



The British Association of
Prosthetics and Orthotics



The current state of workforce planning for NHS prosthetic and orthotic services



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This report presents evidence obtained under the Freedom of Information Act 2000 and the Freedom of Information (Scotland) Act 2002. The findings reveal widespread gaps in workforce planning for prosthetic and orthotic services, particularly where services are contracted to a private provider. The findings identify a national gap that is strongly associated with structural features of the service delivery model.

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Executive summary

Context

To our knowledge, this is the first UK-wide analysis of prosthetic and orthotic (P&O) workforce planning. It is based on Freedom of Information (FOI) responses from 179 of 224 NHS Trusts and Health Boards (an 80% response rate). Workforce planning extends beyond merely considering staff numbers; it involves evaluating skills and competencies, identifying training requirements, planning for succession, and managing the training pipeline. The findings show that P&O services largely sit outside mainstream allied health profession (AHP) workforce planning, particularly where services are subcontracted to external organisations, and this creates systemic risks to service sustainability, equity, and potentially, patient outcomes. This report is written primarily for health departments in England and the devolved nations, NHS England* and Integrated Care Boards (ICBs), NHS Trust and Health Board leaders, Chief AHPs (and equivalents), Board members responsible for AHPs, and national workforce planners.

Headline findings

- P&O is routinely omitted from mainstream AHP workforce planning. Although 84% (108/128) of applicable Trusts/Health Boards reported that they conduct AHP workforce planning, 54% (20/37) omitted prosthetics and 58% (61/105) omitted orthotics from that activity.
- The externally contracted delivery model is strongly associated with omission from workforce planning. Only 19% (4/21) of organisations with externally contracted prosthetic services and 12% (8/68) with externally contracted orthotic services conducted workforce planning for those services, compared with inclusion rates of 80% (12/15) for in-house prosthetic and 87.5% (35/40) for in-house orthotic services. This pattern suggests that the delivery model may be an important factor, although the observational design cannot establish causation.
- The NHS P&O workforce is largely absent from national workforce returns. Only 23.4% (30/128) of Trusts/Health Boards with P&O services included prosthetic and orthotic workforce details in national workforce returns; among contracted orthotic services, this fell to just 4.4% (3/68).
- This invisibility is evident nationally, particularly across England, and appears to disproportionately affect externally contracted services and their staff, which may undermine the provider's (Trusts/Health Boards) ability to meet their statutory responsibilities and could contribute to geographical variation in service sustainability and access.

Implications

Externally contracted P&O staff are clinically indistinguishable from their NHS colleagues in terms of professional registration and NHS patient contact, yet they remain administratively invisible within many NHS workforce systems and return mechanisms. This governance gap impedes the ability of the NHS to plan and support the workforce pipeline effectively through education commissioning, student placement planning, and succession planning.

This also has important implications for the UK's Reception Arrangements for MoD Patients (RAMP). Ensuring that P&O services have the capacity to respond to urgent and potentially increased demand associated with these arrangements requires immediate attention through comprehensive data collection, full visibility of the existing workforce, and realistic workforce and capacity planning.

The current gap also limits assurance that relevant information governance and equality considerations, including the needs of disabled people who rely on P&O services, are addressed consistently. Furthermore, it may hinder efforts to reduce avoidable downstream costs associated with diabetic foot ulcers, amputations, falls and hip fractures, where timely and adequately resourced P&O provision has a recognised preventive role.

This report identifies a significant blind spot in workforce governance. Boards remain accountable for the quality, safety, and sustainability of their services, including those that are subcontracted, regardless of the employment model used to deliver them. Workforce planning cannot stop where employment arrangements change; it must follow responsibility for patient care. Until it does, NHS organisations cannot be fully assured that they understand the skill and resilience of the workforce delivering care on their behalf.

**This report refers to NHS England throughout. As plans for its abolition are underway at the time of writing, references to NHS England should also be understood to apply, where relevant, to any successor organisation or body assuming its functions.*

Recommendations

Section 6 sets out eleven recommendations to close this gap, spanning mandatory workforce data reporting for P&O services, explicit inclusion of externally contracted staff in AHP guidance, workforce standards embedded in service contracts, national leadership for small and vulnerable professions, and alignment of workforce planning with outcome-based pathways. Accountability for delivery is mapped across the Department of Health and Social Care and devolved health departments, NHS England and ICBs, and individual NHS Trusts and Health Boards.

A note on positioning

This report is not an argument against service delivery via a commercial organisation. Sub-contracting to a commercial organisation is the dominant model for P&O provision across the NHS in England, for reasons which may include workforce scarcity, financial pressures, and difficulty sustaining small specialist teams. Nothing in the findings that follow should be read as a case for reversing that model.

What the evidence does show is that externally contracted P&O services are, in the great majority of cases, omitted from the governance arrangements that in-house services receive as a matter of course. The gap identified in this report is not that services are externally contracted; it is that the provider organisation's (Trusts/Health Boards) responsibility for workforce oversight has, in practice, been treated as ending where the contract begins. Clinical staff delivering contracted P&O care are registered, regulated, and clinically indistinguishable from their NHS employed colleagues, yet the workforce planning, succession planning, and national data collection applied to in-house teams have not been extended to them.

This local governance gap compounds a wider problem. P&O is a small and vulnerable profession, and no single body holds a comprehensive, routinely updated, service-level dataset covering the complete NHS P&O workforce. Where a Trust/Health Board does not know the workforce delivering the service to its patients, that workforce is also invisible to NHS England, Integrated Care Boards, Health and Social Care Partnerships, and the devolved health departments responsible for planning at scale. Local governance and national oversight are, in this sense, closely connected problems viewed from different levels. Limitations at each level may reinforce the limitations observed at the other.

The recommendations in this report therefore call for equity of governance and a reliable national evidence base. Contracted P&O services should benefit from the same standard of workforce oversight, data visibility, and commissioning assurance as in-house services, proportionate to their scale and delivered through the contract rather than in spite of it, and that same data should feed a coherent national understanding of the P&O workforce. Where this report is critical, it is critical of an accountability gap that provider organisations and national bodies have allowed to develop, not of the commercial organisation or the staff working within externally contracted arrangements.



Headline finding

The response rate was 80%

179 of 224 NHS Trusts and Health Boards responded to the FOI request. Of the respondents providing prosthetic services (n=42) or orthotic services (n=125), the majority reported that P&O was not included in their organisation's AHP workforce planning.

Omission from AHP workforce planning

Of the applicable organisations, 54% (20/37) omitted prosthetics and 58% (61/105) omitted orthotics from their AHP workforce planning, despite 84% (108/128) reporting that they conducted AHP workforce planning overall.

Contracted model as a structural factor

19% (4/21) of organisations with externally contracted prosthetic services and 12% (8/68) with externally contracted orthotic services conducted workforce planning for those services. In contrast, in-house providers reported inclusion rates of 80% (12/15) for prosthetics and 87.5% (35/40) for orthotics, indicating a strong association between the delivery model and inclusion in workforce planning, and suggesting that the gap may be structural rather than inevitable.

Absence from national workforce data

Only 23.4% (30/128) of all Trusts/Health Boards with P&O services included prosthetic and orthotic workforce details in national workforce returns. Among externally contracted orthotic providers, only 4.4% (3/68) did so, meaning that services delivering the majority of NHS orthotic services contribute almost nothing to the national data upon which strategic workforce planning depends.



1 Methodology

1.1 Data collection and study design

To evaluate workforce planning practices and governance for prosthetic and orthotic services within the NHS, a cross-sectional observational study was conducted using the statutory rights provided by the Freedom of Information Act 2000¹ and the Freedom of Information (Scotland) Act 2002.² FOI requests were submitted in February 2026 to 224 NHS Trusts and Health Boards across the United Kingdom.

The primary objective was to determine whether NHS organisations were conducting AHP workforce planning, whether P&O services were included within that activity, and whether P&O workforce data were being submitted to national workforce returns. As a cross-sectional observational analysis, this study identifies descriptive patterns and associations but cannot establish causal relationships.

Freedom of Information requests

Organisations were asked to provide information across ten questions (see appendix 1) covering the following areas:

- Whether the Trust or Health Board directly provides or subcontracts (via a commercial organisation) a prosthetic and/or orthotic service
- The delivery model used (in-house, contracted, or mixed)
- Whether AHP workforce planning is conducted and, if so, whether P&O services are included
- Whether workforce planning is conducted specifically for externally contracted P&O services, and how data is collected
- What steps are being taken to secure the P&O workforce pipeline
- Whether P&O service workforce data is included in national workforce returns
- The current whole time equivalent (WTE) staffing across the four P&O workforce groups

Sample and response rate

Of the 224 organisations contacted, 179 substantive responses were received, representing an 80% response rate. Responses were received from NHS organisations across England, Wales, Scotland, and Northern Ireland. The Freedom of Information Act 2000 and the Freedom of Information (Scotland) Act 2002 provide a statutory right of access to recorded information held by public authorities. The Freedom of Information legislation provides a right of access to recorded information held by public authorities. It does not generally require an authority to create information that it does not already hold. However, the inability to provide basic workforce information may indicate weaknesses in records management and workforce governance.

