



Associate Parliamentary Limb Loss Group

for the promotion within Parliament and Whitehall of the PREVENTION OF LIMB LOSS and the provision of prosthetic, orthotic, wheelchairs & special seating and other vital rehabilitation services/technologies for ALL PERSONS WITH LIMB LOSS in the UK and Internationally.

Helping to Deliver

PATIENT LED ORTHOTIC SERVICES

with the support of this

Patients Charter

YOU SHOULD EXPECT

Ease of referral

Adequate length of time for appointments

Involvement of technicians in complex cases

Timely appointments and notification of delays

Your local Orthotics provider to be easily accessible

Choice and information about new innovative products

Appropriate and accurate prescribing to meet your individual needs

For repeat problems involvement of technicians and/or manufacturers on site

£1 spent on Orthotics – your NHS saves £4

HISTORY OR MUCH ADO ABOUT NOTHING

For many years sensible and well-researched recommendations for improving Orthotic services have been made. Successive Governments have endeavoured to secure improvements - but these have been circumvented by the financial pressures on NHS staff and resources and “every New Minister” organisational changes.

In 1991 a Disabled Living Foundation report detailed longstanding problems in the provision of therapeutic footwear.

In 1992 Bowker et al provided a critique of Orthotic services commissioned by the Department of Health.

In 1995 the NHS Executive in “Contracting for Orthotic services” made a series of valid comments.

In 1999 the British Society of Rehabilitation Medicine (BSRM) made recommendations.

Also in 1999 the [emPOWER](#) consortium, with the support of the then Health Secretary John Hutton, called for the introduction of a National Service Framework for Rehabilitation Services specifically including Orthotics.

In 2000 the Audit Commission report concluded that “serious shortcomings remain in many parts of the country in the quality of services received by 400,000 users”.

In 2002 the Audit Commission found that “progress in improving orthotics service were disappointing.”

In 2004 the NHS PASA Orthotic Pathfinder (Business Solutions) report recommended direct GP Access and highlighted that for **every £1 spent on Orthotic services your National Health Service saves £1.**

In 2009 the York Health Economics Consortium concluded that, early Orthotic intervention improves lives and saves money, but Orthotic Services generally still receive a low priority.

Results of such reviews to date have been a brief spell of increased top management and political interest, perhaps with temporarily increased resources, and then a lurch back to the scene as before but with increasing disillusionment among staff and patients who see the management share of budgets increasing and the “hands-on” Operational share decreasing. HENCE THE CONTINUING NEED FOR THIS USERS’ CHARTER.

FOREWORD

Throughout England, Scotland, Wales and Northern Ireland this Patient’s Charter seeks to help promote the provision of the highest quality of orthotic, prosthetic, wheelchairs & special seating, and other vital rehabilitation services/technologies for all persons with orthotics needs.

Focusing on Orthotics (there are related Charters for Prosthetics and for Wheelchairs & Special Seating) this Charter applies to the provision of Orthotics Equipment and Services in the full variety of settings,- National Health Services, Contractors to National Health Services, and last but not least Third Sector and Voluntary Services.

It is expected that regard will be had to this Charter in invitations to tender, other contract documents and reviews of services.

This Charter sees the provision of adequate resources, and continued professional development for healthcare professionals, as essential to enable all concerned with Orthotic Services *“to provide the right care, at the right time, and to the right quality without unnecessary delays.”*

It recognises the obligations on Patients constructively and courteously to seek to abate and not to add to the increasing pressures on caring Providers. To enable patients to support such obligations, it is expected that all NHS Trusts and Authorities will have, and will have prominently published and implemented, “zero tolerance” behaviour policies. A Conciliation Officer should be available for each site to whom either the Patient or the member of Staff or Both may refer any irresolvable difficulties.

