Public Service Ombudsman

# Strengthening NHS wheelchair services: commissioning with confidence

November 2026

# Contents


Foreword from the Ombudsman 3

Executive summary 5

Why this matters 5
What we found 5
What needs to change 7
Looking ahead 9

Wheelchair services and our investigations 10

Challenges in commissioning wheelchair services 16

1. Understanding local need through accurate data 16
2. Providing a service that meets the holistic needs of wheelchair users 17
3. Managing quality concerns effectively 19
4. Shaping the provider market 24
5. Measuring outcomes and learning from feedback 25

Recommendations 27

1. Strengthen national oversight, data and quality assurance 27
2. Build ICB capability to commission sustainable, person-centred services 28
3. Measure services by people's experiences and outcomes 29

# Foreword from the Ombudsman

## A wheelchair is not simply a piece of equipment. For people who rely on one, it can be the single thing that enables them to live the independent life most of us enjoy.

It can determine whether they are able to work, attend school, leave home and see friends and family. Wheelchair services play a vital role in supporting people's health, wellbeing and ability to participate in society on an equal basis with others.

When these services fail, the consequences can be profound. Through our investigations, we have seen adults left in pain or unable to move around safely, children unable to attend school, and families forced to adapt their lives around unsuitable or unsafe equipment. We have seen people wait many months for essential wheelchairs or repairs, often without clear information about what is happening or when problems will be resolved.

These are not administrative inconveniences. They are failures to meet people's basic needs, with serious consequences for their health, wellbeing, independence and trust in the NHS. They also undermine stated government ambitions to reduce health inequalities, and they risk higher long-term economic costs by preventing people from participating fully in education and employment.

As Ombudsman, I am interested not only in what went wrong for an individual, and in addressing it where possible, but also in what complaints tell us about the systems that sit behind public services. Complaints are a powerful source of insight. They help us identify patterns, understand where services are struggling and highlight opportunities for improvement.

In recent years, we have received a growing number of complaints about wheelchair services. While our investigations focused on the experiences of individual service users, they also raised wider questions about how these services are commissioned, overseen and improved. Those questions led us to look beyond individual cases and consider what wheelchair services can tell us about the wider move towards strategic commissioning across the NHS.

This report examines the barriers commissioners face in delivering high-quality wheelchair services and considers what support they need to succeed. Although the report focuses on wheelchair provision, its findings have wider relevance.

The challenges we identify, around understanding need, shaping provider markets, managing quality and taking system learning from user feedback, are issues that matter across many areas of public service delivery.

The move towards strategic commissioning offers an opportunity to design services around the outcomes that matter most to people. But that ambition will only be meaningful if it translates into better experiences for those who rely on public services every day.

I hope this report contributes to that goal.

**Paula Sussex CBE**
**Public Service Ombudsman**

# Executive summary

## Why this matters

Integrated care boards (ICBs) are now expected to act as strategic commissioners, using data, insight, partnership working and market stewardship to improve outcomes for their local populations. NHS England's Strategic Commissioning Framework sets out an ambitious vision for how commissioners should understand population need, commission for quality and outcomes, shape provider markets and evaluate impact.

This report uses wheelchair services as a case study to examine how those ambitions are playing out in practice. It draws on evidence from our investigations, alongside engagement with commissioners, providers, regulators and organisations representing wheelchair users. It explores whether commissioners have the information, support and oversight they need to deliver high-quality services and better outcomes for the people who rely on them.

## What we found

There has been a significant increase in complaints to the Ombudsman about wheelchair services, rising from just eight in 2020 to 2021 to 110 in 2025 to 2026. We conducted investigations to understand the poor service people were experiencing. Looking across the investigations, we identified several national and system-level barriers to effective commissioning of wheelchair services.

### Understanding local need through accurate data

Commissioners lack reliable information about the level of need for wheelchair services in their local population. There is no accurate picture of the number of wheelchair users in England, and concerns remain about the quality and value of the national wheelchair dataset for planning services. There is a lack of governance, scrutiny or analysis of the national dataset. Existing data only captures what has been previously funded and does not help commissioners understand unmet need.

### Providing a service that meets the holistic needs of wheelchair users

National guidance expects wheelchair services to consider people's clinical needs alongside their social, educational, employment, lifestyle and family needs. But there is a gap between this ambition and what services fund in practice. Local eligibility criteria

often exclude equipment intended primarily for education, employment, leisure or transport, limiting access to wheelchairs that support independence and participation in everyday life.

Personal wheelchair budgets are intended to provide greater flexibility, including by pooling NHS funding with support from local authorities, Access to Work and other sources. In practice, individuals are often left to identify additional funding themselves, while there is no clear coordinating role to bring organisations together. As a result, well-designed national policy and guidance do not consistently translate into holistic support for wheelchair users.

## Managing quality concerns effectively

Commissioners can struggle to respond consistently when there are concerns about provider performance. Contractual guidance gives ICBs wide discretion, leading to different approaches and levels of investment in improvement. ICBs often manage provider quality issues individually, even where similar concerns affect multiple areas. We found uncertainty about escalation routes and limited mechanisms for sharing intelligence and learning between commissioners across different ICBs. These difficulties are compounded by a regulatory gap: wheelchair assessment, fitting and repair services sit outside health and care regulation, leaving independent providers without equivalent external quality oversight.

