

**Guidelines to Accessing NHS Orthotic Services  
and Orthosis Provision Eligibility**

Last updated  
**May 2019**

**NHS ORTHOTIC MANAGERS GROUP**

**PURPOSE:**

To provide structure and context for the issue and replacement of Orthoses provided by NHS Orthotics Services to ensure cost effective and fair NHS Patient provision to those with clinical need in all localities

**REACH:**

Orthotic users, Orthotic clinical teams, Service managers, and all stakeholders either funding or referring to an NHS Orthotist in England

<b>Guidelines No.</b>	0519
<b>Ratification</b>	Orthotic Managers and Clinical leads of <b>38</b> NHS Trusts  Rebecca Loo, The Orthotics Campaign  Profession Affairs Committee, British Association of Prosthetists & Orthotists
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## 1. Population Needs

### 1.1 National context and evidence base

1.1.1 Orthotic service provision has the potential to achieve significant health, quality of life and economic benefits across the local health economy. To individual patients, the correct supply and fitting of orthotic devices can be a major factor in the management of their condition, improvement in the quality of life and the prevention of future problems. Evidence highlighted in the emPOWER patient led orthotics Charter states that for every £1 spent, the NHS saves £4. A recent national review of orthotics services has highlighted a number of issues in regards to current provision and commissioners are looking to commission a single service from a single provider across a number of community locations providing in reach services to secondary care where appropriate.

1.1.2 An estimated £220 million per annum is spent by the NHS on assistive technologies which include orthotics, audiology, community equipment, electronic assistive technology, telecare and prosthetics. The Foundation for Assistive Technology's recent report states that there are approximately 1,200,000 orthotic users in England. However, the number reported may only be used as a guide, as the report suggests that the total number of patients benefiting from such assistive technologies is unknown<sup>i</sup>.

1.1.3 Orthotic services cover a wide range of clinical areas where they are likely to provide health benefits, some of which are listed below:

- Orthopedics – pre & post-operative joint support preventing deterioration
- Rheumatoid arthritis and osteoarthritis – pain relief utilising custom bracing and footwear
- Stroke – improving independence and well being
- Elderly medicine – improving mobility and reducing risk of falls
- Diabetes – reducing ulceration rates and hospital stays
- Sports injuries – joint rehabilitation
- Cerebral palsy – contracture prevention, allow mobility and reduce progression
- Polio limb dysfunction - improve independence & mobility
- Trauma – post op bracing, or support if no surgical intervention
- Vascular complications – pressure relief and accommodation of swelling
- Other muscular-skeletal complications such as knee instability, broken back or neck, ankle replacements – support & pain relief during rehabilitation
- Biomechanical Foot dysfunctions – improved posture and alignment for pain relief and prevention of deterioration of associated joints

1.1.4 Demand on the service is increasing in line with both the ageing population and the complexity of the associated clinical conditions. There is currently no agreed mechanism for relating the changes in funding to the changes in demand. Orthotic services have generally received a very low priority in the NHS, hidden in secondary healthcare<sup>ii</sup>. Orthotics care can be provided as part of a hospital episode or in its own right as a community-based service.

### 1.2 Terminology

Orthotists are autonomous Allied Health Practitioners (registered with the Health and Care Professions Council<sup>iii</sup>) who assess static and gait alignment to utilise engineering solutions for patients with problems of the neuro, muscular and skeletal systems. They are extensively trained at undergraduate level in mechanics, bio-mechanics, and material science along with anatomy, physiology and pathophysiology. Their qualifications make them competent to design and provide orthoses that modify the structural or

functional characteristics of the patients' neuro-muscular and skeletal systems enabling patients to mobilise, eliminate gait deviations, reduce falls, reduce pain, prevent and facilitate healing of ulcers. They are also qualified to modify CE marked Orthoses or componentry taking responsibility for the impact of any changes. Whilst they often work as autonomous practitioners they increasingly often form part of multidisciplinary teams such as within the diabetic foot team or neuro-rehabilitation team.

