Allied Health Professional case studies: Prosthetists and Orthotists

Index:

NHS England

Improving the Quality of Orthotics Services in England

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Publications Gateway Reference:	**04063**
Document Purpose	Report
Document Name	Improving the Quality of Orthotics Services in England
Author	NHS England
Publication Date	19 November 2015
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, Foundation Trust CEs , Medical Directors, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, NHS England Regional Directors, NHS England Directors of Commissioning Operations, GPs, Directors of Children's Services, NHS Trust CEs
Additional Circulation List	
Description	This document sets out a case for action to tackle the rising demand and variation in access and quality of services experienced by children and adults requiring orthotic care in England. It explains why it is important to improve the commissioning of services in terms of clinical and cost benefits and discusses some of the key issues affecting services currently, along with the experiences that patients and their families have had in using those services
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
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Document Status

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Improving the Quality of Orthotic Services in England

Version number: Final

First published: November 2015

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Classification: (OFFICIAL)

Equality and Health Inequalities Statement:

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce inequalities.

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1 Foreword

Orthotics services play an essential role in enabling quality of life for people with long term conditions, disabilities and limb loss. Being able to access the right orthotics equipment, quickly, and with appropriate support, is of paramount importance. Unfortunately, this doesn't always happen. People can find themselves waiting a long time for equipment and develop secondary health complications. Long waiting times mean that children in particular may have grown before their orthotics equipment finally arrives. These are avoidable and unfair inequalities.

A number of published reports over the last decade and more have discussed the potential benefits of improving orthotic services, including significant health and quality of life benefits for patients, financial benefits for the NHS and economic benefits for the wider economy if a comprehensive, integrated orthotics service is provided consistently throughout the patient pathway. Despite this, challenges with effective commissioning and provision of orthotics services still remain and patient feedback indicates variation in service provision. Quality can suffer for a number of reasons but the lack of quality measures and data have hindered effective commissioning. The failure to get things right first time for the patient is resulting in avoidable inequalities in access, worse outcomes, poor patient experience as well as poor value for public money and unnecessary costs to the NHS, meaning less is available for services for people.

In recent months a number of Clinical Commissioning Groups (CCGs) and NHS Trusts have been working to put that right. Some are now able to provide highly personalised care and next-day delivery for standard orthotics products. We have identified a number of effective models which achieve excellent outcomes and levels of patient satisfaction, some provided in-house in acute trusts or in the community, others outsourced to the private sector. The benefits of this improvement work mean better access through reductions in waiting times for assessment and fitting of orthoses, higher activity levels at reduced costs, more focus on achieving outcomes and a better overall experience of care for patients.

This report has been published following a formal escalation regarding the poor quality of some orthotics services from Healthwatch England in 2014. It incorporates findings from a review[1] undertaken by the NHS Quality Observatory of available data about the quality of orthotics services and commissioners' ability to assure the quality of these services. This review was considered at a round table event in March 2015 for commissioners, service users, professional and trade associations and clinical leaders from across England, where we also listened to patient experiences and shared case studies from CCGs and providers who have worked to improve the quality of services. This document sets out the key issues discussed and the learning from that event and we hope will help raise the profile of the need for effective commissioning of orthotic services both nationally and locally and provide some practical tips on how to do it. This will be the start of further discussions and work about how we can improve outcomes so that people with complex and changing

[1] A. Chavda., K. Cheema (2014) Analysing orthotics: availability of data and information in orthotics services in England, NHS Quality Observatory, Horley.

needs can always get the right equipment in a timely way, with appropriate and continuing support.

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2 Executive summary

This document sets out a case for action to tackle the rising demand and avoidable inequalities in access and quality of services experienced by children and adults requiring orthotic care in England. It explains why it is important to improve the commissioning of services in terms of patient care, clinical and cost benefits and discusses some of the key issues affecting services currently, along with the experiences that diverse patients and their families have had in using those services. Some case studies are presented from CCGs and providers who have worked to improve the quality of services and commissioning tips are provided for CCGs wishing to improve and redesign local services for the future.

Aligned with NHS England's Five Year Forward View, it supports a preventative approach through effective commissioning and provision of quality orthotic care to meet the growing challenge of an ageing population and increasing health needs associated with major clinical conditions including obesity, cardiovascular and peripheral vascular disease, diabetes and stroke. It also stresses the need to develop quality metrics to monitor orthotics services and encourages a move towards more outcome based commissioning and improving equity for patients.

The shared learning from the round table event and case studies highlight a number of common elements that commissioners and providers should consider in redesigning and improving orthotics services to secure efficiencies and quality improvements for patients, namely:

- Continuously engage and involve patients and their families;
- Include patient focused and outcome measures / KPIs in service specifications;
- Implement direct access referral for general practitioners, allied health professionals, registered nurses and consider self-re-referral for appropriate patients;
- Define criteria to accommodate the needs of children and patients requiring urgent treatment;
- Encourage adoption of multidisciplinary approaches and ways of working to maximise skills and efficiency;
- Consider introducing local tariffs for orthotics services.

These form the basis of a number of recommendations aimed at CCGs to help improve effective commissioning of orthotics services which are summarised in section 6.

A number of actions to help improve orthotics services in England were agreed as a result of the round table event and are outlined in section 8. Some of these have already been implemented, for example, the development of a model service specification (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-serv-spec.docx).

It is now imperative that the NHS finds the correct approaches to bring about national and local change that will support the drive to improved patient outcomes for those needing orthotics services alongside efficiency. NHS England is committed to

working with CCGs and other key stakeholders to ensure these actions are implemented so that this review will have the impact that others have not for the direct benefit of those who use these services.

3 Introduction

3.1 Orthotics is a speciality involving application of external devices to the body to support and improve posture, function and mobility and manage pain and deformity. “Orthoses” is the term used to describe the external devices and includes insoles, braces, splints, callipers, footwear, spinal jackets and helmets. Compression hosiery can sometimes be provided as part of the orthotics service. Orthotists are generally the designated professionals responsible for the assessment, prescription, design, manufacture and fitting of orthoses to patients. The role of the orthotist is to consider and discuss with the patient the type of orthoses that will best meet his or her needs. Increasingly, this role is undertaken by other allied health professionals involved in a patient’s care such as podiatrists, physiotherapists and others.

3.2 Orthotics services provide treatment options for people with a wide range of conditions and orthotists work closely with a number of clinical specialties within the NHS including diabetes care, elderly medicine, neurology, orthopaedics, paediatrics, stroke and trauma teams. The correct supply and fitting of orthoses can help improve quality of life by reducing pain, keeping people mobile and independent and preventing more invasive and expensive interventions like surgery, amputation or the need for social care. As a result, the provision of orthotics plays a major role in many rehabilitation programmes. The NHS England Rehabilitation Programme defines rehabilitation as “the development, to the maximum degree possible, of an individual’s function and/or role, both mentally and physically, within their family and social networks and within education/training and the workplace where appropriate”. Good rehabilitation services deliver early intervention, restore or retain independence as much as is possible and enable people to live their lives. Orthotics services play a vital role in the rehabilitation pathway for many people and as such must offer effective, quality and timely interventions to ensure people reach their maximum potential.

3.3 Orthotics service provision in the NHS has been the subject of a number of reviews and reports spanning the last twenty years and more. The Disabled Living Foundation detailed longstanding problems in the provision of therapeutic footwear in its 1991 report[2]. In 1992, the Department of Health commissioned a critical review of the organisation of orthotics services in England and Wales.[3] The Audit Commission produced reports in 2000[4] and 2002[5] which highlighted serious problems with the quality of orthotics services and provided commissioning guidance for Primary Care Trusts in 2004[6] recommending increased levels of service provision, better access to services, and collaboration among multidisciplinary teams. The *“Orthotic Pathfinder”* report[7] identified several problems with the structure of orthotics services and the

[2] Disabled Living Foundation. "Footwear: a quality issue: provision of prescribed footwear within the National Health Service." ;1991

[3] Bowker P, Rocca E, Arnell P, Powell E: A study of the organisation of orthotic services in England and Wales. Report to the Department of Health, UK; 1992.

[4] Fully Equipped – The provision of disability equipment services to older or disabled people by the NHS and social services in England and Wales. 2000, Audit Commission

[5] Assisting Independence - Fully Equipped 2002. Audit Commission.