Potential non-response bias

The analysis was based on organisations that responded to the FOI and were able to provide sufficiently complete responses to the workforce planning questions posed. The findings, therefore, may be affected by non-response bias.

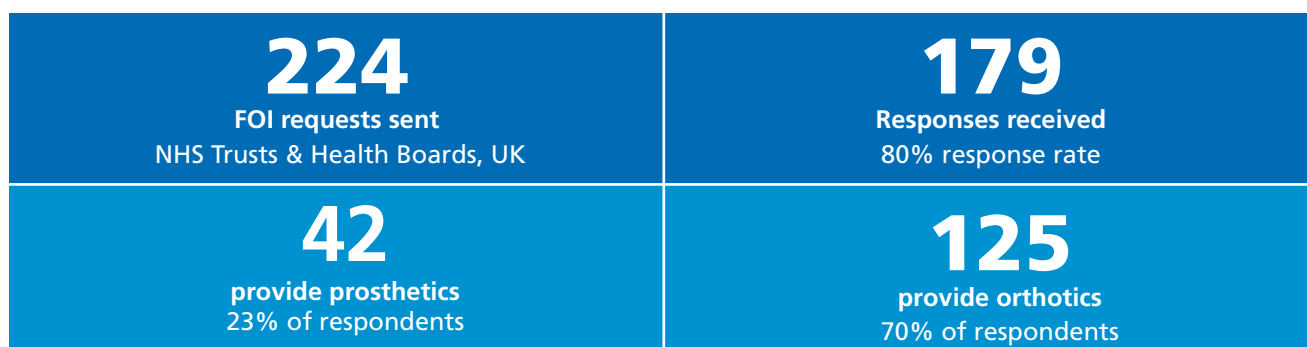


Figure 1: Response rates and service provision landscape from the FOI exercise. Note: Some Trusts/Health Boards have both prosthetic and orthotic services.

1.2 Service delivery models

Prosthetic and orthotic services are commissioned separately, despite frequently being considered together as P&O services. In England, amputee rehabilitation and prosthetic services for people of all ages form part of specialised services and are governed by a national NHS England service specification. Since April 2025, responsibility for commissioning many specialised services, including prosthetic services, has been delegated to ICBs. However, NHS England remains ultimately accountable for services commissioned under these delegated arrangements and holds ICBs to account through formal delegation agreements.

Orthotic services are generally commissioned locally and are not governed by an equivalent mandated national service specification. NHS England published a model orthotics service specification in 2015, but commissioners were advised to consider adopting it rather than being required to do so. This creates scope for variation in service specifications, investment, access, quality measures, and workforce requirements between local areas.

Across the NHS, prosthetic and orthotic services are delivered through three primary models, each with distinct implications for accountability, governance, and workforce planning.

The table below presents information received from Trusts and Health Boards regarding the delivery model used for their prosthetic and orthotic services.

Delivery Model	Prosthetics	Orthotics	Characteristics
Contracted	50% (n=21/42)	54% (n=68/125)	Subcontracted to commercial organisations
In-house	36% (n=15/42)	33% (n=41/125)	Delivered by NHS-employed staff
Mixed	14% (n=6/42)	13% (n=16/125)	Combination of both models

Table 1: Prosthetic and orthotic service delivery models reported by Trusts and Health Boards.

In-house service delivery is not the dominant model in either discipline. This structural characteristic, which is unusual among allied health professions in terms of its scale, is closely associated with the accountability gap examined in this report.



2 Ensuring Trusts and Health Boards understand their externally contracted workforce

2.1 Externally contracted P&O services omitted from mainstream AHP planning

Perhaps the most significant finding in this report is the extent to which NHS Trusts and Health Boards omit externally contracted prosthetic and orthotic services from their AHP workforce planning. This represents a material workforce governance gap for services that the NHS is ultimately responsible for delivering.

Among the Trusts and Health Boards which have externally contracted their prosthetic (n=21) and orthotic (n=68) services to a commercial organisation, workforce planning by the NHS Trust/Health Board is almost entirely absent. This section details the absence and potential consequences.

The important question for Trusts/Health Boards is not whether they conduct general AHP workforce planning (the majority do) but whether they carry out workforce planning specifically for the externally contracted P&O workforce. The data were unambiguous.

Is workforce planning carried out for contracted prosthetic services?	Count (n)	Percentage
Yes	4	19%
No	17	81%
Total applicable respondents	21	100%

Table 2: Workforce planning for contracted prosthetic services (n=21).

Is workforce planning carried out for contracted orthotic services?	Count (n)	Percentage
Yes	8	12%
No	60	88%
Total applicable respondents	68	100%

Table 3: Workforce planning for contracted orthotic services (n=68).

Of the small minority that reported conducting workforce planning for externally contracted services, the mechanisms described were largely confined to operational contract monitoring, including quarterly review meetings, review of waiting times, and capacity data, and submission of assurance templates. None of the responses describing contracted-service workforce planning referenced succession planning, education pipeline analysis, skill mix forecasting, or integration with regional or national AHP workforce strategies.

One Trust reported that workforce data for its orthotics service were submitted directly to NHS England by the commercial organisation. A national mechanism did exist through the [Workforce Minimum Dataset Collection Vehicle](#) for independent providers and subcontracted organisations in England that do not use the Electronic Staff Record (ESR). However, this mechanism has recently been decommissioned.

Monitoring whether a provider has enough staff to deliver next month's clinics is not equivalent to planning the long-term workforce requirements of the service. The FOI responses did not demonstrate consistent access to strategic workforce information or consistent oversight of the service's future workforce needs.

The NHS Standard Contract 2026/273,⁴ requires contracted organisations to cooperate, to the extent reasonably requested, with NHS England, local Integrated Care Boards, NHS Trusts, and NHS Foundation Trusts in developing and delivering local healthcare workforce plans and in planning and providing education and training for healthcare workers. It also requires them, when requested by the co-ordinating commissioner, to provide details of their analysis of staff training needs and summaries of training provided and appraisals undertaken.

Of the applicable Trusts/Health Boards, 84% (108/128) reported conducting AHP workforce planning. On the surface, this appears to be encouraging. However, an examination of whether P&O services are included in that planning activity reveals a concerning pattern of omission.

Prosthetic services

Does AHP workforce planning include prosthetics?	Count (n)	Percentage
Yes: included	17	46%
No: omitted	20	54%
Total applicable respondents (Trusts/HBs carrying out workforce planning for AHPs)	37	100%

Table 4: Inclusion of prosthetics in AHP workforce planning (Trusts delivering prosthetic services, n=42, Trusts/HBs with prosthetic services who are carrying out AHP workforce planning n=37).

Orthotic services

Does AHP workforce planning include orthotics?	Count (n)	Percentage
Yes: included	44	42%
No: omitted	61	58%
Total applicable respondents (Trusts/HBs carrying out workforce planning for AHPs)	105	100%

Table 5: Inclusion of orthotics in AHP workforce planning (Trusts/HBs delivering orthotic services, n=125). Trusts/HBs with orthotic services conducting AHP workforce planning (n=105). Note, one Trust/HB did not respond to this question (105/106). Note: Percentages have been rounded to the nearest whole percentage.

For orthotics, only 44 of 105 respondents with orthotic services (who conducted AHP workforce planning) confirmed that orthotics were included in AHP workforce planning. Many NHS organisations appear to contract P&O services to commercial organisations without evidence of systematic analysis of current and future workforce requirements, including assessment of vacancies, skill mix, succession planning, retirement profiles, and demand modelling to ensure service quality and sustainability.

2.2 Workforce assurance for externally contracted prosthetic and orthotic services

England

When an NHS Trust subcontracts the delivery of prosthetic and/or orthotic services to a commercial organisation, the responsibility for assuring workforce adequacy does not transfer solely to the subcontractor.

The NHS Standard Contract 2026/27³ requires providers (Trusts) to ensure that there are sufficient appropriately registered, qualified, and experienced staff to deliver services, considering both staffing levels and skill mix. Providers are required to continually assess actual staffing and skill mix against planned requirements and undertake a detailed review of staffing requirements at least annually. The contract also makes it clear that subcontracting does not relieve the provider of its contractual obligations and that the provider remains responsible for the performance, acts, and omissions of its subcontractors.^{3,4} The NHS Standard Contract is mandated for NHS-commissioned healthcare services in England, other than primary care.

