The impact of commissioning and contracts on the training, education, and development of prosthetists and orthotists

A review and recommendations

Contents

Glossary of terms

Allied Health Professions (AHP)
A group of fourteen health professions regulated by the Health and Care Professions Council (HCPC).

Block contract
An annual spending envelope for delivering a service, sometimes regardless of the number of patients treated, the type of care provided, or quality of care. The advantage is that they provide certainty of income to providers and certainty of spending to commissioners. The disadvantages can include limited incentives to improve quality and to be responsive to patient needs.

British Association of Prosthetists and Orthotists (BAPO)
The professional body representing prosthetists and orthotists and the wider prosthetic and orthotic workforce in the UK.

Contracted Service Provision
Services provided by external prosthetic and orthotic companies, procured by the NHS to provide services to the NHS.

Continued Professional Development (CPD)
Learning activities that professionals engage in to develop and enhance their personal skills and proficiency throughout a professional's career. All POs must be registered with HCPC in order to practice. CPD activities are a requirement for continued registration with the HCPC.

The four pillars of practice
The four pillars of practice are fundamental concepts used across allied health professions, including Prosthetics and Orthotics to ensure a well-rounded and comprehensive approach to professional learning, development, and practice. Practice-based learning activity during pre-registration education should cover all four pillars.

Freedom of Information (FOI)
Refers to Freedom of Information, referring to the right of the public to request and receive information held by public authorities, as outlined in the Freedom of Information Act 2000.

Health and Care Professions Council (HCPC)
The statutory regulator for health and care professions in the UK, ensuring public protection by setting and maintaining standards for education, training, skills, behaviour, and health of registered professionals.

Higher Education Institution (HEI)
Universities (and sometimes colleges) that provide higher education and training programmes.

Integrated Care Board (ICB)
ICBs are NHS organisations responsible for planning health services for their local population. There is one ICB in each ICS area. They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to improve outcomes for patients and to get the best possible value for money from the funding they receive.

Integrated Care Systems (ICS)
This is a broad alliance of partners who all have a role in improving local health, care and wellbeing. They may also include social care providers, the voluntary, community, and social enterprise sector and others with a role in improving health and wellbeing for local people such as education, housing, employment or police and fire services.

Key Performance Indicators (KPIs)
KPI stands for key performance indicator, a quantifiable measure of performance over time for a specific objective. KPIs provide targets for teams to aim for, milestones to gauge progress, and insights that help people across the organisation make better decisions.

Mutli-disciplinary team (MDT)
A group of health and care staff who are members of different professions (e.g. physiotherapist, prosthetist/orthotist, and a nurse), that work together to make decisions regarding the treatment of individual patients and service users.

NHS England (NHSE)
The body responsible for overseeing the NHS in England.

In-house Service Provision
Prosthetic and orthotic services provided by the NHS for NHS patients. The NHS directly employ the prosthetists, orthotists, and wider support workforce to deliver the service.

Practice-Based Learning (PBL)
Learning that takes place in a practical, real-world setting, such as within a prosthetic or orthotic department.

Prosthetist/Orthotist (PO)
An HCPC registered healthcare professional. POs are autonomous clinicians responsible for the assessment, design, fitting, and review of prosthetic and orthotic treatment interventions.

Prosthetics and Orthotics (P&O)
The profession which encompasses the entire P&O workforce.

Services/session-based contracts
Provision of a prosthetist/orthotist for a fee per session: where a service is made up of a number of clinical sessions.

Supporting Professional Activities (SPA)
This is time that is considered necessary to maintain and improve the overall level of service within the NHS. Time to practice the other three pillars of practice outside the clinical activity pillar. SPA can Include training, education, CPD, audit, research, clinical management, clinical governance, service development, teaching etc.

Whole-time equivalent (WTE)
A measure used to calculate the number of full-time equivalent staff based on hours worked. For example, a person working 22.5 hours would be counted as 0.6 WTE.

Authors

Kay Purnell, a freelance consultant with senior management experience in the field of prosthetics and orthotics, led the project, completing the interviews, the FOI, surveys and analysing the findings.

Dr Nicky Eddison, BAPO Chair, provided strategic oversight of the project and peer review of this report.

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Foreword

The health and wellbeing of patients who rely on prosthetic and orthotic (P&O) services are inextricably linked to the capability, morale, and professional growth of the clinicians who serve them. As the professional body for prosthetists and orthotists in the UK, the British Association of Prosthetists and Orthotists (BAPO) has long recognised the importance of embedding education, training, and development into the structure of P&O service provision. This report – commissioned by BAPO and funded by NHS England – sheds vital light on the reality of workforce development across a diverse landscape of service delivery models.

Through detailed analysis, this report illustrates a disparity between in-house and contracted services in the provision of professional development opportunities. At its heart, this work is not only a call for equitable access to training but a call for recognition: recognition that prosthetists and orthotists – whether employed directly by the NHS or working within commissioned services – deserve to be supported, developed, and empowered in their roles.

The findings presented here expose a system where clinical services are too often viewed through the narrow lens of procurement rather than as a critical part of patient care. This approach has contributed to the underfunding of training, the marginalisation of smaller services, and the erosion of a sustainable workforce pipeline.

Yet this report is also a roadmap for change. Its recommendations provide clear, evidence-based steps to improve the commissioning of P&O services, foster meaningful integration within NHS structures, and ensure that clinicians are equipped not only to meet today's demands, but to shape the future of the profession.

We extend our thanks to all those who contributed to this work – across Trusts, Health Boards, contracted services, and the wider P&O industry. Their insight and honesty have made this report a powerful instrument for progress.

The future of P&O services depends on a workforce that is supported to grow, to lead, and to innovate. It is our hope that the evidence and recommendations laid out in this report act as a catalyst for the change that the P&O profession – and the patients they serve – deserve.

Executive summary

The British Association of Prosthetists and Orthotists, funded by NHS England, conducted a comprehensive review into how education, training, and development are integrated within the commissioning of P&O services. The project aimed to identify the impact of different contracting models on workforce development, highlight challenges, and provide actionable recommendations for more sustainable and equitable service delivery.

Key Findings:

Contract Models Vary Widely: P&O services are delivered through a mix of in-house NHS provision and commercial contracts. Around 60% of orthotic services in England are commercially contracted, often under session-based or block contracts that lack flexibility for workforce development.

Inequity in Access to Training: Protected time for continued professional development (CPD) is significantly more prevalent in in-house services than in contracted services. Funding for training and development is often excluded from contract terms, particularly for contracted services, resulting in lower morale and retention challenges.

Barriers to Education and Development:

- Contract terms do not require or fund training.
- High caseloads and staff shortages restrict access to CPD.
- A lack of outcome reporting and job planning further obscures service effectiveness and workforce needs.

Impact of Viewing Services as Product-Centric: Orthotic services are often treated as procurement-based rather than clinically led, limiting strategic investment in workforce capability and undervaluing the clinician's role.

Workforce Sustainability at Risk: The profession faces high attrition, with only 34% of surveyed prosthetists and orthotists (POs) stating they definitely planned to remain in the profession over the next five years—driven by a lack of progression and training opportunities.

Lack of Leadership and Integration: Few POs hold advanced or consultant roles, and contracted staff often lack integration within NHS organisational structures and leadership pathways.

Training the Future Workforce is Challenging: Placement opportunities for learners are limited due to staffing, space, and inadequate incentives in service contracts.

Recommendations:

1. Update the 2015 Orthotic Service Specification to include protected time and funding for workforce development and include relevant KPIs.
2. Integrate Workforce Training into Contracts, ensuring equitable access to CPD for both in-house and contracted staff.
3. Improve Contract Design by engaging framework providers, commissioners, and clinical leaders early in the procurement process.
4. Enhance Data Collection and Reporting on service outcomes and training to support workforce planning and secure long-term investment.
5. Promote Leadership Opportunities and Role Development within the profession, including the use of the apprenticeship levy and access to advanced practice training.
6. Support Learner Placement Expansion through formal recognition and funding in contracts.
7. Involve Chief AHPs in commissioning and oversight to advocate for integration and development of the P&O workforce.

Dr Nicky Eddison
Chair, BAPO

Introduction

The British Association of Prosthetists and Orthotists (BAPO) is the professional body that represents prosthetic and orthotic (P&O) professionals and associate members in the UK.

As part of a wider commission of education and workforce reform projects, BAPO was commissioned and funded by NHS England to explore how education and training are embedded into commissioning locally for orthotics and with specialised commissioning for prosthetics, with a view to either illustrating how education and training, and career pathways fit into existing contracting, or to work with commissioners to support understanding and new models of commissioning and supply, and retention of the workforce.

This report outlines the findings from the project, which sought to explore the following:

- The current model of supply for P&O services
- The types of contract models utilised in P&O services
- Prevalence of commercial contract styles in P&O
- The role of framework providers in contracted services
- The impact of viewing P&O services as product-centric rather than clinical services
- The impact of below-cost pricing of commercially contracted P&O services
- Benefits of protected time for training and education
- Barriers to protected time for training and education
- Funding of training and education for POs
- The impact of contract models on training and education in P&O
- The role of a National Service Specification
- The integration of the P&O workforce within provider organisations
- Development opportunities for P&O staff
- Embedding the four pillars of practice in P&O services
- Training the future P&O workforce
- The potential role of the Chief AHP (or equivalent) in advocating for P&O services

This report is divided into six sections:

1. **Section one introduces the report**
2. **Section two outlines the context informing the report**
3. **Section three outlines the project methodology**
4. **Section four presents the findings of the project**
5. **Section five outlines the discussions and recommendations**
6. **Section six outlines the key outputs of this project**

The report provides an exploration of the provision of training and education in the current commissioning and contracting of P&O services and considers the potential barriers to delivering training, education, and development for the P&O workforce.

Context

Continued Professional Development (CPD), training, education, and development are the backbone of a 'healthy' Allied Health Profession (AHP) workforce yet are rarely a focus of attention in the service specification and tender requirements of contracted P&O services. As such they're not covered within the costs of the contracted session fee/ service contract. While NHS England (NHSE) is working to embed AHPs more widely into many different patient pathways across the NHS and create opportunities for all AHPs to support the Long-Term Workforce Plan (LTWP)[1], there has been less focus on why the training and personal development needed to fulfil such roles have been difficult to deliver for prosthetists and orthotists (POs). A recent report exploring the UK P&O workforce indicated that only 34% of the POs surveyed were definitely planning to remain in the P&O workforce in the next five years, the number one reason for planning to leave was 'a lack of progression opportunities' in addition to a 'lack of ongoing learning and training opportunities'[2].

The need for training, education, and development of all AHPs is littered throughout the NHS Long-term Workforce plan[1], NHS People Promise[3], NHS AHP strategy for England[4] and is advocated by the Chief AHP Officer, regional AHP leads, Integrated Care Board (ICB) Chief AHPs and Trust-based Lead AHPs.

This report explores the barriers to training, education, and development of the P&O workforce across both in-house and contracted services with a focus on additional potential barriers to accessing training, education, and development for the 60% of contracted P&O services in England[5] caused by contracting terms and/or the interpretation of contracts. The intention is to provide recommendations for ensuring the P&O workforce training, education, and development needs are highlighted and understood and that staff in contracted services be treated equitably and valued by the NHS Trusts/Health Boards who contract them.

Opportunities for training and development differ between the large P&O centres which tend to have more capacity and resilience to offer support compared to the many smaller, mainly orthotic, services delivering care closer to home in smaller services and community settings which creates challenges around support networks caused by silo working and a lack of integration within the wider Trust/Health Board due to orthotics often sitting on the periphery of hospital services and often being not well-integrated into the multi-disciplinary teams (MDTs). When services consist of only a small number of POs, the loss of one or two clinicians due to sickness, annual leave, maternity leave, or staff vacancies often results in a reduction of a significant part of the P&O workforce. Thus, the impact of staff shortages in P&O services requires an understanding of the impact by the Trust/Health Board, P&O services can often not absorb the loss of one or two staff members in the way large AHP services can.

