



Fracture Liaison Service Development and Improvement Guide

Using this guide

The guide is organised in a way that takes you through the service design and development process for a Fracture Liaison Service (FLS) from start to finish. There are six phases plus a section on the how to 'Manage and lead' a development project. The guide has been designed to be easy to use whether you are a clinician or a manager working in any type of organisation in any of the health services in the UK. We have tried to avoid using technical language and have given definitions where relevant.

This guide is just one of the tools available in the Fracture Liaison Service Implementation Toolkit and each of the other tools is referenced at the relevant point in the guide. These are shown in coloured boxes as:

Toolkit resource

The **Royal Osteoporosis Society FLS Tool Kit X** is fully editable and available at: ...

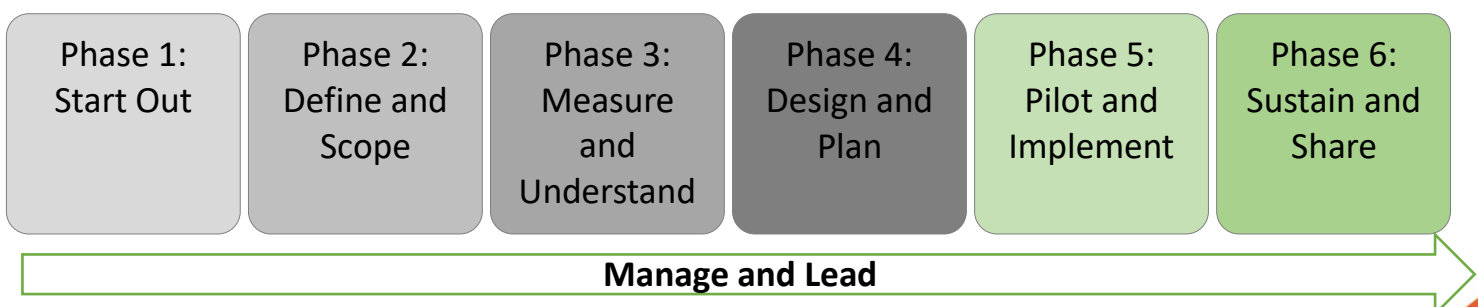
The guide is set out to complement the FLS Improvement Project Plan, an Excel workbook that helps you to manage the project through to success.

There are also several boxes that contain advice and ideas about how to carry out various tasks. These are shown as:

Useful hints

Described here.

This guide aims to help you get to implementation of your FLS. It follows the methodology published by the NHS Institute in 2013 and includes the following sections:¹





Why develop a Fracture Liaison Service?

The FLS model has demonstrated that it is uniquely effective in preventing secondary fractures by delivering assessments to 95-97% of at risk patients within the local population as opposed to only 25% of patients being assessed with other service models². The FLS model is associated with increased treatment initiation and adherence to treatment (65%–88% at 1 year)³. Organisations with an FLS were found to have a 40% reduction in the 3-year risk of secondary fragility fractures to major bones and a 30% reduction of re-fracture to any bone compared with organisations without an FLS⁴. FLS is associated with reduced mortality and it is cost-effective⁵. In May 2011, a formal cost-effectiveness analysis of the Glasgow FLS was published, which showed that between 1998-2008 the Glasgow FLS saw hip fracture numbers in Glasgow reduced by 7.3% versus an almost 17% increase in England (1.8% per year)⁶. Effective secondary fracture prevention throughout the NHS would prevent over 46,000 avoidable fragility fractures (including nearly 20,000 hip fractures) over 5 years in the UK⁷. In Glasgow, it was concluded that £21,000 was saved per 1,000 patients that were managed through the service⁸.

The FLS model, as recommended in Public Health England's Falls and Fragility Fracture Consensus statement (2017) as an evidence-based, cost effective, preventative intervention that can help to improve the health of the population and reduce health and care service demand⁹. In addition, NHS RightCare, whose pathways are designed to support local health economies to concentrate their improvement efforts where there is greatest opportunity to address variation and improve population health, recommend that commissioners focus on three priorities including: falls prevention; detecting and managing osteoporosis and providing optimal support after a fragility fracture. They identify fracture prevention services, incorporating 4 and 12 month follow-up of patients, as a high value intervention on the basis that effective case-finding and appropriate drug treatment reduces risk of further fractures by up to 50%¹⁰.

Phase 1 - Start Out:

Despite good evidence of the benefit of FLS and support from professional bodies such as those named in the introduction, it is estimated that only 55% of health economies in the UK offer some form of FLS.¹¹ As a clinician contributing to the delivery of musculoskeletal, emergency or geriatric care you may be aware of a need that can be used to drive improvement in your service. A good starting point will be to 'establish a rationale for any improvement work and obtain support for this work from an appropriate sponsor'.¹²

The start point is simple: talk to colleagues and others who are directly or indirectly involved in providing care to people with fractures, people at risk of falls or people with osteoporosis. These early conversations should aim to test and to shape ideas and to understand if the improvement project might be viable. In this early work you should agree the most appropriate person to give clinical leadership to the project; we might call this person the 'Clinical Champion' or 'Clinical Lead'.



What should the Clinical Lead/Champion do?

The role of the Clinical Champion is to engage and inspire clinicians, managers, patient groups and others to give their time and energy to the project. There is no requirement for the Clinical Champion to be a doctor but he or she will need to use their skills, influence and experience to promote the FLS to a broad range of individuals and organisations, especially to those that will be asked to pay for the new or improved service. This will include presenting information at public meetings and to a range of professional groups including representative committees and forums.

