Service Provision Guidance for Prosthetic & Orthotic Services

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This guidance is an expansion of a document originally prepared by The British Association of Prosthetics and Orthotics (BAPO) professional Affairs Committee in collaboration with a wider working party consisting of The Health and Care Professions Council (HCPC) registered Prosthetists/Orthotists. The working party represents prosthetists/orthotists from all nations and sectors of the workforce including representation from the National Health Service employed clinicians, contracted service providers, academic professionals, and private providers.

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500 miles · Blesma The Limbless Veterans · Finding Your Feet · Limbless Association #LifeBeyondLimbLoss · Limb Power Living life without limbs · Steel Bones

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Foreword

This new Service Provision Guidance brings together, with great clarity, and as a key resource for all, a blueprint as to what good P&O care looks like, and why it is important. There are great pressures nationwide in recruitment, training and retention in what should and could be one of the most rewarding fields of healthcare. Additionally there is a postcode lottery of practice and provision which urgently needs addressing.

Too often patients face unacceptable waiting times within the NHS and are offered outdated equipment. New technologies and production methods such as 3-D printing should be embraced to minimise waiting times, take pinch points out of the supply chain and provide better outcomes. Advanced technologies such as multi-articulating hands should be the first port of call, not the last thing to be provided after years of pleading and leading sub-optimal lives.

I congratulate all involved in bringing this document together.

Lord Craig Mackinlay

Executive summary

Prosthetic and orthotic services play a vital role in enabling individuals to achieve their highest potential for mobility, independence, and quality of life. Recognising the increasing clinical (physical and mental), social and financial benefits of these services, The British Association of Prosthetics and Orthotics (BAPO) has developed this guidance to support the commissioning, planning, delivery, and continuous improvement of prosthetic and orthotic services across the United Kingdom.

This document is the culmination of extensive collaboration between clinicians, researchers, service managers, and patient representatives, and it reflects the latest best practices, evidence-based recommendations, and professional standards. Our aim is to ensure that prosthetic and orthotic users receive timely, high-quality, and person-centred care that enhances their wellbeing and supports a thriving, inclusive society.

We invite healthcare providers, commissioners, policymakers, and clinicians to use this guide as a foundation to champion excellent service delivery and to advocate for the needs and rights of service users. Delivering on the ambitions of the National Health Service (NHS) Ten Year Plan[1], which sets out a vision for prevention, personalised care, digitally enabled services, and a fundamental shift towards care closer to home, requires a renewed focus on the design, delivery, and funding of prosthetic and orthotic (P&O) services. These services are central to supporting individuals with long-term, often complex conditions to achieve independence, remain active and avoid preventable complications.

The Service Provision Guidance for Prosthetic & Orthotic Services outlines essential standards and recommendations for delivering high-quality prosthetic and orthotic care. It addresses 15 key areas of service delivery:

- Environment, facilities, and location
- Access to information
- Referral, triage, and service access
- Appointing and episodes of care
- Procurement, provision, and timely delivery
- Communication with healthcare professionals
- Inclusion of technical colleagues and support workers
- Continued professional development and workforce planning
- Administrative support
- Systems and record keeping
- Protecting service users and staff
- Clinical governance
- Evidence based practice
- Stakeholders
- Multi-disciplinary working and clearly defined clinical pathways

To deliver the ambitions of the NHS Ten Year Plan[1], particularly in enabling care closer to home, harnessing digital innovation, and preventing avoidable ill health, **appropriately funded, well-designed, and equitable prosthetic and orthotic (P&O) services are essential**. P&O service users often have complex, lifelong conditions requiring specialist, multidisciplinary care. Without the right investment, services struggle to meet rising demand, implement evidence-based innovations, or reduce unwarranted variation in access and outcomes.

Funding is not solely about the cost of prosthetics and orthotic devices, but also about enabling high-quality clinical time, investment in modern facilities, integrated IT systems, research, and ongoing professional development. Services must be designed to allow prosthetists and orthotists to work at the top of their license, supported by a full multi-disciplinary team, and a team of technicians, support workers, administrative staff with the ability to facilitate access to appropriate specialist medical, psychological, social, therapy and nursing care as required. This allows efficient triage and management of varying case complexities, freeing up senior staff to address more complex needs while supporting continuity of care.

Appropriately commissioned and funded services also underpin key NHS objectives such as reducing hospital admissions and preventing deterioration of long-term conditions. Early orthotic intervention can prevent diabetes foot ulcers, limb loss, contractures, loss of mobility, loss of independence, and falls—each of which carries a significant cost burden and long-term health consequences, both physical and mental. Similarly, responsive prosthetic care following limb loss—delivered in well-equipped, accessible environments—can dramatically improve mobility, function, physical, mental and social wellbeing and reduce the risks of deconditioning and social isolation.

Crucially, service design must reflect the shift towards community-based care. Locally accessible clinics, outreach services, and virtual consultations all reduce barriers for service users with reduced mobility or complex needs. These must be underpinned by adequate resources, modern digital infrastructure, and clear care pathways for prosthetic and orthotic service users that ensure equity and consistency across regions.

Ultimately, investment in prosthetic and orthotic services is an investment in **prevention, independence, and population health**. Without it, the NHS will face higher downstream costs, poorer outcomes, and widening health inequalities. With it, prosthetic and orthotic users can live fuller, more independent lives—supported by a service model that is fit for the future.

This guide is intended not only as a framework for establishing new services but also as a benchmark for reviewing and improving existing ones, ensuring that all prosthetic and orthotic service users across the UK receive the high-quality care they deserve.

Throughout all aspects of this document, the key messages are:

Prosthetic and orthotic services are commissioned for the service user, on behalf of the service user

The best interests of the service user must be considered at all stages in development of services

Prosthetic and orthotic services provide unique care and treatments of great clinical and wider benefit

Prosthetists/Orthotists require to be enabled to deliver quality treatment through careful commissioning

Dr Nicky Eddison
BAPO Chair

Who is this guidance for?

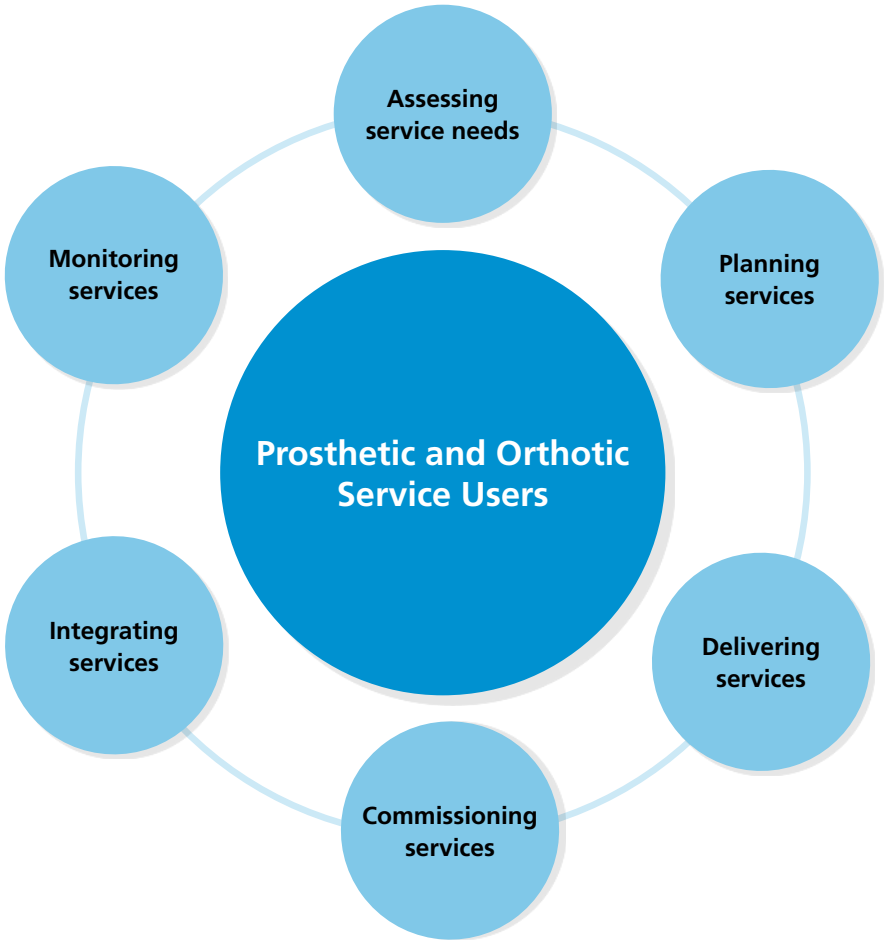
BAPO intends these guidelines to be used by anyone considering commissioning, procuring, developing, or reviewing a prosthetic and/or orthotic service. A previously published survey indicated that only 40% of those managing prosthetic and orthotic services have a clinical background in prosthetics and orthotics[2]. Similarly, following the introduction of the relatively new Chief Allied Health Professional (AHP) role or equivalent across the NHS, there is a need to inform senior leaders about the purpose, potential, and challenges within prosthetics and orthotics.

This document has been produced to guide those looking to establish new services and those with established services. This document directs the reader to resources which will help them benchmark their service to allow a baseline and drive service improvement. BAPO recommends using the plan, do, study, act, (PDSA) cycle[3], which provides a framework for developing, testing, and implementing change.

The following guidance explains the scope, breadth, and depth of prosthetic and orthotic services with reference to the many vital benefits that these services offer to the service user, healthcare provider and wider society. Herein, BAPO discuss their recommendations for implementing the guidance presented at an operational level. The principles and expectations of quality prosthetic and orthotic services are also defined.

On a clinical level, all prosthetists/orthotists practicing in the UK should be familiar with these guidelines and should strive to deliver care and treatment to the service user within the framework presented. Where services fall below the standards set out, clinicians should use the guidelines to support a case for undertaking a service review process and to help drive positive change.

To enable change it must be clear who is responsible for overseeing the quality of the prosthetic and/or orthotic service at each Trust/Health Board. There must be a set of minimum standards in place which are monitored via regular checks, with a clear process of identifying when the service falls belows the minimum required standard so changes can be made to protect the service user and staff.



A call to action

There has been widespread dissatisfaction amongst prosthetists and orthotists as to the suitability of clinical environments, volume of caseloads, and protection of both service users and clinicians for many years. This issue is a recurrent theme in BAPO member surveys.

A report exploring the UK prosthetics and orthotics workforce commissioned by BAPO in 2023 found a high level of dissatisfaction amongst the prosthetic and orthotic workforce. With 55% of prosthetists and orthotists unwilling to commit to remaining within the profession. The issues raised include 1) a lack of progression 2) work/lifestyle balance 3) inadequate appointment lengths 4) skill set and experience not recognised, 5) poor facilities[4] and 6) high levels of burnout and poor mental health and wellbeing within the P&O workforce[5].

The call to action is also from service users to review the state of orthotic provision in the NHS and deliver the 2015 NHS England 'Improving the Quality of Orthotics Services in England' service specification[6].

Longstanding failures in service design and delivery impacts upon the the service user's experience, the quality of care they receive, and ultimately their independence. It also impacts on the prosthetic and orthotic workforce, which now has the highest level of attrition amongst the allied health professions[6].

