



BAPO Standards for Best Practice:

Notification of Change and Guidance for Implementation

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Introduction

This document aims to contextualise the changes planned to the British Association of Prosthetists and Orthotists' (BAPO) standards for best practice, for key stakeholder review. It stands to give notice of the changes, provide the rationale for the decisions made and guide stakeholders in how they might be implemented.

These changes and this guidance document have been approved by the Professional Affairs Committee, Operations committee, and Executive Committee. This review has been led by Katie Prosser, sitting member of the Professional Affairs Committee.

Background

Scheduled Review of standards

BAPO Standards for best practice are subject to routine reviews to ensure content is relevant and recommendations are contemporaneous. The last updates were published in May 2018 with the subsequent review scheduled for May 2020. With the pressures of the pandemic and volunteer workforce constraints, a review of these standards was overdue. During this review, several areas were highlighted for improvement, pertaining to treatment times in particular.

Precedent across Professional Associations

Many professional associations, representing a range of health professions across the UK, give guidance on how their professionals' time should be allocated. The College of Occupational Therapists quotes specified appointment lengths as examples of good practice within an urgent care therapy service [1.] The Chartered Society of Physiotherapists outlines the importance of considering treatment times when establishing primary care physiotherapy services [2.] The Royal College of Surgeons outlines in minutes the minimum and maximum times per intervention [3.] BAPO feels it is beneficial for its members, and the services in which they work, to set minimum appointment times to preserve the quality of care and protect prosthetists and orthotists.

Plan for Prosthetists

The time allocations for prosthetic clinics are typically very different to orthotic clinics, with greater time demands per patient and hence typically, fewer patients allocated per prosthetist per day. Because of this, BAPO at this time has prioritised modifying the recommendations for orthotic clinics only. However, it is recognised that many of the same demands which are increasingly placed on orthotists, affect prosthetists too. It is intended that a prosthetist-led review into prosthetic clinic schedules will be undertaken by BAPO.

Rationale for changes

The role of BAPO is to act on behalf of prosthetists and orthotists and advocate for what is in their best interests professionally. BAPO's standards for **best** practice should dictate the minimum appointment times required for providing the **best** care. Several contributing factors have led to the decision to make the changes, some of which are discussed below.

COVID-19

The COVID-19 pandemic has irrefutably changed the way orthotists, prosthetists, and neighbouring healthcare professionals' work. Orthotists must now be more acutely engaged in infection prevention and control, and new measures have been implemented both nationally and locally to prevent disease transmission. These may include changes to personal protective equipment (PPE) along with donning, doffing and disposal procedures, room cleaning, and patient or visitor screening. Appointment times should reflect the increase in expectations of orthotists.

COVID-19 has infected millions of people in the UK and the effects of long-COVID are still to be fully understood. But increasingly, evidence is showing that the complexity of patient presentations in outpatient settings is increasing as a result of the pandemic [4.]

BAPO recognises that COVID-19 has caused increased pressure on services and in many cases has led to increased backlogs and waiting lists [5.] It is appreciated that making recommendations at this time to increase appointment lengths may too compound waiting lists if not introduced with mitigating measures. However, COVID-19 has also, for many services, provided an opportunity to reflect on current practices and make changes to how clinics operate. It should be during the ongoing recovery of these services that the opportunity for change is taken and changes such as those stated in this document are implemented.

Orthotist Attrition

Orthotist attrition is a documented concern affecting the NHS workforce [6.] Recent evidence gathered before the COVID-19 pandemic found that 'respondents across private and NHS settings consistently reported that they did not have enough time with patients during appointments,' [7.] The paper found that lack of time strongly correlated with job dissatisfaction and intent to leave one's current role. This in turn is strongly correlated with the intent to leave the profession [7.]

Increasing appointment lengths on a wide scale is expected to have a beneficial effect on orthotist retention both within services and nationally.

Outcoming and Data Collection

Ever more evidence is emerging about the importance of outcome measures, not just for patients and Allied Health Professionals (AHPs), but for services and their ability to provide evidence of treatment effect. Thus, demonstrating the importance of undervalued departments [8.] Orthotists often take issue-specific outcome measures (e.g., pain scores) but research is pushing for including more holistic measurements too (e.g., Therapy Outcome Measure scores.) BAPO supports and recommends the routine use of outcome measures and time must be allocated for this in the clinic.

