SCHEDULE 2 – THE SERVICES

A. Service Specifications

1. Service name	Amputee Rehabilitation and Prosthetics Services for People of All Ages with Limb Loss and Limb Difference
2. Service specification number	D01/S/d - 250502
3. Date published	May 2025
4. Accountable Commissioner	https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-d/

5.	**Population and/or geography to be served**
5.1	**Population Covered** The service outlined in this specification is for patients ordinarily resident in England or otherwise the commissioning responsibility of NHS England (as defined in the https://www.england.nhs.uk/publication/manual-for-prescribed-specialised-services/. The service specification is for all ages. The prevalence of amputation or limb difference in England is estimated at 55,000 - 60,000 people, of these approximately 2,500 are children or young people. Vascular disease resulting from diabetes accounts for the greatest incidence of amputation at around 45%. Trauma, resulting from road traffic incidents and similar is responsible for between 9-14%. The average age of amputees is falling, mainly due to early onset diabetes and obesity. Of the 55,000 - 60,000 patients with an amputation or limb difference in England, approximately 25,000 are seen with the prosthetic services annually, (this includes both new and existing patients). Not all patients with an amputation or limb difference are clinically appropriate for prosthesis and some may choose not to use them.
5.2	**Minimum population size** Catchment area of 1-2 million people per specialist prosthetic centre.
6.	**Service aims and outcomes**
6.1	**Service aims** A prosthetic service aims to optimise mobility and/or function, independence and quality of life of the individual following congenital or acquired limb loss or limb difference, working in collaboration with service user (and family if relevant) to

achieve appropriate, timely and service user centred goals. This may extend to facilitating return to work and education and should aim to increase inclusion and participation in society. This is achieved through pro-active multidisciplinary rehabilitation, provision of prostheses when appropriate, regular review, access to and collaboration with additional services and service user / family and clinician education.

6.2 Outcomes

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

Service defined outcomes/outputs Outcome Reference Number

Outcome Reference No.	Domain	Rationale	Name of Metric/Description
TBC	**2,3,4,5**	To ensure service users receive a comfortable and well fitting prosthesis	Proportion of service users with a Socket Comfort Score (SCS) equal to or greater than 7 on delivery of a new socket

Additional outcomes and quality metrics will be considered for monitoring outside of this service specification.

The full definition of the quality outcomes and metrics together with their descriptions including the numerators, denominators and all relevant guidance will be accessible at https://www.england.nhs.uk/commissioning/spec-services/npc-crg/spec-dashboards/ following the next scheduled quarterly refresh of the dashboard metadata document.

7. Service description

7.1 Service model

The care pathway for people with limb loss and limb difference ranges from prenatal into adulthood and is lifelong. All necessary resources must be available to allow for the assessment, investigation, treatment, on-going care and rehabilitation of service users with limb loss and limb difference in line with agreed national standards (see Key Documents 7.9) and within

timescales appropriate to the clinical needs of service users.

The principles of the care pathway are broadly:

- To offer a responsive timely service, with multidisciplinary team (MDT) input as appropriate for clinical need.
- To liaise with local and other services as an individual requires.
- To prescribe an appropriate prosthesis(es) when indicated and deliver, maintain and repair as required in a timely manner.
- To facilitate access to appropriate specialist medical, prosthetic, therapy, psychological and nursing care as required, in a flexible and responsive manner to meet the needs of the individual. This may include, where appropriate, collaboration between services in different centres.

