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| **Service Specification No.** |  |
| **Service** | Orthotics Model Service Specification |
| **Commissioner Lead** |  |
| **Provider Lead** |  |
| **Period** |  |
| **Date of Review** |  |

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| 1. **Population Needs** |
| * 1. **National/local context and evidence base**   1.1.1 Orthotic service provision has the potential to achieve significant health, quality of life and economic benefits across the local health economy. To individual patients, the correct supply and fitting of orthotic devices can be a major factor in the management of their condition, improvement in the quality of life and the prevention of future problems. Evidence highlighted in the emPOWER patient led orthotics Charter states that for every £1 spent, the NHS saves £4. A recent national review of orthotics services has highlighted a number of issues in regards to current provision and commissioners are looking to commission a single service from a single provider across a number of community locations providing in reach services to secondary care where appropriate.  1.1.2 An estimated £220 million per annum is spent by the NHS on assistive technologies which include orthotics, audiology, community equipment, electronic assistive technology, telecare and prosthetics. The Foundation for Assistive Technology’s recent report states that there are approximately 1,200,000 orthotic users in England. However, the number reported may only be used as a guide, as the report suggests that the total number of patients benefiting from such assistive technologies is unknown[[1]](#footnote-1).  1.1.3 Orthotic services cover a wide range of clinical areas where they are likely to provide health benefits, some of which are listed below:   * Orthopedics – pre & post-operative joint support * Rheumatoid arthritis and osteoarthritis – pain relief from custom bracing and footwear * Stroke – improving independence * Elderly medicine – improving mobility * Diabetes – reducing ulceration rates * Sports injuries – joint rehabilitation * Cerebral palsy – contracture prevention * Polio limb dysfunction - improve independence & mobility * Trauma – post op bracing * Vascular complications – pressure relief * Other muscular-skeletal complications such as knee instability, broken back or neck, ankle replacements – support & pain relief during rehabilitation * Foot deformities such as forefoot varus, hyper mobile feet, metatarsalgia and drop foot - biomechanical alignment for pain relief and prevention of deterioration of associated joints   1.4 Demand on the service is increasing in line with both the ageing population and the complexity of the associated clinical conditions. There is currently no agreed mechanism for relating the changes in funding to the changes in demand. Orthotic services have generally received a very low priority in the NHS, hidden in secondary healthcare[[2]](#footnote-2). Orthotics care can be provided as part of a hospital episode or in its own right as a community-based service. |
| 1. **Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**   |  |  |  | | --- | --- | --- | | **Domain 1** | **Preventing people from dying prematurely** |  | | **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **√** | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **√** | | **Domain 4** | **Ensuring people have a positive experience of care** | **√** | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **√** |   **2.2 Local defined outcomes**  **2.2.1 Aims**   * To provide a community-based, cost effective, accessible specialist orthotics service which includes the diagnosis, treatment, and fitting, maintaining and repairing of orthoses for children and adults in line with the agreed access criteria, responding to changing medical and social needs of the orthotics user. * To provide appropriate orthotics, inclusive of elastic/fabric and custom made splints. To provide advice to maximise children’s' motor skills, minimise development of contracture and deformity in the growing child and prevent injury in a caseload of children with neurological and physical health needs. * To facilitate the treatment and rehabilitation of the patient. This is achieved through the assessment of need and the provision of an orthoses that will either remedy or relieve a medical condition or disability, and may prevent the development of more disabling conditions. * To provide access to high quality, safe care that gives timely advice, appropriate support, assessment, diagnosis and treatment for patients according to their individual need * To ensure the service is delivered in line with current policy, learning and best evidence and provide appropriate governance and management for the service.   \*NB: The term orthoses refers to: “Externally applied devices used to modify the structural and functional characteristics of the neuro-muscular and skeletal systems. This includes, but is not restrictive to, the provision of footwear, splints, insoles, collars, spinal orthoses, helmets, lycra/fabric garments, support stockings, braces and any worn devices or appliances that are indicated for the individual patient.  **2.2.2 Objectives**   * To develop a patient centred approach to services. * To continuously improve the quality of the services provided * To be able to systematically identify areas for development and measure improvements made. * To ensure that the services are geared to the needs and concerns of the local population * To support service user involvement in both practice and service development. * To continue to develop areas of outcome measures, audit and goal planning * To maintain an open and honest culture where feedback, whether this be in the form of complaint or comment, is encouraged and acted upon. * To develop a relationship, on a managerial and clinical level, based on mutual trust, honesty and integrity; * To provide a service that provides high quality advice and information to service users and/or their carers. * To ensure that the services are geared to the needs and concerns of children and young people and their families including delivering care within appropriate locations. * To deliver a cost effective, high quality service     **2.2.3 Expected Outcomes**  The expected outcomes from this service include:   * Enhanced patient and carer experience, satisfaction and quality of life * Delivery of a service that enable patients and their carers to obtain information, knowledge and skills to facilitate self-care, wellbeing and to promote independence * Responsive and timely access to a service that supports patients to proactively access the service in a location of their choice * To provide a service that is equitable for all patients * High levels of patient and carer satisfaction * Improved mobility and independence for patient * Reduced pain * Increased choice and capacity locally for patients requiring services * Seamless service through the provision of a ‘one-stop-shop’ approach to orthotics * Improved management of foot care for diabetic patients, to reduce diabetes-related complications * Prevention of ulceration. * Improved communication between provider specialist clinicians and GP’s |
| **3. Scope** |
| **3.1** It is expected that the provider should deliver the following:   * All patients to be offered an outpatient appointment within X weeks (to be locally agreed) of the referral being received into the service **or** within X weeks of contacting the service. * Urgent appointments should be available and allocated against agreed criteria for urgent needs. Patients who have a clinical need against these criteria should be appointed within 48 hours of contacting the service. * The provider will ensure that all devices are ordered from the supplier within one working day of the patient’s appointment at the latest. * The service will include the provision of ready to wear footwear and mainly lower limb orthotic devices, as well as surgical stockings, splints and surgical collars and specialist support/compression stockings and corsets. * Regularly used orthoses should be held as stock items where appropriate to reduce waiting times * The provider will implement a robust clinical ordering system and to agree standards including set delivery times for collection/delivery with a small number of orthotics manufacturers where appropriate. * The provider should ensure that suppliers are held to account for delivery times which should not exceed 10 working days from the point of ordering. Pre-emptive appointments should be made with the patient for the follow up fitting during the first/casting appointment to prevent any delays. * Each patient should have a named orthotist as their ‘case manager’ who is responsible for the development and maintenance of an evidence based care plan for all service users to ensure continuity of care is delivered. * The provider will ensure that there is a governance pathway in place in relation to the delivery of key competencies and standardisation of treatment. * MDTs and Peer Reviews should be an integral part of the service and should be recognised as core and best practice. * The service will ensure that the user and their carers are appropriately trained in the use of the orthoses to gain the best clinical outcomes from their orthosis, and a review of the orthoses is done within clinically appropriate timeframes of being fitted. On-going review and re-assessment if required, to ensure that the orthotic device is:   + worn as advised   + fitting well and pressure points are avoided   + used appropriately by the long term Service User   + and appropriate to clinical need * Ensure appropriate numbers of patients are booked into all clinic sessions to maximise capacity * Ensure effective management, of waiting lists and waiting times via an appropriate clinic booking system and the implementation of efficiency measures in all clinics in order to reduce unnecessary delays within the system * Implement a strategy for identifying and reducing DNA rates in all clinics, including appropriate solutions to minimise and prevent missed appointments and to reduce wasted staff time * Interface/joint work with other appropriate services including musculoskeletal, orthopaedics, elderly care, stroke services, diabetes, paediatrics and secondary care surgical provision including the provision of multi/ interdisciplinary clinics where appropriate. It is of particular importance that the provider and podiatry services work closely together to ensure a seamless approach to patient care. * Deliver basic training for secondary care ward staff * Use the results of the patient survey to develop and improve the service experience * Deliver services in line with professional guidance and national best practice * Ensure patients are integral to the design and on-going development of the service   **3.2** It is expected that this service will offer a comprehensive range of assessments and orthoses for patients tailored to take into account the needs of the local population. The Service Provider should be aware of issues of diversity, (e.g. the service should take into account the cultural diversity of the local population and the differing issues faced by patients living in rural communities).  **3.3** The service provider will be innovative and strive for continual service improvement covering the following areas:  Advice and Information  Advice and information must be accurate, up-to-date, consistent and easily accessible. This requires a regular review of knowledge and the appropriate training and supervision of staff, including administration and reception staff and ward staff trained to fit basic orthoses  The provision of advice and information will be a core component of the service and will include support for carers and other health care professionals.  Appointment times and allocations  The provider should ensure that there is a clear protocol for booking appointments and that there is a dedicated telephone line manned at specified hours and an answer phone service available during call hours should a member of staff not be available. Advice and queries should also be able to be submitted via a dedicated email address and responses returned within one working day. Information in regards to this should be readily available to patients and their carers  Waiting Times  The provider should ensure that an effective system is in place to work within the maximum waiting times set out within this specification.  Secondary Care support  The provider will also be required to provide ward, theatre and outpatient support to the local acute trust which will be funded separately to this service. The Provider will make an appropriately skilled orthotist available 5 days per week on a 52 week basis for work pertaining to the local area and this should be taken into account and costed as part of the provider’s tender model. (See 2.5). It is expected that in the event that the acute trust requires the provider to support additional or out of area work that this is negotiated provider to provider and will not form part of this specification.  **3.4 Entitlement of Patient for Orthotic Equipment Provision**   |  |  | | --- | --- | | **Product Group** | **Maximum\* Provision** | | **Footwear** | **Two** pairs of boots or shoes at any given time. Second pair supplied after trial period completed. Replacement only when beyond economic repair | | **Insoles** | **Two** pairs at any given time | | **KAFO / AFO** | **Two** pairs / items at any given time | | **Temporary devices (wrist splints, stock AFOs etc)** | **One** orthosis | | **Fabric supports** | **Two** pairs at any given time | | **Hosiery** | **Two pairs / items** at any given time. | | **Footwear repairs** | **As required.** If repairs seem too frequent then consideration is given to changes to specification. | | **Footwear adaptations (such as raises, rockers, sockets for callipers)** | **Four per annum.** |   **3.5 Repairs**  Repairs should be completed as quickly as possible. Where only one piece of equipment, which is vital to the user for independence, has been supplied, simple repairs should be done if possible while the user waits. e.g, replacing straps, replacing rivets, heating and easing AFO’s, cranking calliper/ BK iron side members.  All other repairs are undertaken following presentation of old device and re-assessment by orthotist.  **3.6 Replacements**  Replacements will only be provided when the device is beyond economic repair or a change of device is required following assessment due to clinical need or change.  **3.7 Orthotic Referral**  Referral is made to the Orthotic Service on the Referral form and should include all details as requested. The information will assist the orthotist in the assessment of the patient and in the decision of the most appropriate orthoses for the patients need. This may be different to that suggested by the clinician or visualised by the patient.  **3.8 Stabilisation/Orthotic intervention**  Requests for orthoses can be a one off for an acute episode or before or after surgery in hospital contract. It may be for long term use with a period of time specified for repair and replacement. It is the responsibility of the orthotist to ensure the product supplied is appropriate and necessary. If the orthotist feels that the previous provision is now not appropriate or there has been a change in the condition of the patient, this will be referred back to the original referrer for a re-assessment by them. If the original referrer in the case of a consultant has discharged the patient, then the request for re-assessment or up to date information will be requested from the patients G.P.  **3.9 Orthoses will not be supplied where:**   * There is no specific clinical or biomechanical need * The short term need has passed and the patient no longer requires replacements * The orthoses is being supplied as a placebo * They are being supplied for only socio-economic reasons * The need is for sporting requirements only * *No orthoses should be supplied because of historical practice.*   **3.10 Prior Approval for bespoke orthoses**  Any device/orthoses that cost in excess of £xxxx will require Prior Approval from commissioners. The application will need to highlight the reasons as to what additional clinical benefit will be derived from the supply of this device over and above routinely prescribed items.  **OR**  Commissioners will include as part of the contract a list of routinely commissioned orthotics/devices with corresponding prices. If there is a requirement for a patient to receive an orthoses/device that is excluded from the list, prior approval must be sought from the relevant commissioner. The application will need to highlight the reasons as to what additional clinical benefit will be derived from the supply of this device over and above routinely prescribed items.  **3.11 Review of the service**  The specification will be jointly reviewed by the provider and commissioner on an annual basis. In no way should this service specification preclude the provider from innovating and or developing new ways of working.  **3.12 Accessibility/acceptability**  Referrals will be accepted from GP’s, Consultants, other health care professionals and self-referrals will be accepted where the first referral into the service has been made by a suitably qualified healthcare professional.  **3.13 Whole System Relationships**  The approach to delivery should be based on shared care i.e. communication between all clinicians looking after patients, with the appropriate level of staff carrying out appropriate interventions, and structured around the patient journey.  The service provider will be expected to work alongside a number of other services and ensure patients move smoothly through the pathway by facilitating appropriate partnership working and onward referrals with:  • Patients and carers  • Voluntary sector  • General Practitioners  • Practice Nurses  • Social Services  • CCG Commissioners  • CCG clinical leads  • Musculoskeletal Interface Service  • Community Physiotherapy teams  • Other provider services e.g. nursing and therapy teams, intermediate care and rehabilitation  centres  • Secondary care providers and Consultants from a range of specialties  **3.14 Interdependencies**  The provider will interface seamlessly with all other services which would offer benefits to the patient. It is expected that formal agreements for in reach services to acute wards and any community intermediate care beds will be reached between the provider and any relevant Trust.  **3.15 Activity**  • Current caseload split by children and adults – The table below shows activity for the year 2014-15 and is split to reflect both paediatric and adult caseload and new and follow-up activity xxx  INSERT ACTIVITY  The number of orthoses orders raised for 2014-15 was xxxxx  INSERT BREAKDOWN IF POSSIBLE  **3.16 Service model**  The service will be provided by a team of orthotists and their support staff. The team should also have dedicated management time allocated for the service lead and a reporting structure should be created specifying accountability and responsibility for each member of staff.  After initial assessment patients will either be:  •Fitted with an orthotic appliance there and then and either appropriate follow up arrangements or the patient discharged, with advice regarding how to re-engage with the service should this be required.  •Discharged from the service with advice to the patient and referrer  •Assessed by the Orthotist and measured for the items needed. Patients should then be offered an appointment within X working days (to be locally agreed) for the fitting of their orthoses and review appointment.  At each review appointment the provider will ensure as a minimum they:  •Assess the patient  •Maintain and repair orthoses where required  •Respond to changing medical and social needs of the orthotics user  •Refit and re measure the patient where appropriate  Documentation should be available in relation to patient’s entitlement to orthotics and what additional items they would be expected to pay for.  **3.17 Facilities and Location Of Service**  The service should be located within the geographical boundaries of xxxxxxxxxxxxxxx. The provider will provide outreach as agreed with commissioners as an innovative way of targeting at risk groups. The provider should ensure that all facilities used are wheelchair friendly, have appropriate parking spaces and separate waiting areas for adults and children. Disabled washroom facilities and access to changing facilitates for both adults and children should be available. In order to facilitate safe transfer of patients the provider is expected to make provision of hoisting equipment.  **3.18 Other Quality Standards**  The service should be provided within the key principles of the NHS and will operate according to key standards and NICE guidance.  The provider’s premises should meet standards as specified by the Department of Health in its Building note 46  **3.19 Governance**  The provider will ensure that robust clinical governance processes are in place to include:  •Incident reporting  •Significant Event Analysis  •Managing Alerts  •Compliance with national and local standards including NICE and National Service Frameworks  •Compliance with locally and nationally agreed audits  The provider will be expected to allow ad hoc external audit of the service.  