



# Associate Parliamentary Limb Loss Group

the Promotion of the Prevention of Limb Loss and of the Provision of Prosthetic, Orthotic, Wheelchair/Special Seating, Medical and other vital Rehabilitation Services to persons of all ages suffering Limb Loss and associated Complex Physical Disabilities in the United Kingdom and Internationally

*Helping to Deliver*

# PATIENT LED PROSTHETIC SERVICES

*with the support of this*

# PATIENTS CHARTER

*“Create an NHS that helps people to stay healthy” “Get more people more physically active”  
“Move from an NHS that has rightly focused on increasing the quantity of care to one that  
focuses on improving the quality of care” “We will therefore double our investment in  
Apprenticeships”* HIGH QUALITY CARE FOR ALL – Department of Health CM 7432

Developed Collaboratively and Iteratively Under the Aegis of the  
**Associate Parliamentary Limb Loss Group**

## GENERAL PRINCIPLES

Encouraged by a NATIONAL FORUM in PARLIAMENT and reaching out NATIONWIDE, this Charter applies to the provision of Prosthetic Services in the full variety of settings, including the NHS, Contractors to the NHS, and Voluntary sectors. It is expected that regard will be had to this Charter in invitations to tender and other contract documents.

This Charter supports the provision of the highest quality of orthotic, prosthetic, wheelchairs & special seating, and other vital assistive services/technologies as set out in SPECIALISED SERVICES NATIONAL DEFINITIONS SET NUMBER 5 for all PERSONS WITH COMPLEX PHYSICAL DISABILITIES.

This Charter supports

- Enhancing Quality of Life for People with Long Term Conditions
- Helping People to recover from episodes of ill health or following injury.

This Charter sees as essential, long-term workforce planning and practice and adequate resources for continued professional development for healthcare professionals, to enable all concerned with Prosthetic Services “to provide the right care, at the right time, and to the right quality without unnecessary delays.”

This Charter recognises the obligations on patients constructively and courteously to seek to abate and not to add to the increasing pressures on caring providers of vital Prosthetic services. To enable patients to support such obligations, it is expected that all NHS Trusts and Authorities will have, and will have prominently published and implemented, “zero tolerance” behaviour policies. A Conciliation Officer should be available for each site to whom either the User or the member of Staff or Both may refer any irresolvable difficulties.

## QUALITY OF CARE

The Patient assesses Quality of Care by its Effectiveness – the extent to which, and the quality with which, his/her needs and expectations are met. Effectiveness requires Services to be organised and managed around Patient and Carer needs and to deliver maximum possible health and independence for both adult and child patients. Health Professionals should, subject to health and safety requirements, advise the Patient of the optimum solutions to his/her needs. Such advice should not be compromised by resource constraints, although regard must be had in the short-term to any such constraints. The only eligibility criteria must be the clinical, lifestyle and culturally appropriate needs of each individual Adult Service User or Child Service User and their carers and families. Prescriptions must avoid discrimination.

## 10 C's

To meet Patient Needs, Prosthetic Services must meet all of the following 10Cs, adopted by the Associate Parliamentary Limb Loss Group ([www.apllg.eu](http://www.apllg.eu)):

### COMFORT

Equipment must provide adequate support and accurate fit, particularly at the interfaces with the skin, to enable the Patient to achieve optimal pain-free mobility and dexterity, and to avoid tissue breakdown and pressure sores. Staff must be given additional training in the needs of Children and of Older People in all environments.

### CHOICE

Patients need to be able to choose from a variety of convenient high-quality providers, with clear and consistent information and advice to back that choice, money following the patient, and staff having freedom to meet patients' expectations – the location of fitting needs to be convenient with a choice of appointment time to meet the needs of an adult patient and any carer or a child patient and his/her parents/carers – all children with a need at birth for Prosthesis(es) should be referred to a Specialist within the first month of life, and assumptions should not be made that a child will not be suited to the fitting of such support devices;

### CAPABILITY

Equipment must be appropriate to each Patient's requirements, mechanically safe, easily maintained and easy to use – instructions must be given which are suitable for and understandable by children wherever possible as well as their parents – there should be a single point of contact for advice about maintenance/recreation/travel/safety etc;

### COSMESIS

Where necessary for self-esteem, Equipment must be cosmetically acceptable commensurate with optimal function – needs of children and of young people, at the early stages of developing a positive self-image, must be met;