An Orthosis or Orthoses are medical devices that are applied to the body to improve posture, function, and mobility or reduce pain. Orthoses may be described as functional, sensory, active bracing, or accommodative. Functional orthoses apply mechanical forces on joint/s creating moments that reduce pressure, shearing or rate of translational forces that would normally be exerted in their absence. Sensory orthoses utilise the body's proprioceptive feedback from muscles and joints in order to harness primary postural correction mechanisms. Active bracing (sometimes referred to as soft goods) are usually manufactured in fabric/synthetic materials providing warmth, compression and proprioception and less mechanic support than functional orthoses. Accommodative orthoses are primarily used to accommodate or protect an 'at risk' or enlarged limb. They may also have a secondary function of providing mechanical support. For more Information please refer to the British Association of Orthotists & Prosthetists [web page](#).

NHS Orthotic Eligibility refers to right of an individual "ordinarily resident" in the UK to receive care, free at the point of delivery, provided that there is clinical need for use of an orthosis and that the needs of the individual cannot be satisfied safely and reasonably in a commercial settings. This definition is built on the first, second and sixth principles of the NHS Constitution<sup>iv</sup>. This document builds on this philosophy to encourage service providers to use fair and equitable decision making in the provision of Orthoses and Orthotic expertise.

### 1.3 Local Context

NHS Orthotic Services may be provided in a variety of settings , commissioned, and provided by a number of sources. Whilst historically the clinical delivery of Orthotic Services has been carried out in acute hospitals, it is now commonplace for Orthotic clinicians to provide care to their patients from within GP practices, special schools and colleges. The service provider may be an acute NHS trust, a community Trust, social enterprise or a commissioned private company. The Orthotist may therefore be employed by the NHS, by a private company that has been commissioned to deliver orthotic care, or self employed.

For larger services it is likely they will provide a 'hub & spoke' model to the locality. This involves one main base of practice but the delivery of clinics across a wider area of sites. The service model often ensures both in-patient and out-patient services are provided.

For the majority of Orthotic intervention it is strongly advised that a HCPC (*Health and Care Professions Council*) registered Orthotist<sup>v</sup> assesses and provides treatment. However, orthotic care may be delivered by many clinicians whether it be a qualified Orthotist, or other trained members of staff. It is important that non Orthotists recognise the limitations of their training and only operate within their scope of practice.

Possible interventions should be discussed with patients, parents and carers so that a joint decision is made. The input could be one or a combination of options including; advice, insoles, Ankle Foot Orthoses, knee braces, back supports, dynamic sensory orthoses, wrist braces and footwear. The team can assist with a multitude of musculoskeletal, physiological, neurological or congenital conditions to increase mobility, reduce pain or manage chronic disease.

Some orthoses are ready made ('off the shelf'), but many are specifically made to the patient's individual needs and requirements. These are then 'custom made' or 'bespoke' to order. These orthoses are either designed and manufactured by an in-house workshop, or ordered direct from specialist manufacturers.

## 2. Meeting the challenges of the reforming NHS

The current political changes are making much needed sweeping changes to how NHS services will be delivered and commissioned. This will impact on every service within the NHS. With an increasing aging population and increased orthotic treatment options services are under great pressure. Recent and future legislative changes require efficiencies to be made in service delivery while improving quality. Orthotic services must provide patients with appropriate treatment at the lowest possible cost to the NHS. However, Orthotic services within the NHS are often poorly recognised and funded. A focus on the bottom line often misses the point that sustainable retention of quality, well trained clinicians can bring about efficiencies and savings. Staff that are provided the correct resources utilise cost effective treatments, integrate into MDTs, work to evidence based practices and train other staff that ultimately leads to less waste within the system.

