



Manifesto

for healthcare and
assistive technology



The healthcare and assistive technology business sector is represented by the British Healthcare Trades Association (BHTA)¹

The healthcare and assistive technology business sector has a crucial role to play in bringing about more efficient use of public service expenditure, improving patient care and boosting British businesses.

These priorities are very important for the many small businesses in this sector, as well as for larger companies that we represent.

This paper looks at:

£££s

Savings and better value for public expenditure on health and social care

- Reducing the secondary care burden
- Prevention of bed blocking/enabling intermediate care and swifter reablement
- Outsourcing services and removing overhead
- Supporting mechanisms to make products and services readily available in the primary care sector

PATIENTS

Supporting and enabling people who need equipment and related services

- Patient choice
- Personal budgets
- Self-care

JOBS

Supporting growth in the British economy

- Manufacturing versus importing
- Skilling up the workforce
- Barriers to innovation adoption
- Procurement and tendering issues
- Working with SMEs to support exports, promote innovation and relieve regulatory burden

1 The British Healthcare Trades Association (BHTA) is the UK's oldest and largest healthcare association, founded in 1917. Our members - almost 500 companies employing over 17,000 people - make or sell assistive technology products that help people live more independently. These range from wheelchairs and scooters to stair lifts, seating and positioning products, patient support surfaces, rehabilitation products, stoma and continence products, prosthetics, orthotics and augmentative communication devices for people with limited speech.

Introduction

The healthcare and assistive technology equipment and services sector has a crucial role to play in the drive to integrate services and place individuals more in control of better value public sector provision for them.

The challenges facing individuals seeking the equipment and services that they need are often considerable. This is because of the myriad of routes that they may be expected to follow to obtain such necessary support.

Responsibility for the provision of healthcare and assistive technology equipment and services crosses public provision boundaries. As well as National Health and Social Services responsibilities, provision is also an important responsibility in education, housing, for all public access issues and covers all aspects of health (public, physical and mental).

Patients, clients and consumers who will benefit from timely provision of healthcare and assistive technology products include:

- Children and adults with long-term conditions
- Children and adults with complex to simple short-term needs
- Frail elderly people
- Carers

There is a widely accepted definition of assistive technology:

Assistive Technology (AT) is any product or service designed to enable independence for disabled and older people.

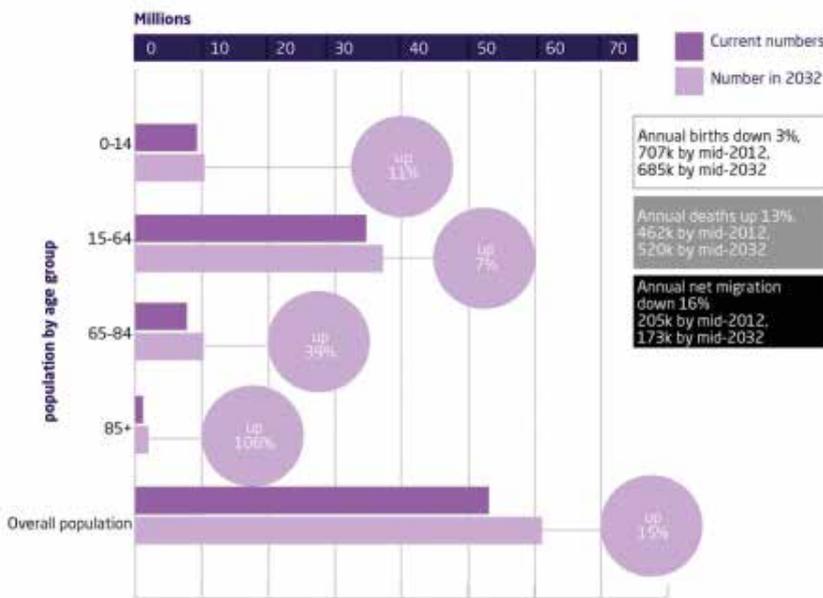
The majority of the equipment falls within the category of “medical devices”, with some items being regarded primarily as electrical or mechanical. There is a growing body of international standards and EU directives or regulations for the products, intended to ensure that they are fit for purpose and safe to use.