The Project Team

The project team will start out as the group of colleagues that come together to get the project underway. This core group should comprise those individuals who are committed to the success of the project and are able to give the time needed to see it through, including regular meetings of the team itself.

The Project Team will draft the documents that are needed to get things moving. The most important of these are:

- **Project Plan** – this is usually an Excel workbook that sets out the key steps in the project, assigning responsibilities and timelines.

Toolkit resource

The **Royal Osteoporosis Society FLS Improvement Project Plan** template is a populated Microsoft Excel workbook that includes the tasks that would need to be carried out to establish or to improve a Fracture Liaison Service. It also allows you to add completion dates, a lead for each task and colour coding (red, amber, green). It is fully editable and available within the FLS Implementation Toolkit on the ROS website.

- **Project Initiation Document** – this is a brief document that describes what you are trying to achieve in a way that can be understood by anyone with an interest in the project, including patient groups, social care professionals and others. It should be brief (2–4 pages, but 1 is good) with any technical terms or acronyms explained. It should include details of how to get involved in the project. This might be called an outline 'project initiation document' or 'project brief'. The value of this document is to communicate to anyone interested what the project is about in a way that is consistent. It also saves time as you can print it out for meetings or attach to emails to quickly communicate what you are trying to do.



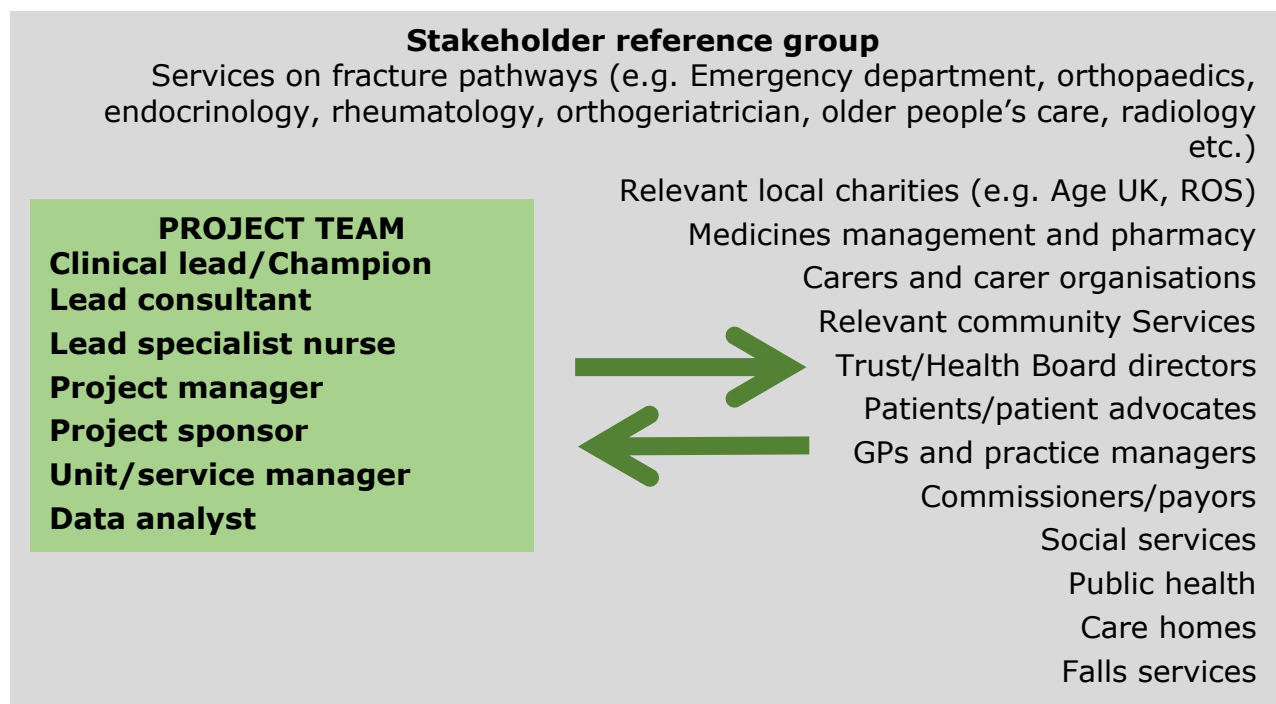
Identify your stakeholders:

Identifying your local stakeholders should be one of the first steps you take when embarking on any change project. Only by including the many different experiences of those who interact with the service is it possible to develop an understanding of the complete service or system.

Stakeholder mapping is not difficult, it just means that you need to think about all of the organisations and individuals that will have an interest in the new service. Once you have identified them and obtained contact details you can invite them onto the project team or include them in a wider Stakeholder Reference Group.

The **Stakeholder Reference Group** should be as inclusive as possible and should, by definition, include all those that consider themselves stakeholders. This means inviting everyone you can think of that may be interested. It may seem like a large number at first which can seem difficult to manage, but numbers will settle down over time and there are real benefits to making sure that everyone has an opportunity to participate.

You now have a basic structure with a Clinical Champion/Lead, a Project Team and a Stakeholder Reference Group. The graphic below shows how these two groups might fit together and who might be involved. Of course, different arrangements will be appropriate for different health communities and this model should not be regarded as prescriptive, you could also think about having a patient representative within the project team too.



