The AHSN Network

Oxford Academic Health Science Network

Musculoskeletal, Falls, Fractures & Frailty

A summary of projects from across the AHSN network

Contents

Foreword

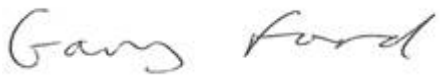
The areas of musculoskeletal (MSK), falls, fractures and frailty are priority areas within the NHS. Collectively they have a major detrimental impact on patients, families and carers, and are a major cost to the NHS. With a growing and ageing population, health and social care services need to be proactive in their response to this challenge. Whilst many different clinical pathways and services are provided to manage these four problems there are clear links between them.

Across the 15 Academic Health Science Networks (AHSN) there is a wealth of experience and practical skills in working with NHS organisations to improve clinical services in these clinical pathways, with service evaluation projects that have been shown to improve patient outcomes and deliver more efficient use of resources. This document has been compiled to show case these projects.

We very much hope this document will help shape discussions with STPs, commissioners and providers regarding the work that could be undertaken to improve services and patient outcomes in these areas, and enable others to implement and / or build on an existing, proven concept. Each project has been summarised and contact details provided to learn more about the work described.

The projects included in this document have been separated into 4 sections; musculoskeletal (MSK), falls and fractures, frailty and projects covering more than one area. Each section contains a mix of projects that have been fully implemented and reported on, those that are currently being implemented, and projects that are in the development and scoping phase.

I would like to thank the many AHSN colleagues who took the time to provide details of the work they are involved with and for their input into developing this report.



Prof Gary A Ford, CBE, FMedSci

Chief Executive Officer

Oxford Academic Health Science Network

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Understanding the Issues – NHS RightCare

Due to the breadth and complexity of the conditions and their corresponding pathways, it can be difficult to pin point the area that should be the focus of improvement work. NHS RightCare can help organisations to identify these areas (https://www.england.nhs.uk/rightcare/).

NHS RightCare provides advice and data to local health economies to make the best use of their resources, understand their performance and focus on areas of greatest opportunity. Ultimately it aims to ensure the best possible care is delivered as efficiently as possible.

Every CCG in England has an allocated Delivery Partner to help implement the RightCare approach.

Section 1: Musculoskeletal

Musculoskeletal conditions, of which there are more than 200, affect the joints, bones and muscles, and also include rarer autoimmune diseases and back pain. People live with musculoskeletal disability for more years than any other long-term condition. MSK conditions:

- Affect 1 in 4 of the adult population – approximately 9.6 million adults
- Account for 30% of GP consultations in England
- Have a huge impact on quality of life of millions of people
- Result in approximately 10 million working days lost
- Are associated with many co-morbidities, including diabetes, depression, obesity
- Account for over 25% of all surgical interventions in the NHS, which is set to raise significantly over the next 10 years (Arthritis Research UK, 2013)

The impact of MSK conditions on people cannot be underestimated, nor can the corresponding impact on NHS resources. MSK conditions can require the input from many different specialty teams, can span different providers and cross primary, community and secondary care sectors. A comprehensive, well delivered MSK pathway will improve outcomes and be cost-effective. Key components include:

- Emphasis on prevention
- Early diagnosis and intervention, particularly for inflammatory forms of arthritis
- A patient-centred approach including rehabilitation, reablement and self-management, with a focus on patient empowerment
- Smooth transition and referral across organisational boundaries

As well as the specific projects detailed in this report, a wealth of information can be found on:

https://www.england.nhs.uk/ourwork/ltc-op-eolc/ltc-eolc/our-work-on-long-term-conditions/si-areas/musculoskeletal/

http://arma.uk.net/msk-clinical-networks-project/msk-clincal-networks-national-seminar/

The following pages contain details of the MSK projects the AHSNs are working on across the country.

Project 1:	**ESCAPE-pain** **(Enabling Self-Management and Coping with Arthritis Pain using Exercise)**
Delivered by:	Health Innovation Network South London
Other AHSN regions working with the ESCAPE-pain programme:	West of England Academic Health Science Network eahsn Eastern Academic Health Science Network Kent Surrey Sussex Academic Health Science Network INNOVATION AGENCY Academic Health Science Network for the North West Coast ACADEMIC HEALTH SCIENCE NETWORK NORTH EAST AND NORTH CUMBRIA

Setting	Overarching aim
Primary Care / Community.	To reduce demand for primary care or secondary care appointments through improved self-management.

ESCAPE-pain Programme

ESCAPE-pain is an evidence-based, clinically and cost-effective rehabilitation programme for people with chronic joint pain. It is designed for people over 45 years and who have had knee and / or hip pain for at least 6 months, who usually have a diagnosis of osteoarthritis, and who are able to exercise. The programme integrates simple education, self-management and coping strategies with an exercise regime individualised for each person. Robust and independent evaluation has shown that the service:

- Reduces pain
- Improves physical function
- Improves psychosocial consequences of pain
- Reduces healthcare and utilisation costs

The programme is typically facilitated by physiotherapists in outpatient departments, but can also be delivered in the leisure and community sector by fitness professionals. The programme is delivered to small groups of people twice a week for six weeks (12 sessions). Each session comprises two components:

- Education component where people learn about the problem, what may be causing it, why they experience pain and simple ways to cope and self-manage their problems

- Exercise component where people undertake a progressive exercise programme tailored to each individual's needs and abilities

Interviews with participants describe their positive experiences of the programme, how it helped them to understand what (not) to do, how to do exercises and what they can achieve (Hurley, 2010). These have been captured in a short unscripted video with ESCAPE-pain participants at https://player.vimeo.com/video/151535343.

ESCAPE-pain has attained multiple endorsements:

- Featured within NICE clinical guideline (CG177) for the management of osteoarthritis
- Highlighted for patients on the NHS Choices osteoarthritis webpage
- Recommended as a self-management resource by NHS RightCare
- Recommended by Public Health England in their report 'Return on Investment of Interventions for the Prevention and Treatment of Musculoskeletal Conditions' (positive ROI of £5.20 for every £1 spent on the intervention)
- Featured as a NICE Quality Innovation Productivity and Prevention (QIPP) case study
- Highlighted as a Tier 3 intervention in Arthritis Research UK's 'Providing Physical Activity Interventions for People with Musculoskeletal Conditions' report
- Included in the Richmond Group's 'Doing the Right Thing' report

With support from the HIN, the ESCAPE-pain programme has been spreading across the county; as per November 2017 it is running in 40 sites. The HIN offers training packages for clinicians and fitness instructors and a range of bespoke implementation resources to help NHS and leisure sector organisations to set up and run the ESCAPE-pain programme. The originator of the ESCAPE-pain programme, Professor Mike Hurley, is the Clinical Director for MSK at the HIN.

The effectiveness of the ESCAPE-pain programme being run outside of NHS settings and within the leisure and community sector was tested in 2015, and the programme has been offered regularly in the leisure sector since then.

West of England AHSN project

The West of England AHSN was interested in understanding the effectiveness and success of taking an 'off the shelf' project and implementing it locally within non-healthcare settings, compared with the original programme. The AHSN funded and coordinated a pilot with South Gloucestershire CCG consisting of four Plan, Do, Study, Act (PDSA) cycles. The evaluation of this is being undertaken throughout October and November 2017 and is due to be reporting in January 2018:

- To understand if participation in the ESCAPE-pain programme in community settings improves patient reported outcome measures and function
- To test whether the programme could be delivered by exercise professionals in leisure centres, as opposed to traditional delivery by physiotherapists
- To test the effectiveness of the pilot process from referral to completion of the programme
- To understand if the programme can be delivered in non-healthcare settings and be as effective as

the original model

Impact

The ESCAPE-pain programme has a robust evidence base, the papers for which can be found following the web links given below. The key points to note include:

Clinical Effectiveness

- Significant improvements in patient-reported physical function immediately after treatment and at 6 months after the programme, compared to patients being managed in primary care alone (as measured by WOMAC-func – Western Ontario and McMaster Universities Osteoarthritis Index physical function sub-score)
- The improvements in physical function are still evident 30 months following completion of the programme, but do decline over time
- Patients undergoing the programme reported reduced anxiety and fear of activities, along with an increased knowledge and understanding of their condition and the importance and value of exercise in the management of pain

Financial Benefits

- Cost-effectiveness analysis has shown the ESCAPE-pain knee programme has a high probability (81-100%) of being more cost-effective than usual primary care management
- The programme produces savings by treating patients in small groups compared with individually, without compromising clinical effectiveness; these savings have been calculated at £2675 per 100,000 population
- Over 30 months post-intervention, patients undergoing the programme incur lower utilisation of healthcare resources and lower healthcare costs (of over £1000) compared to those patients managed by analgesia in primary care
- Wider potential savings include reduced demand for consultations, referrals, investigations such as x-rays and MRI scans, and reduced use of analgesia; however, such savings are variable between individuals

Funding Required

ESCAPE-pain Programme

HIN has invested in the ESCAPE-pain programme since 2013, allocating project management and clinical leadership resources to support the spread and adoption of the programme, and has developed a range of implementation resources that can be shared.

West of England AHSN project

West of England AHSN provided non-recurrent funding for this project and the evaluation, plus 0.2wte quality improvement input and 0.1wte project support.

Reports / Resources

http://escape-pain.org/about-escape/evidence

http://atlas.ahsnnetwork.com/implementing-escape-pain/

http://www.escape-pain.org/about-escape/awards

https://www.nice.org.uk/savingsandproductivityandlocalpracticeresource?id=2597

https://www.ncbi.nlm.nih.gov/pubmed/19627690

For further information

ESCAPE-pain Programme

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West of England AHSN project

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Project 2:	**MSK Programme** **ESCAPE-pain** **Joint Pain Advisor** **Back Pain Forum**
Delivered by:	Health Innovation Network South London

Setting	Overarching aim
Primary Care / Community.	To improve outcomes for patients with joint pain through variety of work streams, with a focus on self-management.

See above for information on ESCAPE-pain programme.

Joint Pain Advisor

Joint pain is the second most common reason for people visiting their GP, however GPs do not always have the time to deliver the NICE core recommendations (CG177) effectively and report feeling overwhelmed by the volume of patients presenting with joint pain (Arthritis UK, 2014; Bishop et al, 2013).

Joint Pain Advisor is a series of one to one, face to face consultations to support people with osteoarthritis of the knee or hip and those with chronic back pain. It is a tailored self-management educational approach to help people improve and manage their pain through simple exercise, diet and weight loss (if needed) plus additional signposting to community / welfare services if required. A variety of professionals / roles can be trained as advisors, e.g. physiotherapists, health trainers or champions, social prescribing navigators or voluntary outreach workers.

The model takes the form of up to 4x30 minute consultations between the advisor and patient, with lifestyle, challenges and goals discussed. A personalised care plan is developed jointly, which includes patient-specific advice and support based on the NICE guidelines. The model has been piloted with 600 patients across two sites, with plans for a further two sites to participate in late 2017 / early 2018. Joint Pain Advisor is endorsed by NICE as an effective intervention that support NICE CG177: Osteoarthritis: care and management.

The pilot study has been evaluated and the key findings are presented in the impact section below.

Back Pain Forum

This quarterly forum was set up to address an identified need for a regular event to showcase innovative interventions, share information and ideas, collaborate and explore possible solutions to help patients manage their back pain. It is open to professionals who work with patients with back pain, have an interest in back pain or who commission services.

Impact

Joint Pain Advisor

The pilot study evaluating the impact of the Joint Pain Advisor has been published, the link for which is provided below. The key points to note include:

Clinical Effectiveness

- Improvement in physical function and ability to carry out daily living activities
- 18% reduction in pain
- 2kg reduction in weight, plus reductions in BMI and waist circumference
- Increase in physical activity by 2 days a week
- Patient reported improvement in mental health (depression and anxiety) of up to 15%
- Reduction in healthcare utilisation (21% fewer GP consultations and referrals for MSK physiotherapy imaging for knee / hip pain)

Financial Benefits

- Total healthcare cost was £2424 lower 12 months post-assessment (£39.10 per patient) compared with 12 months prior to assessment
- Social Return on Investment (SROI) analysis shows the model of care creates a positive social value for people with osteoarthritis and chronic joint pain that is greater than the cost of investment; the social value created ranged from £2.43 to £4.03 for every pound of investment

Funding Required

Joint Pain Advisor

- 1 day training session (delivered by HIN)
- WTE for advisors will depend on population size
- Venue hire for consultations

Back Pain Forum

Venue for meeting including refreshments.

Reports / Resources

Joint Pain Advisor

https://healthinnovationnetwork.com/wp-content/uploads/2017/01/FINAL_HIN_NEF_Joint_Pain_Advisor.pdf

www.nice.org.uk/sharedlearning/the-joint-pain-advisor-approach-for-knee-and-hip-pain

For further information

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Project 3:	**STarT Back Care for Low Back Pain**
Delivered by:	west midlands ACADEMIC HEALTH SCIENCE NETWORK INNOVATION AGENCY Academic Health Science Network for the North West Coast

Setting	Overarching aim
Primary care.	To implement the STarT Back tool, and audit GP practices using the tool to understand implementation issues.

Back pain is the most common reason for middle-aged people to visit their GP, representing an estimated annual cost of £4.2bn to the NHS. It is the second most common reason for sickness absence from work, and for persistent disability and work loss in the under 65s. The current approach for treatment is a 'one size fits all' approach meaning a substantial proportion of patients are over-treated, while a significant number fail to get the right care.