The case for the NHS to support the development of P&O services is well documented in many reports over the last 20 years and the ever-present demographic changes in the UK and around the world have prompted suggestions that the demand for P&O services will increase significantly over the coming years putting even more pressure on a struggling profession in the UK[6]. Previous papers in the UK have established the benefits of P&O services in terms of health benefits and quality of life, financial benefits for the NHS, and also benefits for the wider health economy if patients can access P&O services in a timely manner and be treated by an appropriately skilled workforce.[7,8,9]

P&O is the smallest group of AHPs in the UK[10], it is widely documented that the profession isn't growing fast enough to meet demand[2]. The issues faced by the P&O profession are related to both supply pipeline and retention problems.

1 NHS England, NHS Long Term Workforce Plan, 2023

2 N Eddison et al, Profile of the UK Prosthetic and Orthotic Workforce and Mapping of the Workforce for the 21st Century. The British Association of Prosthetists and Orthotists, 2023

3 The National Health Service, NHS People Promise, 2021.

4 Chief Allied Health Professions Office, 'The Allied Health Professions (AHPs) Strategy for England The AHP Strategy for England : AHPs Deliver 2022 – 2027', 2022

5 N Eddison et al Profile of the UK Prosthetic and Orthotic Workforce and Mapping of the Workforce for the 21st Century. The British Association of Prosthetists and Orthotists, 2023

6 Nicola Eddison et al, 'The UK Prosthetic and Orthotic Workforce: Current Status and Implications for the Future', Human Resources for Health, 22.3 (2024), 1–9

7 Business Solutions, Orthotic Pathfinder: A Patient Focused Strategy and Proven Implementation Plan to Improve and Expand Access to Orthotic Care Services and Transform the Quality of Care Delivered, 2004;

8 Hutton J L and Hurry M., Orthotic Service in the NHS - Improving Service Provision., 2009.

9 Centre for Economics and Business Research., The Economic Impact of Improved Orthotic Services Provision., 2011.

10 'The Health and Care Professions Council. Registrant Snapshot. January 2025.'

Methodology

This project utilised a variety of methods to collate data from across the P&O industry, including freedom of information (FOI) requests to all Trusts and Health Boards, a survey to P&O commercial contractors providing services to the NHS, and a survey of regional Chief /Lead AHPs. Complemented by a range of Interviews and discussions with key stakeholders including:

- The Prosthetic Centre Managers Group
- The National Orthotic Managers Group (NOMAG)
- The British Healthcare Trades Association (BHTA)
- Midlands' Provider Chief AHPs
- Midlands' Regional AHP Board
- NHSE AHP Leads
- NHS Supply Chain – Framework provider
- NHS Shared Business Services (SBS)– Framework provider
- NHSE Safe Staffing Project lead

The FOI request was sent to 219 Trusts and Health Boards in November 2024. 98 responses were received. 123 Trusts/ Health Boards declined to provide a response for the following reasons:

- 61 confirmed that no prosthetic or orthotic services were delivered at their Trusts/Health Boards (mainly mental health Trusts)
- 35 did not respond; some stated a shortage of staff
- 27 declined to answer as their service was contracted out – of these 12 survey responses were received from the contractor via the BHTA contractor survey.

96 Trusts/Health Boards responded and two provided two responses each – one for the prosthetics service and one for the orthotic service to make a total of 98 responses.

The 98 FOI responses represented 286 whole-time equivalent (WTE) Orthotists and 115 WTE Prosthetists.

For the purposes of this project, a large P&O service was considered to be a service with more than three WTE POs.

Both 'large' services and small services were represented. 38 of the 98 Trusts/Health Boards were considered to have large services. 61% of Trusts/Health Boards with these larger services were in-house services. 76% of the large services included protected time for Continued Professional Development/Supporting Professional Activities (CPD/SPA).

The contracted services were a mix of large services, mainly where P&O were delivered together, and small services, representing mainly orthotic services.

In the FOI responses, 33% of the 33 in-house services had three or fewer WTE clinicians whereas 74% of the 65 contracted & part-contracted services had three or fewer clinicians.

A survey of contracted services was completed during the same period. Contractors responded for 37 of their services. There was a mix of smaller services and large services.

A survey of regional Chief /Lead AHPs covering 67 P&O services across all seven NHSE regions also informed the findings and recommendations in this report.

Findings

The Current Model of Supply for P&O Services

While there are many similarities in the delivery of P&O services, there are also some distinct and significant differences.

Prosthetic Services:

Prosthetics is a specialised service (specialised services support people with a range of rare and complex conditions). Prosthetic service providers recognise NHSE's service specification: Prosthetic Specialised Services For People Of All Ages With Limb Loss in delivering the service[11]. This is due to be updated in 2025 after an extensive consultation period. BAPO has responded with suggested wording around training and education for inclusion in the specification.

The specification includes a requirement to provide data to NHSE for a patient outcome measure. In the FOI responses, 100% of the English and Northern Ireland prosthetic services (in-house or contracted) referenced this specification.

The responsibility for prosthetic services transfers from NHSE to ICB Commissioners in 2025/26, presenting an ideal time to raise the profile of P&O services to ICB commissioners and Chief AHPs. Prosthetic patients are lifelong users of the service and demand is increasing with patients living longer, growth in vascular deficiency in the diabetic patient population, an increase in the prevalence of diabetes, and new amputees derived from accident traumas and congenital deformities.

The majority of English prosthetic services are delivered by the three large commercial service suppliers, mainly contracted by NHS Trusts/Health Boards to deliver services within large NHS facilities or contractor-owned facilities which offer clinic and workshop space for prosthetists, support workers, other health professionals, and technicians. Two Prosthetic services are directly commissioned by ICBs. These 'fully managed services' are block contracts with activity and patient outcome key performance indicators (KPIs) as per the national specification. And there are a handful of smaller NHS in-house prosthetic services in England along with seven large NHS in-house services in Scotland and Wales.

11 National Health Service (NHS) England and NHS Improvement, Complex Disability Equipment – Prosthetic Specialised Services For People Of All Ages With Limb Loss, accessed March 2025.

There are 43 prosthetic centres in the UK. These services form a network of tertiary services across England. In addition to this, all enhanced services support a number of standard and satellite centres in a "hub and spoke" model, with the addition of outreach services into the local acute Trusts. The three commercial prosthetic service suppliers also provide prosthetic componentry, customised products, and stock items. In addition, there are a small number of prosthetic componentry companies who do not offer NHS clinical services but often offer private clinical services.

Prosthetic services are mainly consultant / medically led services, led by vascular or rehabilitation consultants. The presence of a consultant at the head of a prosthetic service may be seen as the only model to follow and thus, overlook the potential opportunities to progress clinicians into consultant prosthetist roles. Currently, there are no consultant prosthetists working in the NHS. With the lack of available vascular and rehabilitation consultants, it appears a prime opportunity to develop consultant prosthetists and advanced practice prosthetists to become leaders within the structure of the service.

The geographical distance between prosthetic services means that moving to another service is potentially more challenging and many prosthetists remain in the same service centre throughout their careers with few, if any, progression opportunities.

Conversations with service providers suggested that with few courses available, post-graduate prosthetic training courses are often provided internally either within the individual graduate's centre or via national group sessions organised by the service provider and delivered by clinicians within the service providers centres. These cover practical sessions such as casting techniques and alignment, there may also be anatomy & physiology and new prosthetic techniques. The prosthetic product suppliers provide product training and certification on products where required, they sometimes include wider ranging training on techniques and new technology updates as part of their product training sessions. More generic courses around outcome measures, leadership etc. can be accessed via BAPO, however, there is limited availability of suitable prosthetic-focused courses compared to the broader range of orthotic-focused courses more readily available through both BAPO and the large number of orthotic product suppliers. There is no charity funding for prosthetist training as there is for orthotist training.

88% of the prosthetic service centres who responded to the FOI, also house an orthotic service, often contracted together, but not always.

Orthotic Services

Orthotics is not a specialised service and while there is an NHS Orthotic Service Specification it is not mandated or referenced by all orthotic services contracts. Where specialised services support people with rare and complex conditions, orthotics services support people with relatively common, sometimes acute, but often chronic conditions with a range of complexities. Orthotic services are locally commissioned either directly by the ICB or more often via an NHS Trust/Health Board which either employs orthotists and delivers the service 'in-house' or contracts out to a third-party commercial company to deliver the service at the Trust/Health Board.

In the main, orthotic products are not produced on-site but procured either from the many custom and stock product suppliers or through the contractor who supplies the orthotic service. Contractors have a central fabrication facility to produce customised orthoses and provide stock orthoses for the prescriptions and orders from all the services attended by their clinicians. Of those orthotists working in NHS services, approximately 55% are employed by commercial companies, and 45% are directly employed by the NHS[2].

The majority of the English and Northern Ireland orthotic services that are contracted to a commercial provider are delivered by the three large orthotic service companies along with seven smaller orthotic service suppliers. Outside the orthotic services delivered in the large P&O rehabilitation centre settings, many orthotic service companies are contracted by NHS Trusts/Health Boards to deliver services in NHS outpatient clinics in smaller acute hospitals and a variety of community settings.

Large NHS in-house services make up the rest of the orthotic service provision in England, Wales, and most of Scotland.

The 2015 NHSE paper[12] helped to provide guidance for orthotic services to improve the service delivered to patients and referenced a new 'exemplar' specification which:

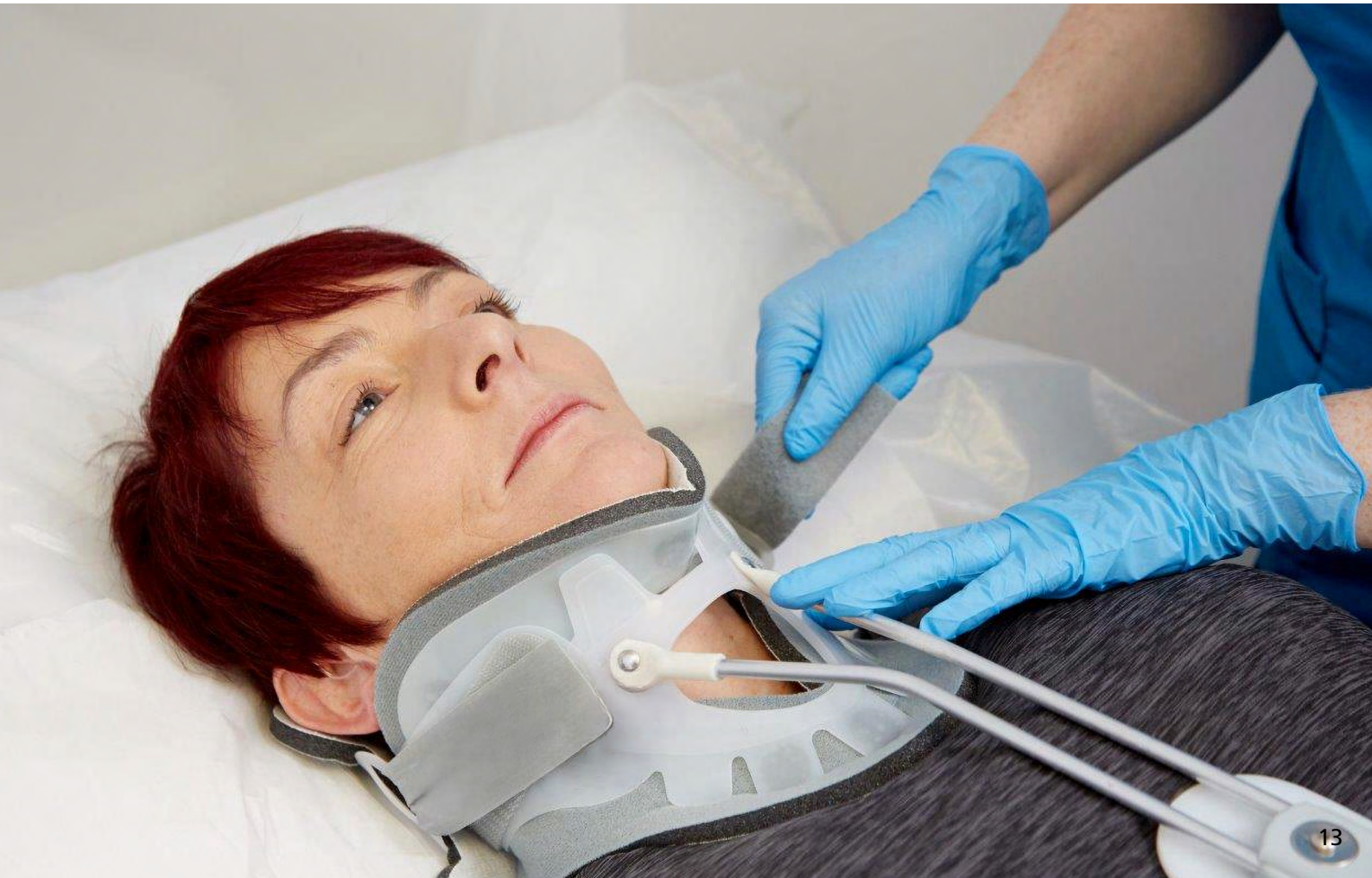
- illustrated key service improvements such as delivering orthotic care closer to home
- encouraged Clinical Commissioning Groups to form an interest in orthotic services
- suggested KPIs aimed at improving the delivery of orthoses to patients

Of the 72 English Trusts providing orthotic services who responded to the FOI, 49% confirmed that the NHS Orthotic Service specification was referenced in their service delivery.

Unlike prosthetic services, many orthotic services are delivered in hospital outpatient departments or community settings to support care closer to home. Orthotic services support many different specialties via several different routes, such as consultant-led pathways or direct GP access. For example, orthotists may be called on to support a spinal surgeon in theatre, a patient with diabetes requiring special footwear in their own home, or a child with cerebral palsy in a special school. The diverse nature of orthotic practice may be one of the reasons that its outputs are overlooked, as they are involved in many different clinical pathways, rather than providing their services in a more concentrated way to one or two patient pathways. This makes orthotic services important to the care of a wide range of patients but the 'nuances' around the service delivery results in them being 'hidden' and thus, not at the top of anyone's list.

One 'advantage' to orthotists (and orthotic technicians and orthotic support workers) wishing to undertake all levels of training and education is the availability of funding from the Orthotic Education Training Trust (OETT), which funds a proportion of the course fees for many different courses and further education. The fund has a finite pot of funds each year and the fund's trustees assess and update funding policies based on demand. The FOI responses suggest that OETT funding supported both in-house and contracted service orthotic teams. Prosthetists, however, do not have access to such funding.

12 NHS England, Improving the Quality of Orthotics Services in England., 2015 <available: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/orthcs-final-rep.pdf [Accessed 8%0ANov2018].>.



The types of contract models utilised in P&O services

In-house and commercially contracted P&O services are funded in the following ways:

Block Contracts
Based on a set amount of funding to cover all service, products and repair costs for an agreed number of patients.

Local tariffs
Where prices for healthcare services are determined by local NHS commissioners and providers, per patient seen and product prescribed.

Fully managed service (contracted only)
With full responsibility and liability for the service resting with the contractor which could include premises and administration staff.

A service plus custom and stock product produced and distributed by the service provider (contracted only)
The service provider employs the clinician and/or orthotic support worker, produces custom products and provides stock product distributed by the service provider.

A session-only contract (contracted only)
Provision of an orthotist(s) for a fee per clinical session: where a service made up of a number of clinic sessions is tendered by the Trust/Health Board. In addition, the successful contractor has the opportunity but no guarantee of custom and stock product sales into the Trust/Health Board along with any other product provider.

The financial pressures in the NHS have caused Trusts/Health Boards to transfer that pressure onto their suppliers, and this has driven the 'commodification' of many P&O clinical services over the last 20 years with the 'clinical quality' element somewhat lacking in the detailed requirements of the Trust/Health Board when a contract is drawn up. The contracts may ask for assurances to deliver the services, but the funding and contracting tend to focus on activity and product cost.

It should be noted that the style of contract often remains unchanged from one contract term to the next as many P&O services receive little scrutiny at Trust/Health Board or ICB level, resulting in no impetus to change the requirements unless excessive complaints are received. This is in part due to the small size of these services, which are often unseen by NHS managers and commissioners.

Prevalence of commercial contract styles in P&O

From the contractor survey, 73% of contracts were reported to be service and session-only models. It is often the case that the agreed session fee is fixed for a number of years and so does not include an annual uplift to cover salary increases. Instead, contractors may be asked to make efficiency savings and use those monies to fund salary increases, this was reported by 10% of services who responded to the FOI.

27% of contracts were classed as a block contract in the survey. Block contracts could be seen to offer more flexibility around clinician costs as long as a set percentage of the block is not allocated to staff costs which could limit flexibility for salaries, training, and education.

Block contracts can cause an issue if service waiting lists, service transformation plans, or other factors are not built into the demand stated in the original tender such that the need to see additional patients or accommodate different referral routes can put further pressure on protected training and education time. Ensuring the Trust/Health Board understands the activity and demand of the P&O service it is tendering, is critical.

There are six ICB directly commissioned, fully managed services under block contracts. The funds for this model go to the commercial contractor directly from the ICB. It is not known what percentage of commissioning funds are retained by the Trust/Health Board who outsource their P&O service, but it is recognised that the proportion of the ICB funding retained by the Trust/Health Board may more than cover the costs to house and support the contracted P&O service.

The role of framework providers in contracted services

The contract value for P&O service tenders means that Trusts/Health Boards usually choose a compliant route to procure their P&O service rather than go out to tender themselves. A framework is seen to offer an efficient option to save time & costs.

Three P&O service and product framework providers operate in England.

- NHS Supply Chain
- NHS SBS (Shared Business Services)
- Health Trust Europe

The framework providers present different approaches to supporting Trusts/Health Boards through a P&O tender process and some have engaged with BAPO and contractor organisations to better understand and support the sustainability of the profession and to inform and advise the Trusts/Health Boards they support with projects that involve the procurement of P&O services.

There are many examples where Trusts/Health Boards do not seem to be aware of the requirements for the service they are procuring or the implications of some of the contract terms, and the framework providers are ideally placed to offer support and encourage the use of appropriate terms in tenders in an effort to develop a more effective service and support the sustainability of the P&O workforce.

In regard to training and education, framework specifications often reference the requirement to undertake CPD to meet the Health and Care Professions Council (HCPC) registration requirements, as would be expected, but rarely ensure ongoing training is provided to develop P&O staff competencies nor the time to undertake such training, not only to meet regulatory requirements but to enhance the skills of the clinician. Where it is stated, the requirement to deliver CPD is rarely audited by the commissioning Trust/Health Board, even though they are indirectly funding the clinical staff.

The impact of viewing P&O services as product-centric rather than clinical services

Historically, P&O services have been viewed as 'product-centric' services with the services being viewed via a procurement lens as opposed to a clinical lens. Prosthetic services tend to be part of larger rehabilitation and specialist centres and benefit from being immersed in the MDT. Orthotic services tend to be isolated services, with poor integration into the MDT and a lack of understanding by Trusts/Health Boards of how their orthotic services operate. In addition, the benefit of the orthotic devices issued is often not fully appreciated, in terms of patient outcomes, and the savings to the Trusts/Health Boards by utilising conservative treatment as opposed to surgical options and the wider benefits of this approach.

The patient cohorts that regularly utilise orthotic services are poorly understood by Trusts/Health Boards. Most orthotic services have the ability to extrapolate the data to show the orthotic treatments provided, the presenting pathologies, and the patient demographics of the people who access the services. However, such data is rarely requested by the Trusts/Health Boards to guide how the service should be funded.

The lack of understanding of who is accessing orthotic services and the complexity of the presentations, the current and projected activity based on the increase of non-communicable diseases like diabetes, the rise in obesity, and an ageing population makes it very difficult for Trusts/Health Boards to appropriately fund orthotic services and to understand the activity and demand of the service. This often leads to large waiting lists and the subsequent pressure to increase clinic loads. A recent report exploring the UK P&O workforce reported that high workload/caseload and inadequate appointment times were two of the top five reasons POs were planning to leave the profession[2].

As a consequence, orthotic services are largely funded based on historical non-PAYE data which fails to plan for future demand and perpetuates the issue. As a consequence, orthotic services' non-PAYE budget is regularly scrutinised for savings without an understanding of the savings these devices are providing for the Trusts/Health Boards. This approach presents a false economy and adds to the perception by POs that their skills are undervalued.

The impact of below-cost pricing of commercially contracted P&O services

In addition to the lack of understanding of the activity and capacity needs for orthotic services, commercially contracted services have historically only paid for the patient-facing time of POs; the contractor's income is based on a set fee per session, or part of a block contract; as well as income from providing and selling products prescribed by the POs.

As such, commercial contractors are only paid for the clinical time stipulated in the contract. The commercial contractor needs to plan that only a proportion of the clinician's time will likely be covered by fees received from the Trust/Health Board. Time for training and education will need to be funded by the commercial contractor.

Commercial contractors who do not charge enough to cover the clinician's costs may do so to be competitive but are also implicit in creating some of the current issues the profession is facing. This method was exposed as being unsustainable during the COVID-19 pandemic when contracted P&O clinics were closed, and no products were being made and sold, which resulted in the clinician costs not being appropriately covered. This was a wake-up call to many commercial contractors and might have encouraged more realistic service fees to be charged in recent years.

Supporting the gap between actual staff costs and contracted fees with product sales has become endemic. Such that, for example, engagement in highly effective service transformation work, which adds interest and offers development and training opportunities which could help retain clinicians in the service, may not be brought to the table as they may not deliver product sales that are needed to support clinician costs.

Contractors' concerns about covering the cost of the clinician in these contracts is another reason to push training and education needs down their own priority list. It would take a two-fold approach to remedy this issue; Trusts/Health Boards would need a mechanism to insist on appropriate session fees (i.e. not below cost), and contractors will need to abide by terms around the fees charged per session. One mechanism for Trusts/Health Boards could be to outline the different roles, skills, and expertise of the clinicians required to meet the needs of the patients in a service. By tendering on the basis of matching the clinical expertise to the needs of the service, the contractor can quote a service fee appropriate to the clinician's costs, and it should be more obvious if a contractor is undervaluing a clinician in a tender when comparing different contractors' submitted session fees*.

Contractors have a role to play in how this could be handled by charging Trusts/Health Boards an appropriate session fee to cover the full cost of an appropriately skilled clinician at the point of submitting their tender. The essential role of training needs to be viewed as an essential investment rather than a cost.

