers – irrespective of their geographical location.’ (Ms Jean Hutfield, Chair of the CEDAB Board).

The DH’s statement “...organisations will manage the retailer accreditation scheme locally...” emphasises local authorities’ responsibility to ensure that retailers selected are sufficiently reputable and have the necessary skills. Without central government support there is no system for passing up this responsibility to a higher level, and organisations adopting the Retail Model need to ensure that they have an appropriate governance procedure in place for managing this. The Standards will include a section on how this could be achieved.

4.1.2 DH discourage the use of contracts with retailers

In addition it is reported that participating authorities are being advised by DH that for legal reasons they cannot have contracts or even a ‘Memorandum of Understanding’ with their retailers. This results in a situation where providing authorities are relying on retailers to dispense equipment to clients without having the ability to safeguard the process, either through contractual agreement or formal

accreditation. Obviously this lack of governance gives rise to considerable risks for authorities, who still retain full responsibility for clients' equipment needs.

The exposure of providing authorities is compounded by the DH's recent statement that it is "down to local areas" to adhere to legislation.¹⁰

4.2 Serious concerns disclosed by recent ADL Smartcare interview¹¹



An enlightening interview took place recently between David Russell, The Homecare Industry Information Service (THIIS), and Peter Gore, ADL Smartcare Ltd, the organization commissioned by the DH to host and maintain the TCES national catalogue and tariff for Simple Aids to Daily Living (SADLS).

This interview disclosed some concerns about the Retail Model, many of which are long-standing and as yet unresolved.

Some of the areas of concern from the interview included:

- Retailers don't have to have a physical store, as long as they can demonstrate they deliver equipment regularly in a van; this raises questions about accessibility for service users, as well as reputational issues.
- Retailers don't have to have 'prescription' items in stock, so long as they can deliver in a 'few' days; this could result in inconvenience for service users, wasted travel time and cost, and delay in receiving equipment. It could also force clients to top-up unnecessarily.



- The retailer is to have knowledge of alternative products suitable for the clinical needs of the service user, with very little training. There are obvious, and potentially serious, risk issues with this.
- The mark-up on the tariff prices is so low for the retailer there is very little incentive for them to

¹⁰ This statement was made in a letter from DH to Community Equipment Solutions, in response to a suggestion to mandate National Minimum Standards for England.

¹¹ <http://tinyurl.com/3x8p3ss>

want to sell the prescription item. This could encourage high-pressure selling of a more expensive item.

- Some Local Authorities only provide a few product lines¹² from the available 218, thus potentially ‘fettering discretion’ of clinical professionals and potentially forcing upselling by retailer.
- Policing of the retailer is the responsibility of the Local Authority.
- No mandatory registration system in place for retailers yet.
- Ambiguity about delivery, collection and installations. This could cause delay, inconvenience or cost to service users, and carries risks for client and organizations through inappropriate installation.
- Local Authorities to retain responsibilities for safeguarding inappropriate upselling by retailers.

There are a wide range of issues here most of which could be at least partially addressed by the application of Standards. These would aim to ensure organizations followed procedures designed to prevent unsafe practices and improve user experience.

4.3 Retailer difficulties: Boots withdraw from the Retail Model because of operational issues



A national pharmacy chain such as Boots, positioned in most towns throughout England, working with a national catalogue of equipment with an agreed national tariff, would seem to be ideal for making the Retail Model work. But this has not been the case; following extensive trials of the Retail Model, Boots has pulled completely out of the scheme.



Boots commented “The variation of the service caused by specific local requirements, expectations and market conditions would make it difficult to operate it consistently across the entire chain.” They added that “For a national retailer, meeting the different requirements that each local authority naturally has **brings operational complexity.**”

¹² Equipment should only be rationed by local authorities according to degree and type of need e.g. critical, substantial, rather than by product type. To do otherwise might be deemed illegal.

Boots also found some logistical challenges in delivering the in-store service, including for example, space to store or display the tariff products. This meant they would have to order prescription items when a prescription was received. The result of this meant that, in some instances, service users would have to come back to the store to collect the product once it has been delivered. Boots added, “This can be a disadvantage, particularly when the customer wants a product urgently.” The nature of the service makes it inevitable that service users’ needs will often be urgent.