Developed by Keele University, STarT Back is an example of stratified care for low back pain, where patients are screened for risk of chronic pain. STarT Back is a prognostic screening tool that places patients with back pain into three risk groups (low, medium or high chance of persistent disabling problems), and for each category there is a matched treatment package.

STarT Back has been shown to:

- Improve clinical outcomes, reduce back pain disability
- Improve care pathways and increase patient satisfaction
- Reduce sickness absence
- Reduce physiotherapy waiting times, GP consultations, referrals to secondary care and referrals for imaging
- Be cost-effective, with an average saving to health services of £34 saving per patient
- Result in a more targeted use of healthcare resources without increased healthcare costs

West Midlands AHSN

Funding through the AHSN has helped academic and NHS colleagues overcome implementation barriers, through:

- Creating capacity for change management
- Establishing support networks for NHS colleagues
- Unlocking funding support for training in the STarT Back approach
- Developing IT solutions to support implementation

The AHSN is supporting the engagement and training of healthcare professionals to adopt the STarT Back tool, with new care pathways being negotiated with commissioners and provider Trusts to support the roll out of this approach. The AHSN is also working with GP electronic systems to embed the STarT Back tool into the systems, so that the tool will 'pop up' each time a patient presents with back pain. Early audit has demonstrated a 30% increase in the use of the tool within GP practices, and reduction in physiotherapy waiting times of up to 6 weeks.

Innovation Agency

Ninety-five GP practices across two CCG areas piloted the STarT Back tool. The Innovation Agency commissioned an audit of these GP practices to understand possible implementation challenges. The audit consisted of a review of practice data to assess the number of patients who activated the STarT Back tool (though the 'pop up' mentioned above) compared with the number of patients who received a stratified risk score.

The StarT Back tool, if followed correctly, suggested that patients who are identified as low risk, need not be referred on to physiotherapy. The audit identified that a high percentage of patients stratified as low risk were referred to physiotherapy services (67% and 81% in participating practices across the two CCG areas). This arose due to those patients perceived as lower risk patients not being assessed and only those deemed suitable for physiotherapy being assessed, as it was a precursor for referral. Through increased compliance with the risk stratification scores and aligned interventions, as they were originally intended, there is the potential for increased cost savings.

A survey assessing the ease of use, training and satisfaction levels was requested from each participating practice. The responses received indicated a range of views regarding the adequacy of training provided and the need for future training. All responses stated the built-in template on their EMIS system was easy to use, although there were differing views regarding the ease of use of the STarT Back questions and ratings. However, the low response rate does not enable the results to be extrapolated to a wider population.

Conclusions from this work state that the implementation and usage of the STarT Back tool has the potential to save CCGs a considerable amount of time and money whilst managing patients more appropriately based on their level of severity. The tool can easily be installed onto GP systems (currently only EMIS), and as with any new system or process improvement, sufficient engagement, training and motivation are key factors in ensuring the value of the tool is realised. A potential concept could be to use the tool twice – first by the GP and secondly by physiotherapy services, to ascertain any scoring variances. However, levers built into the systems to incentivise the use of STarT Back may have had the perverse effect of skewing the results, so that it was only used when a referral for physiotherapy was intended.

Impact

The STarT Back tool has a robust evidence base, the papers for which can be found following the web links given below. The key points to note include:

Clinical Effectiveness

- Significant reduction in back pain (as measured by the Roland and Morris Disability Questionnaire, RMDQ), which was still evident at 4 months and 12 months follow-up
- 65% of patients reported 30% or greater improvement in back pain at 12 months, as measured by RMDQ
- Increase in generic health benefit, as measured by 0.039 additional QALYs
- Significant improvement in fear, depression and general health (physical component) at 12 months follow-up
- Significant reported patient satisfaction with the treatment provided
- Changes in prescribing, including a decrease in the use of nonopioids and a concurrent increase in use of mild opioids (prescription of mild opioids is in line with NICE guidelines for back pain, CG88)
- 30% reduction in the number of sickness certificates issued

Financial Benefits

- Greater health benefits at a lower health care cost, with an average healthcare cost saving of £34 per patient
- Societal benefit from fewer work days lost due to back pain equates to a cost saving of £675 per patient over 12 months

Funding Required

West Midlands AHSN

Provision of project management support, implementation and clinical expertise.

Innovation Agency

Supported external consultant to undertake audit.

Funding will be required to provide training to all GPs and deliver an implementation programme, but the potential for savings is considerable.

Reports / Resources

http://atlas.ahsnnetwork.com/start-back/

http://www.wmahsn.org/programmes/view/start-back-

https://www.keele.ac.uk/sbst/

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2811%2960937-9/fulltext

Innovation Agency

Reports available on request.

For further information

West Midlands AHSN

meridian@wmahsn.org

Innovation Agency

Julia Reynolds, Programme Manager, Innovation Agency North West Coast

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Project 4:	**Redesign of MSK Pathway**
Delivered by:	UCLPartners Academic Health Science Partnership

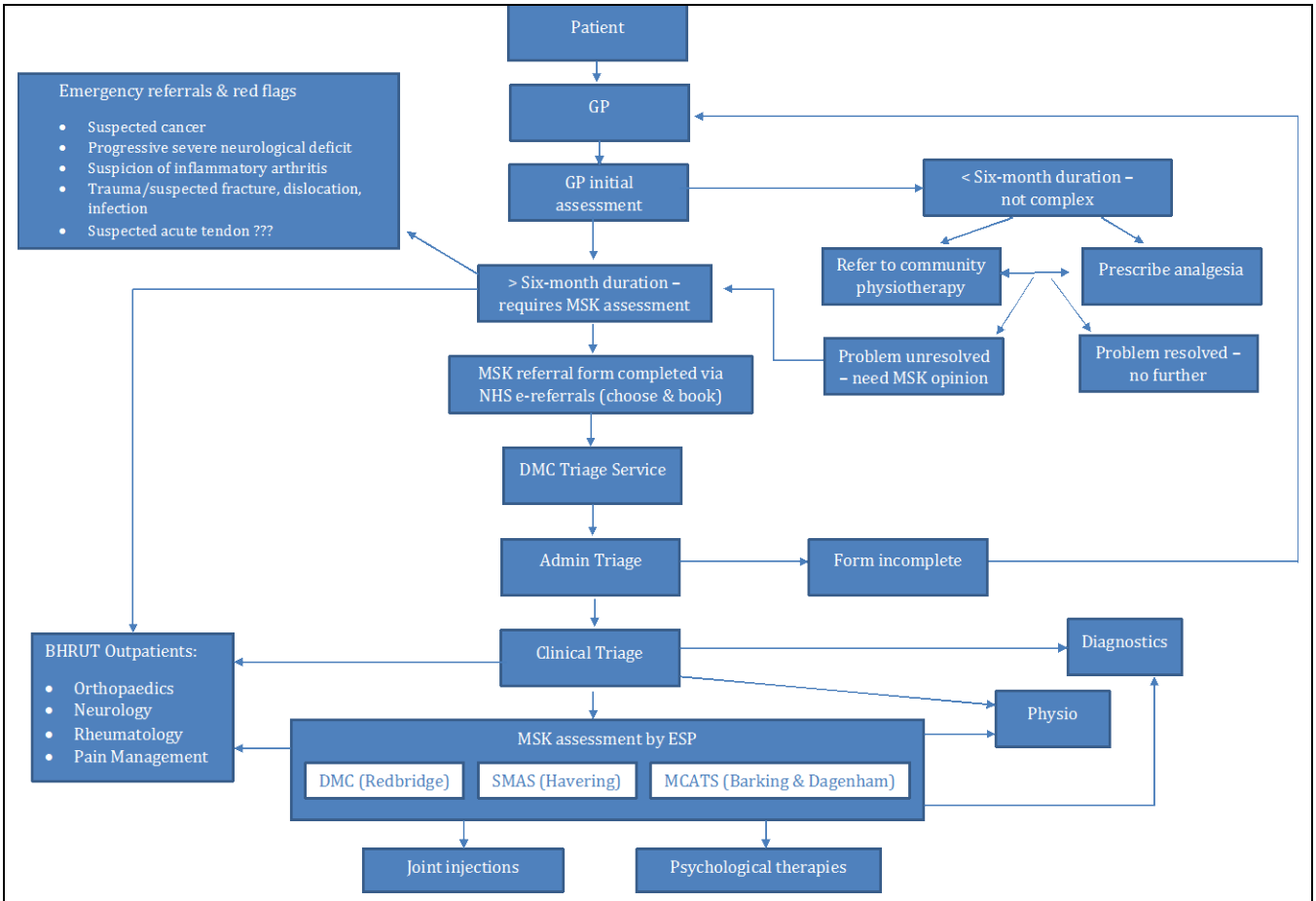
Setting	Overarching aim
Whole system.	To support CCGs in redesigning the MSK pathway and to understand impact of the new pathway.

Within East London, there are three separate CCGs who work together through a single management team using delegated commissioning. UCL Partners, following a request from the CCGs, undertook a review of the MSK pathway that has been in place since June 2016. Several issues emerged including:

- Lack of clarity on pathway and processes across all stakeholders
- Need for improved communication about the pathway
- Different referral forms and processes between CCGs
- Lack of data to demonstrate patient flow through the pathway

The AHSN held a series of workshops with key stakeholders (GPs, commissioners, secondary care clinicians, MSK service provider, physiotherapists) to clarify and agree the pathway, and identify blocks and challenges. Following these workshops, the MSK pathway was redesigned and UCL Partners developed a comprehensive action plan for the CCGs to implement, which included a focus on self-care and the use of social prescribing (such as talking therapies) to assist with long-term chronic pain management.

The redesigned pathway:



Funding Required

AHSN provided support for review of pathway and facilitated workshops.

Reports / Resources

PowerPoint presentation available on request.

For further information

Jenny Mooney, Head of Programmes, UCL Partners

jenny.mooney@uclpartners.com

Project 5: Musculoskeletal Online Service

Delivered by:

iNNOVATION AGENCY
Academic Health Science Network
for the North West Coast

Setting	Overarching aim
Patients' homes.	To reduce demand for primary care or secondary care appointments through improved self-management.

In response to the growing number of people presenting with musculoskeletal problems and increasing waiting times for access to services, the Innovation Agency and West Lancashire Physiotherapy Services have undertaken an initiative to provide web-based support for people with musculoskeletal (MSK) pain. The aims of the project are to support people with MSK pain by:

- Screening for serious conditions, chronic pain and self-limiting MSK pain
- Signposting patients to the most appropriate advice or professional
- Empowering appropriate patients with online support to successfully self-manage their condition, thereby reducing demand for appointments across primary care, secondary care and the community
- Providing a repository of local contacts where individuals can seek support, e.g. patient support groups

Initially the service will address shoulder and knee pain, and improve the quality of patient care by increasing the speed with which patients can access specialist advice. Through the development of an online support tool, faster access will be provided to medical screening, advice and information on self-management, including patients with benign conditions that will improve, patients at risk of developing chronic pain, and patients with more serious problem who require fast tracking.

Patients will be able to self-refer to the service, thereby enabling immediate access to specialist advice. Screening questions will identify patients at risk of serious conditions or chronic pain, and if present would trigger a re-direction to specialist information, online physiotherapy support, or referral to the appropriate healthcare professional.

The Innovation Agency will monitor a range of outcomes to understand and quantify the impact of the online service, including:

- Number of patient contacts with the online service
- Number of referrals for shoulder and knee conditions before and after the introduction of the service
- Appropriateness of referrals
- Waiting times following referral to a healthcare professional before and after the introduction of the service
- Demand for healthcare resources before and after the introduction of the service, such as GP,

physiotherapy, chiropractic, orthopaedic, osteopath appointments for relevant MSK conditions

- Patient reported outcome measures
- GP and patient satisfaction levels with the online service

As of September 2017, this work is in the beta testing phase but is intended to be implemented across West Lancashire CCG and Southport and Ormskirk Hospital NHS Trust.

Funding Required

Innovation Agency and West Lancashire CCG provided capital investment plus project management support.

Reports / Resources

Not applicable.

For further information

Julia Reynolds, Programme Manager, Innovation Agency, North West Coast AHSN

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Project 6:	**MSK Hackathon**
Delivered by:	South West Academic Health Science Network
Setting Whole system.	Overarching aim To identify solutions to local referral and treatment pathway challenges.
Following a request from a community Trust, the South West AHSN facilitated a MSK Hackathon involving the community Trust, primary care, secondary care, commissioners, patients and innovators. The hackathon used patient stories to stimulate discussion for investigating the challenges of local referral and treatment pathways, and enabled an extensive and comprehensive look at possible solutions and actions. The outcomes from the hackathon are being developed into a project by the community Trust, the aim of which is to develop a streamlined, one stop single point of access for people requiring referral, support and treatment for MSK conditions. This project is being developed as part of the Trust's overarching review of all referral and support pathways.	
Funding Required South West AHSN funded the event, including significant set up time.	
Reports / Resources Not applicable.	
For further information Suzy Taylor, Project Manager - Innovation, South West AHSN suzy.taylor@swahsn.com	

Section 2: Falls and Fractures

Anyone can have a fall but older people are more vulnerable and likely to fall, particularly if they have a long-term health condition. Falls are common, with 30% of people over 65 years and 50% of those aged 80 years and over falling at least once a year. While a lot of falls do not result in serious injury, they can cause the individual to lose confidence, become withdrawn and lead to a loss of independence. However, falls are also the largest cause of emergency hospital admissions for people over 65 years and significantly impact on long-term outcomes, for example a fall can be a major precipitant of people moving from their own home to long-term nursing or residential care.