### COMPETENCE

All Healthcare Professionals whether from the NHS, Contractors to the NHS, or the Voluntary sectors, must (be enabled to) have the appropriate educational and career opportunities in order to develop and sustain

their competencies and skills – Staff should be specially trained in dealing with both disabled adult and disabled children’s needs;

### CAPACITY

Budgets must provide adequate Capacity for cost-effective and patient-effective services;

### CONSULTATION

Patients and Carers must be Equal Partners with Professionals in the planning and the operation of services;

### CONSISTENCY

Services delivered must not vary with location except where explicable by clinical variables;

### CALIBRATION

Key performance indicators must calibrate the degree to which services improve health and social outcomes for individuals and for populations;

### CARING

Caring is the Catalyst, respecting dignity and privacy, throughout the entire patient pathway – it is especially important to reassess growing children every 3-6 months to make sure that they always have optimal comfort and performance from their Prosthesis(es).

(Patients may require orthoses, wheelchairs, special seating and other assistive technologies as well as prostheses).

### THE ‘DUTY TO INVOLVE’

Legislation which came into force in 2003 placed a duty on certain NHS organisations to involve and consult when it came to making changes to services. NHS Managers have not always been clear when they have to involve and how best to do this. The changes to the law introduced by the Local Government and Public Involvement in Health Act 2007 make this clearer.

The strengthened ‘duty to involve’ came into force on 3 November 2008. In summary, the duty requires Managers to involve users of services in:

- Planning and provision of services;
- Development & consideration of proposals for changes in the way services are provided;
- Decisions affecting the operation of services.

## **THE NHS CONSTITUTION**

In England, the Government has published the NHS Constitution, setting out the principles, values and rights that guide the NHS in England. These principles and rights include a commitment by the NHS to the highest standards of excellence and professionalism in the care you receive and the right to be involved in discussions and decisions about your healthcare.

The NHS Constitution was produced to inform people of what they should expect whenever they use NHS services. As a reference point, the Government intends for people to compare the services they receive with what is written in the Constitution and to highlight any cases where the standards it describes are not being met. Similarly, it will act as a basis for how local healthcare providers operate.

Anyone providing NHS services will be required by law to "take account" of the Constitution in the planning and delivery of services.

## **VALUE FOR MONEY**

Patients welcome the shared recognition through this Charter that Patient-Centred Commissioning generates Value for Money. Patient-centred treatment and care, as well as improving the Quality of Life of the Patient and the job satisfaction of Health Professionals, also produces the best possible outcomes and lower overhead costs and lower per-case costs and shorter hospital stays and sustained rehabilitation outside hospital settings.

## **USING PATIENT FEEDBACK TO TRANSFORM CARE**

Guidance from the Department of Health highlights the importance of feedback for commissioners, and the need for them to collaborate with providers from all sectors to gather relevant patient feedback, and demonstrate that they are using this to improve care. It sets out issues and questions that all NHS organisations should address when using feedback to understand and improve patient experience. The reference to real time patient feedback, which for people with artificial limbs would presumably be in the fitting rooms, is seen as a most beneficial innovation.

## REHABILITATION FOR LIFE AND FOR INDEPENDENT LIVING

All Patients within the ambit of this Charter should have access life-long to Rehabilitation Services.

Rehabilitation should be multi-disciplinary; for all age groups; address physical, mental, social, emotional and spiritual needs; and seek retention of or return to as independent a life as possible.

“Sometimes the emphasis is on remaining at or returning to work; the role of early diagnosis and intervention will be of great importance here, as will be the various programmes offered by the Department of Work and Pensions to assist people in the workplace. In other circumstances, rehabilitation will focus on personal or social aspects such as study, family or caring responsibilities or active retirement.”

Services offered by third sector and voluntary organisations can be as important as those available directly through health and social care.