The outcomes from this stage should be:

- A functioning Project Team
- A first meeting of your Stakeholder Reference Group
- A populate Project Plan
- An agreed Project Initiation Document

Phase 2 - Define and Scope:

In this stage, the evolving Project Team will develop a better understanding of the current situation, associated issues and start to create a process and plan for the improvement project. At this point it is useful to get your head around some of the terminology used for service improvement (see box below).

Some useful terminology

Patient (or clinical or care) pathway – this is a written or visual depiction of the predictable clinical course followed by a specific group of patients defined by diagnosis or other characteristic. It should be based on clinical evidence as far as possible and the different steps in the pathway should be defined, optimised and sequenced by the professionals involved in the patient care. A patient pathway might be delivered by just one provider (e.g. an FLS) but the term may also be used to apply to the entirety of a pathway including primary care diagnosis/history/referral; diagnostics; prescribing; tertiary care; and so on, whether or not these take place within the hospital.

Pathway redesign – this is a set of activities undertaken by a clinical team and other stakeholders to make changes to a patient pathway.

Service redesign – this is a type of pathway redesign that extends to changes to facilities, funding, staffing, management and/or other resources that need to be made for the new patient pathway to function effectively. A service redesign may be used to describe a set of changes to a service delivered by just one provider (e.g. a rheumatology department in a hospital) but it may also be used to apply to the entirety of a pathway and so includes actions to change such things as referral protocols, diagnostic testing regimes, and so on, whether or not these take place within the hospital. The terms 'pathway redesign' and 'service redesign' are often used interchangeably.

One academic source has described 'healthcare redesign' as 'thinking through from scratch the best process to achieve speedy and effective care from a patient perspective, identifying where delays, unnecessary steps or potential for error are built into the process, and then redesigning the process to remove them and dramatically improve the quality of care'*.

* Locock, L., Healthcare redesign: meaning, origins and application, Quality and Safety in Health Care (2003; 12:53-58)

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743671/pdf/v012p00053.pdf>



Hold an engagement event:

An excellent way to accelerate the project is to hold an engagement event. This will help to create enthusiasm as well as having some really practical outputs such as a map of the patient pathway and the patient journey. See box below for more information on holding a successful event.

Holding a successful event

There are lots of ways to organise your event and any event is likely to be better than no event. However, there are things that you can do which will increase the likelihood of success including:

Plan ahead – planning will usually lead to a better result than not planning. The most important bits of planning are simple questions like when, where, who, what?

Communicate – make sure that people know when the event is being held and what its purpose is. You don't need too much detail at this stage, just get the date in the diary.

Layout – people work well in groups and your event should make this easy. There is no need for lots of rooms, 'cabaret' style tables with 4–8 people on a table make instant work groups.

Programme – give out a programme on the day so that people know when they are meant to listen, when they are meant to work in groups, when they can eat and drink and when they can go home.

Objectives – be clear what you are trying to do and communicate this clearly on the day.

Facilitate – if possible, get someone to facilitate the event. You might even be able to get some sponsorship to fund a professional to do this.

Capture – don't let all the good ideas go to waste. Make sure you have a means to capture what was said. You should write this up and publish to all those that attended

Scope the current service:

There is a range of techniques that can be used for this stage. At the core of this stage should be the technique of 'process mapping'.

Process Map the patient pathway – this can be used as part of your engagement event. It should include all individuals who support, deliver or manage elements across the entire scope of the service in the discussion. Process mapping should identify all the interconnected pathway steps and decisions in a process and enables a multi-disciplinary team to better understand the problems, delays, areas for error and confusion, blockages and bottlenecks in what is currently being delivered.¹³



Process Map the patient journey – to improve care you also need to listen to patients. One way to do this is to map the patient journey. The patient pathway sets out what *should* happen to a patient whereas the patient journey will describe what *does* happen including all the waits, repetition of tests or questions, delays, lapses in communication. This is a skilled job and should be done by someone who is not currently delivering the service and may therefore be a little defensive. Charities and volunteer groups are well placed to do this work on behalf of the Project Team.

Some of the issues that might be revealed through these exercises include:

- Areas where care does not conform to guidelines or current protocols
- Areas where patients can 'drop out' or be missed
- Inconvenience for patients e.g. repeating steps, waiting for something to happen
- Missed opportunities to deliver effective care
- Inefficient use of resources such as staff time
- Long waiting times for appointments, DXA scans or other interventions.

These exercises will, by their nature, generate ideas for improvement which you need to capture (see box above 'Holding a successful event'). They will also help you to identify where you need to gather further information or data, in preparation for the next phase. Try to make sure that all of this is captured and reflected back to the stakeholders who gave up their time. Editing all of this into a brief and informative document can be tricky but is time well spent as it helps to build a consensus. Setting clear objectives is at the heart of this.

Define your objectives.

Having clear objectives is vital to make sure that your project stays on track. Without clear objectives you may find that different groups and individuals have different ideas about what the project is for.

The aim of the FLS is to reduce the incidence of fragility fractures in the older population by responding to the first fracture to prevent the second.

Objectives of the FLS are to deliver care in line with the published [Royal Osteoporosis Society Clinical Standards for FLS](#), which correlate to the FLS-DB National KPIs. See the Service Specification in the Implementation Toolkit for more help with this.