The literature identities the following realities of service failure[7]:

- Increasing volume of complaints
- Variances in appointment durations
- Insufficient appointment durations to complete assessments and design treatment plans
- Variances in waiting times for initial consultations
- Variance in lead time for supply of devices following assessment
- Poor access to technologies
- Poor mental health and wellbeing support for clinical staff

There are many examples nationally of efficient prosthetic and orthotic services delivering excellent care to best enable their service users. These guidelines aim to provide essential information to those responsible for commissioning prosthetic and orthotic services, as well as service management, to promote excellence in care and delivery. It is the objective of these guidelines to equip those involved in the commissioning of prosthetic and orthotic services and the service management with the information to encourage such excellence. This document will also provide a foundation of understanding of the minimal requirements of the prosthetist/orthotist to ensure that they are enabled to deliver high standards of care to those who rely upon their treatment.

1 Introduction to Prosthetic and Orthotic Services

1.1 What is prosthetics and orthotics?

A modern healthcare system must do more than prevent illness and mortality within the population. It needs to enable service users to live their lives, fulfil their maximum potential, and optimise their ability to contribute towards family life and society. The NHS Ten Year Plan[1] aims for three radical shifts, one being a shift from sickness to the prevention of ill health. It is increasingly acknowledged that effective rehabilitation delivers better outcomes, improved quality of life, and has the potential to reduce health inequalities and make significant cost savings across the health and care system[8]. Prosthetic and orthotic services have a major role to play in this.

Whilst prosthetics and orthotics are often considered a single profession (albeit being categorised as distinct allied health professions in Scotland, Wales, and Northern Ireland). There are differences between the two component disciplines.

Prosthetic and orthotic services provide essential care for some of the most vulnerable in society. Getting services right is essential for many of our service users to function, remain independent, and contribute to society. We need urgent action to make our services more accessible and appropriate to enable the best for our patients

Prosthetics

For those with congenital or acquired limb loss or limb difference, prosthetic services provide replacement limbs which are required to be as comfortable, cosmetic, and functional as possible to allow patients to fully realise their potential for independent living. The replacement, artificial limb is known as a *prosthesis*. The clinical skillset for providing prosthetic treatments is the role of a group of Health and Care Professions Council (HCPC) registered clinicians known as *Prosthetists*.

Prosthetists are clinicians who assess gait and movement in order to prescribe engineering solutions to patients with upper and lower limb loss. They are specially trained at an undergraduate level in mechanics, biomechanics, and material science along with anatomy, physiology and pathophysiology. Their qualifications make them competent to design and prescribe prostheses which replicate the structural or functional characteristics of the patient's absent limb. They treat patients with congenital limb loss as well as limb loss due to a wide range of other conditions, including; diabetes, reduced vascularity, infection, trauma, cancer, or other reasons such as chronic pain. Military personnel, many of whom have complex injuries and multiple limb loss, form a notable part of their caseload.

Whilst they are autonomous practitioners, prosthetists usually work closely with rehabilitation consultants, physiotherapists, nurse specialists, and occupational therapists as part of multidisciplinary amputee rehabilitation teams[9].

Orthotics

An *orthosis* is an external device worn on the body which is used to apply force or modify forces acting upon the human body in order to improve mobility, aid function, provide support, correct malalignment, protect, facilitate healing and/or reduce pain/discomfort. This is a broad term and includes devices such as: splints for the upper and lower limb, functional insoles, specialist footwear, spinal braces, neck collars, abdominal supports, conventional callipers, trusses, compression hosiery and protective helmets. The clinical skillset for providing orthotic treatment is the role of a group of HCPC registered clinicians known as *Orthotists*.

Orthotists are clinicians who assess gait and movement in order to provide engineering solutions to patients with deficits of the neuro, muscular and skeletal systems. They are extensively trained at undergraduate level in mechanics, biomechanics, and material science along with anatomy, physiology, and pathophysiology. Their qualifications make them competent to design and prescribe orthoses that modify the structural or functional characteristics of the patients' neuro-muscular and skeletal systems enabling patients to mobilise safely, reduce gait deviations, reduce falls, reduce pain, prevent and enable the healing of wounds/ulcerations. They are also qualified to modify CE and UKCA marked orthoses or componentry, taking responsibility for the impact of any changes. Orthotists treat patients with a wide range of conditions including; diabetes, arthritis, cerebral palsy, stroke, spina bifida, scoliosis, musculoskeletal concerns, sports injuries, and trauma.

Whilst orthotists work as autonomous practitioners, they often form part of multidisciplinary teams such as the diabetes foot care team or neuro-rehabilitation team[9]. In many scenarios, orthotic input will be delivered as a component of these specialist services.

> ***"Prosthetic and Orthotic services are not just about equipment—they're about independence, dignity, and the ability to live life fully. For many of us, these services mean the difference between surviving and thriving."***
>
> **Emma Joy-Staines**
> ***CEO and Co-Founder of Steel Bones***

Defined Specialist Professionalism

Prosthetists/Orthotists have a solid foundation of the professional responsibilities required of all Allied Health Professionals. Both prosthetists and orthotists are supported by highly skilled technicians who manufacture the prosthetic or orthotic device, leaving the prosthetist/orthotist free to concentrate on direct patient care, enabling them to work and communicate closely and effectively to ensure the best result for the service user. The prosthetist/orthotist brings the following unique combination of specialist clinical and technical skills and knowledge to healthcare environments. It is this specific, unique matrix of competencies which equips the prosthetist/orthotist to lead autonomous care of the service user and best advise where their input may compliment other medical treatments.

- Anatomy & physiology training
- Biomechanics proficiency
- Communication and engagement
- Competancy in engineering principles
- Material science experts
- Problem solving and creative design
- Technical workshop skills
- Industry product knowledge
- Adaptability to varied caseloads

"Prosthetics and orthotics aren't just about making devices that help people cope with everyday living, such devices can be life changing. For many of our Military Veterans, first class medical treatment has helped them survive, prosthetists and orthotists help them thrive.

As the prosthetics support officer for Blesma, the Limbless Veterans, I get to witness the skill and care of prosthetists and orthotists. The technology has improved significantly over the 12 years that I have been supporting veterans with limb loss or loss of use of limb. This is a profession that is an exciting opportunity to make a real difference to individuals and to see that has been a privilege."

Brian Chenier MBE
Blesma Support Officer (Prosthetics)

1.2 Who uses Prosthetic and Orthotic Services?

Prosthetic and orthotic services are relied upon to provide a wide spectrum of treatment modalities within current healthcare pathways. Prosthetic and orthotic service users span all age groups, accessing P&O services through a wide range of clinical pathways including; trauma, chronic disease, neurological, musculoskeletal, congenital conditions, and cancer services[10].

The World Health Organisation (WHO) states that rehabilitation interventions should be aimed at achieving the following broad objectives[11]:

- preventing the loss of function
- slowing the rate of loss of function
- improving or restoring function
- compensating for lost function
- maintaining current function

Broadly speaking, prosthetists and orthotists deliver one or more of these treatment objectives. These objectives must be considered alongside service user goals (section 1.3) in order to formulate individual treatment plans.

The WHO estimate that one in ten people globally will require specialist prosthetic and/or orthotic treatment at some point in their lifetime with 0.5% of the population accessing services at any one time[12]. In the UK this would extrapolate to over 342,500 potential persons currently accessing services. Research suggests that in 2007 there was an estimated 1.2 million orthotic users alone in the UK[2]. An additional 142 to 477 prosthetsist/orthotists are needed to meet the WHO's recommendation of 15–20 prosthetists/orthotists per million of the population[13].

Prosthetic Service Users

Those with congenital limb absence will be lifelong candidates for prosthetic care from infancy.

As well as congenital limb absence, the main cause of amputation is commonly linked to diabetes or peripheral vascular disease (PVD) which is most prevalent in later life[14]. Younger patients may undergo amputation because of less common conditions such as meningitis and osteosarcoma (cancerous bone tumours). It is estimated that a 10-year-old child whose lower limb is amputated will go on to require 25-30 prostheses in their lifetime[12].

Not all individuals who have limb absence will want or benefit from a prosthesis. Examples often include; upper limb amputees who have adapted to limb absence well, or those with medical or cognitive impairments. These individuals are still assessed and referred onwards as appropriate. Individuals are able to access amputee specific specialist advice and treatment in prosthetic services. This may include, but is not limited to access to provision of compression garments, medical advice for for issues such as phantom pain and access to physiotherapy and/or occpational therapy, and counselling..

Orthotic Service Users

Some orthotic service users may be identified at birth or infancy. Treatment of children with conditions such as congenital hip dysplasia, congenital talipes equino varus, cerebral palsy, spina bifida and global development delay are common.

Acquired trauma, neurological impairment, stroke, musculoskeletal conditions, arthritis, and diabetes are treated throughout life upon diagnosis. These may require a short episode of care to resolve an acute problem or a life-long package of care if the deficit persists and conservative treatment is favoured.

It is estimated that two to four times more people will require orthotic treatment compared to prosthetic treatment[12]. In prosthetic services, referrals tend to come from the hospitals who perform the amputation/identify a congenital need. In orthotic services, there are a wider range of referring clinicians. One of the challenges is educating potential referrers on the orthotist's scope of practice, and one of the key skills of the orthotist is to assess and identify where and if orthotic intervention is appropriate.

1.3 Service User Goals

Service users may use a prosthesis or orthosis to achieve one or more treatment goals. These include those defined by rehabilitation and re-enablement pathways[15]:

Developing skills for the first time
Children and parents requiring support/counselling may need help to develop skills in order to overcome barriers presented by a range of developmental difficulties and health conditions to achieve maximum health and independence as they grow.

Recovery from unexpected illness
Such as acute admission to hospital following trauma, stroke, surgical complication, infection, etc...

Management of long-term conditions
People with a long-term medical condition may benefit from rehabilitation interventions to help them regain and maximise their independence.

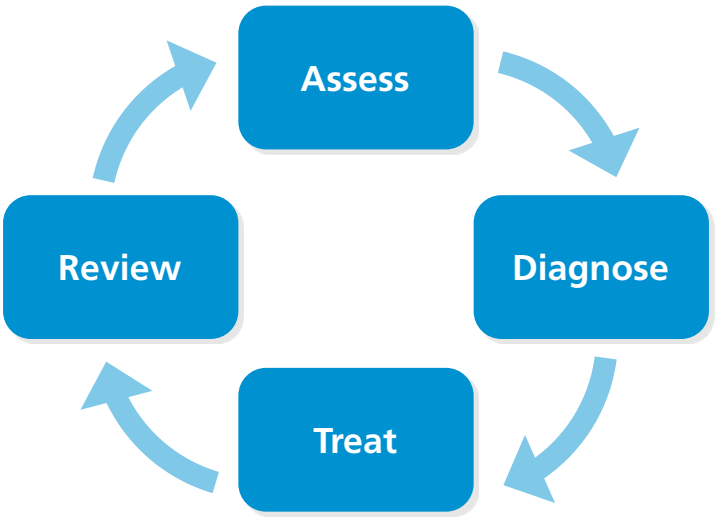
Self-manage conditions
People living with a long-term condition are enabled to manage their own health and reduce the risk of developing secondary problems affecting either their mental or physical health, such as loss of strength and cardiovascular fitness, contractures, pressure ulcers, pain, anxiety and depression.

Recovery from major trauma
Rehabilitation and re-enablement help people to regain and maximise their skills and independence, including returning to work.

Improve function and maximise independence
For progressive conditions, early diagnosis, assessment and intervention can help people to optimise their skills and independence for as long as possible.

1.4 The Prosthetic and Orthotic Treatment Cycle

In order to achieve the optimum outcome, prosthetists/orthotists undertake a streamlined 'Assess – Diagnose – Treat – Review' process for each clinical case they encounter. These four aspects are vital components of the prosthetic and orthotic treatment cycle.