All the products relate to keeping people safe, and many are used in people’s own homes, enabling and enhancing independence. They are important in preventing falls, pressure sores, or stabilising, improving and preventing deterioration in condition. Such devices include powered wheelchairs and specialist beds and mattresses, grab rails and simple aids for daily living.

The sector strongly supports the principle of “no decision about me, without me” and believes that placing the end user at the heart of decision making makes for far better outcomes in every sense including better value. It also considers that support, before and after delivery, education and training of users and of carers are essential ingredients to ensure these outcomes including safe use.

Consequences of demographic change

The population is ageing. The King’s Fund suggests that the combination of extending life expectancy and the ageing of those born in the baby boom, just after the Second World War, means that the population aged over 65 is growing at a much faster rate than the population under 65. Over the next 20 years the population aged 65-84 will rise by 39 per cent and those over 85 by 106 per cent.



Source: The King’s Fund analysis of Office for National Statistics 2010-based National Population Projections. NB These are based on Office for National Statistics mid-2010 estimates and will be superseded by 2011 census-based projections.

The demographic changes forecast over the next twenty years are going to create a demand which cannot be funded entirely from savings in secondary care, although the savings are very much needed simply in order to sustain anything like the present NHS.

As a consequence of the demographic changes the public sector will increasingly struggle to provide support to all those people who would benefit from assistive technology equipment and for whom providing the equipment would be of benefit to the country in very many ways including economically.

The assistive technology sector’s role in private retail is likely to grow and become increasingly important in supporting and underpinning public sector provision. The sector must, therefore, make readily identifiable the businesses in which public and professionals can place their trust – safety and appropriate care must be paramount considerations.

Savings brought about by the private sector are most evident where provision of equipment eliminates (or reduces) the need for people intervention, and for costly stock-holding, by the public sector.

Less visible, but equally important, are savings brought about through improvements to quality of life and general mental health and well-being, reducing the call on other publicly funded services.

Enabling people to stay at home saves manpower and service costs in secondary care. Approximately two thirds of NHS expenditure is staff costs and these are considerably reduced if people do not need to enter the secondary sector, or enter it for shorter and less frequent periods. In contrast, overall expenditure on equipment is quite small in comparison to staff costs.

A study, undertaken by London School of Economics' Personal Social Services Research Unit (LSE PSSRU) in 2012, drawing on extensive research and analysis in the field, found that every pound spent on adaptive technologies delivers a net saving of £1.10 to the public purse². This equates to an annual potential saving of £1,101 per person per year. The Government estimated then that there were over half a million people (568,000) over 60 requiring an adaptation to their home³. If this need was met, it would deliver a net saving of £625m, according to the report.⁴

The LSE PSSRU report cites a review of the evidence on the costs and outcomes of housing adaptations, improvements and equipment conducted by Heywood and Turner (2007) on behalf of the Office for Disability Issues. This highlighted a number of examples of direct savings where interventions led to substantial reductions in demand for other services. As an example, one London borough reported annual savings of £30,000 per client for two wheelchair users who were able to leave residential care due to the provision of adaptations in their homes. Another authority reported reductions in care costs of £1.98 million over five years as a result of an investment of £110,000 in 20 level-access showers.

Longevity and ageing, coupled with the growth of long-term conditions, such as obesity and diabetes, will place increasing strain on every aspect of provision. Steps are needed now to ensure that the industry is geared up to what are likely to be widening gaps, which the public sector will be expected to cope with as costs escalate. The BHTA anticipates that the value of the UK market will rise from £2.5 billion sales to £6 billion by 2025 simply to keep up with demand, without including service costs (based on sales by BHTA members to public sector and individual customers). This is in line with forecasts in the American market.⁵

1. Better value for public expenditure on health and social care - reducing the secondary care burden

1.1 Prevention of bed blocking/enabling intermediate care and swifter reablement

There is, and will continue to be, an important role for equipment in the secondary care sector such as pressure relieving mattresses and beds. Once this demand is met (and cost savings made), future demand will eventually be reduced to the minimum possible without compromising quality and effectiveness of care in these settings. Our focus is therefore on helping the NHS minimise the length of stay in secondary care (and keeping people out of hospital in the first place). Unplanned admissions need to be reduced, along with the accompanying impact upon CCG budgets.