Some falls do result in fracture, and those falls from standing height or less that result in a fracture are called fragility fractures. Osteoporosis is a major risk factor for fragility fracture. Such fractures can cause substantial pain and disability, often leading to a reduced quality of life, and hip and vertebral fractures are associated with decreased life expectancy. As well as the significant impact on the individual, falls and fractures are both high volume and costly for health services:

- Approximately 255,000 emergency hospital admissions related to falls for patients aged 65 and over
- Falls are estimated to cost the NHS more than £2.3billion per year
- Falls in hospitals are the most commonly reported patient safety incident
- Over 300,000 patients present with fragility fractures in the UK each year
- Fragility fractures are estimated to cost the UK £4.4billion, of which £1.1billion relates to social care (Public Health England, January 2017: Falls and Fractures Consensus Statement)

As well as the specific projects detailed in this report, a wealth of information can be found on:

https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/03/falls-fracture.pdf

https://www.nice.org.uk/guidance/cg146/chapter/introduction

https://www.england.nhs.uk/rightcare/products/pathways/falls-and-fragility-fractures-pathway/

https://www.nice.org.uk/guidance/cg161/chapter/introduction

https://improvement.nhs.uk/uploads/documents/Falls_report_July2017.v2.pdf

The following pages contain details of the Falls and Fractures projects the AHSNs are working on across the country.

Project 7:	**FallSafe**
Delivered by:	Oxford Academic Health Science Network
Setting Acute, mental health and community wards.	Overarching aim To reduce the number of falls in hospital.

This is a quality improvement programme developed by the Royal College of Physicians. The programme introduces evidence-based care bundles, the aim of which is to prevent and manage the number of falls patients have whilst in hospital. The programme has been shown to reduce falls by 25% on wards. FallSafe has two care bundles, one for all patients and one for higher risk, more vulnerable patients. Each bundle consists of several elements or factors that may contribute to a patient's fall.

The AHSN is working with a number of Trusts to implement this project within several wards. The ward staff are being supported to deliver improved care by fully assessing patients, and then trying to eliminate (through a team approach) the factors which may contribute to a fall.

The AHSN also provided Quality Improvement training (through an external consultant) which supported staff in delivering the programme with their local ward teams.

Impact

Clinical Effectiveness

The overall impact of the FallSafe programme has been shown to reduce falls by 25% on wards. Other benefits that have been documented from the original FallSafe implementation project include:

- Patients without a call bell in reach reduced by 78%
- Twice as many requests for medication review
- Patients without safe footwear reduced by 67%
- Twice as many patients had their L&S BP checked
- 56% more patients assessed for confusion
- Twice as many patients asked if they were worried they might fall
- 41% decrease in patients given night sedation

It should also be noted that falls can have a significant impact on patients and their families. These can result in social and psychological costs associated with loss of confidence, fear of falling and consequent social

isolation, which while difficult to quantify should not be forgotten.

Financial Benefits

- NHS Improvement (July 2017) has estimated the average cost of an inpatient fall is £2600
- Falls that result in moderate or severe harm will lead to much greater costs for hospitals

Funding Required

Oxford AHSN provided funding for 2x half day sessions of external quality improvement training per Trust, plus 0.2wte project management support.

Reports / Resources

https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original

https://improvement.nhs.uk/uploads/documents/Falls_report_July2017.v2.pdf

For further information

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Project 8:	**Analytical Review of Falls Prevention Literature and Innovations**
Delivered by:	Oxford Academic Health Science Network
Setting Whole System.	Overarching aim To understand research findings and innovations, and undertake analysis of work happening within the region related to falls prevention; in doing so, scope potential projects to support the reduction and prevention of inpatient falls across the AHSN region.

Across the Oxford AHSN region there was agreement from provider and commissioner organisations that falls prevention was a priority area, and a strategy was required to address this issue across acute, community and mental health settings. In order to shape this strategy, a key first step was to undertake an analytical review of the literature on falls prevention and a review of innovations / initiatives for preventing falls.

The literature review highlighted the research and evidence-base for falls prevention within healthcare settings, and the review of innovations provided a summary of results from a range of initiatives across different care settings.

A survey was undertaken with provider organisations (across several departments in each organisation) to identify the falls prevention work being undertaken within each Trust. The survey also gathered information regarding the presence of a falls prevention champion or link nurse, staff awareness of the Trust's falls prevention policy, and staff's interest in undertaking a falls prevention project. The AHSN developed a separate survey for the mental health Trust, based on the Royal College of Physicians Acute Inpatient Audit.

Following a review of the literature, innovations and survey results, agreement was made to implement the FallSafe Care Bundles across three distinct inpatient ward areas – acute, community and mental health wards.

Summary of Literature Review

	Acute	Mental Health	Community
Preventing Falls in Hospitals – *Yorkshire and Humber Academic Health Science Network*	✓		
Report of the 2011 inpatient falls pilot audit - *Royal college of Physicians*	✓		
Preventing falls among older people with mental health problems: a systematic review – *Bunn et al. BMC Nursing 2014, 13:4*		✓	
Exercise for improving balance in older people – *Cochrane Review, Howe TE, Rochester L, Neil F, Skelton DA, Ballinger C*			✓
How to create a community-based fall prevention programmes for older adults – *National Centre for Injury Prevention and Control, Atlanta, Georgia*			✓
Prevention of Falls and Harm from Falls among Older People: 2011-2015 – *Ministry of Health, New South Wales, Australia*			✓
Interventions for preventing falls in older people in care facilities and hospitals – *Cochrane Review, Cameron ID, Gillespie LD, Robertson MC, Murray GR, Hill KD, Cumming RG, Kerse N*	✓	✓	✓
Interventions for preventing falls in older people living in the community - *Gillespie LD, Robertson MC, Gillespie WJ, Sherrington C, Gates S, Clemson LM, Lamb SE*			✓
Reducing harm from falls in acute, mental health & community hospitals; what does & doesn't work – *Sign up to safety*	✓	✓	✓
Hip protectors for preventing hip fractures in older people – *Cochrane Review, Santesso N, Carrasco-Labra A, Brignardello-Petersen R*	✓	✓	✓

Summary of Falls Prevention Innovations

60 randomised controlled trials involving 60,345 participants, 43 trials (30,373 participants) were in care facilities, 17 (29,972 participants) were in hospitals.

	No of trials/ participants	Facility	Result	Impact on rate of falls	Impact on risk of falls
Exercise	13 (3731)	Care facilities	Inconsistent	None	None
Vitamin D	11 (9789)	Care facilities		Reduced	None
Multifactorial	14 (5508)	Care facilities	Possible benefits	Inconclusive	Inconclusive
Additional physiotherapy	3 (137)	Sub-acute wards in hospital	Some benefit	Reduced	Significantly reduced
Carpet flooring	1(54)	Sub-acute ward in hospital	Negative benefit	Significantly increased	Potentially increased
Multifactorial	7(11302)	Hospitals	Possible benefits but inconclusive	reduced	reduced
Part of multifactorial hospital findings above	1(199)	Multi-disciplinary care in geriatric ward after hip fracture surgery compared with usual care in orthopaedic		Significantly reduced	Significantly reduced

17 hospital trials but no clear strategy for successful interventions

Funding Required

0.2wte project management support.

Reports / Resources Report on innovation research and survey undertaken by Trusts available on request.
For further information Alison Gowdy, Clinical Innovation Adoption Manager, Oxford AHSN alison.gowdy@oxfordahsn.org

Project 9:	**Stay in the Bay**
Delivered by:	Oxford Academic Health Science Network
Setting Secondary care.	Overarching aim To reduce the rate of inpatient falls through the introduction of Stay in the Bay intervention.

Following a thematic analysis of reported falls within Buckinghamshire Healthcare Trust, it was identified that the majority of falls take place in the patient bays and most are unobserved. Evidence from other Trusts and suggestions in John's Campaign (www.johnscampaign.org.uk) recommended closer observation of patients to reduce falls. Work undertaken at Guys and St Thomas's Trust demonstrated that workstations in bays increased direct patient contact, reduced falls and improved patient safety, while simultaneously reducing complaints and increasing the Friends and Family Test results.

The hospital was awarded a grant by NHSLA and Sign up to Safety to purchase workstations for wards with a high falls risk and a high percentage of unobserved falls. Each workstation has workspace, a computer and lockable notes drawer. The aim is to help nursing staff spend more time within patient bays and less time at central nurses' stations.

A pilot evaluation was initially undertaken, which included:

- Number of falls, time of falls, observed or unobserved fall
- Observational assessment of the time in the bays pre and post start of the pilot
- Repeat falls
- Patient and staff survey

Following the pilot, the project was rolled out across several wards. A total of 50 workstations have been purchased through the grant, with some additional workstations funded by the Trust. This has enabled 18 wards to be supplied with the number of workstations appropriate to their clinical need and ward layout.

Working in collaboration with the Oxford CLAHRC (Collaboration for Leadership in Applied Health Research and Care), a regression model has been developed which has enabled robust data analysis to be undertaken to evaluate whether this intervention led to a change in the monthly rate of inpatient falls. Data was collected over a 45-month period, from April 2014 to December 2017. At 12 months post-intervention, the results demonstrated an absolute difference in the monthly rate of falls between pre and post intervention of 2.84 falls per 1000 occupied bed days. This equates to a relative reduction of 26.71%. These results were presented in a poster at the Royal Statistical Society's Young Statisticians annual conference in August 2017, and was awarded the prize for best oral presentation.

NHS Improvement (July 2017) has estimated the average cost of an inpatient fall is £2600, although falls that result in moderate or severe harm will lead to much greater costs for hospitals. As such, interventions that reduce the number of inpatient falls will not only have a positive impact on the patient, but will result in financial benefits to the Trust.
Funding Required Grant funding from NHSLA and Sign up to Safety.
Reports / Resources http://www.oxfordahsn.org/news-and-events/news/falls-prevention-project-statistician-wins-conference-prize/
For further information Alison Gowdy, Clinical Innovation Adoption Manager, Oxford AHSN alison.gowdy@oxfordahsn.org

Project 10:	**Reducing Falls in Care Homes**
Delivered by:	eahsn Eastern Academic Health Science Network

Setting	Overarching aim
Hillings Residential Home.	To reduce patient harm through prevention of falls.

A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level (WHO, 2017), and there are over 400 risk factors associated with falling (NICE 2017; www.nice.org.uk/guidance/qs86).

It has been identified that there is a potential to reduce falls within The Hillings Care Home by utilising small changes that can help prevent residents from falling over and injuring themselves. The aim is to reduce the number of falls within the residential care home setting of The Hillings by 20% in six months. The Eastern AHSN is working closely with the CCG and directly supporting the project using the Model for Improvement and QI techniques.

Funding Required

This is a small-scale project which has been carried out within existing teams and resources, led by the CCG.

Access to life.seeDATA tool is required and has been integral to the development and support for the project.

For further information

Caroline Angel, Improvement Director, Eastern AHSN

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Project 11: Stop Falling Before It Starts

Delivered by:

ACADEMIC HEALTH SCIENCE NETWORK
NORTH EAST AND NORTH CUMBRIA

Setting	Overarching aim
Primary Care and Community.	To increase access to multifactorial falls and fracture risk assessment and intervention for older people at risk of falls.

This new service proactively identifies less frail, older people at risk of falls, with the aim of reducing the number of falls and falls-related fractures. The service uses the electronic Frailty Index (eFI) as an initial screen to identify those patients at risk of falls who have the potential to benefit from further assessment via a simple postal questionnaire.

Patients are invited to attend for an evidence-based multifactorial falls and fracture risk assessment, carried out by a health professional with expertise in multifactorial falls assessment. Medical advice on medication modification will be available as part of this assessment if required.

Outcomes from the assessment include:

- Information and advice to patients
- Advice to GP on medication modification and suggested onward referral for any medical issues identified
- Referral for further bone health assessment (DEXA scan)
- Referral to existing falls services for those patients with more complex needs
- Offer of community based or day unit based exercise programme

As part of this project, a new exercise programme based on the FAME Programme has been designed for fitter older people which will be delivered by trained Postural Stability Instructors via existing community exercise providers and sports and leisure services. This programme will consist of 15 weeks of progressive strength and balance training delivered in weekly sessions alongside a home programme to give a total of 50 hours of exercise.

The AHSN NENC is piloting this project to evaluate the new method of service delivery with a view to informing future commissioning intentions.

Funding Required

Funding provided by AHSN NENC (Health Improvement and Patient Safety Collaborative) and Newcastle Gateshead Clinical Commissioning Group.

Reports/Resources

This project is still in the pilot phase.

For further information

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Project 12: Community Admiral Nurse

Delivered by:

ACADEMIC HEALTH SCIENCE NETWORK
NORTH EAST AND NORTH CUMBRIA

Setting	Overarching aim
Primary Care, Community and Social Care.	To reduce the number of falls and falls-related fractures in people with dementia through Admiral Nursing support.