In prosthetics, some devices for upper limb have been developed in order to be fitted off-the-shelf, but in general the prostheses require to be custom-made for each individual to provide adequate comfort, support, and function. Whilst in orthotics, there are a wide range of off-the-shelf devices utlised by orthotists. In some scenarios, provision of these may be undertaken by other members of the MDT under supervision. Principally, such dispensing activity is carefully controlled through locally developed treatment pathways, education packages, and supervision processes; all under the review of the prosthetic/orthotic clinical team. Support workers may be recruited to work under supervision of the clinician to provide support to the clinical activities in line with NHS England's AHP Support Worker Competency, Education, and Career Development Framework[16], the BAPO support worker framework[17] and the BAPO support worker guide[18].

The essential, unique skillset of both prosthetists and orthotists sits in the assessment, design, and engineering of custom devices

Prosthetists and orthotists are supported by a skilled manufacturing team of prosthetic and orthotic technicians who ensure that the complex prescription specification for a custom prosthesis or orthosis is realised and delivered.

The evidence base for treatment with prostheses and orthoses is growing steadily and for many conditions there are established treatment pathways and protocols[19, 20]. For severely complex conditions and for atypical physical presentations, however, the needs of the service user may require a degree of specialist clinical problem solving to address and analyse their unique biomechanical concerns.

In this context, the role of the prosthetist/orthotist is to thoroughly assess the person and establish whether simple pathways are suitable or whether a bespoke package of care is required.

This underpins the need for individual assessment of each service user to allow for differential diagnosis and subsequent planning of treatment, coordinated by the autonomous prosthetist/orthotist

MDT input is often important to ensure prosthetic and orthotic treatments compliment other aspects of the service user's treatment. This ensures an optimised and holistic approach to healthcare provision. In some circumstances efficient pathways of care should allow the prosthetist/orthotist to deliver complete holistic care independently.

2 The Need for Prosthetic and Orthotic Services

Prosthetic and orthotic services will impact upon four of the five indicator domains as set out in the NHS Outcomes Framework[27]:

Domain 2:
Enhancing QOL for people with long-term conditions

Domain 3:
Helping people to recover from episodes of ill health or injury

Domain 4:
Ensuring that people have a positive experience of care

Domain 5:
Treating and caring for people in a safe environment and protecting them from unavoidable harm

Prosthetic and orthotic services have the potential to impact domain 1 (Preventing people from dying prematurely) by being up-skilled to screen for common mental health disorders (including suicidal ideation) and trauma induced care, and making appropriate and timely onward referrals.

In addition, prosthetic and orthotic services have a role to play in the changing healthcare landscape with key shifts from analogue to digital - by harnessing the technology within the P&O sector, working with industry partners to develop technological advancements in prosthetic and orthotic devices and materials, utlising 3D printing, computer-aided design, and scanning technologies ultimately to improve efficiencies and service user outcomes.

The move from hospital to community with the utilisation of a neighbourhood health service in England requires the integration of P&O services to ensure service users have access to prosthetic and orthotic devices at the right time by appropriately skilled prosthetists and orthotists - to aid rehabilitation and prevent, prevent complications, and improve quality of life.

2.1 Clinical Benefits of Treatment

Numerous reports have discussed the potential benefits of prosthetic and orthotic services in improving both health and quality of life for patients[12]. This includes impact upon commissioning priorities such as the reduction of hospital admissions, accident and emergency attendances, and prevention of complications[6].

Prosthetic and orthotic services play a major role in empowering service users to take control of their own lives and manage their conditions; reducing demands upon healthcare providers, family members, and carers

Society benefits from prosthetic and orthotic services as treatments are prescribed with the goal of maximising mobility and independence.

The provision of quality care has a beneficial impact on a range of clinical conditions by relieving pain, increasing mobility and function, protecting tissues, and promoting healing along with other benefits including improved independence and self-image.

The range of clinical conditions benefiting from prosthetic and orthotic treatment includes; chronic diseases and trauma as well as neurological, musculoskeletal, and congenital conditions. Several of the conditions regularly treated within prosthetic and orthotic services remain as policy priorities for the government and the NHS[22], examples of these are set out below:

Diabetes

Prevention of ulceration and re-ulceration, reducing amputation rates, and maximising independence for those living with a prosthetic limb

Mental Health

Mental health conditions are better managed when identified & correctly signposted in a timely fashion and when mobility and independence is improved.

Neurological conditions

Including; stroke, multiple sclerosis and cerebral palsy

Chronic obesity

Leading to type 2 diabetes and musculoskeletal problems

Cancer

Managing the side effects of chemotherapy including peripheral neuropathy

Cardiovascular

Managing peripheral disease such as peripheral arterial disease and peripheral vascular disease

Degenerative conditions

Inflammatory diseases such as rheumatoid arthritis

Congenital conditions

Including; spina bifida, congenital limb absence, congenital talipes equino varus (CTEV) and hip dysplasia

Spinal cord injury and scoliosis

Safeguarding patients during healing, providing post surgical stabalisation, halting deformity progression and reducing the risk of secondary (neurological) complications

Complications of viral infections

Including; poliomyelitis and meningitis

Common musculoskeletal conditions and sports injuries

Maintaining mobility and returning people to work sooner

Treatment of the frail and elderly

Supporting independent living, reducing risk of falls, activities of daily living and mobility

Furthermore, six classes of prostheses and orthoses are noted on the WHO Global Cooperation of Assistive Technology 'priority assistive products' top 50 list[28]. These are: lower limb orthoses, upper limb orthoses, spinal orthoses, CTEV orthoses, lower limb prostheses, and therapeutic footwear.

2.2 Financial Benefits

The needs of an ageing and diverse population, the changing burden of disease and rising patient and public expectations mean that innovative ways of providing effective and efficient high-quality rehabilitation outcomes must be found. There is compelling evidence that rehabilitation services can deliver long-term cost reductions and add value and equality across the health and care systems[29].

Prevention of future illness and the subsequent requirement for costly treatment is key to any efficient modern healthcare system if it is to remain viable.

Effective prosthetic and orthotic services prescribe treatments with this focus in mind to provide the commissioning healthcare provider savings in the longer term. Early intervention can prevent injury and secondary problems arising linked to existing health conditions

One strong example of this is outlined in National Institute for Health and Care Excellence (NICE) guidelines where a costing analysis of the provision of bespoke footwear and insoles to service users with high risk of ulceration demonstrated clear cost savings[30].

Moreover, these services can also provide immediate substantial financial savings to the healthcare provider. Investment in conservative treatments comes with concurrent reduced need for acute admission and for surgical intervention, both of which will save on costly in-patient episodes of treatment and helps meet the NHS Ten Year Plan shift from hospital to community care.[31]. Similarly, effective treatments may mean a reduction in the requirement of prescription medication such as analgesics and antibiotics. Furthermore, prescription of prostheses and orthoses may reduce the frequency of a service user's need to access other services such as podiatry or physiotherapy as the prosthesis/orthosis can be designed to tackle the underlying reason for which the service user attends other services for therapy/treatment. For example, a review of prosthetic alignment may help to manage lower back pain and resolve recurrent access to physiotherapy.

The cost benefits to be gained by improving the commissioning and provision of orthotic services are well argued in previous reports

In summary, savings are likely to be made by reducing the need for consultant appointments and more expensive acute care procedures, in-patient stays, prescribed medications, and surgery. Most savings are expected to be made by by keeping frail, older, and disabled people mobile and independent for longer and reducing the need for expensive social and residential care services. In quantitative terms, the "Orthotic Pathfinder" report[23], estimated that the economic and social consequences of denying patients orthotic care are significant, costing an estimated £390 million per annum based on 2004 data. It suggested that for every £1 spent on improving orthotics service provision, the NHS could save £4[23].

The York Health Economics Consortium report[21], quantified the potential cost savings of using orthotic interventions in primary, acute, and long-term conditions compared to traditional secondary care treatment and surgery. Significant cost savings were demonstrated in the treatment of plantar fasciitis, ruptured achilles tendon, and management of diabetes foot complications respectively. Similarly, the Centre for Economics and Business Research report[32] calculated potential financial savings to the NHS and social care through the better use of orthotic interventions in the treatment of plantar fasciitis, diabetes foot complications and stroke. In addition to the specific cost savings estimated for each condition, it was estimated that around £48 million could be saved by re-locating orthotics services from secondary to primary care[21], in line with the NHS Ten Year Plan[1].

Financial considerations for prosthetic and orthotic services are often viewed solely in terms of product expenditure. However, a comprehensive understanding of costs should encompass initial investments in establishing the service alongside recurring expences, such as; staffing, workforce training and education, logistical operations (including product procurement), service user-related expenses, and service monitoring. While these costs may seem substantial, they pale in comparison to the financial burden on social services required to support individuals who become immobile and dependent.

2.3 Social Benefits

Prosthetic and orthotic services provide clear benefits to wider health and social care priorities including promoting well-being and supporting independence in the community. For example, by reducing the probability of falls in frail, older, and disabled patients and keeping them mobile and independent, it is possible to reduce the need for social care interventions. Such benefits contribute greatly to reducing health inequalities[12, 22]. Furthermore, it is acknowledged that equipment services can help to reduce the need for acute admission to hospital and also facilitate prompt and appropriate discharge of those who have been admitted to hospital[31]. As such, prosthetic and orthotic services are a vital aspect in achieving government targets for provision of care closer to home.

For children, provision of a prosthesis or orthosis may be essential for that person to continue to access and receive an education and therefore contribute to society in the future. Prostheses and orthoses enable people to continue to access services, assist with inclusion and participation for people of all ages and backgrounds within the workplace whilst leading productive, healthy, and dignified lives.

A lack of timely and effective prosthetic and/or orthotic care can have far reaching implications on the user, the NHS, and social care finances. To illustrate this point. One needs to consider the impact of a working aged adult who has undergone an amputation affecting their mobility. Without an appropriate and timely prosthetic device, the user is likely to require the use of a wheelchair, significant adaptations to their home, the provision of care assistance, the provision of physiotherapy to prevent contractures and muscle wasting due to inactivity. Similarly, individuals with progressive neurological conditions such as multiple sclerosis are at risk of rapid deterioration in mobility if timely orthotic intervention is not provided. Without the appropriate orthosis, they may become immobile sooner, significantly reducing their quality of life and placing increased physical and emotional demands on relatives and carers. In contrast, early provision of an orthotic device can help maintain mobility for longer, reducing the risk of contractures, deconditioning, and muscle wasting, and delaying or even preventing the need for more intensive and costly care interventions.

As a consequence, the user is likely to have barriers to accessing meaningful work. Not being in work can significantly impact mental health, often leading to increased stress, anxiety, depression, and decreased self-esteem. Family members will likely need to provide a significant level of care, which has consequences on their employment and their health and wellbeing.

It is clear that prosthetic and orthotic services can act as a tool to bridge the gulf that sits between medical treatment and social support services. NHS guidelines[33,34] advise adults and children should do some type of physical activity every day. Excercising just once or twice a week can reduce the risk of heart disease or stroke. The use of prostheses and orthoses in enabling adults and children to remain active is crucial for physical and social benefits of wellbeing and living and aging well.

2.4 Benefits for Children and Young People

Service providers must consider the holistic needs of children and young people to be functionally and socially enabled by their prostheses and orthoses, whilst also recognising the importance of cosmetic appearence in this cohort. This is essential to ensure inclusive participation in their community during their development. Similarly, their confidence must be maximised in order to facilitate social integration with careful thought placed upon the crucial aesthetics of any devices being provided and subsequent impact upon feelings of self-consciousness.