These requirements are reinforced by Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,⁵ which requires registered providers to deploy sufficient numbers of suitably qualified, competent, skilled, and experienced staff. The CQC guidance further requires a systematic approach to determining the number of staff and the range of skills required to meet patient needs.⁵

Therefore, when an NHS Trust has subcontracted the delivery of its P&O service but remains the provider under the NHS Standard Contract, it must retain assurance that the number, professional composition, skill mix, and competence of the P&O workforce are sufficient to meet the needs of the patient population. This should not be a one-off exercise undertaken at the time of procurement. Workforce capacity and skill mix should remain under active review throughout the life of the contract.

Devolved nations

Legislative and regulatory positions differ across devolved nations. In Scotland, the Health and Care (Staffing) (Scotland) Act 2019⁶ provides a statutory basis for appropriate staffing in health and care services, with the aim of ensuring that the right people with the right skills are available in the right place and at the right time to provide safe and high-quality care that meets service user needs.

In Wales, workforce assurance operates within a different legislative and regulatory framework. The Nurse Staffing Levels (Wales) Act 2016⁷ creates statutory duties concerning the sufficiency of nursing staff, including a general duty on Health Boards; however, there is currently no equivalent legislation establishing comparable staffing requirements specifically for the prosthetics and orthotics workforce.

In Northern Ireland, safe and effective staffing legislation is being developed. Proposals presented to the Northern Ireland Assembly in 2026⁸ adopt a wider Health and Social Care workforce approach, intended to support workforce planning and the delivery of safe, high-quality care across professions.

2.3 Structural factors associated with workforce planning omission

The FOI responses identified several factors associated with the omission of P&O services from workforce planning.

Externally contracted services: The most commonly reported reason for not conducting workforce planning for P&O services was that the service was contracted to a commercial organisation. Many Trusts/Health Boards reported that, because staff are not employed by the NHS directly, workforce planning is the responsibility of the commercial organisation. Although operational workforce planning may be undertaken by the commercial organisation, the NHS Trust/Health Board retains responsibility for proportionate assurance that the service has an appropriately skilled and sustainable workforce. This requires access to sufficient workforce information to monitor contractual quality and continuity risks.

Absence from workforce systems: Externally contracted P&O staff are not routinely recorded in the NHS Electronic Staff Record in England and Wales, in Turas workforce systems in Scotland, or in equivalent national workforce returns. Effective national workforce planning is fundamentally limited without sufficiently complete and reliable data.

Commercial opacity: Several Trusts/Health Boards reported that they could not access workforce data from externally contracted organisations. Some indicated that the contracted service was entirely the commercial organisation's concern. Some organisations cited commercial sensitivity when declining disclosure, further limiting the information available through the FOI exercise.

Lack of institutional awareness: A recurring theme across responses was that Trusts/Health Boards simply did not include P&O in their remit, because externally contracted P&O services have never been framed as a mainstream AHP workforce issue.

Direct quotes from Trusts/Health Boards FOI responses

"Not applicable. The Trust is not responsible for collating such data, it does not collect or provide such data."

"This is a contracted service, and the provider is responsible for ensuring the workforce pipeline."

"We do not have any plans to secure this workforce pipeline as this is a contracted service."

"This is not within our control. The contracted company have direct control and influence of this."

"The service is fully contracted. Information is not held by this Trust. It would need to be acquired from the external provider."

"Orthotics staffing is not included in our workforce metrics as this service is subcontracted to a third party."

"The Trust's Orthotist is contracted to provide a set number of clinics per year, in line with activity plans for the service."

"Managed service SLA with provider - expectation all workforce planning, whether it be succession or continuity, is conducted by provider."

"This is not something we are looking at."

"There is an external contract for orthotist provision, and they complete a 6 monthly assurance template."

"The prosthetic and/orthotic workforce pipeline fall outside of the scope of the trust as we do not employ AHPs in these staff groups. We do however support the contracted providers with the development of competency frameworks for their Orthotists who are largely overseas recruits."

"The Trust does not hold this information."

"Not applicable as the workforce for both Orthotics and Prosthetics is not employed by this Trust."



Examples of good practice:

"All contracted AHPs are included in the trust workforce planning in the same way as direct NHS employed AHPs, using questionnaires, comms, feedback, CPD etc. Contracted AHPs are currently excluded from job planning but we plan to progress to include them in future rounds."

"Service demand, service capacity, waiting times and queue, workforce skill mix. NHS Borders holds all waiting list and activity data through our NHS systems, therefore external providers are not required in order to support workforce planning."



3 A lack of oversight, accountability, and national workforce data

3.1 The disproportionate impact on commercial organisations and their staff

The absence of NHS oversight of the externally contracted P&O workforce creates a feedback loop of disadvantage that ultimately affects both clinicians and patients. Externally contracted P&O staff do not benefit from the NHS Electronic Staff Record. They are indistinguishable from NHS colleagues in terms of their registration, scope of practice, and patient contact; yet they remain administratively invisible.

This lack of visibility has direct consequences. Externally contracted P&O services cannot demonstrate their workforce needs to Trusts/Health Boards in the same manner as in-house services. Succession risks identified by the commercial organisation may not reach the Trust's/Health Board's governance structures. Student placement capacity, apprenticeship development, and continuing professional development infrastructure, all of which depend to some extent on institutional visibility, are more precarious in externally contracted services.⁹

For patients, the consequence is that service continuity is dependent on the commercial viability and staffing decisions of a private organisation, without the NHS oversight that would identify and mitigate future risks which may impact the service. In addition, should the Trust/Health Board decide to re-tender the service or bring the service in-house, they do so with limited or no workforce data to guide their decisions.

3.2 Limited data and its impact on workforce planning

The scale of the workforce data gap is made clear by the staffing figures collected through this FOI request. Across 102 (out of 128) Trusts/Health Boards that provided WTE data, the known P&O workforce totals approximately 708 WTE across the four workforce categories within the profession.

Role	Total WTE	% of Total	No. Trusts/Health Boards Reporting
Prosthetists	137.63	19%	33
Orthotists	337.71	48%	97
P&O Technicians	194.32	27%	100
P&O Support Workers	38.25	5%	98
TOTAL	707.91 WTE	99%	102

Table 6: P&O workforce WTE from 102 reporting Trusts and Health Boards. Percentages are rounded and may not sum to 100%. *102 Trusts/Health Boards provided responses across all four categories of staff.

The 707.91 WTE identified through the FOI responses should be treated as the minimum workforce visible to Trusts and Health Boards, rather than a reliable estimate of total NHS P&O workforce capacity. In 2024, a study of the UK P&O workforce reported 863 prosthetists and orthotists and estimated a total workforce of 1,766 staff when technicians and support workers were included.^{10,11} These figures are not directly comparable because the workforce study reported headcount, while this report presents whole time equivalent staffing. Nevertheless, the scale of the difference indicates that a substantial proportion of the workforce is not captured by the FOI data presented in this report. This is largely because the dataset includes only staff whom Trusts and Health Boards can identify and report. Many organisations with externally contracted services responded with 'Unknown', 'Contracted out, information not held', or equivalent wording, when asked to provide workforce numbers for their prosthetic/orthotic services. Consequently, staff employed through external providers are frequently absent from the returns, meaning that the reported 707.91 WTE almost certainly represents a major undercount.

The monthly workforce data published by NHS England¹² confirm the significant lack of visibility of the P&O workforce. The latest NHS England workforce publication available at the time of writing, covering June 2026, reports 206.15 FTE prosthetists and orthotists employed by NHS Trusts and other core organisations in England. The inability of Trusts/Health Boards to report on the workforce delivering their services is a symptom of the planning failure identified in this report. The true size of the NHS P&O workforce cannot be determined from the data currently available to NHS England.

Without accurate baseline data:

- Higher education institutions, NHS England's workforce, training, and education functions, and corresponding bodies in the devolved nations cannot accurately align the number of training places with workforce need or adequately plan the careers outreach and workforce development required to support and sustain the workforce pipeline.
- Integrated Care Boards cannot make evidence-based decisions regarding service configuration or investment.
- The profession cannot make a credible case for investment to address the known shortages.
- National bodies cannot assess whether the P&O workforce is sufficient to meet the growing demand driven by an ageing population, rising rates of diabetes and vascular disease, and the increasing complexity of patient needs.
- Without complete data on current workforce capacity and specialist skills, the UK cannot develop credible and scalable P&O workforce plans to meet increased demand arising from conflict, including military casualties received through the Reception Arrangements for MoD Patients (RAMP) arrangements.