As dementia progresses people's needs get more complex and the risk of adverse events, such as falls, hospital admission or care home admission, increase. In the North East, 28.2% of emergency admissions with injuries due to falls (age 65+) have a secondary diagnosis of dementia and/or delirium. This is above the national average of 26.8%.

Admiral Nurses are specialist dementia nurses who give expert practical, clinical and emotional support to families living with dementia. The Admiral Nurse has been recruited to this pilot and will embed the recommendations of NICE CG161 (Falls in Older People: assessing risk and prevention) into their role and into dementia care, educating the wider dementia support network in the area of falls and fracture prevention. The aim is to reduce the number of falls and falls-related fractures in people with dementia.

The pilot is running for 3 years and the project will evaluate the new method of service delivery, with a view to informing future commissioning intentions.

Funding Required

1wte Band 8a Admiral Nurse

Funding provided by AHSN NENC Health Improvement Programme, AHSN NENC Patient Safety Collaborative, Dementia Care, Dementia UK, North Star Foundation and AMGEN Pharmaceutical Company.

Reports/Resources

This project is still in the pilot phase.

For further information

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Project 13: Falls Prevention

Delivered by:

Health Innovation Network South London

Setting	Overarching aim
Whole System.	To identify the key focus areas within falls prevention to promote strength and balance exercise, and to reduce falls and prevent hospital admissions.

A falls prevention stakeholder event was held by the Health Innovation Network, AHSN for South London in October 2017, involving all south London falls prevention stakeholders: NHS Trusts, local authority, voluntary organisations, leisure sector, digital companies, Public Health England, London Ambulance Service, London Fire Service and National Osteoporosis Society.

The main aim of the event was to:

- Mobilise south London falls prevention stakeholders to share and adopt good practice through show casing existing south London evidence-based falls prevention innovations

At the event, delegates were asked to prioritise the following key focus areas to inform future work:

- High value, low cost interventions: referral triage and efficient deployment of physiotherapists, exercise leads and clinical leads / GPs
- Case finding to prevent falls, promoting strength and balance
- Digital interventions to offer choice and support / adherence to exercise
- Pathway beyond the NHS and onwards: sustainability of exercise, leisure, libraries and third sector

Following an analysis of the responses (in progress at the time of printing), the key area for focus will be announced and resources will be shared with guidance on how to implement evidence-based best practice.

Funding Required

0.35wte project manager, 0.25wte project support officer, clinical lead support plus cost of venue hire.

Reports/Resources

Key outcomes from the event were not available at the time of publishing; the HIN blog can be accessed via:

https://healthinnovationnetwork.com/blog/keeping-active-is-a-vital-part-of-keeping-steady-for-older-adults/

For further information

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Project 14:	**Population Proactive Approach to Bone Health**
Delivered by:	ACADEMIC HEALTH SCIENCE NETWORK NORTH EAST AND NORTH CUMBRIA INNOVATION AGENCY Academic Health Science Network for the North West Coast

Setting	Overarching aim
Primary care.	To identify 'at risk' patients and start them on a treatment pathway; and to identify patients already on treatment who should be reviewed.

North East and North Cumbria AHSN

The aim of the bone health programme is to improve health outcomes for patients who are at risk of sustaining a fragility fracture and to promote improvements in bone health through patient education, targeted case finding, effective treatment and medication compliance. Through doing this work, the number of hip fracture and fragility fractures is expected to reduce.

This is a collaborative project between NENC AHSN, GP practices, CCGs and a joint working agreement with AMGEN, with technical and clinical support from Interface Clinical Services (ICS). The project supports GP practices in the review and implementation of NICE Clinical Guideline 146 (CG146), along with a proactive review of current prescribing and gaps in care. ICS pharmacists are responsible for the identification of patients, recall of patients, suggestion of medication changes to GPs and triage of patients to secondary care.

The project has 2 parts:

- Identification of 'at risk' patients at GP practice level and commence correct treatment pathway in line with local and national guidance
- Identification of patients already on treatment who should be reviewed, i.e. those patients who have been on bisphosphonates for 5 or more years, patients who are intolerant of bisphosphonates and patients who have fractured despite taking bisphosphonates

Innovation Agency North West Coast

In partnership with the Innovation Agency North West Cost, Fylde and Wyre CCG and Blackpool CCG collaborated with AMGEN to secure a Medical and Educational Goods and Services (MEGS) grant to

pilot the company's Osteoporosis Medicines Optimisation Support Pack across five GP practices. The aim of the pilot was to assess the effectiveness of the pack as an audit tool for identifying patients with or at risk of osteoporosis and to encourage GP practices to review their management of these patients. The MEGS grant enabled the AHSN to fund a member of staff to conduct the audit without the need for practice staff to allocate time to this activity.

The Osteoporosis Medicines Optimisation Support Pack supports the uptake and achievement of a number of key initiatives and targets, including NICE medicines optimisation and osteoporosis guidelines, the Quality and Outcomes Framework (QOF) and the Programme of Action for General Practice. It describes a step by step approach for using existing practice software to search for groups of potential osteoporosis patients in the system and categorise them into smaller sub-groups which can be more easily reviewed to assess fracture risk and review medication needs. At the end of the process, GP practices have information on individual patients in order to help them decide on the next steps to optimise ongoing monitoring and treatment.

The pilot determined that the Osteoporosis Medicines Optimisation Support Pack was a useful tool in producing high quality audit results that would benefit all GP practices involved. With support to set up the audit and implement its findings, the Support Pack may help practices to:

- Overcome some of the barriers they face around conducting regular patient audits
- Establish and maintain a register of osteoporosis patients
- Identify those patients for whom ongoing management in line with QOF indicators is required

The pilot highlighted the value of optimising care for this patient group, and prompted three of the participating GP practices to request further training on osteoporosis and fragility fracture risk management.

Impact

Key findings from the work within North East and North Cumbria AHSN include:

- Within a population of 258,000 over 110,000 patients were identified as requiring a fracture risk assessment
- A FRAX score was calculated for each of these patients, which identified 7.3% of patients (over 8000) had a score greater than 20% and 10-year probability of major osteoporotic fracture
- Using local pathways to further stratify these patients, identified nearly 3000 patients requiring treatment, of which approximately 50% were untreated and/or had no previous evidence of bone health assessment
- Within this untreated cohort alone, 140 hip fractures would be expected to occur, at a direct hospital cost of nearly £2.3million
- Effective treatment could reduce the hip fracture incidence by 40%, which would deliver a saving of approximately £0.9million and prevent 56 hip fractures

Funding Required

North East and North Cumbria AHSN

Funding is provided by AMGEN Pharmaceutical company for the audits undertaken by ICS.

NENC AHSN provides 0.2wte programme lead to support the project.

Innovation Agency North West Coast

MEGS grant funded support for the project.

Reports / Resources

North East and North Cumbria AHSN

http://atlas.ahsnnetwork.com/a-population-based-approach-to-improving-bone-health-and-fracture-prevention-across-the-north-east-and-north-cumbria-now-adopted-across-5-ahsns/

https://www.nice.org.uk/sharedlearning/bone-health-programme-proactive-population-approach-to-bone-health

Innovation Agency North West Coast

Audit report available on request.

For further information

North East and North Cumbria AHSN

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Innovation Agency North West Coast

Andrew Shakeshaft, Head of Programmes, Innovation Agency North West Coast

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Project 15: Fractured Neck of Femur Care Bundle

Delivered by: Kent Surrey Sussex Academic Health Science Network

Setting	Overarching aim
Secondary care.	To improve quality of hip fracture care across KSS AHSN through standardising the approach across 13 acute hospitals.

Working with 13 acute hospitals across the region, the aim was to introduce a fractured neck of femur care bundle, in line with British Geriatrics Society and NICE guidelines. Initially a workshop was held with hip fracture team members across the region to agree the measures for the care bundle. The measures selected were:

- Dynamic pain score: was this measured during initial assessment using validated scale?
- IV paracetamol: was this given?
- Pre-operative nerve block: did the patient have fascio-iliaca compartment block or femoral nerve block pre-operatively?
- Post-operative pain measured: was this measured, reviewed and documented daily for the first week?
- 4AT (4 As Test is a screening tool for delirium in older people) at 24-36 hours post-operative: was this measured?
- 4AT at 4-7 days post-operative: was this measured?
- Patient stand day 1: was the patient able to stand on day one post-surgery?
- Initial physiotherapy goals: were these set within 24 hours?

Data collection is via the National Hip Fracture Database (NHFD), with Trusts setting up custom fields within the NHFD and submit monthly data extracts to KSS AHSN.

Building on this initial work, a peer support process has been introduced in which the 13 Trusts will be visited by a team (Consultant Orthogeriatrician, Consultant Anaesthetist, Surgery, Hip Fracture Nurse) to review areas of good practice and areas for supported improvement.

Funding Required

KSS AHSN funded 1.5 Programmed Activities per month (6 hours) for clinical lead, plus project management and data analysis support.

Reports / Resources http://www.kssahsn.net/what-we-do/better-quality-and-safer-care/Pages/Neck-of-Femur-Fracture.aspx
For further information Gill Potts, Senior Programme Manager, KSS AHSN gill.potts1@nhs.net

Project 16: Fracture Liaison Service

Delivered by:

Oxford Academic Health Science Network

Setting	Overarching aim
Secondary care.	To develop comprehensive Fracture Liaison Services within acute hospitals to reduce the number of secondary fragility fractures.

Osteoporosis is the most common chronic bone disease affecting both women and men, and affects approximately 3 million people in the UK. The disease is characterised by low bone density which is a major risk factor for fragility fractures. Fragility fractures occur in 1 in 2 women and 1 in 5 men over the age of 50. Fragility fractures can cause substantial pain and severe disability, often leading to a reduced quality of life, and hip and vertebral fractures are associated with decreased life expectancy.

People who have had one fracture remain at greater risk of sustaining another, secondary fracture. Prevention of a secondary fracture will therefore improve quality of life and reduce health and social care costs. National guidance provides clear evidence that effective case finding and effective treatments will reduce the risk of future fragility fracture, and that investment in Fracture Liaison Services results in improved quality of care for patients as well as financial savings for commissioners of health and social care.

Fracture Liaison Services are responsible for the secondary prevention of osteoporotic fractures through the systematic assessment of patients who have suffered as fragility fracture. The service will:

- Proactively identify all patients over 50 years of age who have suffered a fragility fracture
- Assess bone health and falls risk, including osteoporosis assessment
- Inform patients of future fracture risk and discuss ways to reduce this
- Intervene to improve bone health such as medication recommendations and referral to specialist services, such as falls prevention
- Integrate across primary and secondary care to ensure long-term management and treatment
- Provide evidence of quality of service provision through data capture and audit

While there are different models for an effective fracture liaison service, they all predominantly follow the

pathway below:
The benefits include:

- Reduced number and cost of unplanned admissions due to secondary fractures, with positive impact on patient flow and capacity through acute hospitals and social care
- Consistent and comprehensive service provision for fracture patients over 50 years of age
- Enhanced communication & coordination of care between health care providers by providing a care pathway for treatment of fragility fracture patients
- Significant reduction in morbidity and mortality for older people
- Increased medication compliance
- Cost-effective way of delivering best practice and achieving outcome indicators

The Oxford AHSN is working with the National Osteoporosis Society (NOS) to implement Fracture Liaison Services across the region. The work undertaken includes mapping service availability and gap analysis for each Trust, engagement with acute Trusts and commissioners to introduce new services or expand existing services.

Impact

Clinical Effectiveness

- FLS can reduce subsequent fracture risk by up to 50% in people with fragility fractures
- Increase medication compliance rates to approximately 80%
- Reduction in mortality rates through a reduction in fragility fractures (20% of hip fractures are fatal)
- Reduce hip fractures by up to 25%
- Increased assessment of bone mineral density, as a result of patients being identified as appropriate for DEXA scan (approximately 50% of patients accessing a FLS will require a DEXA scan)

Financial Benefits

- Significant cost savings are associated through a reduction in the incidence of fragility fractures
- The costs of different fracture types across acute, community/primary care and social care sectors are detailed below (taken from the National Osteoporosis Society's Benefits Calculator)

*note these values will vary slightly depending on the MFF value used

	Hip fracture (inpatient)	**Other fracture site (inpatient)**	**Other fracture site (outpatient)**	**Clinical vertebral**
Acute care	£8,953	£2,002	£399	£2,176
Community and primary care	£448	£57	£57	£59
Social care	£8,237	£150	£150	£2,908
TOTAL - Costs per fracture prevented	**£17,638**	**£2,209**	**£606**	**£5,143**

Funding Required Oxford AHSN provided 0.2wte project management support. National Osteoporosis Society is available to provide support to Trusts and commissioners.
Resources / Reports https://nos.org.uk/for-health-professionals/service-development/fracture-liaison-services/ http://clinicalinnovation.org.uk/wp-content/uploads/2017/04/fragility-fractures-Fracture-prevention-services.pdf http://clinicalinnovation.org.uk/wp-content/uploads/2017/04/fragility-fractures-Effective-interventions-in-health-and-social-care.pdf https://nos.org.uk/media/1776/clinical-standards-report.pdf
For further information Alison Gowdy, Clinical Innovation Adoption Manager, Oxford AHSN alison.gowdy@oxfordahsn.org

Section 3: Frailty

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Approximately 10% of people over 65 years have frailty, which rises to between 25-50% of those aged over 85 years. This loss of resilience means people living with frailty do not recover quickly after a physical or mental illness, accident or other stressful event, and are at risk of adverse outcomes such as changes in their physical and mental wellbeing following an episode that challenges their health (British Geriatrics Society, 2014).

