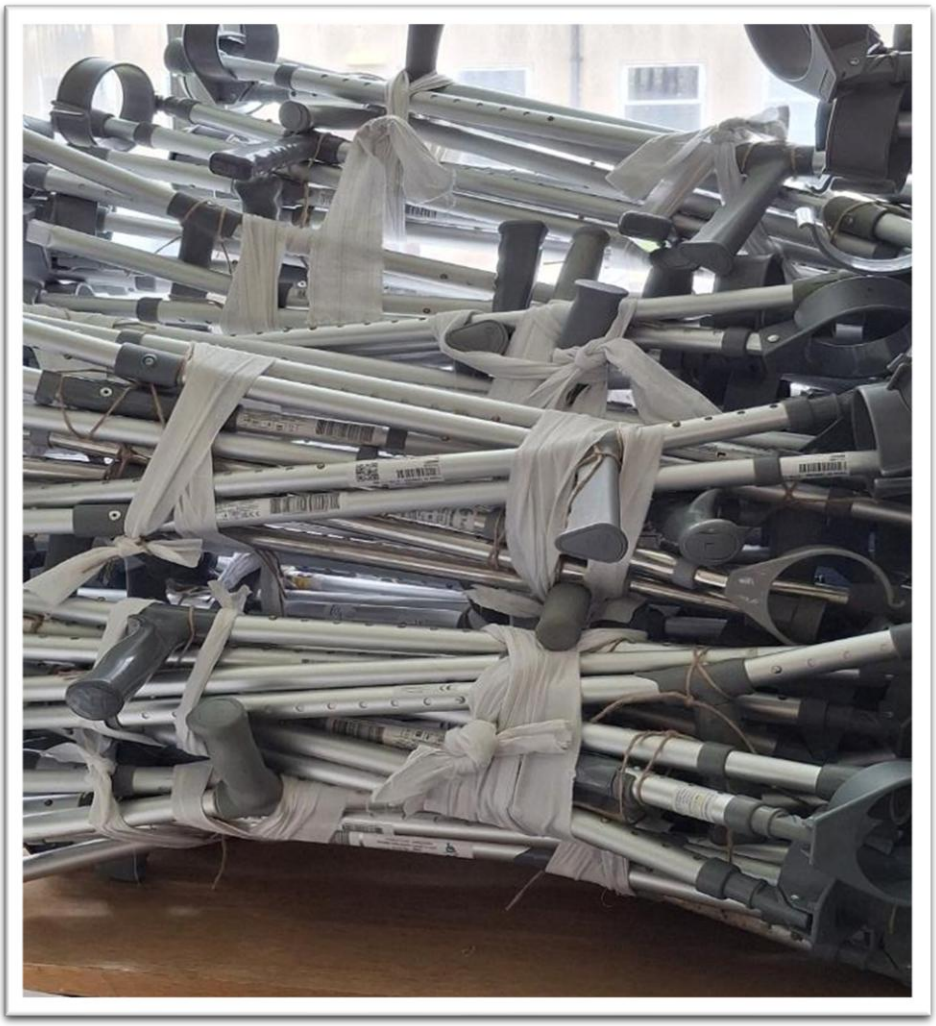
Could the UK be more sustainable in recycling ‘disability’ equipment?



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Executive Summary

This project set out to examine whether the UK could be better at recycling disability equipment, which is also known as community or adaptive equipment. Such equipment is essential for many people to live their daily lives more independently, safely and with improved quality. It can also enable people to stay in their homes for longer, support caregivers and reduce the financial burden of long-term care. However, the system supplying and providing this equipment is extraordinarily complex. It crosses boundaries of health and social care funding, private and public provision, is variable across local authorities and regions, is underfunded to meet growing demand, and haphazard in all aspects of re-use or recycling.

Aside from the financial implications, years of unsustainable approaches throughout the manufacture, supply, delivery and collection of equipment has resulted in: (i) an unknown resource residing in homes and care homes, (ii) a plethora of charities filling the gap to meet a growing demand, (iii) shared equipment between neighbours, family and friends, (iv) unknown quantities going to landfill and causing environmental damage, (v) growth in a largely unregulated private market, and (vi) huge amounts being donated to charities for onward sale or distribution in other countries. This is within the context of climate change already negatively impacting human health and the aim of the UK to have the first net zero healthcare system (Greener NHS, 2020).

Following the demise of a main community equipment supplier on 1st August 2025 (GOV.UK, 2025), there was concern raised about ongoing accessibility, safe care in the community, and sector resilience. Subsequent findings of an All-Party Parliamentary Group for Access to Disability Equipment to investigate matters, chaired by Daniel Francis MP, highlighted a national crisis and called for systemic change (APPG, 2025).

This Fellowship report also emphasises the need for a system change. It is a unique and essential opportunity to address many current barriers to provision, improve equity of access, and embed sustainability at all levels. Education in carbon literacy is needed throughout the workforce and particularly for those who are prescribing equipment. There is also a need to educate the public both in the huge costs of provision and their role in reducing these by returning and recycling. Learning from other countries, the UK could adopt different models of delivery which rely on a greater contribution of the public. Contracts with manufacturers and suppliers who are ambitious for circularity, green energy use and high refurbishment rates, should be prioritised and expedited.

Facilitating equipment amnesties and developing a clear structure for collection could realise unknown assets for refurbishment and reuse. Expanding workshop capability for refurbishment, either as part of or external to supplier contracts, should be trialled in order to put stock back into supply. Involving currently marginalised people, such as the disabled wishing to work, in the refurbishment process could provide new opportunities for improved productivity. Light workshops can offer skill development, social inclusion, rehabilitation or work hardening, all of which reduce the harmful effects of a lack of occupation.

Until there is a significant shift in the present system, equipment currently deemed as unsuitable for use will continue to be ‘wasted’. So in light of the urgent need for it within less developed healthcare systems, it could be more systematically processed, refurbished and distributed as a recognised contribution to international aid.

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Sincere thanks to the Churchill Trust for their belief in this project, trusting my capacity to deliver, and for practical and financial support. I feel extremely honoured and privileged to be a Churchill Fellow.

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This report is dedicated to 'Marius' who despite severe, complex and progressive disability, found huge joy in life and, although only for a short time, in his donated chair. A life too short. May he rest in peace.

1. Who The Report Is For

This report is for:

- Anyone involved or interested in the commissioning, procurement, supply, assessment, provision, manufacture and reuse of disability equipment in the UK, whether in the private or public sector.
- Those with budgetary responsibilities, such as health and social care directors charged with an NHS's key value of delivering the best care whilst using public funds efficiently (Department of Health and Social Care, 2023).
- Professional bodies, such as the Royal College of Occupational Therapists, whose members have a significant role in equipment prescription. It could be used for educational purposes to ensure carbon literacy and embedding of sustainable practice.
- Taxpayers who have a right to know how their money is being spent.

2. Purpose of the Project

This project was carried from the perspective of someone for whom the detailed workings of the supply and delivery of disability equipment was virtually unknown. It was stimulated by a growing concern about the amount of equipment being offered for charitable redistribution.

So the main purpose of the project was to investigate whether the UK could be better at reusing disability equipment. When items are no longer required, it appears that an excess is either despatched to landfill or donated to charities for re-sale or distribution overseas. The first step was to better informed about the supply and distribution of disability equipment. The next step was to learn whether specific practices or projects in other countries could be transferable to the UK. The aim was to identify those which could help to minimise waste, protect the environment, provide cost savings, and assist the NHS in its quest to be the first net zero healthcare system.

3. Background

3.1. What is 'disability' equipment?

Most people seem to know someone who, having experienced a health condition, have struggled to manage their daily life tasks during that time. It may be that they have broken a leg and find difficulty with walking, or mobilising as therapists say. In this situation, they will usually require the use of a mobility aid such as a wheelchair, walking frame or a pair of crutches to get around their home or outdoors.

For a person faced with a more complex situation, such as having multiple injuries from a car crash, or undergoing a significant surgical procedure, or facing the end of their life, even doing the most simple of tasks can be extraordinarily difficult. The activities of daily living (ADL) tasks might be around self-care such as getting washed and dressed or being able to use a toilet or shower, and being able to get in and out of a bed or chair in the process. Other more difficult tasks include being able to go shopping, cooking meals, cleaning a house, going to work, and participating in social or leisure activities. In this scenario, the individual might require a more thorough assessment of what it is that they need or want to do during their day. The assessment is usually provided by an occupational therapist (OT) either working in a hospital or based in the community. Some OTs work as part of a team facilitating the transition between hospital and home. Such an assessment will, with the person's consent, more times than not result in the provision of various aids and equipment to make it easier for the individual or their carer to carry out ADL tasks.

Items can range from a hospital bed to allow for easier repositioning, comfort, or safer moving of the person by others, with a specialised mattress to reduce the risk of sores developing due to inactivity, to a hoist to lift them safely out of the bed and into a chair or onto a toilet. It could be a long-handled reaching aid for obtaining items off the floor when someone cannot bend down, or a gadget for putting socks on. It may involve the strategic installation of grab rails to provide for safer moves (transfers) in and out of the bath or shower, or provision of a bath lift where a shower is not available. With rapid advancement in technology, the ability of people to obtain independence in their environment and manage daily life tasks themselves is ever developing.

Wheelchairs are issued to people with longer term conditions, and may include those that can be self-propelled through to those requiring an attendant to push them or those which are battery powered, any of which could be for indoor or outdoor use, or both.

Under usual circumstances, a disabled person may need different wheelchairs for different activities. For example, one used outdoors is not necessarily suitable for indoor use, as well as requiring frequent cleaning if being brought indoors; a sports-specific wheelchair will be determined by the type of sport played; and those accessing rough terrain need a wheelchair specifically designed for this. In essence, when assessing for and issuing equipment to help in ADL there are many aspects to consider and needs to meet in trying to maximise their independence.

The collective term for this sort of equipment varies considerably across countries and within the UK. The publication of the updated International Organisation for Standardisation ISO 9999:2022 Assistive Products – Classification and Terminology, which classifies assistive devices (including software), according to function, is due to be published in 2026. Refer to appendix II for further information.

For the purposes of this report, the terms 'disability', 'adaptive' or 'community' equipment are used interchangeably to refer to any of the items described above. That is, products which assist people with their mobility and daily life tasks, or their functioning, as described by the World Health Organisation (WHO, 2001). Technological equipment and technology-enabled care systems are outside the focus of this report.

3.2. The provision of disability equipment in the UK

It is difficult to establish how many items of disability equipment are distributed each year in the UK. This is because figures are collected by different organisations such as the NHS, local authorities, charities and the private sector. There is no central database. According to CECOPS (2014)[1], disability equipment services issue approximately 14 million pieces of disability equipment to four million service users every year. Medequip, one of the largest suppliers of community equipment, stated that they distributed approximately one million items in 2024. This figure is only representative of one supplier.

Research carried out by Knight (2025) reviewed data obtained from 150 authorities in England and Wales with responsibility for community equipment services. Although 20 authorities did not submit data, the combined reported expenditure for 2021/2022 was over £420 million, which gives some indication of the level of cost involved.

There are three key ways in which community equipment is made available to the public: the public sector, private healthcare organisations, and the private market.

3.2.1. The Public Sector

Within the public sector, community equipment is provided by local councils and the National Health Service (NHS) after a needs assessment carried out by a health professional. Eligibility criteria include having a disability or medical condition which significantly impacts on ability to carry out ADL, such that it affects the person's wellbeing. Equipment is typically loaned to people free of charge. For certain items, like NHS wheelchairs or riser recliner chairs, there may be a need for a specific medical justification and professional prescription or an application to an approval panel. Having identified the need for an item, an order is placed with a Community Equipment Service (CES).

Community Equipment Services are commissioned by Integrated Care Boards (ICBs) in shared responsibility with Local Authorities (LAs). There are currently 42 ICBs in England[2]. Commissioning arrangements vary locally, but many councils and ICBs operate joint schemes under pooled budgets made possible by section 75 of the National Health Service Act 2006. These partnerships often contract

[1] *Of 18th December 2025, CECOPS published a statement saying it will no longer engage or work with Medequip or Ross Care, both operating under Medux UK part of Medux International, due to their divergence from CECOPS principles of independent, transparent and person-centred standards. Further details are unknown. It is recognised that this report is influenced by the views of Medequip and Medux management staff and may not reflect the views of other key investors in the sector.*

[2] *It is worth noting that to make significant cost reductions by, in part, looking to economies of scale, the majority of ICBs have agreed to form clusters. This means they will remain as legally separate entities but work together across a larger footprint. From 1st April 2026, the government has approved the merge of 12 ICBs in London, the East of England and South East regions. One ICB will see a change in boundary. Other mergers will be agreed in due course with a view to begin operating in the following fiscal year. At the current time, ICBs are focusing on restructuring their organisation, and in implementing new governance and processes to work effectively as clusters (Williamson, S. and Tether, V., 2025).*

with private providers who supply, deliver, and recycle community equipment on behalf of both health and social care commissioners. This decentralised framework is further explained in appendix III, as is the increased pressures experienced by the sector.

Equipment is given to the individual on a loan basis. Who is obliged to track it and retrieve it is not always clear and depends on origin of issue. In some contracts it was reported that the prescribing healthcare professional is responsible for tracking equipment issued. This does not work in practice due to a high turnover of patients from hospitals into the community, at which point the prescriber may no longer have contact with the patient. Where retrieval is deemed uneconomical, suppliers will revert to patients and their carers to assist by delivering to collection bins or a local supplier's depot. Many of the problems are highlighted in the All-Party Parliamentary Group (APPG) report: 'Barriers to Accessing Lifesaving Disability Equipment' published in October 2025.

