The British Association of Prosthetics and Orthotics

The current situation for NHS prosthetics and orthotics funding

A case for reform

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"BHTA's Prosthetic & Orthotic Group welcomes this report from BAPO as a timely contribution to improving understanding of how prosthetic and orthotic services are funded and how that funding is allocated and tracked across the system. The report highlights recurring themes that matter to patients and the sector alike: the need for greater visibility and transparency of funding flows, more consistent reporting and accountability, and commissioning decisions that are increasingly viewed through an outcomes-led clinical lens rather than a purely procurement-led one.

BHTA has not authored this report and does not direct its conclusions; our role has been limited to external review for clarity and factual presentation, and we support its publication to enable constructive, evidence-informed discussion with clinicians, commissioners, policymakers and stakeholders on the changes needed to secure sustainable, equitable P&O provision."

Ben Taylor
(Chair of the British Health and Trades Association (Prosthetic and Orthotic section)

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Executive summary

This report presents a comprehensive analysis of funding data obtained under the Freedom of Information Act 2000[1] from Trusts and Health Boards across the United Kingdom regarding their prosthetics and orthotics (P&O) services.

The findings reveal a fragmented and often opaque funding landscape that undermines accountability and has the potential to create systemic inequities.

The evidence presented here indicates a clear need to review and reform how prosthetic and orthotic services are funded, monitored, and governed within the NHS.

Critical findings at a glance

62.1% (n=77/124) of Trusts and Health Boards providing P&O services could not provide complete five-year financial data. Only 46 of 124 Trusts/Health Boards providing orthotic services (37.1%) and 15 of 38 providing prosthetic services (39.5%), 47 (37.9%) Trusts/Health Boards in total, could provide complete five-year funding data for one or both of their prosthetic and/or orthotic services (where applicable).

Of £379.89 million in funding received by Trusts and Health Boards for P&O services, included in this review, over five years, only £332.96 million (87.65%) reached the services themselves. The remaining £46.93 million, comprising £34.69 million from orthotics and £12.24 million from prosthetics, was retained at organisational level with no transparent accounting for its use.

The most severe real-terms funding cut occurred in 2022/23, when a nominal increase of 4.87% was overwhelmed by CPI inflation of 10.04%, producing a real-terms cut of 5.17%. This permanently deflated the funding baseline; subsequent years have not corrected the shortfall. The cumulative loss in purchasing power from 2022/23 to 2024/25 is approximately £9.65 million across the 61 services in the dataset.

Per capita spending on orthotic services varies by a factor of approximately 44 to 1 across Trusts and Health Boards, ranging from £8.87 per head at the highest to £0.20 at the lowest. Prosthetic spending varies by approximately 15.5 to 1 between major hubs and peripheral services, from £7.57 per head at the highest to £0.49 per head at the lowest.

These findings likely understate the problem. Trusts and Health Boards with the weakest financial governance may well be the least able to provide data. The services excluded from this analysis due to incomplete data may represent the most severely affected.

1 The funding landscape: a fragmented picture

1.1 Methodology

Data collection and study design

To evaluate the financial governance and resource allocation of prosthetic and orthotic services within the National Health Service (NHS), a cross-sectional observational study was conducted using the statutory rights provided by the Freedom of Information (FOI) Act 2000[1]. A FOI request was submitted in July 2025 to 229 NHS Trusts and Health Boards across the United Kingdom.

The primary objective of data collection was to determine the transparency of funding streams and identify disparities between funding income and service expenditure.

Freedom of information requests

Organisations were asked to provide specific financial data for the five-year period covering the financial years 2020/2021 to 2024/2025. The request posed two distinct questions for each year:

1 **Funding received:** What specific funding did the Trust or Health Board receive from any and all government-funded bodies for prosthetics and orthotics services?
2 **Funding allocated:** The amount of funding subsequently allocated to the prosthetics and orthotics service budget, all pay and non-pay (or paid to the external contractor) during the same period.

This paired approach allowed for a direct comparison between the resources intended for service provision and the actual budget available for patient care.

Sample and response rate

Of the 229 organisations contacted, 165 responses were received, representing a 72% response rate. The Freedom of Information Act 2000[1] is not a voluntary code; it creates a statutory right to know for the public. As public authorities, NHS Trusts and Health Boards have a legal duty to record and provide information about their activities.

Data completeness and exclusions

Analysis of the responses revealed a significant lack of financial visibility. Of the 165 respondents, 41 (24.9%) reported they did not have a prosthetics or orthotics service. Of the remaining 124, 77 (62.1%) were unable to provide the requested financial data. These 77 responses were excluded from the comparative financial analysis, leaving a subset of 47 Trusts and Health Boards (46 orthotic services plus 15 prosthetic services, comprising 61 service lines in total) with sufficiently robust data to map the funding trends and gaps detailed in this report.

For the funding per head of population, all Trusts and Health Boards which provided information regarding the funding allocated to their prosthetic and/or orthotic service for the year 2024/25 were included.

Survivorship bias acknowledgment

It is important to note that the subset of Trusts and Health Boards able to provide complete data is self-selecting. Organisations with stronger financial governance, better record-keeping systems, and greater institutional transparency are inherently more likely to have been able to respond fully. Conversely, services operating within the most fragmented, underfunded, or administratively chaotic environments are least likely to produce the required data. The findings presented in this report should, therefore, be understood as potentially conservative; the true scale of the funding gaps and governance failures identified here may be greater than the available data can demonstrate.

Figure 1: FOI data collection and analysis flow

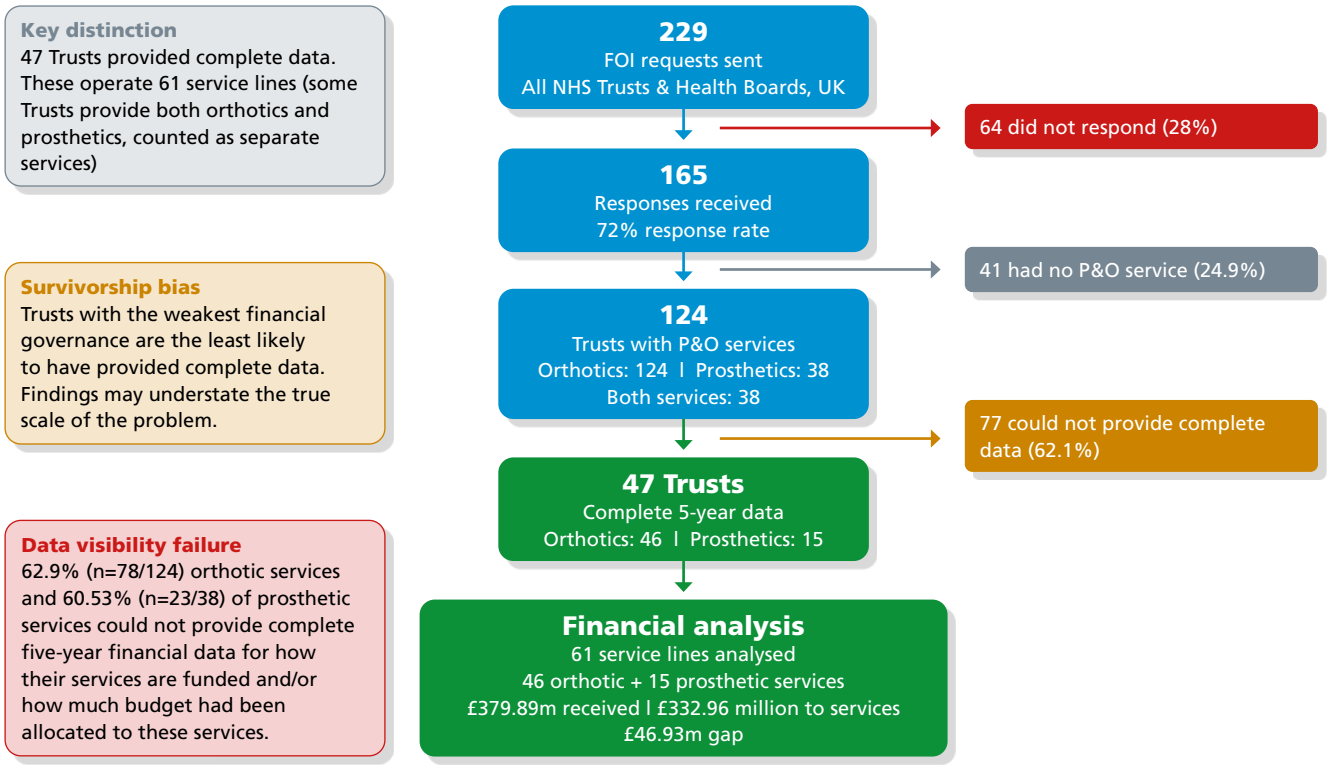

Figure 1: Response rates of FOI requests. Complete data are defined as funding received and allocated to services for all five financial years (2020/2021 through 2024/2025). A further 64 Trusts and Health Boards were contacted several times but did not respond.

1.2 Service delivery models

Prosthetic and orthotic services across the NHS are delivered under three primary models, each with distinct accountability and funding implications. The table below provides information received from Trusts and Health Boards regarding the model under which their prosthetic/orthotic service operated in 2024/2025.