Pre-tender engagement and Tender specifications

Pre-tender market engagement is a good way for Trusts/Health Boards to gain information from contractors who deliver services in other Trusts/Health Boards and may reveal new practices, new models of delivery, and other quality-enhancing initiatives. This is one way that contractors can offer suggestions for more efficient delivery of services or pose questions to the Trusts/Health Boards for consideration in their tender and ensure the benefits of training and education are captured within the tender. It is encouraging that the new 2023 Procurement Act will expand the opportunity for pre-tender engagement[13].

Pre-tender engagement could, for example, present ways in which Trusts/Health Boards could restructure their services and potentially save money. For example, the use of support workers in delivering a proportion of the orthotic clinic workload. The FOI revealed that 36% of in-house service clinicians see patients with needs that are low complexity, and this rose to 74% in the contractor survey. A recent BAPO guide highlighted the potential for orthotic support workers to be utilised in patient-facing roles[14].

* Note: NHS bandings do not necessarily directly equate to a contracted clinician's salary so would not be a basis for structuring a tender pricing schedule.

13 The UK Government, 'The Procurement Act 2023: A Short Guide for Suppliers', 2025.

14 Tempest S et. al, Expanding the Potential of the P & O Technician and Support Workforce into Patient-Facing Roles. The British Association of Prosthetists and Orthotists, 2025.

It is essential that job planning is part of the pre-tender process to highlight the capacity to meet demand within the clinic and determine the correct staffing requirements. Job planning is being implemented across AHP services and must include contracted services. BAPO has recently published a guide for job planning for P&O services[15] which should be utilised by both in-house and contracted services; particularly by organisations planning a tender for a P&O service.

37% of Chief AHPs who were surveyed as part of this project, reported that job planning is not currently underway in the contracted P&O service in their Trust nor in smaller (10%) percentage of the in-house services they worked in. 30% of those surveyed reported they didn't know whether job planning was taking place in the P&O service. See figure 1.

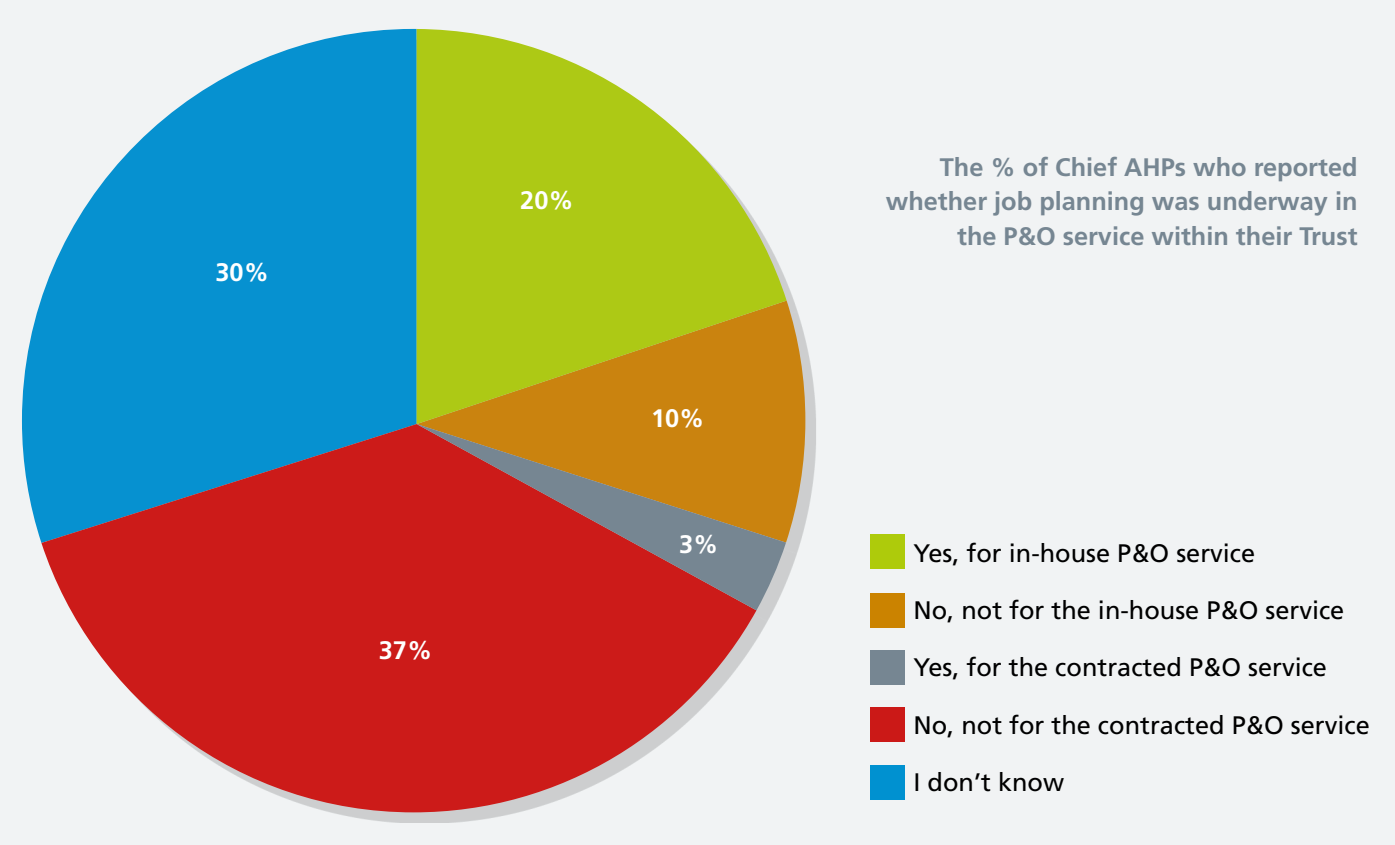


Figure 1: the percentage of Chief AHPs who reported job planning was underway in the P&O service at their Trust

15 Durrant. B, Job Planning Guide for Prosthetists and Orthotists. The British Association of Prosthetists and Orthotists, 2025.

Benefits of protected time for training and education

During this report, the term 'training and education' refers to courses and events outside of any required mandatory training expected by the Trusts/Health Boards

The FOI request asked about the tangible benefits of providing protected time for training and education. The SPA time is recognised by the BMA as 'time that is considered necessary to maintain and improve the overall level of service within the NHS'[16]. 29 / 33 (88%) of In-house services and 19 / 53 (37%) of Trusts/Health Boards with contracted services said they allocated protected time for training and education and suggested a wide range of benefits. See figure 2.

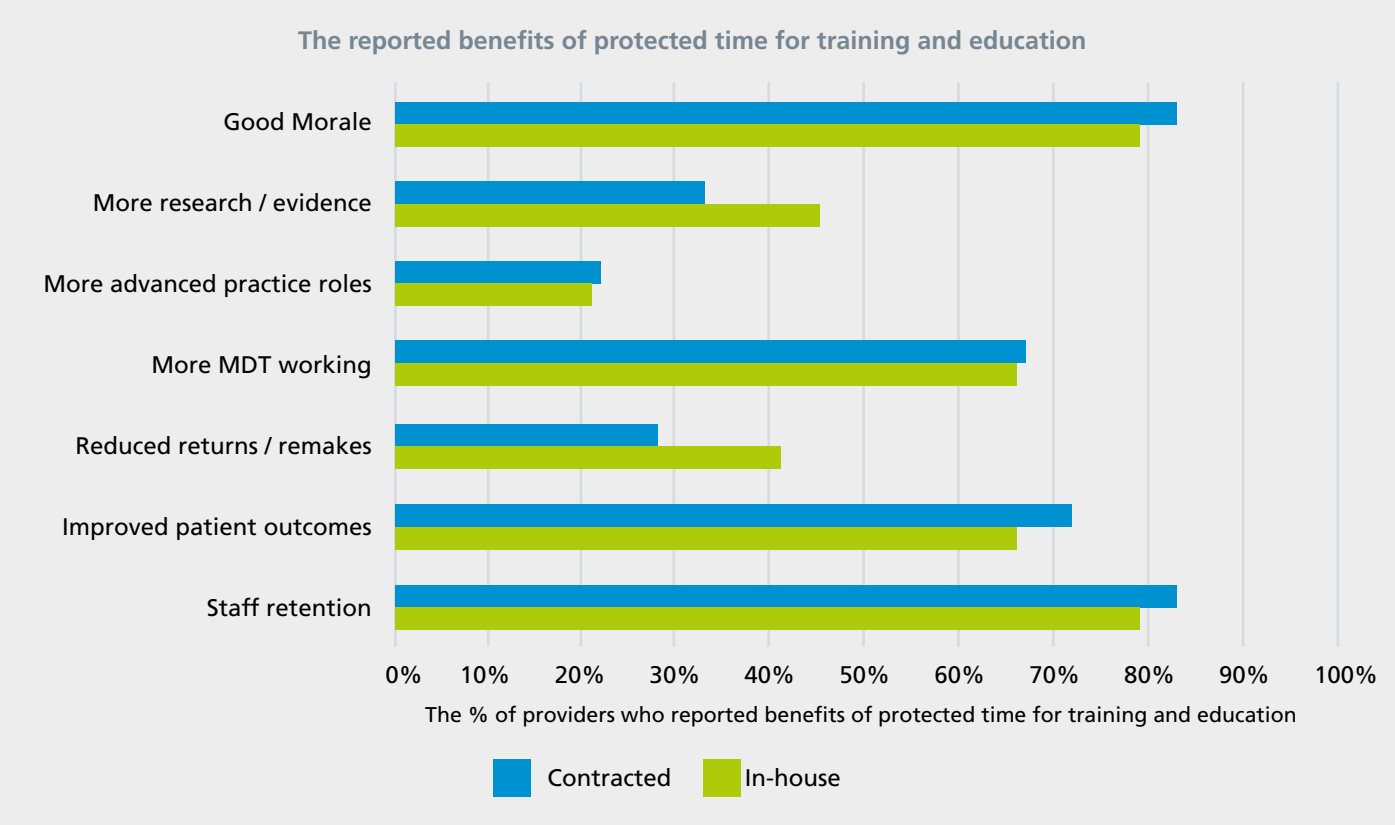


Figure 2: The Reported Benefits of Protected Time for Training and Education for POs

Other benefits included:

- A better understanding of the true capacity to explain demand/capacity gaps for business cases for additional staffing
- Carrying out audits
- Delivering preceptorship
- Clinical training, e.g. delivering part of other hospital courses, interprofessional clinical training, and training across the orthotics team.
- Non-clinical projects, e.g. teaching at universities
- Time for joint multi-disciplinary team appointments
- Peer-supervision
- Service developments achieved, e.g. updated referral guidelines, better self-management resources

16 The British Medical Association, 'Supporting Professional Activities (SPA) Time for SAS Doctors.', 2025 <https://www.bma.org.uk/pay-and-contracts/job-planning/job-planning-process/supporting-professional-activities-spa-time-for-sas-doctors>.

Barriers to protected time for training and education

When asked about any barriers to providing protected time to support training and education, responses covered a wide range of reasons:

- 11 / 53 Trusts/Health Boards with contracted service reported that they were not responsible for training contracted staff or that training must be taken outside contracted clinical hours

This disassociation with the importance of undertaking training and education possibly illustrates why the contracted staff delivering services to the Trust's/Health Board's patients often feel undervalued.

Three out of 33 in-house services failed to respond, for the remaining 30, the main barriers to supporting protected time included:

- Staff vacancies - listed by 43% of in-house services. Whether trying to recruit or unable to advertise - often maternity/paternity leave, long-term sickness etc. These vacancies leave in-house services short-staffed, but the Trust's/Health Board's recruitment policy means that the department is unable to recruit to backfill, with the aforementioned impact of relatively minimal staff shortages in P&O services not recognised. Only 15% of Trusts/ Health Boards with contracted services noted staff vacancy issues but this is likely to be due to contractor vacancies not being visible or impacting their services as the contractor is expected to / contracted to / penalised if they do not deliver the service irrespective of such vacancies.