This report was consequent to a significant event within the sector which occurred during the course of this Fellowship and influenced its focus and findings. On 1st August 2025, NRS Healthcare, one of the main contractors for supplying community equipment (40% in the UK), abruptly ceased to trade. This affected approximately forty councils and became national news as councils were forced to urgently put alternative arrangements in place (GOV.UK, 2025). Other established suppliers were asked to service NRS Healthcare's contracts, including Medequip[3] who is now by far the largest provider of CES in the UK.

The liquidation of NRS Healthcare caused major concern due to severe disruption with the provision of community equipment, and highlighted a reduced resilience within the sector. Many of the APPG recommendations superseded those identified during this Fellowship. Therefore, whilst referenced, the detail will not be repeated here but the reader directed to the APPG report itself.

3.2.2. Private healthcare organisations

Private hospitals and clinics are increasingly commissioned to deliver routine elective surgical procedures to relieve NHS waiting lists, procedures such as elective joint replacements. NHS-funded patients are offered needed mobility aids, such as walking sticks or Zimmer frames and occasionally toileting aids, by physiotherapists or occupational therapists from a hospital supply. For larger and often more expensive items, such as a highbacked chair, referral is made to community services for provision. Where a patient is self-funding their treatment, or their treatment is privately funded, there can be difficulty in obtaining equipment through community services who can deem this the responsibility of the person. In this case, patients are expected to make their own arrangements in obtaining equipment they are advised to utilise during their recovery period.

For mobility aids like crutches, it is common for patients not to need these after about six to eight weeks post-surgery. Patients often want rid of them and are usually very surprised that there is no systematic collection but rather, are advised to take them to the local household waste centre. Some organisations establish their own collaborations with charities to donate returned mobility aids and some private hospitals are trying to align with the NHS initiative for net zero of its partners by 2045 (see example in appendix V).

3.2.3. The private market

There continues to be a growing private market in adaptive, electronic and mobility equipment or technology for the performance of daily life tasks. A plethora of companies exist undertaking widespread marketing. People not wanting to persist on long waiting lists for assessment and provision through social care routes, are buying what they think they need. Many do not appreciate the complexity of identifying an item to meet their individual needs for the long term whilst being safe and durable. This results in poorly fitted, uncomfortable or not fit-for-purpose products which then get discarded.

[3] *In a somewhat ironic twist, Medequip and NRS Healthcare had been embroiled in an earlier High Court battle over a large framework agreement to provide CES across 21 London boroughs for a deal reportedly valued at around £400 million. With Medequip challenging the procurement process, an automatic suspension of the contract award was imposed. However, following Mr Justice Eyre's judgment handed down on 21st December 2022, which allowed the contract to proceed with NRS Healthcare, the suspension was lifted. (The cost of this case to the taxpayer is not known).*

3.3. The collection of disability equipment

At some point in the course of a person's illness or injury, equipment is no longer required. However, there is widespread anecdotal evidence of poor or inefficient procedures to collect or return it.

Do people know how to return it, or where to? Do they have the possibility of returning it if they do not have personal means of transport, the physical or cognitive capacity to take it somewhere? Access to the internet is required to clarify local drop off points or depots which can exclude some people.

Much of it resides in homes around the UK only to resurface when the home and garage are cleared.

It can be frequently found lined up outside charity shops, at second hand dealers (as shown in Figure 1) or on Facebook Marketplace, and other online selling platforms. Zimmer frames and wheelchairs are for sale on Vinted, for example.

Fig.1 Items for sale, including those from a CES, outside a second-hand shop in Wiltshire.

People are known to keep it in the eventuality that themselves or others may require it in the future. Care homes retain it for use with other residents for whom it may not be suitable.

An unknown amount ends up in local household refuse and recycling centres (see Figure 2), often as part of a house clearance process.

Discussing this with professional or personal networks resulted in often-stated phrases: "nobody wants it back"; "I tried to return it and was told that the hospital/clinic doesn't take it"; "I phoned the company that delivered it but they still haven't collected it"; "I don't know how to return it"; "I have several crutches/commodes/toilet seats in my attic [or garage or shed] and don't know what to do with them."

Fig. 2 CES items at a household refuse centre in Bristol.

Additionally, there is anecdotal evidence and personal experience of care homes retaining an excess of equipment which would have been issued to an individual resident. Gradually this builds up and without the necessary storage space, gets thrown out. It is known that a Wiltshire Council audit found £40,000 worth of prescribed equipment in one care home alone, not being used by the individual it had been prescribed for. There are 203 care homes in Wiltshire and 16,566 in the UK. Whilst some of this equipment may get re-used for other care home residents (which is a safety concern without an adequate and proper assessment), then even if taking a view that there is an average of 50% of this within Wiltshire's care homes, this adds up to £4,080,000 of equipment residing in the Wiltshire community or being thrown away. Disappointingly, it was difficult to obtain information on local councils' annual spend on equipment. A previous member of care home staff reiterated that care homes need engaging with: "in my time working in one during COVID-19, I saw hundreds [of items] put in skips because they couldn't get anyone to take them". "'The stuff that gets thrown away is unbelievable, and I was told it is because nobody wants it. They can only store so much, and the rest is skipped." (Knight, 2026)

3.3.1. The responsibility of Community Equipment Suppliers

Whilst Community Equipment Suppliers are contractually obligated to collect unwanted items, particularly if a household contacts them for a collection, their processes for doing this are not always clear and well-organised. Contracts are frequently based on a credit model whereby the supplier gets a percentage of the cost of the item/s delivered when they are returned. Nevertheless, it is not good business sense when the cost of collection is more than the value of the item. This is particularly the case when, generally, the manufacture and bulk purchase of products from places such as China is such that UK manufacture cannot compete. Some suppliers place a limit on collections where the cost of retrieval is greater than the value of the item/s. For example, this limit is set at £20 in Bristol or £30 in Kent, and £30 is the current threshold value for Millbrook Healthcare to collect from a person's home. In these cases, the onus is usually placed on the service user to return goods.

It remains difficult to obtain the rates from contractors as this data is commercially sensitive. Whilst they appear to encourage the return of equipment, clarifying the exact rates for this requires further research. Information found in the course of this Fellowship is described in appendix IV.

3.3.2. Donations to charities

Within the above context there has been, and continues to be, evidence of a large amount of equipment in general circulation within the UK. One place that it is often found is with UK charities. Local charity shops can be found selling an array of CES equipment. There has been a groundswell response by individuals and charities to reduce the perceived waste of items and make them readily available to others. For example, Grace Cares, a Community Interest Company in Staffordshire, in partnership with the Council, collects and refurbishes items dropped at the 14 household waste centres the Council has responsibility for. This equipment is then sold to the public or institutions to fund social groups for marginalised people run by Grace Cares.

Many charities have been collecting unwanted disability equipment for transportation to countries where healthcare systems are less advanced and access to such equipment is difficult, unaffordable or unknown. This has continued for twenty or thirty years in some cases. More recently, a considerable amount has gone to Ukraine due to the exponential increase in the numbers of disabled people resulting from conflict with Russia.

Of the many organisations collecting up unwanted equipment, some have built a reputation on their activity. One founder expressed the view that "**we don't want the UK to become more sustainable; we want the equipment!**"

A more detailed insight into the scope, extent and impact of charitable activity, both in the UK and internationally, is provided in appendix IV.

3.4. Unwanted disability equipment - not a new problem

Identifying and dealing with the collection of unwanted (but taxpayer funded) disability equipment is not a new problem, and quantifying the extent of it remains a challenge. In 2016, the then Health Secretary, Jeremy Hunt, in reacting to an article published by The Mail on Sunday (10th September 2016) 'vowed to take action over the mountain of NHS equipment being thrown away across the country'. At the time, the report stated that £18 million had been spent in England in the previous year on crutches, walking sticks and frames, according to industry sources.

Despite these huge sums, no national policy existed on how NHS or councils should deal with used equipment. However, it did note examples of where hundreds of thousands of pounds could be saved simply by tracking who had been loaned equipment and requesting it was returned. One such example was in Barnsley, where a service run by South and West Yorkshire NHS Trust saved around £330,000 a year by reusing 93 per cent of the equipment loaned to patients. At the Queen Elizabeth Hospital in King's Lynn, Norfolk, of 4,618 mobility items loaned in 2015, refurbishment of 2,777 had occurred. A spokesman had said: "All equipment issued has its own identification and is tracked. All that is returned and deemed safe is refurbished, cleaned and then reissued."

On the other hand, the article also found that other NHS trusts discarded all used mobility equipment, claiming it is unsafe to reuse or too expensive to process. It gave an example of Barking, Havering and Redbridge Hospital NHS Trust saying it would not reuse any crutches, walking sticks or walking

frames, “as infections could be passed on and it is also difficult to check for signs of damage”. The Trust, which had declared a £34 million deficit for 2015-16, had spent £18,568 on crutches alone over the same period. Similarly, it was reported that health bosses in East Kent had declared an ‘amnesty’, calling on the public to return crutches and walking aids worth £27,000 per year, to the Trust. However, two neighbouring NHS Trusts – Maidstone and Tunbridge Wells, and the Kent and Medway Social Care Partnership – said they did not reuse crutches or walking sticks because of 'patient safety'.

At the same time (2016), Stephen Morgan, of the charity Newlife Foundation for Disabled Children (renamed Newlife), reported the recovery and reuse of more than £1 million worth of NHS and local authority wheelchairs in the previous two years.

Also interviewed, Paul Cooper, a professional adviser at the College of Occupational Therapists at the time, said: ”This is a nettle the NHS needs to grasp. Equipment pick-up services and convenient drop-off centres in the community should be available.“

It is, therefore, extremely disappointing that in ten years since there remains no overarching strategy or plan to mobilise services to achieve improvement. In fact, very little appears to have changed except perhaps an increasing public awareness of the waste and a few Trusts adopting amnesty bins.

3.5. Quantifying the problem

It has become very obvious over the course of this Fellowship, that there is no consensus on the actual extent of unwanted or wasted disability equipment in England. Companies supplying equipment services are in competition with each other and so instead of working collaboratively, are understandably protective of any commercially sensitive data. Obtaining ‘waste’ rates, scrappage rates or remuneration for this, is difficult. Whilst all suppliers to the NHS have to demonstrate their commitment to sustainability in line with the Government’s Evergreen framework (NHS Evergreen sustainable supplier assessment, see appendix I), this aspect only accounts for 10-20% of any tender document. Processes for auditing and accountability throughout the period of the contract is also varied according to the commissioning authority.

Verbal evidence from charities involved in sending equipment overseas, and from personal experience, is that the amount of available equipment being donated has been increasing significantly. In 2025, all contacted charities expressed that they were turning donations away and had unmanageable levels in storage. As they all rely on volunteer support to collect, store, check, load and transport, this resource was at its limits. There is no central database to register how many lorry or container loads of equipment has been transported overseas, but all charities report markedly increased activity.

4. What Does it Matter?

Given that much of the lower value equipment is treated as single-use items, some members of the public may take the view that it has served its purpose following its initial provision. Others may be quite content with the idea that commissioners and suppliers can set variable standards for the re-use, or not, of items. Making it available for re-sale within the UK, or distributing it overseas may be thought entirely reasonable.

Alternatively, the level of waste matters on a number of levels.

4.1. Public Funds

Firstly, it is a publicly funded resource which at a time of immense pressure on public finances, should be maximised and any reusable re-entered into the healthcare system to delay buying new and save cost. Even back in 2016, the then Health Secretary, Jeremy Hunt, stated that ”any unwarranted waste, particularly at a time when the NHS is under financial pressure, reduces the amount of money available for frontline patient care.” Since that time, the impact of COVID-19 on the health system and economic turbulence increasing strain on the UK’s fiscal health, has further reduced the available funds. While exact, comprehensive, and recent annual figures for the entire NHS are not centrally published, a report in AT Today (Assistive Technology), claimed that data obtained under the Freedom of Information Act and disclosed to the Press Association, showed hospitals were spending millions of pounds every year on replacing unreturned, unusable or missing crutches. They estimated that 80% of mobility aids were never returned to the NHS. Statistics over the previous five years leading to this report showed that from 66 Trusts across England, **over £14 million was spent on almost 560,000 walking aids** of which 241,779 went missing. Nearly 50 per cent of Trust failed to

provide data at the time and those who did often had incomplete figures, so the true extent and costs were expected to be much higher (Barnett, 2019).

In South Wales, the Chief Executive of the Patients Association charity said, “Patients are often bewildered that the NHS does not ask for equipment back when they have finished using it, and sometimes even find that the NHS can make it bafflingly hard when they try to return it. “This can raise questions in people’s minds about the efficiency of the NHS, and even undermine confidence in it – all completely needlessly.”

Many hospitals reported that they did not do anything to track down missing and unreturned equipment. A Department of Health spokesman added: “Far too often, medical equipment like wheelchairs and walking sticks are being used once before ending up on a landfill…people rightly expect the NHS to make sensible use of their money and also become more environmentally friendly.”

4.2. The environment

Secondly, the constant manufacturing of products, treating them as a disposable resource to go into landfill, and encouraging a ‘throw away’ attitude and behaviour come at a significant cost to the planet. Reusing a refurbished walking aid has a 98% lower carbon footprint than manufacturing a new one. If two out of every five walking aids were returned, the saving for an average hospital would be around £46,000 and 30 tonnes of carbon a year (NHS England, 2024; Bevan Commission, 2025).