The findings of this report are consistent with wider concerns identified by Policy Connect's Trained for Tomorrow inquiry (2026),¹³ which concluded that inadequate data infrastructure and weak strategic coordination are fundamental barriers to effective workforce planning across the NHS. The inquiry found that there is currently no transparent national assessment of workforce supply and demand across all regulated health professions, limiting the ability of employers, education providers, and policymakers to align workforce capacity with future service need.

For prosthetic and orthotic services, this challenge is amplified by the absence of complete workforce data for externally contracted services. Without reliable workforce intelligence, it becomes difficult to forecast future staffing requirements, understand retirement risks, assess geographical variation, or calibrate education and training places appropriately.

The Policy Connect report¹³ highlighted the potential value of emerging workforce intelligence tools, such as the HCPC Data Hub, which provides information on registrant demographics, professional retention, and workforce trends. Greater use of these datasets could help inform future planning for small and vulnerable professions such as prosthetics and orthotics.

3.3 Prosthetic and orthotic workforce planning for conflict preparedness

The workforce planning gap identified in this report has implications for national resilience and international health security. The current geopolitical context makes this an urgent concern. The Stockholm International Peace Research Institute (SIPRI) reported large-scale and sustained violence across multiple regions in 2025, with the number of interstate armed conflicts doubling from three in 2024 to six in 2025.¹⁴ The UK's 2025 Strategic Defence Review commits the country to greater warfighting readiness and a leading role within the North Atlantic Treaty Organization (NATO).¹⁵ The Department of Health and Social Care has also confirmed that it is working with NHS England and defence partners on arrangements for receiving military patients into the NHS.¹⁶ Armed conflict, mass casualty incidents, and other major emergencies can generate a sudden and sustained increase in the demand for prosthetic and orthotic services, including prosthetic rehabilitation, limb salvage, and complex orthotic provision.

Gaza demonstrates how rapidly demand can overwhelm existing capacity. In May 2026, the World Health Organization (WHO) reported that, of the 172,043 people injured between October 7, 2023, and April 1, 2026, an estimated 43,011 had sustained potentially life-changing injuries. The WHO estimated that between 5,161 and 6,710 limb amputations had occurred. Of the 2,277 people with amputations who had been evaluated, only 502 prostheses had been fitted, while only eight prosthetists were working in Gaza.¹⁷ These figures demonstrate that the availability of devices alone is not an adequate response. Effective provision requires a skilled clinical and technical workforce supported by assessment, prescription, fitting, alignment, rehabilitation, maintenance, repair, and replacement services.

Ukraine provides further lessons on the sustained impact of conflict on rehabilitation. Research has identified staff and equipment shortages, fragmented governance and patient pathways, poor continuity between hospital and community services, limited integration of mental health support, and unequal access between military personnel and civilians.¹⁸ In February 2026, the WHO reported that only 4% of hospitals in Ukraine provided inpatient rehabilitation, and only 3% of facilities offered assistive technologies, including prosthetic and orthotic devices.¹⁹ The experience of Ukraine shows that rehabilitation and P&O provision must be incorporated into emergency planning from the acute phase onwards, supported by reliable workforce data, competency mapping, scalable training capacity, coordinated patient pathways, and resilient supply, repair, and replacement systems.

The capacity of individual countries cannot be considered in isolation because the global P&O workforce is already insufficient and unevenly supported. Clarke et al.²⁰ identified some form of national regulation of the orthotist and prosthetist workforce in only 30 of the 197 countries. All nine core practitioner standards, covering minimum education, entry-level competency, scope of practice, professional conduct, course accreditation, continuing professional development, language standards, recency of practice, and return to practice, were present in only six countries. This demonstrates the weakness of the global infrastructure required to educate, regulate, and maintain a safe workforce. The study recommended establishing an international professional body to support the development of effective national regulations²⁰.

The need for international action was reinforced on 2 September 2026 when the United Nations General Assembly adopted its first resolution dedicated specifically to access to assistive technology. Resolution 80/305 recognises personnel as one of the five essential components of an effective assistive technology system. It identifies the lack of suitably trained personnel as a persistent barrier to access and calls for adequate personnel with role-specific competencies to address this issue. The resolution also calls on states to systematically include access to assistive technology in humanitarian preparedness and response, including armed conflicts, disasters, and other emergencies.²¹ This is directly relevant to P&O because it confirms that providing products alone is insufficient without the competent clinical and technical workforce and service infrastructure required to assess, prescribe, fit, maintain, repair, and replace them properly.

International oversight and coordinated global P&O workforce planning are now required. This should include consistent workforce data, internationally recognised competency standards, mapping of clinical and technical skills, sustainable education and training capacity, and coordinated surge arrangements that strengthen rather than deplete local services. The WHO recommends that rehabilitation should be integrated throughout health emergency preparedness, readiness, response, and resilience.²²

For the UK, this means that workforce planning cannot be based solely on routine domestic demand. It must also consider the capacity required to support conflict-related casualties received through arrangements such as the RAMP, respond to a sudden increase in domestic need, and contribute safely to international humanitarian responses.^{16,23} These activities depend on knowing the size, distribution, skill mix, and competencies of the existing workforce and having an education and training pipeline capable of expansion. This report demonstrates that these prerequisites are not currently in place. There is no reliable national baseline for the P&O workforce, and no single body has oversight of its sustainability or readiness to respond.

A health system that cannot account for the size and skill of its prosthetic and orthotic workforce in peace-time, cannot model, mobilise, or scale that workforce in response to conflict. The invisibility documented throughout this report is therefore not only a governance and equity issue in routine service delivery; it is a strategic vulnerability that would undermine the United Kingdom's capacity to prepare for and respond to the rehabilitation demands that conflict or a comparable national emergency would impose.

3.4 The economic case for better workforce planning

The workforce planning gaps described in this report do not exist in isolation from patient outcomes, educational participation, employment, or NHS expenditure. Timely access to prosthetic and orthotic care can enable children and young people to attend and participate more fully in education, support adults to enter, remain in or return to employment, and help people maintain their independence and contribute to their families and communities. In August 2026, the Centre for Economics and Business Research (Cebr) published a Treasury compliant economic analysis, commissioned by the British Association of Prosthetics and Orthotics, that put a monetary value on the cost of the UK's P&O workforce shortfall.²⁴ Cebr estimated that, in 2025 alone, an under resourced P&O workforce left approximately 193,000 eligible patients without adequate care, resulting in £125.9 million in foregone net savings to the NHS and social care system.²⁴

Cebr reported that closing this gap offered a clear economic return. Meeting the shortfall would have required an estimated £98.3 million in additional staff and device costs but would have generated gross health and social care savings of £224.3 million, together with £58.8 million in increased gross value added (GVA) through improved productivity. The GVA figure includes a £14.6 million gain to the Exchequer.²⁴ Set against intervention costs, this equates to a health and social care return on investment (ROI) of 1.28:1 (a benefit cost ratio, BCR, of 2.28) and a total ROI, including productivity gains, of 1.88:1 (BCR of 2.88). Put simply, every £1 invested in expanding P&O provision would have returned between £1.28 and £1.88 in net benefit elsewhere in the system.²⁴

Cebr's analysis also demonstrates that the workforce shortfall driving this gap is itself substantial and growing. There were an estimated 953 practising prosthetists and orthotists in the UK in 2025, against a World Health Organization benchmark of 15 to 20 prosthetists and orthotists per million population for a country at the UK's level of development. Left unaddressed, Cebr projects this gap will widen: the number of patients not receiving adequate P&O care, or experiencing barriers to access, is forecast to rise from 193,000 in 2025 to 238,000 by 2035, an increase of 23%, driven mainly by population growth. Over that ten-year period, continued inaction is estimated to cost the NHS and social care system £1.4 billion in foregone net savings, a further £631 million in lost contribution to GDP, and £156 million in lost tax revenue to the Exchequer (figures expressed in 2025 prices and discounted at the standard Treasury rate).²⁴ Sustained investment to close the gap over the same period would, by contrast, deliver an improved health and social care ROI of 1.84:1 (BCR of 2.84) and a total ROI of 2.68:1 (BCR of 3.68), as costs fall for patients in ongoing or recurrent treatment.²⁴

Beyond the immediate financial case, the evidence for investment is reinforced by demand. The demand for P&O services is dynamic. Multiple converging factors are driving a sustained and accelerating increase in the number of patients requiring prosthetic and orthotic interventions.