The outcomes from this stage should be:

- An understanding of the current patient pathway and patient journey
- An understanding of the patient pathway that you would like to put in place
- A clear set of objectives for your project
- An outline of the Service Model



- Identification of where you need to gather further information or data

Phase 3 - Measure and Understand:

This stage requires the use of data to fully understand the level of need in the local population and to quantify some of the problems you might already have highlighted. Identifying, extracting and analysing these data can be difficult and it is likely that you will need expert support. Public health and commissioners are often able to provide this and will also help you to build support for your planned improvements and you can seek advice from the ROS at fls@theros.org.uk

Understand the service need:

NHS data can be difficult to access and complicated to interpret. It is recommended that you seek the help and advice of the information team in your hospital, Health Board, Clinical Commissioning Group (CCG) or other organisations. It will help to have an idea of what is available and accessible, and the notes and tables below should help you with this.

National hospital statistics datasets are available at:

England	Health and Social Care Information Centre http://www.hscic.gov.uk/hes
Scotland	Information Services Division http://www.isdscotland.org
Wales	NHS Wales Informatics Service http://www.infoandstats.wales.nhs.uk
Northern Ireland	Department of Health, Social Services and Public Safety http://www.dhsspsni.gov.uk/index/statistics.htm



Data items you will need to collect to build your business case:

Data item	Source	Comments
Local population to be treated in the fracture liaison service		
Number of males and females in age ranges to be treated	Local CCGs or Health Boards	
	ROS Benefits Calculator tool contains age band data for every CCG in England and Welsh Health Boards [contact the ROS for support with this]	
Number of patient admitted with fragility fractures by fracture site		
Hip Forearm Humerus Spine Lower leg	National hospital statistics datasets.	You may need help from your local information department to extract and interpret this data.
	If your hospital participates in the UK-wide National Hip Fracture Database you should have access to good quality data on this.	
	ROS Benefits Calculator tool will estimate the number of patients with fragility fractures across all fracture sites [contact the ROS for support with this]	
Cost of treatment of patient admitted with fragility fractures by fracture site		
Hip	In England the SUS dataset will have numbers of admissions which can be selected by procedure and diagnosis.	You may need help from your local information department to extract and interpret this data.
Forearm		
Humerus		
Spine		
Lower leg	No national tariff for the cost of admissions is in place in Scotland, Wales or Northern Ireland although local data sources may be available.	In the absence of local data tariff values using the English National Tariff system are a useful substitute.
Length of stay for patients admitted with fragility fractures		
Hip	National hospital statistics datasets.	You may need help from your local information department to extract and interpret this data.
	If your hospital participates in the UK-wide National Hip Fracture Database you should have access to good quality data on this.	
Other fracture sites	National hospital statistics datasets.	
Number of patients currently receiving bone health assessment		



Hip	If your hospital participates in the UK-wide National Hip Fracture Database you should have access to good quality data on this.	
Other fracture sites	Local audit data may be available.	
Number of patients currently offered bone-protection treatment after positive identification		
Hip	If your hospital participates in the UK-wide National Hip Fracture Database you should have access to good quality data on this.	
Other fracture sites	Local audit data may be available.	
Number of assessed patients currently offered referral for falls assessment or an intervention		
Hip	If your hospital participates in the UK-wide National Hip Fracture Database you should have access to good quality data on this.	
Other fracture sites	Local audit data may be available.	
Number of patients currently recommended drug treatment who are reviewed within 3 months		
Hip	If your hospital participates in the UK-wide National Hip Fracture Database you should have access to good quality data on this.	
Other fracture sites	Local audit data may be available.	

If you have an FLS and input onto the FLS-DB you will also be able to get data from this database.

The project team will then need to analyse and put the data collected into context against national standards and critically identify priorities that the service improvement needs to address.

For some of this work you may need to involve colleagues from the local commissioning organisations or from public health. This is a useful thing to do at an early stage as it should help to build support for funding of the service later in the improvement process.

Outputs from these exercises should allow the team to define more detailed objectives for the FLS and update the project charter and project plan. Take the opportunity to think critically about what is being proposing to ensure that your case answers the likely objections that you might face as you try to gain buy-in and momentum for your improvement work.



Toolkit resource

The **Royal Osteoporosis Society FLS Benefits Calculator** will help you to quantify the likely number of patients that will need to be treated in your FLS. This tool allows you to define the patients that you wish to treat by age, fracture site and so on and should tell you the number of fractures you should expect for your population. It is best used as a working estimate and other data will be needed to validate the outputs before you begin planning in earnest. For further information on this, please e-mail to request support at fls@theros.org.uk

Estimate the capacity required:

The next step is to understand the service need or demand in terms of how much capacity you will need to deliver the service. By capacity we mean:

- how many staff of which type and grade
- how many scans; and so on.

This should allow you to calculate the cost of the service which you will need for your business case.

This part of the process is normally carried out by an experienced clinical manager working with colleagues, so the Project Team is likely to have most of the knowledge that you need. A tool has been created specifically to make this easier for you.

Toolkit Resource

The **Royal Osteoporosis Society** will help you to determine the types and numbers of staff that you should need to deliver the service and will even let you test out different staffing models. For further information on this, please e-mail to request support at fls@theros.org.uk

The outcomes from this stage should be:

- Quantification of the number of patients that your FLS will need to assess and treat.
- An understanding of the likely impact that your service should have on the number of fragility fractures for your population.
- A good idea of the staff and other resources that you should need to deliver the service.