[6] Guidance on the Commissioning of Orthotic Services, 2004, Audit Commission

[7] Orthotic Pathfinder – “A patient focussed strategy and proven implementation plan to improve and expand access to orthotic care services and transform the quality of care delivered” NHS Purchasing and Supply Agency; 2004.

significant benefits to be gained by the NHS, both in terms of improved quality and cost savings if these problems were resolved. In particular, it recommended condition specific direct GP Access to orthotics services and highlighted that for every £1 spent on improving orthotics services, the NHS could possibly save as much as £4. The potential impact of early orthotic intervention and improvements in service provision on health and quality of life benefits for patients, financial benefits for the NHS and economic benefits for the wider community were re-iterated in the York Health Economics Consortium report in 2009[8] and the Centre for Economics and Business Research report in 2011[9].

3.4 Most of these reviews and reports draw similar conclusions and support improved commissioning and provision of better resourced and more integrated orthotics services. They also highlight how orthotics services can help achieve some of the major policy objectives of the NHS. These include: reducing referral to treatment times; hospital admissions; the need for acute treatment; facilitating choice for people with long term conditions with better management and rehabilitation; and keeping people mobile and independent and therefore reducing the need for social care services, as well as getting people back into work or education. All of these contribute to reducing health inequalities. The York Health Economics Report[8] summed up the potential in the following statement:

"*Orthotic provision has the potential to achieve significant health, quality of life and economic benefits for the NHS if a comprehensive, integrated service can be provided, throughout the patient pathway. Service planning and contracting arrangements which emphasise the delivery of an integrated and comprehensive orthotic service are more likely to achieve the benefits to the NHS identified in the many reports."(p.10).*

3.5 Despite the consensus on the potential benefits of improving orthotics services, most agree it is still a "Cinderella service", poorly understood and generally not viewed as a priority for development[7 8 9 10 11]. In addition, the service is often "hidden" as part of other pathways of care contributing to the poor understanding, silo working and increasing confusion about access for patients. Concerns about the poor quality of services remain with patients, their families, clinicians and other stakeholder organisations raising issues about access, quality and variability of orthotics services more recently.

3.6 In July 2014, NHS England responded to a formal escalation by Healthwatch England about the quality of services nationally by commissioning a review, undertaken by the NHS Quality Observatory, of the data available on the quality of orthotics services and commissioners' ability to assure the quality of these services. The findings of the review[1] were shared at a round table event in March 2015 for commissioners, service users, professional and trade associations and clinical leaders from across England. The event also provided the opportunity to listen to the patient experience of those using orthotics services as well as share examples of

[8] Hutton, J., and M. Hurry. "Orthotic Service in the NHS: Improving Service Provision" York Health Economics Consortium, Univ. of York;" 2009.

[9] Centre for Economics and Business Research Ltd . The economic impact of improved orthotic services provision - A review of some of the financial and economic benefits of a better functioning system for the provision of orthotic services; 2011.

[10] Scottish Orthotics Services Review, 2005, NHS Scotland

[11] British Association of Prosthetists and Orthotists, 2015: Improving the Quality of Orthotic Services in England.

effective commissioning and service delivery models, with the aim of sharing good practice and facilitating further action nationally and locally to improve commissioning and provision of orthotics services.

3.7 As mentioned previously, orthotics plays a major role in rehabilitation programmes for children and adults with a range of conditions and in many respects, the issues and challenges affecting orthotics services mirror those highlighted in recent NHS England initiatives targeted at improving rehabilitation and wheelchair services. The *Improving Rehabilitation Services Programme* aims to deliver rehabilitation at the right time, in the right place by the right person for all children, young people and adults in England so they are able to live long, happy and productive lives. NHS England is also working with a number of partner organisations to improve wheelchair services. Both areas have uncovered issues with access, quality and variation in service provision which NHS England is tackling in a number of ways. Improvement priorities for rehabilitation services include: exploring levers and incentives; establishing the economic benefits of rehabilitation and developing an economic model for service provision; and establishing the case of need for improvement in children and young people's rehabilitation services. Priorities for improving wheelchair services are: the development of a national data set; piloting of a tariff for wheelchair services; and the development of resources to support commissioners of wheelchair services.

3.8 The aim is for NHS England to prioritise the improvement of access for people and their experience and outcomes of orthotics services. The purpose of this document is to raise the profile of the need for effective commissioning of orthotic services both nationally and locally and re-invigorate the historic debate for change.

4 The Case for Action

4.1 *"Early orthotic intervention improves lives and saves money"* [8]*(p.1)* and yet the benefits to the NHS are still not fully realised by most commissioners and managers[9]. In this section, the clinical and cost benefits of orthotics services are discussed and the key challenges that need to be addressed are outlined, based on information and evidence from previous papers and reports and re-iterated further in discussions at the round table event.

Clinical Benefits

4.2 The provision of orthotics has a beneficial impact on a range of clinical conditions by relieving pain, increasing mobility, protecting tissues and promoting healing along with a whole host of other benefits including improved independence and self-image.[10] [12] The range of clinical conditions benefiting from orthotics includes chronic diseases and trauma as well as neurological, musculoskeletal and congenital conditions. A number of these remain as policy priorities for the Government and the NHS, examples of which are set out below:

- Diabetes – prevention and reduction of ulceration rates and amputation;

[12] All-Party Associate Parliamentary Limb Loss Group, 2014: Patient Led Orthotic Services Patients Charter

- Stroke and other neurological conditions such as multiple sclerosis and cerebral ;palsy;
- Chronic Obesity – often leading to Type 2 diabetes and musculoskeletal problems;
- Cancer – managing the side effects of chemotherapy (peripheral neuropathy);
- Cardiovascular, including peripheral disease – effects of poor circulation;
- Degenerative conditions – rheumatoid arthritis and osteoarthritis;
- Congenital conditions - spina bifida;
- Spinal cord injury and scoliosis;
- Complications of viral infections such as polio;
- Common musculo-skeletal conditions and sports injuries - maintaining mobility and returning people to work sooner
- Treatment of the frail and elderly such as falls prevention.

4.3 Commissioners and managers should be aware of the positive impact that orthotics services can have on commissioning priorities such as the reduction of hospital admissions, accident and emergency (A&E) attendances and prevention of complications from diabetes, peripheral vascular disease and cancer. Appropriate orthotic management of patients with these conditions can delay and reduce the need for more expensive and complex treatment and the need for surgery. In addition, there are also benefits to wider health and social care priorities including promoting well-being and supporting independence in the community, for example by reducing the probability of falls in frail, older patients and keeping them mobile and independent reducing the need for social care. All of which contribute to reducing inequity.

Benefits for Children and Young People

4.4 It is particularly important that children and young people needing orthotic intervention get it quickly and that the orthoses are well fitted and of good quality. If they have to wait many months to obtain the correct orthoses, most will have outgrown them before they are fitted and endured unnecessary pain and immobility. This is unfair. It also undermines the work of the rehabilitation team and sometimes results in the need for further surgery and dependency on a wheelchair. This affects not only their physical health but also their psychological, emotional and social health. Children and young people will have changing needs as they develop and require responsive and flexible orthotics service provision. If not addressed these young people face avoidable inequalities.

Cost Benefits

4.5 The cost benefits to be gained by improving the commissioning and provision of orthotics services are well argued in previous reports[7] [8] [9]. In summary, savings are likely to be made by treating more people in primary care and reducing the need for consultant appointments and more expensive acute care procedures, in-patient stays, drugs and surgery. Most savings are expected to be made by keeping frail, older people mobile and independent for longer and reducing the need for expensive social and residential care services[9]. In quantitative terms, the *"Orthotic Pathfinder"* report estimated that the economic and social consequences of denying patients orthotic care are significant, costing an estimated £390 million per annum based on

2004 data. It suggested that for every £1 spent on improving orthotics service provision, the NHS could save £4[7].

4.6 The York Health Economics Consortium report quantified the potential cost savings of using orthotic interventions in primary, acute and long term conditions case studies compared to traditional secondary care treatment and surgery. Significant cost savings were demonstrated in the treatment of plantar fasciitis, ruptured achilles tendon and management of diabetic foot complications respectively[8]. Similarly, the Centre for Economics and Business Research report worked out potential financial savings to the NHS and social care through the better use of orthotic interventions in the treatment of plantar fasciitis, diabetic foot complications and stroke. In addition to the specific cost savings estimated for each condition, it was estimated that around £48 million could be saved by re-locating orthotics services from secondary to primary care[9].