During this Fellowship, the United Nations Climate Change Conference (COP30) reiterated the unrefuted evidence of climate change, the impact of which on health is now a reality (WHO, 2025; UK Health Alliance on Climate Change, 2024). As Dr Jeni Mille, Director of the Global Climate and Health Alliance, stated: “When national representatives participate in COP30, they may think they are discussing carbon emissions or the economic costs and impacts of climate action. In reality, they are negotiating people’s lives. Every decision they make, whether on fossil fuels, financing and monitoring of adaptation, or on the principles that underpin a just transition, has direct consequences for people’s health now and in the future.”

Sustainability is everyone’s business, with climate change widely acknowledged as presenting the biggest global threat of the 21st century (The Lancet, 2023; Romanello, M., 2025). It will affect the physical environment as well as all aspects of both natural and human systems, particularly human health (WHO, 2023; UK Health Alliance on Climate Change, 2024). In 2022, Rocque et al (2022), published a systematic synthesis of 94 systematic reviews of the health impacts of climate change showing that it is associated with worsening human health. This suggests the incidence of impaired daily life functioning will increasingly challenge those trying to meet the needs of disabled people.

This situation is also recognised by the NHS whose stated vision in October 2020 was ”To deliver the world’s first net zero health service and respond to climate change, improving health now and for future generations.” This commitment was enshrined in The Health and Care Act 2022, which placed a duty on all NHS organisations to consider climate change in their operations. Sitting within a global economy and supply chain, the purchase of supplies and the waste generated, including that of wheelchairs and equipment for daily living, has an impact on communities far and wide. It is beholden on any organisation, regulatory body or association to set out their strategy and plan for improved sustainability, whether directly or in supporting their members.

Arguably there is not only a moral obligation but a professional obligation on healthcare professionals as set out in their Code of Practice. For occupational therapists, often gatekeepers in the assessment and provision of disability equipment, these are in the ‘Professional standards of practice, conduct and ethics’ consultation draft of October 2025 (RCOT, 2025). Similarly, the Chartered Society of Physiotherapy (CSP) expect those registered with them to ”demonstrate a core knowledge and understanding of: the principles of sustainable physiotherapy practice and consideration of the environment”, as set out in their Physiotherapy Graduate Attributes and Physiotherapy Education Framework (CSP, 2025). The onus is on the individual to take responsibility for reviewing their practice and to introduce thoughtful, sustainable practices which can contribute to the whole system.

4.3. Lack of access to equipment

Thirdly, there is clear evidence that people who need equipment are unable to obtain it and that the 'system' is failing. This has been clearly set out in the 'Barriers to Accessing Lifesaving Disability Equipment' report published in October 2025 by the APPG for Access to Disability Equipment. The report found that: 55% of equipment users do not have the medical equipment they need for their long-term needs; 74% of equipment providers said they were aware of patients experiencing delayed hospital discharge and 44% of equipment providers say community equipment provision is "not at all consistent and equitable."

This is particularly so for families with disabled children and young people where equipment is required to meet their rapidly changing needs. A poor collection and refurbishing process adds to waiting lists for urgently needed items (APPG,2025). To try to meet this need, charities such as Newlife or Re-Cycle Mobility reported an increased level of demand.

4.4. Increasing demand

Fourthly, the UK has an ageing population. According to data from the University of Oxford, there are 10 million people in the UK aged over 65 and three million over 80, with figures expected to double over the next 20 years. People are living for longer and with more complex conditions. They often want the option to stay in their own homes and local authorities want to avoid placing them in care homes for as long as possible. This means utilising adaptive or community equipment to facilitate them to stay at home and reduce the cost of care.

Furthermore, there is an increasingly disabled population. The latest estimates from the Family Resources Survey run by the Department for Work and Pensions (DWP, 2025), and verified by the Office for National Statistics, indicate that 16.8 million people in the UK had a disability in the 2023/24 financial year. This represents 25% of the total population. Whilst some increase in prevalence over time is to be expected given the ageing of the population, recent changes indicate it has more than doubled from 8% to 18% in people aged 16 to 24 and from 11% to 19% in those aged 25 to 34. In 2023/24, the most common impairments among working-age adults were mental health (reported by 48% of disabled people in this age group) and mobility impairments (42%).

Disabled people remain locked out of work at twice the rate of non-disabled people. According to Sir Charlie Mayfield's recent report 'Keep Britian Working' (2025), "…the state faces an unsustainable cost from economic inactivity due to ill-health of £212 billion per year through lost output, increased welfare payments and additional burdens on the NHS". Let alone the cost to employers. There is a need to enable people to remain in work. This can require, in part, providing adaptive equipment and environments to meet their needs and allow them to function at maximum potential.

The population is increasingly obese. The number of people who are classed as bariatric is increasing (UK Parliament, 2025). These are people who have a high body mass (BMI) or are significantly overweight, such as being 40kg above their ideal weight. Equipment for these people is specialised and costs more to manufacture and supply.

4.5. Has there been *any* progress?

There has been some progress and a very gradually improving focus on reuse and recycling of disability equipment. This is coming from community equipment suppliers, supply chain initiatives, alliances, and from individuals and services developing improved systems. Details of these, along with service-level and practice-level examples, are contained within appendix V and outline some of the cost savings achieved.

5. Learning From Other Countries

5.1. Sweden

Brief Introduction

Sweden has an international reputation of having an environmentally conscious population and having adopted policies, practices and technology in its aim to be 'green'. In 2023, Sweden closed the year with the title as the most sustainable country on the planet according to one source. This was based on factors such as the amount of renewable energy used, the percentage of electric vehicles on the roads, or the scope of environmental protection policies. It retained its ranking as top performer in the Sustainable Governance Indicators in 2024 and was ranked 13th in the Climate Change Performance Index (CCPI) in 2025, according to the OECD (Organisation for the Economic Co-operation and Development).

So what of its disability equipment, or as it is termed there, 'assistive technology'.

Sweden is divided into 21 counties or regions. These regions are further divided into municipalities. Whilst central government sets policy, Sweden has a decentralized, largely tax-funded system which is managed in its regions. The regions are responsible for organising and delivering most services, like primary and hospital care, while municipalities manage older adults and disability care. The region of County of Stockholm consists of a population of two million and is subdivided into 26 municipalities.

KommSyn Stockholm

KommSyn Stockholm is part of the Stockholm County Healthcare area and is responsible for providing assistive devices in communication, cognition, computer control, vision and hearing throughout the Stockholm Region. Referrals for an assessment can come from a therapist – either state employed or privately funded – who is also required to attend the assessment.

The department at KommSyn prescribes 65,000 items per year, mostly by technicians but also by speech and language therapists and occupational therapists. Once issued with a device, the patient's name and details are registered on their system and rent for the item is collected from the region.

Fig.3 Outside the KommSyn building

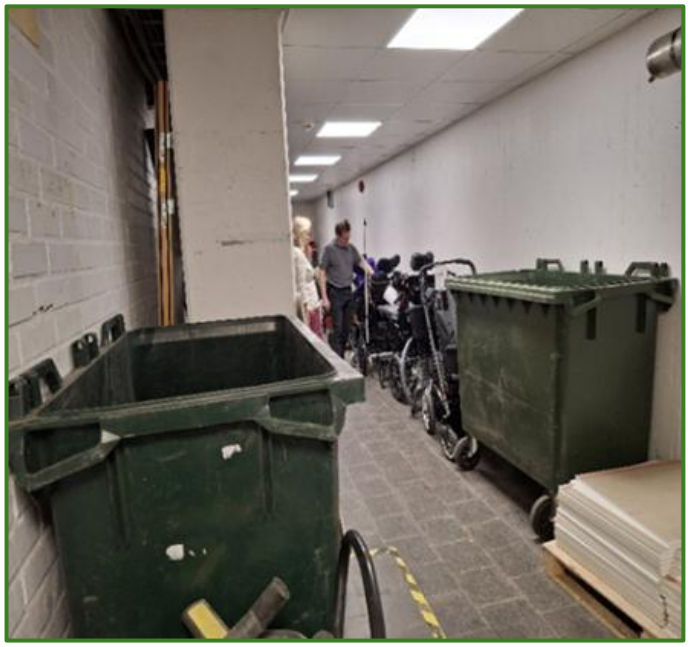


Fig.4 Recycling bins for electronic items

Electronic devices are bought from suppliers, if possible, who can also provide spare parts, so aids are repaired and refurbished.

Once no longer required, materials which can be re-used or recycled are segregated for appropriate disposal at KommSyn. Recycling bins are collected twice per week from here are taken to a private company for refurbishment and cleaning for onward distribution.

Where electronic items cannot be re-issued, they are disassembled at a community-based facility which employs people with learning disabilities. Anything

deemed ‘rubbish’ is sent to incineration plants and the heat generated serves homes in the local town.

Equipment assessed to be non-reuseable in Sweden but useable elsewhere, is systematically collected in bins at the regional sorting area. Shown in Figure 5 are walking aids destined for Ukraine.

Fig.5 Swedish walking aids for distribution in Ukraine

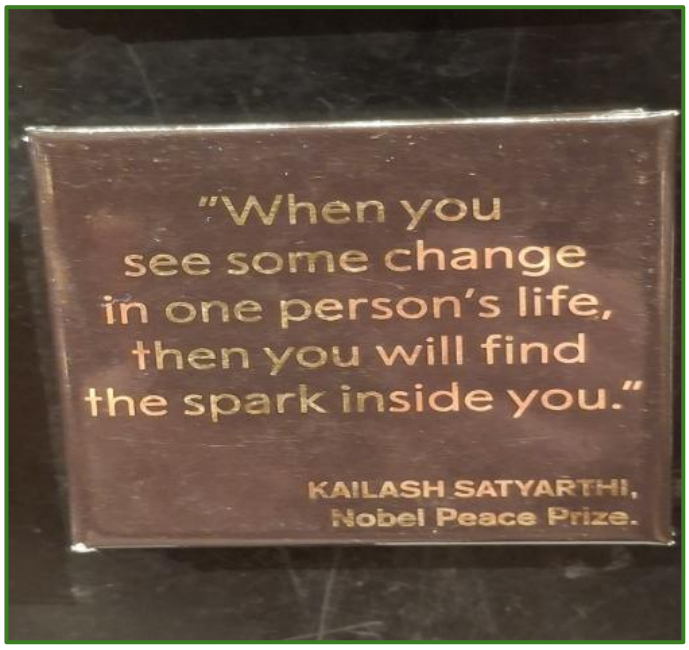


Fig.6 Nobel Prize Museum, Gamla Stan, Stockholm

Findings

- All disability equipment is on loan.
- The public have to contribute towards what they loan. For example, £50 per year for a wheelchair (NB: this is the same as a hearing aid). The approximate hire cost for an electric wheelchair is £200 per month.
- Some regions require a monthly contribution, others want it annually for those with an acute illness and a one-off payment for those with a chronic illness.
- In some regions families do not pay for children’s equipment, but in others there is an expected contribution.
- There is some disparity in what is available to people depending on whether regions are more remote or have a different terrain, living on the archipelago for example.
- Wheelchairs are serviced annually with clients booking into a centre for this purpose or technicians provide home visits. This ensures wheelchairs are tracked and monitored.
- The facility where a prescriber works is responsible for the tracking, collection and responsible recycling or disposal of aids and equipment. As such, recycling facilities are readily available in many locations.
- The local department decides what goes into a community equipment catalogue which will provide the range of aids and equipment that can be issued. [Interestingly, the KommSyn department had seen an increase in the number of referrals of people diagnosed with Amyotrophic Lateral Sclerosis (ALS) in recent years. As a progressive nervous system disorder leading to speech difficulty for the patient, the department has had to purchase an increased number of eye gaze technology systems to facilitate communication for these patients. This increase in ALS was corroborated by Dr Katarina Baudin, occupational therapist and researcher at the Karolinska Institute.] Being attuned to changes in health demographics is important for predicting need and future supply.
- No tendering process is required for a spend of less than £20K (currency equivalent) per annum, this is left to the department to decide.
- There is a drive to use Swedish-made products, particularly evident during the COVID-19 pandemic, which helps to improve sustainability and increases system resilience.
- Occupational therapists have to consider cost when deciding equipment for an individual.

5.2. The Netherlands

5.2.1. Brief outline of the healthcare system

The Netherlands' has a compulsory, insurance-based model which merges both public and private insurance. The private insurers are strongly government-regulated to ensure universal access through a standard (basic) package. Accessing care typically starts with a general practitioner who acts as a gatekeeper for specialist care. All residents are required to purchase statutory health insurance, paying a monthly income-dependent premium (most commonly around €100 per month) and in turn, the insurers are required to accept all applicants.

Financing is primarily public, through premiums, tax revenues, and government grants. Standard benefits include hospital, physician, home nursing, and mental health care, as well as prescription drugs. The national government is responsible for setting healthcare priorities and monitoring access, quality, and costs. It pays for children's coverage up to age 18.

If an individual requires a mobility aid such as a wheelchair, adapted bicycle or a powered chair, these are supplied through the local Council although there is some overlap with insurance provision when equipment is for short term use. Care related products, such as a specialised beds and mattresses, will often be provided through insurance who specify what is available under their scheme. The public are expected to privately purchase their own grab rails and privately purchase certain items such as a rollator (walker).