## WELCOME GOVERNMENT POLICIES AND INITIATIVES

This Charter welcomes Government organisations, policies and initiatives including:

- The Care Quality Commission
- The National Quality Board
- Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Services
- World Class Commissioning: Adding Life to Years and Years to Life
- “Tackling Hospital Waiting – the 18 week patient pathway”
- The National Service Framework for Diabetes, which stresses the importance of an effective services and strategies to manage diabetes, and the Diabetic Foot Guide implementing the NSF standards;
- The Fair Access to Care Services (FACS) initiative, which aims to make eligibility for services dependent on needs and circumstances, not on where people live and where they first access services;
- The National Service Framework for Older People, which details the Government’s expectations of the services that should be available to older people, and the manner of their delivery as part of the NHS Plan;
- The National Service Framework for Disabled Children and Young People, wanting to enable them and their families to live ordinary lives;
- The National Service Framework for Long Term Conditions to transform NHS and Social Services support through easier and quicker access to independent living;

- Human Rights in Healthcare – A Framework for Local Action;
- Practice-based commissioning to give GPs and Trusts and Authorities the tools to influence and innovate local service developments:
- Department of Health Framework for Health and Well Being.
- Command Paper 7424 for Serving Military Personnel and Veterans.

## **UNITED NATIONS CONVENTION ON RIGHTS OF PERSONS WITH DISABILITIES**

Relevant Rights within the United Nations Convention on the Rights of Persons with Disabilities are expected to apply, including those Rights listed in APPENDIX A.

## **EQUAL OPPORTUNITIES AND HUMAN RIGHTS**

Patients are committed to supporting equal opportunities for all, irrespective of age, disability, gender, marital status, race, religion & belief, sexual orientation, transgender and working patterns, all with openness and transparency of process. “Staff should receive regular training in Human Rights principles and positive duties and how they apply to their work”, so that Human Rights are mainstreamed. Keywords, mutually applicable, are dignity, fairness, respect and equality.

## **PATIENT / USER DATA**

Each Centre should arrange for Providers to produce annually statistics of totals of Patients/ Users, reflecting the classifications in the former National Amputee Statistical Data Base so helpfully initiated by the British Society of Rehabilitation Medicine. This should facilitate appraisal of future needs and resources and health inequalities and trends and encourage healthier life styles.

## **CONSULTATION WITH USERS AT EACH SERVICE CENTRE**

In accord with the “Duty to Involve”, Management at each Service Centre should proactively and continuously facilitate, within the Centre’s arrangements for total Consultation, the forming and sustaining of a Prosthetic Patient-Led User Group by the provision of publicity, accommodation, travel/carer support and secretarial services. Each such Group will proactively and continuously and courteously collaborate with Management. As required by law, Consultations must be real and not just procedural. It is also relevant that a Key Action in “Implementing the NHS and Social Care Long Terms Conditions Model” is “Find ways of involving patients and their carers in planning services.”

The foundation stone of effective consultation is the Centre’s ANNUAL BUDGET and INCOMES / EXPENDITURES outcomes. Each Centre should publish annually to its User Group its Business Plan, including the following:

Total Patients	Limb Components	Silicone Cosmesis	Interfaces	Services	Total Budget
No.	£	£	£	£	£

### OPPORTUNITIES FOR COMMISSIONERS

Post-code lotteries -sadly despite the best endeavours of all concerned to see their removal – continue to be widespread. Your service will vary according to where you live. Choice is illusory when you cannot easily travel beyond your local Centre.

Prosthetic Services, as the Pathfinder Report reminded us, may be unsatisfactory because:

- There are unexplained variations in all aspects of service provision around the country, bearing little relation to underlying levels of need;
- Quality of services requires a considered view of the contribution that equipment services can make to the overall needs of the population.
- Increasing patient needs are unmet because of finance restrictions and constant pressure on budgets and staff, which inevitably mean less rather than more.

This Charter shares the recognition that the NHS is still too focused on commissioning for volume and price, rather than quality and outcomes.

This Charter, in accord with the Knowledge Sharing Network for Specialised Services for People with Complex Physical Disabilities, supports effective commissioning by further sharing knowledge about high quality clinical outcomes so that:

- the right patient (clear patient selection criteria and referral guidelines) is offered
- the right treatment (evidence based, clinically and cost effective interventions, in the appropriate setting) by
  - the right provider (monitored against agreed service/clinical quality standards) in
  - the right place (optimising geographical access but avoiding unnecessary duplication of provision)
  - at the right cost (robust costing and information systems and demonstrable value for money)
  - with the right-full involvement of the patient (adequate information to enable supported choice).