Phase 4 - Design and Plan:

By now you should have worked with your colleagues and other stakeholders to get a good understanding of the current situation including:

- Definition of your population
- The level of need in the population (population needs to be defined. Local Authority area? Trust area? CCG area Health Board Population?)
- The service that is currently available to meet (or not) the need
- Quality or other problems in the current patient pathway
- Patient concerns about how their care is delivered.

Going through this process you will have started to form ideas about how the service can be improved: it is time to draw these ideas together into a plan that can be shared with others. This part of the process should involve the widest possible opportunity for people to engage. One really helpful method is to hold an event for your project team and your reference group to come together for a facilitated workshop to describe the patient pathway and draw up a service specification.

More useful terminology

Service specification – this is a document that describes the service that is to be delivered. Where services are commissioned, the specification will list the aims of the service, the patient cohort, the range of interventions, quality standards, desired outcomes and so on. In this way the service specification should define the service in terms of the 'outputs' regardless of who delivers them.

Service model – this is a high-level description of a service and the components required to deliver that service, and is a useful way of thinking about how the service might be delivered in terms of staffing, location(s), skills etc. A service model differs from a service specification in that it generally describes the 'inputs' to a service although the two will often overlap and may be incorporated into a single document, usually the service specification.

Agree your service model:

There is a wide range of possible service models and an FLS can exist in secondary care or in a community setting including, in some cases, in general practice. Similarly, it can be delivered by a range of practitioners who have the appropriate skills and knowledge. Clinical management of the service could be undertaken by a wide range of clinicians from different disciplines including physiotherapy, radiology, DXA, nursing, occupational therapy and so on. What is essential for every service is that it is properly integrated with other services providing care



along the patient pathway including physiotherapy, fracture services, radiology, falls services and general practice and others.

You may already have given some thought to the service model that you want to see (see Phase 2). There are many types of service model that might be put in place and to an extent each FLS will be locally specific and have unique features. When considering your service model, you should be thinking about several different aspects including:

Location – does the service need to be based in the hospital or are there more suitable premises that offer a better patient experience and a better working environment?

Skills – think about what range of skills will be needed to deliver the service and how you will access people when you need them.

Staffing – closely related to skills but staffing, in terms of grade, experience and so on may be determined in some measure by what can be afforded.

Facilities – access to scanning equipment, pharmacy services (if you intend to dispense medicines) and suitable parking for patients are just a few of the considerations.

Integration – a vital part of the planning process is understanding how patients get into your service and their clinical management once they leave it. Make sure you look back at your work on the patient pathway and build this into your service model. For example think about how you will communicate with the patient's GP to make sure that their medication is dispensed and taken properly. You may need to have systems to follow up the patient as part of the service, and the staffing and costs of this will need to be included in your service model.

The Royal Osteoporosis Society '5IQ' model and Clinical Standards for FLS.

The Royal Osteoporosis Society describes a Fracture Liaison Service as a dedicated clinical service that systematically identifies, assesses, and treats all appropriate patients over 50 within a local population who have suffered fragility fractures and takes action to reduce the risk of further fractures. It is imperative the service is delivered to a high standard and for this reason the Royal Osteoporosis Society has published clinical standards for FLS ([ROS Clinical Standards for FLS](#)) which set out and describe the standards for all services, a summary is below:

STANDARD 1 - Identify: People aged 50 years and over with a fragility fracture are systematically identified.

STANDARD 2 - Investigate: Investigations to assess risks of fragility fractures and falls and possible underlying secondary causes for osteoporosis are offered to people identified by the FLS.

STANDARD 3 - Inform: Information and support are offered to people coming into contact with the FLS, and, where appropriate, their carers.



STANDARD 4 – Intervene: Interventions to reduce the risk of fragility fractures are offered to people as required.

STANDARD 5 - Integrate: The FLS will integrate with the wider healthcare system to facilitate an inclusive patient pathway; ensuring effective case finding, onward referrals and long-term management of osteoporosis.

STANDARD 6 - Quality: The FLS demonstrates clinical accountability, effective governance, professional development and ongoing service improvement.

FLS is an essential component of a comprehensive and integrated approach to preventing falls and fractures among people over the age of 50 in a local health system.



A set of 11 KPIs were developed by the Fracture Liaison Service Database (FLS-DB) multidisciplinary advisory group, which includes patient representation. All the KPIs are based on NICE technology assessments and guidance on osteoporosis and the Royal Osteoporosis Society (ROS) clinical standards for FLSs. The FLS should aim to deliver these KPIs as part of their service.

Toolkit resource

The **Royal Osteoporosis Society FLS Service Specification** has been created to save you time. The template is based on the format used by the NHS in England to accompany standard contracts and is part populated with a range of information. The tool is fully editable and available on the ROS website in the FLS Implementation Tool Kit.

Understand the funding options:

Ideally you will have involved in your project team people from the organisation that will have to pay for the service. This may be your trust or the local Health



Board or CCG; or you may be obtaining funding from a variety of sources; or establishing the service as a pilot. It is imperative at this point that you engage with the payors about the kind of service that you, and they, wish to see. See the box below for more information.

Developing a new FLS or improving an existing one takes money. Although the case for FLS is very strong there are many other claims on a limited supply of funding. It is likely that your project will need to compete with others.