The Boots example highlights some issues which make it impractical for retailers to be part of the scheme; the Model could become unworkable if there is not enough incentive for retailers to be part of the scheme. It also highlights client-centered issues. Organisations adopting the Retail Model need to ensure the following issues are considered and allowed for:

- ❖ Clear local requirements and expectations need specified to retailers
- ❖ An understanding of operational complexities
- ❖ Stock issues: participant retailers should be clear of requirements
- ❖ Service users should not need to make multiple trips to the retailer
- ❖ Urgent (prescription) equipment must be immediately available
- ❖ Back up arrangements must be in place if the retailer decides not to operate retail provision any longer (like Boots)

This last point is very important, namely, back up arrangements. Since the launch of the Retail Model a significant number of retailers have pulled out of the scheme, for a variety of reasons. When this happens it is absolutely critical that there is a back-up arrangement in place. Without a back-up in place service users could be unable to obtain the equipment they need; this could mean they suffer an injury or are admitted to hospital.

4.4 Retail Model could be forcing ‘high-pressure selling’ and causing unmet needs



The Office of Fair Trading (OFT) is currently conducting a market study of mobility aids¹³. It is reported that there were an astounding 5000 complaints about the industry made to

¹³ <http://tinyurl.com/2c5okjb>

Consumer Direct in 2009; this was a 20% increase in the number of complaints made in the previous year.

Some of the issues reported include the sector 'not working well', high prices and needs not being met. The OFT will be looking at the informed choices consumers are given to meet their needs; how fairly consumers are being treated, and other sources of market problems including public bodies' behaviour as purchasers and suppliers of these products. One of the other issues they will be looking at is 'high-pressure selling'.

Given that the greater uptake of the Retail Model was in 2009 it is very likely that it has contributed to the increase in the level of complaints received by the OFT, particularly as service users now have an increased point of contact with retailers, whereas under traditional methods of provision they received their equipment from public bodies.

It is easy to see how, under the Model, consumers could be exposed to practices such as high-pressure selling and the sale of inappropriate equipment, resulting in unmet needs. Facets of the Retail Model which could allow this to happen include:

- ❖ Lack of regulation for retailers could result in unreputable businesses supplying products;
- ❖ Retailers are effectively incentivised to up-sell as the margin on prescription items is so low;
- ❖ No obligation for retailers to have goods in stock; this could force a client to top-up if the need is urgent and to avoid a further visit to the retailer;
- ❖ Scant training requirements for staff who are expected to be able to recommend alternative products;
- ❖ Service users are vulnerable to being unfairly treated by retailers as they are often either elderly, sick, disabled, or in pain, and could have travelled several miles to obtain equipment which then is not in stock. This severely compromises their position.

4.4.1 DH marketing Retail Model as lucrative profit earner for retailers¹⁴

Another concerning feature of the Model which has come to light is that it would appear that the DH is marketing retail provision to retailers in terms of the financial

¹⁴ <http://tinyurl.com/2ww6gw7>

rewards it can offer. According to a Mr. Shah, an independent contractor who is part of the pharmacy supplier Sigma, who has been advocating the Retail Model to pharmacists and who has been working with the DH to develop the TCES programme, the DH is implying that although the mark-up on the TCES equipment catalogue is relatively low there is a lucrative profit margin of around 45 per cent on a product sold privately. Mr Shah also says, “There is potential for massive growth in this market which could generate a lot of revenue for pharmacists. When you have got the government pushing a scheme like this, you can’t ask for anything more.” This is a concerning and enlightening comment as it suggests that the DH is encouraging retailers to extract money from service users when the cheaper prescription product may be perfectly adequate for their needs.

On a slightly different but related issue, some of the more reputable and well established retailers are reporting that because the DH tariff prices on the prescription items are so low, it is driving some suppliers to ‘cut corners’ in terms of quality – obviously to save money and improve margins. It is now being asked in the industry if it is even safe to issue these products to service users. This could be forcing reputable retailers to attempt to upsell in the interest of the service user, due to concerns over the quality of the prescription item.

The above issues clearly demonstrate that by its very design the DH Retail Model, and lack of appropriate safeguards in place, is potentially exposing service users (‘consumers’) to poor treatment by some retailers.

It should be noted that retailers are not necessarily at fault in some instances of poor practice, as they are being encouraged to take up the Retail Model when appropriate safeguards are not in place. Thus they may not be fully responsible for the poor quality of service some people are experiencing.

4.5 The Retail Model could be more costly than other methods of provision



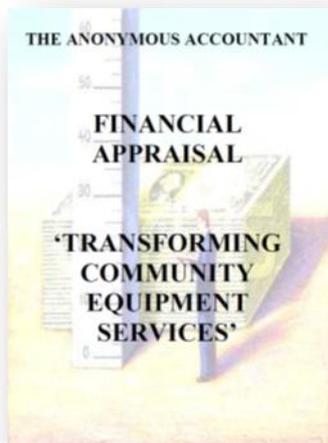
In days of unparalleled austerity within the public sector, when services need to be more efficient, cost-effective and achieve better health outcomes, it is absolutely crucial that whatever services are being provided, they meet these objectives.