All prosthetic services must provide the following:

- A multidisciplinary team comprising Essential Staff Groups (see 7.4) and links to other NHS services (7.6). See also Appendix A.
- On site workshop with facility to fabricate, repair and maintain prostheses
- A process to manage the quality, risk, maintenance, assessment and disposal of prosthetic devices.
- Pre-amputation consultations, initial and subsequent MDT assessments, in addition to prosthetic consultations and therapy appointments for assessment, rehabilitation and reviews (see Appendix B).
- Annual reviews offered for active service users (e.g. those who use a prosthesis(es), have accessed care from the service at least once in the last two years and likely to need / benefit from regular review). This may be carried out either face to face or virtually as appropriate and with the most relevant clinician(s).
- Access to the service for non-prosthetic users where relevant to their needs.
- Telephone or video consultation as an option where appropriate, and ability to post items or leave for collection where appropriate.
- Priority appointments (within one working day) when required, and emergency care to service users of other amputee rehabilitation and limb loss services who are temporarily distant from their usual service.
- Flexibility in appointment times to accommodate service user needs where possible i.e. to accommodate those working, studying at school.
- Flexibility in appointment length to accommodate complex needs or when more time required e.g. multiple limb differences.
- Education, information, advice to service users, families, other relevant services or professionals (see 7.7). Support to maintain and improve existing levels of exercise and fitness.
- Advice, care and links with services to maintain care of contralateral limb e.g. podiatry, orthotics, diabetic services.

Satellite clinics need to be linked to a service that provides a standard service as above.

All prosthetic services are, by definition, specialised in the field of prosthetic rehabilitation. However, some services may need to establish pathways and links

	to other services or centres in order to access the relevant input for particular client groups or individuals. This is to ensure that quality of care is standardised, equitable and available to all. Local arrangements need to be made for this. The required elements for those groups and individuals are outlined below. **Paediatric:** All children (under 18 years of age) with limb difference or limb loss should have access to a prosthetic service that meets the following requirements: • Children's waiting area and clinical rooms are separate to adult areas, and appropriate for children's use (a service can make arrangements to fulfil this requirement as best suits their circumstances e.g. permanently separate areas or designated days within the service when only children seen in the relevant areas). This is a CQC requirement for safeguarding purposes. • Prosthetist(s) and therapists with an appropriate level of practice in paediatric prosthetics. • Routine review of children offered by prosthetist at least every 6 months for lower limb and every 12 months for upper limb (more frequently if clinically indicated). • Access to Community Diagnostic Centres (CDC), community and secondary care paediatric teams, health visitors, Special Educational Needs Coordinator (SENCO) and paediatric safeguarding team where appropriate. • Healthcare Transition arrangements for young people moving from paediatric pathway into adult pathway. A paediatric prosthetic service must provide the following or establish pathways to access: • Pre-natal consultations. • Initial paediatric prosthetic consultations. • Annual reviews with consultant in rehabilitation medicine and relevant MDT members. • Access to paediatric mental health / psychological support. • Combined consultations with surgeons with expertise in surgical techniques relevant to limb difference. • Referrals to medical genetics where appropriate. • System of peer support. **Upper limb:** A service must meet the following requirements or establish pathways to access: • Specialist occupational therapy input including ability to provide upper limb prosthetic rehabilitation. • Prosthetist with an appropriate level of practice in upper limb prostheses • System of peer support.

- Pathway to access trials of multi-articulating hand prostheses where suitable (can be via referral to another service).

Complex prosthetic rehabilitation:

Complexity in prosthetic rehabilitation may relate to a range of issues and is determined by the MDT, this could include patients with multiple limb loss. In order to address the needs of these users a service must meet the following requirements or establish pathways to access:

- Offers second opinions and MDT consultations including a consultant in rehabilitation medicine and/or specialist/consultant prosthetist
- Ability to review service users jointly with relevant surgical teams
- Provision of flexible increased intensity rehabilitation where appropriate, which may include provision of / referral for inpatient rehabilitation if required
- Reviews by therapists / prosthetists / services with specific expertise in a relevant area
- Ability to trial new developments and technology with suitable service users

Care of military veterans

This service specification honours the Cross Government guarantee to our Armed Forces, Veterans and their Families, and the recommendations as set out in the Murrison Report – A Better Deal for Military Amputees. Enhanced facilities for veterans should also benefit all service users with limb loss/limb difference in the wider NHS. Military veterans can choose to attend a centre of their choice or one of the 'Enhanced' centres set up following the Murrison Report. Provision of enhanced specification limbs is managed through the Veterans Prosthetics Panel (VPP).