Frailty progresses with age and with the ageing population in England, the prevalence and impact of frailty will increase. This will lead to growing demand on health and social care services, with a consequential impact on cost.

As well as the specific projects detailed in this report, a wealth of information can be found on:

https://www.england.nhs.uk/ourwork/ltc-op-eolc/older-people/frailty/

http://www.bgs.org.uk/frailty-explained/resources/campaigns/fit-for-frailty/frailty-what-is-it

https://future.nhs.uk/connect.ti/system/home - this invitation only platform aims to support the introduction of changes to the GP contract with regards to routine identification of frailty. It is an informal frailty network for quick and easy sharing of issues and good practice. Access can be requested by emailing platform-manager@future.nhs.uk

The following pages contain details of the Frailty projects the AHSNs are working on across the country.

Project 17: Dorset Malnutrition Programme

Delivered by:

Wessex Academic Health Science Network

Setting	Overarching aim
Whole system.	To reduce malnutrition in community through integrated care pathways and early, effective screening.

Malnutrition can cause significant and long-lasting health conditions, and being malnourished can increase the risk of frailty and is therefore detrimental. Identifying those at risk of becoming undernourished and preventing malnutrition is an important prevention programme which will, in the long term, reduce the need for both health and social care. It has been estimated (Correia et al, 2003) that malnutrition results in a greater use of healthcare:

- 65% more GP visits
- 82% more hospital admissions
- 30% longer hospital stay

Following a successful pilot, an integrated approach for reducing the prevalence malnutrition is being rolled out across Dorset. The programme involved local agreement and implementation of integrated nutritional care pathways including screening, treatment guidelines and referral routes, to enable early identification and intervention. This was facilitated through the development of a novel, electronic system to enable screening data recording, care pathways guidance and information sharing between teams.

Community health and social care teams were trained on the nutritional screening, care planning and use of the new electronic form to enable them to implement the new process. The work undertaken has demonstrated cost avoidance is possible through identification and treatment of high risk patients, with an effective, preventative approach implemented.

Impact

- During the pilot, 561 people were screened for undernutrition, of which approximately 154 (27%) were identified as being at medium or high risk of undernutrition
- 60 (39%) of those at risk experienced a decreased in MUST (Malnutrition Universal Scoring Tool) over the period of the pilot
- Potential cost avoidance calculated at £50k (assuming 60 people were prevented from seeing their GP or other healthcare service as a consequence of improved nutritional status. Guest et al, 2011,

estimates cost avoidance of £1449 per person)

- 75% of people screened in the Purbeck and Christchurch pilots were screened by social care staff, and would not have been screened using the processes in place prior to the intervention

Funding Required

Initial set up and training costs, including training materials, plus project management support.

Ongoing costs are low as this work becomes part as business as usual.

Reports/Resources

Wessex AHSN Nutrition in Older People toolkit:

http://wessexahsn.org.uk/projects/61/evaluating-integrated-approaches-to-undernutrition-screening-care-planning

https://www.gov.uk/government/publications/helping-older-people-maintain-a-healthy-diet-a-review-of-what-works/helping-older-people-maintain-a-healthy-diet-a-review-of-what-works

For further information

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Project 18:	**Development of toolkit and training package to reduce undernutrition in the community**
Delivered by:	Wessex Academic Health Science Network

Setting	Overarching aim
Community.	To reduce undernutrition in community through development of toolkit and training package for health, social care and voluntary sector teams working with older people in the community.

Wessex AHSN piloted two whole system approaches to reducing undernutrition in the community; this involved training for a range of health and social care professionals and voluntary care workers, plus development of bespoke training packages, nutritional care pathways, evaluation framework and resources for the general public. These were published in July 2016 as the 'OPEN toolkit', to provide resources which will help organisations implement localised integrated approaches for nutritional screening, preventing and treatment in the community setting.

The toolkit was developed by nutrition and dietetic experts from across the Wessex AHSN region. The toolkit consists of:

- Bespoke training packages for health, social care and voluntary sectors with a community setting focus
- Nutritional care pathways to guide professionals on appropriate advice to give, actions to take and how to refer to other services; these can be adapted for specific localities
- Awareness materials and resources for the public, including posters on undernutrition and how it can be treated, and leaflets on undernutrition (one for general use, one for people with dementia, one for people with COPD)
- Hydration toolkit, developed in collaboration with Kent, Surrey, Sussex AHSN and North East Hampshire and Farnham CCG
- Evaluation framework to help teams consider how to undertake a robust evaluation of nutrition interventions

New toolkit components currently in development include:

- Patient Association Nutrition checklist; this will include signposting which will be suitable for use by

domiciliary care organisations as well as the voluntary sector

- Interactive tool based on the standard questions in Patient Association Nutrition checklist, for use by voluntary sector organisations and carers

Funding Required

Funding was provided by Wessex AHSN Nutrition in Older People Programme.

Reports/Resources

http://wessexahsn.org.uk/projects/61/evaluating-integrated-approaches-to-undernutrition-screening-care-planning

For further information

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Project 19:	**Frailty Pathway Programme, incorporating Frailty Practitioner**
Delivered by:	Kent Surrey Sussex Academic Health Science Network

Setting	Overarching aim
Whole system.	To support STPs with the frailty programme.

The aim of this work is to outline a way forward for Sustainability and Transformation Partnerships (STPs) to re-design frailty pathways, taking into account the education and training needs of the workforce aligned to frailty pathways. KSS AHSN is supporting STPs with frailty programmes by working with existing projects and resources to develop the structure needed for a collaborative approach in addressing frailty.

The existing projects / work streams that are incorporated in this programme include:

- Polypharmacy
- End of life care
- Hydration
- Respiratory
- Fractures
- Safe discharge and transfer

Support has also been given to East Sussex council and KSS Health Education England to host two events reviewing the work of the frailty practitioner – 'exploring the potential of the frailty practitioner' and 'education and training needs of the frailty practitioner role'.

Funding Required

Funding to University of Surrey to review evidence of prevention and frailty.

0.4wte programme manager support, plus support for the two events.

Reports/Resources

http://www.kssahsn.net/what-we-do/moderating-demand/Documents/Better%20life_A5%204pp%20flyer%20V5.pdf

For further information

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Project 20: SPACE Programme (Safer Provision and Caring Excellence)

Delivered by:

Setting	Overarching aim
Care Homes.	To strengthen the safety culture and reduce adverse safety events in care homes.

Care home residents typically have multiple physical and/or cognitive impairments, and adverse events such as falls often lead to hospital attendance or admission. Developing a safety culture is associated with beneficial impacts on safety outcomes, but the complex needs of care home residents coupled with staffing pressures in this sector pose challenges for positive safety practices to become embedded at the individual and organisational levels.

SPACE is a large-scale care home improvement programme (running in 35 care homes across 24 months) which aims to strengthen the safety culture and reduce the incidence of adverse safety events. The two main elements of the programme are:

- Training events and workshops, to help care home staff and managers develop relevant skills and enhance their understanding of safety-related service improvement
- Facilitated sessions delivered in participating care homes to support staff in implementing changes in practice relating to specific safety concerns, such as falls prevention and pressure ulcer management

The evaluation will assess the extent to which the safety climate in care homes can be improved and the incidence of adverse events reduced, by up-skilling care home staff in service improvement techniques and providing support to enable care homes to implement changes in practice.

Funding Required

Training and workshops for care home staff focusing on clinical and human risk factors, and quality / service improvement techniques.

Facilitated sessions delivered in care homes to support staff to implement changes in practice relating to specific safety concerns, such as falls prevention and pressure ulcer management.

Reports/Resources

http://www.wmahsn.org/programmes/view/safer-provision-and-caring-excellence-space-programme

https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2013-x
For further information Helen Hunt, Assistant Programme Manager – Patient Safety Collaborative, West Midlands AHSN helen.hunt@wmahsn.org

Project 21:	**Older People Living with Frailty - Benchmarking**
Delivered by:	East Midlands Academic Health Science Network Igniting Innovation
Setting Whole system.	Overarching aim To design and develop a new and innovative pathway approach to benchmarking services for older people living with frailty across the health and social care pathway.

The ambition of East Midland AHSN's Older People Living with Frailty Clinical Programme is to improve the experience of older people living with frailty. This programme, a distinct project in collaboration with NHS Benchmarking Network (NHSBN), seeks to:

- Work with East Midlands Clinical Commissioning Groups (CCGs) to ensure that annual benchmarking of urgent hospital care for older people with frailty is incorporated in the commissioning information / quality schedules
- Support all eight East Midlands acute Trusts to develop quality improvement action plans for urgent hospital care for older people with frailty to improve the quality of care for patients
- Work in partnership with colleagues across the East Midlands, Patient and Public Involvement (PPI) representatives and the NHSBN to explore the appetite, benefits, feasibility and practical implications of developing a pathway approach to benchmarking the quality of services for older people living with frailty in the East Midlands
- Develop, pilot and roll out a pathway benchmark for older people living with frailty in one East Midlands STP footprint and use lessons learned to develop the metrics for spread across the East Midlands region
- Explore the wider implementation of the metrics across England and understand ways of how and when to embed into routine commissioning and provider practice, to inform service improvements and quality of care

Following implementation of the above, the following results have been achieved:

- Benchmarking older people's services was established in clinical commissioning quality schedules for 2015-16 and then again for 2016-17 for all original eight acute Trusts within the East Midlands
- The co-production of an East Midlands toolkit that allows all the East Midlands acute Trusts to see

and engage with data provided by all the other acute Trusts in the region. This is an innovative approach as NHSBN data is usually anonymised. The East Midlands AHSN was instrumental in brokering agreement to engender this

- Seven out of eight organisations have incorporated this in action plans and quality improvement plans and/or business cases. Results have been escalated to board level with four acute Trusts
- Pathway benchmark metrics were developed in partnership with NHSBN and colleagues across the East Midlands using findings from the acute benchmark and a stakeholder workshop. Derbyshire was selected as the pilot site for testing the new metrics and reflected the STP footprint with seven of the organisations taking part from CCGs, acute Trusts and community Trusts. Findings from this exercise were shared with clinicians and commissioners, and used to inform the full metrics by the NHSBN
- Roll out of the pathway metrics commenced in January 2017 across the region, with 28 out of 33 organisations taking part
- This has provided a benchmarking toolkit to highlight areas of best practice and learning across the whole patient pathway that is accessible to patients, public and staff. Key findings included:
    - Collecting data on frailty is not easy and as a result an age cut of the data was used instead. Going forward this will be easier once data relating specifically to frailty is collected in primary care
    - The bespoke data collection highlighted poor data on primary care
    - There was overall poor quality data even though the metrics to be collected were pared down following the pilot data collections. From this, it could not be assumed data was easily collectible
    - The data from acute and community providers was much better populated and it was possible to split the data by CCG, thereby allowing chunking up into STP reports. This was useful to see how provision differs across the region
    - Although variation appeared in some of the data when looking at CCG level, once data was reported at STP level the variation evened out and become more useful and easier to analyse
    - All those present at the workshop agreed this was a good start in understanding the diversity of needs for service provision for the frail. However, further work would need to be done on the metrics to be able to use them more widely
    - Providers of healthcare care are able to utilise their benchmarked data in a timely fashion to inform and improve service delivery, and improve outcomes for patients by sharing best practice
- To date, the pathway benchmark data has been used to inform the A&E delivery board work that is ongoing across the region. This data was particularly useful in being able to hypothesise on the impact of how services are commissioned and the rising numbers of older people who are treated in acute hospital A&E departments
- The work has highlighted the urgency of need to communicate the CGA assessments (comprehensive geriatric assessment) carried out by acute care to community colleagues. This work is being started in healthcare of older people services in one of the busiest acute hospitals in the East Midlands

Funding Required Contact AHSN for details.
Reports/Resources http://emahsn.org.uk/programmes-and-projects/frail-older-people/ http://emahsn.org.uk/images/End_of_programme_report_-_Frailty_FINAL_copy_for_web.pdf
For further information Louise Bramley, Programme Service Improvement Advisor, East Midlands AHSN louise.bramley@nottingham.ac.uk

Project 22: Healthy Ageing / Electronic Frailty Index (eFI) Tool

Delivered by:

YORKSHIRE & HUMBER
ACADEMIC HEALTH SCIENCE NETWORK

Setting	Overarching aim
Primary Care / Community.	To deliver high quality, person-centred, coordinated care for older people with frailty and their carers.

Life expectancy is increasing, which offers opportunities and challenges as people who live longer are at risk of developing health conditions related to the ageing process that are likely to have a significant impact on individuals, their families and society. Frailty is a health state that is common in old age; it develops because, as we get older, our bodies change and can lose their inbuilt reserves. This means older people with frailty can experience sudden, dramatic changes in their health when they have an illness.