It is crucially important that children and young people who need prostheses and orthoses receive these in a timely manner and that the device is well fitted and of good quality

If they must wait many months to obtain the correct prosthesis or orthosis, it could be outgrown before they are fitted and this results in endurance of unnecessary pain, immobility, and cost to the NHS. It also undermines the work of the rehabilitation team and sometimes results in the need for further surgery and dependency on a wheelchair. This affects not only their physical health but also their psychological, emotional, and social health. Children and young people will have changing needs as they develop and require responsive and flexible service provision otherwise they will face avoidable inequalities throughout their formative years, which could follow them through life[6]. It is estimated that only 35% of UK services provide standalone clinics for paediatric service users. This means that children may face potential barriers to priority care and may not always be assessed by clinicians who have developed a specialism in paediatric caseloads[2].

A survey conducted by NHS England (NHSE)[35] published in 2024 found that around one in eight children aged between two and 10 in England are obese, with obesity prevalence highest among adults and children living in the most deprived areas. Timely provision of orthoses for children facing musculoskeletal problems linked to bodyweight is imperative to contribute toward obesity management in children and young people as well as adults.

These points are hugely relevant to commissioning. If service cost is considered as a prime driver and saving initiatives are imposed this may increase waiting times, supply arrangements and provision time. Conversely, improving timely access to P&O provision can prevent or delay costly treatments and inpatient stays for patients and thereby reduce costs in other departments in the Trust or Health Board.

> ***"For the prosthetic and orthotic profession to meet the lifelong and often complex needs of those living with limb loss, it's imperative that the sector is committed to ongoing learning, development and improvement – individual and organisational. Through our work at the Limbless Association (LA) we are fortunate to work closely with many highly skilled and dedicated clinicians and MDTs who apply those principles with agility and passion. However, the operating environment has never been more challenging and we fully support the aims and ambitions of these guidelines. At the heart of this vitally important sector are service users whose rehabilitation outcomes can only be realised if there's a commitment to driving service excellence and equity. We believe that this can be achieved through ensuring there's a highly skilled, resourced, valued and supported workforce which these guidelines champion."***
>
> **Deborah Bent**
> *CEO, Limbless Association*

3 Current arrangements

3.1 Current Commissioning Arrangements

The majority of prosthetic and orthotic services in Wales and Scotland are delivered by in-house NHS teams. In Wales, the prosthetic provision is the responsibility of NHS Wales Joint Commissioning Committee (previously known as Welsh Health Specialist Service Team.)[36].

In Scotland, several centres treat prosthetic patients and two specialist prosthetics services (one in Glasgow and one in Edinburgh) are responsible for the assessment, prescription, and provision of 'specialist' prosthetic limbs[38].

Prosthetics in England come under specialised commissioning within NHS England[38]. This consists of a dedicated clinical reference group of clinicians, commissioners, and service user representatives who create a commissioning policy and service specification along with a mandatory patient outcome reporting process. Some prosthetic services in England are delivered by in-house NHS teams but most are contracted out to commercial organisations, including those in Northern Ireland.

While some orthotic services are delivered by in-house NHS teams, most (approximately 65%) services in England and Northern Ireland are commissioned locally to deliver services in outpatient departments, schools, and other locations to support 'care closer to home'. Orthotics may also be packaged as part of other treatments, for example; commissioning of hip replacements may include associated orthotic costs including hip orthoses and shoe raises as a result of leg length discrepancies, and spinal surgery may include the associated orthotic costs including spinal bracing.

There have been and continues to be challenges in the local commissioning of orthotic services, primarily because these services are often incorrectly viewed as a 'fitting' service and contracted in the manner of a product procurement without appropriate clinical input to the commission/contracting process. There have been a series of reports produced over the years to highlight the benefits of orthotic services[21,32,39]. BAPO strongly recommend consideration of this guideline in conjunction with these reports in commissioning and setting up orthotic services.

Services should be commissioned / contracted based on an understanding of current and future demand and capacity based on the output of job planning, such that an appropriate mix of competencies is available to meet the needs of the service as well as supporting practice placements for learners and the required time for the preceptorship of preceptees[40]. A combination of experienced orthotists, graduates, and support workers will, for example, ensure service users are able to see the most appropriate member of the team, enabling low complexity work to be carried out by the support worker and allow the experienced clinician to practice at the top of their licence to support and mentor the graduate.

> *A good prosthetist or orthotist who listens, cares and does what they say they will is everything to the end users confidence, progress and eventual ability. They hold the key to how much or how little we can achieve and our results are in their hands. They should be valued, nurtured and included in the development of equipment choice, patient care and positive results they help us achieve.*
>
> *Thanks to those who listened, cared and did for me.*
> *My results are yours too.*
>
> **Cor Hutton**
> *Founder of Finding Your Feet, Scotland's leading amputee charity*

3.2 'In House' and 'Contracted' Services

'In House' services are where the NHS provides the clinical service directly, with NHS Trusts and Health Boards providing the facilities to run the clinics and employing the prosthetist/orthotist and healthcare support workers, including technical staff, directly. Most prosthetic and some orthotic services will have onsite workshops for manufacturing. These services will undoubtedly still buy in stock and some bespoke products which cannot be manufactured on site.

'Contracted' services are where external companies provide the clinical service and are sub-contracted by the NHS Trust/Health Board or directly by the Integrated Care Board. Custom prostheses/orthoses are manufactured by the company either on site or at the contractor's external premises. The clinicians are employed by the company. A fully managed 'contracted in' service may also involve the contractor being responsible for procurement of stock (including off-the-shelf prosthetic and orthotic products), provision of the clinical facilities/building, and provision of clinic administration staff and systems for recording notes, ordering P&O devices and monitoring the service.

The majority of NHS prosthetic and orthotic services are contracted with the 2023 workforce review demonstrating that 62% of prosthetists and orthotists are employed by external companies providing sub-contracted services to the NHS[4]. This model is most prevalent in England. The majority of Scottish and all Welsh services are in-house services and are delivered by NHS employed staff.

In reality, many services are a hybrid of these models. An example would be a mainly 'contracted' service where the clinical staff and bespoke orthoses or prostheses are provided by the contractor, but where the commissioning organisation retain control of administration and stock goods procurement. Alternatively, a service may be mainly 'in house' where staff are directly employed by the NHS Trust (or Health Board) and most custom products are manufactured on site but a gap in manufacturing capability requires contracts to be established for the procurement of a defined group of bespoke goods.

Examples of real-world models of service delivery can be found in the 2015 NHS England Report 'Improving the Quality of Orthotic Services in England'[6]. The report by BAPO 'The impact of commissioning and contracts on the training, education, and development of prosthetists and orthotists - a review'[40] includes discussion of funding models. It is of note that the majority of in-house services and contracted prosthetic and joint prosthetic and orthotic services are funded by block contracts. The majority of orthotic services, which represent the largest number of services, are based on a session or service fee, often with a commitment from the Trust/Health Board to purchase custom product from the same company.

3.3 Options for service delivery

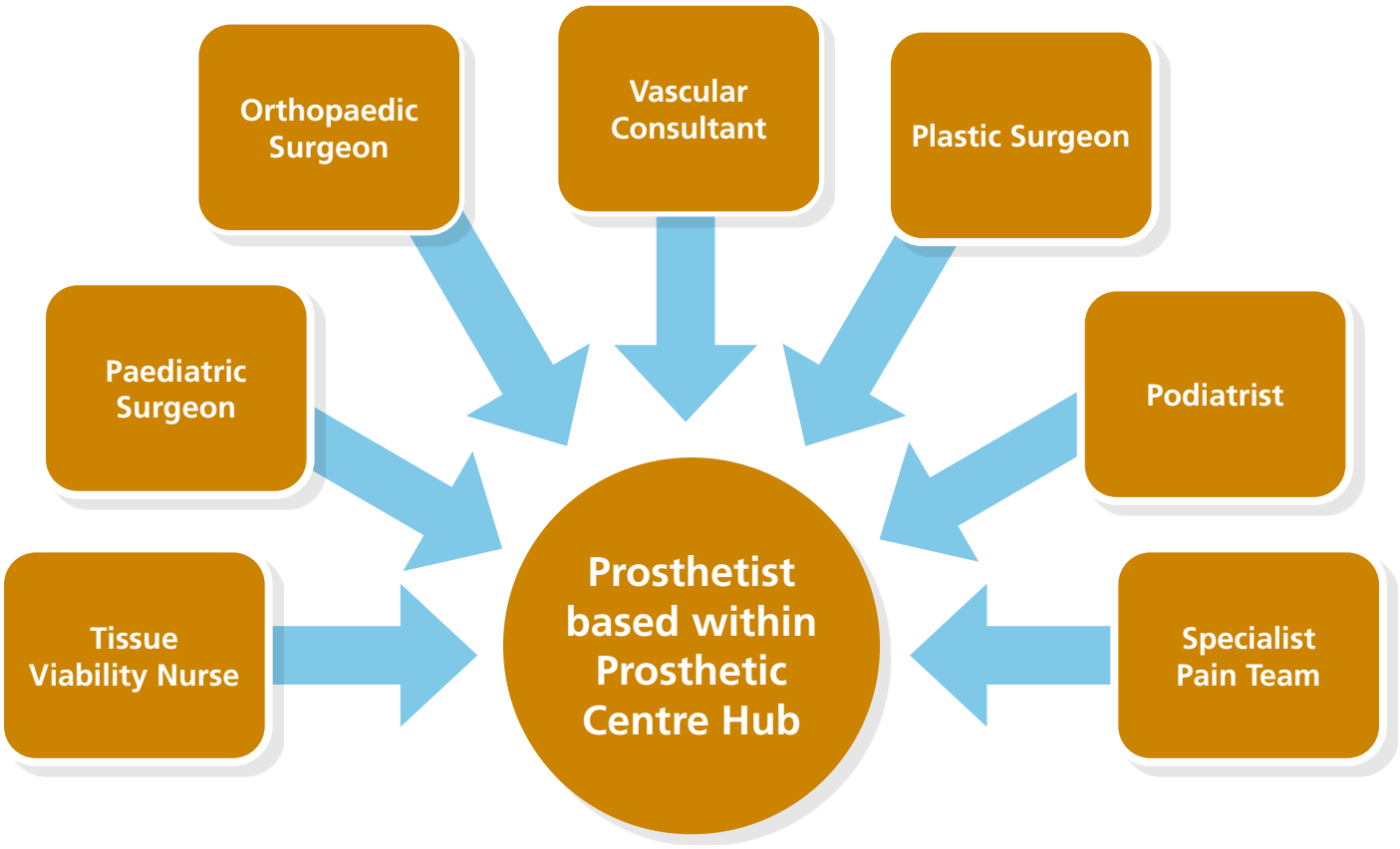
There are many examples of prosthetic and orthotic services being commissioned as a joint service; typically requiring a large specially designed care centre to serve a wide region or high population base. Benefits include; sharing of administration and technical staff whilst also making efficient use of workshop space, machinery and tools, raw materials, stores, and office resource.

It may be beneficial for certain prosthetic and orthotic services to be commissioned as a component element of a larger specialist MDT care centre. Typically, this would be in the form of an integrated mobility service and may involve sharing of resources with disciplines such as; wheelchairs and seating, assistive technologies, physiotherapy, and occupational therapy.

However, not all services are able/suitable to be commissioned as a dual service. Commissioners may wish to separate prosthetics and orthotics into distinct entities and provide these as standalone services, perhaps with the goal of providing care in the community rather than at specialist regional centres.