This Charter seeks to open doors to opportunities for Commissioners by helping them to:

- Locally lead the NHS
- Work with community partners
- Engage with public and patients
- Collaborate with clinicians
- Manage knowledge and assess need
- Prioritise investment
- Stimulate the market
- Promote improvement and innovation
- Secure procurement skills
- Manage the local health system
- Make sound financial investments

## BEST PRACTICES

Sources for information about Best Practices include:

- Associate Parliamentary Limb Loss Group [www.apllg.eu](http://www.apllg.eu).
- Audit Commission [www.audit-commission.gov.uk](http://www.audit-commission.gov.uk)
- British Society of Rehabilitation Medicine [www.bsrm.co.uk](http://www.bsrm.co.uk)
- British Healthcare Trades Association [www.bhts.net](http://www.bhts.net)
- British Association of Occupational Therapists [www.cot.org.uk](http://www.cot.org.uk)
- British Association of Prosthetists and Orthotists [www.bapo.com](http://www.bapo.com)

- Chartered Society of Physiotherapy [www.csp.org.uk](http://www.csp.org.uk)
- emPower Charities Consortium [www.em-pow-er.org](http://www.em-pow-er.org)
- Equality Rights Commission [www.equalityhumanrights.com](http://www.equalityhumanrights.com)
- Healthcare Commission [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)
- International Society for Prosthetics and Orthotics (UK) [www.ispo.org.uk](http://www.ispo.org.uk)
- Kingston University London [www.kingston.ac.uk/pgrehab](http://www.kingston.ac.uk/pgrehab)
- London South Bank University [www.lsbu.ac.uk](http://www.lsbu.ac.uk)
- National Diabetic Support Team [www.diabetes.nhs.uk](http://www.diabetes.nhs.uk)
- National Institute for Health and Clinical Excellence [www.nice.org.uk](http://www.nice.org.uk)
- Society of Chiropractors and Podiatrists [www.feetforlife.org.uk](http://www.feetforlife.org.uk)
- University of Strathclyde [www.strath.ac.uk/prosthetics](http://www.strath.ac.uk/prosthetics)
- University of Salford [www.fhsc.salford.ac.uk](http://www.fhsc.salford.ac.uk)

and the following User organisations:

- Age UK [www.ageuk.org](http://www.ageuk.org)
- British Limbless Ex-Service Men's Association [www.blesma.org](http://www.blesma.org)
- British Polio Fellowship [www.britishpolio.org.uk](http://www.britishpolio.org.uk)
- Circulation Foundation [www.circulationfoundation.org.uk](http://www.circulationfoundation.org.uk)
- Contact A Family [www.cafamily.org.uk](http://www.cafamily.org.uk)
- Douglas Bader Foundation [www.douglasbaderfoundation.org.uk](http://www.douglasbaderfoundation.org.uk)
- Diabetes UK [www.diabetes.org.uk](http://www.diabetes.org.uk)
- Disabled Living Foundation [www.dlf.org.uk](http://www.dlf.org.uk)
- Limbless Association [www.limbless-association.org](http://www.limbless-association.org)
- Murray Foundation [www.murray-foundation.org.uk](http://www.murray-foundation.org.uk)
- PORT-ER (Prosthetics Orthotics Rehabilitation Technology – Education & Research) [www.port-er.com](http://www.port-er.com)
- Reach [www.reach.org.uk](http://www.reach.org.uk)
- STEPS Charity Worldwide [www.steps-charity.org.uk](http://www.steps-charity.org.uk)
- Spinal Injuries Association [www.spinal.co.uk](http://www.spinal.co.uk)

## SERVING PERSONNEL AND VETERANS

Veterans are guaranteed by Government priority for service-attributable out-patient and in-patient treatment. They are entitled to a duplicate limb. They are entitled to reimbursement by their NHS Centre of travel expenses and any loss of earnings.

Supplementing earlier guarantees, the most welcome COMMAND PAPER 7424 includes the following undertakings:

- “We will establish a military ward within the Birmingham New Hospital, building upon the military-managed ward at Selly Oak established in 2007.
- We will continue to invest in Headley Court, building on the recent announcement of £24M to expand its facilities.
- The standard of prosthetic limb provision to injured personnel by the Defence Medical Services will as a minimum be matched post-Service by the NHS in Great Britain.
- We will raise awareness with healthcare professionals – including drawing attention to priority treatment for Veterans with Service-attributable conditions.”