The Chief Medical Officer's 2023 annual report identified population ageing as one of the most predictable and significant drivers of future healthcare need.²⁵ The NHS Long Term Workforce Plan similarly highlights demographic pressure, reporting that while the population of England is projected to increase by 4.2% over 15 years, the number of people aged over 85 is projected to grow by 55%.²⁶

The Darzi Independent Investigation of the NHS in England identified population ageing as the most significant driver of increased healthcare needs because it is associated with rising levels of long-term conditions, multi-morbidity, and frailty²⁷.

Healthy life expectancy is also a concern. The Chief Medical Officer's 2023 report states that the average male in England spends the last 16 years of life in poor health, whereas the average female spends the last 19 years of life in poor health.²⁵ ONS data also show substantial inequalities in healthy life expectancy, with people in the most deprived areas experiencing markedly fewer years of good health than those in the least deprived areas.²⁸

The findings of these reports have direct implications for P&O services, which support rehabilitation, mobility, independence, and function across stroke, arthritis, diabetes, vascular disease, cancer, and frailty pathways. They reinforce the central argument of this report: without workforce planning, underpinned by the national data infrastructure needed to plan, monitor, and evaluate it, the staffing needed in P&O services to meet future demand and secure these returns cannot be reliably delivered.

3.5 The need for proportionate workforce oversight

As stated at the beginning of this report, this is not an argument against commercial service delivery, nor does it fail to recognise the genuine operational reasons that have driven the growth of externally contracted P&O provision. This is an argument for proportionality, transparency, and accountability in the exercise of contracting responsibility.

This workforce planning gap must also be understood in the context of the formal designation of prosthetics and orthotics as a small and vulnerable profession. NHS England's small and vulnerable professions framework²⁹ defines vulnerability not only by workforce size but also by the fragility of the education and training pipeline and the risk that the workforce will be insufficient to meet NHS needs. Under this framework, prosthetics and orthotics has been categorised at vulnerability level one, the highest level of concern, denoting a profession highly at risk of failure. With a 2023 training intake of just 41 students,²⁹ the profession cannot absorb disruption in the way that larger workforces can: an under-recruited cohort, a shortage of practice educators, or a rise in early career attrition can have rapid and disproportionate consequences for the national workforce supply. The absence of workforce planning documented in this report, therefore, compounds an already recognised structural fragility, reinforcing the case that prosthetics and orthotics require targeted national workforce attention.

If Trusts and Health Boards sub-contract P&O services delivered entirely by commercial organisations without conducting workforce planning, requesting workforce data, or including that workforce in national returns, the profession will remain at risk of a fragile and poorly understood workforce pipeline. This creates a risk that future service demand may outstrip available clinical capacity, with limited visibility of the workforce required to sustain safe, timely, and effective P&O care.

The Trained for Tomorrow (2026) inquiry¹³ concluded that effective workforce planning requires both national coordination and regional workforce intelligence. It recommended the establishment of a National Healthcare Workforce Development Forum to bring together government, regulators, education providers, employers and professional bodies to improve strategic workforce planning across healthcare professions.

Given that prosthetics and orthotics has been identified as a small and vulnerable profession, consideration should be given to ensuring that P&O representation is included within any future national workforce coordination structures. This would provide a mechanism for addressing workforce risks that may not be visible within larger AHP workforce programmes.

This report raises key questions about how the NHS is ensuring that P&O services have an adequate and sustainable workforce; what steps are being taken to support the externally contracted P&O workforce through training, succession planning, and pipeline development; and, crucially, how this information is being consolidated to create a reliable national picture of P&O workforce capacity, rather than relying on sporadic local knowledge or informal understanding of individual contracts.

Until these issues are addressed, there is a risk that workforce planning in P&O services will remain fragmented and insufficiently visible. Strengthening oversight in this area would support providers, contractors, P&O staff, and, most importantly, patients by ensuring that all P&O services are underpinned by robust governance, sustainable workforce planning, clear lines of accountability, and national workforce intelligence capable of informing future service planning.

4 Comparing national approaches to P&O workforce planning

The FOI dataset provides, for the first time, a direct comparison of prosthetic and orthotic workforce planning practices across the four constituent countries of the United Kingdom. The national picture is not uniform: Scotland and Wales demonstrate markedly stronger workforce planning integration than England, while Northern Ireland presents distinct structural challenges to workforce planning. These differences are unlikely to be explained by a single factor and may reflect service delivery choices, governance frameworks, and differences in institutional ownership of responsibility for the P&O workforce.

4.1 Response rates and service provision

Scotland and Wales each achieved a 100% response rate to this Freedom of Information request, with all 14 Scottish Health Boards and all 7 Welsh Health Boards responding. England achieved a response rate of 78% (n=155/198), and Northern Ireland 60% (N=3/5) organisations.

Orthotic services are delivered universally across Scotland and Wales, with all 14 Scottish Health Boards and all 7 Welsh Health Boards providing such services. Among the responding organisations, 65% (n=101/155) in England and 100% (n=3) in Northern Ireland delivered orthotic services.

The provision of prosthetic services is more limited across all four countries. Such services were delivered by 50% of Scottish Health Boards (n=7), 43% of Welsh Health Boards (n=3), 20% of responding English Trusts (n=31), and 33% of responding Northern Irish Trusts (n=1).

4.2 Service delivery models: in-house compared to contracted

The four nations differ in their predominant service delivery models, and these differences coincide with the workforce planning patterns identified in the dataset. Scotland and Wales deliver the majority of their orthotic services in-house, at 71% and 57% respectively, whereas England relies predominantly on externally contracted provision (61% externally contracted for orthotics). Northern Ireland has subcontracted all three of its orthotic services to commercial organisations (100% contracted).

Nation	In-house	Externally Contracted	Mixed	Total with Orthotics
England	27 (27%)	62 (61%)	12 (12%)	101
Scotland	10 (71%)	1 (7%)	3 (21%)	14
Wales	4 (57%)	2 (29%)	1 (14%)	7
NI	0 (0%)	3 (100%)	0 (0%)	3

Table 7: A breakdown of service model for orthotic services by nation.

The pattern is even more pronounced in prosthetics. In Scotland, 86% of prosthetic services are delivered in-house, and in Wales, 100% (n=3 of 3) are in-house. In contrast, only 19% of prosthetic services are delivered in-house in England. This difference in service model between Scotland and Wales, on the one hand, and England, on the other, is closely associated with the workforce planning inclusion rates identified in this report.

Nation	In-house	Externally Contracted	Mixed	Total with Prosthetics
England	6 (19%)	20 (65%)	5 (16%)	31
Scotland	6 (86%)	0 (0%)	*1 (14%)	7
Wales	3 (100%)	0 (0%)	0 (0%)	3
NI	0 (0%)	1 (100%)	0 (0%)	1

Table 8: A breakdown of service model for prosthetic services by nation.

**Note: to the authors' knowledge there are no mixed model prosthetic services in Scotland, which is in contrast to the response received via the FOI. It is our understanding that the service in question has a service-level agreement with another Health Board. For transparency we have reported all results exactly as received.*

4.3 Workforce planning inclusion: a national comparison

All Scottish and Welsh Health Boards, and all three responding Northern Ireland Trusts with P&O services, reported having AHP workforce planning. England reached 81% (n=84 of 104 applicable respondents). When analysed to see how many of these Trusts/Health Boards include P&O in their AHP workforce planning, the results are not uniform across the nations.

For orthotics, Scotland (n=11) achieved an inclusion rate of 79% and Wales (n=5) 71%. England's inclusion rate was substantially lower at 35% (n=28). Northern Ireland presents the most acute gap: all three responding Trusts reported that orthotics is not included in their AHP workforce planning. The responses for prosthetics showed a similar theme.

Nation	Yes	No	Total	% Yes
England	28	53	81	35%
Scotland	11	3	14	79%
Wales	5	2	7	71%
NI	0	3	3	0%

Table 9: The number of Trusts/Health Boards including orthotics in AHP workforce planning (of organisations with an orthotic service that carry out AHP workforce planning).

Nation	Yes	No	Total	% Yes
England	8	18	26	31%
Scotland	5	2	7	71%
Wales	3	0	3	100%
NI	1	0	1	100%

Table 10: Number of Trusts/Health Boards including prosthetics in AHP workforce planning (of organisations with a prosthetics service that carry out AHP workforce planning).

This comparison is consistent with the delivery model analysis presented in Section 4.2. Scotland and Wales, where services are predominantly delivered in house, achieve workforce planning inclusion rates more than twice those reported in England for orthotics and up to three times higher for prosthetics, where contracted provision is more dominant.

4.4 Variation in national workforce reporting

The most striking national disparity in this dataset is the inclusion of P&O data in the national workforce returns. Scotland reported the highest rate at 64% (n=9 of 14 Health Boards), compared with 29% for Wales (n=2 of 7) and 18% for England (n=19 of 104). Northern Ireland reports 0% (n=0 of 3).