Traditionally, many prosthetics services were designed as a hub and spoke approach, whereby those with limb absence are referred to a specialist centre for assessment and provision, with satellite clinics to provide routine care. Satellite clinics are now less common and service users usually go to enablement centres for their care. This maximises MDT working, allowing individuals to access to the appropriate specialists during their appointments. This has become increasingly beneficial as the population cohort increases in complexity.

In the specialist centre, alongside the prosthetist the MDT often comprises of members including; a rehabilitation consultant, specialist nurse, occupational therapist, physiotherapist and a psychologist/councellor. Other specialties, such as shown below, are likely to have close working relationships with the centre.



The nature of an orthotic service is often more complex to define. This is because there is the requirement for orthotic input in both primary and secondary care settings. Furthermore, the caseload of potential orthotic service users is also much greater than in prosthetics. Often commissioning groups will seek standalone community based 'general' orthotic clinics which cater for all service users regardless of pathology or type of orthosis required, taking on referrals from medics, general practitioners, AHPs, and nursing colleagues. Some services also allow self referral. Hospital based orthotic clinics are often created when a large cohort of service users are identified with complex but similar needs. Examples of specialist orthotic clinics include; paediatrics, diabetes, stroke, neuro rehabilitation, spinal, orthopaedics and rheumatology. In these situations, it is common practice for the orthotist to integrate themselves as a part of the MDT and take their skillset into the specialist centres to work in close partnership with the medical consultant overseeing the service:

4 Key Aspects of Service Delivery

Introduction

First and foremost, prosthetic and orthotic services are clinical services and require all of the considerations in both environment and support as for any other clinical service with access to the Lead/Chief AHP (or equivalents) whose role is to advocate for the AHPs in the Trust/Health Board and ensure they have a voice in the hierarchies of the organisation - whether they are directly employed by the NHS or contracted[40]. These guidelines are an adjunctive to the national service specifications and seek to ensure that services enable clinicians to work within the standards set by HCPC[41,42] and professional bodies (e.g. BAPO)[43].

BAPO recommend a series of subject matters for consideration when commissioning, planning, or reviewing services, full details are provided below:

- Environment, Facilities and Location
- Access to Information
- Referral, Triage, and Service Access
- Appointing and Episodes of Care
- Procurement, Provision and Timely Delivery
- Communication with Healthcare Professionals
- Inclusion of technical colleagues and support workers
- Continued Professional Development and Workforce Planning
- Administrative Support
- Systems and Record Keeping
- Protecting Service Users and Staff
- Clinical Governance
- Evidence Based Practice
- Stakeholders
- Multi-disciplinary working and clearly defined clinical pathways

4.1 Environment, Facilities and Location

The following information provides specific recommendations for the specialist prosthetic/orthotic environment. The chief function of a prosthetic/orthotic clinic setting is to provide a safe environment for the service user and clinician to provide specialist consultation, examination, and treatment.

Routinely, prosthetists/orthotists report inadequate clinical environments which fail to protect privacy and dignity of service users

Below are listed all the features that would be expected of a main clinical centre. Where prosthetic and orthotic outreach services are conducted, efforts should be made to provide all these features:

- The service must be fully accessible, including wheelchair accessible with an appropriate waiting area and reception facility.
- Separate and appropriate waiting area and treatment rooms for children.
- Service users must be able to be accompanied by a family member, carer or chaperone with sufficient space to accommodate all comfortably.
- Environments must offer service user privacy and protection of dignity.
- The service must have access to a height-adjustable couch or plinth.
- Plaster casting, scanning, computer aided design/computer aided manufacture (CAD/CAM), and/or alternative shape capture and measurement facilities must be available. This should include equipment to facilitate good ergonomic working practices for the prosthetist/orthotist, e.g. height adjustable clinician seating and height adjustable furniture for supporting the service user's limbs.
- A suitably equipped positive plaster cast rectification area should be available for prosthetic services.
- A private, service user walkway must be available, not a public corridor. Gait assessment, whether observational or instrumental, is critical to the process of prosthetic/orthotic practice from assessment to the final dynamic check out of devices. A 10-meter walkway should be considered a minimum to allow the clinician to undertake validated timed walking tests which are approved for outcome measurement in prosthetic and orthotic practice[42].
- There must be ready access to wheelchairs and walking aids, and to a parallel bar set up.
- Access to workshops for the manufacture, repair and adjustment of prostheses and orthoses should be available onsite.
- Adequate storage, infection control and decontamination facilities are particularly important for safe practice. Hand washing facilities must be provided. There must be suitable disposal methods for general, clinical, infectious, and sharp waste. These facilities should be in close proximity to the clinical area
- There must be appropriate lighting, flooring and ventilation, the latter is mandatory in manufacturing areas where there is heavy machinery and/or chemical use (i.e. adhesives and solvents).
- Clinic spaces should have facilities to regulate the temperature in the space.
- At all times there should be a focus on maintenance of the professional appearance of the service environment. This point is also applicable to the professional appearance of staff who should work within a uniform policy and maintain high personal hygiene standards.

Given that a high proportion of prosthetic/orthotic service users present with profound mobility impairment, services should be fully accessible for wheelchair users and walking distances from transport drop offs and the car park should be minimised. Accessible toilets and changing facilities should also be provided.

The service should be provided in a location which is accessible for the patient caseload. Ideally the service will be near public transport links and/or parking to encourage service users to make their own travel arrangements where possible. The service will supply suitable transport services for service users who are unable to make their own way for medical reasons.

Services should be located in close proximity to adjunctive services to minimise travel for service users attending multiple appointments and to allow prosthetists/orthotists to easily link in with colleague AHPs such as physiotherapy, occupational therapy, podiatry, orthopaedics, access to interpreting services and staff access to health and wellbeing support services and occupational health (externally contracted staff should have equal access as their NHS employed colleagues).

4.2 Access to Information

Throughout their contact with the service, the service user should have access to information on all aspects of their care to empower them to make informed choices[12]. The service provider should be able to demonstrate that service users have access to the following:

- Key operational details of the centre such as: opening times, contact details and emergency access pathways
- Details of a named clinician allocated to their care
- Specific written information about care and use of any prosthesis/orthosis provided, any potential problems to be aware of and what to do about them
- Conditions of provision of the prosthesis/orthosis
- User groups and/or service user support systems in the localities served (if applicable)
- Charities and organisations providing relevant support to the service user
- Other sources of information such as web addresses and other local and national organisations
- Carer support networks and organisations

4.3 Referral, Triage, and Service Access

On receipt of a referral, the clinical team should triage the referral and ensure:

- Appropriateness of referral
- Priority and urgency
- Appointment duration required
- Any special facilities or equipment anticipated to be sourced
- Skill level needed to assess the patient (enhanced, advanced, or consultant level practitioner)
- Where possible, enhanced vetting of referrals should be undertaken using active clinical referral triage (ACRT), in line with waiting time initiatives[46].

The prosthetist/orthotist must have full access to referral details including past medical history, medications, comorbidities, and previous device prescriptions – all of which may influence treatment. The clinician should also have full access to medical imaging records and may make requests for further investigations where appropriate.

Prosthetic and orthotic services should meet national 'referral to treatment' (RTT) targets[2] and should ensure a service user's first appointment is timely and timed to complement any other treatments they are receiving. For certain service users and referrals, it will be appropriate to prioritise their assessment and intervention. The service provider will be able to demonstrate that mechanisms are in place to manage new referrals to ensure service users are seen at the optimum time for their first assessment and that the service meets any national, regional or local standards which are in place.

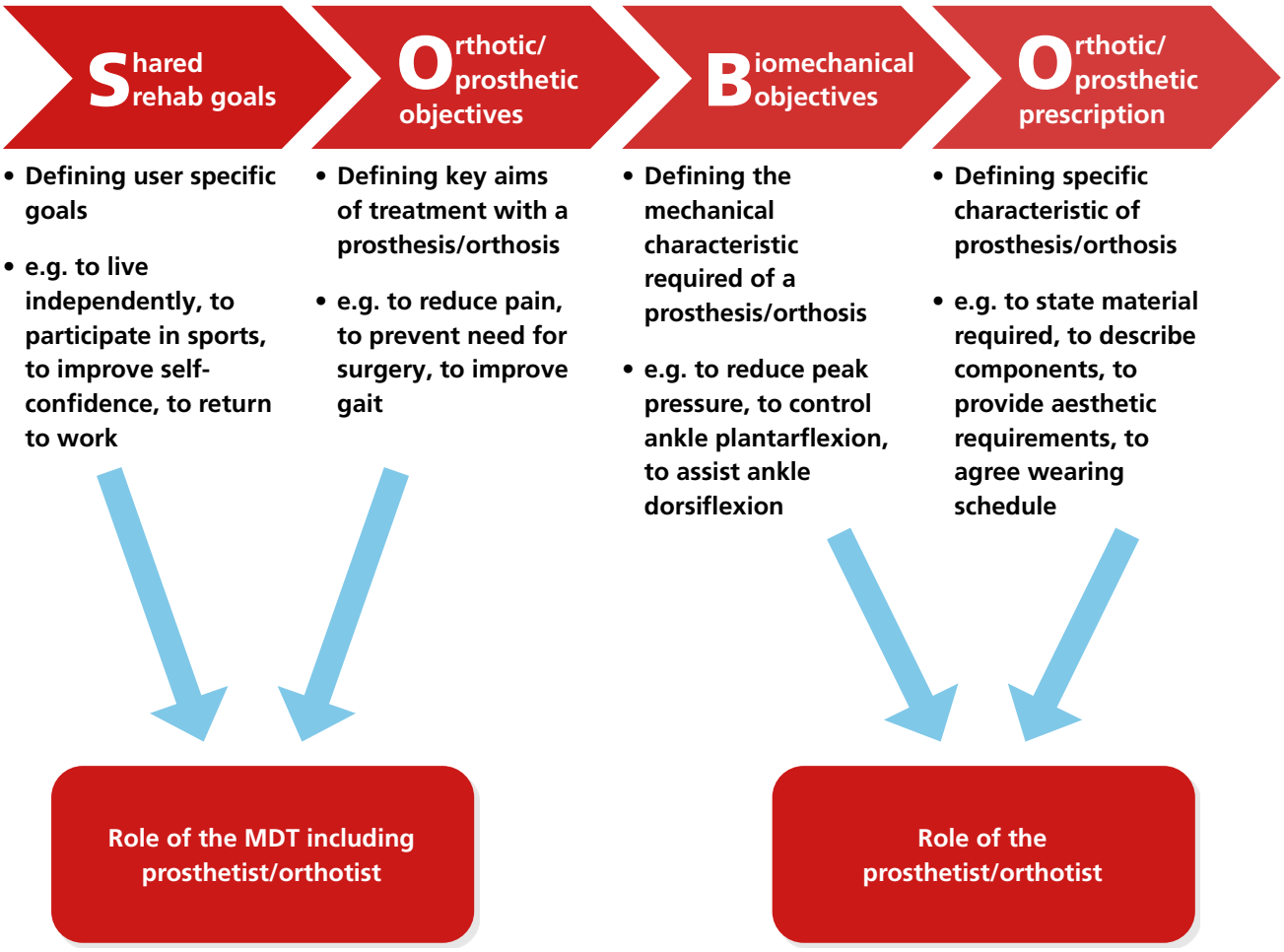
The service should monitor adherence to triage protocols where there is a stated mandate on how this should occur.

Service users will be able to access all the necessary healthcare disciplines to meet their needs within the service and/or by referral to a suitable local provider.