Delivery Model	Proportion	Characteristics
Contracted (external)	Orthotics: 47.6% (n=59/124) Prosthetics: 39.5 % (n=15/38)	Services outsourced to private providers; funding passes through Trusts/Health Boards or direct from the Integrated Care Board (England)
In-house	Orthotics: 27.4% (n=34/124) Prosthetics: 34.2% (n=13/38)	Services delivered directly by NHS-employed staff
Hybrid	Orthotics: 9.7% (n=12/124) Prosthetics: 10.5% (n=4/38)	Mix of contracted and in-house delivery
Trust/HB reported the information was not held	Orthotics: 3.2% (n=4/124) Prosthetics: 5.3% (n=2/38)	
Trust/HB did not provide the information	Orthotics: 12.1% (n=15/124) Prosthetics: 10.5% (n=4/38)	

Table 1: Reported prosthetic and orthotic service delivery models. These data represent the delivery model used in 2024/2025.

2 The visibility crisis

2.1 Trusts and Health Boards cannot track their own funding

Perhaps the most notable finding from this survey is the extent to which NHS Trusts and Health Boards are unable to identify how much funding they receive for prosthetic and orthotic services and, in some cases, how much was allocated to the pay and non-pay budgets. This is not a minor data quality issue; it represents significant weaknesses in terms of financial transparency and accountability. This is particularly concerning given that prosthetics is a nationally commissioned service.

Additionally, one major Health Board in Wales reported that it did not have a prosthetic or orthotic service. When challenged on this, it once again confirmed that these services did not exist, despite having a longstanding orthotics service.

This lack of visibility makes it impossible for service leaders to plan effectively, invest in new technologies, or address waiting lists. It also prevents the NHS from assessing whether it is getting value for money.

Financial year	% unable to report funding received		% unable to report funding allocated		% delivery model unknown	
2020/2021	Ortho. 54.8%	Prosth. 57.9%	Ortho. 38.7%	Prosth. 42.1%	Ortho. 19.4%	Prosth. 21.1%
2021/2022	Ortho. 52.4%	Prosth. 52.6%	Ortho. 33.9%	Prosth. 39.5%	Ortho. 17.7%	Prosth. 21.1%
2022/2023	Ortho. 51.6%	Prosth. 52.6%	Ortho. 32.3%	Prosth. 39.5%	Ortho. 16.9%	Prosth. 21.1%
2023/2024	Ortho. 51.6%	Prosth. 52.6%	Ortho. 32.3%	Prosth. 39.5%	Ortho. 16.1%	Prosth. 21.1%
2024/2025	Ortho. 50.8%	Prosth. 52.6%	Ortho. 28.4%	Prosth. 39.5%	Ortho. 15.3%	Prosth. 15.8%

Table 2: Percentage of Trusts and Health Boards unable to report funding received and allocated for their P&O services. (Orthotics is calculated as a percentage of 124 Trusts/Health Boards and prosthetics as a percentage of 38 Trusts/Health Boards)

2.2 The structural causes of invisible funding

Block contracts: The primary reason Trusts and Health Boards reported for not being able to identify funding flows was block contracts. Many Trusts and Health Boards reported that funding was wrapped into wider block contracts or payment-by-results mechanisms, making it impossible to isolate the specific portion intended for prosthetics or orthotics.

Data availability: A substantial number of organisations stated that they did not hold the information or that it was not recorded in a reportable format.

Outsourcing opacity: In cases where services were contracted out, several Trusts and Health Boards could not reconcile the funding received against the invoice amounts paid to providers.

Commercial sensitivity: Several Trusts and Health Boards declined to provide funding information, citing commercial sensitivity under Section 43(2) of the Freedom of Information Act[1] or excessive cost of compliance under Section 12. While these exemptions may be legally justified in individual cases, their cumulative effect shields a significant portion of NHS prosthetic and orthotic spending from public oversight.

While specific line-item pricing or unit costs from suppliers may legitimately be commercially sensitive, the total envelope of public funding allocated to a service area generally is not so. The public interest in verifying that tax revenue allocated for healthcare actually reaches the front line significantly outweighs the commercial interest in keeping the total budget figures a secret. The application of Section 43 to withhold financial data for contracted services deepens the opacity of the funding landscape and prevents a true understanding of the sector's financial needs.

The absence of basic financial data raises concerns regarding compliance with record management expectations under Section 46 of the Code. The Code of Practice requires public authorities to maintain appropriate record management systems.

Direct quotes from Trust FOI responses:

"Funding for orthotics is part of a block contract, therefore we are unable to provide this breakdown."

"This information is not recorded to the level of detail requested."

"All the income reporting for orthotics/prosthetics is not separated out within the contract. It is incorporated within other specialties."

"Accounts do not identify how much Trust income relates specifically to these services."

"In block funding unable to provide figures."

"As orthotics costs sit primarily within Orthopaedics this service sits within the entire budget of T&O."

"Costs for the service as a whole are not known as it is a multifactorial service under the governance of multiple departments"

"Prosthetic and orthotic funding is not recorded separately"

"The Trust considers the total funding given to the Orthotics and Prosthetics service contractor exempt from disclosure"

"It is estimated that to provide the information that you have requested would exceed the 'appropriate limit' as determined in the Freedom of Information and Data Protection *(Appropriate Limit and Fees) Regulations 2004"*

"Unable to provide information on the funding from government related bodies as the funding is not separately identified in our contracts with the commissioners."

"This information is not recorded to the level of detail requested, therefore we are unable to provide a response"

"The trust considers that at this time the commercial interests of the trust, third parties and overall the NHS could be detrimentally impacted upon [by providing the data requested]"

3 A lack of structure, transparency, and outcomes

Among the Trusts and Health Boards with complete financial data, £34.69 million in allocated orthotics funding and £12.24 million in allocated prosthetics funding were not passed to the services over the five-year period. This equates to a combined total of £46.93 million.

This gap between what Trusts and Health Boards received for P&O services and what they passed to those services requires justification. While a proportion will reflect legitimate organisational overheads, estates, governance, HR, IT infrastructure, and other shared services, the scale of the discrepancy, the absence of any transparent methodology for calculating it, and the inability of the profession to challenge or negotiate it raise fundamental questions about accountability.

An analysis of Trusts and Health Boards that could provide both funding received and funding given to services revealed a systematic discrepancy. Tables 3–5 provide details of the funding reportedly received and allocated per financial year.

Financial year	No. of services	Funding received for orthotic services	Funding given to orthotic services	Difference
2020/2021	46	£37,962,962	£31,193,716	£6,769,246
2021/2022	46	£43,227,359	£35,477,129	£7,750,230
2022/2023	46	£43,659,620	£37,372,383	£6,287,237
2023/2024	46	£46,925,827	£39,559,583	£7,366,244
2024/2025	46	£47,511,500	£40,998,733	£6,512,767
TOTAL		**£219,287,268**	**£184,601,544**	**£34,685,724**

Table 3: Funding received and allocated to orthotic services, 2020/21 to 2024/25 (46 Trusts and Health Boards with complete orthotic data for all five years).

Financial year	No. of services	Funding received for prosthetic services	Funding given to prosthetic services	Difference
2020/2021	15	£27,887,105	£26,042,530	£1,844,575
2021/2022	15	£30,627,754	£28,587,384	£2,040,370
2022/2023	15	£31,496,838	£29,810,718	£1,686,120
2023/2024	15	£34,684,630	£31,556,501	£3,128,129
2024/2025	15	£35,905,502	£32,363,024	£3,542,478
TOTAL		**£160,601,829**	**£148,360,157**	**£12,241,672**

Table 4: Funding received and allocated to prosthetic services, 2020/21 to 2024/25 (15 Trusts and Health Boards with complete prosthetic data for all five years).

Financial year	No. of services	Funding received for both services	Funding given to both services	Difference
2020/2021	61	£65,850,067	£57,236,246	£8,613,821
2021/2022	61	£73,855,113	£64,064,513	£9,790,600
2022/2023	61	£75,156,458	£67,183,101	£7,973,357
2023/2024	61	£81,610,457	£71,116,084	£10,494,373
2024/2025	61	£83,417,002	£73,361,757	£10,055,245
TOTAL		**£379,889,097**	**£332,961,701**	**£46,927,396**

Table 5: Combined prosthetics and orthotics funding received and allocated, 2020/2021 to 2024/2025 (47 Trusts and Health Boards with complete data across both services). Note there were 61 services across 47 Trusts/Health Boards

This £46.93 million gap raises critical questions regarding the metrics used to determine the funding required for prosthetic and orthotic services. It is unclear what outcomes are being measured to determine the effectiveness of these services, to assess growing population needs, and to evaluate return on investment. It is unclear how the data could answer these questions because systems for tracking this funding do not exist. The absence of information was a key finding.

3.1 The disproportionate impact of overhead retention on small and vulnerable professions

It is entirely reasonable and expected that NHS Trusts and Health Boards must recover a proportion of funding allocations to meet legitimate corporate overheads: estates, governance, HR, finance, IT infrastructure, and other shared services that enable clinical delivery. No clinical service operates in isolation, and the costs of organisational infrastructure must be distributed fairly across departments.

However, the data reveal a pattern that warrants further examination, not because overhead recovery is inherently wrong, but because there is no transparency in application, and it has the potential to disproportionately impact small, vulnerable professions with limited institutional visibility and even more limited capacity to absorb such reductions.