The Healthy Ageing programme is a coordinated programme of evidence-based improvement interventions delivered in partnership with primary and community care teams. It supports teams to provide safe care to people with frailty, to better meet the needs of older people with frailty and their carers, and to reduce the use health and social care resources. It builds on Yorkshire and Humber AHSN's electronic Frailty Index (eFI) tool. The eFI represents a major, innovative advance in the care of older people as it enables early identification and severity grading of frailty using existing primary care data without the need for a resource-intensive clinical assessment, and it has been shown to have robust predictive validity for outcomes of mortality, hospitalisation and nursing home admission (Clegg et al, 2016). The tool enables better targeting of interventions, improved planning of health service utilisation and the development of more appropriate, proactive, goal-oriented care.

The eFI contains 36 deficits, including clinical signs, symptoms, diseases and impairments. The tool enables the calculation of a frailty score that can be used to identify people with mild, moderate and severe frailty. A higher eFI score identifies older people at increased risk of hospital admission, care home admission and mortality.

Healthy Ageing projects include:

- **Supported Self-care for people at risk of mild frailty:** working with Connected Yorkshire, part of Connected Health Cities programme to use linked primary and secondary care data to improve self-management intervention targeting and evaluation of a proactive upstream preventative intervention for people at risk of mild frailty in partnership with a GP practice in Bradford and Districts CCG and Age UK Bradford and District. 100 patients (identified as being at risk of mild frailty using the eFI) have received the intervention and will be followed up for 6 months to ascertain if the intervention has had an impact on the primary outcomes of interest – self-management ability and primary care utilisation.

- **Safer Prescribing for Frailty:** working with Harrogate and Rural District CCG's Medicines Management Team and 12 GP practice teams from across North Yorkshire in a breakthrough series approach to provide training and support action in primary care to reduce inappropriate polypharmacy in people at risk of severe frailty (as identified by eFI). Teams are supported with training on psychological theory to support the identification of the barriers to deprescribing (the process of supervised withdrawal of medication) in primary care, quality improvement training and tools to address the barriers encountered, and support small scale tests of change to be implemented. Results demonstrate statistically significant improvement in deprescribing activity alongside individual behaviour change and a culture shift in practices towards holistic medication review to support reductions in inappropriate polypharmacy.
- **Investigating health economic impact of frailty:** using analysis of a large primary and secondary care linked research data set to add to the understanding of the impact of frailty, measured by eFI, on the utilisation and the costs of primary and secondary healthcare.
- **CLEARPATH (in collaboration with the University of Leeds Data School of Computing):** using big data visualisation and care pathway mapping to identify treatment burden, inefficiencies and gaps in service provision for people identified (by the eFI) to be at risk of frailty.
- **Dementia & Frailty:** investigating the relationship between dementia and frailty to enable more timely access to palliative care services. The aim of the work was to examine the distribution of the eFI score for patients with dementia and frailty and their proximity to death to help identify which sub-group are most likely to benefit from more timely access to palliative care services.
- **Supporting primary care to implement the new GMS Primary Care Frailty Contract 2017-18:** working closely with Yorkshire and Humber AHSN Transforming Primary Care team to understand support requirements at STP footprint level related to frailty and frailty care pathway transformation.
- **Primary care clinical frailty template (SystmOne and EMISWeb):** developed a clinical frailty template based on the principles of comprehensive geriatric assessment for the two main UK primary care electronic health record systems to support improved multifaceted assessment and individually tailored needs based care and support planning for people identified to be at risk of frailty in primary care. The template has been published in EMISWeb and is currently being modified for publication in SystmOne - publication has/will enable access to all S1/EMIS users across England.
- **Two frailty intervention cost consequence analyses:** in collaboration with York Health Economics Consortia, a proactive practice nurse-led home-based frailty assessment intervention and a STOPP support medication review with care home residents intervention has been undertaken. The evaluation report for each project is currently being written, anticipated to be published by mid-December 2017.
- **Disruptive and Empowering Innovations in Healthy Ageing**: is a report being developed by Yorkshire and Humber AHSN that will show case some of the best case studies and ideas in health ageing from across the country. It is due to be published at the end of 2017.

Funding Required

Contact AHSN for details.

Reports/Resources

http://www.yhahsn.org.uk/service/population-health-service/healthy-ageing-collaborative/

www.ahsnnetwork.com

https://academic.oup.com/ageing/article/45/3/353/1739750

For further information

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Project 23: Hydration in Care Homes

Delivered by:

Oxford Academic Health Science Network

Setting	Overarching aim
Residential and Nursing Homes.	To reduce the number of urinary tract infections (UTIs) that require antibiotics or admission to hospital by improving the hydration of care home residents.

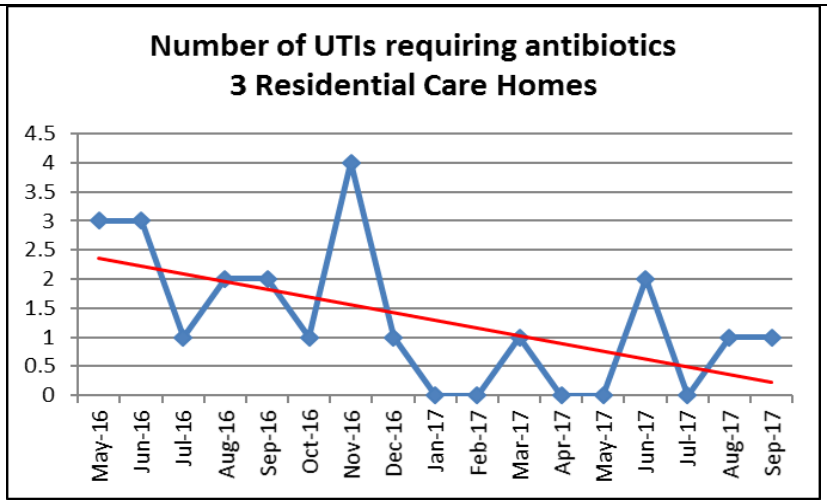
The hydration of people living in residential and nursing homes is improving as a result of a partnership between the Oxford AHSN Patient Safety Collaborative and Windsor, Ascot and Maidenhead CCG.

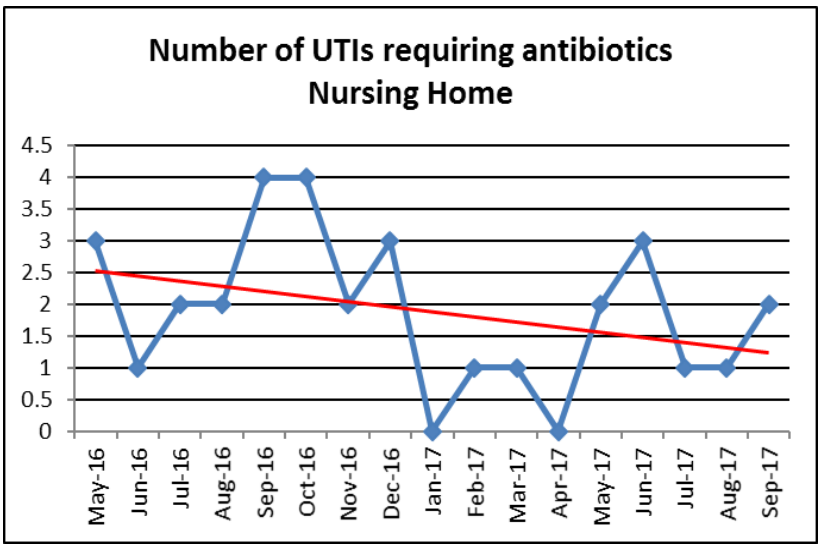
The project, with four care homes, includes provision of training for staff and residents, introduction of structured drinks rounds (seven per day) and use of diaries to record fluid intake and diet where residents have been identified as at risk of dehydration.

Training included:

- Anatomy and physiology of the urinary system
- Importance of hydration and how to recognise dehydration
- Effect of certain medications on the kidneys
- Risk factors of UTI and Acute Kidney Injury
- How to implement a structured drinks round

Results from a year into the project have shown a reduction in the incidence of UTIs and compliance with the seven daily structured drinks rounds, with two care home consistently achieving 100% compliance. The graphs below show the number of UTIs requiring antibiotics across the 3 residential care homes and one nursing home.





Feedback from a focus group involving the four care homes has been extremely positive:

- Greater understanding within staffing groups of the importance of hydration
- Residents have learned how much they were drinking through the use of a diary, which has motivated them to increase their fluid intake
- Noticed improved skin integrity and fewer falls
- Fewer GP visits
- No major increase in cost or time commitment; it is just a different way of working

The project is now being adopted in Oxfordshire and other parts of Berkshire East. Discussions are currently in progress with Chiltern CCG, Swindon CCG and Bedfordshire, Luton and Milton Keynes STP to replicate this work within these areas.

In October 2017, this project won three PrescQIPP awards for innovation and patient safety.

Funding Required 0.5wte project support.
Reports/Resources http://www.patientsafetyoxford.org/clinical-safety-programmes/reducing-the-incidence-of-acute-kidney-injury/hydration-project-in-care-homes-in-partnership-with-windsor-ascot-and-maidenhead-ccg/
For further information Katie Lean, Patient Safety Manager, Oxford AHSN katie.lean@oxfordahsn.org

Project 24: Dementia – Care Home In-Reach Teams

Delivered by:

Oxford Academic Health Science Network

Setting	Overarching aim
Care Homes.	To deliver a person-centred care approach to improve quality of life of people with dementia living in care homes.

Approximately 60 – 80% of people living in care homes have dementia, and they may also have co-existing mental and physical health needs. Recognition of this full range of complex needs can be difficult for the care home staff.

The Oxford AHSN has established a sustainable practice forum for reflecting on, developing and evaluating own good practices. The forum supports the use of evidence-based approaches and is open to health teams that in-reach into care homes, working with people with dementia. In the past, in-reach teams from different geographical areas have worked largely in isolation from each other, with several different models of teams. With this diversity, there is much that they can learn from each other. The network focuses on how services are delivered effectively, measured and maintained, and supports a proactive approach rather than one where the teams are only responding reactively on a patient-by-patient basis.

The AHSN has run CPD events in which teams have been encouraged to identify projects to work on and to share their work on these. Projects identified by the teams have included:

- Establishing a system where pain in people with dementia is routinely assessed
- Training and supporting dementia champions in care homes
- Improving oral care for residents in care homes

Two workshops have also been held for care home staff, to share the work being undertaken.

Funding Required

0.1wte project support plus venue costs.

Reports/Resources

http://www.oxfordahsn.org/our-work/clinical-networks/dementia/care-home-in-reach-teams/

For further information

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Project 25: Improving Care for Frail Older People – Programme of Work

Delivered by:

ACADEMIC HEALTH SCIENCE NETWORK
NORTH EAST AND NORTH CUMBRIA

Setting	Overarching aim
Whole System.	A wide range of initiatives to improve care for frail older people.

The North East and North Cumbria AHSN has been actively involved in a wide range of initiatives that focus on improving care for frail older people. Below is a summary of the 16 initiatives plus 4 learning events hosted by the AHSN that comprise this programme of activity.

Workforce Development

1. ***Addressing Skills Training Challenges in Care Homes:*** The aim is to up-skill care home staff to confidently manage the health status of their residents within the care home setting, and thereby reduce unnecessary interventions by NHS services. Training was delivered in 2 stages to registered nurses and carers in care homes across 3 CCG areas (North Durham; Durham Dales, Easington and Sedgefield; Darlington) with funding from the CCGs and AHSN NENC.

   Stage 1 (registered nurses in care homes): training covered venepuncture, catheterisation, end of life care, verification of death, and emergency response.

   Stage 2 (care staff): training covered application of the 6Cs, best care for long-term conditions, mental capacity and managing challenging behaviour.

   Since the training began, there has been a 72% overall reduction in incidents reported in Darlington, and 65% reduction in County Durham.

   Further information: www.ahsn-nenc.org.uk/project/259/

   Contact: Melanie Hesketh, Adult Safeguarding Lead, North Durham CCG (melanie.hesketh@nhs.net),

   Susan Hepburn, Quality and Development Manager, North Durham CCG (susan.hepburn1@nhs.net) and Joanne Collerton, Frail Elderly Programme Lead, AHSN NENC (joanna.collerton@ahsn-nenc.org.uk)

2. ***End of Life Care Training for Care Home and Domiciliary Care Staff:*** the AHSN NENC and HEE North East funded training that aims to improve the care delivered by care staff at the end of life, both in care homes and the wider community. In doing so the care for older people nearing the end of life will be improved and pressure on the NHS alleviated by reducing avoidable hospital admissions and increasing the proportion of deaths occurring in the usual place of residence. Training helps staff to recognise the signs associated with someone who may be nearing the end of life, and to be aware of the specialist services available in their local area. Training is delivered by palliative care specialists and follows the guidance within the 'Deciding Right' documentation.

Further information: www.ahsn-nenc.org.uk/project/242/

Contact: Jill Smith, Strategic Workforce Development Manager, HEE-NE (jill.smith@ne.hee.nhs.uk) and Joanna Collerton, Frail Elderly Programme Lead, AHSN NENC (joanna.collerton@ahsn-nenc.org.uk)

3. ***Dementia Care Training for Care Home and Domiciliary Care Staff:*** the AHSN NENC and HEE North East funded training for care home staff and social care staff working in the community that focuses on improving the care delivered to people with dementia. The training helps staff to recognise the symptoms and signs associated with dementia, to understand the key issues and treatment programmes, and to be aware of specialist services available locally.