The provider will ensure that information relating to patients is safeguarded and take account of:  •Patient confidentiality  •Caldicott Guardian  •CCG information sharing protocols  The provider will work in ways that support national and local programmes and utilises IT in ways that maximise patient care taking account of:  • Connecting for health  • Communication and use of E-Mail systems  • Participation in CCG audits and data collection  Records must be maintained both for audit purposes and medico-legal reasons. Consent must be obtained, written and documented clearly in the patients’ notes and records should be kept of all appointments. Copies of all correspondence to the patient and other parties should be included in the patient record. The provider will ensure that all clinical records should be treated confidentially, and kept secure at all times.  The provider will ensure that there is a peer review process in place within the service and also look to set up a multi-disciplinary peer review on a regular basis to ensure that continuity of care is achieved for challenging cases.  **3.20 Safeguarding**  The service must ensure that policies and procedures relating to safeguarding are robust, accessible and adhered to, that staff have undertaken training appropriate for their professional role and should be represented on the Local Safeguarding Children’s Board (LSCB) as well as complying with any requirements of the LSCB.  The provider must ensure that all policies and procedures relating to safeguarding are robust, and accessible for all staff working within the service. The provider must also ensure that the patients’ needs are met at the right level and by an appropriately skilled workforce. This will include appropriate support to informal carers.  LINK TO SAFEGUARDING POLICY TO BE ADDED  All staff working will have undertaken an enhanced Criminal Records Bureau check and the service should comply with the safeguarding clauses within the Standard NHS Contract.  **3.21 Environmental issues**  It is essential that services provided should also align with the You’re Welcome quality criteria. All CYP are entitled to receive appropriate health care wherever they access it. The criteria lay out principles to help health services to ‘get it right’ and become young people friendly. It should provide a child friendly and safe environment.  **3.22 Documentation**  •Letter templates should be created for both patient and discharge letters and should be returned back to the referrer copying the patient in within 5 working days of the appointment  •Records must be maintained both for audit purposes and medico-legal reasons.  •Consent must be obtained, written and documented clearly in the patients’ notes and records should be kept of all fittings and appointments. Copies of all correspondence to the patient and other parties should be included in the patient record. The provider will ensure that all clinical records should be treated confidentially, and kept securely.  •The provider will produce monthly reports using the specified commissioner Minimum Data Set sufficient to complete the required Key Performance Indicators (KPIs).  **3.23 Risk Management**  The provider should be able to demonstrate an appropriate system for recording, monitoring and reporting of risk issues and adverse events.  **3.24 Complaints**  The service will deal with complaints and incidents in line with clearly defined policies and there will be a robust system for handling patient safety notices and alerts. This will be demonstrated by the provider as part of the tender exercise. The provider will also provide information to patients as to who to complain to, how that complaint will be handled and also the timeframe they should expect to receive a response within.  **3.25** **Geographic Coverage / Boundaries**  Eligible patients shall be registered with a GP from XXXXX area. The provider should negotiate any out of area activity with individual commissioners  The service will be provided in a range of geographical locations across XXXXX, to ensure equity of access and enable patients to attend a programme as close as is reasonably possible to their home.  **3.26 Location(s) of Service Delivery**  The provider will suggest premises along with costings as part of this tender exercise. Commissioners are looking for one core location with a workshop attached as a minimum.  The Provider shall ensure that:   * All premises are compliant with Health and Safety regulations, Disability Discrimination Act (DDA) requirements and that a risk assessment is undertaken annually. * The locations from which the service is provided are easily accessible by public transport; which patients must be made aware of. The Provider shall ensure that all clinic locations have adequate parking facilities nearby including wheelchair accessible parking. * All premises meet high cleanliness and infection control standards and must provide for the maintenance of patient privacy, dignity and confidentiality, in compliance with Care Quality Commission standards. * The Provider shall ensure that the service location provides full disabled access and facilities such as disabled toilets, changing facilitates and suitable waiting areas for adults and children.   **3.27 Days / Hours of Operation**  The operating times should between 8.30am to 4.30pm Monday to Friday, and clinics will operate for each day of the week. The hours that the service is open for must also be responsive to the needs of patients and therefore there should be provision for at least 2 late sessions up to 8.00pm during the week and/or Saturday morning sessions. The provider must ensure that a safe level of service is offered 52 weeks a year.  **3.28 Discharge Criteria:**  Due to the nature of this service the discharge process will be determined on a patient by patient basis.  **3.29 Patient Information**  Providing written information may not always be the most suitable way for all patient groups, therefore the Provider shall use different ways of delivering self-management guidance including verbal and over the telephone advice.   * The Service will offer a comprehensive range of patient information including advice on self-management and will direct patients to other resources as appropriate. * The Service should give relevant information to patients as to what services to access should a treatment complication arise outside normal working hours. * The Service will make available to patients the agreed procedure for booking appointments and the policy on DNAs and cancellations. * Patient Information will be formatted according to agreed guidelines and should be made available in different languages as required.   The Provider will be expected to submit monthly data on performance against agreed Key Performance Indicators (KPIs). The KPIs should be received by an agreed date each month, and cover the performance for the month immediately previous. The Provider must communicate with the commissioner regularly including attendance at joint meetings to discuss data definition, performance, service delivery, and any development issues.  The Provider will meet with the nominated Contract Manager to discuss performance of the service on a formal basis to agree on specific contract issues as they arise. Representatives of the commissioners will have access to the provider to undertake reviews of the procedures and systems utilised that are used to monitor service delivery.  The provider will keep detailed records of all hardware provision and expenditure against patient level detail to allow for monitoring and comparison in addition to any other information requirements set out in the minimum dataset.  The minimum dataset should be completed and shared with commissioners on a monthly basis. The following fields are required. Patient identifiable information must not be shared directly with CCGs:   * Patient Post Code * Practice Code * Commissioner Code * Source of referral – consultant to consultant, GP, Other health professional, self-referral * Date of referral/date of patient contacting the service * Date of appointment * Type of appointment – first, follow up, fitting * Date of ordering orthoses * Type of orthoses * Date of arrival of orthoses at provider * Date of fitting orthoses * Cost of orthoses * Attend/DNA |
| 1. **Applicable Service Standards** |
| **4.1 Evidence Base**  The following information has been used to inform the service specification:   * emPOWER, the disabilities charities consortium Patient led orthotic services user charter 2011 * Review of North Staffordshire Orthotics Services: Vernon et al 2011 * UHNS Orthotics Review: Barnett 2010 * Guidance on the Commissioning of Orthotics Services: Audit Commission 2002 * University of Leeds Conference Report:2011 * Fully Equipped: assisting independence Audit Commission 2002 * York Health Economics Consortium. Orthotic Service in the NHS: Improving Service Provision 2009 * North Bristol NHS Trust Orthotics Service Good Practice Guidance 2004 * NICE guidance CG10 Type 2 diabetes – Foot care 2004 * NICE guidance CG119 Diabetic Foot Problems – Inpatient Management 2011 * Improving the Quality of Orthotics Services, NHS England, 2015 |
| 1. **Applicable monitoring and quality requirements and CQUIN goals** |
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| *Performance Indicator* | *Indicator* | *Threshold/Expected achievement* | *Method of Measurement* | *Frequency of Monitoring* |
| ***Quality*** |  |  |  |  |
| % of patients satisfied with the service  Number of patient complaints / compliments received | All patients fitted with a device will be given a patient satisfaction survey to complete | 90% of patients are either satisfied or very satisfied with their treatment | Patient Satisfaction survey | Monthly report (including number of PALS contacts about access and waiting, total number of complaints) |
| Service users/carers receive information about their orthoses including leaflets and information on how to care for their orthoses |  | 95% | Patient Satisfaction survey | Annual report and reviewed via clinical review |
| The proportion of users who report that they have achieved their goals. |  | Reported 95%  Goal achieved 80% | Patient Satisfaction survey | Annual report and reviewed via clinical review |
| Percentage of users who report that they are comfortable in their  orthoses. |  | Reported 95%  Goal achieved 95% | Patient Satisfaction survey | Annual report and reviewed via clinical review |
| **Performance & Outcomes** (split per CCG area) |  |  |  |  |
| % of patients fitted within x working days of the orthoses order being placed |  | For | Activity Report | Monthly |
| Number of patients seen within x working days from referral or contacting the service to first appointment |  | To be locally agreed | Activity report | Monthly |
| Total number of patients on the caseload |  | To be locally agreed | Activity report | Monthly |
| DNA Rate  Numbers of clinics cancelled and reasons |  | 5% | Activity report | Monthly |
| Cancellation rate (by the provider) |  | 2% | Activity report | Monthly |

1. <http://archive.audit-commission.gov.uk/auditcommission/sitecollectiondocuments/AuditCommissionReports/NationalStudies/olderpeopleorthotics.pdf>. [↑](#footnote-ref-1)
2. York Health Economics Consortium, July 2009 [↑](#footnote-ref-2)