The scale of retention is significant. Between 2020/2021 and 2024/2025, Trusts and Health Boards consistently retained substantial portions of prosthetics and orthotics funding before reaching clinical services. Over the five-year period, of the £379.89 million received for P&O services, only £332.96 million reached the services. This £46.93 million shortfall, representing approximately 12.35% of the total budget, reduces the service's operating capacity before a single clinical decision is made, prosthetic limb is provided, or orthotic device is fitted.

Significant overhead deductions, while unwelcome, may be absorbed across larger services with a broad staffing base, diversified income streams, and substantial operational flexibility. For prosthetics and orthotics, a small workforce delivering highly specialised, patient-facing medical devices, the same proportional deduction has a materially greater impact on operational viability. There is no surplus capacity to reorganise, no large team across which to distribute the pressure, and no alternative revenue to offset the loss. What might represent a manageable organisational contribution for a large service becomes an existential pressure on a service where the entire clinical workforce for a region may be counted on one hand.

Without comparative data on overhead retention rates applied to other services of comparable size, it is not possible to definitively determine whether P&O services are treated inequitably. However, the absence of comparative data is itself part of the governance failure identified in this report: no mechanism exists to ensure that overhead deductions are applied proportionately, and no process exists through which a small profession can challenge the rate applied to it. It is also important to recognise that prosthetics and orthotics are distinct from other allied health services in that every patient assessment requires the provision of a medical device. This results in a fundamentally different pay-to-non-pay budget ratio compared to other services, meaning that any reduction in funding has a direct and immediate impact on patient care.

3.2 The inflationary impact

Overhead retention is challenging. However, its impact has been dramatically amplified by a funding trajectory that has failed to keep pace with the cost of delivering care at the most critical junctures.

The largest real-terms cuts occurred during the 2022/2023 financial year. While funding technically increased, it failed to keep pace with the historic inflation spike that occurred simultaneously, and it did so at the worst possible time for the industry.

From 2021/2022 to 2022/2023, the combined funding passed to the 61 prosthetic and orthotic service lines in this dataset rose from £64.06 million to £67.18 million. This represented a 4.87% increase.

In isolation, this figure may appear modest but defensible. However, when assessed within a broader context, the financial impact is likely to be substantial. This increase occurred in the immediate aftermath of the COVID-19 pandemic, a period during which the waiting lists for prosthetic and orthotic services grew significantly[2]. Demand surged across the country at the exact point when purchasing power collapsed.

During the corresponding period, April 2022 to March 2023, the UK Consumer Price Index inflation peaked at 11.1% in October 2022[3] (ONS, CPI Annual Rate, Series D7G7), with the annual average running at approximately 10% (ONS, CPI Annual Rate, Series D7G7, mean of monthly 12-month rates, April 2022 to March 2023). To merely stand still and maintain the same collective purchasing power as the previous year, the funding passed to these 61 service lines needed to rise by 10.04% to approximately £70.5 million. Instead, they received £67.18 million. Across the dataset, the services effectively lost £3.32 million in purchasing power in one year. Not through any explicit decision to cut, but through the quiet mechanism of inflationary erosion applied to budgets that were already diminished by overhead retention. The nominal increase of 4.87% against an inflation rate of 10.04% produced a real-terms cut of approximately 5.17%, the most severe in this dataset.

The damage caused in this year has not been corrected. Even when funding increases in subsequent years exceeded inflation in percentage terms, they were applied to a base that appears to have been deflated by the 2022/2023 funding cut. Over the three years from 2022/2023 to 2024/2025, the cumulative shortfall in purchasing power amounts to approximately £9.65 million*.

What makes this particularly corrosive is the following pattern. In 2023/2024, funding growth of 5.85% barely exceeded CPI inflation of 5.72%, producing a real-terms gain of only 0.13%. In 2024/25, funding growth fell to 3.16% against an inflation rate of 2.35%, producing a real-terms increase of only 0.81%. These increases were insufficient to restore the prior purchasing power.

The approximate real-terms change of +0.13% (2023/2024) and +0.81% (2024/2025) applied to a reduced baseline does not recover prior losses; it simply slows the rate at which further decline occurs. Each subsequent year's funding starts from a position of structural deficit, and the gap between what these services need and what they receive is carried forward, incrementally and invisibly.

The compounding effect is stark: had funding across these services simply tracked CPI from its 2021/2022 level, they should have collectively received £76.3 million in 2024/25. They actually received £73.36 million, a structural deficit of approximately £2.94 million per year that has been quietly carried forward.

Financial year	Nominal funding growth	Approx. CPI inflation	Approximate real terms change (nominal growth minus CPI inflation).	Verdict
2021/2022	+11.93%	3.98%	+7.95%	Real growth (post-COVID recovery)
2022/2023	+4.87%	10.04%	-5.17%	SEVERE REAL-TERMS CUT
2023/2024	+5.85%	5.72%	+0.13%	Stagnation (deficit carried forward)
2024/2025	+3.16%	2.35%	+0.81%	Stagnation (deficit carried forward)

Table 6: Combined prosthetic and orthotic funding growth (funding given to 61 services) compared with the UK CPI inflation. Financial year CPI inflation equals the mean of monthly CPI 12-month rates from April to March (ONS, Consumer price inflation time series, Series ID: D7G7, dataset MM23).[4]

*This figure is derived by comparing actual allocations with CPI-adjusted funding required to maintain 2021/22 purchasing power across each subsequent year.

3.3 The compounding effect: pay, inflation, and the rising cost of P&O materials

The case for a real-terms funding cut becomes even more compelling when the specific cost pressures facing prosthetics and orthotics are considered. The standard CPI measures a general basket of consumer goods, such as bread, petrol, and clothing. It does not measure the cost of advanced prosthetic components manufactured from carbon fibre and microprocessor technology, or the cost of specialist orthotic materials. These are highly specialised medical products, frequently imported, and subject to cost pressures that consistently exceed general inflation. Global supply chain disruption, raw material scarcity, and exchange rate volatility, particularly the weakening of sterling against the dollar and euro during the inflationary period, have driven medical device costs upward at rates that the CPI does not capture.

In addition to existing funding pressures, anecdotal reports from prosthetic and orthotic manufacturers indicate that changes to the UK's trading relationship with the European Union have introduced further cost burdens for prosthetic and orthotic services. Many medical devices and components used in patient care are sourced from European suppliers, and the introduction of customs requirements, additional regulatory processes, and associated charges has resulted in increased procurement costs for these products. These additional costs are absorbed within already constrained budgets, further compounding financial pressures on services and, ultimately, on patient care.

Analysis by both the NHS Confederation and the Nuffield Trust has demonstrated that NHS cost pressures consistently exceed general CPI inflation, driven by energy costs, mandated pay awards, and the rising cost of medical goods and services.[5,6] While precise P&O-specific inflation figures are not centrally collected, which is a further symptom of the data vacuum this report identifies, it is reasonable to conclude that the real-terms erosion of purchasing power for prosthetic and orthotic components is materially worse than the CPI-based analysis presented here suggests.

For NHS-employed services, the national Agenda for Change pay awards are non-discretionary. Over the period in question, staff across Bands 5 to 8a, encompassing newly qualified prosthetists and orthotists through senior clinical leads, received five consecutive annual pay rises. While each of the four UK nations negotiates Agenda for Change pay separately, the trajectory was consistent: awards ranged from approximately 2.5% to 5.5% in England, Wales, and Northern Ireland, with Scotland consistently settling at higher levels. Including 4% for Bands 5 to 7 (2% for Band 8a) in 2021/2022 and an average uplift of at least 6.5% for all staff at Band 8a and below in 2023/2024. Cumulatively, these mandated awards represent a pay uplift of approximately 18-22% in England and Wales over the five-year period, and even higher in Scotland. This figure is derived from the compounding effect of successive annual awards applied to published Agenda for Change pay scales across the relevant bands.[7,8]

For contracted services, where prosthetics and orthotics provision is delivered by independent providers, the dynamic is different but no less challenging than NHS provision. These services do not benefit from nationally mandated NHS pay awards, meaning that their workforce may progressively fall behind NHS pay scales, creating recruitment and retention difficulties that directly affect service capacity and continuity of care. Simultaneously, contracted providers must still absorb the same inflationary pressures on materials, energy, and specialist components, often within fixed-price or minimally uplifted contract terms that were negotiated before the inflationary spike.

In both models, the outcome converges on the same point: funding increases that appear adequate in nominal terms are substantially or entirely consumed by cost pressures that the service has no ability to control, leaving progressively less available for the clinical materials and devices on which patient care directly depends.

Consequently, the funding environment has resulted in a decline in the real-terms value of the budget available for clinical materials and devices over successive financial years, while the demand for services has increased. Patients requiring prosthetics and orthotics frequently require lifelong care, with devices necessitating regular review, replacement, and adaptation throughout a patient's lifetime. This inherent demand is further compounded by well-documented demographic and epidemiological trends: an ageing population with a decrease in healthy living years[9] and a sustained growth in non-communicable diseases, including diabetes, vascular disease, and musculoskeletal conditions, which are among the primary drivers of referrals into prosthetic and orthotic services.[10]

Footnote: CPI is used as a proxy and that NHS-specific cost inflation may have been higher in some years (particularly given NHS pay awards), which would make the real-terms analysis conservative.