To date there has been a lack of available evidence demonstrating the financial benefits of the TCES Retail Model, especially when it is considered in the broader context of equipment provision. When the TCES initiative was originally designed there were hopes that stores would close and all service provision would be made via the TCES model, with regional units for complex equipment etc. The savings generated through store closure would fund equipment purchase costs under the Model, and if the take up was great enough, there would be significant economies of scale created via regional complex equipment units.

In the event, the regional units for complex equipment have not materialised, probably because the low take up on the Retail Model has made them unaffordable – the economies of scale simply do not exist. As a result only 1 or 2 services out of 138 have been able to close their stores operations; most remain open as they are needed for supplying other equipment not covered by the Model.

There are also duplication issues here. Approximately 80% of service users requiring beds and hoists etc. will also require equipment provided from a retailer. This is duplication in process for one service user's need. This might be the case where for example some equipment (bed and hoists) will be delivered to the service user's house, but the service user will have to travel to the retailer to get the other pieces of equipment. Standards can help eradicate much of this unnecessary duplication through improved commissioning.

4.5.1 Accountant's financial appraisal of the Retail Model¹⁵



The financial arguments against the Retail Model were well made by a detailed financial appraisal made in May 2008 by an unnamed accountant, clearly with expert knowledge of how the whole equipment industry works. It is believed that this paper encouraged organizations to do their own sums, causing many to shy away from the Retail Model.

The accountant's paper highlighted that if all areas introduced the TCES model, as it was, it could cost approximately **£1.1 billion** initially, with a **£2.2 million on-going cost per local area**.

The paper disputed the DH's financial argument for the Retail Model by pointing out that, as not all equipment is covered by the Model (e.g. CADLs, children's, wheelchairs), it would not be possible in most cases to close down stores operations, which means that there would be relatively few savings released with which to fund the Retail Model. The paper argued that, with a store in place anyway, the marginal cost of handling SADLs is much lower than the DH seem to believe, which throws doubt on the financial validity of the whole scheme.

Another key issue covered is the wastage (economic and environmental) through treating SADLs as disposable even after only a few weeks use, rather than reusing for other clients. A new purchase for each client is obviously the major source of cost under the Retail Model. A lot of what the paper covered has subsequently come to pass e.g. the duplication of stores for complex equipment and retail provision for simple aids.

The report also showed the potential for massive waste by undermining the approximately £500 million invested in these services over previous years under the ICES initiative, which is largely being undone where the Retail Model is adopted.

¹⁵ <http://tinyurl.com/2fwkmv5>

Not all of these issues are resolvable, as they are inherent in the Model itself. However the application of Standards could improve the financial outlook through supporting integrated service provision, and improving commissioning and purchasing, particularly of complex and other equipment not covered by the Model, which represents approximately 74% of equipment spend. Standards will also enable measurement of service outcomes and costs involved, which will assist in decision making.

4.5.2 Centre for economics and business research – report on TCES¹⁶



In 2009, the leading economists *Centre for economics and business research Ltd* undertook an independent financial, economic and environmental assessment of the TCES Model. This supported the case presented by the “anonymous accountant’s report”, and showed the weaknesses of the financial aspects of the Retail Model. It also covered the economic position of retailers and the effect of this on availability of equipment.

Key issues raised by the cebr report include:

- ❖ Adoption of Retail Model would lead to cost increases where a loan store system is in place.
- ❖ Flat rate retail fees may lead to under provision in less densely populated areas, and restricted access to higher value products.
- ❖ As the Model only covers SADLs, only 25.8% of equipment (by value) would be covered by the Retail Model even if all areas in England adopt it. This has implications for suppliers and retailers in the industry.
- ❖ An economic impact assessment shows an extra £13.4m costs incurred by private households and public services in transport under the scheme.

¹⁶ <http://tinyurl.com/2bwbr57>

4.5.3 Other hidden costs emerging from the TCES Retail Model



In addition to the financial issues argued in these papers, new costs for running the Retail Model are starting to emerge, and some of these are discussed below.

4.5.3.1 Unredeemed prescriptions

It is reported from reliable sources, albeit anecdotally, that some areas are reporting *as great as 45 per cent unredeemed prescriptions*. On the face of it this could look like a saving for public sector organizations on the cost of the prescription, but that is a false economy. The wider impact has to be considered to ascertain the full cost this involves, for example:

- What is happening to the 45 per cent of service users who have to manage without the equipment they were prescribed?
- Are these people coming back through the hospital doors, or being admitted to a care home, as they cannot cope at home?
- Are they moving from substantial to critical needs, and thus requiring reassessment and further care and support?