## Shaping the provider market

ICBs are expected to shape sustainable provider markets, encourage innovation and use new contracting approaches to improve outcomes. In practice, the wheelchair services market is constrained, leaving commissioners with few alternatives when providers underperform. ICBs often lack the capacity and flexibility to attract new providers or incentivise different models of delivery. There are also skills gaps in managing provider sustainability, business continuity and supply-chain risks. Organisational change, staffing reductions and short-term pressures make proactive, long-term market stewardship harder.

## Measuring outcomes and learning from feedback

Current performance measures focus mainly on activity, expenditure, access and waiting times, rather than whether wheelchair services improve people’s health, independence and wider wellbeing. Although some person-centred measures have been developed, they are not part of standard data collection across ICBs.

Complaints provide valuable insight, but ICBs often depend on providers' responses and reporting systems, which may categorise feedback differently or lack clear complaints processes. This limits commissioners' ability to identify recurring problems, form an independent view of performance and use people's experiences to shape and improve services.

# What needs to change

If strategic commissioning is to improve outcomes for wheelchair users, commissioners need stronger support to understand need, manage quality, shape markets and evaluate outcomes. National bodies also need to provide clearer leadership, oversight and accountability.

## Our recommendations

We make recommendations in three areas.

### 1. Strengthen national oversight, data and quality assurance

**The Department of Health and Social Care (DHSC) and NHS England should play a stronger role in overseeing wheelchair services, so that they can better support ICBs to commission high-quality services that meet people's needs.**

This should include:

- collecting national data on the number of wheelchair users in England and strengthening the national wheelchair dataset so that commissioners can understand local need, including unmet need
- establishing clear senior national accountability for wheelchair services, including responsibility for scrutinising data and performance and driving improvement
- making sure there are clear escalation routes and coordinated support for ICBs that have concerns about the quality of an independent provider, including arrangements for sharing intelligence and identifying problems affecting more than one ICB area
- deciding how to put in place appropriate and proportionate quality oversight of wheelchair assessment, fitting and repair services.

## 2. Build ICB capability to commission sustainable, person-centred services

**NHS England should make sure the Strategic Commissioning Development Programme equips and resources ICBs to commission sustainable, person-centred services, using wheelchair provision as a practical case study.**

The programme should support ICB capability and capacity to:

- work collectively to shape provider markets and encourage sustainable and innovative models of service delivery
- manage provider performance, sustainability, business continuity and supply-chain risk, particularly where alternative providers are limited
- coordinate funding across organisational boundaries where this would enable equipment to meet people's wider health, educational, employment and social needs
- learn from local authorities' experience of market stewardship, provider sustainability and commissioning in fragile provider markets, particularly in adult social care.

## 3. Measure services by people's experiences and outcomes

**DHSC and NHS England should develop a consistent national approach to measuring wheelchair users' experiences and outcomes.**

This should include:

- expanding the national wheelchair dataset beyond its current focus on activity and expenditure to capture patient experience and the impact of services on people's health, independence and wider wellbeing
- using the upcoming reform of complaint regulations to establish clear expectations for how ICBs collect, analyse and use complaints and other feedback about commissioned services to identify themes and improve quality
- making sure these reforms reflect the principles of the NHS Complaint Standards, including the expectation that complaints should support learning and improvement.

# Looking ahead

The ultimate test of commissioning is not whether services are procured efficiently, but whether they improve the lives of the people who rely on them. For wheelchair users, this means services that are timely, reliable, person-centred and focused on the outcomes that matter most.

# Wheelchair services and our investigations

In England, integrated care boards (ICBs) are responsible for the provision and commissioning of local wheelchair services. These services can be run by NHS bodies, or they can be contracted out to other providers. Sometimes the full wheelchair service, from assessment through to supply and repair, is contracted out. In other cases, only part of the service, like equipment supply, is contracted out.

There are no official figures published on the proportions of services that remain within the NHS compared with those run by other providers. But recent analysis from the Wheelchair Alliance estimates around 45% of ICBs currently contract their service, fully or partially, to another provider.

In recent years, we have received an increasing number of complaints about NHS wheelchair provision and repairs. Complaints we received about NHS wheelchair services increased from just eight in 2020 to 2021 to 110 in 2025 to 2026. More than 80% of the complaints received over this period were about services delivered by independent providers rather than within the NHS.

The following example case studies show how failings have affected service users and their families.

### Case study 1: delays in providing a specialist wheelchair

E is of primary school age. He has cerebral palsy and is non-verbal. He was referred by a physiotherapist for a specialist wheelchair in 2022, when he turned two years old. The referral was declined because E was too young. He was assessed in August 2023 when he turned three, but the wheelchair was not delivered until May 2024, leaving him without suitable equipment for around six months.

**Impact of the delays**

We found that E and his family experienced unnecessary and prolonged hardship because of the six-month delay in providing essential equipment.