Items for care homes, e.g., beds, hoists, mattresses and wheelchairs, are the responsibility of the care home. They may be funded by an individual resident's insurance but there is also central government money available. Any prescriber is obliged to check with the community equipment depot first for an item. If requiring a more specialised item for a patient and applying to the Council, it can take up to eight weeks for approval. Through insurance companies, items such as wheelchairs are made available the same day (reducing delays on hospital discharges). Electric scooters cost around

€29 (approximately £25) a month to hire, which is the responsibility of the individual wanting it.

5.2.2. Medux – major equipment supplier

Medux[4] is a prominent player in the healthcare sector. It is the largest supplier of a diverse range of care support products and services to healthcare insurers, local governments, institutions, and professionals. These include products for homecare, rehabilitation and mobility as well as items such as bathroom aids, adjustable beds, mobility scooters, and personalised/modular wheelchairs. They deliver primarily through three routes: municipalities (which have a 60% re-use rate), elderly care homes (which have an 85% re-use rate) and insurance companies (mainly wheelchairs and toilet aids, with a 90% re-use rate).

Medux has huge influence and thus, responsibility, for sustainability within this sector. As a business they claim to be focusing on the electrification of their vehicle fleet, 100% use of green electricity, energy efficiency and waste reduction projects. They have also been discussing how to further adapt operations within the supply chain to improve sustainability and circularity. This includes liaising with manufacturers in particular. Some aspects of this include:

(i) Utilising modular products

This approach ensures that the basic item is robust and able to withstand frequent adjustment. If modular, they can be repeatedly customised to meet the personal needs of end-users and result in high levels of re-use. If parts break or become damaged, they can be easily replaced for continued use by the client. When no longer required, an item is brought back to a depot's workshop area for refurbishment and repairs before re-issue. Hospital beds are rented out so they can be easily returned to the manufacturer for repair, keeping them in the system for longer. Beds are decommissioned after ten years whereas it is five years in the UK. Taking this approach has resulted in 60-80% of equipment being redistributed. This limits the amount of raw materials required to manufacture new products.

Figs.7a & 9b Modular wheelchairs

[4] *It is worth noting that operating under the umbrella of Medux International, Medux extended its scope with a formalised partnership with Medequip, incorporating Medequip telecare system Connect, and Ross Care (wheelchairs) in the UK in February 2021. In 2025 it began its market entry into Germany and so has positioned itself as the European market leader in the supply of mobility aids.*

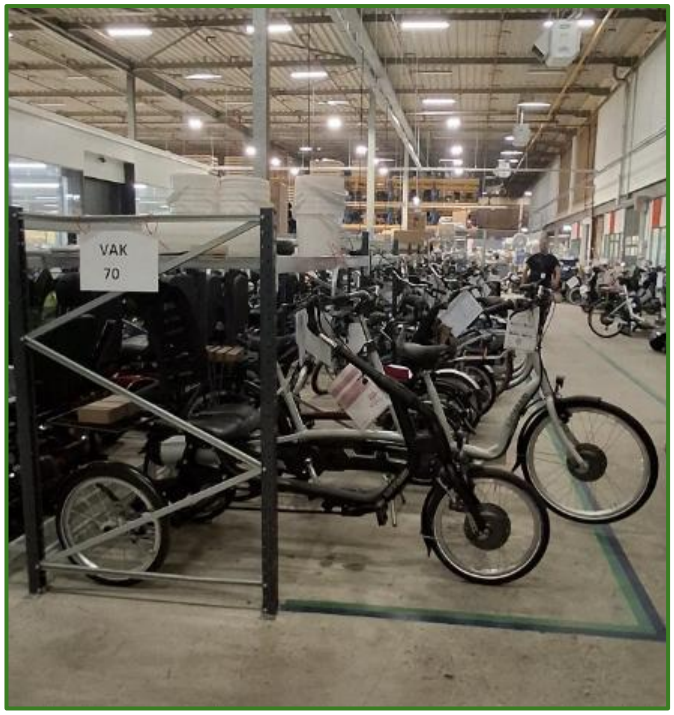


Fig.8 Adjustable bicycles

Fig.9 Modular mobility scooter

(ii) Circularity

Partnership with manufacturers is essential to drive and increase a circular approach, which needs to include a substantial growth in the use of recycled parts and products. After an item such as a bed or wheelchair can no longer be reused, it is returned to the factory for refurbishment, remanufacture or donation to charities. Good relationships and networks exist with charities, enabling a smooth and efficient transfer of unwanted items.

(iii) Understanding CO2 emissions

Understanding the level of CO2 emissions in the production of items and where they are in the supply chain, enables adaptation of systems and processes to reduce or mitigate for them. Customers can then make choices on the provenance and sustainability features of goods as well as price. However, common standards and measurements are needed across the sector to make this meaningful.

Currently, the community equipment supplier creates the equipment catalogue from which prescribers can choose. Whilst professionals, such as OTs, are consulted and give advice, ultimately the decision about what is included resides with the supplier. The result is a smaller catalogue of products rather than a large one which accounts for prescriber preference. In turn this facilitates negotiations with manufacturers for products which are generated with low CO2 emissions and contribute to circularity. Although initial outlay maybe higher, better-quality equipment reduces costs over the lifecycle of the item.

5.2.3. GAiN – a Charity and Council Partnership

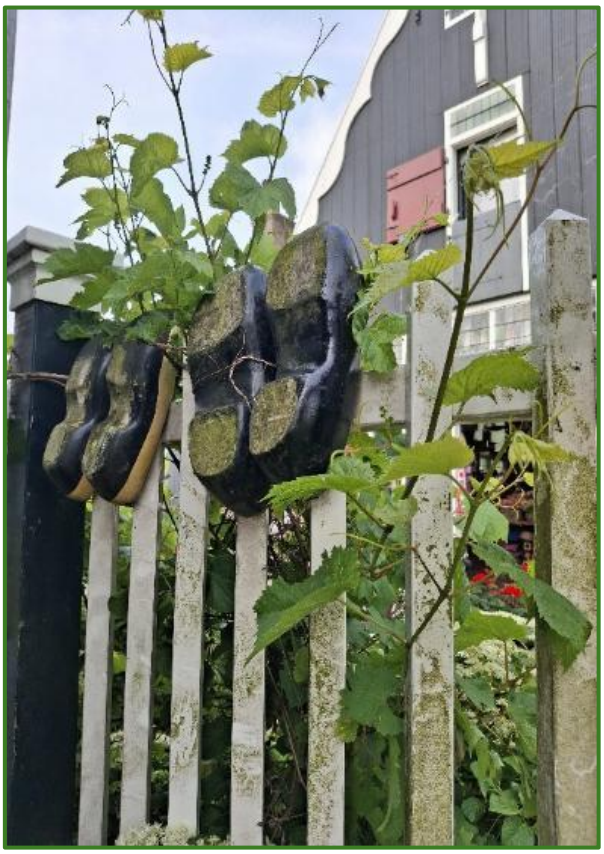
Global Aid Network (GAiN) is a worldwide relief and development organisation. In The Netherlands it regularly sends lorries to Eastern Europe. It also runs shops selling second hand goods e.g. clothes, furniture and household items. These provide the income for the transportation and a supply of humanitarian aid.

In an interesting initiative, GAiN collaborated with the local Council to jointly establish a household waste and recycling centre adjacent to one of their shops. The public can drop items off at the centre where they are sorted and sold in the second-hand shop. Sharing the employment costs with the Council and relying heavily on volunteer assistance, the project sorts, repairs and cleans items, and manages the shop. By buying second-hand goods the public keep them in circulation for longer. Locating the workshop in shared facilities, along with the social care and a disability service, allows for the smooth referral of vulnerable people or refugees into volunteer placements. As those on welfare benefits need to obtain certificates of attendance at volunteer

agencies to continue to receive benefits, GAiN can do this for their volunteers.

Findings

- The public make a means-tested contribution for equipment.
- The expectation is that individuals meet their own needs with lower value products (under €50) which are not available through public funding.
- Items such as mobility scooters and wheelchairs are on loan and are rented.
- Supplier depots have large workshops, with a supply of spare parts, and play a key role in the localised repair and maintenance of products to keep them in circulation, whilst providing employment opportunities.
- Suppliers determine the items in the catalogue of equipment available to prescribers.
- The catalogues are concise, offering a reduced range of products which reduces influence of prescriber preference (they are consulted on functionality of items) and facilitates negotiations with manufacturers on cost, quality and sustainability.
- Choosing products which are modular in design provides good adaptability for a wide proportion of the population, and a greater capacity for cost-effective repair and replacement of parts which can retain the item in circulation for longer.
- Manufacturer-owned beds provide a streamlined process for return, repair and refurbishment.
- Efficient systems for tracking and recalling equipment results in: (i) good maintenance schedules to extend the life of the equipment; (ii) collection of un-needed items for replacement into supply; and (iii) close monitoring of the population to be responsive to changes without 'running off' large quantities of stock.
- Excellent partnerships with charities enable the smooth transition of decommissioned stock, facilitating its continued use.
- Charity partnerships with local household waste centres promotes the continued circulation of goods (reduces waste).
- The GAiN model provides vocational skills training and employment opportunities for marginalised sections of the population, and access to household goods for those on low incomes. It helps the Council to meet its own sustainability goals.
- Individuals who would probably not cope in commercial employment settings are given an opportunity to be productive which improves health and well-being.
- The success of GAiN was reliant on a volunteer workforce which was easily obtainable in the area.



5.3. El Salvador

5.3.1. Brief synopsis of the healthcare system

El Salvador's healthcare system consists of a mixed public-private model. The Ministry of Health (MSPAS) provides free healthcare to most residents but the overburdened public services have limited resources, a shortage of medicines and long waiting times for appointments. The Instituto Salvadoreño del Seguro Social (ISSS) (social services) provides services to people who pay into the system. In major cities, such as San Salvador, private clinics and hospitals offer high quality and modern care which is popular with expats, and increasingly, medical tourists. Rural areas have limited access to healthcare although clinics and community health teams exist and deliver basic care.

In 2025 the government, in partnership with Google Cloud, launched an app called 'DoctorSV'. This is a digital, AI-assisted platform for diagnostics and medication delivery aimed to increase accessibility to services. It has also invested in the building of a large public hospital in San Salvador.

5.3.2. Lack of disability equipment

Visits to two churches and a US-funded charity in San Salvador, provided insight into the vital role of the charitable sector. This gives people on low and middle incomes access to basic and some specialist healthcare, for a small contributory sum or free of charge. Without this provision they would be unable to access any healthcare. Churches have built and resourced clinics and therapy centres to meet the needs of their local population. Church members give of their time at no cost to deliver professional services.

Even so, the dearth of disability equipment at the centres visited highlighted the disparity between what is readily available and 'thrown away' in the West, and what is urgently needed in other countries – as are the therapists.

At one charity centre providing children's therapy services, minimal resources were apparent. For example, one physiotherapy department had only a plinth and a gym ball within, and no mobility aids. In a children's therapy centre one walking frame had to be shared between all attendees, requiring it to remain at the centre for therapy sessions only. This limited children's capacity to mobilise outside the centre and access their local communities. One mother had made her own sling to carry her growing daughter to and from the treatment centre on public transport, detrimentally impacting on her own body. Wheelchairs are not affordable or available (see Fig.10 below).

Fig.10 Carrying child in homemade sling.

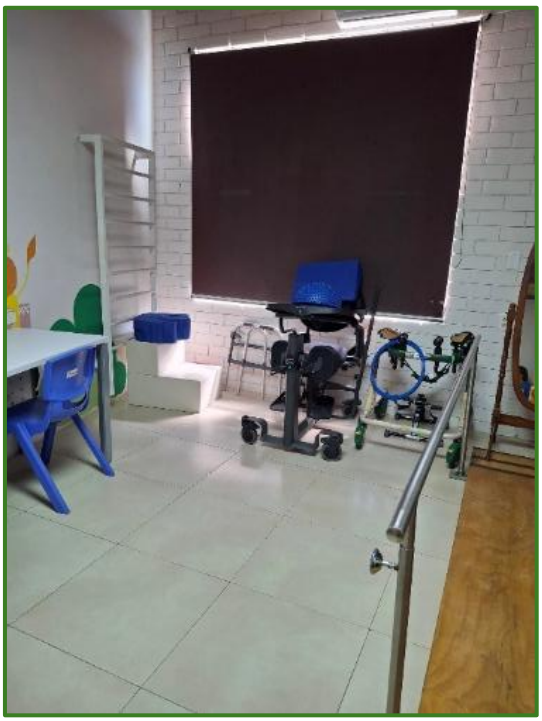


Fig.11 Physiotherapy department at Joni's House

Fig.12 Mural at Joni's House San Salvador depicting the Great Banquet described in the Bible in Luke 14. At this table, those considered by society to be of least value are honoured.

5.3.3. International Restoration Centre

The International Restoration Centre (IRC) is the first of its kind.

It has been established and funded by Joni & Friends, a large North American charity situated in the Agoura Hills, California, and founded by Joni Eareckson Tada in 1979. One aspect of Joni and Friends' work is to deliver a Wheels for the World™ programme. This is a well-coordinated project to distribute previously used wheelchairs to developing countries. Taking teams from the United States and working with locals, Wheels for the World has to date assessed and provided 227,000 wheelchairs to those who would otherwise not have one.

'Harvesting' wheelchairs for the project involves a volunteer workforce to collect, store and transport them for refurbishment. Much of the refurbishment occurs in partnership with the prison service where inmates repair, restore, and load the equipment for transport abroad.