One thing is certain, their needs won't disappear. Besides the potential impact on the health and wellbeing of the service user, and legal duties surrounding failure to supply necessary equipment, there is a potential for huge hidden costs being incurred here and they need to be quantified. Under the current arrangement this is not possible.

The introduction of Standards would enable these issues to be captured and quantified, and would also aim to reduce the level of unredeemed prescriptions through follow-up procedures.

4.5.3.2 The cost and impact of clinical professionals' time

In addition it is being reported that a significant number of prescriptions are being collected by clinical professionals e.g. OTs. Not only does this go against key principles of the Retail Model, namely choice and independence, but it is costing £25-£35 per hour in valuable clinical time for staff to be collecting the equipment. It was hoped that the Retail Model would free-up clinical professionals' time to allow them to focus on re-ablement and rehabilitation activities for example, but this is not proving to be the case.

Meanwhile, whilst clinical staff are collecting equipment from retailers, other service users are not being seen. Intuitively we know when service users are not being attended to their conditions will worsen and potentially they could end up requiring more care, such as a hospital or a care home admission. At present there is no way of capturing these costly issues.

To give some indication of the potential financial impact of clinical professionals collecting equipment the following very simple calculation has been developed:

- Say 300 prescribers (e.g. Physios, OTs and Nurses) per average area
- Say only half of these prescribe on a regular basis = 150
- Say 1 to 2 hours is spent every week collecting equipment = 150-300 hrs
- 150 to 300 hrs per week amounts to 4 to 8 FTE posts over one year (plus mileage)
- This could amount to an extra £400K on clinicians time alone, including mileage

One independent study of the Retail Model, undertaken by Ricability¹⁷ for the DH found that of the prescriptions redeemed only 10% of prescriptions were exchanged by users, 14% by professionals and 49% by family members. The remainder were delivered by the retailer. These figures themselves cast doubt on the success of the Retail Model in encouraging choice and independence; they give the impression

¹⁷ Ricability is an independent consumer research charity providing free, practical and unbiased reports for older and disabled people. See the report: *Evaluating the Transforming Community Equipment Pilots Research Study* Conducted for Department of Health. DoH May 2008

overall that most clients are not well enough to collect the equipment themselves, as was foreseen by most in the care industry.

The application of Standards will help with costing and planning for service provision, including, for example, true logistics costs. They will highlight areas where unnecessary and hidden costs may be incurred. Standards around monitoring and assessing overall performance, including whole system expenditure, will help round up many of the issues highlighted above.

4.6 Concerns about the Retail Model from the industry – BHTA¹⁸



Concerns and recommendations were raised by the British Healthcare Trades Association about the Retail Model early on after its announcement – many of which are still valid.

A summary of the BHTA's main concerns and recommendations now follows:

1. The retail programme needs long term oversight
2. The retail programme needs adequate testing
3. The true cost of the retail programme needs to be identified
4. The Retail Model could add to the current postcode lottery across the country
5. Assurances need to be in place to persuade the state sector that they can trust retailers to provide a good service
6. Needs evidence that the Model increases customer choice
7. Wheelchair services should not be separated out from the programme.

Most of these concerns have not been addressed and this could be one reason for the low level of take up by commissioners, and for the failure of larger retailers to become part of the scheme, which in itself could have enhanced take up.

¹⁸ <http://www.bhta.net/tces-concerns.aspx>

4.7 The Audit Commission's concerns around governance, contract management and monitoring performance may apply to the Retail Model



In 2000 and 2002 the Audit Commission undertook reviews of community equipment services in England and Wales. Significant concerns were raised, and attempts were made to improve services through initiatives such as ICES. The introduction of the Retail Model could reverse those improvements and reintroduce the Audit Commission's original concerns.

Some of the main areas of concern in their findings included:

- Poor commissioning and contractual arrangements e.g. specifications
- Inability to measure performance
- Poor governance, including risk management
- Lack of good quality and available information on activity and spend
- Lack of information to ensure patients' needs could be followed up and the effectiveness of their equipment reviewed
- Duplication of processes between health and local authorities
- Poor financial control

A lot of the concerns identified above were addressed under the DH led Integrating Community Equipment Services (ICES) programme in 2004. It is felt that if not managed appropriately, and without the right Standards in place for monitoring and assessing performance, there is a danger that the introduction of the Retail Model could bring back these concerns, particularly through fragmentation of services, and poor governance.