² On the basis of approximately 45,000 clients receiving adaptive technologies each year at an average cost of £6,000 (broadly comparable to the volumes and costs associated with DFGs), an annual outlay of £270 million would be likely to generate reductions in the demand for health and social care services worth £156 million over the estimated lifetime of the equipment, and to achieve quality of life gains with a value of £411 million over the same period.

³ Disabled Facilities Grant Allocation Methodology and Means Test Report 2011

⁴ 'Building a business case for investing in adaptive technologies in England'. The research was conducted by the Personal Social Services Research Unit at the London School of Economics and Political Science. http://www.bhta.net/sites/default/files/Business_case_for_investing.pdf

⁵ Disabled and Elderly Assistive technologies HLCO47D June 2013 ISBN: 1-56965-436-0

⁶ Bed-blocking statistics to be found here: <http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/05/December-13-DTOC-SPN.pdf>
News report here: <http://news.sky.com/story/1191732/nhs-bed-blocking-reaches-three-year-high>

Elderly people, in particular, cause bed blocking when they are unable to return home either because they still need a level of care that is not available at home, or their home environment will not be safe for them without adaptations and equipment in place.

The need for intermediate care - a stepping stone between hospital and home - has been recognised in a number of areas. Skilled nursing facilities (SNFs) have become the mainstay of care and the link between secondary care and primary care in those countries that have introduced Diagnosis Related Group (DRG) type payment systems including USA, Germany, Italy and Spain.

The absence/inconsistency in provision of SNFs in the UK may be the missing link which results either in 'bed blockers' extending length of stay in secondary care or a lack of suitable care in primary care setting due to the shortage of skilled nursing staff trained and equipped to treat more acutely ill patients returning to the domiciliary setting. Equipment provision in these settings is vital to prevent pressure sores and mobilise and reable the patient.

Community equipment loan stores already play a vital part in enabling swifter discharge and reablement, as well as preventative intervention. Jointly funded by health and care, more often led by local authorities, and in some areas providing prescriptions for individuals to take to approved dispensing retailers, this service is undervalued as a resource available to multiple facets of public sector provision. It also suffers from budgetary limits which can cause cessation of service when the year's money is spent. Consideration of tariffs and budgets which follow the person and thus ensure they receive what they need may seem an open-ended and therefore costly alternative, but the costs of bed-blocking and lack of options to reable people should not be underestimated. Tariffs also help to avoid unfair "post code prescribing".

The role of equipment in prevention cannot be overstated. A good example of where the sector is already working to save NHS costs is in relation to the £3.5 billion cost of pressure ulcers and the harms associated with them. Considerable improvements in this area are achievable with minimal extra resources. One key initiative is 'Your Turn', a campaign set up by BHTA to promote pressure ulcer prevention. One PCT saw a 25% reduction in pressure sores after six months support from 'Your Turn'⁷. Providing appropriate pressure redistributing support surfaces, such as specialist mattresses, is essential to preventing and managing pressure ulcers. The cost to the NHS resulting from pressure ulcers is approximately 4% of the total budget.

Prevention of falls is also very important for keeping people out of hospital, and the simplest pieces of equipment such as grab rails, through to telecare devices all assist with this. Widening up the GP prescribing role to directly cover equipment intervention would be a great step forward.

With a population that is living and working for longer, we have to address the question of some individuals making a greater contribution to aspects of their own healthcare, if they wish to benefit from the best quality, perhaps most innovative, but more costly products.