The IRC in San Salvador was an initiative to increase the volume of restored wheelchairs available to Wheels for the World, and to be a distribution point for Central and Southern American projects, reducing shipping costs. The IRC trains local disabled people to restore wheelchairs to like-new condition, providing employment opportunities or developing the skills needed for alternative employment. Working alongside able-bodied team members for lifting, carrying and reaching higher levels, men who are wheelchair users have an opportunity for productivity in a country where they are discriminated against and considered unemployable.

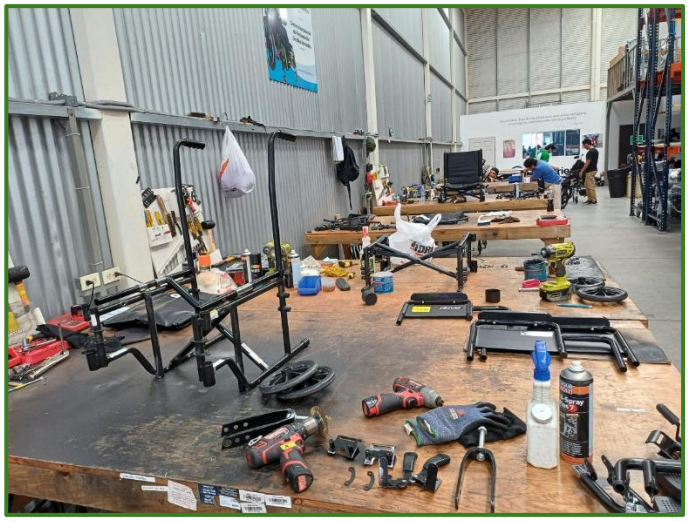


Fig.13 Workstations at the IRC

Fig.14 The wheelchair is broken down into component parts for restoration.

Fig.15 Restoring a wheel

Fig.16 Meeting the IRC management team

Fig.17 Evening view over San Salvador

Fig.18 Murals adorn the roads in San Salvador

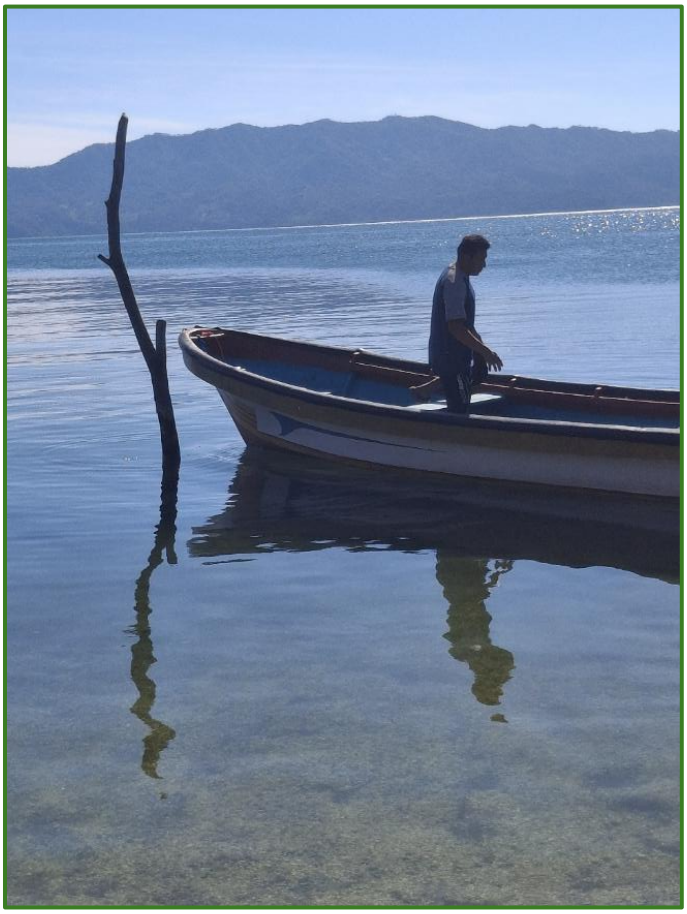


Fig. 19 Fish famer at Lake Ilopango

Findings

- The collaboration with the US prison system for the refurbishment of wheelchairs has been very positive in providing meaningful occupation for inmates. They describe feeling immense satisfaction in contributing to improving the life of others, and from 'giving back' to help communities where life is materially difficult and impoverished. Providing an opportunity for inmates to readjust their perspective on life and circumstances is proving valuable.
- The 'harvesting' of wheelchairs in the USA is reliant on a volunteer workforce. This is a culturally embedded habit amongst the communities visited but may not be easily obtained in other places.
- The IRC depends on the USA for financial support.
- Positioning the IRC within a deprived community, impacts the local economy by bringing opportunities for employment. Apprenticeships and skill development enables individuals to be more attractive to other employers should they wish to move on.

- The IRC brings economic benefit in other aspects, such as transport and logistics support, which in turn attracts investment into the area.
- Collecting, checking, cleaning, repairing and refurbishing aids, especially mobility aids, is a very obvious means to improving a disabled person's ability to engage in their local community. This is fully understood by the workers at IRC, most of whom are disabled, and they are committed to the aims and values of the organisation.
- The refurbishment process itself requires a wide range of physical skills and technical know-how. It can therefore include people with a range of skills, ability and potential to input and develop.
- People with different abilities working together for training, support and delivery promotes team working. Providing a fully inclusive and supportive work environment which was not easily obtainable for the men, produces an increased sense of purpose, greater confidence, financial reward and improved self-esteem. The emotional and psychological benefits have been verbally reported by individuals.
- Exploring the local area highlighted the reality of climate change and its impact. The poorer populations, such as the fish farmers on Lake Ilopango, were scraping a living by each working several jobs. Their housing was poor and they could not live off their own fish, rather they had to sell it in the city's markets. The returns were low despite the high prices the fish attracted in the restaurants. The farmers reported a notable heating of the (dormant) volcanic crater lake, expedited in the last five to ten years. The increased heat caused viruses to flourish, affecting the fish and requiring them to be routinely administered with antibiotics along with their feed.

6. Summary

In the UK it has been easy and free for the public to access adaptive equipment through its health and social care system. However, working through this Fellowship has highlighted that the system has become highly complex, regionally disparate and been subject to increasing pressures. These include trying to meet the rising demand from population growth, and from the complex care and support needs of an ageing and increasingly disabled population.

Budgets for community equipment have not kept pace with the rising demand and their restriction to a twelve-month cycle forces purchasing decisions and poor procurement practices based on upfront costs rather than long-term value. It's a price-driven sector. As such, this leads to equipment that's unsuitable for individual needs, costly repairs, and wasted resources (Naidex, 2025). The liquidation of NRS Healthcare as one of the main community equipment suppliers, precipitated focus on the pressures and weaknesses within the sector.

A subsequent national enquiry has identified systemic failure, widespread shortages, delayed hospital discharges, reduced independence and lack of access to lifesaving equipment (APPG, 2025). The recommendation of the APPG to have a nationally directed strategy and fair, equitable systems across all regions is corroborated by the findings of this Fellowship. A thorough review of community equipment services should incorporate the complete process, from procurement, supply and monitoring systems, through to return, repair, and re-use or recycling. It should involve full collaboration with all stakeholders.

Due to lengthening waiting lists for equipment, the private market has grown. In 2024 this was estimated to be valued at over £1 billion, expected to rise to £1.5 billion by 2030 (Mendes de Costa, D. et al., (2024). People are either buying privately or turning to charities for help, sometimes lacking an appreciation of the complexities of sourcing what is the best fit for their needs, something which occupational therapists manage routinely. This can result in inappropriate and un-used products.

Concurrently, over the past twenty to thirty years, there has been a shift away from manufacturing products in the UK and an increasing reliance on cheaper overseas supplies. The bulk buying of these often lower quality goods (so with a poorer lifecycle), and a prevailing single-use approach within many aspects of healthcare delivery, has resulted in scant attention being given to the environmental impact of this activity.

Aside from the significant cost implications to public finances when they are under considerable strain, the combination of continually issuing and buying new, having poor collection systems and discarding items to landfill, is worrying. This, together with a previously unsustainably focused supply chain, has

a currently un-estimated impact on the environment. At a time when climate change is irrefutably affecting human health, all healthcare services need reviewing as highlighted by the World Health Organisation (WHO) Report 'Decarbonising the healthcare supply chain – strategic actions for health systems' (2025).

Greener NHS frameworks, sustainability goals for suppliers, frontline staff and service initiatives are all indications of a start at addressing the problems. However, there is a significant job to be done in educating an overburdened workforce to embed sustainable practices in service delivery. In the context of community equipment services, sustainable approaches are patchy and they lack overall strategy and governance.

Until change in the sector occurs, there is a plethora of disability equipment available in the community. There is an unknown quantity unaccounted for in homes and care homes. Some of this is being collected by charities and sold back to the public or to institutions after localised refurbishment. Furthermore, extensive amounts are distributed in countries where access to such equipment is limited or non-existent. Similarly, an unresearched quantity is scrapped for recycling of useable metals or ends up in landfill sites.

The UK can learn from its progressive neighbours in all aspects of sustainability and certainly consider different models of service delivery. Other countries have developed solutions to making best use of 'waste', providing opportunities for out-of-work groups to engage in meaningful occupation, and established links to ensure maximum re-use or re-distribution of items. A concerted and international effort for the sustainable manufacture and circular supply of equipment is required. Until this improves, there will continue to be disparity. Huge quantities surplus to requirement will reside in some places with a near-complete lack in others. Learning from other countries, it is possible to envisage a more consistent and 'joined up' approach to refurbishing and re-using. This is essential to save cost but to also mitigate the effects of climate change.

7. Recommendations & Next Steps

Trying to improve the reuse of disability equipment in the UK can appear overwhelming in light of the system's complexities. It requires a 'top down' as well as a 'bottom up' approach. However, making any change, at any level, including replicating what some individuals and services are already doing on a small-scale, can contribute positively. A wider system and attitude change is definitely needed.

Recommendations identified during the course of this Fellowship are as follows:

1. System Review and Strategy

A **national strategy** with clear lines of accountability which will address the inadequacies and inequalities of the current system is needed. Not only should it focus on resolving the inherent problems but concurrently address the continued 'shocking' waste of resources.

A national system to **collate and monitor data** is required to ensure a levelling up of access and provision, to oversee key performance indicators of service delivery, and provide clarity on changing demographics and emerging health trends. Alignment with the NHS 10-year plan is needed, which aims to focus on community care and will bring greater demands on equipment provision. Clear planning and provision for this, alongside the Greener NHS objectives to achieve a net zero healthcare system by 2045, should be incorporated.

A consideration of different **models of provision** such as a means-tested contribution by the public or equipment deposit/rental schemes. As controversial as this may be, in some areas aids under the value of £50 are no longer being provided in any event. Not only are people more likely to value self-purchased items, this approach could reduce the multiple supply of the same product to a household.

The establishment of a **national register** of 'specialised' equipment for all regions to draw on. Transportation of items can be through a network of providers. When trialled across 21 London Boroughs, it resulted in savings in the millions of pounds.

Why not have centralised, **national procurement** to manage standards, reduce costs and increase sustainable purchases?

A clarification of the contractual obligations for private hospitals is needed to ensure patients reasonable and equitable access to equipment, as well as healthcare providers' full commitment to Greener NHS objectives.

Encourage investment in companies who want to manufacture equipment in the UK (providing employment and skills development) and will establish lower carbon repair and refurbishment pathways.

Consider that disposing of 'waste' equipment to other countries through the charitable sector is a form of **overseas aid**. Scoping the extent of this activity may facilitate a more systematic and funded approach for this to be recognised and effective. Additionally, this could bring vocational opportunities.

2. Streamline and Stabilise Commissioning

All-party agreement with a longer-term perspective of cost to ensure **adequate funding** and investment in sustainable products and partnerships with sustainability-focused manufacturers.

Simplify the process and reduce its cost.

Community equipment suppliers' **contracts need to be standardised** for equitable and consistent provision across boundaries.

Equipment **catalogues should be standardised**, smaller, and focused on buying better for greater adaptability, re-use and longevity. This will save money and make tracking more efficient. Include specialists for advice but eliminate the effect of prescriber preference.

Develop **alliances**, such as the Circular Economy Healthcare Alliance but focused on daily living aids and community equipment; as well as networks and systems for the dissemination of good practice initiatives.

3. Return and recycling

Clear, 'coherent and (easily) accessible' **return and recycling systems,** to reduce waste and cost, with far better monitoring and accountability so resources are used more effectively, are needed. Collaboration is needed with supermarkets, household waste centres, GP surgeries, sports centres, churches, etc., which are all potential drop off points for no longer needed equipment.

Draw on the expertise within the sector where recycling initiatives have been successful, to obtain views and models of effective practice. Facilitate dissemination of information for the implementation and benefit of all areas.

Facilitate a national **equipment amnesty** of equipment residing in the community in homes, care homes and institutions, to realise resource, save money and reduce the purchase of new equipment. This will further reinforce the loan model to the public.

Incentivise companies such as DGT Services (case study 4, appendix V), whose low carbon model works effectively in the repair and refurbishment of wheelchairs.

Encourage an increase in **trained technicians** at equipment depots for more complicated repairs and to adapt products for end-users, negating the need for so many specialised items.

Improve **accountability** of equipment suppliers for greater levels of reuse, refurbishment and recycling.

4. Education and training

Education and training providing a **strong focus on sustainability** has become very clearly required at all levels. This includes commissioners, procurement staff, service leads, healthcare professionals, equipment suppliers and the public. Content needs to cover carbon literacy, cost of equipment services, the environmental impact of the sector, the need for improved, joined-up, efficient systems and processes, and the impact of climate change on health.