This Charter applies to the provision of the full range of Orthotics including CALLIPERS, BRACES, KNEE-ANKLE-FOOT ORTHOSES (Kafos), NECK COLLARS, CORSETS and SPECIALIST FOOTWEAR INCLUDING SHOE INSERTS AND INSOLES,

CLINICAL BENEFITS

The following are among the clinical areas where Orthotic Services have a beneficial impact, support pain relief and prevent deterioration of associated joints.

- Rheumatoid arthritis and osteoarthritis
- 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
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CONSULTATION WITH PATIENTS

Alongside legislative duties, good business practices and goodwill join together Patients and Managers and all other staff concerned, collaboratively in the

- Planning and provision of services;
- Development & consideration of proposals for changes in the way services are provided;
- Decisions affecting the operation of services.

USING PATIENT FEEDBACK TO TRANSFORM CARE

Commissioners are required to receive from Providers the feedback Providers positively gather from Patients and to obtain evidence that such feedback is being used further to improve care. We welcome the actions by all National Health Services to understand and improve Patient experience. *Real-Time* Patient feedback is seen as a most beneficial addition to the range of more remote questionnaires and surveys.

REHABILITATION FOR LIFE AND FOR INDEPENDENT LIVING

Each Patient within the ambit of this Charter must have access at his/her Centre to a Consultant in Medical Rehabilitation Services.

Rehabilitation should be multi-disciplinary; for all age groups; address physical, mental, social, emotional and spiritual needs; and seek retention of or return to as independent a life as possible. *“Sometimes the emphasis is on remaining at or returning to work; the role of early diagnosis and intervention will be of great importance here, as will be the various Government to assist people in the workplace. In other circumstances, rehabilitation will focus on personal or social aspects such as study, family or caring responsibilities or active retirement.”*

Services offered by third sector and voluntary organisations can be as important as those available directly through health and social care.

UN CONVENTION ON RIGHTS OF PERSONS WITH DISABILITIES

Relevant Rights within the United Nations Convention on the Rights of Persons with Disabilities must apply, including those Rights listed in **APPENDIX A**.

EQUAL OPPORTUNITIES AND HUMAN RIGHTS

Patients are committed to supporting equal opportunities for all, irrespective of age, disability, gender, marital status, race, religion & belief, sexual orientation, transgender and working patterns, all with openness and transparency of process. “Staff should receive regular training in Human Rights principles and positive duties and how they apply to their work”, so that Human Rights are mainstreamed. Keywords, mutually applicable, are dignity, fairness, respect and equality.

CONSULTATION WITH USERS AT EACH SERVICE CENTRE

Management at each Service Centre should proactively and continuously facilitate, within the Centre's arrangements for total Consultation, the forming and sustaining of a User-Led Group by the provision of publicity, accommodation, travel/carer support and secretarial services. Each such Group will proactively and continuously and courteously collaborate with Management. As required by law, Consultations must be real and not just procedural. A Key Action is to "Find ways of involving patients and their carers in planning services."

The foundation stone of effective consultation is the Centre's ANNUAL BUDGET and INCOMES/EXPENDITURES outcomes. Each Centre should publish annually to its User Group its Business Plan, including the following:

Total Patients	Components	Cosmesis	Services	Total Budget	Per Patient
No.	£	£	£	£	£

OPPORTUNITIES FOR COMMISSIONERS

Post-code lotteries - sadly despite the best endeavours of all concerned to see their removal – continue to be widespread. Your service will vary according to where you live. Choice is illusory when you cannot easily travel beyond your local Centre.

Orthotic Services, as the Pathfinder Report reminded us, may be unsatisfactory because:

- There are unexplained variations in all aspects of service provision around the country, bearing little relation to underlying levels of need;
- Quality of services requires a considered view of the contribution that equipment services can make to the overall needs of the population.
- Increasing patient needs are unmet because of finance restrictions and constant pressure on budgets and staff, which inevitably mean less rather than more.

This Charter shares the recognition that the National Health Services may historically have focussed on commissioning for volume and price, rather than quality and outcomes.