Tariffs enabling wide access, greater use of personal budgets⁸ and encouragement of self-care will all play a part in addressing these problems.

⁷ Details of the Your Turn campaign can be found at: <http://www.your-turn.org.uk>

⁸ More comment from the BHTA about personal health budgets here: <http://www.bhta.net/content/personal-health-budgets-will-improve-quality-life-and-reduce-hospital-costs.html>

1.2 Outsourcing services / removing overhead

The biggest cost for the public sector is staff. Moving activity out of secondary care, closer to the patient, already makes sense for health, with leg ulcer clinics and aspects of diabetic care being good examples of making better use of resource by delivering long-term care closer to home.

Orthotics, prosthetics, wheelchairs, and audiology are all services which do not need to be delivered in the hospital setting, or indeed in expensive public sector buildings. In orthotics and prosthetics it is already the norm for the service to be provided by a commercial contractor who employs the healthcare professionals involved, but the service is still delivered at public sector premises, with the public sector controlling aspects such as the appointments system.

Again, tariffs enabling wide access, greater use of personal budgets and encouragement of self-care will all play a part in addressing the ability to outsource and move care closer to home.

2. Supporting and enabling people who need equipment and related services

The BHTA believes that enabling the money to genuinely follow the patient or client is the only way of ensuring that they will in future be able to access the equipment they need.

Personal budgets (based on the principle in some cases of there being only 'limited subsidies' available for some healthcare products and services) can only help in this regard.

Bringing together budgets from other areas such as education, to ensure a holistic approach, is also necessary. Budgetary silos urgently need to be overcome and until the barrier between health and social care is broken down and it becomes clear to everyone what is "free", what is "paid for", what is "not provided at all", then timely and adequate equipment/adaptation provision will continue to be very difficult to achieve.

Opportunities to reduce unscheduled admissions, to speed up reablement, to enable full participation in education and in work, and to enable self-care and co-participation, will continue to be missed. Extension of personal budgets and their recognition of equipment as an aspect of what someone needs is very welcome.

Prevention is rightly moving up the health agenda. Funds are shifting to local authorities as there is increasing focus on care spending. But the problem remains one of increasing demand. With an ageing population, causing substantially more demand for a growing range of products, some of which cannot be considered to be cheap, we have to address the question of greater contribution by some individuals to their own care.

Tariffs which are outcome based fit well with provision of equipment. The health system, in particular, focuses on what a person's condition is, whereas equipment tends to address task/life scenarios. It is easily overlooked, but a "whole person" approach should include equipment as part of a solution. For people with complex needs and for children and their families in particular, personal budgets calling on tariffs, with known rules of engagement, can make a huge difference to timely access and delivery.

Public perception is also important. Members of the public accept that if they need a mobility scooter they will have to buy it themselves. Yet these vehicles are simply another form of wheelchair. We all accept that we will choose our spectacle frames and pay for them. Increasingly, local authorities are limiting the equipment they will provide and people have to buy their own simple aids for daily living. Is it time to open up the debate about what the public sector must provide and what people will have to purchase for themselves? Is it time to link equipment from which any elderly, frail person may benefit to public health messages and encourage elderly people to think ahead and provide more for themselves?

Signposting by public sector bodies to good private providers/retailers has become increasingly vital. There is already recognition of the need for this in the Care Act. A simple means of recognising businesses which can be trusted, employing staff with appropriate competency becomes of paramount importance. Consumer Codes of Practice, such as the TSI Approved Code operated by the British Healthcare Trades Association⁹, and Voluntary Accredited Registers can provide these. This is an emerging retail market and consumers are currently largely unaware of the useful equipment that exists to help them; nor are they aware of named retailers to get the appropriate equipment from. If we do not establish an effective means of signposting to trusted private sector partners, the door will be left open for unscrupulous direct selling operators to take advantage of vulnerable people.