The service should endeavor to minimise multiple hospital visits by combining prosthetic/orthotic appointments and other therapy appointments where viable.

Telehealth / video / telephone appointments should be embedded into the service to provide alternative modes of access, reducing the burden of treatment for service users with long-term conditions. The service must have a robust process for determining which services users should access treatment via telehealth, following the guidance in the AHP Telehealth Guidelines[47].

Service referral forms should be designed with: shared rehabilitation goals, orthotic/prosthetic objectives, biomechanical objectives, and orthotic/prosthetic prescription (SOBO), and referrals made should promote 'SOBO Steps to Success'. Referrals which dictate a specfic prosthetic or orthotic device instead of requesting an assessment are not appropriate. BAPO has dedicated orthotic referral forms which indicate the information required for an appropriate orthotic referral



Clinical urgency may necessitate immediate access for a service user. Scope should be provided within appointing diaries to allow treatment of unexpected emergency cases, should they arise. Similarly, emergency requests for repair of a broken or faulty prosthesis or orthosis (upon which the service user is reliant) should be appointed to clinic within one working day.

Prosthetic service users may be referred either pre-operatively (before elective surgery) or post-operatively. Children with congenital anomalies can be referred as soon as the condition is identified (i.e. parents may be referred to the service before the child is born).

Established service users should be able to self-refer at any time for review/repair/re-assessment.

Amputees not currently registered with centres should be able to be referred by their GP, healthcare professional, or previous prosthetic centre. There should be provision for out of area emergency appointments for prosthetic service users.

If a service user does not move address, but wishes to be seen by another service, the current service must be informed, the prospective receiving service must agree to take on care of the service user and the host clinical commissioning body must agree to fund the transfer of care.

Service users who are war pensioners and access services because of injury whilst in the armed forces are entitled to priority treatment for that condition[46].

4.4 Appointment Logistics and Episodes of Care

Episodes of care should be planned upon the completion of assessment, with careful scheduling of follow up appointments. Where a series of appointments are required within an episode of care, these should be scheduled at the outset to minimise timescales between appointments. Full guidance on using episodes of care within prosthetic and orthotic practice is outlined in the BAPO Standards for Best Practice[42].

The service should offer flexibility in appointment times to meet the needs of individuals and offer choice to the service user making appointments. This may include the availability of appointments outside normal working hours, if considered viable, based on service user demand and resources available (including; finances, personnel, facilities, etc...).

For the safety of the service user, the service should empower the clinician to work within BAPO recommended appointment time guidelines

The service will have a clear policy for the follow up of service users. This may include a patient initiated follow up (PIFU) policy. Minimum review periods should be established for:

- Paediatric and adult user groups
- Service users undertaking their first episode of care (known as primary service users)
- Users of prostheses and orthoses which require regular mechanical inspection and service as outlined by the manufacturer

Domiciliary visits should be an option where the need of the service user warrants this, and the resources available.

To comply with HCPC Standards of Proficiency[42], the service will strive to record meaningful outcome measures for every service user reviewed and all current service users will have an up-to-date care plan. The service will audit and track the proportion of records with these aspects detailed. There should be a requirement to appropriately demonstrate to service commissioners the service user outcomes and the results of any audits conducted.

Apart from mandated prosthetic outcome measures in England, patient outcomes are rarely requested or presented to service commissioners which may, for example, somewhat impede service development requests and investment in the service if evidence of service benefits is limited.

The service will have a discharge, onward referral and outcome reporting policy which will include did not attend (DNA) protocols. The DNA protocol must have mechanisms to flag potential safeguarding issues. For further information on safeguarding see BAPO's guidance[48].

4.5 Procurement, Provision and Timely Delivery

Systems are required to support prompt and accurate ordering of the prosthesis and orthosis following assessment. Stock products should be available on a 24-hour delivery service for urgent cases. Bespoke products should be available in five working days for simple products, 10 working days for more complex and up to a maximum of 30 working days for complex bespoke products. For service users dependent on their prosthesis or orthosis, a spare device should be issued. Provision allowances should be in line with national policy where applicable[49].

An efficient rapid repair service should be available which will ensure extended lifespan of each prosthesis/orthosis[12].

Services should have the ability to electronically track and trace prostheses and orthoses and their componentry parts. Unique reference codes for each device and batch codes for individual components should be documented in the service user's clinical notes and linked prosthetic/orthotic order to allow manufacturer recalls to be processed.

The service should have a policy for the provision of high-cost components which is agreed with commissioners of the service and includes a process for scoping funding of exceptional cases.

The scope of services covered will be defined by the commissioning arrangements. Services should have clear protocols for signposting or managing service users who may present who are out of that scope. There are special arrangements for military personnel via the Ministry of Defence. The requirements for children's services should also be considered.

Unmet clinical need should be identified, quantified, and brought to the attention of the commissioners for consideration for individual funding

After assessment, the service should enable timely delivery of the prosthesis/orthosis. What can be considered 'timely' varies greatly depending upon the presentation of the service user, complexity of their condition, type of prosthesis or orthoses to be supplied, and readiness of access to ad-hoc resources. The service should be guided by recommendations made by the clinical team.

The service should regularly review delivery times and look to identify and remove any barrier to timely delivery.

Services should establish and monitor target timescales for delivery of 'standard' devices, particularly for the areas of practice that constitute the main volume of caseload of the service. Regular audit should be undertaken to report performance in meeting targets. Services should also be conscious of aggregating orders to improve efficiency and to schedule deliveries in line with the environmental / carbon reduction policies under which the service has been commissioned.

Satisfaction with speed and quality of provision should be a core theme to consider when approaching service user representatives to garner feedback on the service

> ***"This guidance rightly highlights the urgent need for increased funding and investment in the prosthetic and orthotic workforce—without it, meaningful change simply isn't possible. As both a service user and advocate, I know how life-changing timely, high-quality provision can be. Even under immense pressure, there are outstanding examples of good practice across the UK. We must learn from these, raise standards, and end the postcode lottery in care for everyone who relies on these vital services."***
>
> **Kiera Roche**
> ***Founder and CEO of LimbPower***

4.6 Communication with healthcare professionals

Prosthetists and orthotists should be enabled to make onward referrals if the outcomes for the service user could be further improved or if they may be better met by access to a different clinical service. Time will be required to discuss specific service user needs and explore adjunctive treatment options with other healthcare professionals.

Likewise, building relationships with referrers improves communication and optimises service efficiency. Services should be delivering training to referrers on treatment and prescription options to ensure receipt of thorough, appropriate referrals and also ensure that the wider healthcare workforce are skilled to identify potential prosthetic or orthotic users. Outcome reporting should be undertaken to ensure that, at the end of the episode of care, the referrer is aware of the findings of assessment, prescription rationale, treatment success, and future plan.

Prosthetists and orthotists should have the ability to refer service users to counselling services and engage the service user in social prescribing. Prosthetists and orthotists should be trained in mental health and public health skills to support their role in holistic management of the service user. Enabling them to provide a 'preventing ill health approach' and ensuring the right and timely care by the right professional.

4.7 Inclusion of Healthcare Support Workers and Technicians

Prosthetic and orthotic technicians and support workers play a key role in the delivery of timely and quality prosthetic and orthotic treatment solutions

Time should be set aside to allow the prosthetist/orthotist to communicate with healthcare support workers and prosthetic and orthotic technicians.

Services must encourage communication channels to be multi-directional between the clinical, administration and technical teams.

Development of working relationships with bespoke manufacturers should be encouraged to improve and/or maintain ‘right first time, on time’ rates[50].

Development of working relationships with stock manufacturers should be encouraged to allow local product training, awareness of innovative or new products and feedback discussions with the supplier and procurement negotiations.

Processes should be in place to allow technicians to participate in clinical procedures under the supervision of the clinicians. Normally this would be during events such as device fittings, particularly in more complex cases. In some services, patient-facing prosthetic technicians may see service users on their own for repairs where competencies are in place and monitored.

Processes should be in place to allow support workers to participate in clinical procedures under the supervision of registered prosthetists and orthotists, or autonomously where appropriate competencies have been assessed and demonstrated. The specific areas of practice undertaken by support workers will be determined by the needs of the employer.

Non-conformance processes should be established with regular review of performance.

BAPO Support Worker Framework

BAPO report on expanding the potential of the P&O technician and support workforce into patient-facing roles

4.8 Workforce Planning

The 2023 workforce review demonstrated low job satisfaction among the prosthetic and orthotic community. Evidence also indicates high levels of poor mental health and wellbeing within the P&O workforce related to burnout[5]. In order to improve the long-term sustainability of prosthetic and orthotic services, employers should consider implementing strategies to improve staff recruitment, support, satisfaction and retention[51]. The development of clinical staff and progression planning should be considered in line with career frameworks including enhanced, advanced and consultant practice[52-54].

Effective job planning is essential for optimising resources and ensuring the highest quality of care for both service users and staff. By systematically documenting professional activities including time for education and training, job plans enable employers to better understand workforce capacity and align it with service demands. A lack of managerial level training in mental health awareness and support is also required. Research indicates that adequate training has a positive impact on sickness absence[55, 56].

Time and resources should be provided to enable the prosthetist/orthotist to undertake training and supervision of prosthetic and orthotic learners, graduates on preceptorship programmes and support workers, should they be working within the service.

4.9 Continued professional development and supporting professional activities

Prosthetists and orthotists must keep up to date with treatment options and the continually expanding evidence base to support and guide treatment rationale. This includes keeping abreast of advances in materials, techniques, componentry and associated products.

Continued professional development (CPD) is a mandatory aspect of HCPC registration. The service provider must ensure sufficient time is set aside to allow the prosthetist/orthotist to participate fully in this task[41, 42].

Services must ensure that staffing numbers are appropriate for caseloads and that competency frameworks are in place to ensure that the skillset of the clinical team is sufficient to meet the needs of the service users

Meeting the needs of the ageing population is a concern for the national prosthetic and orthotic workforce with increased demand for clinical expertise linked to the rising prevalence of obesity, diabetes, cardiovascular, and peripheral vascular diseases[57]. The service should have a workforce plan to blueprint how they will develop their clinical team going forward with reference to the four pillars of practice (Clinical and Technical, Education and Facilitating Learning, Leadership and Management, Evidence, Research, and Development). This should be based on any identified local factors which indicate that changes to the clinical skillset may be required in the future. Commissioners should take guidance from the nationally approved career framework, education framework and preceptorship guide[58-60].

The service must have structured arrangements to allow management to support staff to develop and improve, ensuring time for mentoring and supervision is built into the role for appropriately experienced staff. Time is also required to support learners on placement, provide preceptorship for preceptees, and to ensure the wider education requirements for prosthetists and orthotists are met. Up to date records of staff training should be held. Individual learning needs should be identified and regularly reviewed alongside performance. Preceptorship for new graduates and a clinical supervision programme should be implemented.

The service should have a clear management structure and leadership development programme.

4.10 Administrative Support

Administrative support is an essential aspect of prosthetic and orthotic services. Prosthetists and orthotists require access to appropriate levels of administration support to meet all administrative tasks required at a local level.

Service users must be given contact details for administrative and appointment booking purposes.

Administrative staff must be given training on the scope and nature of the service in order to best act as a strong liaison between the service user and clinician.

4.11 Systems and Record Keeping

Services should enable the clinician to meet all aspects of clinical record keeping and storage as set out in professional standards[42,43]. Digital systems should meet the same standards expected when processing physical hardcopies.