Drawing up a business case is dealt with in the next section but before you put pen to paper you need to do some homework. At the very least you need to understand:

- **Which** body will pay for the service – is it your own trust or another organisation?
- **How** do they make the decision – what is the process and what do they need from you to make it?
- **When** will they decide – are there important deadlines that you just cannot miss?

Note that some service models may lead to changes to the way that a service is paid for and/or may entail making payments to other providers in the patient pathway who will be doing more or different things in the future. This might require changes to legal contracts (especially in England) and may even lead to a formal procurement process for the FLS that you are developing. Make sure that you take advice on this from business management or commissioning colleagues.

On rare occasions it is possible to develop a new service entirely from resources that are already in the system in your local area. It is much more likely that some new funding will be needed to get the FLS established. FLS is a highly cost-effective service in that it helps to prevent fractures that lead to very significant costs on the health and social care system. But these savings take time to realise and may be hard to identify. For these reasons you will almost certainly need to make the case for the FLS that you are setting up.

Draw up a business case:

Creating a compelling business case is essential and it requires some skill and time to do properly. The business case will need to set out the clinical and financial arguments in support of the service improvement, underlining the potential for improvements in patient outcomes, quality of care and cost savings over a prolonged period.

Toolkit resource

The **Royal Osteoporosis Society FLS Business Case** is a part populated template designed to save you time and effort. The tool includes referenced



data and information about the costs and benefits of an FLS. The tool is fully editable and available on the ROS website in the Implementation Tool Kit.

Once you have your business case you will need to get it approved. It is important to remember that, in the end, it will be people, maybe even colleagues who make the decision whether to fund your FLS. A good written business case will take you so far but having put all this work in, you do not want to leave anything to chance. That is why you need to go a little further to get the 'yes' that you need. See the box below for more.

Getting to yes!

As we all know, the NHS operates under financial constraints and there is often strong competition among different services for investment in service improvements. To get the business case approved you need to do more than just trust the system to favour your case. There is a lot you can do starting with some basic rules:

1. **Do your research** – understand the process of who, when and where.
2. **Shape the expectation** – don't be tempted to keep it under wraps until the day and have a big reveal. What you want is your funders to have decided to say yes before the meeting even starts.
3. **Persuade** – people make decisions, not organisations. Lobby, influence, cajole – find your allies and get them on your side.
4. **Be a problem solver** – and solve your funder's problem, not your own.
5. **Be there** – try to attend in person.

Toolkit resource

The **Royal Osteoporosis Society FLS Getting To Yes** is a power point presentation that demonstrates how to effectively communicate your business case to commissioners and get to 'yes' by avoiding the pitfalls and is available on the ROS website in the Implementation Tool Kit.

Note that the business case may be for a pilot phase only. Securing funding for a service beyond this (usually one or two years) will depend on being able to demonstrate the effectiveness of the service.

Draw up plans to pilot/implement:

This last stage of your planning process involves getting all the essential resources lined up and ready to go. What you need to do will depend on a number of factors such as whether it is a brand new service or a change to an existing one. Ideally you will have a separate mobilisation plan which details with everything you need to do but whatever your situation the plan should cover the following areas:



Workforce – you will need to build in time for recruitment processes, secondments and inductions to be carried out in good time.

Premises – make sure that they are ready and fit for purpose and any statutory obligations like Care Quality Commission authorisation are met in good time.

Information flows – any pilot project will have to demonstrate its effectiveness if it is to become sustainable, so good planning at this point will help you make sure that patients get good continuity of care and that all of your activity is properly recorded. Referral forms, discharge communications, DXA requests all need to be finalised and should be reviewed and agreed with other parts of the NHS that have to use them. Just to give one example, GPs get fed up with referral forms that don't integrate with their systems and you can win friends by asking some practice managers to look at the communications you are planning to use.

Communication – having all your communication activities planned is an important part of the process which must not be neglected. Poor communication will lead to slow uptake and could greatly affect the effectiveness of the service and outcomes you are hoping to achieve. Communication should begin well ahead of the start date, not on it!

Toolkit resource

The **Royal Osteoporosis Society FLS Implementation Plan**, which is an Excel documents and has been created to save you time. The tool is fully editable and available on the ROS website in the FLS-Implementation Tool Kit.

The outcomes from this stage should be:

- A clear description of the service standards, outcomes and service model all captured in a clear service specification.
- A business case that has been approved, thereby securing your funding.
- Detailed plans to get your pilot up and running.

Phase 5 - Pilot and/or Implementation of your service:

Once funding and organisational approval has been obtained for the project, implementation is the next stage. This really means carrying out the plans that you drew up in the previous phase so there is no need to go over these again. However, there are some important things to remember.

Communication needs to carry on past the service commencement date. There is an old saying in the 'science' of communications that goes...

'If they haven't heard it, you haven't said it'

What this means is that, if your message is not getting through and people are following your treatment plans then it is no good blaming them. People usually need a lot of persuading to change their behaviour. Take every opportunity to



communicate with important stakeholders via every method you can think of. There may be ready-made communications channels for you to use such as educational events, newsletters and regular professional meetings.

Capture and record data:

Also important is the accurate and comprehensive recording of all the information that you will need to demonstrate the success of your pilot or service if you can just go straight to service implementation. Many pilots fail to make it to mainstream services not because they were not effective but because they could not demonstrate it. The people who agreed to fund your pilot will not see the patients that you see and will not be able to perceive the outcomes that you get with these individual patients. It is important not to let a backlog of information build up that you will 'get around' to inputting into the computer.