The delays had a serious impact on E's quality of life, wellbeing and safety. Without an appropriate wheelchair, his family had to adapt a buggy that did not meet his needs. This led to E falling multiple times and sustaining injuries that required visits to A&E.

Without a suitable wheelchair, E was unable to attend school between January and May 2024. This limited his access to education, therapies and healthcare support provided through his school. Being unable to attend school alongside his twin brother was particularly upsetting for him.

This also affected E's family. His parents described feeling traumatised by his injuries and said they lost confidence in taking him out. They also had to pay privately for therapies that E would otherwise have received through school.

**Communication failings**

As well as the delays, poor communication from the provider added to the family's distress.

We found the provider failed to communicate clearly and consistently with E's family. They were not given accurate information or realistic timescales and had to repeatedly chase for updates. This lack of communication added further stress, frustration and uncertainty during an already difficult time.

## Case study 2: delays in providing a suitable wheelchair and repeated equipment failures

Mr O has spinal muscular atrophy, a rare degenerative condition that causes muscle weakness and significantly affects mobility. He relies on a powered wheelchair to maintain his independence and manage everyday life.

When a new provider took over the local wheelchair service in October 2022, Mr O's wheelchair was already experiencing faults. Despite repairs, the problems continued. Following an assessment in May 2023, the provider concluded that his wheelchair was unsafe and unsuitable for use and said he should receive an urgent replacement. But a suitable wheelchair was not provided until October 2025.

**Impact of the delays**

We found that delays in providing a suitable wheelchair, alongside repeated equipment failures, had a significant impact on Mr O's quality of life and independence.

For around two and a half years, Mr O had to rely on wheelchairs that did not meet his needs. He experienced pain, distress, frustration and worry while using equipment that was known to be unsafe or unsuitable. The problems affected his ability to transfer to his wheelchair safely, use bathroom facilities and manage his health needs, because the wheelchair no longer provided the positioning, recline and tilt functions he needed.

A replacement wheelchair was provided in September 2024, but it was not in full working order and did not resolve the problems. Persistent battery and electrical faults left Mr O uncertain whether he could travel safely and independently. On some occasions, the battery failed while he was away from home, leaving him reliant on his son for help.

**Communication and record-keeping failings**

We also found significant shortcomings in the provider's communication and record-keeping. Records did not adequately explain what action had been taken to progress repairs or get replacement equipment, and Mr O was not given clear information about delays or realistic timescales.

These failings contributed to a loss of trust in the service. Mr O told us he remains concerned about relying on the provider in future for equipment that is essential to his independence and quality of life.

## Case study 3: repeated delays in providing a suitable wheelchair for a child

A is of primary school age and has achondroplasia, a form of dwarfism. He needs a bespoke wheelchair to support his mobility and participation in everyday activities. He was assessed for a new wheelchair in April 2023, and it was noted that the new wheelchair was needed before a planned family trip abroad in July. But the wheelchair was not delivered until September 2023. When it arrived, it was the wrong size and unsuitable for A's needs. A suitable replacement was not provided until June 2024.

### Impact of the delays

We found that A and his family experienced significant and prolonged hardship because of the delays in providing a suitable wheelchair.

Although A received a wheelchair in September 2023, it was unsafe and he could not use it independently because the dimensions were wrong. The only time the family used the wheelchair, the backrest and handles detached, causing A to fall out. He became too distressed to use the wheelchair again.

The period between referral and receiving a suitable wheelchair was around 90 weeks, significantly longer than the 18-week target. During this time, A was left without the equipment he needed for daily activities, which significantly affected his quality of life and independence.

### Communication and record-keeping failings

We also found shortcomings in the provider's communication and record-keeping. Records did not adequately explain the reasons for delays or the actions taken to resolve problems with A's wheelchair. The family were not given clear timescales and frequently had to chase for updates.

These failings added to the family's uncertainty and frustration at a time when they were already dealing with the impact of not having suitable equipment.

We received a large number of complaints from people waiting far longer than the 18-week target for new wheelchair equipment or parts from the largest UK independent provider, AJM Healthcare. We found failings relating to long delays in providing the right equipment (linked to its process for managing queues), poor communication and poor record-keeping.

In the investigations we conducted, we upheld or partly upheld the complaints about AJM Healthcare and recommended that it should apologise and pay financial remedies to the people affected. We also made systemic recommendations requiring AJM Healthcare to develop action plans covering queue management and clinical prioritisation, procurement and supplier arrangements, communication, and record-keeping.

AJM Healthcare's management team has changed since the time of the experiences of the people who complained to us. AJM Healthcare accepted that our complainants' experiences had been very poor and did not want them to be repeated. It accepted our findings and recommendations in their entirety and took a proactive approach to providing remedies for all complainants who came to us. It has engaged in discussions about possible improvements to the sector without denying its responsibility for what happened in the cases we have seen.

We did not uphold the complaints about the relevant ICBs. The ICBs had generally specified, funded and monitored the services in line with the standards and guidance in place at the time. But their approaches did not always fully reflect what the guidance intended.