All healthcare workers need **mandatory training** in sustainable practice, the NHS Greener objectives and the impact of climate change on health. They need educating in their own responsibility with regard to their day-to-day practice in order to effect attitude change.

Prescribers, in particular, need training in carbon literacy, in the provenance of equipment, in understanding the supply chains and embedding sustainability into practice. For example, in discussing recycling with a patient at the point of issue. Prescriber training and improved tracking monitoring and retrieval systems could further reduce duplication.

Additionally, prescribers need a **structured training programme** to increase confidence in prescribing and adapting equipment for an individual's needs, product choice and justification of 'specialised' orders to reduce over-prescription, perceived fear of litigation or safety aspects and professional responsibilities for tracking and recycling items.

Consistent and standardised training is needed at **undergraduate level**, endorsed by professional bodies and incorporated into re-validation of professional programmes, such as the wide adoption of the Planetary Health Report Card (2019).

Improved reinforcement of the loan model for community equipment may be required for the public, together with clear information of **returning and recycling options**, and wider accessibility to drop off points.

Therefore, any next steps would include:

A. Developing a training package for equipment prescribers, particularly occupational therapists and physiotherapists, and undergraduates who will become prescribers.

B. Trialling a refurbishment workshop. This already occurs at a low level within charities distributing equipment. The idea of refurbishing equipment to the benefit of those for whom paid work is not currently an option, should be explored. From the occupational therapy literature, we know that productivity, paid or unpaid, is vital for health and wellbeing. Light workshops for those people who are lonely, those with enduring health conditions, or utilising the untapped disabled workforce, would be of benefit. Providing structure, social inclusion, productive and goal-focused vocational opportunities, skill development and work hardening, could benefit a growing proportion of the population who are increasingly marginalised. Working collaboratively with the charitable sector and the community equipment suppliers, workshops could refurbish equipment for re-entry into the supply chain or for donation to overseas aid in a more systematic way. With adequate funding, initial options have begun to be discussed locally with a Council, an equipment supplier, with charities working collaboratively, and with a private healthcare provider.

C. Dissemination of findings with the professional bodies, such as the Royal College of Occupational Therapists, linking with NHS England Supply Chain (initial discussion has occurred), Greener NHS, the Centre for Sustainable Healthcare and professional networks, to share initiatives and collate examples of good practice.

D. Connection with member organisations such as the National Association of Equipment Providers (NAEP) will continue, to bring sustainability and circularity to the top of the agenda. A proposal submitted to NAEP in June 2025 suggesting the setting up of a sustainability working group for their members has so far not elicited a response.

E. An immediate action is to question the progress of the APPG 'Access to Disability Equipment' report recommendations, as the findings of this Fellowship have strongly aligned with those of the APPG.

F. Should the opportunity arise for more formal research, several areas require further clarity and exploration:

   (i) Support research of suitable products which are already readily available (e.g. Wealden Rehab's RAZ shower chair or Hoople technology), which involves client-facing clinicians, to encourage sustainable thinking and lifecycle assessments.

   (ii) Reasons for over-prescribing amongst healthcare professionals and the risk averse behaviours which facilitate this. Related to that, examine whether increasing prescriber knowledge and confidence reduces over-prescription.

   (iii) Through freedom of information requests, identify actual scrappage rates and scrutinise the recycling process for further cost reductions and reuse opportunities.

   (iv) Engage a specialist organisation (e.g. Climate Stewards) to assess the carbon cost of a lorry load of disability equipment being transported overseas, and compare this with the potential carbon cost of the same quantity of equipment if it was to be refurbished and re-used in the UK.

   (v) Trial improving the information for return and recycling of walking aids in a targeted area and assess the outcome.

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Appendix II Glossary

Activities of daily living (ADL) – everyday tasks that people need or want to do related to personal self-care, such as washing and dressing (PADL), or domestic tasks such as cooking, shopping or cleaning (domestic activities of daily living, DADL), or getting ready for a day's work.

Carbon footprint – a measure of the amount of carbon dioxide released into the atmosphere as a result of the activities of a particular individual, organization, or community.

Carbon literacy – understanding the carbon impact of activities and being motivated to reduce these

Community Equipment Code of Practice Scheme (CECOPS) – a code of practice for setting out standards for the provision of disability equipment, wheelchair, telecare and seating suppliers which was launched in 2011. It is for suppliers, commissioners and clinical staff to adhere to and is endorsed by various regulatory and professional bodies, such as the Care Quality Commission and the Health and Safety Executive. CECOPS is the only independent standards body in the UK to cover commissioning and provision of all 'assistive technology' or community services.

Community Equipment Service (CES) – provides equipment to people at home to enable them to live more independently or safely after a hospital stay or due to a long-term health condition. Equipment is provided on loan. Minor adaptations can also be made to someone's home, such as grab rails in a bathroom or the installation of a second stair rail.

'Disability' equipment – there is a current debate about the terminology or collective term used for equipment that people use to assist them in their daily life. This could be items to help with mobility, such as walking frames, wheelchairs, hoists or crutches. It could be items which assist with self-care such as shower chairs, raised toilet seats or toilet frames; or it could be items such as bed levers, dressing aids, pressure care cushions or riser recliner chairs and grab rails. Different healthcare professionals and different countries use different terms. Often UK occupational therapists call it 'OT equipment', but physiotherapists may call it 'rehabilitation' or 'rehab equipment'. Nursing students might call it 'medical equipment'. Contractors or commissioners can call it community equipment. In other countries it can be called 'assistive devices' or 'assistive technology'. However, within the UK assistive technology usually refers to technology-enabled systems such as communication or environmental aids.

(Thanks to Laura Knight, MSc Occupational Therapy student, University of Winchester, for her research entitled 'What are the barriers and enablers to sustainable and accessible redistribution of occupational therapy (OT) equipment in the community?' and helpful discussions around this, along with those with Dr Katarina Baudin, Division of Occupational Therapy, Department of Neurobiology, Care Sciences and Society, Karolinska Institute, Sweden)

Integrated Care Boards (ICB's) – these are the statutory elements which operate within an Integrated Care System (ICS). An ICS is a partnership of health and care organisations intended to plan, commission and deliver joined-up health and care services for the local population. The ICB, along with the Local Authority (LA), have responsibility for providing community equipment services (CES) and care services.

LOLER – Lifting Operations and Lifting Equipment Regulations, 1998. This legislation stipulates that all workplace lifting equipment, including that used in healthcare in the community, is fit for purpose, properly marked, and subject to regular examination by an appropriately trained person.

National Health Service (NHS) – the National Health Service is the collective term for the four separate publicly funded healthcare systems of the UK: England, Wales, Scotland, and Health and Social Care (Northern Ireland). The original systems were founded in 1948 following the second world war with the founding principles that services should be comprehensive, universal and free at the point of delivery.

NHS Evergreen Sustainable Supplier Assessment – a strategic initiative developed by the NHS in the UK, aimed at promoting sustainability and ethical practices among its suppliers. This programme is a critical component of the NHS's broader commitment to environmental stewardship and social responsibility, reflecting its dedication to achieving net zero carbon emissions by 2045. The Evergreen Assessment provides a comprehensive framework for suppliers to evaluate and improve their environmental, social, and governance (ESG) performance, thereby aligning their operations with the NHS's sustainability goals.

The Evergreen Assessment is designed to ensure that suppliers meet stringent standards in areas such as carbon reporting, social value creation, modern slavery prevention, and supply chain auditing. By setting high benchmarks, the NHS encourages its suppliers to adopt best practices and continuously strive for improvement.

Occupational Therapy (OT) – is a science-based health and social care profession which is registered by the Health and Care Professions Council. Occupational therapists (OTs) facilitate people of any age to carry out daily life occupations or activities that they need or want to do, and that contribute to their health and wellbeing. An occupation can be related to self-care, such as washing, eating or sleeping; or be about the person's productivity in work, study, volunteering, or in a caring role, as well as their domestic activities such as preparing meals or shopping, or engaging in sports or socialising. It can be about looking after emotional, spiritual, physical and mental wellbeing to maintain balance or to enjoy an improved quality of life.

What is a meaningful activity is determined by the person themselves. However, it can take the skill of the occupational therapist to elicit this as OTs are experts at analysing the complex interaction between the person, the occupation and the environment in the 'doing' of tasks. The OT can analyse any barriers the person may have for successful completion of occupations and come up with solutions to maximise the person's potential to carry out them out, leading to greater independence or an improved quality of life. Solutions can involve, for example, adapting the person's environment, or teaching them new ways of doing tasks. In some situations this may or may not involve the use of disability equipment.

Sustainability – 'the idea that goods and services should be produced in ways that do not use resources that cannot be replaced and that do not damage the environment' (taken from Cambridge Advanced Learner's Dictionary and Thesaurus, © Cambridge University Press).

Appendix III Provision of Disability Equipment – Further Information

Public Sector Commissioning

”At a strategic level, local authorities and Integrated Care Boards must jointly prepare Joint Strategic Needs Assessments (JSNAs) under the Local Government and Public Involvement in Health Act 2007, to assess population-level health and care needs and inform commissioning. However, since JSNAs and Section 75 agreements are locally determined with no national template, the structure, quality, and delivery of community equipment services vary widely across England. The Department of Health and Social Care has confirmed that responsibility for ensuring timeliness and quality sits with local NHS and councils' procuring authorities. This decentralised framework has led to a complex commissioning landscape, where overlapping duties, mixed funding, and reliance on external providers make coordination and consistency across the system challenging” (APPG, 2025). It has become a “postcode lottery” as neighbouring authorities do not provide the same equipment.

Current Community Equipment Providers and Services

Currently, there are a number of different organisations delivering community equipment services in England. These include:

- Hoople Group – supplying to Herefordshire Council, Wye Valley NHS Trust, Lincolnshire County Council
- Millbrook Healthcare – managing seventeen CES contracts
- Medequip – by far the largest provider across various regions of the UK (see Figure A1 below)
- British Red Cross – Nottingham area only

Wheelchair services may be delivered concurrently with the CES or as a separate entity and may or may not be provided by the same contractor. Organisations supporting with the provision of NHS wheelchair services include but are not limited to:

- Ross Care – acquired by Medequip in 2023
- AJM Healthcare Group
- Millbrook Healthcare

CES contractors are required to undergo a tendering process for an area's contract. Neighbouring authorities have been known to collaborate in order to create a contract that offers greater cost efficiencies. Re-tendering occurs approximately every five years. This is a long and costly process for the incumbent and potential supplier as they attempt to prove capability in response to a service specification document. These documents set out a variety of elements against which delivery and monitoring of services have to be measured. They include aspects such as the population to be served, the types of equipment to be supplied, expected operational standards and quality frameworks, such as CECOPS (refer to appendix II). Also, there is a responsibility to provide and use local services as a means to reduce carbon footprint and be socially responsible. Without doubt, price is a major factor.

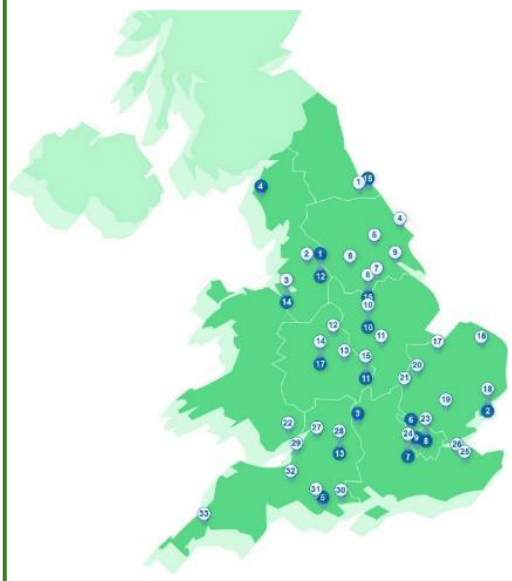
(i) Sector pressures and system problems

Many of the problems with the current system for service provision are set out in the publicly available report of the All-Party Parliamentary Group for Access to Disability Equipment, called ‘Barriers to Lifesaving Disability Equipment’, published in October 2025.

From a CES perspective, they are experiencing greater pressures with a growing demand on services, no change in funding caps for over a decade (APPG, 2025), and an increased financial ‘squeeze’ driven by tight public budgets. Several interviewees expressed the view that budgets for providing an adequate service were simply not realistic. They reiterated some other problems are related to poor commissioning and over

laborious systems. Frustration was expressed as to a lack of sector knowledge by commissioners (compounded by rapid turnover in the role), resulting in poorly understood tendering documents. Additional pressures can come from inefficient boundaries. For example, the areas of Calderdale and Kirklees are geographically close but managed by two different commissioners. Combining these areas could potentially save £1 million (according to James Ibbotsun, Chief Executive Officer of Medux-UK), money which could be put back into the healthcare system.

Another example given was that of Derbyshire and Derby City, which each have their own equipment depots and associated costs but could save money by collaborating. An additional challenge is a lack of communication and collaboration at service level as big companies are now pitched competitively against each other.