This Charter, in accord with the Specialised Definition Set for People with Complex Physical Disabilities, supports effective commissioning by further sharing knowledge about high quality clinical outcomes so that:

- the right patient (clear patient selection criteria and referral guidelines) is offered
- the right treatment (evidence based, clinically and cost effective interventions, in the appropriate setting) by
- the right provider (monitored against agreed service/clinical quality standards) in
- the right place (optimising geographical access but avoiding unnecessary duplication of provision)
- at the right cost (robust costing and information systems and demonstrable value for money)
- with the right-full involvement of the patient (adequate information to enable supported choice).

QUALITY OF CARE

The Patient assesses Quality of Care by its Effectiveness – the extent to which, and the quality with which, his/her needs and expectations are met. Effectiveness requires Services to be organised and managed around Patient and Carer needs and to deliver maximum possible health and independence for both adult and child patients.

Health Professionals should, subject to health and safety requirements, advise the Patient of the optimum solutions to his/her needs. Such advice should not be compromised by resource constraints, although regard must be had in the short-term to any such constraints. The only eligibility criteria must be the clinical, lifestyle and culturally appropriate needs of each individual Adult Patient or Child Patient with his/her Carers/Families. Prescriptions must avoid discrimination.

SERVING PERSONNEL AND VETERANS

Veterans are guaranteed by Government priority for service-attributable out-patient and in-patient treatment. They are entitled to a duplicate orthosis. They are entitled to reimbursement by their National Health Service Centre of travel expenses and any loss of earnings. Government guarantees include:

- The standard of Orthotics provision to injured personnel by the Defence Medical Services will as a minimum be matched post-service by the National Health Services in Great Britain.

- We will raise awareness with healthcare professionals – including drawing attention to priority treatment for Veterans with Service-attributable conditions.

TALKING THERAPIES

The following in no way implies that there are not benefits from “talking therapies” but there are recognised risks. Patient problems may originate because the Orthotic services Provider, because of inadequate resources, cannot meet all the needs essential to the Patient’s wellbeing. In such instances, the decision (by whom?) to refer the patient for talking therapies, may not be productive. Hopefully the patient spends most of his/her life away from Hospital or Service Centres.

Therapy services are now available from General Practitioners. Referral to/through the Patient’s General Practitioner should enable the total Community picture of the Patient’s lifestyle to be taken into account and all necessary health and community services brought into play collaboratively. Patient-led support groups and “Buddy” services and Volunteer Visitors are key team players.

THE REHABILITATION TEAM

Assessment for the Orthosis or Orthoses should be undertaken by the named Orthotist appropriately, organisation and resources permitting, after consultation with all Members of Staff (the Rehabilitation Team) concerned with the rehabilitation of the Patient. The Orthotist should share any written Report of Assessment with the Patient (or for a Child the Parent / Carer), which should, with his/her consent, be circulated to all relevant parties.

The needs for Services and Technologies additional to Orthotics because of additional problems should be addressed. Regrettably, where there is fragmentation of services, Orthotists may feel undervalued, and work in isolation from other allied health professionals.

GOALS & PROMS

Collaborative, realistic, and attainable Goals must be set and agreed. The patient cannot decide /demand these independently. In some instances a, Wheelchair, Special Seating, and/or other Assistive Technologies, may need to be (included in) the appropriate Prescription. Groups and Individual Patients should take a supportive interest in, and should be enabled to share in, the development and application of, *Patient Related Outcome Measures (PROMS)*.

PRESCRIPTION

Prescription must be undertaken by an appropriately qualified Health Professional, who may be working individually or within a team setting. Simple provision of treatment may be undertaken by an Assistant working within agreed protocols of care under the direction of the Health Professional, with clear lines of responsibility and oversight in place.

Each Prescription should be individually formulated to suit the Patient’s rights and needs and lifestyle and goals. If, because of lack of funding or pressure on resources, the most appropriate solution cannot be provided, the reasons must be fully documented by the Orthotist in a written Report of Prescription and circulated to all concerned.