3.4 The false economy: downstream costs of underfunded P&O services

The financial pressures described in this report do not exist in isolation from other pressures. Underfunded prosthetic and orthotic services generate substantial downstream costs elsewhere in the health and social care system, which significantly exceed the investment required to prevent them. The evidence presented in this section demonstrates that inadequate P&O provision is not merely a service-level concern but also a systemic driver of avoidable harm, hospital admissions, and expenditure.

Diabetic foot disease and the cost of preventable amputation

A person with diabetes who does not receive timely orthotic intervention for a developing foot deformity faces an elevated risk of ulceration, infection, and ultimately, amputation. Diabetic foot disease is one of the most expensive complications managed by the NHS. Total healthcare costs for ulceration and amputation in diabetes in England have been estimated to be as high as £962 million per year, equivalent to approximately 0.8 to 0.9 percent of the entire NHS budget.[11] This exceeds the NHS expenditure on breast, prostate, and lung cancers combined.

Approximately 9,000 lower limb amputations are performed annually in individuals with diabetes in England. Five-year mortality following major amputation has been estimated at 68 to 79 percent.[11,12] In its thematic review of clinical negligence claims, NHS Resolution reported that up to 85 percent of diabetes-related amputations examined in negligence claims were considered avoidable with appropriate and timely care.[12] This figure arises from claims review rather than population-level modelling, but it underscores the scale of preventable harm identified within the system itself.

Orthotics interventions that may interrupt this progression, including specialist footwear, offloading devices, insoles, and ankle-foot orthoses that redistribute plantar pressure and address biomechanical abnormalities, represent a small fraction of the downstream expenditure associated with ulcer management, hospitalisation, surgery, and long-term rehabilitation. The counterfactual is simple. Even a modest reduction in ulceration and amputation rates would offset substantial proportions of the current spending.

Falls, hip fractures, and the role of prosthetic and orthotic services

Falls are the leading cause of injuries among older adults. Around 90 percent of hip fractures in people aged 65 and over result from ground level falls.[13] Prosthetic and orthotic services play a central role in fall risk reduction in the populations they serve. Delays, suboptimal fit, and limited follow-up increase exposure to fall risk during periods of heightened vulnerability.

The incidence of falls among lower limb prosthesis users is high. More than half of the patients report at least one fall per year, with many experiencing multiple events.[14,15] A systematic review reported that fall incidence increased from approximately 21 percent during acute hospital stays to 58 percent among community-dwelling amputees in the years following amputation.[16] A nationwide retrospective cohort study of more than 19,000 amputees reported a 9.24-fold increased risk of hip fracture compared with matched non amputee controls.[17] This represents an association rather than proof of direct causation; however, the proposed mechanisms, including reduced bone mineral density, impaired balance, and higher fall rates, are biologically and biomechanically plausible.

The quality and timing of the device are important. Poorly fitting prosthetic sockets are associated with an increased fall risk.[18] In a UK-wide survey, socket fit was identified as the single most important factor affecting rehabilitation by 48 percent of amputees and 66 percent of clinicians.[19] Delayed prosthetic provision further compounds this risk. Adults not fitted with a prosthesis within 6 to 12 months of amputation have been shown to incur approximately 25 percent higher total healthcare costs in the first post-amputation year,[20] alongside increased odds of mortality and complications related to deconditioning. Earlier prosthesis receipt has been associated with reduced emergency department utilisation for fall-related injuries.[21] Increased waiting times for prosthetic evaluation lead to preventable complications such as muscle weakness, oedema, and contractures are documented.[22]

Orthotic provision exhibits similar patterns. Strong evidence supports the use of ankle foot orthoses to improve gait speed, dynamic balance, and mobility across multiple neurological populations.[23,24,25] A randomised controlled trial found that early AFO provision following stroke led to significantly greater improvements in balance and independence, with participants reaching safe independent walking 4 to 10 weeks sooner than those receiving delayed provision.[26,27]

This difference is not trivial. The early post-stroke period is characterised by a high risk of falls. Each additional week without adequate mechanical support represents cumulative exposure to preventable injuries. The argument is not that all falls are preventable through P&O alone, but that reducing risk during this high-vulnerability window has measurable downstream implications.

The cost of hip fracture to the NHS and social care

The economic consequences of fall-related injuries are substantial. The REDUCE study, a record linkage cohort analysis of 178,757 patients with hip fractures, reported mean inpatient costs of £14,642 per patient in the year following hip fracture, with significant variation between hospitals.[28] More than one in four patients died within one year of the fracture.

Social care costs add to the pressure. A recent population-based study estimated the mean social care costs of £15,525 per patient following hip fracture, equating to approximately £1.25 billion annually across the UK hip fracture population.[29] Combined, average direct health and social care costs exceed £30,000 per patient in the year following fracture.

With over 70,000 older adults admitted to UK hospitals with hip fractures each year, even a conservative estimate suggests more than £2 billion in combined annual expenditure associated with hip fractures alone. The total annual fragility fracture costs have been estimated at £4.4 billion, of which hip fractures account for approximately £2 billion.[30]

Against this backdrop, the economics of prevention become clearer and more relevant. If timely prosthetic and orthotic provision reduces fracture incidence by even a small percentage among high-risk populations, the marginal savings would be substantial relative to the comparatively modest cost of service expansion.

A structural false economy

Every pound withheld from timely, high-quality P&O provision risks generating multiple pounds in avoidable downstream costs. Delayed prosthetic fitting increases first-year healthcare expenditure. Delayed orthotic provision prolongs the exposure to fall risk. Poor device fit contributes to instability, repeated clinic visits, and injury. These are not speculative claims but associations that have been repeatedly demonstrated in the peer-reviewed literature.

Economic dynamics are structural. Preventive services often sit in different budgetary silos from the acute and social care sectors, which absorb downstream costs. The service that invests in prevention is not always the one that captures the savings. In economic terms, this creates an externality and information asymmetry. Without integrated outcome data and aligned incentives, underinvestment can appear fiscally rational at the commissioning point while increasing total system expenditure.

The lack of nationally collected linked outcome data compounds this problem. Without robust metrics connecting P&O funding to fall reduction, amputation rates, emergency department utilisation, and long-term care costs, commissioners are left with partial visibility. NHS England acknowledged in 2015[31] that limited quality measures and data had hindered the effective commissioning of orthotic services, contributing to inequalities in access, poorer outcomes, and suboptimal value for money. A commitment was made to develop a national minimum dataset incorporating key performance indicators from the model service specification. More than a decade later, this commitment has not been delivered.

This absence of data is both a symptom and a cause. Without evidence, investments are constrained. Without investment, the infrastructure required to generate high-quality evidence cannot be built. The result is a feedback loop in which preventive services remain under-resourced despite credible indications that their expansion would reduce avoidable harm and expenditure.

The conclusion is not that prosthetic and orthotic services alone can eliminate falls, fractures, and amputations. Even modest improvements in timing, fit, and follow-up would likely produce system-level savings that exceed their marginal costs. In fiscal terms, this is not cost containment. This is a cost deferral with interest.

3.5 The transparency vacuum

Perhaps the most concerning issue is the lack of systematic transparency regarding these dynamics. The data highlight not only the scale of retention and the reality of inflationary erosion, but also the vacuum in which these funding decisions are made. There is no consistent, publicly available methodology for calculating overhead deductions for prosthetics and orthotics. There is no clear rationale for the annual fluctuations in the retained proportion. There is no evident mechanism through which the profession can challenge or negotiate allocation decisions. There is no formal assessment at the Trust, Health Board, or national level of the cumulative clinical impact of a funding gap, compounded by years of below-inflation increases.

When small professions lack the institutional weight to demand accountability, and when Trusts and Health Boards are under no obligation to provide itemised justifications for their retention decisions, the conditions are created for a gradual, incremental erosion of service capacity that attracts no scrutiny precisely because no one is required to explain it. The absence of records is not simply an administrative gap; it is the mechanism by which a vulnerable profession experiences sustained defunding without any single decision-maker being required to account for its outcome. The fragmented commissioning structure makes it unlikely that the full extent of variation will be visible at the national level.

3.6 A call for proportionality, transparency, and accountability

This is not an argument against organisational overhead recovery, nor is it a failure to recognise the extraordinary fiscal pressures that Trusts and Health Boards face. This is an argument for proportionality, transparency, and accountability in the distribution of pressure.

If Trusts and Health Boards are retaining £46.93 million over five years from small, specialist clinical services, and if those services are simultaneously absorbing historic inflationary pressures without compensatory adjustment, then the profession and the patients it serves deserve clear answers to these straightforward questions.

What are the retained funds used for? How is the deduction rate determined, and is it applied equitably relative to other services of comparable size? What assessment has been made of the clinical impact of cumulative real-terms funding reductions on patient outcomes and access to care? What mechanisms exist for the profession to meaningfully engage with these decisions?

Without such answers, the funding gap cannot be reasonably characterised as a routine overhead contribution. The below-inflation funding trajectory cannot be dismissed as a budgetary inevitability. Together, they represent a cumulative reduction in clinical capacity, disproportionately borne by a profession without the institutional scale to absorb it, and insufficiently visible within the NHS's complex system to attract the scrutiny it deserves.