The organisation which employs professional staff who make patient records is the legal owner of those records. Clinicians and administration staff have a duty to protect the confidentiality of those records. Where a professional is contracted to provide a clinical service to another organisation, contractual conditions will normally specify the legal owner of any records.

'Shared' or 'integrated' record keeping systems (to which all members of the healthcare team contribute) may be used in some situations in accordance with an agreed local protocol. However, prosthetists and orthotists must always have access to relevant aspects of the service user's clinical record to allow them to develop and maintain an appropriate treatment plan.

The service should have an integrated information communication technology system which enables the storage, appropriate management of information and run operational systems. The system should be able to provide:

- service user demographic information
- clinical note keeping
- referral and transfers between centres
- financial information
- appointment utilisation
- equipment/components currently and previously issued
- service user outcome reporting
- total service user numbers

The management of any systems in use within centres will comply with the Department of Health Policies for Information Governance[61].

A recent study reported that:

'The UK needs to establish appropriate processes to record the quality of service provision to enable improvements in clinical management and to get good value for money'[2]

4.12 Protecting Service Users and Staff

Service providers will train all staff in safeguarding and a named person will act as safeguarding lead, with links to local community and emergency safeguarding services established.

The service will ensure service users' rights to privacy and ensure that dignity is maintained at all times

The service should be able to respond to requests for a service user's chosen person: a partner, carer, relation, guardian, or advocate to accompany them during their treatment.

The service user may make a request for treatment by a clinician of the same sex, which should be accommodated where possible. All services users should have access to a suitable chaperone if requested or required during service user treatments.

The clinician and service user must have access to interpreting services and not be reliant on non-licensed interpretation provided by a relation or friend.

Comprehensive print guidance should be made available to help the service user, and their carer where applicable, safely understand and utilise the prosthesis/orthosis prescribed. Similar documentation will be available to instruct and advise on common areas of self-management care. Printed resources are not universally accessible by all service users and therefore the service should be able to demonstrate equality considerations by providing flexible guidance arrangements based on the foremost needs and capabilities of the service user.

Incident and near miss reporting systems should be in place and monitored for all health and safety and medical device concerns.

The service should have a planned preventative maintenance programme to ensure all prescribed devices are serviced within manufacturers stated timescales.

The service should have a detailed safe staffing policy in line with guidance produced by NHS Improvement (NHSI)[62].

The service should have a policy detailing zero tolerance to bullying, discrimination, and harassment and consider how NHS plans such as the equality, diversity, and inclusion improvement plan and people promise can be embedded[60,61].

There must be a clear process for staff to raise concerns with access to whistle blowing procedures, freedom to speak up (or equivalent), and grievance processes. Similarly, there must be a clear process for service users to raise concerns and this should be clearly documented within the department, on the organisation's website, and in patient information leaflets.

'Off-label use' is when a medical device is adapted, altered or used in a manner other than that specified by the manufacturer. Services should have risk assessment procedures in place where 'off-label' devices are in use. These should meet Medicines and Healthcare products Regulatory Agency (MHRA) stipulations[65].

Clinical and patient facing staff will be subject to ongoing need for criminal and disclosure checks as appropriate depending upon the region of the UK.

Services which have prosthetic and/or orthotic workshops require appropriate health and safety and COSHH regulations and processes. Staff operating machinery and tools require appropriate training.

The prosthetic and orthotic workforce require appropriate access to health and wellbeing services and occupational health within the Trust/Health Board in which they work.

BAPO has produced a compehensive guide on **safeguarding for prosthetists and orthotists**.

4.13 Clinical Governance

Clinical governance is 'a framework through which organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'[66, 67].

Services must engage in regular audit of performance in all aspects of service delivery including clinical, technical and administrative areas to illustrate, for example, service efficiency and service user outcomes. Routine monitoring and reviews against agreed key performance indicators (KPIs). A DNA rate of 5% or below should be the standard; the national mean for orthotics is estimated to be 8%[2].

Services must adopt evidence-based practice and establish recommended treatment pathways for service users which are underpinned by this. Services must contribute to national outcome measures to support national guidance.

The service provider should be able to demonstrate the following:

- service users receive the most appropriate treatment to meet their needs
- the role of each member of the team in the care pathway
- clear criteria is in place to identify the range of prescription options that are made available to service users based upon presentation of the individual
- a record is kept of audit activity in relation to clinical effectiveness of treatment
- there are policies in place to cover the participation of service users in research and development activity
- processes are implemented to oversee the introduction of new treatment modalities should these arise or when novel components are introduced to the marketplace

Services must have a strategy for acceptance and responding to compliments and complaints from their service users. Similarly, services should actively seek to involve and consult local service user groups regularly.

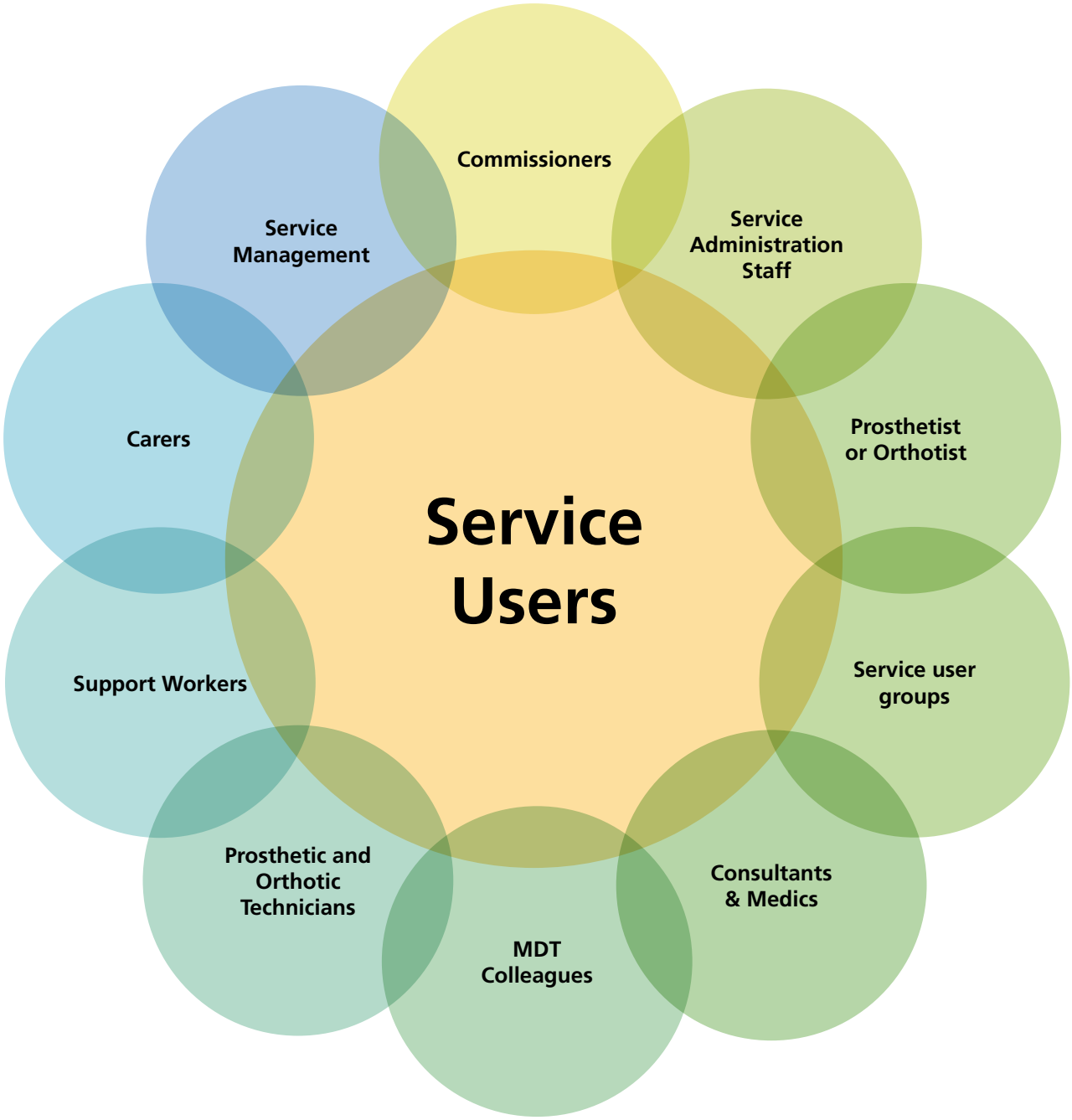
A quality system should be in place (e.g. International Organisation for Standardization (ISO)) to monitor and improve standards of service. This includes; quality of technical work being carried out, quality of product and, quality of service provision.

The service should have policies to cover all aspects of health and safety and demonstrate monitoring and action plans to resolve problems. This includes industry specific equipment issues (such as; MHRA reporting, component reuse, and component maintenance, etc...) and general workplace issues (such as incident reporting, moving and handling, first aid, fire safety, infection control, etc...)

> ***"When it comes to quality of life, P&O services are game changers. I know just how vital these services are to the people who rely on them. The services BHTA members provide are life-changing, empowering service users to live independently, remain active, engaging in society. This guidance is a key step toward making sure everyone has access to consistent, high-quality support—wherever they live. P&O is perfectly positioned to deliver the NHS 10-year plan; delivering care in the community, utilising digital technologies and preventing ill health. Through effective commissioning and engaged service managers I am confident we will create the framework to position the profession to deliver a world class service."***
>
> **Ben Taylor**
> ***P&O Section Chair, British Healthcare Trades Association***

4.14 Stakeholders

Services without active stakeholder engagement risk stagnation[12]. The practice of having a meaningful dialogue with provider organisations and local populations produces huge benefits as building partnerships enables a shared vision of which outcomes are most valued[24]. For these reasons, services should establish stakeholder representative groups. The make-up of these will vary on a local level but should include:



The service must ensure that it promotes itself and its actions to all within the stakeholder group. The stakeholder group should be consulted regarding any proposed changes in service delivery.

Service management will have a regular and active presence in clinical environments to walk the service user journey and consider service delivery from both the service user, administration, technician, and clinician's viewpoint.

4.15 Evidence Based Practice

Where sufficient guidelines and literature are published, services should establish treatment pathways which are supported by quality evidence and adapted to sit within the framework of the service model.

Trusts and Health Boards must support and empower research within their prosthetic and orthotic services to enable the best outcomes for its service users.

The service will identify 'priority' products and devices for key health conditions to establish treatment pathways. Areas of consideration would be products or health conditions which consume the largest financial spend or demand upon clinical time.

Treatment pathways should be reviewed cyclically to establish whether there is updated literature on the topic. Feedback should be considered from the service users and clinical success examined by reviewing outcome measures collected.

In the absence of clinical evidence, there should be a record of sound clinical reasoning in justifying treatment choice and prosthetic/orthotic provision.

At all times, the service will align its delivery of care with the current public health agenda and support people to live healthier lives

"The best day of my life was the day I took my first independent steps on my first prosthetic legs - because in that moment I knew that I was getting my life back – that I was getting a second chance to be out there really living my life and being who and all that I am. That is what I tell first year P&O students embarking on a profession that will give them the opportunity to transform lives every single working day and the power to facilitate the hopes, dreams and ambitions of multiple people at every stage of life.

Pain-free, independent mobility is impossible to put a value on – whoever and wherever you are. My legs are my most valuable possession. They give me autonomy, dignity and hope. And it is my deep gratitude to my prosthetists that motivated me to set up and run a charity which supports P&O services in Africa. I wanted to give people who have no autonomy, no dignity and no hope, simply because they were born in a different country from me, the same second chance to live their lives that we have the luxury of taking for granted through the excellent services in this country."