When asked directly via the contractor survey, 28% of the contracted services noted that staff vacancies were also an issue. See figure 3.

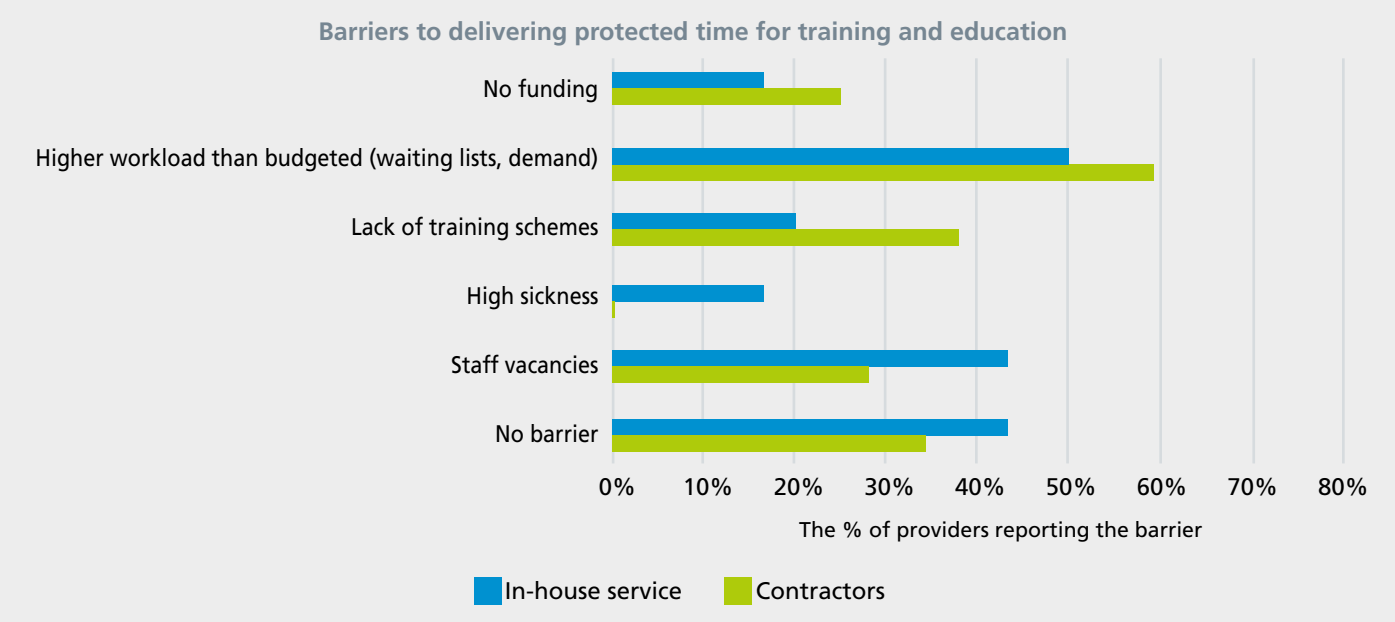


Figure 3: Barriers to Protected Time for Training and Education of POs

- 17% of in-house services noted high sickness rates, however, no sickness absence was reported in any Trusts/Health Boards with contracted services.

The lack of sickness absence reported by contracted services may point to an inequity, where the contractor is expected to / contracted to / penalised if they do not deliver the service irrespective of such absence. Often leading to the use of other P&O clinicians from the wider team, managers, and locums to backfill wherever possible to prevent the penalty of loss of session fees. This will inevitably impact protected time for training and education as covering clinicians are asked to prioritise delivery of a colleague's clinical activity over their personal training and education time.

Both the FOI and the contractor survey highlighted the impact of a 'higher workload than budgeted' as a major barrier to undertaking protected training and education time. The aftereffects of the pandemic and the growing demand due to the UK's changing demographics, as well as waiting time targets and outpatient transformation pressures mean that workloads are higher than expected in over 50% of services.*

An understanding of capacity and demand was a regular theme in conversations with contractors who felt that Trusts/Health Boards often use historical data in the tender process without consideration for the current and future demands that would become the reality when the service commences.

The capacity and demand planning occurring in all areas of the NHS is one of the drivers for job planning being undertaken in AHP services. Neither capacity and demand planning nor job planning has reached contracted P&O services in many cases.

Responses to the FOI revealed that 73% of in-house P&O services had completed or were in the process of completing job planning, this dropped to 33% of the 48 responses from Trusts/Health Boards with contracted services.

Funding of training and education for POs

Another barrier to delivering training and education was funding, to cover, for example, the course costs, the cost of supervision, the cost of backfilling the clinician's CPD time.

The different factors affecting how training and education is funded are presented below.

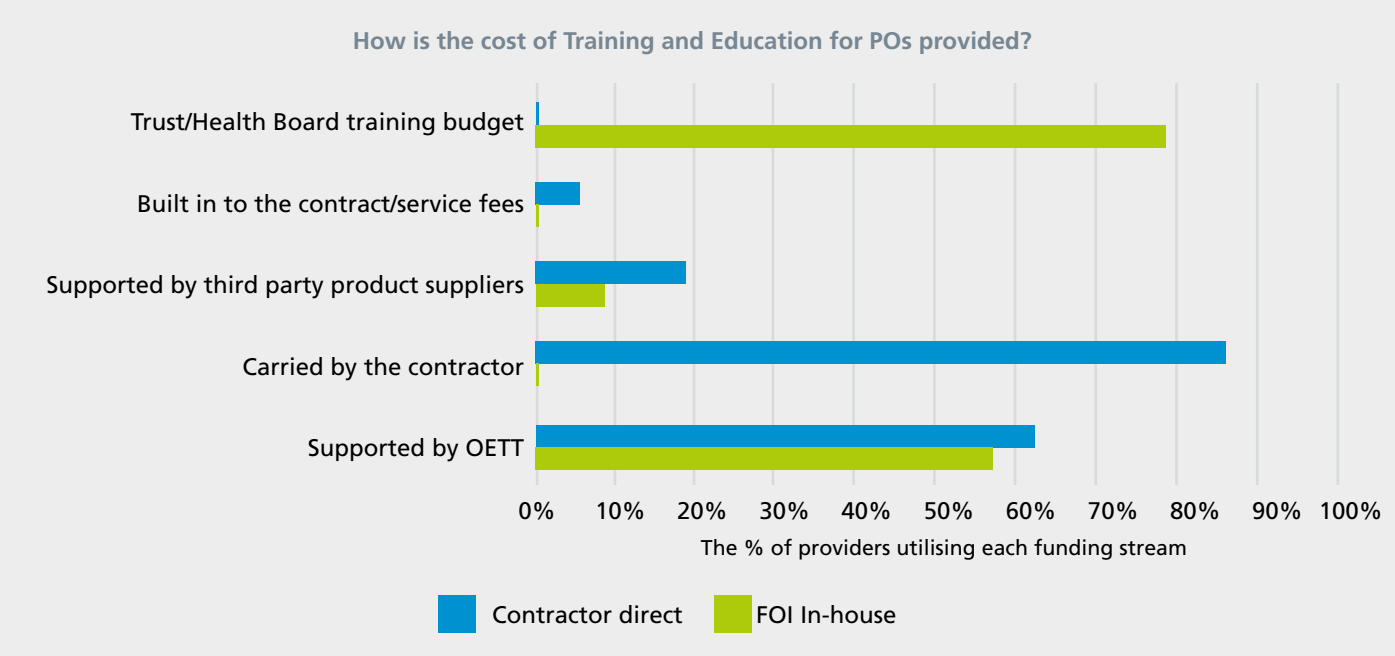


Figure 4: how the cost of Training and Education for POs is provided by in-house and contracted services in the NHS

* Note: Based on attending BHTA meetings and speaking with contractors it is doubtful that the 33% is actually representative of 'genuine' job planning as only one out of the 37 services in the contactor survey said that job planning had been completed. In most cases, outside of fully managed services, contractors cannot control this and don't have the NHS systems to record different types of activity. Contractors need to engage with and support their Trusts/Health Boards customers in their job planning processes - this is an NHS initiative which should be driven by NHS staff but include contracted staff.

For NHS staff, 79% of Trusts/Health Boards confirmed that they offer funding support for training and education, with other 'outside' support coming from product suppliers and the OETT charity funding.

The Trusts/Health Boards with contracted services indicated that in 20% of contracted services, the costs were covered within the contract (this was somewhat different to contractors' views who suggested less than 5% of contracts covered training and education costs). It was clear that many Trusts/Health Boards with contracted services expected the cost to be carried by the contractor, and the contractor survey confirmed this with 92% of the 37 services stating that training and education costs are a cost carried by the contractor. Third-party product suppliers and OETT charity funding were also a funding option for many contracted services*.

AHP training in NHS services has benefited from the Learning Beyond Registration Fund in recent years which has not included contracted AHP. It would seem more equitable if any future iterations of this funding for AHP training and education also included staff contracted to see NHS patients. From conversations with NHSE Regional Teams and AHP Faculty Leads, it is believed that there is support for this change.

In a further training funding-related FOI question, none of the 98 Trusts/Health Boards reported a clinician accessing the apprentice levy for an Enhanced Practice programme and only 1 in-house clinician had accessed the apprentice levy to support an Advanced Practice qualification. This route has not been well publicised in P&O services historically and particularly in the contractor services - the suite of updated enhanced and advanced practice guides produced by BAPO in March 2025[17,18] is expected to encourage more use of this funding route, as would closer contact with the Trusts/Health Boards Lead/Chief AHP to support such training needs.

During interviews and conversations with Lead AHPs, NHS P&O services, and the contractors, the 'desired' CPD/SPA time was typically quoted as 10%-20% or 0.5-1 day of a 5-day working week – it should be noted that as there are no statutory agreements on protected time, none of the interviewees had a policy or specific guidance to identify a recommended number of hours or days for CPD/SPA time per week for AHPs, other than an understanding that CPD is fundamental to the development of AHPs[19].

* Note: OETT supported 103 applications for funding both short-term and long-term (MSc) courses during 2024.

17 https://www.bapo.com/enhanced-practice/

18 https://www.bapo.com/advanced-practice/

19 The Chartered Society of Physiotherapy, 'A Joint Statement on Continuing Professional Development for Health and Social Care Practitioners', 2007 <https://www.csp.org.uk/publications/joint-statement-continuing-professional-development-health-social-care-practitioners>.

The impact of contract models on training and education in P&O

The relatively complex model of P&O service delivery has many interdependencies but the real barrier to undertaking training and education is allocating 'time'. To understand how protected time is lost/reallocated in contracted services an understanding of contract styles and terms is required.

P&O commercial contractors have been providing P&O services to the NHS for many years. It is important to support the retention of POs in contracted workforces as well as the in-house services.

The FOI and contractor survey identified that protected time for training and education was least available in contracted services, and in discussions with contractors, the many smaller orthotic services are the ones that are particularly affected. While many of the P&O centres with larger teams of clinicians may find it easier to plan training and education, backfill colleagues who are undertaking training and education and benefit from management and leadership opportunities, the contracting of the smaller orthotic services raises a set of challenges for contractors.