4.7 In practice there are examples of delays in early orthotic intervention resulting in increased costs of care to the NHS as experienced by Rebecca and Des and their son David. David had a stroke in the womb so has a condition called hemiplegia which is a one sided form of cerebral palsy and has required orthotic care from when he first began to stand. In the early part of David's childhood, it was a struggle to get the speedy and responsive orthotic care he needed to keep up with his growth. It would usually take 18 weeks from identifying need to obtaining the support for his foot and ankle. At least four pairs of expensive orthopaedic boots had to go into clinical waste either at the point of provision or within a few weeks because they were too small.

4.8 By the age of nine, David's ankle and foot were getting more and more deformed. The family believe this was a direct consequence of his poor access to orthotic care. His orthopaedic surgeon recommended serial casting to set his foot straight with the associated increased costs to the NHS of:

- 5+ outpatient appointments with the orthopaedic surgeon and nursing team lasting over an hour each to cut off each plaster cast, wash his foot and reapply a new plaster cast;
- An attendance at A&E when one of the casts was applied too tightly.

4.9 David should have had an ankle foot orthosis (AFO) to wear immediately after serial casting to keep his foot and ankle straight. It took 17 weeks to get one and within days he had lost all his mobility and even the ability to weight-bear. The further costs of this to the NHS included:

- a wheelchair assessment;
- a wheelchair;
- months of intensive physiotherapy to try and recover the damage;
- a 10 week course of counselling for David due to the psychological and emotional stress caused by this situation;
- a six week parenting course the parents had to attend in order for him to be considered for counselling;
- complex foot surgery at a Children's Specialist Hospital out of area;
- outpatient follow ups at the Children's Hospital;

- more frequent reviews by his local paediatrician due to the impact on David's progress and development;
- occupational therapy advice to address his mobility in the home.

4.10 In addition to this increased financial cost to the NHS of delayed, poor care, the personal cost to David in terms of his development, education and emotional well-being were catastrophic. The impact on the whole family was immense both emotionally and financially. A real example of what is meant by avoidable and unfair health inequalities.

4.11 Clearly the potential cost savings associated with improved orthotics service provision warrants further consideration by CCGs and policy makers alike.

A Growing Challenge

4.12 It is a challenge to obtain accurate figures on the numbers of people in England treated by orthotics services currently, partly due to the complexity of pathways of care and as availability and accessibility of data in this area is poor, which was highlighted recently in the national review of orthotics data commissioned by NHS England[1]. The last known, referenced figure of 1.2 million[7] [8] was based on the 2007 report produced by The Foundation for Assistive Technology[13] which suggested using this number as a guide only as the total number of people benefiting from orthotics was unknown. An extrapolated figure based on a compound annual growth rate of up to 6% over 2010-2017, stated by *Global Pipeline Analysis, Competitive Landscape and Market Forecasts for Orthotics and Prosthetics*[14] would put current estimates at around 2 million.

4.13 This number will continue to grow, firstly due to expected increases in the ageing population. The majority of people requiring orthotic services are over 50 years of age[7] and the Office for National Statistics (ONS) forecasts that the English population aged 55 and over will have increased by 35 per cent from approximately 14.8 million in 2011 to 20 million in 2031[15]. At least 23 per cent of the total projected population of 60.4 million will be 65 and over[8]. This is likely to lead to an increase in demand for orthotics services.

4.14 The other factors affecting growth in demand are the rising prevalence of obesity, cardiovascular and peripheral vascular disease, diabetes and stroke[8] [15] [16]. Predicted rates of obesity are likely to affect around half the population by 2050 according to the UK Health Forum[17]. Obesity can contribute to musculoskeletal problems and is a major risk factor for developing diabetes and cardiovascular disease; in fact diabetes doubles the risk of developing cardiovascular disease[18].

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[13] Down K, Assistive Technology Workforce Development. The Foundation for Assistive Technology. June 2007.

[14] http://www.businesswire.com/news/home/20110419006508/en/Research-Markets-Orthotics-Prosthetics---Global-Pipeline#.VWcvw9JViko

[15] Centre for Workforce Intelligence, 2012: Workforce Risks and Opportunities. Prosthetists and Orthotists. Education Commissioning Risks Summary from 2012.

[16] National Allied Health Patients' Forum. 2011: Patient Concerns over the shortage of Prosthetists & Orthotists

[17] UK Health Forum, 2014: Obesity rates are rising but new predictions by National Obesity Forum may be an overestimate according to UK Health Forum. http://nhfshare.heartforum.org.uk/RMAssets/NHFMediaReleases/2014/Statement%20from%20UK%20Health%20Forum%20on%20NOF%20report.pdf

[18] NHS England, 2014: Action for Diabetes

Estimates suggest that the number of people with diabetes is likely to increase by 5% year on year from over 2.5 million people currently to more than 4 million by 2030[15]. Diabetes and cardiovascular /peripheral disease often result in foot complications, the worse-case scenario being amputation. Approximately 100 people a week have a lower limb amputated as a result of diabetes which could be avoided with the help of preventative foot care including appropriate orthotic provision[19].

4.15 Improvements in neonatal care mean that children are surviving with more complex disabilities and this together with the expansion of the ageing population and prevalence of major clinical conditions will impact significantly on the NHS and social care budget. They can all benefit from cost effective orthotic intervention.

4.16 The Five Year Forward View**Error! Bookmark not defined.** supports a preventative approach to the growing challenge of increasing health needs and encourages improvement in both the commissioning and integration of services and providing innovative models of care, ensuring that people of all ages are actively supported and empowered to lead the lives they want for themselves and their families in the best possible health. This would lead to reduced inequalities in access to services and the outcomes achieved. It will be important for CCGs to consider the Five Year Forward View and the factors affecting increased need for orthotics services in their commissioning decisions and to take account of this predicted growth in demand in the future commissioning and redesign of orthotics services.

The Data Challenge

4.17 The national review of orthotics data commissioned by NHS England and undertaken by the NHS Quality Observatory in 2014 concluded there was minimal routine, quantitative data accessible and available to review the quality of orthotics services and understand how they were delivered around the country[1]. The reasons behind this are predominantly due to coding issues, poor recording, block contracts with lack of tariff incentives, multi-speciality referrals “hiding” orthotics related information and commercial sensitivity around data held by private companies.

4.18 This significant lack of data poses a challenge for CCGs. The review expressed the need for a clear mandate to identify and collect process, outcome and patient experience measures from orthotics services that could be regularly monitored and reviewed to assess quality and identify areas of best practice. In particular, it recommended that a national data collection tool be developed in collaboration with commissioners of orthotics services and the British Association of Prosthetics and Orthotists (BAPO) to help inform an ongoing dataset to improve the information available on the quality of orthotics services.

4.19 The review also considered data obtained by Medway NHS Foundation Trust in response to its national orthotic service questionnaire which highlighted significant variation in a number of elements of orthotics service provision across the UK. These are discussed in more detail in the next section. Whilst this was not a formal audit commissioned by NHS England, the NHS Quality Observatory review acknowledged it had produced useful data to illustrate the lack of parity and equity of orthotics

[19] Diabetes UK, 2013: Putting Feet First https://www.diabetes.org.uk/Documents/campaigning/Putting-feet-first-campaign.0213.pdf

service provision. It suggested a more formal audit process should be developed and implemented and this should be considered further by commissioners and policy makers.

The Quality Challenge

4.20 In addition to the lack of data available, there is also a lack of clear and measureable standards for orthotics services which results in the variation of access and quality around the country mentioned in various reports[1 7 12] and is the cause for concern for patients, their carers and organisations such as The Orthotics Campaign[20], the All-Party Associate Parliamentary Group on Limb Loss[12], Arthritis Research UK[21] and Healthwatch.

4.21 This may be due to the fact that historically orthotics services have been commissioned using a "commodity product" model based on volume and price rather than quality and outcomes[8 12]. It is also a result of the lack of specific policy guidelines for commissioners on what a "good" orthotics service looks like. Orthotics have been mentioned in National Institute for Health and Care Excellence (NICE) guidelines such as stroke rehabilitation, Type 2 diabetes foot problems and spasticity in children and young people with non-progressive brain disorders. These highlight the role of orthotics within a multidisciplinary team approach rather than provide specific measureable standards for orthotics services which commissioners can use to monitor and review quality.

4.22 The extent of variation in orthotics service provision was evident from the responses to a recent national orthotic service questionnaire conducted by Medway NHS Foundation Trust which was used to inform the data review commissioned by NHS England[1]. This looked at a number of areas including: staffing; clinical; waiting lists; budget and management; information technology; suppliers and procurement; geographical demographics; referral types; audits; patient experience and key performance indicators (KPIs). 55 organisations responded out of 188 surveyed in England, Wales and Scotland. The findings are indicative of significant variation and lack of consistency of provision of orthotics services supporting the continued notion of postcode lotteries[12]. For example, referral to treatment waiting times varied from 1 week to 58 weeks for both adults and children as illustrated in Figures 1 and 2 below.