Prosthetic provision

Amputees identified as suitable for prosthetic rehabilitation following assessment should be provided a clinically appropriate prosthesis (one per site of amputation; additional prostheses subject to consideration as detailed below).

The specification of the prosthesis will be dependent upon a number of factors including MDT assessment and the individual's:

- Potential and ability to use a prosthesis safely.
- Physical and cognitive capability to use the prosthesis safely and effectively.
- Lifestyle, occupation and hobbies.
- Rehabilitation goals and functional needs.

Where there is uncertainty as to exceptionality for issuing of a prosthesis outside of the normal prescribing parameters a request can be made to the Veterans Prosthetics Panel for their independent consideration.

Additional prostheses:

Provision of an additional functional prosthesis(es) for an individual is subject to consideration by the MDT. This would be to support necessary activities, health and wellbeing needs that cannot be fulfilled by their usual prosthesis, and therefore would be required on a regular basis. This includes prostheses for hygiene use and in or around water and terminal devices for upper limb prostheses. Potential candidates may need to fulfil certain eligibility criteria, a prioritisation process (which may entail placement on a waiting list) and potentially a trial prior to final prescription.

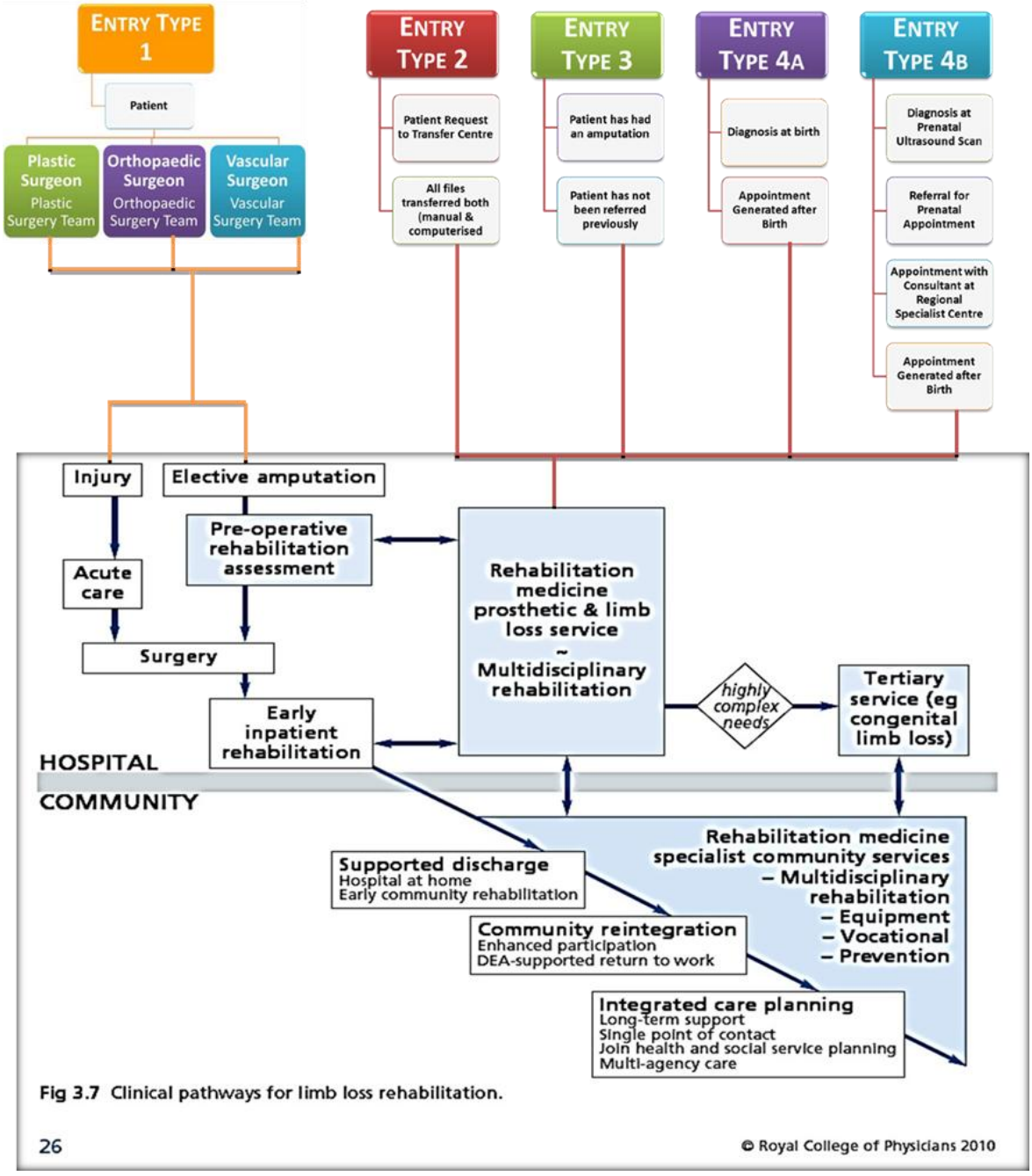
Children's Activity and Sports Limbs Programme