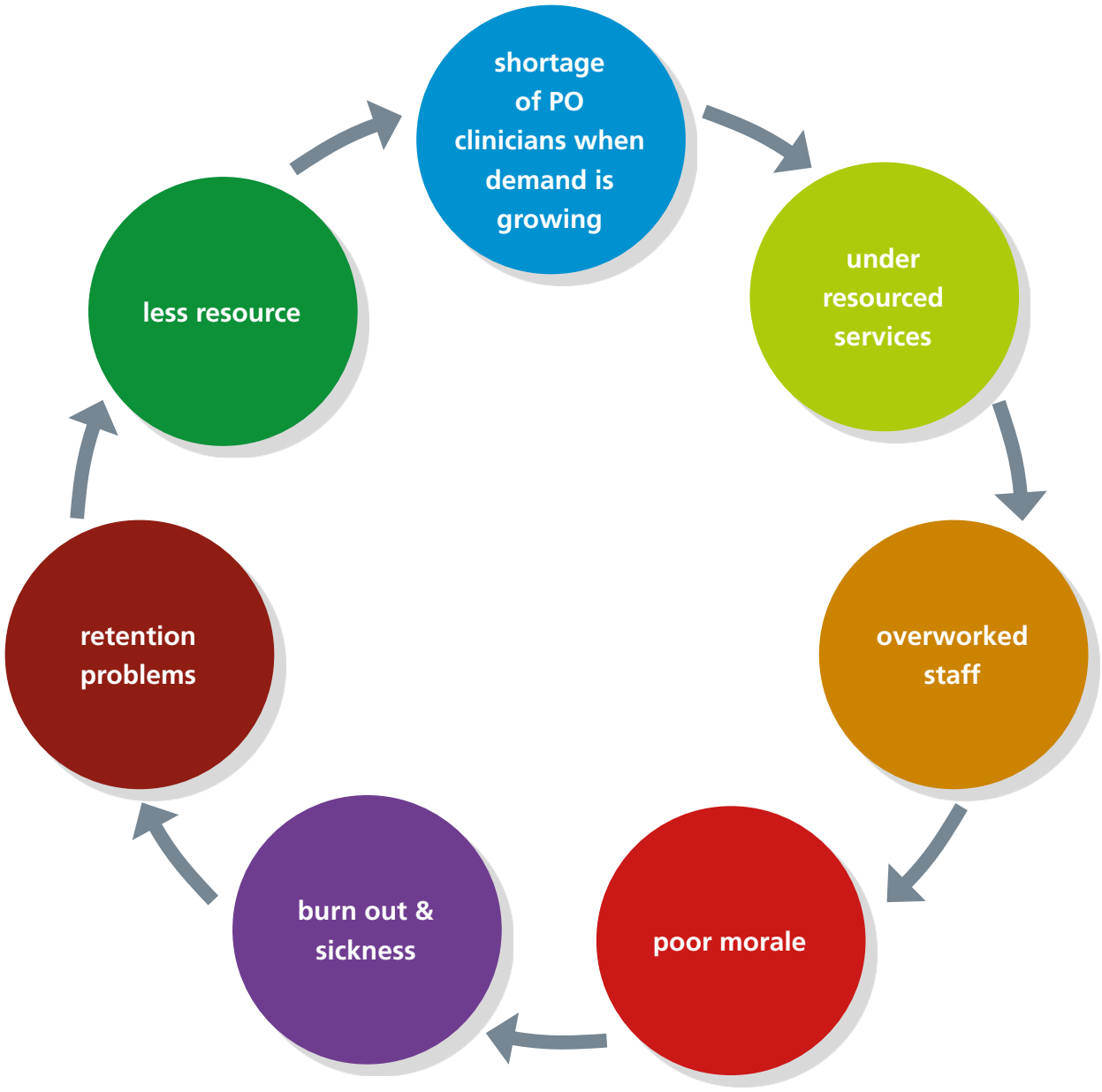
The ability to support protected training and education in smaller orthotic services is often based on how they are contracted and the inflexibility of those contracts. Focussing on the contracted services which account for approximately 60% of orthotic services and where 74% of the contracted services are small, they typically:

- Use frameworks and tender processes which do not differentiate between roles and competencies, which, if they did, would allow contractors to appropriately bid for the wide range of expertise required to support the orthotic patient caseload. In some services, this potentially drives the inappropriate use of graduates in some clinics, as the least costly clinician, and in others leaves experienced clinicians doing low-complexity work.
- The service specification does not reference the training, education, and development which is essential to retain and engage clinical staff. Compare this to other AHPs such as physiotherapists and speech & language therapists where CPD/SPA is built into their job description, the service plans, and the clinician's diary to ensure appropriate time is allocated to training and education.
- Services are often procured by Trusts/Health Boards with 'rigid /restrictive' terms and with little consideration of the service benefits and patient outcomes. For example, activity-based contracts which only focus on activity such as a requirement for two clinical sessions five days per week. Even where the NHS orthotic service specification is referenced, there is a lack of evidence of patient outcomes or any reporting for these services
- Have contracts without annual uplifts to cover wage rises for orthotic staff
- Often requires a small number / one clinician per service who does not have the opportunity to engage with other AHPs at the Trusts/Health Boards, which further contributes to the lower profile of these services within the organisation.

The demands on contractors to support the smaller orthotic services means that the contractor's management teams need to build flexible capacity into their team to cover annual leave, sickness and training requirements. While experienced clinicians (5+ years) will typically be more established in their contracts with a regular weekly clinic list, graduates in the team are required to progress to this stage and in the meantime often have fewer regular clinics and are expected to cover planned annual leave or training time of the more experienced colleagues.

For any unplanned staff absence, it is often the contractor's graduates and (clinically qualified) area managers who are called on to provide clinical cover, as Trusts/Health Boards, do not typically allow the cancellation of contracted orthotic clinics. Note the inequality, where in-house orthotic services will routinely cancel or re-arrange clinics due to unplanned staff absence.

One of the challenges that comes from the need to cover unplanned staff absence is the wide geographical area the contractor's staff are based within. This can mean orthotists must travel long distances to cover an unfamiliar clinic to ensure contracted clinic appointments are delivered. This additional cover is not funded by the contracting Trusts/ Health Boards, putting an extra burden on the contractor from both a cost and time perspective, and contributes to high workloads, poor morale, and subsequent retention issues amongst orthotists.



Whilst contracted POs are entrusted with the care of NHS patients and are key contributors to patient care within the hospital, there appears to be a lack of understanding and responsibility from the Trusts/Health Boards in relation to the well-being of the contracted POs.

Patient outcome reporting

The historical model of activity versus outcome-based contracts leads to cost versus quality-based services. Only 12 (23%) of the fully contracted out services reported being asked to submit any patient outcome measure data or KPIs. The majority of them were joint prosthetic and orthotic service providers where a prosthetic outcome measure is a mandatory NHSE KPI.

In addition, only 24% of the In-house services reported being asked to submit any patient outcome measure data or KPIs. A lack of reported patient-related outcomes makes it difficult to validate the benefits of orthotic services and should be a key feature of any future service specification and tender process.

The NHSE prosthetic service specification requires a specific outcome measure to be reported each month, resulting in 100% of English prosthetic services supplying this information - confirmed by 100% of the English prosthetic services who responded to the FOI. The new prosthetic service specification is also expected to include a nationally recognised and reported outcome measure. It is evident that when the body funding the service mandates reporting of a specific KPI, the data is recorded and reported. The lesson here is 'What gets measured, gets done'.

In orthotic services, this is somewhat turned on its head as what is being done and paid for, is often not being measured in any clinical sense!

This lack of outcome reporting in many orthotic services increases the perception that these services are not valued by the Trusts/Health Boards, and as a consequence, neither are the staff who deliver them. POs have reported 'not feeling like a valued member of the team'[2]. All AHPs would expect to be reporting on evidence-based patient outcomes, and new service development outcomes, and evidencing their existence, impact, and case for investment.

The role of a National Service Specification

Information from the FOI results indicated that 100% of English Prosthetic service providers (in-house and contracted) utilised the national prosthetic service specification in guiding service delivery. Only 40% of the Trusts/Health Boards with in-house orthotic services and 41% with an outsourced orthotic service referenced the NHSE orthotic service specification. Conversely, when commercial contractors were asked the same question 59% reported that their service utilised the NHSE orthotic service specification. The reference to both the NHSE prosthetic and orthotic specifications suggests a more robust approach to the use of the specifications.

The cost of training and education are rarely captured in the service fees charged by a commercial contractor, partly because the need to deliver, record, and report training is not outlined in the service specification or tender documentation. As a result, contractors do not have the means to cover the costs of backfilling the clinician's time and delivery of the training for the POs undergoing training and education.

The NHSE orthotic service specification does not include terms around training and education for POs delivering the service. A solitary sentence states "The Provider will make an appropriately skilled orthotist available". Conversely, there is detail about the clinician's role in training other clinicians from the wider MDT and educating patients and carers, despite there being nothing relating to the PO's own training requirements. P&O service specifications must also include terms around expectations of competence for the clinicians delivering the service, requirements for practice across the four pillars, and a mechanism for continually monitoring training, education, and progression of the POs delivering the service.

Service specifications are only meaningful if applied. If training and education and the associated monitoring of KPIs were added as part of the suite of activity and outcome KPIs, it would only be effective if it was monitored by Trusts/Health Boards. It is therefore essential that Trusts/Health Boards enforce the specifications based on a 'what gets measured, gets done' approach. The current KPIs in the NHSE orthotic service specification are not consistently monitored by Trusts/Health Boards or ICBs, as demonstrated by less than 25% of in-house and contracted P&O services reporting they are requested to provide patient outcome data. To remedy this the ICBs must ensure P&O services are visible to them and request Trusts provide service outcomes for their P&O services.

In-house services and commercial contractors have a role to play in raising standards across P&O and must adopt the recommended service KPIs as part of their reporting. The FOI showed that the majority of contracted service IT systems could record and report outcome measures. Reporting KPIs in this way would have the added advantage of formally publishing the patient benefits and effectiveness of the service. It should be noted that barriers may exist for some of the small P&O services that are still using paper records.

The integration of the P&O workforce within provider organisations

The relationship between Trusts/Health Boards and commercial contractors should be symbiotic, but interviews with commercial contractors highlighted a perceived perception of mistrust towards the contractors; believed to be because they are perceived only in the context of a 'for-profit' organisation, resulting in contractors feeling undervalued. This perceived poor relationship may be a barrier to the integration of the contracted P&O staff within the provider organisation.

It may be that if a service has been contracted out for many years, the (often non-clinical) NHS staff managing that service are unfamiliar with AHP workforce guidance and therefore unaware of any inequity that their contracting may be bringing to clinicians delivering the service, compared to NHS employed AHPs in the same organisation. The involvement of a senior AHP clinical representative at the point of tendering would benefit the finance, procurement, and P&O service manager 'team', who usually undertake the procurement process, in understanding the expectation of training, education, and development within a clinician's role. An AHP advocate from the Trusts/Health Boards staff could also support and improve the integration of the P&O clinical team within the organisation on the award of contract as the service is implemented. To this end, commissioners and contractors should seek out the Trusts/ Health Boards Chief AHP or equivalent for professional support for their workforce at the point of tender and for the duration of the contract.

However, the integration of the P&O workforce is not only an issue for contracted services. In-house P&O services are, in general, poorly integrated. The causes of this are multi-factorial and include:

- A poorly understood service – outcomes rarely reported at a senior level
- A small workforce which is often not visible
- No voice of influence within the organisation – few advanced / consultant practitioners or senior PO leaders
- A low profile within the Trusts/Health Boards
- A lack of integration within the MDT
- Often not seen as an allied health profession
- Incorrectly coded as part of the technical and scientific workforce in HR processes
- The directorate in which the service sits can impact the integration

Training the future P&O workforce

Prior to graduating, P&O learners are required to undertake a number of placements within an in-house or contracted service. Practice-based learning (PBL) placements offer the practical application of the learning as part of a pre-registration P&O programme or apprenticeship, and as such are critical for developing the future P&O workforce.