4.23 The information analysed from the Medway questionnaire also found that not all services used KPIs and there is a lack of consistent KPIs monitored by those who do.

4.24 No doubt some of this variation is due to differences in the diversity of population demographics and case mix depending on whether a standard or more complex, specialised service is provided, as well as whether the service caters for children and adults only or both. However, what is clear is that variation and inequity do exist and the reasons why should be further explored.

[20] http://www.orthoticscampaign.org.uk/what-pts-say.html

[21] Arthritis Research UK, 2012: A Call to Action: Providing better footwear and foot orthoses for people with rheumatoid arthritis.

Figure 1: Adult Waiting Times 2013/14

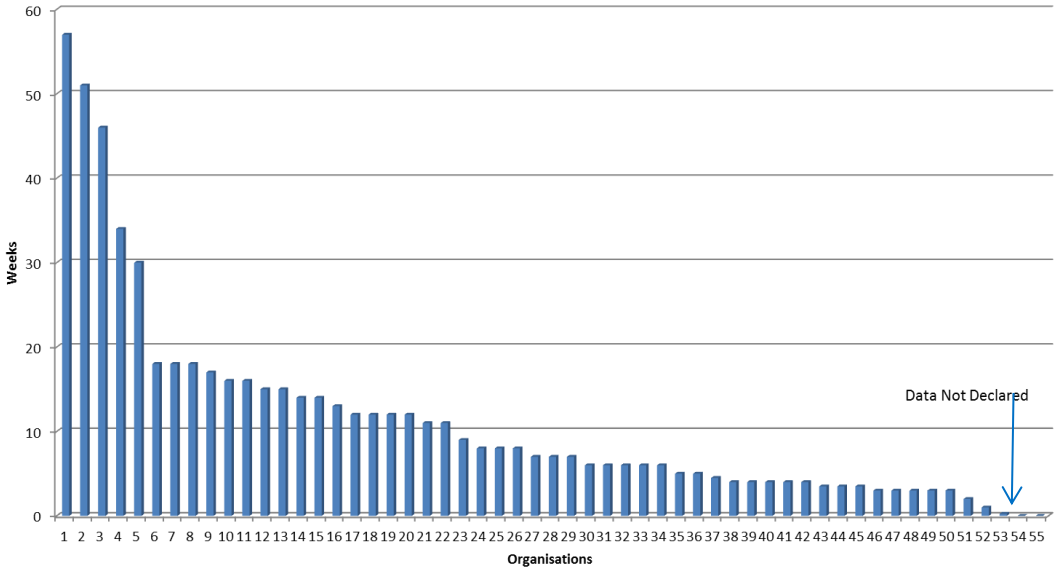
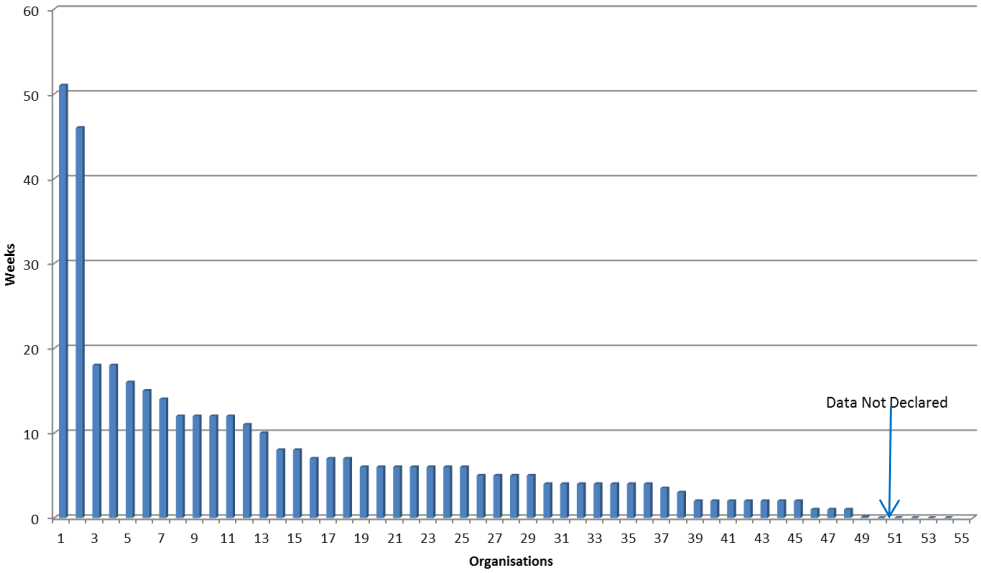


Figure 2: Paediatric Waiting Times 2013/14



The Workforce Challenge

4.25 The lack of data on orthotics service provision also relates to national workforce data, which is poor and incomplete. The number of orthotists working within the NHS is not accurately measured and reported[15]. Over 70% of orthotists are employed through sub-contracted companies in the private sector who deliver services on behalf of the NHS and do not have a unique occupation code for use in electronic staff records systems. However, the number of orthotists (and prosthetists) registered with the Health and Care Professions Council (HCPC) at the time of

writing was 1012. Currently, fewer than 500 of these are estimated to be practicing as orthotists[11 22]

4.26 As discussed previously, the demand for orthotists is likely to rise in line with increases in the ageing population and rising prevalence of obesity, diabetes and cardiovascular and peripheral vascular diseases. However, there are major concerns regarding the current severe shortage of orthotists within the NHS[16 22] resulting from high attrition rates and a retiring workforce. The British Healthcare Trades Association (BHTA) view is that there will need to be a 30 to 50% increase in the number of orthotists to meet current and future demands of new models of care[22].

4.27 The lack of accurate workforce planning data needs to be addressed to identify current establishment and help plan for future supply. Recent initiatives providing guidance on career frameworks[23], education[24]and preceptorship[25] for prosthetics and orthotics should help to develop and sustain a flexible workforce and support commissioners in planning education and service development. They will also help support and promote skill mix and multi-professional working in integrated teams which is the approach needed to meet the increasing needs of patients and help tackle some of the current issues facing the orthotics profession, particularly within the context of scarce resources. In addition work is ongoing with the relevant professional and trade associations and educational establishments in Scotland to develop a national training programme for technicians involved in orthotic manufacture. This will be the first qualification of its type in the UK and will be launched in March 2016.

4.28 Some of the case studies presented in this document have adopted innovative approaches to reducing waiting times and improving orthotics services by developing a more multidisciplinary approach to the provision of orthotic care. This involves working with appropriately trained allied health professionals including podiatrists and physiotherapists, and registered nurses, as well as multidisciplinary clinics for specific conditions such as diabetes and others. This has had a positive impact and helped reduce waiting times for initial assessment as well as speed up in-patient treatment and reduce length of stay, therefore, a multidisciplinary team approach to the provision of orthotic care should be encouraged and considered in the redesign of orthotic services.

5 The Patient Experience

5.1 A key purpose of this document is to facilitate action in response to more recent concerns regarding the quality of orthotics services raised by patients and their families. They cover a range of issues such as unacceptable waiting times, lack of getting the orthotics fitted “right first time”, unrealistic clinic slot times, inconsistent product entitlements and generally poor quality services which have an impact on people’s daily lives affecting their level of pain, mobility and capacity to remain employed or attend school or higher education. The experiences of the few patients and their families presented here have been provided with kind permission by The

[22] All Party Associate Parliamentary Group on Limb Loss, 2014: Campaign for More Orthotists.
[23] Health Education North West and University of Salford, 2014: Career Framework Guide Prosthetics and Orthotics
[24] Health Education North West and University of Salford, 2014: Education Framework Guide Prosthetics and Orthotics
[25] Health Education North West and University of Salford, 2014: Preceptorship Guide Prosthetics and Orthotics

Orthotics Campaign and help to understand the important issues from the patient perspective. They are a few examples of many, with well over a 130 patient/carer stories of poor quality NHS Orthotic care in England shared with The Orthotics Campaign to date. All show the reality of unavoidable health inequalities as result of poor services.