3.7 Variations between Trusts and Health Boards

The disparity in funding relationships between individual Trusts and Health Boards is significant. Some organisations allocate less than they receive, some allocate more, and some allocate the exact amount. In 2024/25:

Trusts and Health Boards receiving more than they pass to services (examples):

- Lancashire Teaching Hospitals:
  Received £6m, allocated £2.3m to the service – a gap of £3.7m
- Leeds Teaching Hospitals
  Received £3.85m, allocated £2.98m to the service – a gap of £870k
- NHS Dumfries and Galloway
  Received £385k, allocated £29k to the service – a gap of £356k
- Walsall
  Received £298k, allocated £72.8k to the service - a gap of £225k

Trusts giving more to services than they receive (examples):

- Barking, Havering, and Redbridge
  Received £753k, allocated £1.1m to the service – an internal subsidy of £347k
- Great Western
  Received £422k, allocated £461k to the service – an internal subsidy of £39k
- Warrington and Halton
  Received £485.9k, allocated £691k to the service - an internal subsidy of £205k

This inconsistency suggests that there is no standardised funding model, transparent allocation formula, or mechanism to ensure the equitable distribution of resources.

4 The postcode lottery effect

4.1 Orthotics

The funding pressures described in the preceding sections do not fall evenly. When spending on orthotic services is calculated per head of the population served by each Trust or Health Board, the variation is significant. The highest-spending Trust, Hywel Dda University Health Board, invested £8.87 per head of population in orthotic services. The lowest was NHS Dumfries and Galloway, which spent £0.20. That is more than a 44-fold difference in per-capita spending on the same category of clinical services delivered.

The gap between the highest and lowest spending is not a gentle gradient but steep. The data reveal a sharp divide, with a cluster of Trusts and Health Boards investing significantly more than others in orthotic provision and a significant number spending less than £1 per head, a figure that raises serious questions about what level of service, if any, can realistically be sustained at that rate. This variation spans all four UK nations and cannot be easily attributed to differences in commissioning models, population demographics, or local clinical strategies. This suggests a variation in how prosthetics and orthotics services are valued, prioritised, and funded at the local level, which may influence the quality and availability of care patients receive depending on their location.

Status	NHS Trust / Health Board	Spend per head orthotics
TOP	Hywel Dda University Health Board	£8.87
TOP	Lancashire Teaching Hospitals	£5.89
TOP	Torbay and South Devon	£4.94
TOP	Airedale NHS Foundation Trust	£4.68
TOP	Belfast Health and Social Care Trust	£3.67
	(Average gap: ~£5.61 per person)	
BOTTOM	University Hospitals of Derby and Burton	£0.42
BOTTOM	Imperial College Healthcare	£0.33
BOTTOM	Nottinghamshire Healthcare	£0.28
BOTTOM	Walsall Healthcare	£0.27
BOTTOM	NHS Dumfries and Galloway	£0.20

Table 7: Disparity across Trusts and Health Boards – orthotic services spent per head of population (2024/25).

Orthotics: chaotic inequality without structure or logic

Orthotic funding demonstrates chaotic variance across the UK. The data reveal not a hierarchy but a postcode lottery, with allocations that bear no consistent relationship to the size, age profile, or clinical needs of the population served.

The bottom tier of orthotic funding includes major territorial boards spanning all four nations. However, chaos is not simply a result of the rural neglect. The 44-fold gap indicates a system that reflects local administrative variation rather than any strategic design. These examples illustrate a discipline in which funding decisions appear to be detached from any transparent or consistently applied commissioning framework.

4.2 Prosthetics

The centralisation premium in prosthetic services

The financial data reveal stark structural inequality in the provision of prosthetic services, characterised by a hub-and-spoke economic divide. Funding is heavily concentrated within major metropolitan centres, creating a centralisation premium that appears to disadvantage the peripheral regions.

Evidence of disparity: Major regional hubs, such as Lancashire Teaching Hospitals (£7.57 per head), Cardiff and Vale (£7.12 per head), and Leeds (£6.91 per head), receive funding allocations significantly higher than smaller local units.

Rural deficit: This disparity is most acute in rural and coastal communities. Trusts serving large non-metropolitan populations, such as East Suffolk and North Essex (£0.49 per head) and NHS Highland (£0.85 per head), operate on a fraction of the per-capita resources available to urban centres, such as Lancashire and Glasgow.

The service gap: The population with the highest prevalence of frailty and disability is migrating towards coastal and rural areas (for example, Sussex and Norfolk). The per-capita funding pattern observed in this dataset suggests a concentration of resources in major metropolitan hubs.

Structural disadvantage: Consequently, patients in areas of greatest demographic need receive the lowest amount of local funding. This forces vulnerable populations to either travel significant distances to access well-resourced hubs or rely on local services funded at approximately one-fifth the level of their urban counterparts.

Status	NHS Trust / Health Board	Spend per head prosthetics
TOP	Lancashire Teaching Hospitals	£7.57
TOP	Cardiff and Vale University Health Board	£7.12
TOP	Leeds Teaching Hospitals	£6.91
TOP	Guy's and St Thomas' NHS Foundation Trust	£5.12
TOP	NHS Greater Glasgow and Clyde	£4.83
	(Average gap: ~£5.50 per person)	
BOTTOM	Grampian	£1.02
BOTTOM	Betsi Cadwaladr University Health Board	£0.96
BOTTOM	NHS Highland	£0.85
BOTTOM	Imperial College Healthcare	£0.58
BOTTOM	East Suffolk and North Essex	£0.49

Table 8: Disparity across Trusts and Health Boards – prosthetic services spent per head of population (2024/25).

4.3 The disproportionate impact on rural and coastal communities

Funding data reveal a fundamental divergence in how inequality manifests across the two disciplines, with profoundly different implications for rural and coastal communities. In prosthetics, the disparity is systemic and predictable: services in non-metropolitan areas consistently receive significantly lower per-capita allocations than those in major urban centres, suggesting an entrenched commissioning structure that has not adapted to the demographic shifts that are now reshaping demand. In orthotics, the inequality is chaotic: funding allocations bear no consistent relationship to population size, demographic needs, or geographic circumstances. Both modes of inequality demand distinct reform strategies but converge in their effect on the populations least able to absorb the consequences.

A note on the use of individual Trust and Health Board data

The per-capita figures cited throughout this section are drawn from data provided directly by NHS Trusts and Health Boards through the FOI request and are used solely to illustrate the scale and nature of funding variation across the UK. The inclusion of any individual organisation is not intended as a criticism of that Trust or Health Board, nor of the clinicians and managers working within them. In the overwhelming majority of cases, local teams deliver the best care they can within the budget they are allocated. The disparities identified in this report are the product of long-standing systemic weaknesses in how prosthetic and orthotic services are commissioned and funded at a national level, not of local decision-making. No Trust or Health Board created these funding gaps; they inherited them from a system that has never established a consistent, needs-based funding methodology for either discipline. The purpose of presenting this data is to demonstrate that the problem is structural and UK-wide, requiring national policy intervention rather than local remediation.

Convergent impact: a structural mismatch with demographic reality

Whether the underlying pattern is an identifiable urban skew or no discernible pattern, the effect on rural and coastal communities remains the same. Public Health England's 2019 evidence review on health inequalities in ageing in rural and coastal areas confirmed that older populations in these settings experience significant health inequalities and poorer access to services,[32] and it is precisely these populations that have the highest prevalence of the conditions driving demand for prosthetic and orthotic care: diabetes, vascular disease, musculoskeletal degeneration, frailty, and falls. The Chief Medical Officer's Annual Report 2023[33] reinforces this concern, showing that England's older population is already unevenly distributed, with higher concentrations in rural, coastal, and peripheral areas rather than major urban centres, and that this pattern is expected to intensify over time. Therefore, the concentration of prosthetic funding in metropolitan centres is directly at odds with the demographic trajectory of the populations these services exist to treat. The hub-and-spoke model may have once reflected where clinical expertise was located, but it has become entrenched as a funding hierarchy that systematically disadvantages communities with the greatest and fastest-growing needs. Similarly, the chaotic funding of orthotic services also fails to address the growing needs of underserved ageing populations.

This is not a problem exclusive to England. The Scottish Parliament's Health, Social Care and Sport Committee found that Scotland's funding formula fails to meet the specific needs of remote and rural areas, which face an ageing population, depopulation, and higher costs of service delivery.[34] Age Scotland has further warned that Scotland is ageing faster than the rest of the UK, with rural and island populations doing so to a greater extent.[35] In Wales, the Welsh Government's own Age Friendly Wales strategy acknowledges the challenges that an ageing population and deep-rooted inequality present for rural communities.[36] In Northern Ireland, the Department of Health's Health and Wellbeing 2026: Delivering Together strategy acknowledged that an ageing population presents significant challenges to services and that the differences in health and wellbeing outcomes between the most and least deprived areas remain stark and completely unacceptable,[37] while the Department's Health Inequalities Annual Report has documented persistent disparities between urban and rural populations across a range of health indicators.[38] Across all four nations, the policy direction recognises the growing concentration of elderly and clinically vulnerable populations in non-metropolitan areas, yet the funding of prosthetic and orthotic services has not been adapted to reflect this reality.

The critical policy implication is that systemic and chaotic inequalities require different solutions. Prosthetic funding requires a deliberate rebalancing of the hub-and-spoke model to reflect where patients live, not where services were historically established. Orthotic funding requires something more fundamental: the imposition of a rational commissioning framework, where none currently exists. In both cases, the consequences for the patients are the same. Vulnerable and often elderly people in rural and coastal areas are left to either travel significant distances to access services elsewhere or accept care from local providers operating with significantly lower per-capita allocations.