That did not mean the commissioning system was working as well as it should. Looking across the investigations, we identified recurring national and system-level barriers that made it difficult for commissioners to secure and assure high-quality services. These included:

- a lack of available data about the wheelchair user population (locally and nationally)
- a lack of robust, nationally defined data collection metrics that can be used for planning and commissioning local services
- a lack of robust national data returns and analysis that can be used for benchmarking between ICBs locally
- no regulation of independent providers of wheelchair services that fall outside the Care Quality Commission's (CQC) regulatory remit
- no formal national escalation routes or robust governance arrangements for when independent providers are not performing well

- a lack of choice of providers in the market, which means ICBs have few alternatives when existing providers persistently underperform despite robust contract management.

Our individual investigations identified these issues. This report takes the next step. It examines what those recurring findings reveal about the conditions in which wheelchair services are currently commissioned.

The rest of this report sets out the underlying issues we have identified for commissioners in five areas:

- understanding local need through accurate data
- providing a service that meets the holistic needs of wheelchair users
- managing quality concerns effectively
- shaping the provider market
- measuring outcomes and learning from feedback.

These areas align closely with NHS England's Strategic Commissioning Framework, particularly its emphasis on understanding population need and lived experience, commissioning for quality and outcomes, shaping provider markets and evaluating impact. This examination of wheelchair services provides a practical test of whether commissioners currently have the data, capability, oversight and system support they need to deliver those ambitions.

For each area, we explain what we observed and what needs to change. The report ends with our priority recommendations. These have been informed by engagement with organisations representing wheelchair users, providers, regulators, NHS England, the Department of Health and Social Care (DHSC) and ICBs.

# Challenges in commissioning wheelchair services

## 1. Understanding local need through accurate data

The Strategic Commissioning Framework expects ICBs to improve how they use population health data to plan services, including by assessing risk across population segments, forecasting future demand and addressing unwarranted variation. An accurate understanding of local need is essential to achieving this. The Operating Model for NHS-Commissioned Wheelchair Services says commissioners should accurately identify the level of service provision needed, including the level of unmet need.

However, the data available to commissioners about levels of need for wheelchair users is poor. There is no accurate picture of the numbers of wheelchair users in England. The NHS, which makes referrals to wheelchair services, does not record patients who are using wheelchairs. It only records the underlying health condition that results in the need for one. There are also no mechanisms to capture changes, such as when someone dies or moves to another area.

Commissioners rely heavily on data from previous providers to estimate the level of service they need to procure. They can combine this with information about population growth and increases in complex health needs from the local joint strategic needs assessment. (This is an analysis of the local population's health and wellbeing needs produced by health and wellbeing boards – statutory bodies that bring together local authorities, ICBs and other partners to assess current and future health and social care needs.) But these assessments do not usually include detailed information about wheelchair users' changing needs.

Since 2016, NHS England has collected information from providers through the national wheelchair dataset. This includes the number and complexity of referrals, the number of assessments and repairs, levels of need and performance against the 18-week referral-to-treatment target. This data is seen as unreliable, and there is no governance to make sure providers and ICBs submit accurate, comparable information. We heard concerns that wheelchair services' ability to 'stop the clock' on someone waiting for a wheelchair may at times be used to distort accurate data about waiting times. (This is when measurement against a target waiting period is paused because delays are due to

patient or clinical reasons, rather than service issues.) In a 2025 Wheelchair Alliance survey, 78% of responding commissioners said the dataset did not support service planning.

It is unclear how the dataset is scrutinised and used centrally. NHS England's quarterly statistical briefings contain no analysis or commentary on the data and how it differs across ICBs. The briefings only report the proportion of patients whose episode of care was closed in the reporting period and prescribed equipment was delivered in 18 weeks or less.

Available data does not help commissioners understand **unmet** need because it only captures what ICBs previously agreed to pay for under their eligibility criteria. This data also misses anyone who felt they could not get what they needed from the NHS and sought private or charity help instead. Evidence from third-sector organisations suggests demand on these 'non-NHS' routes to getting a wheelchair is very high. In September 2025, the charity Whizz Kids, which supports wheelchair users up to 25 years of age, closed its specialist wheelchairs waiting list for the first time in its 35-year history. It cited squeezed NHS budgets creating huge demand for its service (BBC News, 'The lives on hold waiting for wheelchairs').

### What needs to change

If the commissioning of wheelchair services is to improve, there must be better data about levels of need in the population. This will require building an understanding of need that goes beyond a record of what has been funded previously.

## 2. Providing a service that meets the holistic needs of wheelchair users

The NHS 10 Year Health Plan for England says commissioners should commission services that will improve health outcomes and reduce long-term health inequalities. The Strategic Commissioning Framework similarly emphasises delivering best value for the public, including working with partners to address social, economic and environmental factors that influence people's mental and physical health (often referred to as the wider determinants of health). For wheelchair provision, this means commissioning services that consider an individual's full range of needs, including social, educational and employment needs. There is evidence that this is an 'invest to save' approach over the longer term. Research suggests further NHS investment in wheelchair equipment could deliver additional benefits that 'outstrip the additional costs by a ratio of almost 3:1' ('The value of a wheelchair').