   Further information: www.ahsn-nenc.org.uk/project/174/

   Contact: Jill Smith, Strategic Workforce Development Manager, HEE-NE (jill.smith@ne.hee.nhs.uk) and Joanna Collerton, Frail Elderly Programme Lead, AHSN NENC (joanna.collerton@ahsn-nenc.org.uk)

Dementia

4. ***North East Dementia Innovation Hub (Newcastle University):*** AHSN NENC funding supported the development of the North East Dementia Innovation Hub and the delivery of two specific projects:
   a. RCGP Dementia Roadmap: an e-resource that provides information about the dementia journey, alongside specific information on local services, support groups and care pathways. The roadmap has been piloted in 3 areas in the North East.
   b. Sound Doctor Dementia Films: information films that provide practical advice on how to cope with dementia and get the most from life. A DVD (Living Well with Dementia) can be purchased from Amazon and CCGs can purchase access to the films for their patients through the Sound Doctor company.

   Further information: www.ahsn-nenc.org.uk/project/179/

   Contact: Lynne Corner, Director of NE Dementia Innovation Hub (lynne.corner@ncl.ac.uk) and Joanna Collerton, Frail Elderly Programme Lead, AHSN NENC (joanna.collerton@ahsn-nenc.org.uk)

5. ***Living Well with Dementia:*** designed and delivered by the North of England Mental Health Development Unit, this is a self-care programme for people recently diagnosed with dementia and/or their carers. The AHSN NENC provided funding to support the development of this programme. The programme focuses on:
   a. Knowledge of dementia services and providers, and an understanding of what a 'good' standard of care looks like
   b. Personal outcomes including the ability to overcome personal care barriers, confidence, problem solving strategies and practical skills that make a difference to daily life
   c. Skills required to help shape services and challenge provision, including the ability to present issues in a constructive way and to articulate the needs of self and others

   A self-care wheel has been developed, consisting of 6 'I' statements related to specific elements of self-care and self-management.

   Further information: www.ahsn-nenc.org.uk/wp-content/uploads/2016/11/DaveBelshaw2.pdf

   Contact: Dave Belshaw, Project Lead, AHSN NENC (dave.belshaw@ahsn-nenc.org.uk) and Elaine Readhead, Mental Health Programme Lead, AHSN NENC (elaine.readhead@ahsn-nenc.org.uk)

6. ***CRESTA (Clinic for Research and Service in Themed Assessments) for Dementia:*** CRESTA provides a one-stop assessment, where patients see a number of healthcare professionals at the same outpatient visit. The clinic also identifies potential patients to get involved in research and clinical trial projects. The clinics are delivered by Newcastle upon Tyne Hospitals NHS Foundation Trust, working with Newcastle University. AHSN NENC funding is supporting a pilot study of CRESTA for patients with dementia.

   Contact: Elaine Readhead, Mental Health Programme Lead, AHSN NENC (elaine.readhead@ahsn-nenc.org.uk)

7. ***MindMate:*** MindMate is an award-winning App designed to provide an assistance platform for people with early stage dementia, their carers and family. The App aims to engage the person living with dementia and help keep their mind active, facilitating the retention of memories, and by connecting the family, it enables the sharing of information with their carers. Currently there are 3 separate products – MindMate for patients living with dementia; MindMate Family; MindMate Pro (for care facilities).

   Further information: www.ahsn-nenc.org.uk/project/mindmate-an-app-based-platform-empowering-people-with-dementia/

   Contact: Susanne Mitschke, MindMate Ltd (susanne@mindmate-app.com) and

   Carol Nicholson, Deputy Director of Innovation, AHSN NENC (carol.nicholson@ahsn-nenc.org.uk)

Nutrition and Hydration

8. ***Hydration Monitoring Solution for Care Homes:*** this project saw the introduction of a standardised hydration policy across all 18 care home in North Tyneside CCG, and the development of a mobile hydration monitoring app (Hydr8), which was trialled in 5 nursing homes in North Tyneside. Each resident has their own profile on the Hydr8 app, where all their fluid intake is recorded. The cumulative total can be viewed at a glance with an infographic displaying the percentage of hydration status attained. Residents at risk of becoming under or over hydrated can be easily identified and a standardised protocol then guides staff to the appropriate response. Data from all residents is relayed back to a central data store which is accessible to the care home manager, care home provider, CCG and authorised clinicians.

   Further information: www.ahsn-nenc.org.uk/project/130

   Contact: Gary Charlton, Project Lead, North Tyneside CCG (gary.charlton@northtynesideccg.nhs.uk) and

   Joanna Collerton, Frail Elderly Programme Lead, AHSN NENC (joanna.collerton@ahsn-nenc.org.uk)

9. ***Health Call Undernutrition Service:*** County Durham and Darlington NHS Foundation Trust has developed an innovative digital method of monitoring patients who have been prescribed oral nutritional supplements. This programme of work explores the impact of changing dietetic service delivery from traditional outpatient appointments or home visits to using the Health Call Undernutrition Service locally, regionally and nationally.

   The pilot evaluation showed potential cost savings of over £150,000 if the Health Call Undernutrition Service was rolled out to 1000 patients. It is now in used in 3 localities, in both patients' homes and care homes. It is currently being piloted by Age UK lunch clubs.

   Further information: www.ahsn-nenc.org.uk/project/evaluation-of-health-call-undernutrition-service/

   Contact: Catherine McShane and Ian Dove, Project Leads, County Durham and Darlington NHS FT

(catherine.mcshane@nhs.net / ian.dove@nhs.net)

Joanna Collerton, Frail Elderly Programme Lead, AHSN NENC (joanna.collerton@ahsn-nenc.org.uk)

Advanced Care Planning

10. ***Deciding Right:*** this is an initiative that aims to help people make healthcare decisions in advance, with individuals who do not have capacity or may lose capacity in the future being empowered to make the right decisions about the care they wish to receive in an emergency or at the end of their lives. Forward planning in this way should reduce the number of deaths occurring in hospital and increase the number of people who are able to die in their own homes.

    This project delivered practical training on the use of the 'Deciding Right' documentation across the region, developed a 'Deciding Right' app to guide healthcare professionals in the assessment of mental capacity, and brought 'Deciding Right' into the public domain through a media launch.

    Further information: www.ahsn-nenc.org.uk/project/40

    Contact: Adrienne Moffett, Project Lead, Northern England Clinical Network (adriennemoffett@nhs.net)

    Joanna Collerton, Frail Elderly Programme Lead, AHSN NENC (joanna.collerton@ahsn-nenc.org.uk)

Integration / Shared Electronic Records

11. ***Electronic Palliative Care Coordination System:*** this project, led by North Tyneside CCG, the Northern England Clinical Network and Connected Health Cities, aims to:
    a. Enable clinicians in all organisations to have access to the same vital information on end of life patients so that patients' wishes are respected even when they are too ill to communicate
    b. Provide better coordinated care for people at the end of their life
    c. Allow more people to die in their place of choice
    d. Reduce inappropriate hospital admissions at the end of life and thereby reduce the number of deaths occurring in hospital

    The Medical Interoperability Gateway (MIG) has been adopted as the records sharing solution locally. The MIG allows acute Trusts and other healthcare services to view primary care records and a summary of care within them. The project is now facilitating the development of an Electronic Palliative Care Coordination System (EPaCCs) within the MIG, and the next phase is to develop a more sophisticated system to allow multiple organisations to have read and write access to a shared electronic system.

    Further information: www.ahsn-nenc.org.uk/project/39

    Contact: Kathryn Hall, Project Lead (Kathryn.hall@nhs.net) and

    Joanna Collerton, Frail Elderly Programme Lead, AHSN NENC (joanna.collerton@ahsn-nenc.org.uk)

12. ***Strata Resource Matching and E-Referrals – Palliative Care and Care Homes:*** Failures in coordination between care providers can seriously impact on patient safety. Strata is a software programme that allows care providers to see a full directory of services available in their region and their current capacity. Patients' needs can then be matched to the most appropriate service available and an electronic referral made in a timely manner.

    The Strata system greatly improves the transition of care between organisations, improves real-time visibility of the resources available, reduces inefficiency and unsafe practices, and improves the quality of record keeping. Funding from the AHSN NENC and AHSN NWC supported the implementation of this

system within hospices, specialist palliative care teams, and residential and nursing care homes across Cumbria. It has been estimated that the e-referrals have a cost saving of £23 per referral.

Further information: www.ahsn-nenc.org.uk/project/56

Contact: William Lumb, Project Lead, Cumbria CCG (william.lumb@cumbriaccg.nhs.uk) and

Joanna Collerton, Frail Elderly Programme Lead, AHSN NENC (joanna.collerton@ahsn-nenc.org.uk)

Vanguard Working

13. ***Well Connected Care Home:*** AHSN NENC is working with two Vanguard organisations (Sunderland Multispecialty Community Provider Vanguard and Gateshead Care Home Vanguard) to support their digital care home projects, to enable care homes to be 'well-connected' in two ways.

    a. Clinical monitoring for ongoing care: care home residents are monitored by care home staff across a range of clinical domains, with the information recorded directly onto hand-held tables and then uploaded to a secure cloud-based storage system. Using standardised protocols, care home staff are guided as to the appropriate response to changes in a resident's profile. The data can be accessed by the care home staff, community nursing teams and GPs.

       All residents have baseline National Early Warning Scores (NEWS) and Abbey Pain scores recorded, and all are digitally monitored for nutritional status (Malnutrition Universal Screening Tool). Further NEWS monitoring is conducted if there is clinical concern, with escalation of monitoring frequency and referral determined by the actual score. Additional domains for digital monitoring are in development, including AF detection, hydration, falls, wound management, pressure ulcers.

    b. Shared Patient Records: there is currently no system widely in place to ensure all health and social care providers can access basic clinical and end of life information about patients. AHSN NENC is working with the Connected Health Cities programme to develop a digital shared records system for care home residents. A core set of clinical information will be shared between the various health and social care organisations with each having read and write access.

    Further information: www.atbsunderland.org.uk/wp-content/uploads/2016/06/ATB-New-technology-using-universal-medical-assessments-NEWS-to-track-the-health-and-wellbeing-of-older-people-in-the-city.pdf

    Contact: Rachael Forbister, Sunderland CCG and Lesley Bainbridge, Newcastle and Gateshead CCG, Project Leads (racheael.forbister@nhs.net / lesley.bainbridge@nhs.net) and

    Joanna Collerton, Frail Elderly Programme Lead, AHSN NENC (joanna.collerton@ahsn-nenc.org.uk)

Pressure Ulcer Prevention and Management

14. ***North East and North Cumbria Pressure Ulcer Collaborative:*** This programme brought together over 100 participants from 9 NHS Foundation Trusts, together with CCGs, care homes and universities in the North East and North Cumbria into a health improvement collaborative, based on a model from the Institute for Healthcare Improvement (IHI). During the collaborative, participants were expected to apply this knowledge and learning to a focussed project which aimed to reduce the number of avoidable pressure ulcers by at least 50% (from their baseline) within 12 months, and ultimately get to zero avoidable pressure ulcers. The aim of this approach was not only to significantly reduce harm but to support teams to develop a sustainable infrastructure to support improvement work going forward. Within 12 months the Collaborative held 5 collaborative meetings and a number of onside learning sessions.

The total number of pressure ulcers across the region over 15 months was significantly reduced by 36%. Individual Trusts, for example at Gateshead NHS Trust, reported a 71% reduction in harm within 12 months; Brackenthwaite Care Home in Cumbria has reported a 5-month period with zero pressure damage and (as of March 2016) were rated as Pressure Harm Free.

This programme was extended until December 2017 and training has been co-delivered with colleagues from South Eastern Health and Social Care Trust in Northern Ireland.

Further information: http://www.ahsn-nenc.org.uk/project/pressure-ulcers/

Contact: Andreia Cavaco, AHSN NENC lead (andreia.cavaco@ahsn-nenc.org.uk)

Medicines Optimisation

15. ***Transfer of Care using E-Referrals:*** Newcastle upon Tyne Hospitals Foundation Trust working with North of Tyne Local Pharmaceutical Committee and Pinnacle Health have developed an electronic referral template using PharmOutcomes, with the aim of improving medicine adherence, patient safety and patient outcomes. Hospital pharmacy staff can refer patients on discharge to their chosen local community pharmacy for continued support with their medicines using existing NHS services.

    AHSN NENC supported the development and implementation of this framework throughout the North East and North Cumbria region, and to date over 1000 patients have received follow-up support. Community pharmacists have reported nearly 90% of patients have a better understanding of their medicines as a result of their consultation and therefore will be more likely to adhere to their prescribed medicine regime.

    Further information: http://www.ahsn-nenc.org.uk/programmes/medicines-optimisation

    Contact: Julie Fletcher, Medicines Optimisation Programme Manager, AHSN NENC (julie.fletcher2@nuth.nhs.uk)

16. ***Supporting Vulnerable Adults with Medication Review:*** a scoping exercise was undertaken across the region which showed a high level of variation in pharmacist-led medication reviews, and varying amounts of resources dedicated to this work across CCGs. The purpose of the exercise was to highlight the geographical variation of a service that has been proven to be beneficial in both patient outcomes and financial savings.

    Further information: http://www.ahsn-nenc.org.uk/wp-content/uploads/2015/01/AHSN_Report_Medication_Review_Jan_16_updated.pdf

    Contact: Julie Fletcher, Medicines Optimisation Programme Manager, AHSN NENC (julie.fletcher2@nuth.nhs.uk)

Regional Events Hosted by AHSN NENC

A series of events was held with key stakeholders across the region to showcase the work happening across the AHSN NENC region and beyond.