For several years, P&O education providers have raised concerns about the scarcity of PBL opportunities for prosthetic and orthotic learners. This is particularly the case for prosthetic placements.

The availability of NHS placements is influenced by multiple factors and is further complicated by the contracting arrangements for prosthetic and orthotic services. Currently, the procurement of P&O services does not formally recognise the contributions made by contracted companies offering PBL within contracting and procurement processes. As a result, PBL provision relies on informal 'goodwill' arrangements between education providers and contracted service providers.

Every stakeholder in the P&O industry is aware of the benefit of placements and PBL but the lack of provision in P&O service contracts is severely hampering the ability of commercial providers to offer an adequate number of placement opportunities. In addition, the underfunded in-house P&O services that have not been provided with adequate funding to meet their activity often do not have the allocated time built into their day to support learners. A recent report commissioned by BAPO indicates that PBL demand as a proportion of the P&O workforce size is small (27%) and thus, the PBL demand should be comfortably met by the P&O workforce[20]. The fact that it does not, indicates that other barriers are present.

Contractors reported the following issues with practice placements:

- If the service has staff vacancies, maternity leave, or long-term sickness absence they do not offer to take a learner.
- The contractors reported a perceived lack of underpinning knowledge and skills that they would expect learners to have to be able to fully participate in clinical activity, which they felt added to the burden of managing PBL placements. 50% of contractors felt a need for the learners to show increased skills before commencing placements. In the contractor-specific survey, respondents noted the following lack of both practical and personal skills in learners and graduates:
  - footwear knowledge
  - casting and alignment
  - life-skills such as time management and dealing with patients
  - lack of 'self-starter' attitude (required to become an autonomous clinician)

  These issues may be pointing to a disconnect in the expected knowledge and experience learners and graduates should possess and the unreasonable expectations required to fit into a busy and pressured clinical environment and contribute to reducing service pressures. The lack of skills highlighted may also be highlighting that the education of P&O learners is focussed heavily on the clinical pillar at the detriment of the other three pillars. Resulting in a less rounded clinician without a wide range of skills.
- Available physical space was also highlighted as a potential barrier, i.e. lack of space for more than one clinician per clinic or no adjacent clinic rooms for appropriate supervision. Whilst only 6% of in-house services stated that their clinic space was inadequate, 18% of contractors felt the space was inadequate.

While all graduates should be given a dedicated preceptorship period and the space to build on the foundational knowledge they have acquired through their degree or apprenticeship, these unreasonable expectations may be a prime driver in P&O having the highest level of attrition amongst all the allied health professions for graduates leaving the profession within the first four years of practice[20].

It has been recommended that the number of practice educators within the P&O profession needs to increase to support current and future training & education, supervision, and mentorship[21]. To enable the educator capacity to increase, it is essential that the educator workforce is a key consideration in integrated workforce and service planning.

20 Insight & Analytics Team., How Long Do New Registrants Stay Registered for? An Analysis of First-Time HCPC Registrations: 2013 to 2018, The Health and Care Professional Council (HCPC), 2023.

21 Durrant. B, An Exploration of Practice-Based Learning in Prosthetics and Orthotics in the United Kingdom. The British Association of Prosthetists and Orthotists., 2025.

Development Opportunities for the P&O Workforce

A review of how to deliver protected time for appropriate training and education has to be complemented by reviewing the opportunities for career development. A lack of progression is known to be a key driver in the high attrition rate within the P&O profession[2]. Undertaking training and education and enhancing one's practice does not necessarily lead to a career development opportunity in many P&O services. The opportunity for 'development' is influenced by:

a) personal development via education and training opportunities available to clinicians to embed the appropriate skill base for developing their role

b) the opportunity to develop a role within a wider team, deliver service improvement initiatives, or be recognised within the Trust/Health Board or commercial organisation to take on more senior roles

c) an understanding of the transferable skills POs can offer in the wider healthcare space

Advanced and consultant practice roles are scarce within P&O. There are only two recognised advanced practice orthotists and two consultant orthotists working within the NHS. All of whom are directly employed by the NHS. There are no recognised prosthetists in advanced and consultant roles*.

Several contractors expressed concern about being able to replace experienced staff who wished to progress to less clinical roles and often outside the P&O service. They did not underestimate the potential benefit of having more P&O staff in more senior roles in the Trust/Health Board, but the practicalities of recruiting and replacing experienced staff due to the general shortage of qualified clinicians, caused contractors some concern. This presents another barrier to progression. BAPO's ongoing work to improve the pipeline of POs to reduce staff vacancy rates should help alleviate this fear.

The NHS Long Term Workforce Plan[1] objective is to increase the number of Advanced Practitioners by driving the number of clinicians undertaking advanced practice programmes from the current 3,000 p.a. to 5,000 p.a. across England by 2028. Even as the smallest allied health profession, POs should have equal opportunities to take this route.

During the 12 months of the project, it became apparent that contractors were less aware of the potential to use the apprentice levy to support enhanced and advanced practice development and the availability of the regional faculty for advancing practice for both advice and financial support for supervisors supporting the clinician undertaking the advanced practice training.

In addition, 56% of Trusts/Health Boards, (incorrectly) believed that their contracted P&O staff were unable to apply for leadership roles at the Trust/Health Board they worked in as they were not an NHS employee.

* Note: There are many experienced P&O clinicians who use the term 'Advanced' in their job title but have taken the title based on their years of experience and denotes a high level of clinical expertise and to meet the agenda for change banding requirements rather than being in line with the understanding of advanced and consultant titles in NHSE's multi-professional framework for advanced practice in England and the Multi-professional consultant-level practice capability and impact framework

Embedding the four pillars of practice in P&O services

Ensuring POs have a varied and rewarding career is vital to reduce attrition. P&O has historically focussed heavily on the clinical and technical pillar of practice, driven by the activity-based contracting and a lack of time for other activities, the lack of appropriately funded service design causing high waiting lists, and the lack of opportunities for training and education. This has led to POs becoming frustrated with the lack of opportunities to expand their skill set and engage with research, education, and leadership. Results from this project indicated that the research pillar is most often neglected for both in-house and contracted services.

The FOI results indicated that Trusts/Health Boards, potentially have little understanding of the need for the P&O workforce to engage with the four pillars of practice, with over 25% responding that they were unsure about the contracted staff's opportunity for practice across any of the four pillars. This was most obvious for the research pillar where 40% of the 53 Trusts/Health Boards with contracted services, suggested that they were unsure. This is despite the widely accepted position that healthcare services that engage with research improve the quality of care of their service users[20].

Leadership is another key area where P&Os lack visibility when it comes to senior AHP leadership positions[21]. The causes are multi-factorial, including, a lack of training and education opportunities, lack of visibility and understanding of their transferrable skills, a lack of visible role models in senior leadership positions, a lack of equity (for contracted staff) to access leadership positions within the Trust/Health Board they work in. The reasons include 1) they do not have access to NHS communications, 2) they are often not included in the AHP lead meetings, and 3) they are not considered part of the organisation despite often working in the same organisation for large parts, if not, their entire careers, albeit with their employers changing (under TUPE law) in line with the change of contract provider.

The potential role of the Chief AHP (or equivalent) in advocating for P&O services

A key role for Chief AHPs (or equivalents) is to "advocate for the AHPs in the Trust and ensure they have a voice in the hierarchies of the organisation"[22]. This should include all POs regardless of whether they are directly employed by the NHS or contracted.

Information from the FOI indicated that 94% of in-house P&O service leads had regular communication with the organisation's Chief AHP (or equivalent), but only 51% of the contracted P&O service leads had the same access. This means that the Chief AHP leading AHP development at the Trust/Health Board, is likely to be unaware of the needs of the clinicians in the contracted P&O service resulting in these POs not being included in AHP-related updates, policies, staff news, and development opportunities, resulting in having no voice in any AHP related developments or changes.

20 Heather Iles-Smith and others, 'The Clinicians' Skills, Capability, and Organisational Research Readiness (SCORR) Tool', International Journal of Practice-Based Learning in Health and Social Care, 7.2 (2019), 57–68 <https://doi.org/10.18552/ijpblhsc.v7i2.644>.

21 Nicola Eddison, Aoife Healy, Nina Darke, and others, 'Exploration of the Representation of the Allied Health Professions in Senior Leadership Positions in the UK National Health Service', BMJ Leader, 0 (2023), 1–8 <https://doi.org/10.1136/leader-2023-000737>.

22 Chief Allied Health Professions Office, 'Chief Allied Health Professionals Handbook', 2022 <https://www.england.nhs.uk/wp-content/uploads/2022/06/Chief-AHP-Handbook-v17-FINAL-13062022.pdf>.

The survey of Chief/Lead AHPs across the regions also confirmed this. Despite being responsible for advocating for all AHPs, a quarter of Chief AHPs reported a lack of engagement with and responsibility for the P&O service in their Trust. See figures 5 and 6.

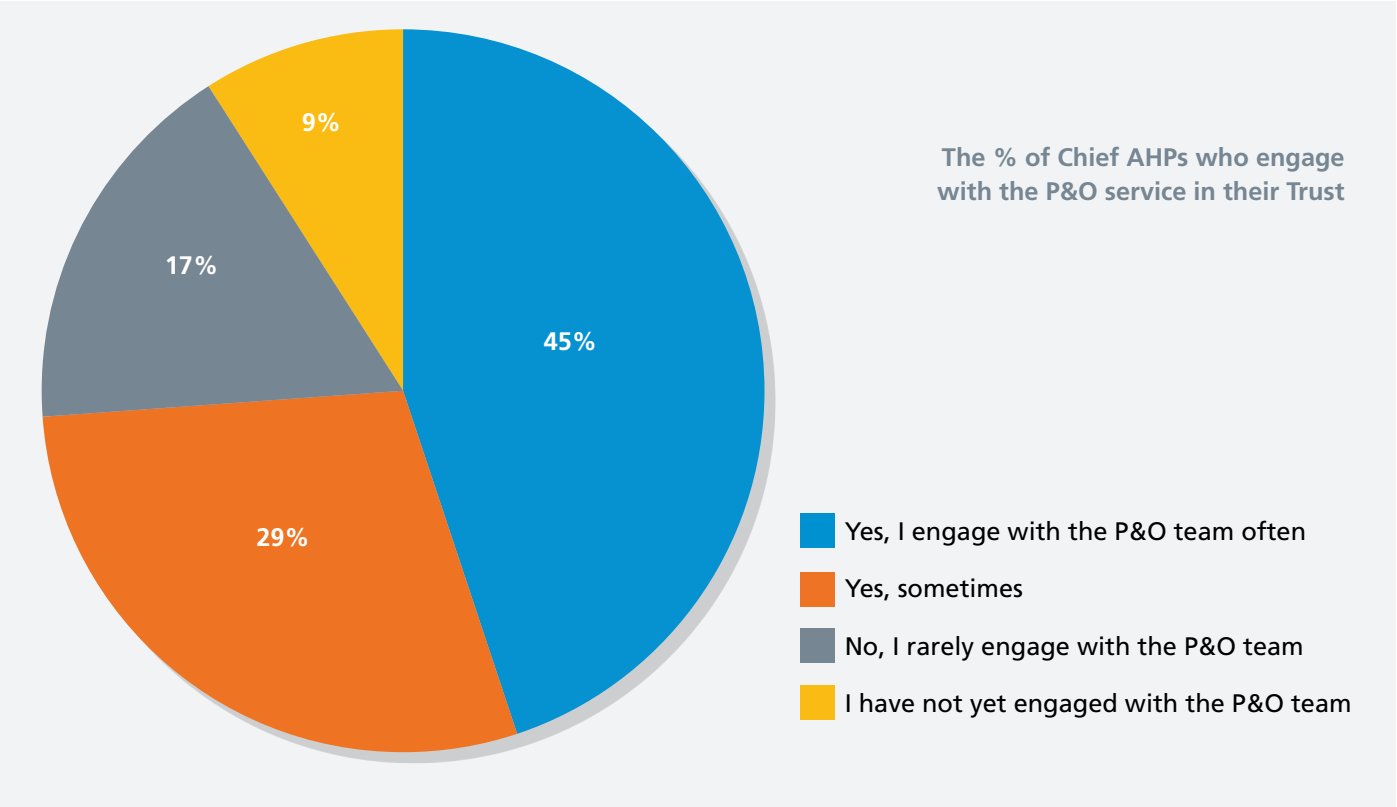


Figure 5: the percentage of Chief AHPs who reported engaging with the P&O service in their Trust