Public Health Championing

Increasing focus is being placed on AHPs helping to prevent as well as treat disease. AHPs are increasingly being encouraged to have conversations surrounding key areas of public health e.g., smoking cessation, healthy diet, exercise etc. in line with interventions such as 'making every contact count' [9] and 'the active and independent living programme in Scotland' [10.] These discussions and the onward referrals they generate; require a small allocation of time for each patient.

Standards for Best Practice: Current Content

Treatment Times: Orthotics

- 4.4.1** Care episodes are recommended in 20-minute treatment blocks
- They should be differentiated as:
- (1) Initial assessment and analysis
 - (2) Measurement and device specification
 - (3) Trial evaluation of the device
 - (4) Supply and final evaluation of the device
 - (5) Review and fine tuning of treatment
 - (6) Final review of treatment outcomes
- Each block includes time for a record to be made at each stage without exception. This recommended time does not include the time required for the Orthotist to conduct essential user-related tasks which support clinical activity
- 4.4.2** Responsibility for screening written referrals lies with the Orthotist who may delegate this locally to a designated individual working within a defined protocol. This enables clinical prioritisation and allocation of appropriate treatment times. More complex cases may require the allocation of more than one time block
- 4.4.3** The initial history-taking is to be included in the assessment time which should be considered separately to the measurement and specification process
- 4.4.4** The number of treatments per clinical session may be allowed to vary dependent upon such factors as the accuracy of clinical screening of referrals and the degree of 'live' clinic cover required. It is recommended that one or more treatment times per session are left empty to accommodate local conditions and achieve a balance in the workload of the clinician
- 4.4.5** The requirement and format for a review appointment should be specified and documented during all episodes of care once agreed with the service user.
- 4.4.6** The recommended times are for fully-competent practitioners only. For Orthotists with less than one years' experience, or for more complex cases, it is advisable to increase these times to reflect the level of experience or complexity
- 4.4.7** If more time is required than an appointment allows, then this should be explained to the patient and a further appointment made

Issues identified with current content

The following points were raised as issues with the standards in their current form.

Undefined tasks as part of the appointment

No clear guidance on what parts of patient-specific administration tasks should be included as part of appointment times, or when else these tasks should be completed. These include order placing, clinical note entries, onward referrals, inter-professional correspondence.

Care episode blocks

The current guidelines recommend a 20-minute block of time per 'care episode' included in each appointment. These are defined as:

- i. Initial assessment and analysis
 - ii. Measurement and device specification
 - iii. Trial evaluation of the device
 - iv. Supply and final evaluation of the device
 - v. Review and fine tuning of treatment
 - vi. Final review of treatment outcomes
- With 40 minutes allocated to those with a 'complex pathology'

By this method of time allocation, a stock insole appointment which includes initial assessment measurement, fitting, and supply of the device could in theory be allocated 80 minutes. An AFO casting appointment for a patient with a complex pathology including initial assessment and measurement would be allocated 1hr and 20 minutes (2 x 40mins.)

BAPO felt this was often excessive, poorly understood by the orthotic community and not adhered to.

Key Proposed Changes

The attached document outlines exactly the proposed changes to the standards for best practice pertaining to treatment times.

Multiple blocks

The simplification of what requires multiple blocks should prevent interpretation of the standards to mean excessive time allocations

Clarification of task inclusion within appointment times

The proposed changes state exactly which tasks should be included in appointment times, preventing tasks left outside of clinic time which need to be 'squeezed in' to orthotist working hours, or completed outside of the working day

Administration slot allocation

In addition to in-appointment tasks, admin tasks which are not single-patient specific (e.g., triaging, answering queries) are highlighted and recommendations are made to allocate time in the clinical diary for this.

Triaging responsibility

This proposal places responsibility for triaging directly with the orthotist – and advises delegation of triaging to non-clinical staff only with appropriate training.

Standards for Best Practice: Proposed Content

Treatment Times: Orthotics

4.4.1 Appointment lengths are recommended to be in blocks of 30 minutes, with multiple blocks allocated if one or more of the following applies:

- a) A complex pathology
- b) A cast, scan, or complex measurement
- c) A multidisciplinary assessment
- d) Difficulties in communication or behaviour
- e) More than one type of orthosis is likely to be required

This is not an exhaustive list and there may be other factors which would require a lengthier appointment as dictated by the Orthotist in line with local protocols.