A set of outcomes has already been devised by the Royal Osteoporosis Society to act as a start point in the discussion about outcomes.

Toolkit resource

The **Royal Osteoporosis Society FLS Outcome and Performance Indicators** is a Microsoft Excel workbook that includes a set of indicators that you might want to use to demonstrate the success of your service. A set of 11 KPIs were developed by the Fracture Liaison Service Database (FLS-DB) multidisciplinary advisory group, which includes patient representation. All the KPIs are based on NICE technology assessments and guidance on osteoporosis and the Royal Osteoporosis Society (ROS) clinical standards for FLSs. The FLS should aim to deliver these KPIs as part of their service.

The tool is fully editable and is available on the ROS website in the Implementation Tool Kit.

Phase 6 - Sustain and Share:

'The most successful organisations are those that can implement and sustain effective improvement initiatives leading to increased quality and patient experience at lower cost'.¹⁴ This means that the process of improvement never really ends, and you should look on the commencement of the pilot as the start and not the finish of the project.

Creating an improvement plan is a useful way to capture ideas generated by your team and to prioritise these in such a way that you don't try and do too much.

Linking to formal improvement programmes

One really powerful tool for improvement is to compare yourself and your unit to others doing the same job. There are a number of important programmes in the area of falls, fractures and osteoporosis that can really help you to accelerate improvements in your service. Some of these are shown below:



**Royal
Osteoporosis
Society**

Better bone health for everybody

Falls and Fragility Fracture Audit Programme:

<https://www.rcplondon.ac.uk/projects/falls-and-fragility-fracture-audit-programme-fffap-2014>

National Hip Fracture Database, FLS-DB and National Audit of Inpatient Falls:

<https://www.fffap.org.uk/>

A set of 11 KPIs were developed by the Fracture Liaison Service Database (FLS-DB) multidisciplinary advisory group, which includes patient representation. All the KPIs are based on NICE technology assessments and guidance on osteoporosis and the Royal Osteoporosis Society (ROS) clinical standards for FLSs. The FLS should aim to deliver these KPIs as part of their service.

Staff development

There are of course a wide range of training and professional development courses and programmes for your team to improve their skills. Some useful addresses and ideas are shown below:

Royal Osteoporosis Society: <https://theros.org.uk/healthcare-professionals/courses-and-cpd/>

International Osteoporosis Foundation: [Educational Hub | International Osteoporosis Foundation](#)

Nursing Times (online course): [Learning Units and Portfolio - Nursing Times](#)

Measuring improvement

The NHS Scotland Quality Improvement Hub states that 'measurement is important to determine whether changes that are believed to lead to improvements in quality do in fact result in improvements'.¹⁵ Measurement for improvement is not just for others (commissioners, the finance team) but should provoke discussion about what better looks like and how improvement will be recognised.

Having clear measures such as patient numbers, patient satisfaction scores and so on, makes it easier to tell your story when the time comes to decide whether the pilot should continue.

Sustainability is built on comprehensive service planning with firm understanding of how the service fits within the wider healthcare environment, engagement of the right people and realistic expectations about what is achievable within a given timeframe and budget. FLS have been successfully run around the world for over 20 years with a wealth of literature and resources available to support the development and planning of new service improvement.¹⁶ Any change requires a significant investment of time, financial resource and leadership effort throughout the duration of the project. The project team should critically assess the development of the service model throughout the project, ensuring that (where possible) key obstacles are resolved before the point of implementation.



Manage and Lead:

Maintain your Project Team and Stakeholder Reference Group.

This part of the improvement process refers to the less glamorous but no less important activity of keeping your project running and keeping everyone engaged. Many of your stakeholders will be giving up their own time (whether leisure time or lunch-breaks) to support your project. Keeping them engaged will depend on making it easy for them to input to the project and to see that their input has been listened to. Some tips for this are shown in the box below:

'Rules of engagement' – keeping people on board

There are some simple things you can do to make it easy for people to engage in your project.

A meetings calendar – setting a calendar of meetings several months ahead shows commitment to a project and makes it more likely that people can plan their time to attend. Try not to cancel or postpone unless there is a real crisis!

Clear agendas – try and set your agenda and stick to it. This gives the impression to everyone of a well-managed project that is likely to make it to completion. Sticking to your agenda depends on a good chair, another role for your 'Clinical Champion'.

Every minute counts – do your minutes as soon as possible after a meeting. Generally, action points are sufficient, so you don't need to quote everyone unless they specifically request it. Ideally you can find someone to type them as the meeting is going on and have them out the same day – very impressive.

'Feedback' is a verb – if you have an event or ask people to comment on a document or idea, make sure that you let them see how you have changed it.

Communicate, communicate, communicate – a regular update is really useful for maintaining engagement and enthusiasm. It shows that things are moving forward (or even that something has got in the way!) and that the recipient is part of that success. Don't worry if you end up with a bit of repetition but also there is no need to set yourself a timetable that is not sustainable.

Share and include – many people make the mistake of trying to manage engagement so that only certain kinds of people, such as professionals, can attend certain types of meeting or comment on certain types of material. This takes more work and can rebound if people come to think that there is a 'hidden agenda'. You should include all stakeholders unless there is a good reason not to.



Communicate with stakeholders:

Communication has already come up several times in this guide and there is a little more to be said except to ask you to think about your communications, who will read them and how they will make sense of them. For example, when speaking about engaging people in your project we might write...