The provision of children's activity and sports limbs is now included within the core provision of a paediatric prosthetics service. Children and young people up to the age of 18 years can be prescribed an activity or sports limb if clinically appropriate.

The aim of the Children's Sports Prosthetics Programme is to enable children and young people to be included in sports and leisure activities, improving inclusion in education, support mental wellbeing and linking in to childhood obesity strategies. Whilst children can access a range of sporting prosthesis the programme does not include access to elite sports prostheses.

High Activity / Sports Prostheses

Dedicated bespoke high activity/competitive sport prostheses are not routinely commissioned by NHS England for neither adults or children . They can be obtained through the National Governing Bodies of Sport, private arrangements and funding streams. This may be subject to review in the future pending further evidence. However, many fitness and physical activities can be carried out with a non-sports specific prosthesis commissioned routinely by the NHS. When considering provision of a non-sports prosthesis or adaptations that would facilitate engagement in fitness and physical activities, the MDT should believe the service user is fit to engage in the activity, would benefit from the activity, demonstrates an interest or history of participation and that the prosthesis is likely to be of continuing use.

7.2	**Pathways** Overall service user pathway  Fig 3.7 Clinical pathways for limb loss rehabilitation. 26 © Royal College of Physicians 2010 Healthcare Transition All healthcare services are required to deliver developmentally appropriate healthcare to service users and families. Children and young people with ongoing healthcare needs may present direct to adult services or may be required to transition into adult services from children's services.

	Healthcare transition is defined as a 'purposeful and planned process of supporting young people to move from children's to adults' services'. Poor planning of transition and transfer can result in a loss in continuity of treatment, service users being lost to follow up, service user disengagement, poor self-management and inequitable health outcomes for young people. It is therefore crucial that adult and children's NHS services, in line with what they are responsible for, plan, organise and implement transition support and care (for example, holding joint annual review meetings with the child/young person, their family/carers, the children's and adult service). This should ensure that young people are equal partners in planning and decision making and that their preferences and wishes are central throughout transition and transfer. NICE guidelines recommend that planning for transition into adult services should start by age 13-14 at the latest, or as developmentally appropriate and continue until the young person is embedded in adult services.
7.3	**Clinical Networks** All Providers will be required to participate in a networked model of care to enable services to be delivered as part of a co-ordinated, combined whole system approach.
7.4	**Essential Staff Groups** • Prosthetist & Prosthetic Technician. • Physiotherapist. All centres must establish a pathway to access the following staff if not available within the service: • Consultant in Rehabilitation Medicine. • Occupational Therapist. See also Appendix A.
7.5	**Essential equipment and/or facilities** • On site workshop with facility to fabricate, repair and maintain prostheses. • Facility for gait training and prosthetic assessment e.g. adjustable parallel bars. • Paediatric waiting area and clinical rooms separate to adult areas, and appropriate for children's use (can be organised as permanently separate areas or designated days within the service when only children seen in the relevant areas).
7.6	**Interdependent Service Components – Links with other NHS services** • Mental health and psychology services including counselling, psychotherapy, psychology and psychiatry based on need and assessment, • Nursing, • Orthotics,