Nation	Yes	No	Don't Know	No response	Total	% Yes
England	19	54	28	3	104	18%
Scotland	9	5	0	0	14	64%
Wales	2	5	0	0	7	29%
NI	0	3	0	0	3	0%

Table 11: The number of Trusts/Health Boards including P&O in national workforce returns.

Scotland's relatively strong performance on this measure may be linked to its higher number of in-house services and the presence of NHS-employed P&O service managers across all delivery models. This setup enables direct connections between service managers and Health Board AHP directors, enhancing visibility, engagement, and influence. In comparison, externally contracted P&O staff in England do not tend to have regular contact or a direct line of communication with Chief AHPs and report feeling under-valued within their Trust.⁹

Over a quarter (27%) of NHS Trusts in England reported that they did not know whether P&O workforce data were included in national workforce returns. This indicates more than a simple gap in available data; it suggests weaknesses in organisational awareness, data governance, and assurance. Where Trusts cannot confirm whether their P&O workforce is captured within national reporting systems, their ability to demonstrate effective oversight, accountability, and escalation is limited.

4.5 What national variation tells us about workforce planning

Comparing the four nations reveals three distinct patterns. First, the in-house delivery model is associated with substantially better workforce planning at Trust/Health Board level in England, Scotland, and Wales. This pattern is evident in workforce planning inclusion rates and national workforce returns and demonstrates a strong association between the delivery model and workforce planning inclusion. The findings suggest that the delivery model may be an important structural factor.

Second, Scotland reported higher rates on almost all measures in this descriptive dataset. This may reflect, in part, Scotland's greater use of in-house service delivery and its model of directly employing P&O service managers to ensure continued communication between the commercial organisation and the Health Board.

Although England and Wales have the ESR, there is a misconception that the ESR is limited to NHS directly employed staff only. NHS ESR guidance³⁰ identifies both PAYE and non-PAYE contractors as recognised person types and recommends that staff recorded within these categories are provided with Employee Self Service access. This enables contractors to maintain their records and access relevant workforce functions subject to appropriate local approval. Although the guidance does not require every employee of an externally contracted organisation to be entered onto the relevant Trust's/Health Board's ESR system, it demonstrates that ESR has the functionality to record contractor workforces. Extending the consistent use of ESR to include P&O staff delivering NHS-contracted services could provide a practical mechanism for improving the national visibility of the externally contracted P&O workforce. If supported by clear national guidance and consistent reporting arrangements, this approach could help ensure that the workforce delivering NHS-funded P&O services is captured more comprehensively within workforce planning and national returns.

Third, the workforce planning gap in England cannot be explained solely by the absolute number of organisations in these unadjusted descriptive data. England has more NHS organisations than Scotland and Wales, but the descriptive data show substantially higher proportionate rates of P&O omission from workforce planning in England. No statistical adjustment or control for differences in service provision was undertaken. The findings are consistent with structural and governance differences, but the observational analysis cannot establish causation.

Four nation coordination and oversight are essential to achieving meaningful and sustainable reform. The P&O workforce does not operate solely within one UK nation. Clinicians move between health systems, education and training pipelines serve the whole profession, and commercial providers operate across national boundaries. Reforms addressing England's workforce planning deficit must therefore be aligned with the devolved frameworks in Scotland, Wales, and Northern Ireland.

A UK Four Nations P&O Workforce Board should be established to provide strategic oversight of the entire workforce. The Board should bring together representatives from all four governments and health systems, alongside employers, education providers, professional bodies, commercial providers, and patient representatives. It should oversee consistent workforce data collection, assess current and future workforce requirements, monitor education and training capacity, identify emerging risks, and coordinate a long term UK workforce strategy while respecting the responsibilities of each devolved nation.

5 The need for a more accountable approach

5.1 The impact of workforce planning gaps on patients and services

These data represent individuals at various stages of life, from birth to end of life, who experience limb loss, limb differences, mobility challenges, neurological disorders, diabetes, and vascular diseases. They rely on prosthetic and orthotic services to sustain their independence, dignity, and quality of life. Where the workforce delivering these services is not adequately planned, monitored, or visible to the bodies ultimately responsible for delivering them, there is a risk that services may be inadequately staffed, have an inadequate skill mix, rely on shorter appointment times, and reduce opportunities for continuing professional development, supervision, and service improvement. Over time, this may contribute to longer waits, reduced access, variability in patient outcomes, and wider impacts on patient health, independence, and quality of life.

Effective workforce planning is constrained by incomplete or inaccurate data. Over a decade ago, NHS England's review of orthotic services³¹ stated, *"the lack of quality measures and data have hindered effective commissioning"* and that *"the lack of accurate workforce planning data needs to be addressed"*. Over two decades ago, the Audit Commission made it very clear that *"Commissioning of services should reflect the future growth in demand for the orthotics service"*, and *"Service providers should be required to maintain a database on behalf of commissioners which contains all client, staff, and equipment data required for operating the contract or service level agreement"*.³² Commissioners have a weaker basis for evidence informed service configuration when workforce information is incomplete. Yet, over two decades later, none of these recommendations have been realised.

Evidence presented to the Trained for Tomorrow inquiry (2026)¹³ highlighted that healthcare workforce challenges often originate within education and training pipelines rather than within employment systems alone. The inquiry concluded that workforce shortages emerge when training capacity, placement opportunities, educator capacity, and workforce demand are not planned as a connected system.

In prosthetics and orthotics, evaluating workforce sustainability requires more than merely considering the current staffing levels. This necessitates an examination of the robustness and stability of the entire workforce pipeline. This encompasses the processes of attracting individuals to the profession, retaining seasoned clinicians, and cultivating the specialised skills essential for service provision. Consequently, sustainability is contingent upon the following:

- **Learner recruitment and retention:** insufficient numbers entering or completing approved programmes directly reduce the future supply of qualified prosthetists and orthotists.
- **The availability of high-quality clinical placements:** learners cannot complete their training or develop the required clinical competencies without sufficient supervised experience. Placement shortages can restrict university intake, even when the demand for courses is strong.
- **Educator and practice educator capacity:** universities and clinical services require appropriately skilled staff to teach, supervise, and assess learners. Pressure on the existing workforce can reduce its capacity to support learners, creating a cycle in which workforce shortages further restrict future growth.
- **Access to apprenticeships and alternative entry routes** can widen participation, support recruitment from local communities, enable existing support staff to progress, and reduce reliance on a single traditional route into the profession.
- **Continuing professional development opportunities:** the workforce must retain and develop the clinical, technical, leadership, research, and educational capabilities required to meet increasingly complex patient needs. Limited development opportunities can contribute to staff dissatisfaction, attrition, and loss of specialist expertise.

These factors are particularly critical in a small profession. Even modest reductions in university intake, placement availability, or educator capacity can affect a significant proportion of the future workforce. Because professional training takes several years, any disruption to the pipeline may not become fully visible in workforce data until shortages are already established and difficult to reverse. Workforce planning must therefore monitor and actively support every stage of the pipeline, rather than responding only when vacancies, service pressures, or patient access problems reach a critical level.

5.2 Factors impacting national workforce planning for prosthetics and orthotics

1

No P&O specific national workforce planning standard identified

There appears to be no established framework in England that requires NHS organisations to include P&O in AHP workforce planning. Whether the service is contracted or in-house, planning appears to be discretionary and, in most contracted services, absent.

2

No mandatory workforce data reporting for contracted P&O services

Externally contracted P&O staff are frequently absent from NHS Electronic Staff Record data and may not be captured consistently through alternative national workforce reporting mechanisms. Although the NHS Standard Contract contains provisions requiring contractors to cooperate with workforce planning and to supply specified workforce education and training information when requested, NHS providers are not, on the whole, collecting or reporting subcontracted workforce data, including staffing levels, vacancies, skill mix, succession risks, and training pipeline capacity, to national workforce returns.

3

No complete national baseline workforce data

The reported NHS P&O workforce of approximately 708 WTE across 102 reporting Trusts and Health Boards is a significant undercount. HCPC registration data provide the number of registered prosthetists and orthotists, and the 2024 national workforce studies^{10,11} provide valuable information on the size, demographic profile, and employment characteristics of the wider UK P&O workforce. However, neither source provides a complete, routinely updated, service level picture of the workforce delivering NHS P&O services, including technicians, support workers, externally contracted staff, vacancies, skill mix, and geographical distribution. No national body currently holds a comprehensive and routinely maintained dataset capable of supporting national P&O workforce planning.