The importance of a holistic approach is emphasised in the available guidance on commissioning wheelchair services. The Operating Model for NHS-Commissioned Wheelchair Services says all services should 'provide for the holistic needs of the user in conjunction with the clinical needs, (including social, educational, lifestyle and family/carer requirements)'. This is reflected in ICB contracts we have seen. For example, one ICB when setting out the scope of the service said the provider must:

> 'undertake a holistic, person-centred assessment for all wheelchair and associated equipment needs with the Service User, their families and carers and other agencies, as appropriate, ensuring all aspects of the individual's current and future clinical needs are taken into consideration. This assessment shall include social, educational, employment and/or lifestyle requirements.'

But there is a gap between wide-ranging, holistic assessment and what ICBs feel able to fund, given the competing priorities they manage. The eligibility criteria we have seen from ICBs often contain major exclusions, for example, around 'equipment for sole use within educational establishments, work environments and leisure facilities' and 'equipment for the sole use of accessing transport'. The eligibility criteria appear to work as a cost control mechanism, without clear acknowledgement of the unmet need this creates.

In theory, personal wheelchair budgets should give wheelchair users flexibility to purchase equipment that supports their needs and goals around work, education and social life. This has been a legal right since 2019 for anyone who meets the eligibility requirements of their local NHS wheelchair service. Money provided by the NHS to meet assessed clinical need can be pooled with money from other health and care services, Access to Work and local authorities, so that one chair meets a range of needs. All services involved must agree that the pooled funding meets the person's assessed needs and is cost effective. People can also choose to use non-statutory funding that may be available from voluntary and charitable organisations, nationally and locally, to 'top up' their wheelchair budget.

While there are some examples where personal wheelchair budgets have been used successfully to fund a wheelchair that meets wider needs (for example, NHS England, 'Flexible funding allows Dylan to live independently'), we understand this is not consistent or widespread practice. The onus still appears to be on individuals to find funding sources and show that the extra budget will help meet their wider goals. There is a gap in the coordinating role needed to broker conversations across agencies and bring this policy to life for more wheelchair users. This is despite the recent wheelchair quality framework acknowledging the importance of a clear system to support budget pooling. For example, when explaining what is expected from ICBs when doing

assessments, the framework states: ‘Governance is in place to support personal wheelchair budgets processes and facilitate access to wider funding streams, supporting an integrated approach to care planning and assessment.’ This is another example of well-designed policy and guidance not translating into the reality experienced by service users.

### What needs to change

If there is to be a genuine commitment to strategic commissioning that shifts wheelchair services towards prevention over the longer term, there must be clear expectations on ICBs to give people access to a more holistic service. There has been important work to develop policies, such as personal wheelchair budgets, that are part of enabling this shift. But there is much more that could be done by working in partnership with others, particularly local authorities, to deliver better outcomes for wheelchair users.

## 3. Managing quality concerns effectively

Effective commissioning also depends on actively managing providers to protect quality and value for money. This starts with designing contracts that focus on quality and outcomes. Block contracts, which pay a fixed sum for a defined scope of services, can be problematic because they pay providers the same regardless of how many patients are seen or the quality of care. Wheelchair providers have also told us block contracts are difficult to manage because inflation and rising workforce costs increase their expenses while the contract’s value stays fixed.

The NHS 10 Year Health Plan for England committed to moving away from block contracts so that commissioners fund based on the activity, quality and outcomes of care delivered. NHS England has asked ICBs to begin deconstructing block contracts for community services and wheelchair provision will be in scope.

Once a contract is in place, ICBs are expected to use their contractual levers to manage situations where a wheelchair provider is not meeting quality expectations for service delivery. The NHS standard contract and technical guidance encourages ICBs to take informal routes and collaborative approaches first. It sets out formal processes that ICBs can follow, such as issuing a contract performance notice, but ICBs have wide discretion in how they use these levers. For example, there is no guidance about how long to allow an informal process to prompt change before formal processes become more appropriate. We observed very different approaches from ICBs, with some dedicating a lot more resource than others to supporting the provider to improve (see the Hertfordshire ICB case study on page 22).

We have also seen that, although a provider may exhibit similar quality issues in multiple ICB areas, ICBs tend to manage these in isolation. There is no positive duty for ICBs to share information with each other about issues with individual providers, and we heard some ICBs were anxious about legal challenge from providers if they shared performance concerns with others. This uncertainty appears to be preventing open discussion. Equally, when an ICB's approach has succeeded in improving performance, there is not always a forum to share that learning. This is a missed opportunity for system-wide learning on managing providers that hold contracts across multiple ICBs.

We have seen that ICBs are not always clear about the escalation routes available to them, beyond their own risk registers and boards, to raise concerns about the quality of independent providers. ICBs can alert NHS England's regional teams to a problem, and these teams can also raise issues nationally. But we did not see evidence of an agreed approach that would support a consistent national mechanism for assisting ICBs (in contract management with any provider), and the ICBs we spoke to did not mention it as a resource that might help them.