As discussed above, nationally accessed tariffs may be the answer to providing a consistent system 'set of rails' to facilitate access to equipment following professional assessment, regardless of which aspect of the public sector is making it available and/or alongside self-care/self-funding and financial contribution by individuals. The system needs to be readily understood by commissioners, professionals and individuals alike, just as it is for optical and dental provision, allowing access by all parties, and with ease of signposting.

One factor which needs to be addressed with personal budgets if these are to become more widely adopted will be certainty about who co-ordinates various aspects in the new market place, who will act as the advocate to identify funding/needs, and information for GPs, professionals and end users to facilitate this.

3. Supporting growth in the British economy

The healthcare and assistive technology equipment and services sector can contribute far more to "UK plc" than is currently the case.

If it is to do so a number of factors need to be addressed:

3.1 Manufacturing v importing

Much of the equipment provided in the UK is now manufactured elsewhere, (although there are a number of areas of manufacturing that have never left the UK, such as wound management products, stoma products, prosthetics, coated fabrics, compression hosiery). Many large scale labour intensive manufacturing operations have shifted to low cost manufacturing areas, but there are now signs that some of them are coming back and there is clearly a will to bring more manufacturing back to the UK. It is very important to note that local manufacturing can, of course, lead to increased exporting.

⁹http://www.bhta.net/code_of_practice.html

At present, innovation is largely occurring outside the UK, and there is a negative trade balance. Whilst the NHS is seen as being one of the most efficient health systems in the world, it is not being exploited for locally generated innovation, employment and export in this sector.

3.2 Skilling up the workforce

Much of the workforce in the sector works alongside (or as part of) a multi-disciplinary team, involving state registered professionals, such as occupational therapists, speech & language therapists, hearing aid audiologists, physiotherapists, orthotists, prosthetists, and nurse prescribers.

The sector crosses boundaries between sector skill councils and does not fit entirely with any of the existing provisions, with for example, engineering, health, and care. There is a lack of formal qualifications within the sector.

There is a definite need to develop and enhance skills in the workforce and to make the sector one which is visible to young people as a career option, and to older people as a second career option. It also plays an important role in providing training to healthcare professionals about the equipment provided, to improve their capability and understanding. This is largely unrecognised and is increasingly vital as the number of professionals reduces.

The industry is a relatively immature one which needs input from government and other sectors. It is currently not attracting in enough expertise from other sectors.

A programme to try and address the question of individual competence and evidence thereof has been embarked upon, via the Healthcare & Assistive Technology Society, with the intention of attaining Voluntary Register Accreditation via the Professional Standards Authority, but this is a long-term project¹⁰.

Formal, ongoing training of staff is not yet the norm throughout the sector. With a large number of small businesses, this needs to be addressed. Signposting to opportunities for funding of training and the potential for apprenticeships needs to be improved.

3.3 Barriers to innovation and its adoption

The most immediate barrier to innovation is the immaturity of the sector, with a multitude of very small, unsophisticated businesses which do not know how to access funds, write appropriate business plans, or identify appropriate business partners. There is a strong need for mentors from other sectors.

In terms of gaining approval for use on the market there are barriers in relation to proving the efficacy of products. The equipment provided by this sector is often low cost, relatively simple, used primarily in a care setting or a person's own home, with minimal healthcare professional input. The level of proof required by NICE, for example, may simply not be an option. Where it is, NICE should give precedence to examining UK-led innovation.

Public sector tendering systems reduce the opportunity for introduction of innovation if they are based upon existing, known, equipment and it is difficult to introduce something new once an agreement is in place. Commissioners and procurers tend to be risk averse and stick to the products they know, even when evidence is in place to support new solutions.

¹⁰ <http://www.professionalstandards.org.uk/voluntary-registers>

A further factor impacting negatively on this is the length of time it is taking for CCGs to fully get to grips with their budgets and many of them are largely oblivious to this sector.