4

Lack of Coordinated Workforce Oversight at Every Level

There is a significant lack of adequate oversight of the sustainability of the prosthetics and orthotics workforce using accurate, comprehensive, and up-to-date workforce data. Addressing this gap requires a coordinated and layered system of oversight across all four nations.

- **Organisational oversight:** NHS Trusts and Health Boards should monitor the workforce supporting all P&O services for which they are responsible, including externally contracted provision. This should cover workforce numbers, skill mix, vacancies, succession risks, training needs, and future service demand.
- **Regional oversight:** Integrated Care Boards and regional workforce structures should coordinate workforce planning across providers, identify shared risks, and ensure that P&O services are included in regional workforce strategies.
- **National oversight:** A designated national body should maintain comprehensive workforce data, benchmark provision, assess future demand, and hold the system accountable for addressing workforce risks. For specialised prosthetic services in England, this must include clear oversight by NHS England, as the responsible commissioner.
- **Four nation oversight:** England, Scotland, Wales, and Northern Ireland should formally coordinate workforce planning, recognising that clinicians move between health systems and many commercial providers operate across national boundaries.
- **Global oversight:** UK workforce planning should align with international competency standards and contribute to global workforce monitoring, recognising the worldwide shortage of appropriately trained P&O personnel and the growing international demand for such services. Currently, NHS England, Integrated Care Boards, NHS Trusts, Health Boards, commissioners, and devolved health authorities seem to function without an adequately coordinated framework for the monitoring, benchmarking, and management of P&O workforce risks.

5**Limited ability to link workforce capacity with service outcomes at a national level**

Without consistent and transparent workforce data, it is difficult to examine the relationship between staffing levels, skill mix, patient outcomes, waiting times, and service quality. Evaluation and service improvement remain possible at local level, but the current arrangements significantly limit meaningful comparison, benchmarking, and assessment of how workforce capacity affects outcomes across services and regions.

6**Repeated warnings have not led to sustained action**

P&O workforce problems have been repeatedly highlighted through national reviews, peer-reviewed publications, workforce studies, and NHS-commissioned projects. However, these warnings have not resulted in routine data collection, coordinated workforce planning, or measurable national action. The NHS Long Term Workforce Plan proposed increasing P&O training places but did not include a profession-specific assessment of demand, shortages, retention, geographical distribution, placement capacity, or the technical and support workforce. As this report demonstrates, the national workforce data available at the time were incomplete and did not capture much of the workforce delivering NHS services. The evidence base used to determine the proposed increase in training places was therefore inadequate and could not reliably reflect the scale or nature of workforce need. This reinforces the need for continuous, profession-specific workforce data and planning.



6 Recommendations

The evidence set out in this report indicates that the current approach to P&O workforce planning is inadequate, and this is not a deficiency that local initiatives alone can address. Coordinated action is required across health departments, national workforce bodies, NHS England and Integrated Care Boards (ICBs), NHS Trusts and Health Boards, and contracted providers across all four nations. The recommendations below are grouped into three areas: data and reporting, governance and accountability, and workforce planning integration.

6.1 Data and reporting

- 6.1.1 Ensure comprehensive workforce reporting for externally contracted P&O services.** Every NHS Trust and Health Board with an externally contracted P&O service should collect and submit workforce data covering whole-time equivalent figures by role, vacancies, succession risks, and student placement and apprenticeship capacity. Clear reporting definitions must ensure that apprentices are not counted twice as both employees and learners. These data should be incorporated into national workforce returns alongside those for directly employed allied health professionals.
- 6.1.2 Deliver a national minimum dataset for P&O services.** NHS England's 2015 commitment to develop a national minimum dataset for orthotics, including key performance indicators, remains undelivered. This should now be progressed as a priority and extended to prosthetic services. Relevant national bodies must have access to complete data across all providers, rather than partial datasets, covering demand, activity, waiting times, access, performance, and outcomes. The dataset should be embedded within commissioning, contracts, service planning, and national oversight.

6.2 Governance and accountability

- 6.2.1 Clarify accountability across the system.** The Department of Health and Social Care (England) and the devolved health departments should set policy direction on mandatory workforce data reporting, national workforce planning standards for P&O, and statutory or regulatory levers where these are necessary. National commissioning frameworks and workforce strategies should explicitly reference P&O and address the structural gaps identified in this report, rather than leaving the profession to be captured, or not, within generic AHP guidance.
- 6.2.2 Embed workforce standards in P&O service contracts.** Contractual minimum standards should be introduced for P&O services, requiring annual workforce data submission, explicit succession planning, and agreed student placement and apprenticeship targets. Compliance with these standards should form a core component of ongoing contract monitoring and renewal, not an optional addition considered after the fact.
- 6.2.3 Appoint a national lead to oversee small and vulnerable NHS professions.** This lead must work across NHS England and the Department of Health and Social Care (DHSC), maintaining continuity as NHS England is abolished and its functions transfer to DHSC, Integrated Care Boards (ICBs), and alongside their counterparts in the devolved nations to standardise workforce planning, support vulnerable professions, and escalate systemic risks directly to ministers.
- 6.2.4 Require NHS Trusts and Health Boards to review their own position.** Trusts and Health Boards should immediately review whether P&O services, including those delivered under external contracts, are included in existing AHP workforce planning, and address any gaps this reveals. Mechanisms should be established to require external contractors to provide Trusts/Health Boards with the workforce information needed for assurance and to clarify which information is held on behalf of the Trust or Health Board for FOI purposes.

6.2.5 Use the Fragile Services Framework to strengthen national oversight. NHS England must ensure that providers apply the Fragile Service Identification Tool to all P&O services, including externally contracted provision, with input from relevant professional and clinical leaders. Assessments should examine quality, workforce, operational, commissioning, and financial risks and form part of annual business planning. Services identified as at risk, high risk, or critical should be reviewed at the frequency specified within the final NHS England Fragile Services Framework. Commissioners should provide the first point of escalation, with findings consolidated through existing regional performance and accountability arrangements. Risks affecting multiple providers or regions should be escalated for national intervention and inform national P&O oversight and reporting. Equivalent arrangements should be developed across devolved nations.

6.3 Workforce planning integration

6.3.1 Strengthen Chief AHP oversight of contracted services. AHP guidance, including the Chief Allied Health Professions Handbook, must make clear that Chief AHPs and their equivalents are responsible for oversight of all AHP services for which their organisation is accountable, including subcontracted P&O provision. This must include workforce planning, professional leadership, clinical quality, patient safety, service performance, and emerging risks across every delivery model. Chief AHPs must ensure that subcontracted P&O workforces are included in NHS workforce returns and that contracts are actively managed through a clinical and professional lens, with clear accountability for data quality, workforce sustainability, and service assurance. The handbook and regional reporting arrangements must explicitly address these responsibilities. NHS England and the devolved nations must provide specific training and practical resources to ensure that Chief AHPs understand how P&O services operate, including their workforce models, clinical pathways, technical workforce, risks, quality indicators, and contractual arrangements. This knowledge is essential for effective contract assurance, interpretation of workforce and service data, and application of the Fragile Services Framework.

6.3.2 Align workforce planning with outcomes, quality, and patient safety. Integrated care pathways should use outcome frameworks that explicitly link P&O workforce capacity and skill mix to access, quality, safety, and patient outcomes. Measures should include time to prosthetic fitting, timely orthotic provision for patients at high risk, falls, pressure damage, avoidable amputations, delayed discharge, device-related incidents, and patient-reported outcomes. Providers should consistently record and report actual or potential harm arising from delayed access, insufficient capacity, or inappropriate provision, including incidents and near misses. This would enable workforce risks to be assessed alongside their impact on patients, support earlier intervention, and create shared accountability for the clinical and financial consequences of inadequate P&O provision.

6.3.3 Establish oversight of P&O workforce planning and education across the four nations. As described in this report, a UK Four Nations P&O Workforce Board should be established to provide strategic oversight of the entire prosthetics and orthotics workforce. P&O workforce sustainability cannot be planned effectively by each nation in isolation. Scotland has only one higher education provider, while Wales and Northern Ireland have no domestic P&O education programme, meaning all four nations depend on a small, interconnected education and placement system.

The Board should jointly forecast workforce and education requirements, monitor recruitment, attrition, placement capacity, graduate destinations and workforce movement, and coordinate training commissions, apprenticeships, and placements. It should also address barriers to cross-border placements, and ensure that workforce and placement needs across all four nations are reflected in national planning.