## PAIN

- All amputees will experience amputee-related pains, which may (to put it mildly) limit independence and quality of life if not remedied. There is:
- Early post-operative pain following surgery;
- Residual limb pain which may be referred/radiating, skin, vascular, neuropathic, complex, due to neuroma, or due to bone spurs and infection;.
- Prosthesis –related pain because of an ill-fitting socket, alignment, interface material, or suspension. (Phantom limb pain may be triggered.)
- Phantom limb pain (apparently) in the missing portion of the amputated limb(s) may vary from being just tolerable to being totally disabling.
- Other sources of pain may include degenerative joint disease, inflammatory joint disease and overuse injuries.

When pain is Chronic an interdisciplinary approach is recommended. Unfortunately, Amputees with chronic pain may find it difficult to be referred to specialist interdisciplinary services.

## **THE REHABILITATION TEAM**

For Centres to be both cost-effective and patient-effective, and to save scarce resources elsewhere in the NHS, the full range of vital health professional skills must be available including, Consultants, Nurses, Prosthetists, Orthotists, Chiropodists, Podiatrists, Physiotherapists, Occupational Therapists, Healthcare Scientists, Posture & Mobility experts, Clinical Technologists and Technicians. It may not otherwise be feasible fully to address possibilities of avoiding amputation or re-amputation, or to give the highest quality of care after amputation.

Assessment for the Prosthesis or Prostheses should be undertaken by the named Prosthetist after consultation with all Members of the Rehabilitation Team concerned with the rehabilitation of the Patient. The Prosthetist should share any written Report of Assessment with the Patient (or for a Child the Parent / Carer), which should, with his/her consent, be circulated to all relevant parties. The needs for Services and Technologies additional To Prosthetics because of additional problems should be addressed.

## **GOALS & PROMS**

Collaborative, realistic, and attainable Goals must be set and agreed. The patient cannot decide /demand these independently. In some instances an Orthosis, Wheelchair, Special Seating, and/or other Assistive Technologies, may need to be (included in) the appropriate Prescription. Groups and Individual Users should take a supportive interest in, and should be enabled to share in the development and application of, Patient Related Outcome Measures (PROMS).

## **PRESCRIPTION**

Prescription of the artificial limb or limbs must be by a qualified Prosthetist recognised by the Health Professions Council. Each Prescription should be individually formulated to suit the patient's rights and needs and lifestyle and goals. If, because of lack of funding or pressure on resources, the most appropriate solution (see 10Cs) cannot be provided, the reasons must be fully documented by the Prosthetist in a written Report of Prescription and circulated to all concerned.

## **DELIVERY**

Delivery will be in stages and the final outcome should include satisfactory (to the Patient) fitting of the limb or limbs, testing for suitability and stability and dexterity, confirmation of objectives, and validation of education of Patient and Carers. Delivery and Maintenance of high quality artificial limbs require maximum

possible involvement of the Technician, at the invitation of the Prosthetist, with the Patient, in a Trio of Effectiveness. For a Child Patient the Parent/Carer must also be involved.

## **REPAIRS AND MAINTENANCE**

In support of the defined mechanism for Repairs & Maintenance, including regular reviews, Patients and Carers must keep the service informed of any relevant changes in their personal circumstances.

## **PATIENT PATHWAYS**

The needs of the individual Patient will change, or new assistive technologies will become available. The Service must provide the most appropriate Prosthesis (including a “second” Prosthesis if required for employment/independence/lifestyle or obligatorily for Serving or ex-Service Military Personnel) for the individual Patient throughout each stage of his/her lifetime pathway.

The patient must if s/he wishes to be enabled to see the same Prosthetist on each appointment. The patient’s transition from childhood to adulthood must be secured without any gaps or lack of clarity in responsibilities.

On request by the User, there should be Reasonable and Fair Access to a Centre other than that nearest to the User.

From Consultant or GP or other Referral to final delivery and acceptance of the artificial limb or limbs, including diagnostic tests and procedures and outpatient treatments, the Patient Pathway should not exceed 18 weeks except where there are additional complications.

From prescription to final delivery and acceptance of the first Prosthesis or other equipment for mobility/dexterity, the total length of the patient pathway should not exceed 28 days maximum. In the majority of cases it should not exceed 21 days.

## **‘PAIN-STOP’ OR HEALTH & SAFETY APPOINTMENTS**

“Pain-Stop” or Health & Safety Appointments should be met on the Day of Request or the following Day.

## **“TRIO” WITH THE TECHNICIAN**

Circumstances permitting, high quality services require maximum practicable involvement of the Technician, at the invitation of the Prosthetist, with the Patient, in a Trio of Effectiveness. For a Child Patient the Parent/Carer must also be involved.