Although there are many examples of good practice that represent value for money, there are large inconsistencies within orthotic departments within the UK regarding pathways, procedures and patient eligibility. The number of orthoses a patient can be prescribed under the NHS is one area that needs to be addressed. The *British Association of Prosthetists and Orthotists (BAPO)* and *NHS Orthotic Managers Group (NOMaG)* have contributed to commissioning guidelines for orthotic services for *NHS England*. The paper [Improving the Quality of Orthotic Services in England](#)<sup>vi</sup>, published November 2015 suggests that all orthotic departments should have a "patient entitlement policy".

There is currently no national patient eligibility policy for orthoses prescribed to patients. A number of *National Institute for Health and Care Excellence (NICE)* guidelines recommend orthotic provision such as; [Diabetic foot problems: prevention and management](#)<sup>vii</sup>, [Selective dorsal rhizotomy for spasticity in cerebral palsy](#)<sup>viii</sup>, [Spasticity in under 19s: management](#)<sup>ix</sup>, but fall short of defining standards and provision. Therefore many Orthotic departments have policies based on historical practice and commercial service contracting legacy.

The NOMaG undertook an audit in 2010 of patient entitlement policies within In-house NHS orthotic departments to gain a recognised consensus. NOMaG represented 24 NHS Trusts who provide Orthotic Services at the time of the audit. Current practice along with the views of the Clinical leads and Managers of the group were considered in the adoption of a national recommendation for patient eligibility for NHS prescribed orthoses. In 2012 a chair review of the audit<sup>x</sup> stated to 2 important recommendations;

- 1) Orthotic departments must operate in a financially efficient manner in the modern NHS. A strict patient orthosis provision policy can assist in this process and be clear for all users and commissioners of the service.
- 2) Orthotics departments must try to establish those patients who have an ongoing need for orthotic treatments whilst recording patient focused outcomes to prove orthotic services are efficient and good value for the NHS pound.

### 3. Stabilisation of Referral

'Stabilisation of referral' refers to the time period in which a referral is valid for. In Primary care this can be compared to 'repeat prescriptions'. All NHS patients requiring Orthotic intervention must be referred by an appropriate clinician for initial assessment.

Depending on the local service specification, referrals received from Primary Care, Secondary and Tertiary sources may either be lifelong, or remain valid for a set period of time (Stabilisation period). For presenting problems which are stable or advancing within normal disease parameters, and there is no further reason for consultant/ General Practitioner review, then a patient may return to the orthotic department for reassessment, review or repair within the stabilisation period.

If, within the stabilisation period, the product has worn out, no longer gives adequate support, or the patient's condition has developed and the item is no longer suitable, then the patient will be re-measured and the orthosis replaced. Products will be replaced one for one, within the allowances set out in this document.

If the patient's condition has changed significantly (advanced or improved) and the orthosis originally prescribed no longer fulfils the patient's requirements, then the Orthotist is obliged to re-assess and prescribe an alternative Orthosis within their scope of practice. This does **not** require a new referral for the same clinical presentation or condition.

After the stabilisation period a new referral will be required by the service to continue providing orthotic intervention to the patient. This is a historical process linked to the funding of services. It is designed to provide a deliberate stop to ensure the long term needs of patients are considered by their General Practitioner who has an opportunity to consider other care pathways. If Orthotic management is to continue, the authorisation of an ongoing referral approves the financial and clinical aspects of the treatment. For those localities with a "stabilisation period" in place, it is recommended this is a period of *five years*.

### 4. Exclusions

#### 4.1 Elapsed Referrals

If an established patient presents with a new condition or disease which requires additional Orthotic intervention then the clinician must either; seek further approval from the appropriate health care professional before any treatment is carried out, **OR** the GP/referring clinician be informed of the findings and treatment rationale following any intervention – see local service specification / agreement for more information. The Orthotist must continue to work within their scope of practice.

Patients who no longer require an Orthosis for a functional, clinical or biomechanical reason, the Orthotist will request the patient to cease use and will discharge the patient regardless of the remaining stabilisation period.