The National Quality Board issues guidance to ICBs on managing quality issues involving independent sector providers. ICBs can follow the framework, but the framework itself says: 'Note that for independent sector providers as there is no NHSE [NHS England] regulatory remit for oversight of quality or quality governance, other regulators and commissioners must use their contractual levers to influence…regional quality governance'. As wheelchair providers are not CQC-registered, there is no regulatory route available here. We have had constructive discussions with NHS England colleagues about these gaps for escalating quality concerns. We understand it is something they recognise and are keen to address.

## What needs to change

There needs to be a clear framework for ICBs to raise quality concerns about contracted providers, and a way to share intelligence, so the response can be targeted and efficient. There is also an opportunity for ICBs to share more best practice on contractual approaches to managing quality, to build skills in this area. There needs to be an assessment of whether wheelchair service providers have enough structural oversight of their quality, given they do not currently fall under CQC-regulated activities.

## Wheelchair services: a grey area for health and care regulation

Wheelchairs are regulated by the Medicines and Healthcare products Regulatory Agency (MHRA), as they are defined as medical devices under its legislation. It defines medical devices as those that are intended for 'diagnosis, monitoring, treatment, alleviation of or compensation for an injury or handicap'. Intention is the relevant factor here. A wheelchair used by hospital staff to transport different patients between wards is not considered a medical device. In contrast, a wheelchair provided to support a disabled person's mobility and independence is considered a medical device, because it is intended to 'compensate' for that individual's disability.

MHRA regulates the device itself, so manufacturers must register their products and monitor for any adverse incidents caused by faults.

There is no regulatory oversight of the services around NHS wheelchairs, such as assessment, fitting and repair. This is because, while CQC describes regulated activities very broadly as 'an activity involving, or connected with, the provision of health or social care', its remit is set by a list of 14 types of activity set out in Schedule 1 of the 2014 Regulated Activities Regulations. This includes a category of 'Treatment of disease, disorder or injury', but it does not cover wheelchair services because activities in this category must be supervised by a 'health professional'. The Schedule's list of health professional roles does not include physiotherapists or occupational therapists, who are the people involved in wheelchair assessments.

CQC's 2014 Regulations do refer to wheelchairs. For example, under Regulation 15, all providers registered with CQC must make sure all equipment used for care (including wheelchairs) is clean, suitable, well maintained and properly used. Under Regulation 12 of the 2014 Regulations, care and treatment must be provided safely, including making sure equipment is safe and used safely. CQC has also published guidance on managing risks of wheelchair use when delivering registered activities, including learning from safety incidents.

But none of this creates regulatory oversight of the systems that assess and fit people with a suitable wheelchair. These are services that can have serious health impacts. A poorly fitted wheelchair can contribute to pressure injuries, compromised posture, and upper body injuries from inefficient propulsion.

This regulatory gap is a particular concern given the increasing numbers of full contracts, from assessment through to supply and repair, being delivered by independent providers. NHS-delivered wheelchair services take place in a Trust environment where many other elements of the organisation will be covered by CQC inspection, such as whether it is well led. Independent providers sit entirely outside this oversight.

## Managing the quality of wheelchair services at Hertfordshire ICB

Between July 2024 and February 2026, Hertfordshire ICB worked intensively with its contracted provider, AJM Healthcare, to help improve the wheelchair service. This followed a consistent increase in concerns about long waits for equipment and repairs, and poor communication with service users.

It wrote to the provider outlining its concerns, which had been discussed in regular contract and quality review meetings but were ongoing. The ICB asked AJM Healthcare to develop an action plan with clear timelines for resolving equipment handovers for people waiting longer than 18 weeks. It also asked for information about processes for handling orders, managing delays and issuing loan chairs while people were waiting. The ICB asked for assurance about training given to the customer service team. It also asked about its processes for informing service users about delays in equipment handover, and for managing service user queries and complaints.

The ICB went on to use contractual levers, issuing a contract performance notice and instructing the provider to prepare a remedial action plan. Actions were developed and logged through fortnightly escalation meetings with AJM Healthcare. The ICB worked with AJM Healthcare in other ways to improve service delivery, including:

- meeting AJM Healthcare’s managing director and senior staff to make sure they were fully aware of problems
- holding system quality meetings with AJM Healthcare and local community and acute NHS trusts, the local authority and Hertfordshire Healthwatch to develop a shared understanding of risks and action needed
- holding multidisciplinary team reviews with input from the ICB’s quality and clinical staff to review the most complex cases on the waiting list and agree plans to resolve them

- increasing the frequency of contract and quality review meetings from monthly to fortnightly
- reviewing AJM Healthcare's policies and processes and challenging their adequacy
- examining data relating to equipment ordering and encouraging AJM Healthcare to place orders for bespoke equipment promptly to mitigate delays in provision
- encouraging AJM Healthcare to work with a wider range of suppliers to avoid reliance on a small number
- escalating the service delivery problems internally to the ICB's executive directors and recording them on its risk register to make sure adequate resource could be allocated to improvement work.