3.4 Procurement and tendering issues

Within the health service, and also when addressing the needs of local authorities, there is a balancing act to be addressed between the two extremes of individual service/one-off purchases (such as in the case of sophisticated seating for a disabled child) versus tenders which aim to aggregate volume and restrict to just a small number of suppliers and delivery points.

Observations are as follows:

- i. In secondary health care there have been constant reviews of procurement¹¹ but market forces do not seem to be sorting out problems satisfactorily. Whilst aggregation of volume should deliver savings, the NHS in England has been devolved into more than 300 organisations and this undermines such efforts (particularly since the majority of these have no volume commitments whatsoever). This needs to be recognised and accepted in a sector where volumes can be low anyway. Specialist commissioning is not yet really addressing the problems and achieving what is needed.
- ii. There is an expectation that products can be treated as commodities, yet specialist support and training is necessary alongside provision of the equipment, and/or participation of the contractor in establishing which product is right for the end user, as well as ongoing after sales support. There are hundreds of delivery points, and with the added requirement of providing training, the contractor cannot just drop the product at the door.
- iii. The increasing dependence that commissioners now place on training, education and other value added services such as audits and prevalence surveys has the effect of diluting discounts. These services have to be paid for and are usually reflected in the price of the product, or sometimes through separate fees, which are charged to product costs.
- iv. There is disparity in price for the same product across the UK and the points above are all factors, along with varying costs for delivery between built-up and rural communities, for example, and between delivery in hospital, in residential care, and in the patient's/client's own home.
- v. Framework agreements, whilst ensuring the same price for the product wherever the order comes from, hinder introduction of innovative products, and stifle competition. Paying a commission to whichever party arranges the agreement just adds cost and reduces available funding for the necessary products or services.
- vi. VAT can introduce perverse incentives/behaviours where the VAT to be applied varies depending on:
 - a. the type of provider/contractor (in-house, private, or third sector)
 - b. where it is delivered (NHS premises, contractor's premises)
 - c. to what extent state registered healthcare professionals are involved.
- vii. Organisations issuing tenders need to be encouraged to take the

¹¹ BHTA statement on October 2013 procurement review here: <http://www.bhta.net/sites/default/files/BHTA%20response%20-%20Making%20public%20sector%20procurement%20more%20accessible%20to%20SMEs%2017%2010%202013.pdf>

most lenient approach possible to ensure that local provision by UK bidders is recognised and valued.

- viii. There is too much wasteful repetition of effort that is a huge “hidden” cost to all concerned. Tenders for similar equipment are being issued by local authorities and health services, and in multiple areas. The government has promised there will be a common mechanism for storing and retrieving:
 - a. information about opportunities to tender; and
 - b. standard company information to support tender bids.

The industry is sceptical that it will be used consistently by all parties but welcomes the intent to reduce wasted time, effort and cost.

- ix. There is a plethora of differences in the supply chain/procurement route. Methods vary across local authorities (social services and housing), regional local authorities, NHS Trusts, CCGs, regional NHS, external bodies such as SBS, NHSSC, education and access to work. Then there is also variation in where the equipment is actually to be provided - in hospital, in clinics, in a retail setting, in residential care or the person’s (patient’s/client’s) own home.
- x. Framework agreements, tenders (based on geographical location or on volume), preferred suppliers (providing quotes for equipment as part of the team working alongside assessors who are state registered healthcare professionals, or assessors who are themselves appointed by contract), prescriptions (issued to contractors by GPs or to retailers via community equipment services) - all make for a system that is confusing for purchasers, providers, and public alike.
- xi. The funding model needs to be a consistent one that attracts investment and innovation, which is sustainable, allows patient/client independence and choice, and enables co-participation.
- xii. A properly constructed tariff system may be the answer, one which can be accessed from multiple points of entry across the public sector, and allowing for private purchase alongside. Whilst tariffs can be difficult to construct initially, they have distinct advantages over framework agreements. They should be constructed to reward outcome and to enable trigger by commissioners, prescribers, and assessors (as appropriate). Entry criteria for approved contractor/supplier status should be standardised and new contractors would be able to participate as soon as they demonstrate that they meet those criteria - this removes the need for costly tendering exercises and eliminates duplication of exercises. A tariff can also overcome budgetary silos, removing barriers to provision of funding, and ensuring nationally consistent delivery on provision and outcomes. Part IX of the Drug Tariff, listing appliances available on prescription, is a good example of a tariff which enables nationwide access, with choice for patient and clinician, and a central system allowing ready adoption of innovative products whilst scrutinising value for money.
- xiii. In health, examples already exist (such as optical and dental) where the system is clearly understood by all parties, with easy access, clearly signposted. The principles behind these primary care services could be extended to the healthcare and assistive technology equipment sector, with a central system to manage tariffs, reimburse/remunerate contractors, and monitor commercial entry. The tariffs could follow an iterative model i.e. one which