Where a stabilisation period (as defined in section 3) is in place all patients regardless of condition must have an appropriate referral no older than the agreed period of stabilisation. If a patient is "out of stabilisation", it is the patient's responsibility to contact their General Practitioner for a medical opinion and or new Orthotic referral before any further Orthotic intervention can take place.

Orthotists and Orthotic Co-Ordinators must remind patients living with long term chronic disease of this policy. For individuals living with an incurable condition the system will appear bureaucratic and the

reasons are not immediately obvious. It is within the remit of the service to educate and ensure candour.

For existing patient whose stabilisation period has lapsed, existing orthoses or footwear will be repaired pending a new referral.

#### 4.2 Lifelong Referral

It is understood that most patients requiring Orthotic management have long term chronic conditions with consistent reliance on orthoses. To this end, many service providers with agreement of commissioning groups are moving to '*lifelong stabilisation for the same condition*'. This streamlines processes, reduce bureaucratic burden on GPs and supports the autonomy of Orthotists. The NHS Orthotic Managers group supports this move which has a direct positive result on patient experience.

#### 4.3 Self Referrals

The direct access model means that patients are able to refer themselves to a service (self-referral) without having to see another health professional, or without being told to refer themselves by another health professional.

The agreement to accept self-referrals by an Orthotic Service must be made at local level with the consensus of commissioning bodies and the service provider. Self-referral may be appropriate within the wider scope of a localities service model to improve greater access to Allied Health Professional intervention and reduce unnecessary delays. The introduction of this care model relies on Orthotic Services employing clinicians with specific training in order to provide differential diagnosis along with access to request diagnostic imaging. The clinical team must also have the ability to make appropriate onward referrals when required as well as access to primary care patient records.

Self-referral will not be appropriate for every sub-category of orthotic service user but there may be several conditions (or groups of conditions) where a well defined self-referral pathway can be established such *acute MSK foot and ankle*. Once established, periodic review must ensure the skillset of a local workforce and infrastructure supports the delivery of a self-referral model.

#### 4.4 Treatment not provided under the NHS

Orthotists have a duty of care to assess the clinical needs of their patients and provide appropriate treatment, if required, within their scope of practice. Some patients who seek orthotic treatment might have preconceived ideas about what may be available, they might incorrectly assume they meet treatment/eligibility criteria, or they may have unrealistic expectations about their treatment outcomes.

By honestly discussing treatment options with patients, and providing accurate evidence-based information, a positive, open and trusting relationship can be developed. In this way, orthotists can use their communication skills and clinical knowledge to ensure that patients are guided towards clinically effective interventions. This fosters sound clinical reasoning and helps the orthotist and the patient to work together to develop clear, explicit, and realistic patient-centred goals.

Primarily, an orthosis prescription must meet the requirements for the users everyday lifestyle and so allow for participation in an active, healthy lifestyle as defined by the users rehabilitation goals and objectives. As such, the prescription may be tailored for exercise hobbies but should not be prescribed solely with these activities in mind.

Orthoses will not be supplied where:

- There is no specific clinical or biomechanical need. (Nb. Instead reassurance and information will be given on how to monitor a possible future need)
- The short term need has passed and the patient no longer requires replacements
- The orthoses is being supplied as a placebo with no clinically defined outcome
- They are being supplied for only socio-economic reasons. (instead information to sources of support will be made available)
- Orthoses will not be provided for purely competitive and professional sporting pursuits.
- No orthoses should be supplied because of historical practice if it does not provide a clinically defined benefit