Over time, this combination of a 'hands-on' approach with the use of contractual levers led to significant improvements in waiting times for wheelchairs. The contract performance notice and remedial action plan closed in February 2026.

However, it is important to note that Hertfordshire ICB told us the level of investment it put into managing this contract was far beyond its usual resourcing. It said it would be difficult to maintain in future, particularly given the recent restructuring and headcount reductions affecting all ICBs.

# 4. Shaping the provider market

Alongside managing quality in existing contracts, commissioners are responsible for actively shaping the market of providers bidding for contracts. The NHS 10 Year Health Plan for England is clear that ICBs should look to commission services from a wide range of providers, including private and third-sector organisations, to deliver care effectively.

The Operating Model for NHS-Commissioned Wheelchair Services already states that commissioners should 'support supplier and market development to improve quality in the long term as well as in the short term'. The new Strategic Commissioning Framework places more emphasis on this role, expecting ICBs to 'shape the development of providers and use of novel contract models to create the right provider landscape to deliver population health improvement'.

From what we saw in our investigation and in discussion with other stakeholders, ICBs are not currently in a strong position to play this market-shaping role for wheelchair services. The ICBs we spoke to said they felt they had to continue working with a provider, even when it was consistently underperforming, because there were few alternatives if they ended the contract. There was little sense that ICBs had the capacity or flexibility to work proactively to encourage new providers into the market – for example, by setting longer-term outcome metrics that might incentivise different kinds of bids. There also appear to be skills gaps in managing provider sustainability, business continuity and supply chain resilience when alternative providers are limited.

This lack of capacity is perhaps unsurprising given the significant organisational change and resource pressures currently affecting many ICBs. Research from the Health Foundation, based on interviews with ICB leaders, describes how short-term pressures, restructures and unclear roles and responsibilities have diverted attention from longer-term policy goals around preventing and reducing health inequalities. And this is not a short-term issue – the Health Foundation notes that NHS commissioning bodies 'have been on a constant treadmill of reform since the 1990s'.

## What needs to change

There will need to be a significant focus on skill development, so that ICBs can take a more active role in shaping the markets for the services they commission, including wheelchair services. This will require a sustained period of stability and consistent resourcing, so they can focus on these skill gaps.

# 5. Measuring outcomes and learning from feedback

As the Strategic Commissioning Framework recognises, evaluating a service's impact is an important stage in the commissioning cycle, and ICBs are expected to build feedback into their commissioning decisions. This means carefully tracking patient experiences of services.

Work has been done over the last decade to develop person-centred outcome measures for wheelchair users. For example, a team at Bangor University developed questionnaires that let wheelchair users identify what is important to them and assess whether their wheelchair service has helped them make improvements in those areas. But there is currently little incentive to use this approach. The mandated national dataset focuses only on volumes, expenditure and access to services. It does not capture outcomes for patients' overall health and wellbeing that could help assess ICB performance.

The NHS 10 Year Health Plan for England commits to collecting patient-reported experience and outcome measures (PREMs and PROMs) more systematically, but this will take time to develop. The recent quality strategy for NHS-funded care in England states an ambition that people's experiences are used routinely to inform the design and governance of services 'within the next decade'.

Complaints are another form of intelligence that can help commissioners measure user satisfaction with a service. If unhappy with the service they are receiving, patients can complain to the provider directly or to the commissioner of the service. ICBs often signpost complaints back to the provider concerned. This can be appropriate, since issues are often resolved more effectively closer to service delivery. Even when patients choose to complain to the commissioner, ICBs often rely on the provider's response rather than investigating the issue themselves and forming an independent view.

The Complaint Regulations 2009 make it clear that patients cannot escalate to the commissioner if they remain unhappy with the provider's response. While this system is designed to give patients a choice of routes and avoid the same issues being investigated twice, it raises a question about how well placed ICBs are to capture user insight through complaints.

As part of contract monitoring meetings, ICBs will usually ask about complaints. But this relies on the provider's own reporting system and how it categorises feedback as a formal complaint, concern or query. Wheelchair Alliance research has highlighted that

not all wheelchair services have clear, formalised complaints processes. The Alliance regularly receives complaints from people who feel their provider has not heard them.

## What needs to change

There needs to be a clear commitment to developing patient-reported experience and outcome measures as a central part of how ICB performance is assessed. For wheelchair services, this means being able to judge not only whether equipment was provided within a set timeframe, but whether the service has supported people's health, independence, education, employment, family life and wider wellbeing. This needs to be supported by a well-functioning system to draw insight from complaints and other feedback data. Without this type of outcome-focused insight, ICBs, NHS England and DHSC will not have a clear basis for understanding where commissioning is working well, where it is falling short, and what action is needed to improve services for wheelchair users.

# Recommendations

The shift towards strategic commissioning will only deliver meaningful improvements for service users if responsibility is matched by the support and resourcing needed to fulfil it. Our investigations found committed commissioners working in systems that do not always provide the information, capability, oversight or capacity needed to deliver the outcomes expected of them.