17. ***North East Frailty Summit:*** this summit provided a great opportunity to find out about innovative approaches to improving the health and care of older people living with frailty. Event resources particularly relevant to this report include:

    a. Plenary session on New Models of Care for Frail Older People which showcased the innovative work of two local Vanguard programmes - Gateshead Enhanced Health in Care Homes and Sunderland

Multispecialty Community Provider - together with North Tyneside CCG's Care Plus programme, which demonstrated how major changes can be effected without additional funding.

b. Workshops on: Well Connected Care Homes; Frailty Nursing in Primary Care; Acute Frailty Network and Silver Trauma; Workforce Requirements for Healthcare in Care Homes; Recognition of End of Life in Frail Patients; Depression and the Frail Elderly.

c. Posters: 45 posters showcasing a host of innovative approaches to improving care for frail older people across a variety of care settings.

Further information: http://www.ahsn-nenc.org.uk/article/frailtysummit16/

Contact: Joanna Collerton, Frail Elderly Programme Lead, AHSN NENC (joanna.collerton@ahsn-nenc.org.uk)

18. ***Community Exercise to Prevent Falls:*** organised by the North East Regional Falls Task Group and the AHSN NENC, this event showcased innovative approaches to engaging older people in community based exercise from across the region. Further information: http://www.ahsn-nenc.org.uk/article/community-exercise-to-prevent-falls/

    Contact: Helen Ridley, Falls and Fractures Programme Manager, AHSN NENC (h.ridley@ahsn-nenc.org.uk)

19. ***Communicating Complex Needs Across the Interfaces of Care – Enabling Safe and Timely Transfers of Care for Older People:*** organised by AHSN NENC and Newcastle Gateshead CCG, this event brought together health and social care practitioners from primary, community and secondary care, and third sector colleagues. The focus was on considering the patient's whole journey through the care system, particularly around the interfaces of care.

    Further information: http://www.ahsn-nenc.org.uk/article/event-resources-communicating-complex-needs-across-interfaces-care/

    Contact: Joanna Collerton, Frail Elderly Programme Lead, AHSN NENC (joanna.collerton@ahsn-nenc.org.uk)

20. ***Care Home Matters:*** organised by AHSN NENC and Newcastle Gateshead CCG, this event celebrated and shared best practice within care homes. It was structured around the Enhanced Health for Care Homes Framework and drew on the expertise of the Gateshead Care Home Vanguard Pathways of Care Group and care home staff.

    Further information: http://www.ahsn-nenc.org.uk/article/carehomesmatter/

    Contact: Joanna Collerton, Frail Elderly Programme Lead, AHSN NENC (joanna.collerton@ahsn-nenc.org.uk)

Funding Required

See individual projects.

Reports/Resources

See individual projects.

For further information

See individual projects.

Project 26:	**I'm Still Me**
Delivered by:	UCLPartners Academic Health Science Partnership
Setting Whole system.	Overarching aim To develop a set of narrative statements to describe the way older people want high quality coordinated care to support them.

This is a joint project undertaken by National Voices, Age UK and UCLPartners to develop a set of narrative statements that describe the way in which older people want high quality coordinated care that supports them. The aim of these statements is to help commissioners and providers of health and social care to work together with older people, to design care and support that will be successful in achieving the outcomes that matter most to them.

Extensive research was carried out, including a literature review, online survey, focus groups, ethnographic research and one to one interviews. UCLPartners provided significant research support and workshop organisation for this project.

The 'I' statements were initially drafted by the project steering group around the key themes that emerged from the literature review, survey, interviews and workshops. The narrative was then reviewed, revised and verified through further discussion with older people.

The 'I' statements are:

- I can maintain social contact as much as I want
- I am recognised for what I can do rather than assumptions being made about what I cannot
- I am supported to be independent
- I can do activities that are important to me
- Where appropriate, my family are recognised as being key to my independence and quality of life
- I can build relationships with people who support me
- I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes that are important to me
- Taken together, my care and support help me live the life I want to the best of my ability
- I can make my own decisions, with advice and support from family, friends or professionals if I want it

Funding Required Project support provided by UCLPartners.
Reports/Resources https://uclpartners.com/what-we-do/patient-insight-and-involvement/examples-of-our-work/
For further information Jenny Mooney, Head of Programmes, UCLPartners jenny.mooney@uclpartners.com

Project 27: Safety in Care Homes

Delivered by:

East Midlands Academic Health Science Network
Igniting Innovation

East Midlands
Patient Safety Collaborative

Setting	Overarching aim
Care Homes.	To establish a mechanism for measuring, recording, analysing and sharing the prevalence of common care problems at an individual care home level across the East Midlands.

Care homes providers use different benchmarks for care quality. Data is collected in different ways, particularly in large chains, making cross-sector comparisons difficult. System wide improvement in this area is difficult to attain as there are currently no reliable measures for benchmarking the prevalence of common care problems. It is known that residents within care homes are at risk of a number of common care problems including pressure ulcers, incontinence, falls and polypharmacy. There are no reliable, nationally agreed benchmarking tools for these common care problems in care homes so it is impossible to know their true incidence or prevalence. This means it is also difficult to have robust conversations about what "good" care looks like and which elements of care practice have improved safety and should be spread and adopted.

The East Midlands AHSN and Patient Safety Collaborative are working with care homes to improve their capacity and capability to recognise, prevent and manage care problems through the introduction of measurement tools and techniques supported with quality improvement interventions. LPZ (National Prevalence Measurement of Quality of Care) is an internationally renowned annual independent audit for the measurement of care quality, and has been chosen for this work (www.lpz-um.eu/en).

Since the beginning of the project, a number of resources have been designed and produced to support care homes deliver evidence based care in medicines management, nutrition, pressure ulcers, preventing and managing falls, preventing delirium, promoting continence and reacting to moisture. A range of care standards for care homes in conjunction with NICE and 360 Assurance have also been produced. These standards can be used by care homes directly or to inform commissioning decisions.

In 2017, further care homes have been invited to take part in the LPZ audit. The AHSN and Patient Safety Collaborative are also undertaking an academic evaluation and health economic evaluation, and are working with health and social care commissioners with a view to embed LPZ in the contractual process. A number of case reports are being produced, which will be available on the East Midlands AHSN website.

Funding Required Contact East Midlands AHSN and Patient Safety Collaborative for details.
Reports/Resources http://emahsn.org.uk/psc-priority-areas/safety-in-care-homes/ http://emahsn.org.uk/images/Section_4_-_How_we_are_making_a_difference/Patient_Safety/EMAHSN_Care_Home_LPZ_A3L_Infographics_26.01.17.pdf http://emahsn.org.uk/images/PSC_A1_LPZ_Poster_V2b_PROOF.pdf
For further information Dr Cheryl Crocker, East Midlands AHSN Regional Lead: Patient Safety Collaborative cheryl.crocker@nottingham.ac.uk

Project 28: iSPACE – Dementia Friendly Surgeries

Delivered by:

Wessex Academic Health Science Network

Setting	Overarching aim
Primary care.	To better manage pathways of people living with dementia and their carers after a diagnosis of dementia.

The aim of iSPACE is to better manage patients living with dementia from first identification of the illness through diagnosis to post diagnostic care in the primary care setting.

- The key to the spread of iSPACE is the **engagement of staff teams** and a recognition that people with dementia need a more personalised care plan and access to resources to help them and their carers better manage the pathway
- Ultimately it is about keeping more people at home in dementia friendly communities and preventing a move to residential or nursing care.

The project had 6 sections:

- I – Identification of a champion in the surgery to drive the project
- S – Staff training
- P – Partnerships between the surgery and the patient, carer, their family and the local dementia services
- A – Assessment and early identification of this illness
- C – Care planning post diagnosis and ongoing care in the surgery
- E – Environmental changes to the building and spaces where care is delivered in the surgery

Impact

This project was implemented across Wessex between 2015 and 2017 and in that time over 150 surgeries completed the steps to become dementia friendly. This was subsequently evaluated in 40 surgeries to assess the quantitative impact of the project.

- Dementia diagnosis rates increased by 15.9% for people aged over 65
- The number of patients with dementia for whom a carer has been identified increased by 26%
- The number of staff trained more than doubled – over 1000 staff trained in 2016
- There was a reduction in clinical consultations by 6% by people living with dementia

Focus groups were held in three surgeries with patients and their carers.

- Patients and carers reported better care and understanding from the staff team
- Questions such as 'have you been offered an annual review?' elicited responses such as 'yes, this covered progression of the disease, social contacts, physical health, carer (spouse) consulted regarding concerns'
- A practice manager within Southampton reported that 'it has revolutionised the (patient's) annual review. We used to just do blood pressure, weight, and it felt like a tick box exercise. Now we have "This is Me", take details of the carer and give information about local services. Doing iSPACE has improved our care'

Funding Required

Funding was provided by Wessex AHSN Dementia Programme.

It takes approximately 8 hours to implement iSPACE, plus staff training and resources.

Reports / Resources

http://wessexahsn.org.uk/ispace

http://wessexahsn.org.uk/img/projects/Dementia%20Friendly%20Surgeries%20Summary%20Report%202017.pdf

For further information

Katherine Barbour, Senior Programme Manager, Wessex AHSN

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Section 4: Projects crossing more than one component of MSK, Fractures, Falls and Frailty

Project 29: Frailty, Falls and Fractures Programme

Delivered by:

Health Innovation Manchester

Setting	Overarching aim
Primary care.	To support strategic developments focusing on improving early identification and management of frailty, osteoporosis and falls risks in older people.

This programme builds on the implementation of the e-frailty assessment as part of the GP contract. In tandem with the use of the e-frailty tool, the use of a systematic fracture risk stratification will assist in the identification of those individuals in Greater Manchester who are at greatest risk of osteoporosis and falls, and commence the use of bone sparing therapy. It is anticipated the number of fall-related fractures will reduce.

The project is in development phase and seeks to design and implement a search tool which encompasses frailty and fracture risk assessment.

Funding Required

Not yet defined.

Reports / Resources

https://www.england.nhs.uk/publication/supporting-routine-frailty-identification-and-frailty-through-the-gp-contract-20172018/

http://www.yhahsn.org.uk/service/population-health-service/healthy-ageing-collaborative/

For further information

Dai Roberts, Programme Development Lead, Health Innovation Manchester

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Project 30: Polypharmacy Prescribing Comparators

Delivered by:

Wessex Academic Health Science Network

Setting	Overarching aim
Primary Care.	To highlight variation in prescribing activity at a CCG and GP practice level through the use of prescribing comparators.

Polypharmacy is the use of multiple medications by a patient, generally in older adults over the age of 65 years. In 10 years, between 2002 and 2012, there was a 62% increase in the number of medication items dispensed, and over a third of over 75 year olds take at least 6 medicines.

The key factors for addressing polypharmacy include:

- A person taking 10 or more medications is 300% more likely to be admitted to hospital
- 6.5% of hospital admissions are for adverse effects of medicines; this rises to 17% in the over 65 age group
- 30 – 50% of people do not take their medicine as intended by the prescriber
- Over £14bn is spent on medicines each year
- Over 70% of hospital admissions due to adverse reactions to medicines could be avoided

Wessex AHSN led a working group of GPs, pharmacists, prescribing analysts and clinical specialists who developed prescribing comparators from NHS Business Services Authority (NHS BSA) and NHS Digital. An initial suite of prescribing comparators at CCG and GP practice level was developed to highlight the variation in prescribing activity with respect to polypharmacy. Following this, the comparators were reviewed at a workshop open to the 15 AHSNs and the Royal Pharmaceutical Society; modifications to the comparators were made in light of the comments and suggestions made.

The purpose of Polypharmacy Prescribing Comparators is to highlight variation and to support CCGs and GP practices in addressing their polypharmacy work in the context of their medicines optimisation priorities. Furthermore, the comparators can be used to evaluate the impact and effectiveness of efforts already made to address polypharmacy.

The comparators available at GP practice and CCG level include:

- Average number of unique medicines prescribed per patient
- Percentage of patients prescribed 8 or more, 10 or more, 15 or more, 20 or more, unique medicines
- Percentage of patients with an anticholinergic burden score of 6 or greater, 9 or greater, 12 or greater

- Percentage of patients prescribed specific STOPP medicines (from STOPP / START tool)
- Percentage of patients prescribed multiple anticoagulant regimes
- Percentage of older patients prescribed medicines likely to cause Acute Kidney Injury

The comparators are available nationally on the NHS BSA ePACT2 platform, from which plans can be developed locally to address specific issues.

The NHS number can now be linked to prescription items and therefore much better quality in the prescribing in key areas can be demonstrated. As of September 2017, 92% of all prescription items can be linked to an NHS number with an accuracy of 99%; age and date of birth can be linked to 73% with an accuracy of 99%. As the use of electronic prescribing increases, the coverage and accuracy of this data will increase.

Funding Required

Partner organisations supported the development of the comparators in kind.

Polypharmacy Prescribing Comparators are available nationally via the NHS BSA ePACT2 platform.

Reports / Resources

http://wessexahsn.org.uk/projects/55/polypharmacy

http://wessexahsn.org.uk/programmes/11/medicines-optimisation

For further information

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