	• Podiatry, • Diabetes management including diabetic foot teams, • Vascular surgery, • Orthopaedic surgery (adults, plus paediatric for centres providing paediatric prosthetic service), • Plastic surgery, • Chronic pain management, • Paediatric services, • DVLA approved driving assessment centre, • Wheelchair service provider.
7.7	**Additional requirements** **Information sharing** Sharing of service user information and data transfer will be required to ensure an optimal care pathway for each individual. This needs to take place in a safe and timely manner to facilitate best practice care and attainment of quality indicators. Providers must put in place local and regional mechanisms to achieve this, adhering to guidance from NHS Digital and General Data Protection Regulation (GDPR), and in line with the NHS Standard Contract. **Information reporting** All prosthetic centres will be contractually obliged to report on a standardised dataset at an agreed frequency. Obligations for providers to comply with these requirements are defined in the contract and include any consequences for both failure to provide information required and failure to achieve required standards. **Provision of information and support** In addition to the services mandated through the specification, the provider should be able to demonstrate that service users have access to the following information at the centre: • Information about the centre and the services provided including opening times, contact details and access. • Contact details of the named clinicians involved in their care. • Educational material as appropriate in written, video, digital or other format • Details of service user groups, support systems, national charities and organisations in relation to limb difference / loss. • Links to local and national amputee, prosthetic or disability activity, sporting or other relevant groups or events. • Details of sources of information on benefits, welfare advice and social support.

	The provision of this information should adhere to the NHS England Accessible Information Standard which aims to ensure that service users and service users, their carers and parents can access and understand the information given to them. This includes making sure that people get information in accessible formats and get support from a communication professional if needed. **Staff Training** All services must provide ongoing professional support and opportunities for training and development of staff.
7.8	**Commissioned providers** The list of commissioned providers for the services covered by this specification will be published in due course.
7.9	**Links to other key documents** **Clinical Commissioning Policies:** **Microprocessor Knees -** https://www.england.nhs.uk/publication/clinical-commissioning-policy-microprocessor-controlled-prosthetic-knees/. **Multi-grip Hand & Upper Limbs -** https://www.england.nhs.uk/publication/clinical-commissioning-policy-multi-grip-prosthetic-hand-all-ages/. **High Definition Silicone Covers** – not routinely commissioned https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/d01pa-hd-silicone-covers-oct15.pdf. **Direct Skeletal Fixation** – not routinely commissioned https://www.england.nhs.uk/publication/clinical-commissioning-policy-direct-skeletal-fixation-for-transfemoral-limb-loss/. BSRM (now BSPRM) Amputee and Prosthetic Rehabilitation 2018 – Standards & Guidelines 3rd Edition - https://www.bsprm.org.uk/resources/guideline-documents/. BACPAR – all publications - https://www.bacpar.org/publications/. NCEPOD report 'Lower Limb Amputation: Working Together 2014 - NCEPOD - Lower Limb Amputation: Working Together (2014). BAPO Service Provision Guidance for Prosthetic and Orthotic Services 2021- 1st Edition - https://www.bapo.com/wp-content/uploads/2025/02/BAPO-Service-Guidelines-2021-Website.pdf

	BAPO Standards for Best Practice 2024 - https://www.bapo.com/wp-content/uploads/2025/01/Standards-for-Best-Practice-2025-2.pdf A Better Deal for Military Veterans 2011 – Andrew Murrison – https://www.gov.uk/government/publications/a-better-deal-for-military-amputees A Best Practice Clinical Care Pathway For Major Amputation Surgery 2016 – Vascular Society - https://vascularsociety.org.uk/_userfiles/pages/files/qips/best-practice-care-for-major-amputation-april-2016.pdf

Appendix A

Staff Group Definitions

Sections 7.1, 7.4 and 7.6 detail staff groups that are and interdependent / linked services / staff groups.