SUPPLY TIMESCALE GUIDELINES

The following are the maximum reasonable timescales to provide an adequate service to Orthotics Patients, who attend as out-patients. It is expected that a modern cost-effective organization that promotes customer service will be able further to improve on these timescales.

For clarification, these timescales are from the appointment at which the orthotic solution is specified until the satisfactory delivery or fitting to the Patient.

<u>Orthosis</u>	<u>Timescale</u>	<u>Usual number of fittings</u>
AFO)	10 working days	2 fittings
KAFO) --		
Spinal)		
Bespoke Footwear (Including adapted stock footwear)	25 working days	2 fittings
Stock Footwear	15 working days	1 fitting

These timescales are for routine cases. Clinically dependent, high-risk, and discharge-dependent cases will require much shorter timescales.

SUPPLY OF DUPLICATE ORTHOSES AND FOOTWEAR

It is important that Orthoses such as KAFOs are supplied in duplicate and alternated by the user both for hygienic reasons and to avoid an intolerance developing to any slight change such as occurs when a replacement is required.

Similarly the Patient must always have at least one spare pair of footwear so the footwear can be alternated for hygienic reasons and to allow for repairs or drying of footwear which gets wet in bad weather.

These minimum provisions of duplicate orthoses and footwear were prescribed in the National Health Service publication, "Provision of Medical and Surgical Appliances, MHM 50". The following is reproduced from MHM50:

"APPLIANCES SHOULD ALWAYS BE PROVIDED IN DUPLICATE WHEN-

- a. THE PATIENT WOULD, WHEN THE APPLIANCE BECAME UNSERVICEABLE, BE UNABLE TO CONTINUE HIS EMPLOYMENT OR OTHERWISE SUFFER HARDSHIP; OR**
- b. THE PROVISION OF 2 APPLIANCES IS NECESSARY ON MEDICAL OR HYGIENIC GROUNDS**

Examples of where duplication is justified are calipers and fabric supports. Two pairs of surgical footwear should be the minimum and the provision of a third pair should be authorized where there appears to be a genuine need. For instance, if the Patient's employment requires him to do a lot of walking or otherwise causes excessive wear and tear to his boots or shoes. It may also be justified to provide a third pair of footwear for youngsters with active recreational pursuits. Each case should be judged by the prescribing consultant on its merits."

Although MHM50 is no longer current, it is important that standards are not allowed to fall below the above minimum provision.

REPAIRS AND MAINTENANCE

In support of the defined mechanism for Repairs & Maintenance, including regular reviews, Patients and Carers must keep the service informed of any relevant changes in their personal circumstances.

PATIENT PATHWAYS AND PATHFINDING

The needs of the individual Patient will change, or new assistive technologies will become available. The Service must provide the most appropriate Orthoses for the individual Patient throughout each stage of his/her lifetime pathway. On the other hand it must be appreciated that not all equipment/prescriptions are "for life", and that review may indicate mutually beneficial cessation of service.

The Patient must if s/he wishes to be enabled to see the same Orthotist on each appointment. The Patient's transition from childhood to adulthood must be secured without any gaps or lack of clarity in responsibilities.

On request by the Patient in consultation with his/her General Practitioner, there should be Reasonable and Fair Access to a Centre other than that nearest to the Patient.

WORKFORCE PLANNING

There appear to be no nationally agreed guidelines for workforce planning. It is suggested that, excluding management and consultation responsibilities, the following guidelines for minimum national standards for workforce planning are required for 3,500 appointments per year.

Actual staffing numbers required for each location should be varied pro rata as the actual appointments per year vary for the location concerned. The standards must apply whatever the form of management organisation, otherwise inequitable post-code prescribing and variations in service levels will continue.