Olivia Giles, OBE
CEO of 500 miles (www.500miles.co.uk)

4.16 Advocating for prosthetic and orthotic services

Prosthetics and orthotics is the smallest of the allied health professions in the UK. While there are examples of well-integrated P&O services within Trusts and Health Boards, these services are too often siloed, perceived more as procurement functions than as vital clinical service, and are not fully embedded within healthcare organisations. P&O services have a significant impact on both individuals and society. Through relatively low-cost interventions, they help alleviate pain, enhance mobility and independence, and improve quality of life. These outcomes not only reduce pressure on other healthcare services but also enable many individuals to return to work and actively contribute to society. However, these benefits are currently limited to those who are referred to P&O services.

Many potential referrers remain unaware of the scope of prosthetics and orthotics and the benefits they offer to service users. Currently, there is no formal mechanism to raise awareness and understanding within the broader healthcare community. By improving communication and outreach, there is a tremendous opportunity to expand the reach of P&O services and extend health and social benefits to many more individuals who are not currently being served.

Chief AHPs, or their equivalents, play a critical role in changing this narrative. They must advocate for P&O services, ensuring they are recognised, valued, understood, and embedded within the wider organisational structure and clinical pathways. This responsibility extends to all prosthetic and orthotic services treating NHS patients, regardless of whether the staff are directly employed by the NHS or by contracted providers. It is essential for Chief AHPs to familiarise themselves with their organisation's P&O services, understand how they operate, identify the challenges they face, and determine the support they need. A commitment to collaboration, barrier removal, and equitable treatment is essential to addressing the unique challenges faced by smaller services.

Chief AHPs also have a vital role in ensuring prosthetists and orthotists have access to preceptorship, training, and educational opportunities. Their support in commissioning discussions is especially important, advocating for services to be commissioned with a clinical lens rather than solely through procurement considerations.

A recent BAPO report[40] revealed that fewer than half of Chief AHPs engage with their organisation's P&O service. This lack of engagement often means Chief AHP, who lead the development of AHPs within Trusts and Health Boards, are unaware of the needs of clinicians in P&O services. Consequently, these clinicians may be excluded from AHP-related updates, policy discussions, staff communications, and development opportunities, leaving them without a voice in key professional matters.

Chief AHPs hold positions of significant influence and can be powerful advocates for the P&O workforce. Their leadership is essential in ensuring the P&O profession is:

- Fully integrated within Trusts and Health Boards
- Appropriately funded to meet service user needs
- Granted equitable access to training and education
- Offered equal opportunities for secondments and job progression
- Actively included in AHP initiatives and meetings
- Valued for its contributions and clinical expertise
- Given a voice equal to other allied health professions

It is time to ensure prosthetics and orthotics are no longer the hidden profession within the allied health professions. Through proactive leadership and intentional inclusion, we can create a more equitable, effective, and integrated healthcare system.

5 Implementing this guidance

5.1 Key points

The 2015 NHS England report 'Improving the Quality of Orthotics Services in England' presented '10 Steps towards Effective Commissioning'[6]. BAPO support these key recommendations:

1. Understand what orthotics care is by talking to service users, carers, managers, clinicians and the MDT
2. Examine all of the funding streams being utilised
3. Unbundle these funding streams to understand the total orthotic investment and consider using a tariff
4. Consider adopting the model service specification
5. Clarify the service delivery model required
6. Think about the location
7. Promote access and choice
8. Encourage MDT working by commissioning multi-disciplinary pathways for specific conditions which includes prosthetic and orthotic care
9. Look at case studies to inform the most appropriate commissioning model in the area
10. Involve service users in performance reviews of the service

In addition, BAPO propose the following when commissioning prosthetic and orthotic services:

1 Recognise the prosthetic and orthotic services already commissioned	Does the Intergrated Care Board have a listing of all providers and their services?
2 Have ambition for the services & the people they serve	Consider encouraging services to start small and then support them to grow. Collect and document evidence of the benefits of the service.
3 Prosthetic and orthotic services should not be 'extra' or an 'add-on'	Does walking the pathway of care with a user identify any gaps or areas for improvement? Have the prosthetics and orthotics services been considered integral to sustainability and transformation plans?
4 Consider outcomes to be achieved	The key principle behind commissioning for outcomes is a clear focus on the actual results being achieved and putting in place the most effective model to then achieve those results
5 Identify some common measures and ask services to work together	Establish what outcome measures are already being collected. Are they robust and can they be used for benchmarking? What processes are in place to collect information on the service user experience? How is this used by providers to improve service provision?
6 Consider the range of settings where services are delivered, especially community settings	Have services been commissioned that focus on care closer to home? This is particularly important for prevention of admissions and maintenance of long-term conditions? Can aspects of paediatric care be delivered in schools which cater for children's additional support needs which is often an effective way to link with the physiotherapy team. What are the governance arrangements in community settings?
7 Take a strategic view to invest to save	Consider how prosthetic and orthotic sevices can help deliver primary, secondary and early intervention for a local diverse population? Complete an assessment identifying current inequalities in access and outcomes and future potential demand?
8 Cross-check services against the local rehabilitation model to identify gaps or duplication	Are traditional aspects of prosthetic and orthotic care being undertaken by the other AHP groups at present? Could these be done better or more efficiently by a stand alone service? What is the limit/ceiling of treatments provided by other AHP groups?
9 Ask for advice and support if necessary	What forums are used to share good practice locally, regionally and nationally? Engage with peer review or site visits to other services which are similar
10 Note that there is no single evidence-based model or blueprint for commissioning	Commissioners need to find the best approach for any given situation with the confidence to create innovative and transformational change

5.2 Steps to Effective Planning and Service Review

BAPO recognise the performance indicators, such as those set out within the national 'Orthotics Model Service Specification', as an important tool of use for continuous monitoring of successful service delivery[39].

The World Health Organisation suggest a four-step process which could be implemented as a service review cycle[12]. It is vital to be realistic about the time expected for benefits of change to be realised and for providers to build the capacity to realise the desired changes.

Below, BAPO has added some suggestions of questions to consider to achieve this process:

Establish a baseline

a What data is currently collected and available?
b What feedback do you hold?
c How does this compare to other services you manage?
d How does this compare to other prosthetic and orthotic services?

Prioritise for action

a What aspects require the foremost action?
b Consult and plan with relevant stakeholder groups

Prepare a strategic plan with targets

a Document how, what, why and when changes in services will occur.
b Consult strategic service plans and targets with relevent stakeholder groups.
c Set SMART goals (Specific, Measurable, Achieveable, Realistic, and Timely).

Compare against baseline

a Has the data or feedback changed?
b Is this a result of the changes which have been made?
c Is the outcome satisfactory to the stakeholder group and principal service users?

6 Principles and Expectations

A good prosthetic and orthotic service should be based on the principles of a good rehabilitation service; good rehabilitation services will[15]:

1. Optimise physical, mental, and social wellbeing and have a close working partnership with people to support their needs
2. Recognise service users and those who are important to them, including carers, as a critical part of the interdisciplinary team
3. Instil hope, support ambition, and balance risk to maximise outcome and independence
4. Use an individualised, goal-based approach, informed by evidence and best practice which focuses on people's role in society
5. Require early and ongoing assessment and identification of needs to support timely planning and interventions to improve outcomes and ensure seamless transition
6. Support self-management through education and information to maintain health and wellbeing to achieve maximum potential
7. Make use of a wide variety of new and established interventions to improve outcomes
8. Deliver efficient and effective treatment using integrated multi-agency pathways including, where appropriate, seven days a week and extended/out of hours service provision
9. Have strong leadership and accountability at all levels, with effective communication
10. Share good practice, collect meaningful data / information that supports decision-making and contributes to the evidence base by undertaking evaluation/audit/research

"Prosthetic and orthotic services are not just about device provision — they are about restoring dignity, independence, and participation in life. A silent long-term partner who is always there to provide a solution to an individual's ever changing life goals. The services offer a cost-effective approach to empower individuals to move, work, and live fully, while also preventing secondary complications and improving overall well-being. The key to all services is accessible, responsive, and equitable person-centered care to transform lives."

Stephen Seccombe
Chair of International Society for Prosthetics and Orthotics; UK Member Society

Commissioners and service managers should be aware of the positive impact that prosthetic and orthotic services can have on the individual service user's quality of life. There are also wider financial savings and social benefits to be appreciated in maintaining employment, independence, reducing care needs, improving accessibility, access to education, integration and participation

It has been documented that the benefits of prosthetic and orthotic services to the NHS are still not fully realised by most commissioners and managers, with a need to ensure that services provide 'the right care, at the right time, to the right quality without unnecessary delays'[21, 22].

Case studies that highlight the devastating outcomes that failing services inflict upon the service user are well documented and should provide a compelling call for action to all commissioners[6, 23]. All commissioners (not exclusive to prosthetic and orthotic services) now face huge challenges in terms of how to; deliver better care for less, how to protect fundamental principles of universal health care, and empower service users with more control over their own care[25].

Prosthetic and orthotic services can provide a much easier and more cost-effective alternative to more complex interventions such as surgery, and maybe more favourable to both the service user and the healthcare budget

Historical service models have viewed prostheses and orthoses as commodities rather than individually prescribed solutions tailored to the service users need[25]. This has, to some extent, devalued the clinical skillset of the prosthetist/orthotist as the importance has been placed on providing products cheaply rather than focusing on the quality of specialist assessment and treatment. However, national workforce planning and upskilling of the profession has changed this landscape greatly.

In the past, those referring into prosthetic and orthotic services would provide a diagnosis and request a device with the prosthetist and orthotist then acting to fulfil the prescription. Such pathways are outdated making access for the service user convoluted[25] and often simplified models where the prosthetist/orthotist is foremost in assessment and follow up, provide greater efficiency for the wider workforce.

The United Nations Convention on the Rights of Persons with Disabilities mandates that healthcare systems ensure that people with disabilities are supported to achieve personal mobility for greatest possible independence[26]. With this comes a corresponding responsibility to promote and ensure the ability of access to mobility aids, devices and assistive technology; including prostheses and orthoses. The importance of ensuring efficient and quality prosthetic and orthotics services cannot therefore be understated.

"I have brittle bones; I spent much of my childhood either in plaster or with my leg in traction following yet another fracture. Each time, I would be back on my feet within days of discharge, learning to walk all over again with the aid of callipers to protect and support me. I owe so much to the dedication of successive orthotists because without them, my bone density, mobility, fitness and capacity to remain independent would have been totally compromised. In my experience, a good orthotist is invaluable and integral to an NHS that delivers a substantial return on taxpayers' ever-growing investment. Their fantastic efforts to enable individuals like me simply to keep the show on the road deserve to be recognised and supported."

Lord Kevin Shinkwin

7 Appendices

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Appendix 2 – Contact Details

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8 Glossary

AHPs	Allied Health Professionals
BAPO	British Association of Prosthetists and Orthotists
CAD/CAM	Computer Aided Design/Computer Aided Manufacture
CCG	Clinical Commissioning Group
CPD	Continuing Professional Development
CTEV	Congenital Talipes Equino Varus
DNA	Did Not Attend
HCPC	Health and Care Professions Council
ICT	Information Communication Technology
KPI	Key Performance Indicators
MDT	Multi-Disciplinary Team
MHRA	Medicines and Healthcare Products Regulatory Agency
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
QOL	Quality of Life
RTT	Referral to Treatment
WHO	World Health Organisation

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