> ***"The geography of older age in England is already highly skewed away from large urban areas towards more rural, coastal and other peripheral areas... Expansion of medical and NHS services need to be in these areas."*** *Chief Medical Officer's Annual Report 2023: Health in an Ageing Society*[33]

4.4 Methodology note: calculating per-capita spend

Per-capita spending was calculated by dividing each Trust or Health Board's 2024/2025 service funding (the amount allocated to the service budget as reported through FOI responses) by the estimated population served. Population estimates were derived from publicly available sources, including Trust and Health Board annual reports, CQC provider profiles, and published catchment population data. These figures are approximate and intended to provide a reasonable basis for comparison rather than precise population-level accounting.

Several considerations were applied to ensure that the analysis was fair and representative. Large metropolitan Trusts and Health Boards, particularly those in London and other major urban centres, were generally excluded or treated with caution, where their catchment populations, referral patterns, and service configurations made meaningful per-capita comparisons unreliable. Many London Trusts serve overlapping populations, receive tertiary referrals from well beyond their geographic footprint, or operate within integrated care systems where provision may be distributed across multiple providers in ways that a single Trust-level funding figure cannot accurately reflect.

Where a Trust or Health Board is known to operate as a regional hub, receiving referrals from a wider area than its immediate catchment, the population figure used reflects the broader served population rather than the Trust's local registered population alone, in order to avoid artificially inflating the per-capita spend figure. Conversely, when a Trust provides only locally commissioned services to its immediate population, the catchment figure reflects this more limited scope.

It should also be noted that some Trusts and Health Boards serve populations that extend beyond their immediate geographic boundary through hub-and-spoke or specialist referral arrangements, and the precise boundaries of a service's catchment are not always coterminous with the Trust's general acute catchment.

These factors introduce a degree of imprecision that is unavoidable in the absence of nationally standardised service-level population data for prosthetics and orthotics.

Notwithstanding these limitations, the scale of variation observed, more than 44-fold between the highest and lowest per-capita spending, is far too large to be explained by methodological imprecision alone. Even allowing for generous margins of error in population estimates and acknowledging the complexities of different service models, the gap between £8.87 per head and £0.20 per head represents a disparity of a magnitude that demands an explanation beyond the differences in data methodology. The population estimates and sources used for each Trust and Health Board are disclosed in full in Appendix A.

4.5 The equality dimension

The geographic disparities identified in this report have a significant equality dimension that warrants explicit recognition. The majority of patients served by prosthetic and orthotic services are disabled individuals, as defined under the Equality Act 2010:[39] individuals with physical impairments that have a substantial and long-term adverse effect on their ability to perform normal daily activities. Many are elderly or belong to other protected groups.

Under Section 149 of the Equality Act 2010, public authorities, including NHS Trusts, Health Boards, and Integrated Care Boards, have a duty to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between persons who share a protected characteristic and those who do not. The systematic underfunding of services that predominantly serve disabled populations, compounded by geographic variation that is not justified by clinical need, raises serious questions about whether this duty is being fulfilled.

The United Kingdom is also a signatory to the United Nations Convention on the Rights of Persons with Disabilities, Article 25,[40] which recognises the right of persons with disabilities to the highest attainable standard of health, without discrimination. A funding model that produces a 44:1 variation in per-capita spending on services for disabled patients, with no transparent rationale, raises questions about the consistency of this obligation.

This is not an argument that any individual Trust or Health Board is deliberately discriminating. The argument is that the system as a whole, through its lack of standards, opacity, and absence of oversight, may produce unequal outcomes, and that the public sector equality duty requires action to address this issue.

5 The case for reform: why change is imperative

5.1 The human cost of system failure

Behind these financial figures are patients: amputees, those with mobility impairments, children with developmental conditions, stroke survivors, and countless others who depend on prosthetic and orthotic services to maintain their independence, dignity, and quality of life.

Where funding lacks clarity and consistency, it becomes difficult to plan, evaluate, and improve services in a structured manner, and patients may ultimately experience the consequences. Workforce planning is impossible without understanding the resource allocation. Commissioners cannot make evidence-based decisions regarding service configurations. The NHS cannot demonstrate that it is meeting its legal obligations under the Equality Act 2010 for those who depend on these services.

5.2 Six fundamental problems requiring immediate action

1 **No national funding standard**
No established formula or methodology exists for allocating prosthetic and orthotic funding. Allocations appear to be based on historical accidents rather than population needs, clinical demands, or service quality.

2 **No ringfencing of specialist funding**
Block contracts allow funding intended for prosthetics and orthotics to be absorbed into general Trust or Health Board budgets without a trace. There is no mechanism to ensure that the allocated funds reach their intended destinations.

3 **No mandatory reporting framework**
Trusts and Health Boards are not required to separately identify or report prosthetic and orthotic funding. Approximately half of the Trusts and Health Boards cannot state what funding they receive, which is a direct consequence of this issue.

4 **No central oversight body**
No single national body has a clear responsibility for monitoring prosthetic and orthotic funding across the NHS. NHS England, Integrated Care Boards, and devolved health authorities operate independently, with no coordination or benchmarking.

5 **No link between funding and outcomes**
Without transparent funding data, correlating investments with patient outcomes, waiting times, or service quality is impossible. Therefore, evaluation and improvement are structurally impossible under current arrangements.

6 **No assessment of downstream economic impact**
No systematic analysis exists of the relationship between prosthetics and orthotic funding levels and avoidable downstream NHS costs. The false economy of underfunded prevention is neither properly measured nor managed.

6 Recommendations for reform

The evidence presented in this report requires urgent action.

6.1 Immediate actions

Establish mandatory annual reporting of prosthetics and orthotics funding by all NHS Trusts and Health Boards. Every Trust and Health Board providing or commissioning P&O services should be required to report, as a minimum, the following: the total funding received from commissioning bodies for P&O services; the total funding allocated to the service budget (or paid to contractors); and any difference between the two, with an explanation of how the funding requirements of the service were derived.

Publish a national dashboard showing funding by Trust and Health Board, region, and delivery model. This should be updated annually and made publicly accessible to enable benchmarking, scrutiny, and evidence-based commissioning.

Commission an independent audit of block contract arrangements affecting P&O services, with a specific examination of the proportion of identified P&O funding that reaches the clinical service versus the proportion retained at the organisational level, and the methodology by which retention rates are determined.

6.2 Medium-term reforms

A national funding formula should be developed based on population, demographics, disease prevalence, and clinical needs. This should draw on the precedent of weighted capitation formulas used for other NHS allocations and be developed in consultation with clinicians, professional bodies, and patient representatives.

Introduce ring-fenced budgets for prosthetics and orthotics with protected minimum spending levels, ensuring that funding identified for P&O services cannot be diverted to other budget lines without explicit approval and transparent reporting.

Establish a national clinical lead with responsibility for P&O service standards and oversight, with sufficient authority to hold commissioners and providers accountable for variations in funding and outcomes.

Ensure funding allocations are linked to measurable outcomes, including waiting times, patient-reported outcome measures, device provision rates, and service access metrics.

Commission a health economics analysis of the downstream NHS costs attributable to delayed or inadequate P&O care, including avoidable amputations, falls, hospitalisations, and extended rehabilitation episodes. This analysis should quantify the investment-to-savings ratio of adequately funded P&O services in the future.

6.3 Long-term transformation

Consider national commissioning arrangements for complex prosthetic and orthotic services, drawing on the model used for other specialised services, to ensure that hub-and-spoke networks are funded equitably and that peripheral populations are not systematically disadvantaged.

Integrated care pathways should be developed with outcome-based payment models that incentivise timely preventive intervention and penalise avoidable downstream costs.

Establish a national P&O data repository linking funding, activity, workforce, and patient outcomes, to systematically build the evidence base for this specialty over time.

6.4 Accountability framework: who must act

Implementing these recommendations requires coordinated action across multiple bodies, each with distinct responsibilities.

Department of Health and Social Care (England) and devolved health departments
Policy direction on mandatory reporting, ring-fenced budgets, and national funding standards. Ministerial accountability for ensuring that commitments made to Parliament regarding P&O service quality are delivered.

NHS England and Integrated Care Boards
Commissioning reform, block contract transparency, national dashboard publication, and delivery of the national minimum data set for orthotics, which was committed to in 2015, and remains outstanding. Appointment of a national clinical lead for P&O services.

NHS Trusts and Health Boards
Compliance with mandatory reporting requirements, transparent accounting for overhead retention from P&O budgets, and fulfilment of obligations under the Freedom of Information Act 2000 and the Public Sector Equality Duty.

Devolved administrations (Scotland, Wales, Northern Ireland)
Parallel actions should be taken within their respective commissioning and funding structures. The geographic disparities identified in this report span all four nations and cannot be addressed by England-only reforms.

7 Conclusion

The data presented in this report tell a consistent story: prosthetic and orthotic services in the NHS operate within an opaque, unequal, and unaccountable funding system.

When over half of Trusts and Health Boards could not provide complete five-year funding data, when **£46.93 million was not allocated to front-line P&O service budgets**, when funding per head of population varied by a factor of **44:1**, and when the most significant inflationary crisis in a generation produced a **5.17% real-terms** cut to services already under severe financial pressure, the system demonstrated systemic weaknesses in transparency, equity, and accountability.