Region	Medequip Depot / Location
North East	1 Newton Aycliffe, County Durham
North West	2 Leyland, Lancashire 3 Bromborough, Wirral
Yorkshire & The Humber	4 Scarborough 5 York, North Yorkshire 6 Brighouse, West Yorkshire 7 Doncaster 8 Rotherham, South Yorkshire 9 Hull, East Riding
East Midlands	10 South Normanton, Derbyshire 11 Leicester
West Midlands	12 Stafford, Staffordshire 13 Birmingham 14 Telford 15 Warwickshire
East of England	16 Norfolk, Norwich 17 Downham Market 18 Ipswich, Suffolk 19 Braintree, Essex 20 Cambridge & Peterborough 21 Bedford, Bedfordshire
Wales	22 Newport, South Wales
London and South East	23 Woodford Green, Essex 24 Heathrow (Head Office & Depot) 25 Maidstone, Kent 26 Rochester, Kent
South West	27 Emersons Green, Bristol 28 Calne, Wiltshire 29 Weston-super-Mare, Somerset 30 Bournemouth, Dorset 31 Piddlehinton, Dorset 32 Taunton, Somerset 33 Cornwall - St Austell

	Location
medequip Connect Technology Enabled Care Service	1 Rawtenstall 2 Suffolk 3 Oxfordshire 4 Cumbria 5 Dorset 6 Barnet 7 Heathrow 8 Woodford Green 9 Sutton 10 Alfreton, Derbyshire 11 Warwickshire 12 Wigan 13 Wiltshire 14 Wirral 15 Redcar & Cleveland 16 Rotherham 17 Telford & Wrekin

Fig A1: Medequip's National Coverage as at December 2025 © Medequip Assistive Technology Ltd

Because suppliers use different manufacturers, they hold different 'catalogues' of equipment for the areas they supply although all the equipment serves a similar purpose. This results in costs varying widely for the same product depending on geography.

Another common occurrence is for an incoming contractor to clear any previous stock to make way for their preferred catalogue, resulting in disposal of perfectly useable stock. This is usually to the benefit of charities but is a clear waste of resources.

(ii) Prescriber behaviour

Another area causing financial pressure was apportioned, in part, to prescriber behaviour. Vardy (2024) describes a problem with risk averse behaviour, especially around the discharge of patients from hospital into the community, which results in an over prescription of items. Less experienced and possibly less confident practitioners, together with a lack of pre-discharge home visits, results in the over-prescribing of products as a way to ensure all options are covered. A fear of professional liability, real or not, can exacerbate this behaviour. An incomplete assessment, or reduced accessibility to tracking systems, may also fail to identify that equipment is already at a patient's home and does not require re-ordering. Vardy considers this is one of the biggest costs to the service she manages and that a change in prescriber practice and behaviour could realise savings of 20-25%.

(iii) 'Specials'

'Specials' is another area of huge cost. Vardy, and many other interviewees, all raised this as a problem. Specials are defined as those pieces of equipment which are not available in the standard catalogue. If the

prescriber is of the professional opinion that none of the catalogue equipment is suitable for a patient's specific needs, they will propose an alternative item. For items costing over a certain threshold, which varies according to service area, these need to go before a panel of commissioners, senior therapists and service managers for justification of the spend. In July 2024, Vardy received 50 requests for new specials; this is not unusual. Many of these items, if approved, are not necessarily suitable for the general population but are for one individual. It may also be further adapted to that client. Once no longer needed by that individual, the 'special' item is returned to the CES depot indefinitely. Particularly with children's equipment where the child can quickly grow out of them, there is an untapped resource sat on shelves. The cost to services is immense. Tons of such items have been donated to charity or discarded. Having a regional or national catalogue of 'specials', together with more training for healthcare professionals/prescribers, could potentially broaden the available stock and open up an opportunity for re-use, which would save money.

(iii) Abandonment

Abandonment is an infrequently discussed matter but one of concern. Knight (2025) highlights the research by Money et al. (2015), which found that only 50% of specialist equipment installed through home adaptation services post discharge, was used by patients. Spiliotopoulou, Atwal and McIntyre (2017) describe equipment abandonment rates of up to 30% one year after provision. Further investigation is needed to establish reasons for this and highlights the potential need for prescriber follow-up or recall.

Appendix IV Collection of Disability Equipment – Further Information

Re-use, Recycling and Scrappage Rates for Public Sector Funded Services

Researching the recent recycling rates for the various Community Equipment Suppliers was difficult and some do not appear to be publicly available. It is likely that there is inconsistency across contracts.

Equipment that is deemed to be beyond economic repair or cannot be reused is scrapped. For some contracts, any item with an initial purchase value of over £100 cannot be scrapped without authorisation of the Contract Manager or other nominated representative and agreed by the Commissioners of the service.

In part, difficulty with collection and reuse is due to the tight margins on which CES are expected to deliver a service[5]. Additionally, each contractor has to meet high standards with regard to the equipment that is issued as both demanded by commissioners, which varies across contracts, and the public. There is anecdotal evidence from professional colleagues that some members of the public only want new equipment and return items which they think have been previously used. This may be due to perceptions of hygiene, or in some cases, is related to providing the 'best' option for their family member.

Other reasons given for the non-reuse of products may include the following:

- An item is unable to be cleaned due to heavy use or cost effectiveness, being rusty and/or not fit for purpose.
- Products imported from the Far East/China are often made with lightweight aluminium which is coated in a white polymer/plastic. These are usually referred to as single use items. If the plastic coating is scratched to expose the metal beneath, it is considered, theoretically at least, to be a potential infection risk. It has not been the focus of this project to examine the evidence or data, if obtainable, of actual harm as a result of such injury. It would be worth examining this in more detail.
- Time limits are set for the use of equipment such as wheelchairs or hoists after which they are decommissioned. In Wiltshire, wheelchairs are decommissioned after five years. This is regardless of usage and whether parts can be replaced. There are legal requirements for certain items, such as hoists which come under LOLER regulations for testing, six monthly checks and servicing, ensuring that these are regularly maintained. Should the safety of these be compromised they will likely be decommissioned rather than repaired.

Scrappage rates, the selling of unwanted equipment to waste disposal companies and the process that it then undergoes was not part of this project. In the context of a circular economy this is an important area for further understanding.

Since the commencement of this Fellowship, there has been a noticeable increase in the conversation around sustainability amongst those in the disability equipment sector. This is due to the requirement of partners or suppliers of the NHS to support it to achieve net zero by 2040/45. There is increasing discussion at health-related events, such as the activity and interest at the National Association of Equipment Providers annual conference in June 2024 entitled 'Sustainability: Social, Human, Economic, Environment' (NAEP, 2024; Davies, et al. 2024). Medequip (the principal sponsor of the NAEP annual conference) is itself now reporting two key recycling metrics for the community equipment that it handles. For the 2024/25 period they stated an overall reuse rate is approximately 70% (77% collected, of which 90% is reused) of all equipment originally delivered. This is an improvement on figures presented in a 2019 article, which noted that the national average for community equipment return (all services) was 55% at that time.

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[5] *It is known that where possible and feasible, one CES moves stock between contract areas in order to keep items in use and reduce expenditure. Whilst this increases carbon with the transport involved, it keeps that item out of landfill or scrappage for longer.*

Equipment Donations to Charity

Some examples of charitable activity **in the UK** attempting to make use of unwanted equipment are given:

- In Devon, (the recently closed) Terry's Zimmers shop was set up and operated for several years to provide previously NHS supplied equipment at low cost to the public.
- Warrington Disability Partnership has noticed in the past decade that mobility and other independent living products have become more readily available. With increased consumer demand but lower prices and greater choice associated with mass production, they consider it not surprising to see items discarded in general household waste, refuse centres and landfill sites. In response to this they launched an innovative scheme called LovedB4, which recovers, recycles and reuses electric mobility scooters and wheelchairs, manual wheelchairs, crutches, wheeled and framed walkers. Donated equipment, once restored, is used in their Shopmobility fleet and independent living equipment loan services. Surplus goods are sold on at affordable prices from their distribution centre. For example, prices are £10 for a perching stool, £15 for a Zimmer frame, £50 for a manual wheelchair or £299 for a four wheeled mobility scooter.
- Grace Cares (CIC) was incorporated in 2022, and spotted an opportunity to relieve organisations or individuals of unwanted equipment, refurbish it, and make it available to individuals or care providers. Amongst other activities, they have an online shop and a hub in Lichfield where they are based, from which people can buy equipment. Some of this was issued by CES's. The profits generated are used for hardship funds and to provide social and activity groups to older people, unpaid carers and care providers.

  With Staffordshire County Council, Grace Cares runs a scheme called Medicycle, which facilitates the disposal of unwanted items at any of the Council's 14 household waste recycling centres. Grace Cares then takes on the responsibility of cleaning, repairing, and refurbishing the equipment to ensure that it is safe and ready to be sold on. Additionally, they offer a monthly amnesty collection service to pick up equipment from care homes, GP practices, NHS Trusts, estate agents, etc. within a 10-mile radius of their headquarters. In a newer venture, Grace Cares now partners with Birmingham Community NHS Trust in picking up any working and reusable care equipment that they need to get rid of. Any care providers can donate or purchase equipment.

Other in-country platforms or organisations for the donation or purchase of pre-used disability goods include: Skiggle – direct community sharing platform, Age UK, British Red Cross, Mobility Direct UK, Scope, Recare, SOS Alert, Re-cycle Mobility, Mid Devon Mobility, New Forest Disability, E-bay, Facebook Marketplace, Gumtree, Preloved.

With regard to the re-distribution of disability equipment **internationally**, there are also many active charities. These include: Wheels to Heal, Hope and Aid Direct, Ukrainian Rotary Club of Rutland, British Red Cross (BRC) – who also have a community equipment services contract (Nottingham area) and have internal processes in place for excess disability items to be dispersed through their overseas operations, Jacob's Well Appeal, Jubilee Outreach Yorkshire (ceased operating in 2025), Mission and Relief (logistics), Disability Equipment Sent Overseas (DESO), Global Aid Network (GAiN), Child Aid Eastern Europe, New Forest for Ukraine, Humanity and Inclusion.

PhysioNet

PhysioNet is an example of one charity which has built its reputation on such activity. Established in 2008, it is a charity dedicated to providing surplus physiotherapy and mobility equipment to children and adults with disabilities in low- and middle-income countries (Nagy L., 2022). To give some scale of their activity, at the end of March 2024, they loaded their 150th consignment (supplying to 31 countries since 2009) of mostly 40-foot containers.

Alternatively, external organisations have an option of buying a van load of equipment from PhysioNet. PhysioNet's volunteers, who are either therapists or are trained by them, provide a checking and refurbishment process prior to goods being sent on.

Belief in Action

Similar to PhysioNet, Belief in Action (BiA) has been active in regularly transporting unwanted disability equipment since around 2004. Unlike other charities, BiA has focused on delivering only to the same charity, which is located in the southeastern Transylvanian area of Romania. Partnership working with a local Romanian-registered charity has enabled the establishment of an Equipment Loan Scheme (Robinson, S., Eyres, P. and Small, E. 2022; Robinson, S. and Small, E. 2023). Using a loan model has enabled more people to benefit through the return and re-issue of products. This also allows the local charity to be responsive to changing needs which is particularly important for any children, but also for those with degenerative disorders for whom reassessment and alternative equipment can be given as they grow or change.

In poorer communities there can be a tendency for donated 'aid' to be obtained for onward sale. By having processes and systems in place, equipment can be tracked and monitored. This also keeps it out of landfill for longer and at the end of its useful life, any salvageable materials can be recycled. The project has opened up opportunities to support disabled people and their families in other ways, such as meeting a need for food, clothes, social interaction or groups, or the need for medical attention. Crucial to the success of the Equipment Loan project has been the building of local knowledge and skills in the assessment and provision of suitable items to meet the needs of individuals.

Being personally involved in the collection, transportation and onwards distribution of equipment over many years, it has been my experience that many items, such as walking sticks, crutches, 'helping hands' or items considered damaged, are not considered economically viable to reuse. Examples include commodes with the pan or a rubber leg tip missing, ferrules (which are rubber 'stoppers' on the end of walking aids) being damaged or missing, scratches on the plastic coating of aluminium products such as commodes or toilet seats, or worn brake blocks on walkers. With minor repairs, these smaller items can be quickly and cost effectively re-used.

It is not just about smaller items. In 2022, BiA were astounded to be offered 500 hospital beds which were fully operational and in good condition from a hospital on the east coast. Not wanting to renew the lease on these, the London-based asset management company (with whom the responsibility for disposal lay), was looking to offload them. Unfortunately, the logistics involved in moving so many beds within a short timeframe was not feasible for a small charity.

It is BiA's experience that the amount of unwanted equipment continues to grow exponentially. This may be in part due to the change of contractors following the liquidation of NRS Healthcare. It may also be a result of greater publicity on the part of the charities.

Appendix V Progress with Re-use

Below are various examples of the slow progress that is being made. It is not an exhaustive list but intended to highlight the motivation of particular organisations or individuals and initiatives which could be replicated.

1. Private Healthcare Organisations

There is evidence of an improved approach to reusing issued equipment at Circle Health Group (private) hospitals. After many years of collecting walking aids from Bath Clinic, a Group-wide policy that all local sites should have adopted has been in place since April 2025. In practice, this involves patients being told at pre-admission and during their hospital stay that walking aids are accepted back. On receipt, a physiotherapy assistant completes a checklist of tasks, including cleaning and replacing ferrules (rubber stoppers) as needed, and they are then made available to another patient. It is unclear whether there is a centralised record-keeping of re-issue levels and the reduced number of new walking aids purchased, or a recording of the carbon or financial savings generated by the initiative. At the current time, maintenance of records is the responsibility of the local hospital site. However, Circle Health Group have recruited a Head of Sustainability to plan and action a strategy to achieve net zero by 2040.

2. Community Equipment Suppliers

As a major CES, Medequip emphasises the company's commitment to the "return, recycle, and reuse" principle, highlighting that this approach generates substantial financial savings for the NHS and local authority partners and supports sustainability goals. It is required to be a net-zero partner with the NHS by 2045.