reflects each level of provision required. This is being successfully proposed in the orthotic sector.

- xiv. Such a system would particularly make sense for equipment issued in relation to specialised services which are commissioned nationally, and for services where co-payment is sensible (i.e. where the individual is expected to contribute, above a set threshold). Legislation to enable wider use of prescriptions or vouchers (available in some areas of the country for wheelchairs and for community equipment), to which members of the public can add their own money has to be considered on a significantly wider scale. Benefits of extending this approach would include greater choice and control for equipment users as well as helping to get the best outcome for the patient and not just address a particular functional need.

4. What steps do we need to take now?

Responsibility for this area should be in the hands of a specific minister. This ministerial portfolio should include responsibility for the assistive technology sector with responsibility for coordinating on cross-departmental issues including health, care, housing, education, work, health and safety, occupational health and could perhaps come under the responsibility of a Public Health Minister.

There must be more government assistance to encourage job creation in assistive technology manufacturing in the UK.

With integration of health and social care, we need to clarify what is expected to be “free” at the point of use and what cannot be. The costs of providing assistive technology should always be considered in the context of proper cost/benefit analysis as there are many benefits to wider society and the economy as well as to the individual able to lead a more independent life.

Assistive technology needs to be driven by an Assessment Prescription model with public freedom to access the supplier system that provides:

- Potential to be driven by personal budgets
- Potential for AQP models in some sectors
- Potential for co-payment (public/charity/private individual)
- Potential for insurance back up to be attracted by a model that can be costed out
- Potential for vouchers/prescriptions
- Potential for low cost items to be purchased by public (families) – signposting with confidence; and with proper consumer protection

There is a need to consider primary legislation changes to enable wider use of prescribing/vouchers/part-funding. Local authority responsibility beyond assessment (as per the Care Act) imposes provision of assessment and then signposting requirements to support self-funders. We believe that this should drive market confidence for private consumers.



Further relevant papers:

The Kings Fund: Making our health and care systems fit for an ageing population

<http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population>

The Kings Fund: Making best use of the Better Care Fund, Spending to save?

<http://www.kingsfund.org.uk/publications/making-best-use-better-care-fund>

Audit Commission Briefing: Fully Equipped 2002, Assisting Independence

<http://archive.audit-commission.gov.uk/auditcommission/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/brequip02.pdf>

Department of Health: Better Procurement, Better Value, Better Care:

A Procurement Development, Programme for the NHS

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226835/procurement_development_programme_for_nhs.pdf

NHS Future Forum: Choice and Competition - Delivering Real Choice

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213749/dh_127541.pdf

Care Act 2014

<http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted/data.htm>

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The CareFlex HydroCare, copyright Careflex

Ottobock Aqualine prosthetic system





There's never been a better time to be a BHTA member – we've gone from strength to strength and are delivering even more to our growing number of members.

All BHTA members are committed to the industry's only Trading Standards Institute operated Code of Practice, boosting their credibility and giving them closer links with local Trading Standards Officers and Citizens Advice.

Find out how we can support your business at **www.bhta.net/joinbhta** or contact us today on **020 7702 2141 / membership@bhta.com** to start benefitting from membership.

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