David's Story

5.2 As discussed previously, David, who is now 15 years old has received orthotic care since he was 18 months having been diagnosed with hemiplegia. The main focus of care in his early years was provided by a combination of orthopaedics, physiotherapy and orthotics to get him walking properly and prevent a foot deformity from developing. However, he and his family experienced long delays in getting appointments for the assessment and fitting of the orthotics he needed which sometimes led to waits of between 4 to 6 months. These delays were caused by a number of issues including staff shortages, poor administrative processes and outdated recording procedures. They generally resulted in the orthotics being the wrong size for David as naturally he would outgrow them during the long delays. The delays in care also meant that David only had sporadic access to a splint or pair of boots that he could actually tolerate or fitted properly without being in pain. This meant he did not get the full benefit of each orthotic intervention and then required further, more expensive intervention. In summary David went from needing Piedro boots to an ankle foot orthosis (AFO) and serial casting, only to wait 17 weeks for a properly fitted AFO. During this time he had to use a wheelchair and could not attend school as his classroom was upstairs. The personal cost to David of this poor care was a lot of pain, 17 weeks of lost education, lost mobility and the need for an unnecessary wheelchair. He also missed important family events and had difficulties managing and enjoying other family occasions such as holidays and a family wedding. He began to show his feelings and frustration about this and ended up needing counselling. Crucially he lost precious childhood experiences that he will never get back. As already mentioned, the wider impact of this on David's family was immense.

Simon's Story

5.3 Simon is a young adult with spina bifida. He usually has to wait for months or even years for new shoes to be authorised for him. He is only allowed 1 pair at a time. His shoes look really worn out and he feels embarrassed when he sees people looking at them.

Karen's Story

5.4 Karen has a young daughter who needs an AFO on her right ankle /leg and an orthotic insole for her left shoe to help her walk as her feet turn inward. She went for the casting of the heel cup for the left foot which took weeks to arrive and was too small. She was re-measured for a new one which was very hard and not well padded and caused blisters. The heel cup was returned for additional padding for extra comfort and as it had started to deteriorate. This incurred additional costs and delayed treatment for another 4 to 6 weeks .Karen's daughter also needed a hand support/splint for her right hand. It has been over a year since Karen requested this and she is still waiting. In the meantime, a lycra hand glove was made for her

daughter which, on collection was too small. Again her hand and arm had not been measured properly and the glove had to be thrown away. Karen wonders why the orthotics cannot be made correctly the first time which would save money, unnecessary appointments and prevent the discomfort and long delays her daughter experiences.

Safeera's Story

5.5 Safeera is 16 and living with a degenerative muscular condition which leaves her with chronically weak muscles. From early childhood, she has needed a number of orthoses to help delay the onset of deformities, support her in a standing frame and maintain her everyday functioning. These have included the need for well-fitting foot splints (day and night); specialist footwear; a spinal brace (up to the age of 8); night-time wrist splints and a neck collar. Her mother describes the service provided in the early years as *"woeful*" having to experience ill-fitting splints that *"chewed"* Safeera's feet; spinal jackets that *"disappeared"* into her armpits leaving deep red tracks and hearing Safeera cry in her sleep due to the pain and discomfort caused. As well as this, Safeera often had to go to school in trainers, whilst the specialist footwear she needed sat on the shelf in the orthotics department because there was not an appointment to pick them up in time for the new term. The lack of responsiveness and flexibility of appointments often meant that Safeera's therapy and much needed orthotic intervention were delayed and hindered her progress. On top of this, there was one occasion when, after months of waiting for new splints they arrived and they were both for the left foot and the same vicious circle of waiting started again!

Diane's Story

5.6 Diane is 51 years old and has left sided hemiplegia. After a bout of suffering badly from pains in her legs and feet she conceded to needing help with footwear. She was referred to have a pair of shoes made. She felt embarrassed and ashamed that she needed help but still went along and had her feet measured and had imprints of her feet taken. She was shown the catalogue of shoes to choose from and was horrified. They were all unflattering and old fashioned. She waited months for the shoes to be made and although she did not like them, she was hoping for a comfortable pair of shoes to wear on a day to day basis. When the shoes arrived, they were far too big and slipped off with every step. After waiting weeks for an appointment to take them back, she saw a different orthotist who asked if she was sure she had been measured for the shoes. She is still putting up with her pain and now waiting for another fitting for her shoes. The whole experience has left her feeling angry and upset and she wishes she had not bothered. She believes that nothing can make her feel better about her disability and that she will never have a properly fitting pair of shoes. In Diane's view, the service offered for making footwear in the NHS needs a major overhaul.

5.7 These stories highlight examples of poor care; however some patients have a much more positive experience to share:

Keith's Story

5.8 Keith has cerebral palsy and needs specialist orthotic shoes to help him walk. Without them he wouldn't be able to go anywhere and would have no quality of life. He needs to visit his local orthotic service located in a large acute hospital trust every six weeks which is quite a long distance away from his home and costs at least £30 in travel costs each month. Keith is happy with the service he receives although couldn't help thinking it would be far more convenient having a service closer to home. He discussed this idea with the head of the service and in less than two months non-acute orthotic treatments were offered in two additional community settings in more convenient local areas for patients, enabling those patients to be treated and followed up closer to home and saving them time and money. Keith was delighted that someone actually listened to his idea and made it happen. In Keith's eyes this change will have a major positive impact on his life.

Factors affecting the Patient Experience

5.9 There are a number of factors affecting the patient experience of orthotics care in the NHS, some of which have been discussed previously. The Orthotics Campaign has categorised the main issues into nine key themes which are summarised below: (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-1.pdf).

- Commissioning (lack of guidance and data, historical bundling into procedural based and outpatient based tariffs, unintended consequences of block contracts and perverse incentives – income generation of surgery via payment by results versus cost of orthotic preventative care);
- Fragmented procurement ("commodity" approach rather clinical service with individual prescription tailored to needs; bureaucratic administrative processes adding to delays; focus on contract price, not timeliness and quality)
- Lack of quality standards and agreed KPIs;
- Service delivery (different provider models – lack of benchmarking, equity and consistency for patients)
- Substantial shortage of clinicians (impacts on waiting times and quality of service)
- Unrealistic clinical slot times not tailored according to the needs of the patient (clinics overbooked, waiting time delays and repeat appointments needed);
- Location of services - patients generally prefer a non-hospital setting with free parking close to the service;
- Access to bespoke footwear services when required according to need;
- Variation in patient entitlements;
- Education and specialist training (only one training centre in England, more courses required to facilitate multi-professional care)
- Stifled innovation (private companies have innovation ideas which may be too expensive for the NHS to implement)
- Skewed market forces.

What would a Quality Orthotic Service look like?

5.10 Much of the focus at the round table event was on what a good quality orthotics service would look like. Stakeholders at the event discussed key issues such as developing quality metrics to monitor orthotics services, what elements were important to consider in moving towards outcome based commissioning and the development of local tariff schemes for orthotics services, along with how the workforce would need to develop to support more outcome based commissioning.

5.11 From the patient perspective it was felt that the following key principles should underpin all services:

- Patients should have a voice in the decision making process throughout referral and service provision;
- The patient's quality of life should be better;
- Orthotics should cause no harm;
- It should not be a struggle to obtain them;
- The service should be timely and responsive;
- Care should be agreed and coordinated;
- Patients should expect consistency of care, for example seeing the same clinicians;
- The time and effort taken by the patient should be outweighed by the benefits to them;
- Quality is not measurable within one contact.

5.12 All stakeholders at the event expressed the need for national guidance to support more efficient commissioning and to be assured that orthotics services are of high quality and that outcomes are defined and reported. There were calls for the development of a model service specification for orthotics services which would cover agreed key elements and KPIs thought to be illustrative of a good quality service. Some of the key elements suggested and discussed included:

- Easy access via simple referral processes;
- Patient self-referral for follow up episodes once under care;
- Defined criteria to accommodate the needs of patients requiring urgent treatment and children who need a more responsive service and faster turnaround times to allow for growth;
- Agreed, acceptable maximum waiting times for first and follow up appointments;
- Agreed timescales from first appointment to supply of orthosis necessitating agreed timescales for manufacture by companies;
- Appropriately timed clinic slots for simple and complex cases;
- Named "orthotists" as case manager for a patient's care;
- Provision of patient information about their orthoses and care;
- Clear guidelines on patient entitlements;
- Agreed set of core KPIs to include patient outcome measures (e.g. comfort and goal achievement), feedback, complaints as well as other indicators such as waiting times, proportion of definitive treatments at first appointment, return rates of orthoses etc;

- Encouragement of multidisciplinary working and joint clinics with other specialisms where value can be demonstrated in terms of benefits to patients;
- Appropriately skilled and trained workforce to provide service.