6.3.4 Undertake a dedicated P&O deep dive within RAMP. The Ministry of Defence, Department of Health and Social Care, NHS England, and the devolved nations must include a dedicated P&O deep dive within Reception Arrangements for MoD Patients. This must assess whether civilian P&O services have the workforce capacity, specialist skills, infrastructure, manufacturing capability, and supply chain resilience required to respond to a sudden or sustained increase in military trauma and limb loss. It must include directly employed and subcontracted services, map referral and rehabilitation pathways, identify gaps in specialist prosthetic and orthotic capability, establish mutual aid arrangements, and test P&O readiness through national planning exercises. The findings must result in an accountable action plan to address identified risks.

The data presented in this report show that prosthetic and orthotic services frequently operate within a fragmented workforce planning landscape, with significant gaps in visibility, accountability, and the capacity to identify and respond to workforce risks.

Most Trusts and Health Boards providing externally contracted P&O services do not engage in workforce planning. Contracted provision is largely omitted from NHS workforce planning processes, and P&O staff are rarely included in national workforce returns. The FOI responses did not demonstrate consistent workforce oversight across externally contracted P&O services. The fact that only an incomplete, minimum visible total of approximately 708 whole-time equivalent staff could be reported by 102 Trusts and Health Boards illustrates a structural weakness in workforce governance and may create systemic risks to service sustainability and patient access.

Prosthetic and orthotic care is essential for many patients throughout the UK, requiring lifelong attention. The P&O profession is considered small and vulnerable. Measures needed to support the sustainability of the profession cannot be reliably considered without access to its national workforce data.

The case for national action extends beyond incremental changes.

Workforce planning structures and accountability mechanisms for prosthetic and orthotic services across the United Kingdom must be prioritised for reform to address these issues.



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Glossary

Allied Health Professions (AHPs) are a group of registered health professions distinct from medicine, nursing, and dentistry that provide assessment, diagnosis, treatment, and rehabilitation across health and care settings. Prosthetists and orthotists are allied health professionals regulated by the Health and Care Professions Council.

Externally contracted delivery model means that the service is delivered under a contract with a commercial organisation (e.g., a private prosthetic or orthotic company) who directly employs prosthetists and/or orthotists.

Freedom of Information (FOI) is the statutory right of access to recorded information held by public authorities, established by the Freedom of Information Act 2000 and, in Scotland, the Freedom of Information (Scotland) Act 2002.

Health and Social Care Partnerships (HSCPs) Scotland has 31 HSCPs, each associated with an integration authority responsible for planning and commissioning integrated health and social care services. The statutory framework was established by the Public Bodies (Joint Working) (Scotland) Act 2014, and the partnerships became fully operational on 1 April 2016. Integration aims to improve outcomes through coordinated, preventative and anticipatory care. Thirty integration authorities currently operate through an Integration Joint Board, while Highland uses a lead agency model.

In-house delivery model means that the service is delivered by staff directly employed by the Trust/Health Board.

Integrated Care Board (ICB) is a statutory NHS body in England, established under the Health and Care Act 2022, responsible for planning and commissioning health services for a defined local population.

Mixed delivery model means that the service is delivered through a combination of in-house and externally contracted provisions.

The national workforce returns are the routine submissions of workforce data made by NHS organisations to national bodies, which are used to monitor and plan the workforce at the regional and national levels.

The NHS Electronic Staff Record (ESR) is the national electronic workforce and payroll system used by NHS organisations in England and Wales to hold information on directly employed staff. Staff employed by contracted providers do not appear in the ESR.

Orthotic services refer to the provision of orthoses (external devices such as braces, splints, and insoles) and associated clinical services to patients with musculoskeletal, neurological, or other conditions.

An orthotist is a registered allied health professional who assesses, designs, and provides orthoses (external devices such as braces, splints, and insoles) to support, align, or improve the function of a part of the body.

P&O is the abbreviation used throughout this report for prosthetics and orthotics, referring collectively to prosthetic and orthotic services and the workforce that delivers them.

A P&O support worker is a member of the P&O workforce who provides clinical, technical, or administrative assistance to registered practitioners and technicians.

Potential non-response bias is the possibility that individuals or organisations that did not respond differ systematically from those that did, meaning the findings may not fully represent the wider population.

Prosthetic and orthotic technicians are members of the P&O workforce who manufacture, modify, and repair prostheses and orthoses, typically in a workshop or laboratory setting, in support of clinical staff.

Prosthetic services refer to the provision of artificial limbs and associated clinical rehabilitation services to patients following amputation or limb absence.

A prosthetist is a registered allied health professional who assesses, designs, and provides prostheses (artificial limbs) for people with limb loss or absence.

Public Sector Equality Duty. The duty under the Equality Act 2010 requiring public authorities to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations between people who share a protected characteristic and those who do not.

Skill mix is the balance of different roles, grades, and competencies within a workforce.

Succession planning is the process of identifying and developing staff to maintain continuity in key roles as others retire or leave.

Workforce planning refers to any systematic analysis of current and future workforce requirements, including the assessment of vacancies, skill mix, succession planning, retirement profiles, and demand modelling.

WTE means to the Whole Time Equivalent, reflecting the proportion of full-time hours worked.

Appendix one: Freedom of Information Request

Workforce Planning for Prosthetic and Orthotic Services

Reference: BAPO/FOI/WFP/2026

Information Requested

Please provide responses to each of the following questions. Where a question is not applicable to your organisation, please state "Not Applicable" and briefly explain why.

No.	Question	Response Format
1	Does your Trust/Health Board currently provide or commission a Prosthetic service?	Yes / No
2	Does your Trust/Health Board currently provide or commission an Orthotic service for patients?	Yes / No
3a	If you answered Yes to Question 1: Is your Prosthetic service delivered in-house (i.e. directly employed NHS staff) or is it contracted out to an external provider?	In-house / Contracted / Mixed (please specify) / Not applicable
3b	If you answered Yes to Question 2: Is your Orthotic service delivered in-house (i.e. directly employed NHS staff) or is it contracted out to an external provider?	In-house / Contracted / Mixed (please specify) / Not applicable
4	Does your Trust/Health Board carry out workforce planning analysis for your Allied Health Professional (AHP) workforce?	Yes / No
5a	If you answered Yes to Question 4: Does your AHP workforce planning specifically include your Prosthetic service workforce (whether in-house or contracted)?	Yes / No / Not applicable
5b	If you answered Yes to Question 4: Does your AHP workforce planning specifically include your Orthotic service workforce (whether in-house or contracted)?	Yes / No / Not applicable
6a	If your Prosthetic service is contracted out (as indicated in Question 3a): Does your Trust/Health Board carry out workforce planning for the contracted Prosthetic service?	Yes / No / Not applicable
6b	If your Orthotic service is contracted out (as indicated in Question 3b): Does your Trust/Health Board carry out workforce planning for the contracted Orthotic service?	Yes / No / Not applicable
7a	If you answered Yes to Question 6a: How does your Trust/Health Board collate workforce planning data from the contracted Prosthetic service provider? Please describe the process, including the frequency of data collection and what data is gathered.	Free text
7b	If you answered Yes to Question 6b: How does your Trust/Health Board collate workforce planning data from the contracted Orthotic service provider? Please describe the process, including the frequency of data collection and what data is gathered.	Free text
8	If your Trust/Health Board does not carry out workforce planning for its Prosthetic and/or Orthotic services (whether in-house or contracted), please explain what steps you are taking to secure the prosthetic and/or orthotic workforce pipeline.	Free text
9	Does your Trust/Health Board include data from its Prosthetic and/or Orthotic services (whether in-house or contracted) in any workforce returns submitted to NHS England, NHS Wales, NHS Scotland, or equivalent national workforce planning bodies?	Yes / No / Don't know – please specify which returns
10	Please provide the current whole time equivalent (WTE) staffing establishment for your Prosthetic and/or Orthotic services, broken down by: (a) Prosthetists, (b) Orthotists, (c) Prosthetic/Orthotic Technicians, (d) Prosthetic/Orthotic support workers (e) Please indicate whether each figure relates to in-house or contracted staff.	Numerical breakdown with in-house/contracted designation

Definitions and Clarification

For the purposes of this request:

Prosthetic service refers to the provision of artificial limbs and associated clinical rehabilitation services to patients following amputation or with limb absence.

Orthotic service refers to the provision of orthoses (external devices such as braces, splints, and insoles) and associated clinical services to patients with musculoskeletal, neurological, or other conditions.

In-house means the service is delivered by staff directly employed by your Trust/Health Board.

Contracted means the service is delivered under a contract with an external provider (e.g. a private prosthetic or orthotic company) who directly employ the prosthetists and/or orthotists.

Workforce planning refers to any systematic analysis of current and future workforce requirements, including assessment of vacancies, skill mix, succession planning, retirement profiles, and demand modelling.

WTE means Whole Time Equivalent, reflecting the proportion of full-time hours worked.





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