The MDT (multidisciplinary team) is the team providing assessment appointments with the patient. The prosthetics team is a wider team who may or may not have direct patient contact or may see the patient separately from the MDT.

Prosthetists

Prosthetists are all registered Allied Health Professionals with the Health Professions Council and have undertaken an accredited training period of 3 or 4 years or equivalent with a degree in prosthetics and orthotics. Prosthetists should be conversant with the guidelines published by the British Association of Prosthetists and Orthotists (BAPO) and available on their website (www.bapo.com). Designated prosthetists should manage or oversee the prosthetic care of service users with the rarer types of limb loss (e.g. congenital limb difference or upper or multiple limb loss) in order to develop and maintain the specialist experience necessary to meet the needs of these service users.

Prosthetic Technicians

A Prosthetic technician's main role is to manufacture the various types of prosthetic devices (prostheses) supplied by their specialist rehabilitation service centre. Technicians are supplied with a measurement sheet, body cast, body tracing or a job card by a prosthetist. The technician will then be required to use their skills to manufacture the required prostheses, which can be manufactured using a wide range of materials, including plastics, metals, leather, carbon fibre, and composite materials. All of the prostheses manufactured are bespoke - designed specifically for each service user and may require multiple adjustments. Frequently the technician will be involved in the design stage. Given this is the case, on site workshop and manufacture of prostheses at the prosthetic centres is required. There are different levels of prosthetic technician including that of Prosthetic Support Worker.

Physiotherapists

Physiotherapists in a prosthetic service should be specialist and experienced in amputee management, including lower limb prosthetic training, have a good understanding of prosthetics, be able to look after amputees with complex problems, and be conversant with the evidence-based clinical guidelines produced by BACPAR. They should have established channels of communication and be able to liaise with and advise the physiotherapists in the referring and rehabilitating hospitals. Education of colleagues is particularly important. It is recommended that at

least one physiotherapist within each Centre has a relevant post-graduate accredited qualification in Amputee Rehabilitation and should be graded as a clinical specialist.

Consultant in Rehabilitation Medicine

A Consultant in Rehabilitation Medicine is a specialist in the assessment, diagnosis, long term health care planning and co-ordination of multidisciplinary input for rehabilitation needs, in particular those with complex and disabling conditions. Supporting medical staff may include Speciality Doctors and Higher Specialty Trainees in Rehabilitation Medicine undertaking training. The Consultant in Rehabilitation Medicine should have completed the accredited training for a Consultant in Rehabilitation Medicine (CCST or CST or CESR in Rehabilitation Medicine which includes training in Amputee Rehabilitation). A consultant should have experience in the relevant areas provided by their service, such as the management of congenital limb difference, complex and multiple limb loss and more specialised prosthetic techniques.

Occupational Therapists

Occupational Therapists should be specialist and be able to undertake training of lower limb service users in regard to safe transfers with or without a prosthesis on, prosthetic limb training for service users with upper limb amputation or limb difference, including training in one-handed activities where relevant. They also undertake training for activities of daily living for both upper and lower limb amputees and arrange home or school visits in liaison with physiotherapists and community therapists. A suitably experienced occupational therapist should be accessible to all centres. Occupational Therapists should be conversant with the guidelines produced by the Royal College of Occupational Therapists and be members of the Prosthetic Amputee Rehabilitation (PAR) forum.

Clinical Nurse Specialists

Clinical Nurse Specialists are nurses trained in the holistic care of amputees. They should have undertaken training in tissue viability and wound management and have a good understanding of prosthetics and amputee rehabilitation. The role of the CNS in rural areas incorporates the maintenance of close links between hospitals and the prosthetic centres.