5.13 There was consensus that developing local tariff schemes based on cost and volume rather than block contracts, although challenging, was beneficial in incentivising quality and helped improve data recording and capture to monitor quality improvement. Some of the case studies outlined in this document have successfully implemented cost and volume tariff schemes for orthotics services.

5.14 The CCG and provider case studies described in Section 7 will set out examples of this as well as development of referral protocols, service specifications, KPIs, patient focused outcome measures and other useful information for those CCGs and providers wishing to improve and redesign orthotics services in their local area.

6 Top Tips for Commissioners and Providers

6.1 A number of common elements have been highlighted by the case studies and the stakeholder discussions at the round table event that may provide wider learning to commissioners and providers wishing to review and redesign orthotics services to secure efficiencies and quality improvements for patients.

Engage and Involve Patients and their Families

6.2 They have the best ideas on how the service can be improved and can be involved in a variety of different ways as well as the usual feeding back via patient surveys. By listening to individual service user stories you can truly understand the need for and benefits of orthotic care. For example consider involving them in: informing and shaping the service specification including KPIs and quality requirements; tender shortlisting and interview panels; and forming part of the performance steering groups with the providers of orthotics services.

Include Patient Focused and Outcome Measures / KPIs in Service Specifications

6.3 The case studies presented in this document have provided a number of examples of outcome based quality measures that can be incorporated into service specifications to review and monitor the performance of providers and to ensure the service meets the expectations and needs of patients. These may include the following amongst the many examples:

- Maximum referral to treatment times;
- Orthoses delivery times;
- Orthoses fitting times from initial assessment;
- % right first time;
- Patient outcome measures based on goal attainment scores, for example the proportion of users who report that they have achieved their goals and the percentage of users who report that they are comfortable in their orthoses,

- % of products failed;
- % of patients satisfied with the service;
- Number of patient complaints / compliments received;
- DNA rates

Implement Direct Access Referral for GPs, AHPs, Registered Nurses and consider Self-re-referral for Appropriate Patients

6.4 Direct access referral has been shown in the case studies to improve access for patients and considerably reduce waiting times for assessment and treatment as well as reduce length of stay for in-patients in hospital. Competency based educational packages and training programmes can be implemented to support direct access referral.

6.5 Self-referral can ease and simplify access for those patients who have longer term conditions and are in regular touch with orthotics services and can be supported by clear criteria.

Define Criteria to accommodate the needs of Children and Patients requiring Urgent Treatment

6.6 Urgent appointments and referrals for adults and children (who need a more responsive service and faster turnaround times to allow for growth) should be catered for in service specifications. Examples of urgent criteria may include the following:

- All in-patients;

- Outpatients with the following:

  - ulcerated foot
  - fracture clinic referral for acute injury
  - fracture of spine
  - post botox treatment
  - conditions triaged by clinician as needing ‘urgent’ treatment
  - patients with only one device that has broken and this cannot be repaired by technician
  - recently discharged patients with e.g. hip, spine brace – who are having problems with devices
  - patients requiring HALO vests.

Encourage Adoption of Multidisciplinary Approaches and Ways of Working to Maximise Skills and Efficiency

6.7 The development of a more multidisciplinary approach to the provision of orthotic care, involving appropriately trained AHPs including podiatrists and physiotherapists, registered nurses and multidisciplinary clinics for specific conditions such as diabetes and others has had a positive impact on care for patients. It has helped reduce waiting times for initial assessment as well as speed up in-patient

treatment and reduce length of stay, therefore, a multidisciplinary team approach to the provision of orthotic care should be encouraged and considered in the redesign of orthotic services.

Consider Introducing Local Tariffs for Orthotics Services

6.8 As discussed previously, some of the case studies outlined in this document have successfully implemented cost and volume tariff schemes for orthotics services which although challenging, has been successful in incentivising quality and helped improve data recording and capture to monitor quality improvement.

10 Steps towards Effective Commissioning of Orthotics Services

6.9 The following steps are a summary of the key recommendations to commissioners to help improve commissioning of orthotics services:

1. Understand what orthotics care is by talking to patients, carers, managers clinicians and the MDT
2. Examine all of the funding streams your CCG is using to fund orthotic care in your local health economy
3. Unbundle these funding streams to understand the total orthotic investment and consider using a tariff
4. Consider adopting the model service specification (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-serv-spec.docx) which includes patient satisfaction measures, KPIs and includes patient outcomes
5. Clarify the service delivery model you would like to use – for example, retain NHS employed staff (‘in house’) who may use multiple product manufacturers, versus privately employed clinicians who would largely provide their employers’ own products
6. Think about the location - patients generally prefer a non-hospital setting with free parking close to the service
7. Promote access and choice – can you offer near-to-home clinics from local health centres, community venues, day services or special schools?
8. Encourage multidisciplinary working by commissioning multi-disciplinary pathways for specific conditions such as diabetic foot clinics and orthopaedic clinics
9. Look at case studies to inform the most appropriate commissioning model for your area.
10. Involve service users in performance reviews of the service.

7 Clinical Commissioning Group and Provider Case Studies

7.1 Orthotics services are generally funded by CCGs, with some specialised commissioning occurring for patients with highly complex needs requiring specialised pathways of care, for example, spinal surgery, orthopaedics, paediatric neurology and specialised rehabilitation.

7.2 More than 70% of NHS funded services are provided by private companies[1] and a variety of service models exist. The in-house model uses NHS employed orthotists. These staff may have the freedom to use any product supplier or may have to procure the bulk of their product via a specified supplier who wins a product-supply contract. Other services are operated by privately employed orthotists who work for a particular company and who are expected to order products for their patients from that company.

7.3 There seems to be a general consensus that service models for orthotics should be focused on delivering individually prescribed solutions tailored to patient needs and should not rely on a "commodity product procurement" model[8]. In addition and in line with current Government policy**Error! Bookmark not defined.** [26] locally commissioned services should be based on outcomes and monitored on achievement of these rather than inputs[8]. The case studies presented here illustrate some examples of how this is being achieved to improve patient care and provide value to the NHS.

North Staffordshire CCG and Stoke on Trent CCG – Redesign of Orthotics Service

Overview

7.4 North Staffordshire CCG alongside Stoke on Trent CCG and in conjunction with The Orthotics Campaign (which was previously the North Staffs Orthotics Campaign (NSOC)), has completely redesigned the orthotics service locally which sees approximately 5000 adults and children a year. Historically, the orthotics service in Northern Staffordshire was provided by two separate organisations which was confusing for patients and carers. There were also long waiting times amongst other concerns and complaints. An external review in 2011 identified over 150 recommendations for improvement with the main one being that the service should be delivered by one provider. Since then there has been significant service user and carer involvement in the redesign of services and the re-tendering process and the newly commissioned service was contracted out earlier this year to one private provider which provides a hub and spoke model of care.

Developing a Service User and Outcome Based Service Specification

7.5 The overall aim of redesigning the orthotic service was to take account of the needs of patients as a priority and improve the service within existing budgets. The intention was for the redesigned service to deliver the following improvements:

- Better quality of life for patients and carers;
- Delivery of better information to patients and carers to help manage their own conditions;
- Better physical access to services;
- A service that offered equal access to anyone that needed it in the area;

[26] Department of Health, 2014: The NHS Outcomes Framework 2015/16

- To invest in the prevention of deformity to avoid or delay, and where possible, surgical intervention.

Outcome and Quality Measures

7.6 The service specification includes a number of outcome and quality measures that were felt to be priorities for patients and carers. These include measures such as: time to first outpatient appointment; advanced booking of appointments for fitting whilst patients are in clinic; clear and standardised orthoses delivery times; bi annual patient satisfaction surveys; patient reported outcome measures taken from goal attainment scores (measuring before and after for improvement in function, improvement in ability to carry out day to day tasks, patient perception of the difference the orthotic device has made and improvement in gait); and the availability of clear information and advice in both written and verbal form. More detail on the key elements of the service specification that were felt to be crucial in the delivery of a quality orthotics service can be found at (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-2.pdf).

7.7 The outcome and quality measures form the basis of a monthly core data set which is listed below and used to monitor the contract and performance of the provider:

- % of patients satisfied with the service,
- Number of patient complaints / compliments received,
- Service users/carers receive information about their orthoses including leaflets and information on how to care for their orthoses,
- The proportion of users who report that they have achieved their goals,
- Percentage of users who report that they are comfortable in their orthoses,
- Do Not Attend (DNA) rate,
- Numbers of clinics cancelled and reasons,
- Cancellation rate (by the provider).