## **CONTINUED PROFESSIONAL DEVELOPMENT**

Invitations to tender and service agreements should provide for and show transparently “Continued Professional Development requirements” for all staff. Delivering the workforce skills to meet Patient rights and needs requires, for all Allied Health Professionals involved, sustained opportunities for Continued Professional Development, and clear career “stepping stones”.

Undergraduate and Postgraduate studies and training need to be accessible regardless of distance both geographically and academically.

Workforce planning and practice must facilitate:

- Involvement of Prosthetists in clinical/planning responsibilities and requisite post-graduate training leading to the appointments nationally of Consultant Practitioners
- Opportunities for Technicians and Assistants to qualify for and achieve appointments as Consultant Technicians or the relevant ISPO Category
- Opportunities for Administrators further to enhance their Management skills and achieve additional responsibly.

## **RESEARCH & DEVELOPMENT**

Invitations to tender and service agreements should provide for and show transparently Research and Development requirements and percentage of total budget funding. Resultant best practices should be shared nationally through the Knowledge Sharing Network for People with Complex Physical Disabilities. Staff should be enabled to introduce Innovations in technology and in practice with minimum delay. Beneficial developments and knowledge achieved locally should be made available to patients nationally. Listening to Patients and seeking their views will ensure that problems seek solutions and not vice-versa.

## **NOT A BLUEPRINT**

This Charter is a pathway partnership to sharing improvements and best practices – not a blueprint for how services should be delivered. It recognises the need for mutual respect and support among patients/families/carers, and the providers of services whose skills and commitment are essential to maintaining the right mix of incentives, transparency, plurality of providers, specialised commissioning, practice-based commissioning and patient choice and consultation.

## **Appendix A**

The following are extracts from the United Nations General Assembly Convention on the Rights of a Person with Disabilities, Resolution number 61/106 dated 24th January 2007. For a full copy of this convention see [www.apllg.eu/charters.html](http://www.apllg.eu/charters.html).

### **ARTICLE 3 GENERAL PRINCIPLES**

The principles of the present Convention shall be:

- (a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
- (b) Non-discrimination;
- (c) Full and effective participation and inclusion in society;
- (d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- (e) Equality of opportunity;
- (f) Accessibility;
- (g) Equality between men and women;
- (h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

### **ARTICLE 9 ACCESSIBILITY**

1. To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:

- (a) Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;
- (b) Information, communications and other services, including electronic services and emergency services.

2. States Parties shall also take appropriate measures:

- (a) To develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public;
- (b) To ensure that private entities that offer facilities and services which are open or provided to the public take into account all aspects of accessibility for persons with disabilities;
- (c) To provide training for stakeholders on accessibility issues facing persons with disabilities;
- (d) To provide in buildings and other facilities open to the public signage in Braille and in easy to read and understand forms;
- (e) To provide forms of live assistance and intermediaries, including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public;
- (f) To promote other appropriate forms of assistance and support to persons with disabilities to ensure their access to information;
- (g) To promote access for persons with disabilities to new information and communications technologies and systems, including the Internet;
- (h) To promote the design, development, production and distribution of accessible information and communications technologies and systems at an early stage, so that these technologies and systems become accessible at minimum cost.

## **ARTICLE 17**

### **PROTECTING THE INTEGRITY OF THE PERSON**

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

## **ARTICLE 19**

### **LIVING INDEPENDENTLY AND BEING INCLUDED IN THE COMMUNITY**

States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

- (a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
- (b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
- (c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

## **ARTICLE 20**

### **PERSONAL MOBILITY**

States Parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities, including by:

- (a) Facilitating the personal mobility of persons with disabilities in the manner and at the time of their choice, and at affordable cost;
- (b) Facilitating access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost;
- (c) Providing training in mobility skills to persons with disabilities and to specialist staff working with persons with disabilities;
- (d) Encouraging entities that produce mobility aids, devices and assistive technologies to take into account all aspects of mobility for persons with disabilities.

## ARTICLE 25

### HEALTH

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

- (a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
- (b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
- (c) Provide these health services as close as possible to people's own communities, including in rural areas;
- (d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
- (e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
- (f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

**ARTICLE 26**  
**HABILITATION AND REHABILITATION**

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

- (a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;
- (b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

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