Patients who depend on these services deserve better. They deserve to know that the funding allocated for their care actually reaches them. They deserve equitable access to healthcare, regardless of their location. They deserve services that are planned, resourced, and evaluated based on transparent criteria.

The findings of this study are likely to be conservative. The services excluded from this analysis due to incomplete data, those Trusts and Health Boards with the weakest financial governance and the poorest record-keeping may represent the most severely affected. The true scale of the funding gap, overhead retention, and geographic inequity is likely conservative due to the exclusion of incomplete datasets.

The case for reform extends beyond incremental changes and requires substantive action. Funding models and accountability structures for prosthetic and orthotic services in the United Kingdom must be prioritised for strengthening and reforming.

7.1 Data sources

This report is based on an analysis of the NHS Services Funding Freedom of Information dataset, containing responses from 165 NHS Trusts and Health Boards across the United Kingdom, covering the financial years 2020/2021 through 2024/2025.

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Appendix A:
Per-capita spending methodology, population estimates, and sources

The per-capita analysis presented in Sections 4.1 and 4.2 of this report required an estimate of the population served by each Trust or Health Board's orthotic service. The table below discloses the population figure used for each organisation, the 2024/25 funding allocated to the service (as reported through the FOI responses), the resulting spend per head, and the reasoning behind the selected population estimate.

Population estimates were derived from publicly available sources, including NHS Trust and Health Board annual reports and accounts, Care Quality Commission (CQC) provider profiles, NHS Scotland Information Services Division

(ISD) board population data, Stats Wales mid-year population estimates, Northern Ireland Statistics and Research Agency (NISRA) population data, and Office for National Statistics (ONS) mid-year population estimates at the local authority level. Where a Trust/Health Board operates as a regional hub receiving referrals beyond its immediate catchment area, the broader served population was used. Where a Trust provides only a locally commissioned service, the local catchment figure is used. Figures marked with an asterisk (*) indicate cases where the population was adjusted from a wider published figure to reflect the actual service catchment more accurately, with reasoning provided.

Appendix A(i): Per-capita orthotic services spending by NHS Trust / Health Board (2024/25) from 87/124 Trusts and Health Boards who could provide 2024/2025 orthotic service budget data

NHS Trust/Health Board	Funding 2024/25	Population	Spend per head	Population basis and reasoning
Hywel Dda University Health Board	£3,405,103	384,000	£8.87	Territorial Board. Covers Carmarthenshire, Ceredigion, Pembrokeshire.
Lancashire Teaching Hospitals NHS Foundation Trust	£2,297,562	390,000	£5.89	Local Host (Preston/Chorley). Immediate catchment areas were used.
Torbay And South Devon NHS Foundation Trust	£1,413,478	286,000	£4.94	Local Catchment. This is consistent with the integrated care footprints.
Airedale NHS Foundation Trust	£935,036	200,000	£4.68	Local Catchment. Accurate figure for Airedale, Wharfedale, and Craven.
Belfast Health and Social Care Trust	£1,247,000	340,000	£3.67	Local Host (Belfast), UK Used city population.
Tayside	£1,386,453	389,000	£3.56	Territorial Board. Covers Dundee, Perth, and Kinross.
Leeds Teaching Hospitals NHS Trust	£2,981,933	845,000	£3.53	Local Host (Leeds City Council). Updated: ONS 2024 mid-year estimate of 845,189 for the Leeds metropolitan borough.
Medway NHS Foundation Trust	£1,464,000	427,000	£3.43	Local Catchment. This accurately reflects the Medway and Swale.
Gateshead Health NHS Foundation Trust	£674,859	200,000	£3.37	Local Catchment. Accurate for the Gateshead borough.
NHS Greater Glasgow and Clyde	£4,315,168	1,300,000	£3.32	Territorial Board. Largest Health Board in Scotland.
County Durham and Darlington NHS Foundation Trust	£1,892,610	600,000	£3.15	Local Catchment. It covers County Durham and Darlington.
Calderdale and Huddersfield NHS Foundation Trust	£1,393,041	450,000	£3.10	Local Catchment. It covers the Calderdale and Kirklees areas.
Guys and St Thomas NHS Foundation Trust	£1,913,596	624,000	£3.07	Local Host (Lambeth and Southwark). Rejected 2m+ regional figure.
Royal Berkshire NHS Foundation Trust	£1,810,625	600,000	£3.02	Local Catchment. Covers Reading and West Berkshire.

Somerset NHS Foundation Trust	£1,589,819	544,000	£2.92	County-Wide. Integrated trust covering Somerset County.
Salisbury NHS Foundation Trust	£649,484	225,000	£2.89	Local Host. Core local population of the Salisbury area.
Alder Hey Children's NHS Foundation Trust	£930,483	330,000	£2.82	Specialist Proxy. Used approx. regional child population as a proxy for demand.
NHS Lothian	£2,381,933.87	850,000	£2.80	Territorial Board. It covers Edinburgh and the Lothians.
NHS Orkney	£61,345	22,000	£2.79	Territorial Board. Accurate for the island population.
NHS Forth Valley	£796,349	306,000	£2.60	Territorial Board. It covers Falkirk, Stirling, and Clackmannanshire.
The Royal Wolverhampton NHS Trust	£1,216,600	500,000	£2.43	Local Host. Wolverhampton city and its immediate surroundings were included.
NHS Ayrshire & Arran	£868,765	368,000	£2.36	Territorial Board. Accurate administrative figure.
North Tees and Hartlepool Foundation Trust	£892,754	400,000	£2.23	Local Catchment. Combined Stockton and Hartlepool
Bradford Teaching Hospitals NHS Foundation Trust	£1,222,871	550,000	£2.22	Local Host.Bradford city population was used.
Harrogate and District NHS Foundation Trust	£435,904	200,000	£2.18	Local Catchment. It covers Harrogate and the surrounding areas.
Southport and Ormskirk Hospital NHS Trust	£564,392	260,000	£2.17	Local Catchment. Covers Sefton/West Lancs area.
The Rotherham NHS Foundation Trust	£568,791	265,000	£2.15	Local Catchment. Accurate for the Rotherham borough.
University Hospitals of Morecambe Bay NHS Foundation Trust	£786,314	365,000	£2.15	Local Catchment. Dispersed North Lancs/South Cumbria.
Cardiff and Vale University Health Board	£997,097	472,400	£2.11	Territorial Board. Precise administrative figure for Cardiff and Vale.
Warrington and Halton Teaching Hospitals NHS Foundation Trust	£691,495	330,000	£2.10	Local Catchment. Accurate for the two boroughs combined.
NHS Fife	£770,124	370,000	£2.08	Territorial Board. Accurate administrative figure.
NHS Highland	£652,318	320,000	£2.04	Territorial Board. Largest geographic health board in Scotland.
Royal Stoke University Hospital	£1,425,182	700,000	£2.04	Local Catchment. North Staffordshire, Stoke-on- Trent.
Great Western Hospitals NHS Foundation Trust	£461,000	233,000	£1.98	Local Host (Swindon). Adjusted to the Swindon Borough.
East Suffolk and North Essex NHS Foundation Trust	£1,536,410	800,000	£1.92	Merged Catchment. It covers the Colchester and Ipswich populations.
Royal Surrey NHS Foundation Trust	£630,288	330,000	£1.91	Local Catchment. Covers Guildford and surrounding area.
NHS Grampian	£1,131,510	600,000	£1.89	Territorial Board. Covers Aberdeen, Aberdeenshire and Moray.
Powys Teaching Health Board	£240,000	133,000	£1.80	Territorial Board. Covers Powys county.
The Dudley Group NHS Foundation Trust	£807,682	450,000	£1.79	Local Catchment. This is consistent with the findings of the Dudley borough.
Barts Health NHS Trust	£1,249,182	700,000	£1.78	Local Host (Tower Hamlets and Newham). The two core host boroughs were used.
Cwm Taf Morgannwg University Health Board	£769,035	450,000	£1.71	Territorial Board. Covers Merthyr Tydfil, RCT, and Bridgend.