4.4.2 Appointments include not only time spent with patient, but also time to complete other essential parts of that patient's care. Appointment lengths should include time for the following without exception:

- a) Clinical record-keeping
- b) The raising of any orders
- c) Completion of fitting instructions to technicians or manufacturers
- d) Cleansing of the clinical environment and equipment
- e) Completion of any onward referrals
- f) Public health, or 'making every contact count' conversations

4.4.3 Appointments do not include the time required for the Orthotist to conduct essential user

- related tasks which support clinical activity, including but not limited to:

- a) Triaging referrals
- b) Corresponding with clinical colleagues
- c) Responding to queries.

Where the orthotist is also expected to complete these tasks, one or more blocks of 30 minutes may be left free per clinic to accommodate this as required.

4.4.4 Telephone appointments for triaging, screening, advice, and simple reviews may be appropriately scheduled less clinical time where an assessment is not conducted. Telephone appointments should be allocated a minimum of 10 minutes.

4.4.5 Virtual appointments including a video link should be allocated a minimum of 30 minutes. If, following a virtual assessment, it is decided that a face-to-face appointment is required; the in-person appointment time may be abridged to account for part of the assessment being completed previously by virtual means.

4.4.6 These recommended times are for competent practitioners only. For orthotists with less than one year's experience or occupational health needs, times should be increased to reflect this.

4.4.7 If more time is required than is allocated at the appointment, this should be explained to the patient and a further appointment made with the required time. Appointments should not be rushed as this can lead to mistakes in care. It is the responsibility of the orthotist to ensure adequate time is allocated for their patients and to manage their caseload safely, whilst optimising time spent and productivity.

4.4.8 Responsibility for screening and triaging written referrals lies with the Orthotist who may delegate this locally to a designated individual working within a defined protocol. This enables clinical prioritisation and allocation of appropriate treatment times.

Standards for Best Practice: Current appendix

APPENDIX 2: ORTHOTIC SERVICE USER TREATMENT TIMES

All times have been rounded to the nearest twenty minutes. In most cases, the contact times have been rounded up, but in some instances, these have been rounded down. These contact times include the requirement to make a clinical note of the episode of treatment.

These contact times are for guidance, and it is expected that in some instances longer time slots will be required. Custom spinal orthoses and knee ankle foot orthoses are examples of treatments typically associated with requirement for longer appointment time. The clinician must consider the service user holistically when scheduling appointments as comorbidities or social circumstances may warrant an extension of planned contact times.

The treatment times tabled below refer to the amount of time required to deal with a single disabling condition requiring one orthotic device. Multiple disabilities would require more time slots to be booked.

These treatment times are expected to be sufficient for experienced clinicians. Those who are beginning a post-graduation preceptorship pathway or who expanding their clinical skills into wider fields must ensure that treatment times are increased until routine experience and skills are developed. The extent of additional time required will likely vary on a local level depending on many factors such as supervision, complexity of caseload, familiarity of administration duties, need to document reflections, etc.

Scheduling of sessions must avoid excessive physical demands on the clinician, which are associated with some casting methods and other clinical procedures. It has been reported that the prosthetic and orthotic professions are subject to risk factors for work-related musculoskeletal disorders (Anderson et al, 2015). Where appropriate risk assessment should be undertaken to generate a plan to safely perform tasks that may pose an increased risk.

Table 1: Recommended Treatment Times

	Simple pathology	Complex pathology
Initial assessment	20	40
Measurement Specification	20	40
Trial Evaluation	20	40
Final Evaluation & Supply	20	40
Review	20	40

BAPO note that in some circumstances an Orthotist may undertake more than one stage of the treatment cycle within a single clinical contact. In such a scenario BAPO advise treatment times should be lengthened to ensure that all stages can be completed fully within the given contact time. An example of this is when a clinician undertakes an initial assessment, measurement, 'off the shelf' orthosis trial, evaluation, and supply within a single session. The Orthotist must extend contact time appropriately to suit the specific tasks, in accordance with their level of practice. BAPO recommend that all stages of the treatment cycle are undertaken for each episode of patient care. Aspects of this may be undertaken by support staff who are supervised by the clinician as outlined in the Section 2 of these standards (Role of the Prosthetic/Orthotic Assistant Practitioner).

The new recommendation is that this appendix is removed completely for clarity.

Guidance for Implementation

It is recognised that for many services, implementing a minimum time slot of 30 minutes for all face-to-face and virtual appointments represents an increase in time allocation, and this is likely to impact on utilisation of clinical time and number of patients seen per day. This in turn, without mitigating changes to service design, could lead to increases in waiting times.