#### 4.5 Orthotic Treatment not provided within standard NHS Orthotic Service Contract

- Functional Electrical Stimulation. (Nb. Patients should have access to services that offer F.E.S. treatment. This may be an alternative service or additionally provided by the Orthotic Service under additional funding)
- Walking aids, buggies, wheelchairs and assistive devices
- Orthoses of low clinical effectiveness, where there is either:
  - 1) a lack of robust evidence of clinical effectiveness, OR
  - 2) a perceived effectiveness by the treating clinician OR
  - 3) there are significant safety concerns
- Orthoses which are clinically effective but where more cost-effective products are available
- Orthoses that have no identifiable outcome or goal
- Any Specialised product where there is not sufficient expertise and knowledge by the local team to ensure effectiveness. Commissioning arrangements should be in place to ensure local patients receive specialist intervention if not provided by the local provider (such as; Scoliotic bracing, stance phase KAFO, and Functional Electrical Stimulation)
- Where the local Orthotic Service is unable to cater for the needs of a local patient, funding arrangements must be in place to allow the patient to be seen by alternative providers (such as; specialist products, complex footwear, Knee Ankle Foot Orthoses)

### 5. Patient eligibility of Orthotic Equipment Provided by the NHS

It is recommended that all NHS Orthotic Services work to nationally agreed eligibility of standard Orthoses for patients attending a NHS Service as outlined by the NHS Orthotic Managers Group, England. In most cases the below table outlines a fair and equitable service free at the point of delivery.

NHS Orthotic eligibility is an important tool for managing costs but it must be recognised that patients attending Orthotic Services have varied and wide ranging needs and lifestyles. It is therefore important the Orthotist is not constrained by the below guidelines. Where there is a clear clinical need to support a patient's quality of life and independence by providing additional orthoses Orthotists should have the autonomy to do so.

Many orthotic service users may be identified as vulnerable persons and do not have the foresight to identify that they need regular repair or replacement or an Orthosis. There is responsibility on the clinical team for safe care of the user by ensuring that they have full allowance of orthoses were appropriate.

Product Group	Standard NHS Provision when Clinically required
<b>Orthotic Footwear</b>	<p>Period of rapid change in size or clinical need - <b>One pair</b></p> <p>Period of slow change in growth or clinical need - <b>Two</b> pairs of serviceable boots or shoes supplied after the trial period completed.</p> <p>Replaced immediately when no longer clinically effective or patient has outgrown.</p> <p>For patients clinically at risk of harm or deterioration, the Orthotist may consider exceptional circumstances.</p> <p>It is the patient's responsibility to check the condition of the footwear issued at regular intervals. It is recommended a locally agreed <i>Standard Operating Procedure or policy</i> is in place detailing how footwear can be repaired, and who is responsible for the cost.</p> <p>Footwear provided to the patient are the property of the hospital and patients must ensure footwear issued are maintained. However, replacements must be issued when beyond economic repair if still clinically required.</p>
<b>Footwear adaptations – raises, rockers, sockets for callipers</b>	<p>Period of rapid change in size or clinical need – <b>One pair</b></p> <p>Period of slow change in growth or clinical need - <b>Two</b> pair at any given time.</p> <p>Stable clinical presentation - <b>Three</b> in the first year following the initial referral to department. <b>One</b> in consecutive years thereafter.</p> <p>Replacements should be issued if size or clinical circumstances change.</p>
<b>Foot Orthoses</b>	<p><b>One</b> or one pair at any given time.</p> <p>It expected that patients transfer their Foot Orthoses into alternative shoes as required.</p> <p>Activity, patient weight, shoe design, material choice and insole thickness influence longevity. Patients should be advised (at supply) the expectant lifespan of their orthoses. They should also be advised on how to seek repair or replacement when the current orthoses no longer meet their needs.</p> <p>For patients at high risk the Orthotist may consider exceptional circumstances.</p>
<b>AFO</b>	<p><b>One</b> orthosis or <b>One pair</b> depending clinical presentation.</p> <p>Patients who require long term input, have no changing clinical need,</p>