Rehabilitation Engineers

A Rehabilitation Engineer advises on technical matters related to the quality, risk management, maintenance, assessment and disposal of prosthetic devices. Rehabilitation Engineers can be either Clinical Scientists or Clinical Technologists. The former are registered under the Health and Care Professions Council, the latter are registered on the Voluntary Register of Clinical Technologists, after completing training schemes with the Institute of Physics and Engineering in Medicine. Registrations are under review by the Academy of Healthcare Science.

Orthotists

Orthotists are all registered Allied Health Professionals with the Health and Care Professions Council and have undertaken accredited degree education with a recognised UK or overseas University. Orthotists should be conversant with the guidelines published by the British Association of Prosthetists and Orthotists (BAPO) and available on their website (www.bapo.com). Within their HCPC registration they are qualified and able to assess, diagnose, prescribe, and provide appropriate orthotic treatment.

Assistant Practitioner

Assistant Practitioners act under the guidance of a qualified registered healthcare professional. The role can be very varied depending upon the area in which the person is employed.

Healthcare Assistants

Healthcare assistants act under the guidance of a qualified registered healthcare professional. The role can be very varied depending upon the area in which the person is employed. Their role includes: washing and dressing, feeding, helping people to mobilise, toileting, generally assisting with service users overall comfort, monitoring service users conditions by taking temperatures, pulse, respirations and weight.

Podiatrists

A Podiatrist should be available, particularly to provide care for the remaining foot in unilateral lower limb diabetic or dysvascular amputees, or appropriate links with local podiatric services must be established.

Psychologists / Counsellors

A counselling or psychology service must be provided by the centre, either on site or via referral to another centre or service. Although basic counselling will indirectly be provided by many members of the Amputee Rehabilitation team, service users in all services should have the option of seeing a counsellor or psychologist. They should also be available to see relatives or carers of the amputee. A psychologist will have registration with the Health and Care Professions Council, should have experience in dealing with the particular problems of service users with physical disabilities and should be readily available to see selected service users.

Dietician

Provides counselling regarding nutrition issues to improve health, aid in optimal weight maintenance and healthy living.

Employment advisor / Vocational Rehabilitation Service

Appropriate links should be established with the local Disability Employment Advisor as early as possible for those amputees employed at the time of becoming an amputee. Ideally, there should be access to Vocational Rehabilitation. There is a higher incidence of amputees returning to work in mainland Europe where Vocational Rehabilitation is better established.

Peer Group Volunteers

Peer volunteers facilitate and support individuals or groups of people with similar long-term conditions or health experiences to come together. The power of this lies within their own lived experience and being able to connect people with shared experience to create an encouraging, inspiring and safe space where individual differences are recognised in an environment where everyone can contribute. They are empathetic, with good listening skills. They will also encourage access to clinical advice and support when there is an unmet medical need, helping to ensure individuals get the right kind of support they need at the right time. Consideration should be given to how those involved are fully supported to participate – both service user and peer mentor volunteer. Refer to NHSE ‘Supported Self-Management: Peer Support Guide’ published 1 September 2023 and updated 15 September 2023.

Appendix B

Type of consultations offered by an amputee and prosthetic service

Consideration should be given as to whether a face to face consultation is required, or whether a telephone and/or video consultation is appropriate.

Pre-natal consultation

A congenital limb difference (previously termed deficiency or defect) may be identified in utero during antenatal scanning. If this occurs, a referral to an appropriate amputee and prosthetic service should be offered where a pre-natal MDT consultation can take place with the prosthetic team, paediatrician if possible and parents. Appropriate advice and/or input can be issues and plans made for follow up after birth. Expectations and outcomes should be discussed.