The following measures should be considered to minimise the impact of treatment time increases:

Use of Orthotic Assistants / Orthotic Support Workers

Orthotic assistants and orthotic support workers are staff working under the supervision of qualified Orthotists to support the delivery of orthotic care.

Well-trained orthotic support workers often undertake the following roles:

- manufacturing, maintaining and repairing orthotic devices
- supporting and developing manufacturing processes to meet quality standards
- making sure work areas and equipment are maintained and kept clean
- ordering materials and equipment [11.]

Orthotic assistants often undertake similar roles including:

- Fitting simple orthoses
- Writing clinical notes
- Adjusting, repairing, and assembling orthoses
- Assisting Orthotists with complex cast work and completing simple casts as required [12.]

Alleviating these duties from orthotists with the utilisation of assistants should be considered where beneficial to caseload management and optimising the correct skill mix within the team.

Use of telehealth: virtual and telephone-based appointments

Telehealth, defined as ‘the use of communication technologies to deliver healthcare services such as disease prevention, diagnosis and treatment, and other related activities as research and staff training’ [12] is being increasingly used within the NHS and in orthotic services [13, 14.] Its use in many settings has been found to give ‘comparable or higher outcomes than face-to-face consultations, good patients’ satisfaction, greater accessibility, convenience, and reduced travel’ [13.] It has the potential to reduce health inequalities and the burden of treatment [15]. Governing bodies are encouraging increased use of telehealth within outpatient services [17, 18] and the NHS Long-term plan aims to reduce face-to-face outpatient appointments by a third over five years by using virtual and telephone-based appointments [19.] Telehealth has also been found to be an appropriate way to make use of clinicians, who may be isolating or needs to work from home [13.] BAPO recommends implementing virtual and/or telephone appointments for appropriate areas of orthotic practice. BAPO plans to create more comprehensive guidance outlining the ways in which telehealth can benefit P&O services in due course.

Removal of ‘administration’ slots

The new treatment time guidelines clearly outline what should be completed as part of the appointment slot. Where orthotists are not expected to complete additional duties, including but not limited to; triaging referrals, corresponding with clinical colleagues regarding service or patient-related matters, and responding to queries, administration slots may be removed from the clinical day and instead used for patient appointments.

Patient initiated follow-ups / Patient initiated review

Patient initiated follow-up (PIFU) is a method of patient management following the completion of an episode of care. Historically for many services across the NHS, patients with ongoing health needs have been provided with recurring routine reviews. PIFU is the method whereby patients are not formally discharged from the service for a period of time but are only given a follow-up appointment at their request.

NHS England is now promoting the use of PIFU and promotes its benefits for patients: '(PIFU...) makes it easier and more convenient for patients to receive care and support when they need it, whilst avoiding unnecessary trips to hospitals and clinics, saving them time, money, and stress,' [20.] NHS Scotland also recommends the implementation of a patient-initiated review for the management of outpatient clinics [21.]

Using this method of caseload management reduces unnecessary appointments and ensures that those patients who feel they need care most are able to access it.

More information on PIFU is available at: <https://www.england.nhs.uk/outpatient-transformation-programme/patient-initiated-follow-up-giving-patients-greater-control-over-their-hospital-follow-up-care/>

Review of referral acceptance criteria

Regular review of referral acceptance criteria is recommended as services within trusts change. Where neighbouring services such as podiatry, vascular nursing and occupational therapy have the relevant skills and capacity, referrals for simple insoles, compression hosiery and basic upper-limb splinting may be diverted to these services where appropriate. Many orthotic services across the UK have criteria in place for referral acceptance and it is recommended that this is routinely reviewed to ensure appointments are only offered to those patients where the skill of the orthotist is required. This should remain in line with local policy for referring rejected referrals onwards to more appropriate services.

Regular capacity and demand modelling

Services should regularly review the capacity they are offering, and the demand being placed upon them. Precise predictive models and statistical consultation should be sought where needed to ensure accuracy in capacity and demand planning. Where these recommendations represent an increase in standard appointment times, these services should consider an immediate capacity and demand remodel and review. These changes may inform job planning and alter clinical hours to contact (CHtC) deployment metrics. Further information and exemplification of this process are available at: <https://www.england.nhs.uk/wp-content/uploads/2021/05/increasingp-clinical-capacity-of-ahps-using-job-planning-at-ipswich-hospital.pdf>

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