"Engagement will ensure that the model endeavours to meet the needs of patients but also considers how to optimally manage and staff the service."

We might write this, but we certainly wouldn't speak nonsense like this. It is not clear who is endeavouring to do what to whom and what does endeavour mean anyway? There is no value in this kind of English and you will find that you reach a much better level of understanding and shared purpose if you just use plain English (see box below).

Writing in Plain English

The Plain English Campaign has been struggling against the bureaucrats of public service industries (including the NHS), local councils, banks, building societies, insurance companies and government departments and others. If we want to communicate effectively with all our stakeholders, whether clinical or management, patient or carer we need to use a form of English that does not exclude anyone. The main advantages of plain English are:

- It is faster to write
- It is faster to read
- You get your message across more often, more easily and in a friendlier way.

According to the Guide to Plain English you can follow some simple rules:

- **Keep your sentences short**
- **Prefer active verbs** e.g. '70 people attended the meeting' is better than 'the meeting was attended by 70 people'.
- **Use 'you' and 'we'** – rather than 'patients using the service' or 'the trust'.
- **Use words that are appropriate for the reader** – avoid jargon but don't be afraid to use technical terms if these are appropriate but give an explanation.
- **Don't be afraid to give instructions** – 'arrive five minutes before' rather than 'arrival five minutes early will enable etc. etc...'
- **Use lists where appropriate** – bullet points are fine.

For more information and a really useful guide go to:

<http://www.plainenglish.co.uk/files/howto.pdf>



References

1. The NHS Institute (2013). Project Management Guide. Available from: http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/project_management_guide.html. (Accessed September 2014).
- ² McLellan AR, Reid DM, Forbes K et al., (2004) NHS Quality Improvement Scotland. 'Effectiveness of Strategies for the Secondary Prevention of Osteoporotic Fractures in Scotland'. Available at: http://www.healthcareimprovementscotland.org/previous_resources/audit_report/osteoporotic_fractures_audit.aspx (accessed February 2020)
- ³ McLellan AR, Reid DM, Forbes K et al., (2004) NHS Quality Improvement Scotland. 'Effectiveness of Strategies for the Secondary Prevention of Osteoporotic Fractures in Scotland'. Available at: http://www.healthcareimprovementscotland.org/previous_resources/audit_report/osteoporotic_fractures_audit.aspx (accessed February 2020)
- ⁴ McLellan AR, Reid DM, Forbes K et al., (2004) NHS Quality Improvement Scotland. 'Effectiveness of Strategies for the Secondary Prevention of Osteoporotic Fractures in Scotland'. Available at: http://www.healthcareimprovementscotland.org/previous_resources/audit_report/osteoporotic_fractures_audit.aspx (accessed February 2020)
- ⁵ McLellan AR, Reid DM, Forbes K et al., (2004) NHS Quality Improvement Scotland. 'Effectiveness of Strategies for the Secondary Prevention of Osteoporotic Fractures in Scotland'. Available at: http://www.healthcareimprovementscotland.org/previous_resources/audit_report/osteoporotic_fractures_audit.aspx (accessed February 2020)
- ⁶ Skelton D, Neil F (2009). 'NHS Greater Glasgow and Clyde Strategy for Osteoporosis and Falls Prevention 2006-2010: An evaluation 2007-2009'. Available at: http://library.nhs.gov.uk/mediaAssets/OFPS/NHSGGC%20Strategy%20for%20Osteoporosis%20and%20Falls%20Prevention%2020062010_An%20Evaluation_Skelton%20and%20Neil%202009.pdf (accessed March 2020)
- ⁷ Royal Osteoporosis Society FLS Benefits Calculator available at: <https://theros.org.uk/healthcare-professionals/fracture-liaison-services/implementation-toolkit/>
- ⁸ McLellan AR, Wolowacz SE, Zimovetz EA, Beard SM, Lock S, McCrink L, Adekunle F, Roberts D (2011) 'Fracture Liaison Services for the evaluation and management of patients with osteoporotic fracture: a cost effective evaluation based on data collected over 8 years of service provision'. Osteoporosis International 22(7), pp2083–2098
- ⁹ Public Health England (2017) 'Falls and fracture consensus statement: Supporting commissioning for prevention' Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/586382/falls_and_fractures_consensus_statement.pdf (accessed March 2020)
- ¹⁰ NHS RightCare (2017) 'RightCare Pathway: Falls and Fragility Fractures' <https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2017/12/falls-fragility-fractures-pathway-v18.pdf> (accessed March 2020)
- ¹¹ Royal College of Physicians. Falling Standards, Broken Promises: Report of the national audit of falls and bones health in older people 2010. 2011 London: Royal College of Physicians. & Scottish Government. Up and about or falling short: A report of the findings of a mapping of services for falls prevention and management and fracture prevention in older people in Scotland. 2012. Edinburgh: Scottish Government
12. The NHS Institute (2013). Project Management Guide.
13. NHS IQ (formerly NHS Improvement) (2011). First steps towards quality improvement: A simple guide to improving services.
14. The NHS Institute (2013). Project Management Guide.
15. NHS Scotland Quality Improvement Hub website (2012). Measurement for improvement.
16. Mitchell PJ. (2011). Fracture Liaison Services. Osteoporosis Int. 22 (Suppl 3):S487–S494.