	<p>and are unable to cope with daily activities without, may be issued with a second AFO to ensure servicing and safety. The timescale is dependent on condition and circumstance and therefore should be decided by the Orthotist.</p> <p>They will be replaced when beyond economic repair, outgrown or no longer clinical effective.</p>
<b>KAFO</b>	<p><b>Two per limb</b> as required at any given time. Second supplied after trial period completed.</p> <p>They will be replaced when beyond economic repair, outgrown or no longer clinical effective.</p>
<b>Temporary devices (wrist splints, stock fabric AFOs, temporary footwear, etc.)</b>	<p><b>One</b> orthosis. Due to the breadth of clinical input the Orthotist should exercise their right of autonomy to ensure patients are safe and provided with cost effective treatment.</p>
<p><b>Graduated Compression Hosiery *</b></p> <p>*If applicable to service</p>	<p><b>Two per limb</b> as required initially and then discharged to GP care. If to be managed by the Orthotic service long term <b>Two per limb</b> every 6 months (i.e. <b>four per limb</b> per year).</p>
<b>Abdominal Supports, Fabric belts &amp; Truss</b>	<p>If used throughout the day, on a regular basis - <b>Two</b> at any given time</p> <p>If used infrequently or sparingly – <b>One</b> at any given time</p>
<b>Repairs</b>	<p><b>As required.</b> If repairs seem too frequent then consideration is given to changes to specification. Please see 5.1 for further guidance</p>

## 5.1 Repairs

A system should be in place to ensure repairs are completed as quickly as possible to minimise delays whether the device or footwear are sent away or repaired locally. Services should ensure only experienced staff review and arrange the repair of Orthoses or footwear. All non-qualified staff have a duty of care to raise concerns of unusual wear or breakages. Clinicians have a duty of care to ensure supporting staff are competent in making these decisions.

Repairs should not be undertaken to adapted retail footwear unless adapted component requires refurbishment.

If the trust has an in-house Orthotic workshop, it is recommended that patients and carers have direct access for simple repairs to be done while the user waits. e.g., replacing straps, replacing rivets, heating and easing AFO's, cranking calliper/ BK iron side members.

All major repairs should be undertaken following presentation of the orthosis and re-assessment by orthotist.

## 5.2 Replacements

Replacements will only be provided when the device is beyond economic repair or a change of device is required following assessment due to clinical need or change.

## 6. Private purchase of Orthoses

NHS Orthotic Services are delivered for NHS patients only and should run separately to private provision for transparency. Private patients should not be seen within the working hours of an NHS service unless the NHS receives reimbursement for use of resources. It is however recognised that many patients wish to purchase orthoses over and above their NHS eligibility. In these circumstances, additional orthoses may be purchased directly from the manufacturer/ supplier. The NHS Orthotic department may be able to assist the patient by;

- Supplying an appropriate contact name
- Referencing previous orders raised with the supplier
- Completing a *VAT exemption declaration* (Appendix A) where applicable

It is the suppliers/manufacturers responsibility to liaise with the patient concerning payment and delivery. NHS Trusts cannot be involved with any other administration. The supplier/manufacturer also has a duty not to deviate from the clinical specification provided to the patient through their NHS assessment and provision.

If the orthosis is produced by an in-house workshop or it is not possible for a patient to order directly, NHS departments may be able to offer a system in which orthoses can be bought/and or manufactured by the department on behalf of the patient. Each trust will need a robust system in place to ensure that it is equitable and fair, and that there is no additional cost to the service provider/commissioner.

NHS prescription charges do not apply for orthoses purchased by a patient as they are not within the scope of NHS treatment.

## 7. Lost or stolen Orthoses

Patients are required to maintain and take all reasonable precautions to protect their orthoses from being lost or stolen. The Trust cannot be held responsible for the loss or damage of an orthosis while in the patient's possession. The circumstances of patients who require a replacement orthosis will be treated individually. If a patient cannot demonstrate reasonable precautions from loss or theft, they may incur the full cost of replacement as outlined in section 6.

# Appendix A

## 10.1 Eligibility declaration by a disabled person

Please note there are penalties for making false declarations

### Customer

If you are in any doubt as to whether you are eligible to receive goods or services zero-rated for VAT you should consult Notice 701/7 VAT reliefs for disabled people or contact our National Advice Service on 0845 010 9000 before signing the declaration.

I (full name) .....

of (address) .....