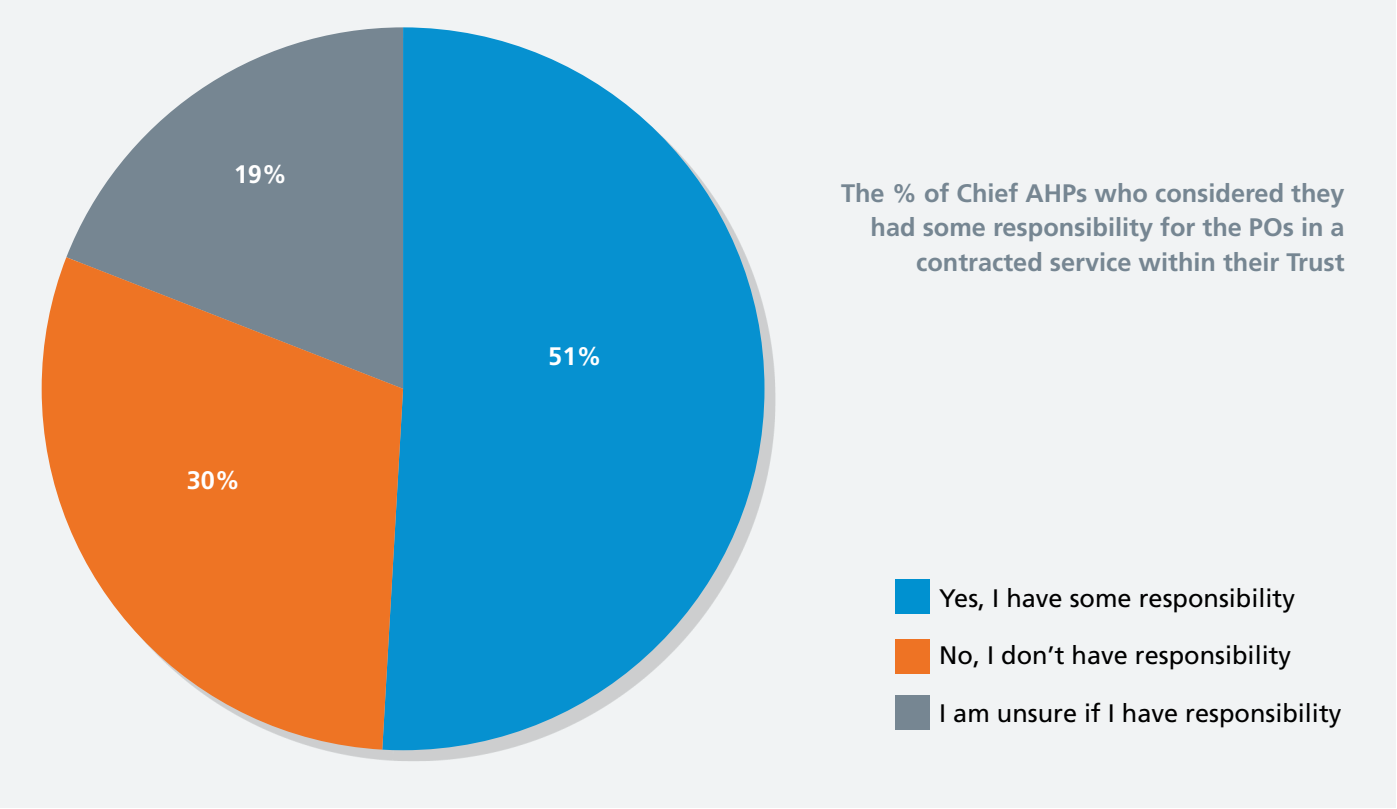


Figure 6: the percentage of Chief AHPs who considered they had some responsibility for the contracted P&O service

Communication between Chief AHPs and contracted P&O staff must improve. Contractors need to seek out and engage the Chief AHP and this needs to be reciprocated with a focus on understanding the needs of the P&O service and an offer to support the delivery of effective and sustainable services from their P&O contractor.

Chief AHPs (or equivalent) hold positions of influence and can act as key advocators for the P&O workforce. They have a key role to play in ensuring the P&O workforce is:

- Integrated within the Trust/Health Board
- Appropriately funded to meet the needs of its service users
- Has equitable time for and access to training and education opportunities
- Has equitable access to secondment opportunities
- Has equitable access to job progression opportunities
- Visible and included in AHP initiatives and meetings
- Valued and their skills acknowledged
- Has an equitable voice amongst the other allied health professions

Meetings with NHSE regions and local Lead AHPs as part of this project has enabled BAPO to raise the profile of P&O services, deliver the statistics from the P&O workforce survey to highlight the workforce issues the profession is facing, and develop a route for future information, new guidance, and policy changes produced by BAPO to be distributed to this influential group.

Discussion and recommendations

The prosthetics and orthotics profession faces a range of complex, multifaceted challenges—both practical and cultural—that have contributed to long-standing, systemic issues across the workforce and service delivery landscape. Addressing these challenges will require concerted, collaborative action from all stakeholders. After years of operating at the periphery of NHS strategy, the profession is at a pivotal juncture. Realising meaningful change will demand a unified commitment to strategic reform, driven by shared accountability and purpose.

The engagement of NHS England and the leadership of the British Association of Prosthetists and Orthotists will be critical in driving this transformation. This report provides a clear roadmap, outlining actionable recommendations designed to support the development of a resilient, integrated, and future-ready workforce.

The recommendations that follow are rooted in three core principles:

1. **Ensuring Patient Safety and Quality:** Upholding the rights of service users to safe, effective, and well-governed care.
2. **Securing Workforce Sustainability:** Creating the conditions for a thriving workforce, equipped with opportunities for professional growth, career progression, and parity with other Allied Health Professions.
3. **Protecting Public Investment:** Maximising the value of training and education funding by investing in a workforce that is retained, developed, and empowered.

Recommendations

1. Revise and update the 2015 Orthotic Service Specification

The orthotic service specification must be revised to ensure it mandates provisions for staff training, education, and development—particularly for services delivered by commercial providers. This revision should:

- Explicitly reference protected time and funding for professional development.
- Include relevant KPIs for workforce development and outcomes.
- Support equity between in-house and contracted service provision.

The updated specification should be disseminated across professional and commissioning networks, including CAHPO and regional AHP leads, ICB Chief AHPs, Trust/Health Board-based Chief AHPs, framework providers, education institutions, and service managers.

2. Implement Job Planning Across All P&O Services

Job planning is essential for understanding service capacity, optimising clinical skill mix, and identifying training needs. This must extend to all prosthetists and orthotists, including those working in contracted services. Job planning should:

- Identify time for CPD and non-clinical duties.
- Support strategic workforce planning.
- Promote equity and integration across NHS and commercial teams.

Commercial providers also have a duty to ensure their clinicians are recognised as integral members of the wider AHP workforce.

3. Embed the Four Pillars of Practice to Enhance Professional Development

The profession must move beyond a service model solely focused on clinical activity. To build a more fulfilled and capable workforce, opportunities must be expanded across all four pillars of practice: clinical practice, education, leadership, and research. In particular, the research pillar requires urgent attention.

BAPO and NHS England should collaborate to:

- Promote research as a routine component of clinical practice.
- Identify and support role models in research leadership.
- Integrate research engagement into KPIs and service quality frameworks.

4. Develop a Four-Nations Workforce Strategy for the P&O Profession

To ensure sustainability across the UK, a co-ordinated approach to workforce policy is required. NHS England should work closely with its counterparts in Scotland, Wales, and Northern Ireland to:

- Address profession-wide workforce vulnerability.
- Promote consistency in standards, training, and service expectations.
- Share intelligence and best practices across national systems.

5. Develop an Employers' Guide for Prosthetics and Orthotics

In collaboration with BAPO, NHS England should publish a dedicated Employers' Guide on the NHS Employers platform. The guide should:

- Articulate the scope and value of the P&O workforce.
- Outline expectations for education, training, and progression.
- Serve as a resource for commissioners, managers, and providers.

6. Produce Targeted Guidance for Chief AHPs (or equivalent post)

Chief AHPs have a critical role in ensuring visibility, advocacy, and equitable treatment of the P&O workforce. BAPO should develop concise guidance for Chief AHPs to:

- Improve engagement with P&O teams, including those contracted via third parties.
- Promote the integration of P&O into organisational AHP structures.
- Raise awareness of training, development, and service standards.

7. Collaborate with Framework Providers to Develop a Buyers' Guide

To support effective procurement of high-quality P&O services, BAPO should collaborate with framework providers to produce a comprehensive Buyers' Guide. This should include:

- Recommendations on pre-tender job planning and service design.
- Guidance on including education and CPD in contract weighting.
- Strategies for building sustainable cost-to-competency ratios.
- Promotion of support worker roles for low complexity cases;
- Clear KPIs on patient outcomes and clinician training, education, and development.
- Advice on engaging AHP leaders during the procurement process.

8. Promote Organisational Equity and Visibility for P&O Services

AHP leadership at provider Trusts and Health Boards must ensure P&O services are:

- Visible and represented within organisational structures.
- Included in strategic discussions and service development plans.
- Afforded equitable access to training, leadership, and progression.

In parallel, P&O service leads—both NHS and contractor-employed—must actively raise the profile of their services.

9. Mandate Outcome Reporting at Provider and ICB Level

To demonstrate impact and value, P&O services must be required to report on outcomes at both the organisational and ICB level. KPIs should be meaningful, measurable, and aligned with workforce and service quality. Key organisations involved in commissioning of prosthetic and orthotic services must:

- Embed outcome reporting requirements into service frameworks.
- Promote use of nationally recognised metrics across contracts.
- Support transparency and accountability in commissioned services.

Key outputs delivered to date

- Contribution to the NHSE prosthetic service specification consultation.
- Distribution of guidance to support the use of the apprenticeship levy and regional funding for enhanced and advanced practice.
- Targeted engagement with Chief AHPs at Trust, ICB, and NHSE regional levels.
- National survey to assess Chief AHP engagement with P&O clinicians.
- Ongoing collaboration with framework providers to inform tendering processes and develop a Buyers' Guide.
- Dissemination of regional faculty contacts and funding application resources to contractors and service managers.
- Refinement of terminology and pricing models in framework agreements to reflect varying levels of clinical competence, including:
  - Senior Support Worker / Technician
  - Assistant Practitioner
  - HCPC-Registered Prosthetist/Orthotist (New Graduate)
  - HCPC-Registered Senior or Enhanced Clinical Practitioner
  - HCPC-Registered Advanced Clinical Practitioner
  - Consultant Prosthetist/Orthotist
  - Consultant / Senior Manager / Director

Registered address:
Clyde Offices, 2/3 48 West George Street, Glasgow G2 1BP
Tel: 0141 561 7217 E-mail: enquiries@bapo.com
www.bapo.com