The suggested workforce planning guidelines for 3,500 appointments per year are:

Principal Orthotist	1
Orthotists	2
Medical Technical Officer	1
Technician/Assistant Support	3
Administration/Reception	2

CONTINUED PROFESSIONAL DEVELOPMENT

Invitations to tender and service agreements should provide for and show transparently “Continued Professional Development requirements” for all staff. Delivering the workforce skills to meet Patient rights and needs requires, for all Allied Health Professionals involved, sustained opportunities for Continued Professional Development, and clear career “stepping stones”.

Undergraduate and Postgraduate studies and training need to be accessible regardless of distance both geographically and academically. Workforce planning and practice must facilitate:

- Involvement of Orthotists in clinical/planning responsibilities and requisite post-graduate training leading to the appointments nationally of Consultant Practitioners;
- Opportunities for Technicians and Assistants to qualify for and achieve appointments as Consultant Technicians/Assistants or the relevant ISPO Category and to take Foundation Degrees;
- Opportunities for Administrators further to enhance their Management skills and achieve additional responsibilities.

RESEARCH AND DEVELOPMENT

Invitations to tender and service agreements should provide for and show transparently Research and Development requirements and percentage of total budget funding. Resultant best practices should be shared nationally through the Knowledge Sharing Network for People with Complex Physical Disabilities.

Staff should be enabled to introduce Innovations in technology and in practice with minimum delay. Beneficial developments and knowledge achieved locally should be made available to patients nationally. Listening to Patients and seeking their views will ensure that problems seek solutions and not vice-versa.

NOT A BLUEPRINT

This Charter is a pathway partnership to sharing improvements and best practices – not a blueprint for how services should be delivered. It recognises the need for mutual respect and support among patients/families/carers, and the providers of services whose skills and commitment are essential to maintaining the right mix of incentives, transparency, plurality of providers, specialised commissioning, practice-based commissioning and patient choice and consultation.

APPENDIX A (which is an integral part of this Charter)

Extracts from the United Nations General Assembly Convention on the Rights of a Person with Disabilities, Resolution number 61/106 dated 24th January 2007. For a full copy of this convention see <http://www.un-documents.net/a61r106.htm>

Article 3 - General Principles

The principles of the present Convention shall be:

- a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
- b) Non-discrimination;
- c) Full and effective participation and inclusion in society;
- d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- e) Equality of opportunity;
- f) Accessibility;
- g) Equality between men and women;
- h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Article 9 - Accessibility

1. To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:

- a) Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;
- b) Information, communications and other services, including electronic services and emergency services.

2. States Parties shall also take appropriate measures:

- a) To develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public;
- b) To ensure that private entities that offer facilities and services which are open or provided to the public take into account all aspects of accessibility for persons with disabilities;
- c) To provide training for stakeholders on accessibility issues facing persons with disabilities;
- d) To provide in buildings and other facilities open to the public signage in Braille and in easy to read and understand forms;
- e) To provide forms of live assistance and intermediaries, including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public;
- f) To promote other appropriate forms of assistance and support to persons with disabilities to ensure their access to information;
- g) To promote access for persons with disabilities to new information and communications technologies and systems, including the Internet;
- h) To promote the design, development, production and distribution of accessible information and communications technologies and systems at an early stage, so that these technologies and systems become accessible at minimum cost.

Article 17 - Protecting the integrity of the person

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

Article 19 - Living independently and being included in the community

States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

- a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

- b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
- c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

Article 20 - Personal mobility

States Parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities, including by:

- a) Facilitating the personal mobility of persons with disabilities in the manner and at the time of their choice, and at affordable cost;
- b) Facilitating access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost;
- c) Providing training in mobility skills to persons with disabilities and to specialist staff working with persons with disabilities;
- d) Encouraging entities that produce mobility aids, devices and assistive technologies to take into account all aspects of mobility for persons with disabilities.

Article 25 - Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

- a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;
- b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
- c) Provide these health services as close as possible to people's own communities, including in rural areas;
- d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
- e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
- f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Article 26 - Habilitation and rehabilitation

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

- a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;
- b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.