Moving from a Block Contract to Local Tariff

7.8 There were significant challenges associated with the proposed move from block contract to cost and volume tariff resulting from the lack of a national tariff and accurate reference costs, as well as the absence of an accurate clinical information system and orthotics ordering system locally, which led to unreliable and infrequent data being presented. The CCGs decided that this approach would be beneficial as a lever to drive and incentivise the quality and performance requirements within the contract which can be at times restricted through the use of block funding arrangements. To overcome the issues faced, a cost and volume arrangement has been agreed with the provider based on one fixed price and inclusive of all costs, with a risk share arrangement in place to cover growth or any decrease in demand to give a level of protection to both commissioner and provider.

7.9 The CCGs have acknowledged that within the first year, this will be a risk for commissioners due to the lack of historic information to allow accurate understanding of the numbers of patients across Northern Staffordshire who will be utilising the service. However, they are confident this model of service delivery will improve

outcomes for patients and in turn reduce the demand for high cost surgery for patients in whom orthoses should have prevented their condition from progressing to a level where surgical intervention is required.

7.10 Since the introduction of the redesigned service, early feedback from patients and monitoring of performance is encouraging with signs of improvement in access, patient outcomes and reducing costs. For example, performance is currently running at 60% over activity due to the clearance of a backlog and reduction in waiting times, whilst cost savings are projected to be approximately £300, 000 within this financial year against the historical block contract value across both CCGs. This continues to be monitored on a month by month basis alongside all quality and performance indicators.

Medway CCG and Medway NHS Foundation Trust – Improving Patient Pathways for Orthotic Services

Overview

7.11 The orthotics service provided by Medway NHS Foundation Trust consists of externally contracted orthotists. The service treats adults only from the age of 16 years onwards and treats between 14, 000 to over 18, 000 patients a year. The service has been recognised as a centre of excellence in the South East and was awarded this status in 2010 for its training and innovation and in the way it delivered timely treatments to patients.

7.12 Historically pre-2007, the service used to be provided as part of consultant led elective pathways only. This meant that patients had to be referred to a consultant to gain access to treatment whether the consultant added any clinical value or not to the patient pathway. This led to unacceptable waiting times for patients who generally had to wait at least 16 weeks to see a hospital consultant before reaching the assessment and definitive treatment stage within the orthotics service. It also wasted valuable consultant clinic time. In addition, there was no opportunity for primary or community care services to refer directly as part of the treatment package they could potentially offer to patients. This also led to issues with tariff payments in that the only tariff payable for orthotics were those tariffs attracted by the consultant input either through outpatients or any treatment pathway. A large proportion of patients prescribed an orthotic will require this to be renewed or replaced for the rest of their life and as the tariff only applied to consultant input there was no further payment for this orthotics activity, as often there was no further consultant input to the patient.

Developing Direct Access Pathways for Primary Care and Community Services

7.13 During 2012/13 Medway CCG, Medway NHS Foundation Trust and Medway Community Healthcare worked together to develop direct access pathways for primary care and relevant community services. This involved significant process mapping of existing and potential referral pathways to see where improvements could be made and analysis of referral and activity data which found that around £114K was being needlessly invested in outpatients appointments. A business case outlining the benefits to patients and the NHS organisations involved was approved

and a service specification produced to describe the new referral and direct access pathways and the tariff arrangements depending upon the route of referral. (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-3.pdf).

Locally Defined Outcomes

7.14 The outcomes defined in the service specification include the following:

- Improve timely and appropriate access to orthotics,
- Enable direct access to orthotics for primary and community services,
- Reduce unnecessary delay to patients caused by a tariff driven pathway rather than patient outcome pathway,
- Clearly defined and accounted for funding streams,
- Reduce the amount of unnecessary secondary care and community referrals,
- Reduce the amount of unnecessary consultant outpatient appointments,
- Deliver an easy to navigate pathway in line with national and NICE guidance.

The Direct Access and Referral Pathways

7.15 Five pathways are described in the service specification, which are the:

- Community Allied Health Professionals (AHP) Direct Access Pathway
- GP Direct Access Pathway
- Consultant Treatment Pathway
- Consultant Treatment or Diagnosis Pathway with concurrent orthotic input
- Consultant Assessment and Diagnosis Pathway

https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-4.pdf

Locally Agreed Tariffs for Direct Access

7.16 Local tariffs for direct access have been agreed and cover 53 orthotics descriptors categorised into 3 bands. More detail on these can be found at https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-5.pdf

7.17 The new direct access pathways have cut out around 20 stages in the referral process and resulted in marked improvement in waiting times, being reduced by 15 weeks. Currently, average referral to treatment times for orthotics are between 1 to 3 days.

Quality Initiatives and KPIs

7.18 In addition to improved access and referral pathways, the orthotics service at Medway NHS Foundation Trust has also worked on a number of other areas to improve the quality of the service and reduce costs. For example, it has a workshop on site and can offer some patients a one-stop-shop service. This means that an assessment, plan, implementation and evaluation system can be achieved within a single appointment. It has also specified expected average treatment times for assessment and fitting of various orthoses which help maximise clinic appointments

and ward based work. These are listed at (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-6.pdf).

7.19 Clinical evaluation of orthotics products takes place to ensure patients receive the most appropriate treatment to suit their clinical requirements. A scoring template is used by staff to rate different products in a number of areas along with reviewing outcomes such as product fails. (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-7.pdf) These are categorised by patient discomfort, and referring clinicians re-referring patients to the orthotic service if they or the patient feel that the prescribed treatment has not worked by not having an improvement in their condition or their activities of daily living. This process has helped to reduce cost and still use high quality products without compromising patient care. Over an eight year period since 2007, the service has saved over £1million and the average cost per treatment provided has fallen from £63 to £32.

7.20 Finally, the service has adopted a rigorous system for continuously monitoring and improving quality and performance and uses a monthly scorecard consisting of numerous KPIs in categories covering quality, performance, workforce and finance. (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-plstr-photo-scorecrd-2015-16.xlsx)

Nottingham University Hospitals NHS Trust – Modernising the Orthotics Service

Overview

7.21 The orthotics service at Nottingham University Hospitals NHS Trust is provided as an “in-house” NHS service with its own workshop on site. It treats both adults and children across two hospital sites and sees over 14,000 patients a year. Over the last seven years the service has been modernised to improve patient care by improving access and reducing waiting times and reducing costs whilst improving quality.

7.22 Prior to the service redesign, there were substantial staffing, operational and infrastructure issues which left the service struggling to meet the demands of the hospital and patients. This resulted in significant performance problems with long delays in treatment, multiple referral to treatment time breaches and a high level of complaints regarding the inability to access the service in a timely way. Less than 2% of referred patients were issued their orthotic treatment at their first appointment and there was no service specification or KPIs to monitor performance or improvement. Financially, the service was £500K overspent.

Redesigning the Service

7.23 The overall aims of redesigning the service were to:

- Put patient care at the centre of all decisions;
- Improve quality and efficiency;

- Document agreed pathways and policies;
- Develop a new financial structure and processes;
- Implement a new IT system

Improving Patient Access

7.24 A number of initiatives were put in place to improve access and reduce waiting times. This included implementing a triage system for referrals, so that all referrals are triaged by a senior orthotist to ensure urgent patients are seen as quickly as possible. Choose and book direct GP access and referral has been introduced across all sites. Clinic slots for new patient assessments have increased from 20 to 30 minutes as a minimum to allow sufficient time for accurate assessments. Patients with long term conditions that meet specified clinical criteria are able to self – refer back to the service after the initial GP referral. It is estimated this saved approximately 378 GP appointments and the associated costs in 2012/13.

Developing a Multidisciplinary Approach

7.25 Specific multidisciplinary or multi-clinician clinics are held for paediatric patients, diabetes patients, neurology patients, spinal patients and patients with knee and foot orthoses (KAFO). The joint clinics have reduced initial assessment waiting times and allow for patients to be seen at the most appropriate time; the multiple clinicians allow each patient to have a suitable amount of time for their appointment and facilitate learning amongst the clinicians.

7.26 The orthotics service has developed competency based educational packages and training programmes , so that trained physiotherapists and registered nurses can provide specific orthoses in their clinical areas which helps speed up in-patient treatment and reduce length of stay.