.....

declare that:

- I am chronically sick or have a disabling condition by reason of: (give full and specific description of your condition); and that
- I am receiving treatment from the Orthotic Services Department of \*\*\*\*\*

\* the following goods which are being supplied to me for domestic or my personal use:

\* the following services to adapt goods to suit my condition:

\* the following services of installation, repair or maintenance of goods:

and I claim relief from value added tax.

..... (Signature)

..... (Date)

### Supplier

The Orthotic Services Department of \*\*\*\*\* is supplying to the person named above:

\* the following goods:  
(description of goods)

\* the following services of adapting goods:

(description of services and goods)

\* the following services of installation, repair or maintenance of goods:

(description of services and goods)

for the intended use of the prescribed person

..... (Signature)

..... (Date)

\*Delete words not applicable

**Note**

You should keep this declaration for production to your VAT officer. The production of this declaration does not automatically justify the zero-rating of the supply. You must ensure that the goods and services you are supplying qualify for zero-rating.

**Which equipment and services can be bought without paying VAT?**

If you have a long-term illness or you're disabled, you won't have to pay VAT when you buy any of the following items:

- adjustable beds, chair lifts, hoists and sanitary devices
- auditory training aids
- low vision aids
- medical and surgical appliances designed solely for the relief of a severe abnormality or a severe injury
- alarms
- motor vehicles, boats and other equipment and appliances designed solely for use by chronically sick or disabled people

You also won't have to pay VAT on any charges made for the installation, repair and maintenance of these items, or on any spare parts and accessories needed for them.

## References

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- <sup>i</sup> <http://archive.audit-commission.gov.uk/auditcommission/sitecollectiondocuments/AuditCommissionReports/NationalStudies/olderpeopleorthotics.pdf>
- <sup>ii</sup> York Health Economics Consortium, July 2009
- <sup>iii</sup> <http://www.hcpc-uk.org/aboutus/>
- <sup>iv</sup> [The NHS Constitution for England](#)
- <sup>v</sup> [http://www.hpc-uk.org/assets/documents/10000522Standards\\_of\\_Proficiency\\_Prosthetists\\_and\\_Orthotists.pdf](http://www.hpc-uk.org/assets/documents/10000522Standards_of_Proficiency_Prosthetists_and_Orthotists.pdf)
- <sup>vi</sup> <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/orthcs-final-rep.pdf>
- <sup>vii</sup> [Diabetic foot problems: prevention and management, NICE guideline \[NG19\] Last updated: January 2016](#)
- <sup>viii</sup> [Selective dorsal rhizotomy for spasticity in cerebral palsy, Interventional procedures guidance \[IPG373\] Published date: December 2010](#)
- <sup>ix</sup> [Spasticity in under 19s: management, Clinical guideline \[CG145\] Last updated: November 2016](#)
- <sup>x</sup> Orthotic Patient Eligibility: Meeting the challenges of the reforming NHS, NHS Orthotic Managers Group

## Documents that have shaped and informed this guidance

Orthotics Model Service Specification

<https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-serv-spec.docx>

The Assessment and Provision of Equipment for People with Complex Physical Disabilities (all ages) - Definition no.5

<http://www.webarchive.org.uk/wayback/archive/20130328000401/http://www.specialisedservices.nhs.uk/doc/assessment-provision-equipment-people-with-complex-physical-disability-all-ages>

*Patient and Public Involvement in Health: The Evidence for Policy Implementation*

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4082334.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4082334.pdf)

Health reform in England: update and commissioning framework

[http://webarchive.nationalarchives.gov.uk/20080817111652/http://www.dh.gov.uk/en/Publicationandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4137226?IdcService=GET\\_FILE&dID=26380&Rendition=Web](http://webarchive.nationalarchives.gov.uk/20080817111652/http://www.dh.gov.uk/en/Publicationandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137226?IdcService=GET_FILE&dID=26380&Rendition=Web)

The NHS Five Year Forward View

<https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>