UCLH - University College Hospital	£838,000	500,000	£1.68	Local Host (Camden). Camden and its surrounding boroughs were used.
Bedfordshire Hospitals NHS Foundation Trust	£1,023,168	620,000	£1.65	Merged Catchment. It covers the Luton and Bedford populations.
Tameside and Glossop Integrated Care NHS FT	£408,603	250,000	£1.63	Local Catchment. Accurate for Tameside and Glossop areas.
Barnsley Hospital NHS Foundation Trust	£379,022	250,000	£1.52	Local Catchment. Accurate for Barnsley borough.
Epsom and St Helier University Hospitals NHS Trust	£735,743	490,000	£1.50	Local Catchment. Covers SW London/Surrey borders.
Mid and South Essex NHS Foundation Trust	£1,800,000	1,200,000	£1.50	Merged Catchment. Covers Southend, Basildon, and Broomfield.
West Hertfordshire Teaching Hospitals NHS Trust	£736,576	500,000	£1.47	Local Catchment. Watford, St. Albans and Hemel Hempstead, respectively.
Stockport NHS Foundation Trust	£419,900	290,000	£1.45	Local Catchment. It covers the Stockport borough.
Barking, Havering And Redbridge University Hospitals NHS Trust	£1,107,289	800,000	£1.38	Local Catchment. It covers three host boroughs.
Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust	£460,229	350,000	£1.31	Local Catchment. Covers Wigan borough.
Dartford and Gravesham NHS Trust	£622,738	500,000	£1.25	Local Catchment. It Covers North Kent population.
Kingston and Richmond NHS Foundation Trust	£429,856	350,000	£1.23	Local Catchment. Formerly, Kingston Hospital NHS FT merged with Hounslow and Richmond Community Healthcare NHS Trust on 1 November 2024. Covers Kingston and surrounds.
Portsmouth Hospitals University NHS Trust	£772,314	675,000	£1.14	Local Catchment. SE Hampshire population.
South Warwickshire University NHS Foundation Trust	£564,392	500,000	£1.13	Integrated Trust. It covers both acute and community aspects.
West Suffolk NHS Foundation Trust	£294,200	280,000	£1.05	Local Catchment. It covers the West Suffolk area.
Cannock Chase Hospital Trust	£415,354	400,000	£1.04	Local Catchment. It Covers Cannock Chase and the surrounding areas.
Western Health and Social Care Trust	£313,371	300,000	£1.04	Territorial Trust. Standard population for the Western Trust area.
Sheffield Teaching Hospitals NHS Foundation Trust	£629,100	640,000	£0.98	Local Host. Standard Sheffield metro population.
Dorset HealthCare University NHS Foundation Trust	£762,500	800,000	£0.95	County-Wide. Community and mental health services across Dorset.
Lewisham and Greenwich NHS Trust	£602,737	666,000	£0.91	Local Catchment. Combined orthotic budgets from Queen Elizabeth Hospital (£527,039) and University Hospital Lewisham (£75,698). Both sites operated by Lewisham and Greenwich NHS Trust, serving 666,000 across Lewisham, Greenwich and Bexley were used.
Royal Free London NHS Trust	£527,039	600,000	£0.88	Local Host (Camden and Barnet). Used host boroughs.
Maidstone and Tunbridge Wells NHS Trust	£490,056	600,000	£0.82	Local Catchment. It covers West Kent and Northern East Sussex.
Gloucestershire Hospitals NHS Foundation Trust	£523,664	650,000	£0.81	County-Wide. Acute trust serves the entire county.
Homerton University Hospital NHS Foundation Trust	£237,000	320,000	£0.74	Local Host (Hackney). It covers the City of London and Hackney.

University Hospitals Dorset NHS Foundation Trust	£580,375	800,000	£0.73	Merged Catchment. Bournemouth, Poole, and wider Dorset.
University Hospitals Sussex NHS Foundation Trust	£565,071	900,000	£0.63	Merged Catchment. Brighton, Worthing, and Chichester
Mersey Care NHS Foundation Trust	£835,190	1,400,000	£0.60	Community/Mental Health. It covers Liverpool and its surrounding areas.
Betsi Cadwaladr University Health Board	£407,051	700,000	£0.58	Territorial Board. Prosthetics were provided from the east (Wrexham and Flintshire).
NHS Borders	£63,830	115,000	£0.56	Territorial Board. The accuracy was high for the Scottish Borders.
Hampshire and Isle of Wight Healthcare NHS Foundation Trust	£773,858	1,400,000	£0.55	Community/Mental Health Trust (formed in October 2024). Serves ~1.4 million people across Hampshire and the Isle of Wight. Hampshire Hospitals NHS FT (acute) did not provide financial data; the £773,858 budget belonged to Hampshire & IoW Healthcare only.
Northern Health and Social Care Trust	£258,611	479,000	£0.54	Territorial Trust. Standard population for the Northern Trust area.
Sussex Community NHS Foundation Trust	£656,000	1,300,000	£0.50	County-Wide. Community health services in Sussex.
Birmingham Community Healthcare	£488,235	1,100,000	£0.44	Local Host (Birmingham City). Core community services for 1.1 million residents.
Norfolk Community Health & Care NHS Trust	£383,251	900,000	£0.43	County-Wide. Rural community health services in Norfolk.
University Hospitals of Derby and Burton NHS Foundation Trust	£417,503	1,000,000	£0.42	Merged Catchment. Derbyshire and SE Staffordshire.
Imperial College Healthcare NHS Trust	£488,730	1,500,000	£0.33	Local Host (NW London). Specialist Trust across eight NW London boroughs.
Nottinghamshire Healthcare NHS Foundation Trust	£341,975	1,200,000	£0.28	Community/Mental Health. Covers Nottinghamshire.
Walsall Healthcare NHS Trust	£72,775	270,000	£0.27	Local Catchment. Accurate for the Walsall borough.
NHS Dumfries and Galloway	£28,971	148,000	£0.20	Territorial Board. Accurate administrative figure.
Central London Community Healthcare NHS Trust	£336,045	N/A	N/A	Community Overlay. Covers 11 boroughs for community needs only.
East London NHS Foundation Trust	£297,423	N/A	N/A	Mental Health/Community. Niche service provision across a wide area.
Essex Partnership University NHS Foundation Trust	£504,000	N/A	N/A	Mental Health/Community. Specific non-acute service layer:
The Walton Centre NHS Foundation Trust	£219,347	N/A	N/A	Specialist Neuro. Does not serve the general population.
Great Ormond Street Hospital NHS Foundation Trust	£636,405.03	N/A	N/A	Specialist Paediatric. National catchment; perhead not applicable.
Royal Orthopaedic Hospital NHS Foundation Trust	£1,712,662	N/A	N/A	Specialist Elective. National catchment; per-head not applicable.
UCLH - National Hospital for Neurology and Neurosurgery	£458,140.31	N/A	N/A	Specialist Neuro. National catchment; per-head not applicable.

Appendix A(ii): Per-capita prosthetic services spending by NHS Trust / Health Board (2024/25) – from 23/38 Trusts and Health Boards who could provide 2024/25 prosthetic service budget data

NHS Trust/Health Board	Funding 2024/25	Population	Spend per head	Population basis and reasoning
Lancashire Teaching Hospitals NHS Foundation Trust	£2,950,422	390,000	£7.57	Local Host (Preston/Chorley). Used immediate catchment.
Cardiff and Vale University Health Board	£3,362,182	472,400	£7.12	Territorial Board. Precise administrative figure for Cardiff & Vale.
Leeds Teaching Hospitals NHS Trust	£5,842,124	845,000	£6.91	Local Host (Leeds City). Updated: ONS 2024 midyear estimate of 845,189 for Leeds metropolitan borough.
Guys and St Thomas NHS Foundation Trust	£3,193,127	624,000	£5.12	Local Host (Lambeth and Southwark). Rejected 2m+ regional figure.
NHS Greater Glasgow and Clyde	£6,273,954	1,300,000	£4.83	Territorial Board. Largest Health Board in Scotland.
Portsmouth Hospitals University NHS Trust	£3,227,236	675,000	£4.78	Local Catchment. SE Hampshire population.
Belfast Health and Social Care Trust	£1,600,000	340,000	£4.71	Local Host (Belfast). Used city population.
Sheffield Teaching Hospitals NHS Foundation Trust	£2,832,100	640,000	£4.43	Local Host. Standard Sheffield metro population.
NHS Lothian	£2,730,473.33	850,000	£3.21	Territorial Board. It covers Edinburgh and the Lothians.
Birmingham Community Healthcare	£2,773,133	1,100,000	£2.52	Local Host (Birmingham City). Core community services for 1.1 million residents.
University Hospitals Dorset NHS Foundation Trust	£1,753,028	800,000	£2.19	Merged Catchment. Bournemouth, Poole, and wider Dorset.
Tayside	£758,775	389,000	£1.95	Territorial Board. Covers Dundee, Perth and Kinross.
Northampton General Hospital NHS Trust	£756,000	427,000	£1.77	Local Catchment. Serves the population of West Northamptonshire.
Bedfordshire Hospitals NHS Foundation Trust	£1,023,168	620,000	£1.65	Merged Catchment. It covers the Luton and Bedford populations.
Sussex Community NHS Foundation Trust	£1,974,000	1,300,000	£1.52	County-Wide. Community health services in Sussex.
Norfolk Community Health & Care NHS Trust	£1,335,541	900,000	£1.48	County-Wide. Rural community health services in Norfolk.
The Royal Wolverhampton NHS Trust	£595,060	500,000	£1.19	Local Host. Wolverhampton city and its immediate surroundings.
University Hospitals of Derby and Burton NHS Foundation Trust	£1,088,000	1,000,000	£1.09	Merged Catchment. Derbyshire and SE Staffordshire.
NHS Grampian	£614,535	600,000	£1.02	Territorial Board. Covers Aberdeen, Aberdeenshire and Moray. Updated:
Betsi Cadwaladr University Health Board	£670,426	700,000	£0.96	Territorial Board. Prosthetics were provided from the east (Wrexham and Flintshire).
NHS Highland	£272,520	320,000	£0.85	Territorial Board. Largest geographic health board in Scotland.
Imperial College Healthcare NHS Trust	£874,374	1,500,000	£0.58	Local Host (NW London). Specialist Trust across eight NW London boroughs.
East Suffolk and North Essex NHS Foundation Trust	£390,428	800,000	£0.49	Merged Catchment. Covers Colchester and Ipswich populations.

Appendix A: Per-capita spending on orthotic and prosthetic services by the NHS Trust and Health Board (2024/25). Population estimates, funding figures, and spending per head for all Trusts and Health Boards that provided 2024/2025 financial allocations to prosthetic and orthotic service budgets.

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