Moving from Block Contract to Local Tariff

7.27 A cost and volume tariff has been agreed with commissioners irrelevant of source of referral. Coding for orthotics has been simplified and includes 16 descriptors categorised into four tariff bands which are described in more detail at (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-8.pdf).

Service KPIs, Patient Allowances and Patient Experience Measures

7.28 Key performance indicators are now clearly defined in the service specification and include the following:

- Patient treatment will be given within 18 week RTT pathway,
- All patients to have appointment generated within 5 days of receipt of referral,
- All routine patients to be appointed within 10 weeks of receipt of referral,
- All orthosis to be fitted within 6 weeks of initial assessment,
- All in-patient referrals to have treatment plan initiated within 24 hours of receipt of referral,
- Waiting time for a scheduled Orthotic appointment at the Trust will be kept to a maximum of 30 minutes.

7.29 Patient Allowances are also covered in the service specification and are outlined at (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-rep-attach-9.pdf).

7.30 The orthotic service routinely monitors patient experience measures through patient satisfaction audits, the family and friends test and specific audits such as a foot wear audit and insole pain audit. Patient outcome measures are also used. These include 10m walking test, 3m up and go test and VAS pain scores.

7.31 Overall, these service redesign initiatives have led to substantial improvements in quality and patient experience, as well as reduce costs. For example, paediatric waiting times have reduced from 10 weeks to 2 weeks for an initial assessment and maximum waiting times for fittings have reduced from 8 weeks to 2 weeks. In-patient waiting times have reduced from up to 4 days to the treatment plan being initiated within 24 hours. Over 34% of patients now have their orthotic treatment issued at the first appointment and 98% of patients report a positive benefit from their orthotic treatment with an absence of complaints. Average costs per patients have also been reduced.

Leicester Specialist Mobility Centre – Redesign of Disablement Services Centre

Overview

7.32 Prior to the redesign, the Disablement Service Centre in Leicester was originally commissioned by East Midlands Specialised Services team and services were provided by the University Hospitals of Leicester NHS Trust across three separate hospital sites. The services provided included orthotics, prosthetics, wheelchairs and environmental controls. At the time, the orthotics service was subcontracted to a commercial provider to provide the clinician expertise with a separate contract for product provision, which led to extended waiting times for patients as clinician's prescriptions were administered by trust staff and orders issued to a variety of stock and bespoke product providers.

7.33 As a result of disinvestment decisions and organisational changes within the NHS, the contract transferred across to the CCGs in Leicester (Leicester City CCG, East Leicestershire & Rutland CCG and West Leicestershire CCG) in 2011, with Leicester City CCG acting as lead commissioner. During this transition, a service review determined that a single provider operating under a fully managed, directly commissioned service would offer all orthotic patients a better quality service. The new provider would employ staff, locate facilities, manage the service and report on patient outcomes. The tender for a directly commissioned service required an experienced provider to deliver an outcome based service under a block contract (equal monthly reimbursements) with the option to move to cost and volume over time. The current service is contracted out to a private provider and has an active caseload of approximately 10,000 orthotics patients.

Key Elements of Service Redesign

Outcome Based Quality Measures

7.34 The new service model is based on a number of outcome based quality measures which require the most efficient model of provision where clinical input and product provision (either produced in-house or procured) are managed together as part of the same process. There is rigorous reporting on the quality measures which are based on the NHS Quality Schedule and include a host of measures such as: infection prevention; patient experience; patient feedback; reporting of complaints and incidents and others (https://www.england.nhs.uk/wp-content/uploads/2015/11/lcstr-orthcs-case-study-temp-qual-sched-rep.xlsx). Specifically for orthotics, a 'right first time' quality measure has been introduced to reflect patient feedback about the historically lengthy process for delivery of orthoses. The % right first time indicator ensures the accuracy of the measurements taken by the orthotists and the manufacture and production enable for the first time right fit. The performance threshold is to ensure 95% or more of patients' orthoses are right first time. Other indicators, such as waiting times, sources of referral and orthotic spend are also monitored. (https://www.england.nhs.uk/wp-content/uploads/2015/11/lcstr-orthcs-case-study-temp-kpi.xlsx).

Flexibility of Location of Service Provision

7.35 The current service has relocated to a fit for purpose, community based facility and aims to meet the needs of patients by providing services in the most suitable setting for them, whether that is at home, school, clinic or in hospital.

7.36 Numerous satellite clinics in community hospitals and special schools cater for the rural community. There are 6 community hospitals and a host of special schools where the orthotists attend on a regular basis. Domiciliary visits are also catered for when the patient is unable to attend any of the clinics. Some of these services are contracted with the provider by a separate contract and paid in addition to the main block contract.

7.37 As the service is no longer located on the hospital sites, a timed ward service caters for the acute hospital's discharge policy. Ward referrals are sent electronically and orthotists will visit the hospital sites daily with the objective of fitting 75% of patients on the day to allow discharge.

Innovative Information Technology (IT)

7.38 There has been significant development in IT systems to enable easier booking of appointments and facilitate patient choice. Electronic patient records can now be accessed by other associated services such as prosthetics, physiotherapy and the wheelchair service and allows greater visibility and access to patient notes by clinicians as they attend satellite clinics.

7.39 The IT system facilitates reporting on all outcome measures and episode of care data and management information which helps to monitor improvements in quality and performance as well as identify accurate information On-going work with the provider is to develop a new process to review volumes of patients, types of

patients, referral routes etc. which is important in terms of full validation of data and recognising patient quality and safety and assists the unbundling of funds from block contracts to move towards tariff based systems.

8 Actions agreed at the Round Table Event to Improve Orthotics Services in England

8.1 Commissioners do not currently have all of the tools they need to commission high-quality orthotics services. A number of actions were agreed at the national round table event which have been taken forward.

Agreeing and Developing the Key Elements of a Model Service Specification for Orthotics Services

8.2 North Staffordshire Clinical Commissioning Group has led a process of developing a model service specification for commissioning orthotics services, along with supporting material including key performance indicators. This has taken into account the learning achieved by a number of CCGs and providers. The model service specification is outcomes-based and addresses key issues identified by patient groups. It also addresses how improvement might be achieved step by step. (https://www.england.nhs.uk/wp-content/uploads/2015/11/orthcs-serv-spec.docx).

Improving Data Quality for Orthotics Services

8.3 NHS England will develop a national minimum data set for orthotics services, which will take into account the KPIs from the model service specification. A workshop will be held in November 2015 in partnership with national professional bodies and patient groups to review orthotics data and develop a plan to take forward a national data set.

Workforce Development Issues

8.4 Health Education England (HEE) and NHS England will work together to assess workforce development needs for orthotics service provision, with oversight from HEE's Allied Health Professional Advisory Group chaired by the Chief Allied Health Professions Officer.

Sharing Good Practice

8.5 NHS England, The Orthotics Campaign and Healthwatch Staffordshire will work together to raise awareness of the variability in quality and highlight the good practice which has been identified to improve the quality of services.

Rehabilitation Framework

8.6 NHS England recognised that the issues affecting the quality of orthotics services are also experienced in other areas of rehabilitation and will ensure that common factors are addressed in future developments.

9 Key Contacts for Case Studies

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10 Acknowledgements

NHS England is grateful to all the key stakeholders who participated in the round table event and those who contributed case study material and have been involved in this work and for the time and contribution they have made to the publication of this document. In particular, special thanks are offered to:

Vicki Booth, Southampton Clinical Commissioning Group
Kate Cheema, NHS Quality Observatory
Julie Croysdale, Leicester Specialist Mobility Centre
Simon Dickinson, Talarmade
Lindsey Hughes, NHS England
Steven Hunt, Plymouth Community Healthcare
Colin Hurley, British Healthcare Trades Association
Fay Lacey, West Kent Clinical Commissioning Group
Rebecca and Desmond Loo of The Orthotics Campaign
Jane McAdam, University of Salford
John Mclaughlin, Medway NHS Foundation Trust
Tracey Parkington, East Lancashire Hospitals NHS Trust
Kay Purnell, Blatchford
Chloe Peacock, Healthwatch England
Suzanne Rastrick, NHS England
Desra Robinson, Leicester City Clinical Commissioning Group
Jan Sensier, Healthwatch Staffordshire
Gemma Smith, North Staffordshire Clinical Commissioning Group
Ian Spencer, Alder Hey Children's Hospital NHS Foundation Trust
Liz Thomas, Nottingham University Hospitals NHS Trust
Sandra Wilks, Lancashire Teaching Hospitals NHS Trust
The patient leaders who contributed to the project.