Pre-amputation consultation

This is only applicable if an amputation is planned electively. In these circumstances, a service user should be referred to the most appropriate prosthetic centre for a pre-amputation / pre-natal consultation and appropriate advice and/or input should be issued. Referrals should be made by the obstetrician, GP or surgeon depending on circumstances. The relevant members of the MDT should be present or available with, if possible, the referring surgeon. Prosthetic expectations, outcomes and complications must be discussed.

Initial consultation

This is the initial consultation that takes place post amputation and should be an MDT based assessment. More input is required for those that have not undergone a pre-amputation consultation. During the consultation prosthetic expectations, outcomes and complications must be discussed. The process of assessment for suitability for prosthetic use and appropriate goal setting should be explained to the service user and this is the period of most intensive rehabilitation and input for the majority of service users.

Congenital limb differences that are identified at birth (rather than in utero) may also be referred for initial consultation. These referrals may be initiated by an obstetrician, paediatrician, paediatric orthopaedic or plastic surgeon, GP, specialist nurse or AHP related to paediatric care. Referral to the appropriate specialist services should be offered and an MDT assessment offered. Provision of a prosthesis may not be appropriate at the time of initial consultation but advice, information and planned follow up should be given, and other appropriate inputs such as OT and counselling. Expectations and outcomes should be discussed.

MDT consultation

An MDT consultation consists of more than one relevant members of the MDT (rehabilitation medicine consultant, prosthetist, physiotherapist, psychology, OT, nursing) as required. Such consultations may be appropriate for review of service

users with specific needs both within particular service user groupings (paediatric, congenital, multiple loss) and more complex needs (for example, physical and mental health co-morbidities, psychosocial issues, persistent difficulties with socket fit, satisfaction with prostheses or pain).

Combined consultation / clinic

The combined clinic must include a consultant in prosthetic medicine and the consultant in the relevant speciality (this may include vascular, orthopaedic, paediatric orthopaedic, plastic surgery or a medical sub-speciality). Access to the other members of the MDT should be available (prosthetists, physiotherapists, psychology, OT, nursing). These clinics can either be run as a regular clinic or on an as required basis.

Second opinion consultation

A second opinion consultation is undertaken by an alternative prosthetic centre to that which a service user usually attends. The referral could be received from another centre, or clinicians in primary or secondary care. The reviewing team should include members of the MDT team to appropriately meet the concerns highlighted within the referral. Required information and processes for the referral should be agreed between centres, including use of standardised templates or forms to achieve appropriate and consistent information sharing to aid consultations.

Transfer in consultation

The team should include as a minimum the consultant and prosthetist. Other members of the MDT should be available as required.

Review appointment – solo or joint

May be with any of the clinicians who have seen the service user previously. Joint appointments can combine reviews from various members of the MDT, either seeing the service user together if required or in succession.

Prosthetist appointments:

Cast and measures appointment

Appointment with prosthetist to cast and measure for a new or replacement socket. This may be combined with the primary appointment if the service user is ready to proceed to casting.

Fitting +/- Delivery appointment

Appointment with prosthetist to fit a new socket or limb. If the fitting is satisfactory and limb is finished, delivery of the limb (i.e. handing over the limb to the service user for use) will be included.

Joint Cast & Measure and Delivery appointments

For production of sockets within the day where relevant.

Examination with the prosthetist

A review appointment which may be utilised for a variety of purposes depending on service user need.

Minor repair

This usually refers to jobs that can be completed on the day. For example lining a socket, shortening/lengthening a limb by cutting/replacing a tube, removing a cover to adjust alignment, altering the setting on a knee or trimming a socket. Upper limb – replacing a cosmetic glove, easing a socket.

Major repair

This covers more extensive work usually requiring that the limb is kept in the workshop with an additional appointment required to deliver the limb. For example – keeping a limb in to replace/shape a cosmetic cover, repair of a cracked socket that may need an additional lamination, replacement of a major component – although this can often be done in a day the component will usually need to be ordered in from the manufacturer, dismantling the socket in order to realign – fitting may be required.

Parts only order

The prosthetist orders items e.g. liner/lubricant spray/utilities to be collected by the service user.