Equipment that cannot be reused is stripped for usable parts, and the remaining materials are sent to specialist recycling facilities. They have partnership agreements and processes with charities for the re-distribution of goods deemed not fit for purpose in the UK, and assist in the transit of these to charity storage depots.

3. Supply Chain Level – Aids for Daily Living Framework Supporting a Greener NHS

NHS Supply Chain

Taken from the NHS Supply Chain article dated November 2023: 'In 2022, pre-tender planning for the launch of the new Aids for Daily Living framework presented an opportunity to support the NHS' ambition to become the world's first carbon net zero national health system by 2045, as set out in the Delivering a Net Zero NHS report. Aids for Daily Living have historically been seen as single patient use, however a lot of the products that sit under the framework can be cleaned and reissued safely without compromising care or product performance. Reusing walking aids was agreed as one way in which to support the NHS, and NHS England set a target of 40% of walking aids to be returned for reuse by 2025'.

Supplier and NHS trust engagement revealed several challenges limiting the return and reuse of products on the framework, especially walking aids.

"Through collaboration with NHS Supply Chain and NHS Trusts and by using a market sounding exercise, we have identified the most effective solution for walking aids reuse, that is designed to maximise the return and reuse of these devices.

This framework provides confidence to patients that the walking aids they receive are safe for use and by keeping suitable devices in circulation, the NHS saves money and reduces its carbon". *Nicole Fletcher, NHS England Sustainable Procurement Lead, 2023*

Solutions to Challenges Identified:

- Manufacturer guidance – Suppliers are required to provide cleaning and reuse information in the Information for Use (IFU). This was an essential feature on the product specification where reuse is appropriate.
- Patient convenience – Linking up to the Recycle Now website to provide a QR code and postcode checker to inform patients where their nearest reuse drop off point is.
- 'Patient awareness – 2022' saw 54 NHS trusts, 14 local councils and suppliers link up as part of the annual Recycle Week to run local campaigns to collectively raise awareness of return and reuse schemes for walking aids.
- Liability and Risk – NHS Resolution confirmed the low risk of reuse, with no liability claims recorded, and adequate cover provided by their insurance for trusts.
- Best practice – Supported NHS England to develop their 'Walking Aid Reuse How To Guide' for NHS Trusts to share best practice on product reuse.
- Service provision – Developed a managed service lot (36) to support trusts to collect, reuse and recycle.

The framework commenced 1 November 2023 and ran until 31 October 2025 with an option to extend for a further two years. A series of links providing information have been made available by the working party including: NHS England – Walking Aid Reuse, Recycle Now Website, Recycle Week, Walking Aid Reuse How to Guide, Recycle Now Postcode Locator, Aids for Daily Living.

The outcome of this initiative is not yet known.

4. The Alliance for Transformative Action on Climate and Health (ATACH)

ATACH is a World Health Organization (WHO) hosted network which during the writing of this report published a report, 'Decarbonising the healthcare supply chain: strategic actions for health systems' (WHO, 2025). The report was co-led by the Greener NHS, NHS England and the WHO Environment, Climate Change and Health Department.

It focuses on two complementary approaches for health systems to decarbonise their supply chain, as well as build its resilience: (i) accelerating supplier decarbonisation through procurement criteria, and (ii) optimising demand and how supplies are used. Examples and suggestions of how recommendations can be tailored for different healthcare systems, contexts and priorities are given.

5. Circular Economy Healthcare Alliance

Central London Community Healthcare NHS Trust (CLCH), together with University College London Hospitals, University Hospitals Sussex, Cambridge University Hospitals, West London NHS Trust, Imperial College Healthcare, and Chelsea and Westminster Hospital NHS Foundation Trust, have come together to form the Circular Economy Healthcare Alliance and have outlined their intentions to reduce waste and carbon emissions. The alliance is headed by Professor Mahmood Bhutta, a consultant ear, nose and throat (ENT) surgeon and clinical lead for environmental sustainability at University Hospitals Sussex, and Professor of Sustainable Healthcare at Brighton and Sussex Medical School (BSMS, 2024).

The alliance is focusing on three key areas of change: avoiding the use of items that are not needed, utilising reusable items rather than single-use wherever possible and safe to do so, and ensuring end-of-life items are returned for remanufacture or recycling where feasible.

Whilst primarily talking about single-use *medical* equipment and consumables, the aim is to reduce these, or reuse where clinically possible. Professor Bhutta states: "The NHS in England generates a staggering 440 tonnes of medical waste every day. While discarding items has become commonplace, our research and analysis reveal that this is often unnecessary and perpetuated by misconceptions about infection risk."

“By forming this alliance, we advocate for a shift towards using reusable products whenever safe to do so and will always prioritise suppliers that value sustainability. We encourage others in the NHS to join us.”

6. Service level examples

Other examples of ‘greener’ initiatives and good practice are encouraging, and again, the following is not an exhaustive list. The Greener NHS initiative has helped to generate an increased awareness and facilitate the conversation to try to effect change. Without doubt, many more good examples at service and practice level are occurring but the difficulty is in knowing about these. Sharing knowledge and learning at a strategic as well as at a local level remains a challenge.

Case Study 1 – Royal National Orthopaedic Hospital NHS Trust

Senior Occupational Therapist, Lucy Swift, spearheaded a project to reduce the Trust’s spend of £18,000 on bathing and toileting equipment in 2022, and address the environmental impact of supplying single use items to post-operative patients. The majority were for short-term use after which they are disposed of, if not recycled, and may end up in landfill. As a national hospital, the team were required to liaise with multiple local authorities and community equipment services. Additionally, some equipment was refused transport by hospital vehicles due to lack of space and had to be sent separately by taxi, adding to cost and carbon footprint. Having identified various solutions and some remaining barriers, Lucy and her colleagues also wrote a new standard operating procedure for staff regarding equipment provision. A shift in understanding and attitude was observed amongst staff and patients.

It remains a project in progress, but on the strength of the findings Lucy and her team decided to review the similar situation with walking aids. By adopting an approach of asking patients if they already had items and so avoiding the need to issue new, and by refurbishing and re-issuing, the Trust’s spend was reduced from around £24,000 in 2023 to around £16,000 in 2024 and the number of new items purchased fell from 796 to 476 in that year (Swift, L., 2023).

Case Study 2 – Guy’s and St Thomas’ NHS Trust

In 2025, the therapies team at Guy’s and St Thomas’ NHS Trust started a scheme to improve patient access to walking aids and to help protect the environment at the same time. They installed bright blue collection bins at several of the Trust’s sites to make it easier for patients to drop off crutches and metal walking sticks they had finished using. On return, these walking aids are given a full check-up, a deep clean, and any wear and tear is fixed prior to them being re-issued. This is part of a longer-term programme of roll out of collection bins across various Trust sites. Their Chief Allied Health Professional, Sandra Noonan, has commented “Walking aids often play a key role in helping patients recover from illness, build their independence and support mobility. Returning these aids will help us protect the environment, provide patients with the equipment they need, and save money which can be better spent elsewhere.”

Case Study 3 – Wiltshire Wheelchair Service

Darren Bayliss, a wheelchair technician for Wiltshire Wheelchair Service, is an unrecognised hero. Since 2019, after noticing that many decommissioned wheelchairs had further use, and aware that scrappage costs could be reduced, he began to refurbish wheelchairs in his *own* time (with the permission of his employer). Since that time, he has refurbished well over 400 wheelchairs and wheelchair cushions for donation to Belief in Action, as well as saving the service several hundred pounds per month. Furthermore, at his own expense, Darren has travelled to Romania on a number of occasions to train local charity team workers and assist in the maintenance and distribution of wheelchairs.

Fig.AV1a Darren with the first donation of refurbished wheelchairs

Fig.AV1b Darren assisting in Romania.

Case Study 4 – DGT Services Ltd, Chelmsford, Essex

DGT Services Ltd are listed on the NHS Supply Chain as a company providing repair and maintenance services to NHS Wheelchair services for almost 40 years. Serving Essex, Hertfordshire and North and East London, they also provide reconditioning of wheelchairs.

Using this service can deliver significant savings. During the period 1 April 2024 to 31 March 2025 this amounted to a combined £1,580,575.00 from ten different wheelchair services. This was achieved from recycling and refurbishing thousands of wheelchairs and their associated spare parts and pressure cushions.

The company reported the savings as a comparative calculation, where the NHS unit cost of purchasing a new item is set against that of recycling or reconditioning the same item.

(Figures provided by DGT Services Ltd and not independently verified).

Additionally, they have an internal competency-based training scheme within their reconditioning workshop, running similarly to an apprenticeship. It enables an individual to develop the necessary technical skills and provides an opportunity for progression to wheelchair service engineers for those who want to further their career with DGT Services.

Case Study 5 – Kirklees

“In Kirklees the equipment team includes a contract manager, two occupational therapists and a community assessment and support officer. Following discussion at regional and national levels, with commissioners, strategic leads and practitioners, it became evident (sic)… of the need to reconsider existing commissioning models to deliver the best service possible, creating a model for equipment services across the country.

These discussions highlighted the financial pressures faced by local authorities, with many approaching the commissioning of equipment service from a cost-centric basis, restricting access to catalogue stock and delivery speeds.

Working in conjunction with Kirklees Health and Care Partnership, we identified the impact of limited access to equipment on increased hospital admissions, delayed hospital discharges and the quality of life of residents – specifically a reduced ability to participate in society and to undertake occupations that are meaningful and purposeful to them.”

In two years, the Kirklees Integrated Community Equipment Services (KICES) team reviewed, “planned, implemented and embedded new ways of working to provide a responsive, comprehensive and cost-effective community service”.

Their headline results were:

- A reversal of £500,000 overspend in 12 months
- Delivery key performance indicators of more than 99.7%
- Evidenced cost avoidance in the financial year 2024-25 of £820,000
- A further £600,000 savings by the recall and reuse of special order equipment (‘specials’)
- Very high levels of service user and prescriber satisfaction
- Scrap rates reduced by 38%
- Urgent equipment delivery service tracking to save NHS £5.6million in 2024-25 year, at a cost of only £36,000 to the service

(Mark Rance, Contract Manager for KICES, and Dr Anita Mottram, Principal Occupational Therapist, t*aken from their article published in OT News, July 2025).*

Case Study 6 – Rotherham and Sheffield

In this area, several initiatives were instigated in a campaign to collect equipment back from the community. These included having staff allocated to reviewing the Council’s list of the deceased and checking these against the provision of equipment records. This highlighted those items which were no longer required and could be collected back. In Durham, a telephone system was being used to call people who were recorded to have equipment and check the status of the ongoing requirement or need for return.

Equipment amnesty bins were placed outside doctors’ surgeries as well as at household waste collection centres in collaboration with the waste managers (in this case Veolia). Other amnesty events were scheduled to occur at local supermarkets.

(*Thanks to Liz Vardy, former Lead Practitioner for the Integrated Community Equipment Loans Service Sheffield)*

Case Study 7 – East Lancashire Hospitals NHS Trust

Drop off points have been set up at Blackburn, Burnley, Pendle and Clitheroe Hospitals where crutches, sticks or frames can be returned for use by future patients. Since the initiative started, nearly 1,000 walking aids have been returned, refurbished and reused – this includes 433 crutches and 429 frames. *(ELHT Green Newsletter, January 2026)*

Appendix VI About the Author

Susanna Davies (aka Robinson) is an Occupational Therapist (OT) with more than thirty-five years of experience. Having qualified from Derby School of Occupational Therapy in 1987, Susanna moved to the Bristol/Bath area for various clinical roles before taking up a unique role of Research Occupational Therapist within a charity. Susanna obtained an MPhil from the University of Bath (1994) for research which examined the relationship between cognitive status and functional capacity in people with dementia living in the community. Simultaneously, she developed a role for occupational therapy within a Community Mental Health Team for the Elderly, and established a credible research programme.

Susanna contributed to the standardisation and cross-cultural validity of the Assessment of Motor and Process Skills (AMPS) both in the UK and internationally, and saw this innovative and ground-breaking tool widely integrated into OT practice.

Working independently from 1995, Susanna instigated AMPS (UK) Ltd through which to deliver training, monitor research, and collaborate internationally. She was also Training Manager and co-Director of Harrison Associates, before establishing Harrison Training in 2007, a main UK provider of continuing professional development opportunities for occupational therapists and other healthcare professionals. Harrison Training carried out many consultancy projects, including an investigation to identify the need for a standardised, accredited or certified professional pathway for case managers in the UK for the Case Management Society of the UK (CMSUK). Susanna also contributed to the Royal College of Occupational Therapy working party on Standard Terminology, and was an assessor for a (previous) Department of Trade and Industry project providing verification of range of disability.

Susanna has been preparing reports on functional ability for legal purposes since 2009 and continues to work as an Expert Witness. She is a registered member of the British Association of Occupational Therapists and World Federation of Occupational Therapy, as well as a variety of professional communities and organisations. Until the end of October 2025, Susanna was a Quality Manager Expert Witness at Keystone Case Management Ltd. with responsibility for assisting in the development and operation of the business, together with the governance and quality control of the expert witness work.

Susanna volunteers extensively as a trustee of charities assisting overseas organisations working with disabled people. This has included the setting up and supplying of a sustainable Equipment Loan Scheme with a Romanian-registered charity.

Additionally, Susanna is a Visiting Specialist at the University of Plymouth, as well as a doctoral student in their School of Health Professions, looking at the sustainability of disability-focused charities overseas.

"I never worry about action, but only inaction' – Sir Winston Churchill

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