As previously mentioned, it is reported that the DH has informed organizations adopting the Retail Model that they should not have contracts with their retailers, or even a 'Memorandum of Understanding' in place. As Local Authorities and NHS Bodies still have their commissioning and care duties and obligations to fulfill, it is hard to imagine how they can ensure clients are in receipt of a safe and good quality service, without having appropriate contract management arrangements in place.

The application of Standards would assist with governance procedures and ensure compliance with legislation and other obligations.

4.8 Potential for undoing pooled funding arrangements and integrated service provision

Over the past 6 years there has been a significant amount of investment in England establishing pooled funds (using health act flexibilities s.31, now s.75), together with the integration of health and Local Authority community equipment services. This has resulted in efficiency savings and a more seamless service for users. Under the current government there is also a real drive for ensuring health and Local Authority partners work together. However the current Retail Model is very much Local Authority focused, and therefore has the potential for undermining partnership arrangements.

Having Standards in place to assist pooled spend and integrated provision will encourage retention of joint working arrangements.

4.9 Legal and risk implications of the Retail Model



At the National Association of Equipment Providers (NAEP) national conference in 2008 Jonathan Nash, a Solicitor, gave a presentation on the legal and risk issues to be considered in relation to the Retail Model. These are listed below.

- Delay between prescription and redemption
- Private installation
- Instructions
- Closure of cases and on-going maintenance / replacement / reassessment
- Repeat prescriptions
- Costs of delivery / maintenance v NHS 'free' service
- Lack of supplier stock
- Top up ownership
- Resale / traceability
- Carers redeeming prescriptions
- Identification and treatment of self-funders

- Data Protection
- Retailer's code of practice (There is no legal duty to stock spare parts)
- Installation and instruction
- On-going duty of care and duty to re-assess where material change of circumstance or equipment unfitness / deterioration
- Negligence including duty of care, breach (omission or commission), causation, foreseeable harm, employer's vicarious liability or primary liability for systemic failures and S.2 Unfair Contract Terms Act 1977– Liability cannot be reduced for negligence resulting in PI or death
- Consumer Protection e.g. Medical Devices Regulations 1994

As can be seen, there is a broad range of legal issues surrounding the Retail Model which have not as yet been answered. There has not been any guidance or advice made publicly available by the DH in respect of these issues. This means that organizations who adopt the Retail Model need to take careful consideration as to how they can protect themselves from criticism or even liability. It is only a matter of time before a legal challenge or claim gets made and it remains to be seen what a court would make of the legal issues involved in the Retail Model.

Standards will aim to provide guidance around what organizations could do to protect themselves and their clients, and abide by legal duties and requirements.

5. Conclusion

The many issues and concerns identified in this document clearly demonstrate the importance and urgent need for having appropriate safeguards introduced for the Transforming Community Equipment Services Retail Model.

Community equipment is provided to some of the most vulnerable members of our society e.g. disabled, elderly and sick, and it is our legal duty, if not moral obligation, to ensure they are in receipt of a safe and good quality service. In its current design the TCES Retail Model has many areas of concern which potentially expose these service users to poor quality and unsafe service levels.

Owing to the lack of appropriate safeguards currently in place there is also increased exposure to civil and even criminal prosecution for commissioning and funding authorities, as well as retailers.

The current TCES Retail Model fragments services and potentially inhibits seamless, coherent, timely, efficient and integrated provision.

The way the TCES model has been set up e.g. low tariff for prescription equipment, could be encouraging some retailers to engage in poor practice, e.g. high-pressure selling; inappropriate equipment provided, as identified by The Office of Fair Trading.

There have been many issues identified in relation to the retailer, and the services they are expected to provide. Although national standards exist for retailers via CEDAB, because the DH pulled away from supporting these there is ambiguity and inconsistency in the standards retailers are expected to work to locally, if any exist at all.

Given the many (hybrid) versions of the Retail Model emerging it is difficult to monitor, assess and benchmark overall performance.

As demonstrated in this paper and in the referenced documents the TCES Retail Model could be an overall costly option if not given adequate consideration, as there are significant financial costs associated with adopting the Model, many of which are not immediately obvious.

To date the TCES Retail Model hasn't satisfactorily addressed the commissioning of services, particularly where pooled funding and integration are concerned.

As can be seen from this document there are many areas that the Standards would need to be applied to. Although having Standards in place for the TCES Retail Model would undoubtedly make services safer and of a better quality, under no circumstances does this paper conclude that Standards would address all of the concerns with the Model, or that they can be eradicated. However, by having appropriate safeguards in place, in the form of Standards, there will be a greater degree of protection afforded to service users, commissioning and funding organizations, and to retailers, together with better service outcomes.