ICBs need the skills, tools and support to commission services around the outcomes that matter to people. Government and national NHS bodies must provide clear leadership, accountability and coordinated support where concerns cannot be resolved locally.

We have identified three strategic priorities for strengthening the commissioning of wheelchair services. Although these recommendations focus on wheelchair provision, they offer wider learning about the conditions ICBs need to fulfil their role as strategic commissioners effectively.

## 1. Strengthen national oversight, data and quality assurance

While services should be commissioned to reflect local need, stronger national leadership is needed to support ICBs and give assurance about the quality of wheelchair services. We heard during our investigations that wheelchair provision can receive limited attention because it represents a relatively small proportion of ICB expenditure. But failures in these services can have serious consequences for people's health, safety, independence and ability to participate in society. They may also create greater costs for health and public services in the future.

There is currently no accurate national picture of the number of wheelchair users or the level of unmet need. Limitations in the national wheelchair dataset also make it difficult to compare performance, identify emerging problems and understand whether services are achieving positive outcomes for wheelchair users.

Stronger oversight is also needed when quality concerns extend across ICB boundaries. Individual contract management is not enough when the same provider operates across several areas and similar problems happen in each. ICBs need clear routes for sharing intelligence, escalating concerns and accessing coordinated support.

There is a further gap in quality assurance because the assessment, fitting and repair services surrounding wheelchair provision currently fall outside health and care regulation. The Government should decide how these services can be given appropriate and proportionate oversight.

**We recommend that the Department of Health and Social Care (DHSC) and NHS England play a stronger role in overseeing wheelchair services, so that they can better support ICBs to commission high-quality services that meet people's needs.**

This should include:

- collecting national data on the number of wheelchair users in England and strengthening the national wheelchair dataset so that commissioners can understand local need, including unmet need
- establishing clear senior national accountability for wheelchair services, including responsibility for scrutinising data and performance and driving improvement
- making sure there are clear escalation routes and coordinated support for ICBs that have concerns about the quality of an independent provider, including arrangements for sharing intelligence and identifying problems affecting more than one ICB area
- deciding how to put in place appropriate and proportionate quality oversight of wheelchair assessment, fitting and repair services.

## 2. Build ICB capability to commission sustainable, person-centred services

Our investigations suggest that ICBs face barriers in carrying out some of the functions expected of strategic commissioners. In wheelchair services, commissioners described working in a constrained provider market, with limited alternatives when services were underperforming. They are expected to manage provider performance and risk while also encouraging innovation and supporting the longer-term sustainability of the market.

Commissioners also face challenges in coordinating funding across organisational boundaries. National policy supports a holistic approach to wheelchair provision, including the use of personal wheelchair budgets. But access to equipment that

supports people's wider educational, employment and social needs remains inconsistent. Stronger collaboration between the NHS, local authorities and other organisations is needed to turn these ambitions into practice.

These issues are not unique to wheelchair services. But wheelchair provision provides a clear example of the capacity, skills and partnership working that ICBs need to commission services around the outcomes that matter to people.

**We recommend that NHS England makes sure the Strategic Commissioning Development Programme equips and resources ICBs to commission sustainable, person-centred services, using wheelchair provision as a practical case study.**

The programme should support ICB capability and capacity to:

- work collectively to shape provider markets and encourage sustainable and innovative models of service delivery
- manage provider performance, sustainability, business continuity and supply-chain risk, particularly where alternative providers are limited
- coordinate funding across organisational boundaries where this would enable equipment to meet people's wider health, educational, employment and social needs
- learn from local authorities' experience of market stewardship, provider sustainability and commissioning in fragile provider markets, particularly in adult social care.

# 3. Measure services by people's experiences and outcomes

Commissioners need reliable information about the outcomes that services achieve and the experiences of the people who use them. Without this insight, it is difficult to assess whether commissioned services are delivering value, improving lives or meeting local needs.

This is particularly important for wheelchair services. Measures of activity, expenditure and waiting times provide only part of the picture. Services should also be assessed by whether they support people's health, safety, independence, education, employment, family life and wider wellbeing.

Complaints and other forms of feedback are an important source of intelligence about service performance. But there is currently variation in how ICBs use this information to identify themes, understand the causes of service failure and drive improvement.

Commissioners need a more consistent way to bring together information about patient experience, outcomes, complaints and service performance.

**We recommend that DHSC and NHS England develop a consistent national approach to measuring wheelchair users' experiences and outcomes.**

This should include:

- expanding the national wheelchair dataset beyond its current focus on activity and expenditure to capture patient experience and the impact of services on people's health, independence and wider wellbeing
- using the upcoming reform of complaint regulations to establish clear expectations for how ICBs collect, analyse and use complaints and other feedback about commissioned services to identify themes and improve quality
- making sure these reforms reflect the principles of the NHS Complaint Standards, including the expectation that complaints should support learning and improvement.

If you would like this document in a different format, such as Daisy or large print, please email content@ombudsman.org.uk

Public Service Ombudsman
Citygate
Mosley Street
Manchester
M2 3HQ
United Kingdom

Telephone: 0345 015 4033

www.ombudsman.org.uk

Follow us on: