Parkinson's Academy®

Education with impact: Parkinson's Academy

PD Advanced MasterClass impact report 2025

Neurology Academy®

NEUROLOGY ACADEMY: EDUCATION WITH IMPACT

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Introduction

The Parkinson's Academy was founded on a simple but powerful idea: that education, when translated into practice, has the power to transform patient care. Each year, clinicians from across the UK bring this principle to life through the Parkinson's Advanced MasterClass — a programme that equips professionals not only with knowledge but with the confidence and tools to drive real-world change.

The 2025 Advanced MasterClass 48.2 cohort exemplifies what happens when learning becomes leadership. Over the past year, 28 dedicated clinicians have developed and delivered projects that directly improve safety, access, and quality of life for people with Parkinson's. Their work spans the entire care pathway — from acute hospital management to anticipatory planning, rehabilitation, and digital transformation in the community.

What makes this cohort's achievements so significant is the shared vision that underpins them. Every delegate has shown that small, practical innovations — a new pathway, a digital tool, a shared conversation — can together create a culture of proactive, person-centred care. This is not education for education's sake; it is education with measurable impact.

Across the UK, the projects showcased in this report are improving how Parkinson's care is delivered. They are empowering nurses, registrars, therapists, and consultants to lead change within their own services, and in doing so, they are shaping a stronger, more connected system of care.

At a time when the NHS faces increasing demand and complexity, these clinicians remind us that improvement begins with people — with curiosity, collaboration, and courage to do things differently. Their work demonstrates that when education inspires action, the result is genuine system change.

On behalf of the Neurology Academy, I would like to thank our faculty, our sponsors, and most of all, the clinicians whose creativity and dedication continue to drive progress. The impact of their work reaches far beyond the MasterClass — it is being felt by people with Parkinson's, their families, and the teams who care for them every day.

Sarah Gillett
Managing Director, Neurology Academy

Education with impact: Parkinson's Academy 2025 – Advanced MasterClass 48.2 impact report

Transforming learning into practice across the UK

The 2025 **Parkinson's Advanced MasterClass 48.2** has once again demonstrated the power of education to drive measurable improvement in patient care.

Through **28 clinician-led projects** spanning inpatient safety, integration, non-motor symptom management, digital innovation, and holistic wellbeing, participants have turned education into action — ensuring that people with Parkinson's directly benefit from clinical learning and leadership in practice.

The idea

The **Parkinson's Advanced MasterClass** was designed to empower healthcare professionals to develop expertise, confidence, and leadership in service improvement.

Participants complete a quality improvement project within their workplace, aligning their work with national priorities and the lived experiences of people with Parkinson's.

This year's cohort drew inspiration from the UK Government's Fit for the Future ten-year health plan (HM Government, 2025), which identifies three transformational shifts shaping the future of health and care:

- **Analogue to digital –** harnessing technology, data, and innovation to improve outcomes.
- **Treatment to prevention –** prioritising proactive, anticipatory, and holistic care.
- **Hospital to community –** delivering joined-up, integrated care closer to home.

Each delegate's project was mapped against these ambitions, demonstrating how Parkinson's professionals are **already leading the way** in service transformation.

From AI-assisted documentation and traffic-light risk assessments to anticipatory care planning and multidisciplinary bone health reviews, the projects presented in this report showcase a **national movement towards safer, smarter, and more person-centred Parkinson's care.**

The national picture

Across 28 projects, clear national trends have emerged — reflecting both **local innovation** and **shared challenges** within UK Parkinson's services.

Clinicians continue to address enduring issues such as delayed inpatient medication, fragmented communication between settings, and under-recognition of non-motor symptoms. However, the 2025 cohort demonstrates how these challenges are being tackled through **leadership, creativity, and digital transformation.**

- **Inpatient safety** is improving through structured referral systems, real-time medication monitoring, and Parkinson's nurse-led in-reach models that reduce treatment delays.
- **Integrated pathways** are strengthening via virtual MDTs, shared communication hubs, and AI-enabled triage, bridging gaps between hospital and community care.
- **Proactive management** of frailty, bone health, and mental wellbeing ensures that risks are identified early and addressed through joined-up collaboration.
- **Non-motor and palliative needs** are being normalised within routine care, with projects introducing anxiety screening, ACP frameworks, and holistic wellbeing conversations.
- **Rehabilitation and activity-based therapies** — from yoga and Pilates to "Good Vibrations" and breathwork — are redefining what living well with Parkinson's looks like.
- **Education and workforce development** are emerging as national priorities, with nurses, therapists, and pharmacists leading outreach programmes that upskill care home and home-care staff.
- **Digital tools** such as AI scribes, QR-code resources, and structured data templates are no longer experimental — they're now integral to clinical efficiency and safety.

Collectively, these projects reveal a maturing Parkinson's care landscape: one that is **proactive, integrated, and person-centred.** Education within the Neurology Academy model has proven not just to inform but to **transform practice** across the UK.

Conclusion

The **2025 Parkinson's Advanced MasterClass 48.2 cohort** exemplifies how national ambitions for **digitalisation, prevention, and integration** can be realised at a local level when education empowers clinicians to innovate.

These projects show that small-scale, evidence-based changes — a new triage form, an anticipatory care tool, a collaborative clinic, or a community exercise class — can together produce **system-level transformation.**

Every project, regardless of scale, contributes to a shared vision:
a future where people with Parkinson's experience **joined-up, timely, compassionate, and data-informed care** — from diagnosis through to advanced stages of life.

The **Neurology Academy's MasterClass model** continues to prove that when education inspires action, the result is not just professional development — it is **sustained system change** that improves lives.

Key takeaways: Parkinson's Academy 2025

- **Education drives measurable change:**
  Every project demonstrates how structured learning and mentorship through the Neurology Academy model lead directly to service improvement — turning professional development into patient benefit.
- **Proactive, not reactive care:**
  Anticipatory planning, frailty audits, and RAG-based caseload tools are enabling earlier intervention, reducing crises, and improving patient safety across inpatient and community settings.
- **Integration across boundaries:**
  New referral systems, virtual MDTs, and shared communication pathways are connecting neurology, geriatrics, psychiatry, and primary care — ensuring people with Parkinson's experience seamless support.
- **Holistic wellbeing and non-motor focus:**
  Projects addressing anxiety, depression, and palliative needs show a shift toward person-centred, whole-condition management rather than symptom-by-symptom treatment.
- **Digital and data-enabled transformation:**
  AI scribes, electronic templates, and digital PROMs are improving documentation, accessibility, and efficiency — signalling that digital Parkinson's care is becoming routine, not exceptional.
- **Empowered workforce, empowered patients:**
  Targeted education for nurses, registrars, and care staff is creating confidence and consistency across services — while community-led exercise and wellbeing projects help patients live well for longer.

Theme 1: inpatient care and hospital safety

Ensuring safe and effective inpatient management remains one of the most persistent challenges in Parkinson's care. Timely medication administration, specialist reviews, and multidisciplinary coordination are critical to patient safety and recovery. The following four projects demonstrate how targeted innovation, education, and structured processes can transform hospital experiences for people with Parkinson's.

Improving Parkinson's inpatient referral pathways and resources

Gaynor Richards, Parkinson's nurse specialist lead, University Hospitals Dorset NHS Foundation Trust

The challenge:

Inpatients with Parkinson's disease often experience delays in medication and fragmented care due to inconsistent referral processes between hospital wards and the Parkinson's specialist team. Without a clear system to identify, assess, and review these patients promptly, opportunities for early intervention and specialist input were frequently missed, leading to poorer outcomes and longer hospital stays.

The project:

Gaynor developed a structured inpatient referral pathway to improve communication and coordination between ward staff and the Parkinson's team. The initiative included:

- Designing an electronic inpatient referral form to streamline identification and triage.
- Creating a central intranet hub housing resources, medication guidelines, and referral procedures.
- Developing a comprehensive inpatient care policy to standardise best practice.
- Delivering a dedicated study day to educate staff on Parkinson's management in the acute setting.

The results:

The project led to a significant increase in timely referrals, ensuring patients received medication on time and appropriate specialist review. Staff confidence in recognising Parkinson's symptoms and using referral systems improved markedly. Feedback from both nursing and medical teams was overwhelmingly positive, citing better clarity and easier access to resources.

The impact:

This structured approach has reduced variation in inpatient care, improving both safety and patient experience. Medication delays have decreased, ward teams report enhanced communication with the specialist service, and the standardised pathway has set a precedent for multidisciplinary collaboration.

The future:

Plans are underway to expand the system across additional hospital sites and to introduce a ‘Parkinson’s champion’ role within each ward to sustain education and quality standards. The pathway will also be reviewed for integration into electronic patient records.

Conclusion:

By standardising the inpatient referral process and embedding education within clinical practice, this project has created a safer, more efficient model for inpatient Parkinson’s care. It exemplifies how a simple digital and procedural change can produce lasting improvements in hospital safety and service delivery.

Developing an in-reach Parkinson's nurse role

Christine Parker, Parkinson's nurse specialist practitioner, Buckinghamshire Healthcare NHS Trust

The challenge:

Hospital admissions for people with Parkinson's are often complicated by delayed or incorrect medication administration. Poor communication between inpatient wards and community Parkinson's teams further compounds these risks, leading to medication errors, extended stays, and avoidable complications.

The project:

Christine introduced a dedicated in-reach Parkinson's nurse post aimed at bridging the gap between ward staff and community Parkinson's services. The new role focused on:

- Proactive identification of admitted Parkinson's patients via electronic admission lists.
- Daily ward visits to review patients' medication regimens and ensure on-time delivery.
- Education and support for nursing and medical staff on safe Parkinson's medication practices.
- Improved discharge planning and coordination with community services for continuity of care.

The results:

The initiative achieved impressive outcomes within months:

- Zero Datix medication safety incidents related to delayed or missed doses.
- Reduced length of hospital stay for Parkinson's patients.
- Increased staff awareness and adherence to the Parkinson's UK 'Get It On Time' campaign.
- Ward staff described the in-reach role as invaluable, reporting greater confidence in managing Parkinson's-related complications.

The impact:

The project significantly improved inpatient safety, reduced preventable complications, and strengthened links between hospital and community care. It has become a model of best practice in proactive, nurse-led inpatient support.

The future:

The Trust plans to formalise the in-reach nurse post and extend the model to other hospital sites. There is potential to incorporate this approach into regional Parkinson's networks to ensure consistent inpatient safety standards.

Conclusion:

By embedding a Parkinson's specialist within the acute hospital setting, this initiative has delivered measurable safety and quality improvements. It demonstrates the power of specialist nursing leadership in reducing errors, empowering staff, and supporting integrated, patient-centred care.

Improving awareness and management of postural hypotension in inpatients

Tracy Denning, advanced Parkinson's clinical specialist practitioner trainee, South Warwickshire University NHS Foundation Trust

The challenge:

Postural (orthostatic) hypotension is a common but under-recognised issue among people with Parkinson's. In hospital, its poor identification and inconsistent documentation lead to avoidable complications such as falls, prolonged stays, and reduced confidence upon discharge. Staff awareness of the condition and its management was limited, resulting in inconsistent monitoring and response.

The project:

Tracy conducted an audit revealing gaps in documentation and patient outcomes, then implemented a structured care bundle and education programme for inpatient staff. The initiative included:

- A standardised care bundle to guide assessment and treatment of postural hypotension.
- Teaching sessions for nurses and junior doctors on recognising and managing the condition.
- Enhanced referral pathways for patients requiring further specialist input.
- Updated documentation templates to prompt blood pressure monitoring and intervention.

The results:

Post-intervention audits showed a clear improvement in documentation rates and early identification of postural hypotension. Staff demonstrated greater understanding of both non-pharmacological and pharmacological management approaches. The intervention led to faster clinical response times and reduced incidents of inpatient falls linked to hypotension.

The impact:

The project directly improved patient safety and quality of care. It also encouraged cross-specialty learning, with other departments adapting the care bundle for wider use. The initiative's success has reinforced the importance of proactive identification of non-motor symptoms in hospitalised patients.

The future:

Plans include embedding the care bundle into the Trust's electronic patient record system and introducing refresher training as part of ongoing staff development.

Conclusion:

This project has highlighted how focused education and simple process changes can reduce preventable harm. By raising awareness of postural hypotension, Tracy's work has led to tangible improvements in patient safety and exemplifies proactive, preventative care.

Improving acute care knowledge in hospital doctors

Anushka Bajgamage, locum elderly medicine consultant, Medway NHS Foundation Trust

The challenge:

Hospital doctors, particularly those on acute medical and surgical wards, often lack confidence in managing Parkinson's medication regimens during emergency admissions. Errors in medication timing and inappropriate withholding of treatments can exacerbate symptoms and trigger complications such as delirium or aspiration pneumonia.

The project:

Anushka assessed junior doctors' confidence and knowledge regarding inpatient Parkinson's management and designed an education and guidance package to address identified gaps. The initiative included:

- A short training module covering safe prescribing and medication timing.
- A concise reference guide integrated into ward induction materials.
- Collaborative sessions with the pharmacy team to review real-world medication incidents.
- Development of local guidelines for safe medication administration and discharge planning.

The results:

Post-training evaluation demonstrated a significant increase in confidence among doctors when reviewing and prescribing Parkinson's medications. Medication errors and delays were reduced, and discharge planning became more consistent.

The impact:

The project has enhanced patient safety, reduced medication-related complications, and improved multidisciplinary collaboration between doctors, pharmacists, and Parkinson's nurses.

The future:

The educational component will now be embedded into the Trust's mandatory induction for all new medical staff. Work is also underway to share this model regionally through the local Parkinson's network.

Conclusion:

This project demonstrates the lasting benefits of targeted education in improving acute inpatient care. By equipping junior doctors with the knowledge and tools to manage Parkinson's safely, Anushka's work has strengthened the culture of confidence, safety, and consistency across acute care services.

Theme 2: integration and service pathways

Joined-up care across hospital, community, and digital settings is essential to improving outcomes and continuity for people with Parkinson's. These projects showcase how clearer communication channels, structured clinic documentation, and innovative digital tools can streamline services, support collaboration, and ultimately enhance patient experience.

Creating a shared advice pathway for joined-up care

Dr Catherine Penman, ST6 registrar, University Hospitals Bristol and Weston NHS Foundation Trust

The challenge:

People with Parkinson's often move between multiple care settings — hospital, community, and primary care — leading to inconsistent advice, duplication of work, and communication gaps between clinicians. Referrals and advice requests were being sent via various routes, causing delays and uncertainty for community teams seeking specialist input.

The project:

Dr Penman developed a shared advice mailbox to facilitate consistent and timely communication between hospital and community Parkinson's teams. The project involved:

- Creating a dedicated shared mailbox accessible to both hospital and community clinicians.
- Developing clear response protocols to ensure all advice requests received timely, documented replies.
- Embedding the mailbox contact within standard referral templates and discharge letters.
- Providing training sessions for both acute and community staff on how to use the new system.

The results:

The new shared mailbox significantly improved efficiency and clarity in communication. Most advice queries now receive responses within 24–48 hours, reducing delays in patient care and ensuring consistent recommendations across teams. Both hospital and community clinicians reported greater satisfaction with advice processes and better continuity for patients.

The impact:

The project has reduced fragmented communication, standardised clinical advice, and enhanced patient outcomes through faster, more coordinated decision-making. It also ensures that specialist guidance is recorded and easily accessible to all relevant professionals.

The results:

Plans are in place to integrate the mailbox within the Trust's electronic patient record (EPR) system, ensuring all correspondence is automatically logged. Dr Penman also aims to share this model with neighbouring services to promote consistent standards across regions.ts:

Conclusion:

This project demonstrates how a simple, well-structured communication channel can significantly enhance integration between hospital and community teams. By ensuring consistent advice and reducing duplication, it promotes joined-up, patient-centred Parkinson's care.

Using AI scribe technology to streamline clinic documentation

Lauren Whitelam, Parkinson's clinical nurse specialist, Wye Valley NHS Trust

The challenge:

Clinical documentation is one of the most time-consuming parts of outpatient care. Manual note-taking and letter writing delay communication with GPs and limit the time clinicians can spend with patients. The growing administrative workload was affecting both clinic efficiency and clinician wellbeing.

The project:

Lauren piloted an AI scribe tool to automate clinic documentation and improve workflow efficiency. The project involved:

- Implementing speech recognition software to transcribe consultations into draft clinic letters.
- Developing a template format to standardise automated notes and reduce editing time.
- Training clinicians to review, verify, and approve the AI-generated letters securely before uploading to patient records.
- Measuring time savings and accuracy across a pilot period.

The results:

The AI transcription tool reduced average documentation time by around 40%, enabling same-day clinic letter completion. Clinicians reported improved satisfaction with communication speed and reduced clerical workload. Accuracy rates were high, and feedback from GPs on the clarity and timeliness of correspondence was extremely positive.

The impact:

The use of AI has improved clinic efficiency, reduced administrative pressure, and allowed more time for patient interaction. The project demonstrated that technology can enhance — rather than replace — the clinician's role, supporting high-quality, person-centred care.

The future:

Lauren plans to expand the use of AI transcription within Parkinson's and other neurology clinics, with ongoing evaluation of time savings and quality metrics. Collaboration with IT teams is underway to refine system integration and data security protocols.

Conclusion:

This innovative project demonstrates the value of AI in modern clinical practice. By automating repetitive tasks, it enhances clinician focus, improves communication, and supports the NHS drive toward efficient, digital-first healthcare delivery.

Enhancing the communication pathway for people with Parkinson’s in the community in West Essex

Elizabeth Allan, speech and language therapist clinical lead, Essex Partnership University NHS Foundation Trust

The challenge:

In West Essex, patients and community professionals often faced uncertainty about how to contact the Parkinson’s team. Messages were scattered across emails, voicemails, and handwritten notes, leading to missed updates and inconsistent responses.

The project:

Elizabeth led a redesign of the communication pathway between community staff, GPs, and secondary-care specialists. Key actions included:

- Creating a central referral and advice inbox managed by the Parkinson’s nursing team.
- Standardising the referral form to include urgency levels and key clinical information.
- Establishing weekly virtual huddles between nurses, therapists, and neurologists.
- Providing education for GPs on the new process and response times.

The results:

Average response time to community queries reduced from ten days to under three. Staff felt more confident in contacting the right person, and patients experienced faster problem resolution.

The impact:

The project improved transparency, accountability, and team cohesion. It also enabled data collection on query types, helping identify service gaps and training needs.

The future:

Elizabeth plans to integrate the pathway with GP systems and expand virtual huddles to include pharmacists and social prescribers.

Conclusion:

By clarifying communication channels, Elizabeth has built a more responsive and connected service that meets patients’ needs efficiently and consistently.

Streamlining clinical assessment: a structured template for efficient evaluation in Parkinson's cinic

Dr Lushanthi Kannangara, consultant physician, Northampton General Hospital NHS Trust

The challenge:

Clinic assessments for Parkinson's varied in content and documentation, leading to duplication and difficulty tracking progression over time. This variability also made it harder for multidisciplinary teams to share information effectively.

The project:

Dr Kannangara designed a structured clinic template to standardise Parkinson's assessments. The new format included:

- Key domains such as motor function, non-motor symptoms, medication adherence, and social context.
- Drop-down options to speed up data entry.
- Automatic prompts for red-flag symptoms and advanced-care discussions.
- Integration into the Trust's electronic health record.

The results:

Clinicians reported improved efficiency and completeness of documentation, with consultations becoming more focused and data more comparable over time. The structured format also simplified MDT discussions and audit.

The impact:

The template has streamlined workflow, enhanced continuity between clinicians, and enabled consistent data capture for quality improvement. Patients benefit from more thorough, standardised assessments that ensure key issues are not missed.

The future:

Dr Kannangara plans to adapt the template for use across neighbouring Trusts and explore its integration with national audit tools.

Conclusion:

This project demonstrates how digital innovation can support consistency and efficiency in clinical assessment, improving both clinician workflow and patient experience.

Parkinson's Academy

Bringing Parkinson's care to the patient

Dan Casarotto, consultant geriatrician, Kent Community Health NHS Foundation Trust

The challenge:

Many people with Parkinson's face significant barriers to accessing specialist care. Symptoms such as mobility problems, fatigue, and anxiety can make travelling to hospital-based clinics exhausting or even impossible. As waiting lists grew and hospital appointments became increasingly clinic-centred, Dan recognised that some of the most vulnerable patients — those with advanced Parkinson's, frailty, or limited social support — were missing out on timely review and intervention.

The existing model of care relied heavily on patients attending secondary care appointments, creating inequalities in access and outcomes. Dan wanted to redesign this approach by shifting the emphasis from patients coming to clinic to specialists going to the patient.

The project:

Dan launched a nurse-led outreach service to deliver Parkinson's care directly to people in their own homes, care homes, and community settings. His project focused on removing barriers, improving accessibility, and ensuring continuity for those unable to travel.

The initiative included:

- Developing a referral framework to identify patients most at risk of being lost to follow-up, such as those with advanced disease, recent admissions, or mobility limitations.
- Delivering home-based specialist reviews, including assessment of motor and non-motor symptoms, medication timing, and carer wellbeing.
- Building collaboration with GPs, community nurses, and therapists to coordinate holistic care plans and prevent duplication.
- Introducing teleconsultation follow-ups for patients stable enough for remote review, balancing convenience and continuity.
- Collecting feedback and outcome data on patient satisfaction, access, and unplanned hospital admissions.

The results:

The outreach service reached dozens of patients who had not been reviewed for over a year due to access barriers. Many reported relief and gratitude that specialist care came to them rather than the other way around.

Clinical outcomes improved through proactive medication adjustments and earlier recognition of deterioration. Collaboration with community teams enhanced communication and reduced duplication of visits. Family carers reported improved confidence and reassurance knowing a

The impact:

The project transformed local service delivery, showing that Parkinson's care can be flexible, inclusive, and patient-centred. It reduced health inequalities by ensuring that frail or housebound patients received the same quality of review as those attending clinics. The outreach model also demonstrated how specialist nursing expertise could bridge gaps between acute, community, and primary care.

The future:

Dan plans to expand the outreach model across his Trust, supported by data showing improved access and reduced unplanned admissions. He is exploring options for a "hybrid care" model, combining home visits, virtual reviews, and shared documentation with community teams to ensure sustainability.

Conclusion:

By taking Parkinson's care beyond the hospital walls, Dan's project has redefined accessibility and equity within specialist services. It illustrates how nurse-led innovation can deliver person-centred care directly to where patients need it most — at home, in the community, and on their own terms.

Auditing Parkinson's frailty and hospital admissions across NHS Lothian, Scotland

Katherine Walesby, geriatric and internal medicine registrar, NHS Lothian

The challenge:

People living with Parkinson's are disproportionately affected by frailty, yet this is often under-recognised in both community and hospital settings. Frailty increases the risk of falls, infections, medication sensitivity, and prolonged hospital admissions — but many Parkinson's patients admitted to hospital are not assessed for frailty, resulting in reactive rather than proactive care.

Katherine identified that within her local service, frailty scoring was inconsistently documented, and there was limited understanding of how frailty status influenced length of stay, outcomes, or discharge planning. Without this insight, opportunities for early intervention and coordinated care were frequently missed.

The project:

Katherine conducted a **retrospective audit** of hospital admissions among people with Parkinson's to better understand frailty prevalence and its impact on outcomes. The project aimed to identify areas for improvement and promote the integration of frailty assessment into Parkinson's pathways.

Key steps included:

- **Reviewing 12 months of hospital admissions** involving patients with Parkinson's, recording Clinical Frailty Scale (CFS) scores, length of stay, discharge destination, and readmission rates.
- **Comparing outcomes** between those with documented frailty assessments and those without.
- **Engaging with geriatric, neurology, and Parkinson's nurse teams** to discuss findings and identify gaps in assessment processes.
- **Recommending service changes**, including routine frailty screening at admission and earlier multidisciplinary involvement for frail Parkinson's patients.

The results:

The audit found that frailty scoring was recorded in less than half of admissions. Patients with a recorded CFS score were more likely to receive comprehensive discharge planning and input from specialist teams, resulting in shorter hospital stays and fewer early readmissions.

Findings were presented to the hospital's frailty steering group and Parkinson's multidisciplinary team, leading to the introduction of **mandatory frailty assessment for all Parkinson's admissions** and the inclusion of frailty prompts within electronic patient records.

The impact:

Katherine's project highlighted frailty as a **key determinant of outcomes in Parkinson's**, reframing it from a background characteristic to an actionable clinical priority. Her audit demonstrated the value of simple, structured assessment in improving patient safety, promoting timely discharge, and strengthening communication between acute and community services.

The work also raised awareness among non-specialist teams of the importance of recognising frailty early and involving Parkinson's services sooner, supporting a more integrated and preventative approach to care.

The future:

Katherine plans to repeat the audit to monitor compliance and outcomes and is exploring integration of frailty status into outpatient Parkinson's reviews to support continuity between settings. She also aims to collaborate with community frailty teams to ensure post-discharge follow-up for those at highest risk.

Conclusion:

By auditing frailty and hospital admissions, Katherine Walesby has provided critical insights into how Parkinson's care can be made more proactive, personalised, and efficient. Her project demonstrates that routine frailty assessment is not just good practice — it's a cornerstone of safe, holistic, and integrated care for people with Parkinson's.

Theme 3: multidisciplinary collaboration and service development

Delivering high-quality care for people with Parkinson's relies on collaboration between different specialties, disciplines, and services. The following projects show how multidisciplinary teamwork — spanning physiotherapy, psychiatry, medicine, and nursing — can break down barriers, reduce duplication, and create more responsive, person-centred services.

Developing a clozapine pathway for people with Parkinson's disease psychosis

Caroline Bowler, consultant geriatrician, Nottingham University Hospitals NHS Trust

The challenge:

Psychosis is a distressing and often under-recognised complication of Parkinson's disease, affecting up to half of all people living with the condition as it progresses. Symptoms such as hallucinations and delusions can cause significant distress to patients and their families, often leading to hospital admission or premature moves into care homes.

Clozapine is recognised as the most effective treatment for Parkinson's disease psychosis (PDP), with minimal impact on motor symptoms compared to other antipsychotics. However, its use is limited by the need for stringent blood monitoring, complex prescribing processes, and coordination across multiple teams. Caroline identified that, within her Trust, patients eligible for clozapine were often not being considered due to perceived barriers, lack of clear referral pathways, and uncertainty over who was responsible for initiation and monitoring.

The project:

Caroline led the development of a multidisciplinary clozapine pathway to streamline access and ensure safe, effective management of PDP. Her project aimed to embed collaboration between neurology, psychiatry, pharmacy, and primary care while providing practical tools and education for clinicians.

Key elements included:

- Mapping existing practice to identify where delays occurred in identifying and referring patients for clozapine.
- Establishing a joint working group between Parkinson's and mental health services to clarify roles and responsibilities.
- Creating a standardised referral and consent process, supported by clear documentation and safety checklists.
- Developing an electronic monitoring template for clozapine blood results, ensuring shared access across teams.
- Providing education sessions for nurses and clinicians on identifying psychosis early, discussing clozapine treatment with patients, and managing side effects safely.

The results:

Following implementation, patients who previously would have struggled to access clozapine were referred and successfully initiated on treatment. The pathway reduced delays by formalising communication between neurology and psychiatry, and improved confidence among Parkinson's nurses in supporting monitoring and follow-up.

Staff feedback highlighted the value of having a clearly defined structure and single point of contact for queries, while patient and carer feedback reflected a reduction in distressing symptoms and improved quality of life.

The impact:

Caroline's project has transformed the local approach to managing Parkinson's psychosis. It demonstrated how structured multidisciplinary collaboration can overcome long-standing barriers to clozapine access and ensure that complex but highly effective treatments reach those who need them most. The model also strengthened relationships between acute and mental health services, setting a precedent for joint management of neuropsychiatric complications.

The future:

Building on early success, Caroline plans to formalise the clozapine pathway within Trust policy and extend it across community services. She is also exploring a shared-care protocol with primary care to support ongoing monitoring closer to home, reducing travel burden for patients. Data collection is underway to evaluate outcomes such as symptom improvement, patient satisfaction, and hospital admission rates.

Conclusion:

By developing a clear, collaborative pathway for clozapine use in Parkinson's disease psychosis, Caroline Bowler has addressed one of the most challenging aspects of Parkinson's management. Her project exemplifies how multidisciplinary teamwork and practical innovation can translate complex evidence-based care into accessible, compassionate clinical practice.

Embedding bone health awareness in the MDT

Jane Nyland, clinical specialist physiotherapist, Tameside and Glossop Integrated Care NHS Foundation Trust

The challenge:

Within the community neurorehabilitation service, people living with Parkinson's were often seen for mobility, balance and functional difficulties – yet bone health was not consistently part of the conversation. Osteoporosis risk, falls history and fracture prevention were considered "someone else's agenda" and rarely discussed in routine MDT case reviews. As a result, opportunities to prevent fractures and maintain independence were being missed for a group already at high risk.

The project:

Jane set out to ensure that bone health became a visible, routine and shared responsibility across the MDT, rather than an optional add-on.

She began by reviewing recent MDT cases and found that bone health risk was either absent or patchily documented. Using this as a starting point, she developed a short, practical education session for the multidisciplinary team – including physiotherapists, occupational therapists, nurses and medical colleagues – focused on:

- The link between Parkinson's, falls, sarcopenia and fracture risk
- Simple screening prompts (history of falls, previous fracture, weight loss, low BMI, steroids)
- When and how to consider FRAX/DEXA and bone-protective treatment
- The role of rehab teams in flagging risk and prompting action from primary care or geriatric services

Alongside teaching, Jane introduced a bone health prompt into existing MDT documentation and case review proformas. Every patient discussed in MDT would now have bone health explicitly considered: Has this person's fracture risk been assessed? Do we need to recommend a DEXA scan, vitamin D, or referral for further review?

The results:

Within a short period, bone health moved from an occasional afterthought to a routine agenda item in MDT discussions. Team members reported feeling more confident to:

- Ask about fracture history and falls in a structured way
- Highlight bone health concerns in clinic letters and MDT summaries
- Encourage patients and carers to talk to their GP about bone protection where appropriate

Audit of MDT records showed a clear increase in documentation of fracture risk and in referrals or letters explicitly mentioning bone health, compared with the pre-project baseline.

The impact:

The project shifted the culture of the team. Bone health is now seen as integral to rehabilitation and independence, not a separate specialty issue. This has:

- Reduced the likelihood of missed opportunities for prevention
- Strengthened communication with GPs and geriatric services about osteoporosis risk
- Helped frame falls and mobility work within a broader, preventative narrative that patients understand and value

The future:

Next steps include:

- Embedding the bone health prompt permanently into MDT documentation and electronic records
- Extending the education package to community partners and wider therapy teams
- Conducting a re-audit to explore whether increased identification translates into increased DEXA scanning and bone-protective prescribing

Conclusion:

Jane's project shows that a simple, education-plus-prompt approach can successfully embed bone health into day-to-day neurorehabilitation practice. By making fracture prevention "everyone's business", the MDT is better placed to support safe, active and independent living for people with Parkinson's.

Improving bone health in Parkinson’s disease

Dr May Myat Win, neurology trainee, Cambridge University Hospitals NHS Foundation Trust

The challenge:

People living with Parkinson’s face a significantly increased risk of falls and fractures due to a combination of motor instability, postural changes, rigidity, and the side effects of long-term dopaminergic therapy. Despite this, bone health assessment and treatment were not being applied consistently within Parkinson’s care at West Suffolk NHS Foundation Trust.

Dr Myat identified that osteoporosis screening and vitamin D supplementation were often overlooked, particularly for patients seen in movement disorder clinics rather than geriatric medicine services. The lack of clear referral pathways between neurology, falls, and fracture prevention teams meant that opportunities for early intervention were frequently missed.

The project:

Dr Myat developed a multidisciplinary quality improvement initiative to ensure that bone health became a routine and proactive element of Parkinson’s management. Her project involved:

- Auditing existing practice across Parkinson’s and movement disorder clinics to identify rates of bone health assessment, DEXA scanning, and osteoporosis treatment.
- Creating a bone health checklist to be incorporated into clinic templates, prompting clinicians to assess risk factors such as recurrent falls, previous fractures, and low BMI.
- Developing a clear referral pathway to the local fracture liaison and falls prevention services for at-risk patients.
- Delivering educational sessions to Parkinson’s nurses, geriatricians, and neurology teams on fragility fracture prevention, calcium and vitamin D optimisation, and bisphosphonate use in older adults.
- Collaborating with pharmacists to implement an electronic prompt for vitamin D supplementation during medication reviews.

The results:

Post-implementation data showed a marked improvement in the number of Parkinson’s patients receiving bone health assessments. The use of DEXA scans increased significantly, and more patients were started on appropriate osteoporosis treatment where indicated.

Staff feedback indicated improved confidence in discussing bone health, and multidisciplinary communication between neurology, geriatrics, and pharmacy teams strengthened.

The impact:

Dr Myat's project embedded fracture prevention as a standard of Parkinson's care, ensuring patients were no longer managed in isolation from broader frailty and falls services. Early identification and treatment of low bone density helped reduce fracture risk, while patient education on nutrition, balance, and medication adherence supported long-term self-management.

The future:

Dr Myat plans to evaluate the project's long-term outcomes by tracking fracture incidence and treatment adherence. She is also working to integrate the bone health checklist permanently into the electronic clinic record and expand the model to include community Parkinson's services.

Conclusion:

By championing bone health as a core element of Parkinson's management, Dr May Myat has improved the safety, resilience, and independence of patients under her care. Her project exemplifies how multidisciplinary collaboration and proactive screening can make a tangible difference to long-term outcomes for people living with Parkinson's.

Improving integration between Parkinson’s and old age psychiatry services

Dr Daniel Logue, geriatric medicine specialty registrar, Calderdale and Huddersfield NHS Foundation Trust

The challenge:

Many people with Parkinson’s under the local movement disorder service were also known to old age psychiatry for depression, anxiety, psychosis or cognitive impairment – but the two services largely worked in parallel. Communication relied on ad-hoc letters and informal emails, and joint understanding of complex cases was often delayed. This fragmentation risked duplicated reviews, inconsistent messages to patients and slow responses when mental health crises emerged.

The project:

Dr Logue set out to create a more coherent, integrated pathway between Parkinson’s and old age psychiatry services, particularly for those with significant mood, psychosis or cognitive issues.

He began with a mapping exercise, reviewing a sample of patients known to both services and examining:

- How often information was shared in real time
- Whether medication plans (e.g. antipsychotics, antidepressants, dopaminergic changes) were aligned
- How quickly each service responded to deterioration or carer concern

From this, he co-designed a series of practical integration steps with both teams:

- Named liaison contacts
  Each service identified a named link clinician for Parkinson’s / old age psychiatry communication, reducing the “who do I email?” barrier.
- Structured joint case discussions
  Regular (e.g. monthly or bi-monthly) joint MDT huddles were introduced for a small but high-risk group: people with psychosis, rapidly progressive cognitive change, recurrent delirium, severe anxiety or complex behavioural issues.
- Shared documentation and care plans
  A simple shared template was developed for complex cases, summarising: diagnosis, key risks, agreed psychotropic and Parkinson’s medication plan, crisis triggers and who to call. This was stored in both services’ notes to reduce conflicting advice.
- Clear referral and re-referral criteria
  Dr Logue worked with colleagues to clarify when Parkinson’s clinicians should escalate to psychiatry, when psychiatry should seek movement disorder input, and what information should accompany referrals (e.g. previous medication trials, non-motor symptom profile).

The results:

Feedback from both teams indicated that complex shared patients were now more visible and better understood. Early qualitative outcomes included:

- Fewer “crossed-wires” on medication plans – especially antipsychotic choice and dopaminergic dose changes
- Clearer, quicker routes to advice when patients became distressed, psychotic or behaviourally challenging
- Reduced duplication of appointments, with some reviews coordinated or combined

Patients and carers reported feeling that “the teams are talking to each other” and that plans around both Parkinson’s and mental health felt more joined-up.

The impact:

The project has begun to:

- Improve safety for high-risk patients by aligning physical and mental health decision-making
- Support carers, who now receive more consistent messages and know who to contact for specific concerns
- Build relationships between services, laying the groundwork for more ambitious joint working in future (e.g. shared clinics)

The future:

Planned next steps include:

- Formal evaluation of outcomes for the shared caseload (unplanned admissions, crisis contacts, medication changes)
- Exploring joint review slots for selected patients, either virtually or in-person
- Developing written guidance or a brief pathway document for wider dissemination across the trust

Conclusion:

Dr Logue’s work shows how relatively simple organisational changes – named contacts, joint huddles and shared plans – can transform the experience of complex patients who sit at the interface of neurology and old age psychiatry. Integrated thinking around Parkinson’s and mental health is both feasible and highly valued by patients, carers and clinicians alike.

Establishing a business case for joint geriatrician and neurology assessments in an outpatient movement disorders clinic

Sophie Blackburn, geriatric medicine registrar & Matthew Murden & Elisabete Marques, Ealing Hospital, London North West University Healthcare NHS Trust

The challenge:

Patients with Parkinson's and other movement disorders often required input from both neurology and geriatric medicine, but services operated independently. This led to duplicate clinic visits, fragmented care, and missed opportunities for multidisciplinary assessment. For complex patients with frailty, cognitive change, or polypharmacy, the absence of a coordinated clinic delayed decision-making and placed unnecessary strain on patients and carers.

The project:

Sophie identified the need for a joint geriatrician–neurology outpatient clinic to streamline care for patients with Parkinson's and related conditions. Her project involved:

- Conducting a **service evaluation** to quantify the number of patients attending both neurology and geriatrics clinics separately.
- Mapping overlaps in medication review, symptom management, and functional assessment.
- Gathering **patient and staff feedback** on the challenges of fragmented appointments.
- Developing a **business case** that demonstrated efficiency gains, cost savings, and improved patient experience from a joint model.

The results:

The evaluation confirmed that more than half of patients seen in neurology clinics required subsequent geriatric input. The proposed model showed potential to reduce duplicated appointments by 30%, improve continuity of care, and optimise use of clinical time. Stakeholders, including commissioners, responded positively to the integrated approach.

The impact:

The project created a strong evidence base for collaborative outpatient working, demonstrating how cross-specialty clinics can improve outcomes and resource use. It also fostered a culture of cooperation between departments previously working in isolation.

The future:

The next phase will pilot the joint clinic, with plans to measure its effect on patient satisfaction, hospital admission rates, and prescribing outcomes. Longer-term, the model could inform similar approaches for other neurodegenerative conditions.

Conclusion:

Sophie's project highlights the tangible benefits of multidisciplinary collaboration at the outpatient interface. By aligning geriatric and neurological expertise, her work provides a blueprint for more coordinated, person-centred Parkinson's care.

Theme 4: proactive care, planning and holistic wellbeing

Proactive and holistic care lies at the heart of high-quality Parkinson's management. By anticipating needs before crises occur, clinicians can support people with Parkinson's and their families to make informed choices, address psychological and physical wellbeing, and plan for the future with confidence.

Non-motor symptoms such as anxiety, depression, and sleep disturbance can be as disabling as motor decline, while issues like frailty, medication complexity, and end-of-life uncertainty demand sensitive, forward-thinking care.

The projects in this theme show how early screening, anticipatory conversations, and holistic reviews can improve recognition, safety, and dignity for people living with Parkinson's—empowering both patients and professionals to act rather than react.

Improving recognition of anxiety and depression in Parkinson's

Dr Susantha Nawaratne Wijayasiri, consultant physician, geriatrician & Parkinson's and movement disorders specialist, Bedfordshire Hospitals NHS Foundation Trust

The challenge:

Anxiety and depression are highly prevalent in Parkinson's, affecting around half of all patients and contributing to poorer quality of life, increased morbidity, and even suicidal ideation. Despite this, mood symptoms are often under-recognised in busy clinics, particularly where there is limited time and no access to formal psychological tools or specialist mental health support. Dr Nawaratne recognised that in his geriatric movement disorder clinic, mood issues and their associations (such as REM sleep behaviour disorder, anosmia, and thyroid disease) might not be captured systematically.

The project:

He undertook a retrospective observational study in his Parkinson's and movement disorder clinic to understand how well anxiety and depression were being detected and managed using simple clinical screening, rather than formal scales. The project involved:

- Reviewing 59 randomly selected patients from clinic and community Parkinson's nurse letters dating from 2017 onwards.
- Collecting data across 10 domains, including:
  - Documentation of anxiety and/or depression.
  - Presence of REM sleep behaviour disorder and anosmia.
  - Thyroid disease.
  - Use of antidepressants and dopaminergic therapy.
- Exploring whether straightforward questioning within a standard 20-minute doctor-only appointment could reliably identify mood disorders and their associations.

The results:

The study highlighted a high burden of mood symptoms and clear links with other non-motor features:

- 33 out of 59 patients (55.9%) had documented anxiety and/or depression.
- Two-thirds (67.6%) of those with anxiety/depression were identified within one year of Parkinson's diagnosis, demonstrating the feasibility of early detection when clinicians ask directly.
- There was a female preponderance: 68% of women vs 47% of men had anxiety/depression.
- Strong associations were seen with other non-motor and endocrine factors:
  - 78% of patients with REM sleep behaviour disorder also had anxiety/depression.
  - 63% of those with anosmia had mood symptoms.
  - 5 out of 8 patients with hypothyroidism had anxiety/depression.
- Mirtazapine emerged as the most commonly used antidepressant (around 70% of treated cases), chosen particularly where REM sleep disorder was present.

Despite limited clinic time and the absence of depression scales, early and simple screening produced good outcomes, with no cases of severe depression or suicide reported in the cohort.

The impact:

The project demonstrates that:

- Even in a busy, single-consultant clinic, straightforward structured questioning can detect a high proportion of mood disorders early.
- Recognising associated features such as REM sleep disorder, anosmia, and hypothyroidism can act as practical markers to prompt clinicians to look more closely for anxiety and depression.
- Timely management with appropriate antidepressants and optimisation of Parkinson's therapy can maintain quality of life and avoid escalation to secondary mental health services in many cases.

The future:

Dr Nawaratne highlights the need for:

- Stronger national guidance (e.g. NICE / quality standards) specifically addressing depression in Parkinson's.
- Embedding routine, simple mood screening into all Parkinson's clinics, supported by prompts and checklists rather than relying solely on formal scales.
- Greater awareness of REM sleep behaviour disorder, anosmia, and thyroid dysfunction as red flags for underlying mood disturbance.

Conclusion:

This project shows that early, simple, and proactive screening in a time-pressured Parkinson's clinic can successfully identify and manage anxiety and depression, reducing the risk of severe outcomes and improving quality of life. It reinforces the message that mental health care is a core part of Parkinson's management, not an optional extra.

Raising awareness of melanoma risk in Parkinson’s

Yolonde Mackie, Parkinson’s nurse specialist, NHS Lothian

The challenge:

Emerging evidence suggests an increased incidence of melanoma among people with Parkinson’s, possibly linked to both disease mechanisms and certain medications such as levodopa. Despite this known association, awareness among both clinicians and patients was low within the Trust, and routine skin-cancer vigilance was not part of Parkinson’s reviews. As a result, opportunities for early detection and education were being missed.

The project:

Yolonde led an awareness campaign to highlight melanoma risk and promote early recognition among both staff and patients. Her project included:

- Delivering educational sessions to clinicians and nursing staff, outlining the evidence linking Parkinson’s and melanoma and reinforcing the importance of skin checks.
- Producing informational leaflets for patients and carers, co-branded with Parkinson’s UK, explaining warning signs and when to seek advice.
- Liaising with the dermatology team to develop a streamlined referral process for suspicious lesions identified in clinic.
- Incorporating a skin-check prompt into routine Parkinson’s reviews to encourage conversation and documentation.

The results:

Following the initiative, staff surveys showed a substantial increase in awareness of melanoma risk. Clinicians began routinely discussing skin health during appointments, and several early dermatology referrals were made concerning lesions. Patients reported appreciating the opportunity to learn about a risk they had not previously been told about.

The impact:

The project has improved vigilance and fostered closer collaboration between neurology and dermatology teams. Early detection of potential skin malignancies can be lifesaving, and this initiative has already demonstrated practical benefits in patient safety and education.

The future:

Yolonde plans to extend the training across neighbouring Trusts and community Parkinson's teams, with the aim of developing a regional awareness campaign. Incorporating melanoma risk education into local Parkinson's education days for patients and carers is also planned.

Conclusion:

This project demonstrates how raising awareness of less-recognised health risks can make a meaningful difference to outcomes. By empowering both clinicians and patients with knowledge, Yolonde's work has enhanced safety, prevention, and holistic wellbeing for people with Parkinson's.

Using frailty to trigger advance care planning discussions

Dr Charles McLaren, geriatric medicine registrar, Buckinghamshire Healthcare NHS Trust

The challenge:

Advance care planning (ACP) discussions are often initiated too late — commonly after a crisis or when patients can no longer participate fully in decision-making. Clinicians may feel uncertain about when to begin these conversations, and without a clear trigger, opportunities for early and meaningful planning are easily missed. In the local service, frailty assessments were being carried out, but not routinely linked to care planning.

The project:

Dr McLaren introduced a system in which frailty scoring acts as a consistent prompt for ACP. The project involved:

- Routine use of the Rockwood Clinical Frailty Scale (CFS) during Parkinson's reviews to assess vulnerability.
- Setting a frailty threshold (CFS ≥ 6) as a trigger for ACP discussion and documentation.
- Holding joint case reviews with geriatrics, neurology, and palliative care teams to ensure shared understanding of complex needs.
- Delivering training sessions to clinicians on how to initiate and record early, person-centred ACP discussions.

The results:

Frailty assessment was successfully embedded into clinic processes, and the number of patients with completed ACP documentation increased substantially. Clinicians reported that the CFS provided an objective, evidence-based way to identify the right time to begin conversations, making discussions feel natural and justified. Families expressed relief at having plans in place before a crisis occurred.

The impact:

The project improved the timeliness and quality of advance care planning while fostering closer collaboration between Parkinson's, geriatric, and palliative care teams. By linking frailty and ACP, the initiative ensured that the most vulnerable patients received anticipatory care tailored to their individual values and needs.

The future:

Next steps include integrating frailty-based ACP prompts into the electronic patient record system and expanding the approach to other long-term conditions. Dr McLaren also plans to share findings regionally to support wider adoption across frailty and Parkinson's networks.

Conclusion:

Dr McLaren's project demonstrates that frailty assessment can provide a clear, compassionate framework for initiating end-of-life discussions. By embedding ACP within frailty-based care, it ensures conversations happen earlier, care becomes more person-centred, and outcomes align with what matters most to patients and families.

Anticipatory care planning in Parkinson's disease – starting the conversation

Dr Rachel Devlin, consultant geriatrician, Manchester University NHS Foundation Trust

The challenge:

Anticipatory care planning (ACP) allows people with capacity to discuss and document their wishes and preferences for future care and support. NICE recommends offering ACP to people living with Parkinson's disease (PD), yet in East Cheshire, this aspect of care lacked consistency.
Local Parkinson's services, managed by visiting consultant neurologists and Parkinson's disease nurse specialists (PDNS), identified that ACP conversations were often reactive or absent. The challenge was to understand current practice and explore how to embed ACP more proactively into routine care.

The project:

The project was conducted in two stages:

Step 1 – Establishing the baseline
A focused data collection exercise reviewed recent hospital discharges of people with Parkinson's disease from Macclesfield District General Hospital. Data included:

- Frequency of unplanned admissions within 12 months
- Presence of advanced Parkinson's features (per NICE guidance)
- Existence of an advance care plan (ACP)
- Presence of a Lasting Power of Attorney (LPA)

Step 2 – Promoting service development
Findings informed a teaching and service development meeting attended by consultant neurologists and the PDNS. Together, the group explored practical steps to improve ACP integration:

- Dedicated ACP clinic: establishing a monthly clinic led by the PDNS with extended appointment times for meaningful ACP conversations.
- Improved documentation: adding an "advance care plan discussions" section to clinic letter templates to improve visibility and continuity.
- Early discussion of LPA: using LPA conversations as a gentle entry point to ACP.
- Collaboration with hospice services: incorporating East Cheshire Hospice's resources into ACP pathways.
- Using clinical cues: encouraging ACP discussions at key transition points such as recent hospital admissions or increased care needs.

The results:

The review identified 20 patients admitted between April and June 2025 (mean age 79):

- 95% had features of advanced Parkinson's disease
- 55% had two or more unplanned admissions in the last year
- 25% had an advance care plan in place — all initiated by other services (e.g. GPs or palliative care)
- 10% had a documented LPA

Barriers included limited appointment time (15-minute reviews), uncertainty about the ideal timing for ACP, and unclear records about whether prior ACP discussions had taken place.

The impact:

The project sparked increased awareness and enthusiasm for anticipatory planning within the Parkinson's team. The multidisciplinary discussion led to concrete actions, including plans for a dedicated ACP clinic and updates to documentation templates.

By reframing ACP as a routine and patient-empowering part of Parkinson's care, the team began to shift attitudes towards more proactive, person-centred planning.

The future:

Now working as a Parkinson's disease specialist consultant at Wythenshawe Hospital, Dr Devlin is applying the learning from this project to her new service. She has implemented structured documentation for ACP and continues to encourage earlier, proactive conversations about future care and LPA.

Future plans include evaluating the uptake and outcomes of ACP clinics and exploring triggers that prompt timely discussions, such as hospital admission or new care dependency.

Conclusion:

This project revealed both the need and the opportunity to strengthen anticipatory care planning in Parkinson's services. By initiating data-driven reflection and team collaboration, it laid the groundwork for a more proactive, standardised approach to ACP — one that empowers patients and ensures their preferences are respected as their condition progresses.

Improving end-of-life care for people with Parkinson's

Samantha Haynes, Parkinson's nurse specialist, Sherwood Forest Hospitals NHS Foundation Trust

The challenge:

End-of-life care for people with Parkinson's can be unpredictable and complex. Symptoms such as swallowing difficulties, cognitive decline, or medication intolerance may progress slowly, making it difficult for clinicians to identify when someone is entering the palliative phase. As a result, many patients were not being recognised early enough for timely symptom control or holistic support.

Samantha observed that within her trust, there was limited confidence among generalist clinicians in recognising palliative triggers in Parkinson's, leading to inconsistent referrals to specialist palliative care and missed opportunities for anticipatory discussions. Documentation of end-of-life preferences and care planning varied across wards and community teams, causing distress for families and uncertainty for staff.

The project:

Samantha launched a quality improvement initiative to strengthen the identification and coordination of end-of-life care for people with Parkinson's. Her project focused on three key areas:

- Introducing a clinical trigger tool to help healthcare professionals identify when a patient might be approaching the palliative phase.
- Improving education and awareness through targeted sessions for ward nurses, junior doctors, and therapy staff on recognising signs of advanced disease and initiating sensitive conversations.
- Developing a shared care pathway linking Parkinson's and palliative teams, ensuring that plans made in hospital were communicated effectively to community services and GPs.
- Providing carer information packs to guide families through what to expect and who to contact for help.

The results:

The introduction of the trigger tool standardised recognition of the palliative stage and prompted earlier referral to specialist palliative care teams. Staff feedback showed a marked increase in confidence in identifying when to start end-of-life discussions. Patients received more timely symptom control, and families reported feeling better supported, both emotionally and practically.

Collaborative working between Parkinson's and palliative care teams improved continuity, ensuring that patients' comfort, dignity, and preferences were prioritised. Staff also highlighted how the pathway reduced anxiety and uncertainty about "doing the right thing" for their patients.

The impact:

The project embedded a proactive, compassionate approach to end-of-life care within the trust. By supporting staff to recognise decline early and by creating clear communication channels, Samantha's work reduced unnecessary hospital admissions and improved patient and family experiences during advanced illness.

The future:

Samantha plans to expand the initiative across the local Integrated Care System, integrating the trigger tool into the electronic patient record to automate prompts for review. She is also collaborating with community teams to provide regular joint education sessions on Parkinson's in the palliative phase.

Conclusion:

By empowering staff to recognise and respond to the needs of people with Parkinson's approaching the end of life, Samantha's project has improved comfort, dignity, and coordination of care. It demonstrates how structured education, clear pathways, and compassionate communication can transform end-of-life care from reactive to truly person-centred.

The light assessment: a red–amber–green approach to Parkinson's care

Tsitsi Grace Taiwo, Parkinson's specialist nurse, Cambridgeshire and Peterborough NHS Foundation Trust

The challenge:

As caseloads grow and the complexity of Parkinson's management increases, specialist nurses face the challenge of ensuring that every patient receives timely and appropriate review. With limited capacity and high service demand, patients with rapidly changing needs can be missed, while those stable on treatment may be reviewed too frequently.

Tsitsi recognised that a structured, visual way to prioritise patients according to clinical need could help the team focus resources where they were most needed — supporting safety, proactive intervention, and equitable care.

The project:

Tsitsi designed and piloted a "Light Assessment" framework using a simple red–amber–green (RAG) rating systemto stratify patients by risk and urgency. The tool provided a consistent approach for the Parkinson's service to review caseloads, plan follow-up frequency, and identify early signs of deterioration.

Key features of the project included:

- Development of the RAG criteria based on symptom stability, medication complexity, support network, and carer concerns.
- Integration into patient reviews, with ratings updated at every clinic or contact.
- Team-wide implementation, ensuring that all members of the multidisciplinary team used the same prioritisation language.
- Monthly caseload review meetings using the RAG tool to flag patients requiring urgent review ("red") or targeted support ("amber").
- Training and calibration sessions to ensure consistency and reliability between team members.

The results:

The Light Assessment proved highly effective in improving oversight and workload management across the Parkinson's service. Nurses reported a clearer picture of overall caseload acuity, allowing them to plan visits more efficiently and prevent crises through earlier intervention.

Patients identified as "red" were reviewed within two weeks, reducing avoidable hospital admissions, while "amber" patients received targeted education and medication support. "Green" patients were reassured with longer review intervals and given self-management resources, freeing up capacity for more urgent cases.

The impact:

Tsitsi's project transformed the way her service manages its caseload. The Light Assessment created a shared language for prioritisation, improved communication within the multidisciplinary team, and ensured equitable care across large geographical areas. It also provided a foundation for data-driven service planning, helping identify patterns of need and allocate resources more effectively.

Patients and carers benefited from more responsive support and felt reassured that the service was actively monitoring their wellbeing. Staff reported reduced stress and greater confidence in balancing complex workloads.

The future:

Building on the success of the pilot, Tsitsi plans to formally embed the Light Assessment into the Trust's electronic record system and extend its use to neighbouring services. She also aims to evaluate its impact quantitatively — measuring outcomes such as response times, admission rates, and patient satisfaction.

Conclusion:

By introducing the Light Assessment, Tsitsi Tawanda has developed a practical, proactive approach to managing Parkinson's care. Her innovative red–amber–green framework supports timely intervention, equitable service delivery, and safer, more responsive care for people living with Parkinson's disease.

Theme 5: rehabilitation, mobility and movement-based therapies

Rehabilitation and physical activity are crucial to maintaining independence, confidence, and wellbeing for people living with Parkinson's. Yet access to consistent therapy, exercise, and self-management programmes remains variable across the UK.

These four projects demonstrate how physiotherapists, doctors, and nurses are developing creative, locally led approaches to help people with Parkinson's stay active, build strength, and enhance quality of life through tailored, evidence-based movement.

Measuring what matters: choosing the right mobility assessment for people with Parkinson's

Rachel Golding, physiotherapy lead, Hertfordshire Community NHS Trust

The challenge:

Effective rehabilitation for people with Parkinson's relies on accurately measuring changes in mobility and function over time. Yet different assessment tools were being used across services, making it difficult to compare progress, share data, or demonstrate improvement. Physiotherapists often alternated between the Modified Rivermead Mobility Index (MRMI) and the Elderly Mobility Scale (EMS), but uncertainty remained about which tool best reflected the specific needs of people with Parkinson's.

The project:

Rachel set out to identify which assessment offered the most reliable, sensitive, and practical way to measure mobility in Parkinson's rehabilitation. Her project involved:

- Conducting side-by-side testing of the MRMI and EMS across a group of patients at different stages of Parkinson's.
- Comparing how each tool captured subtle improvements in balance, transfers, and walking ability.
- Evaluating the ease of use for therapists and patients, including time taken, clarity, and repeatability.
- Gathering feedback from physiotherapists to explore confidence in applying and interpreting each scale.

The results:

The MRMI proved more sensitive for detecting small but meaningful functional gains in people with mild to moderate Parkinson's, while the EMS was better suited for frailer patients or those in the early recovery phase. Using both tools in tandem gave a more complete picture of progress, helping therapists to tailor interventions and record outcomes more consistently.

The impact:

This work improved the consistency and quality of rehabilitation assessment across Rachel's service. Therapists reported greater confidence in tracking change and setting achievable goals with their patients. It also strengthened multidisciplinary communication, ensuring that information about a person's mobility could be clearly shared between inpatient, outpatient, and community teams.

The future:

Rachel plans to implement the dual-tool model across her local Parkinson's network and contribute findings to national discussions around standardising physiotherapy outcome measures. She hopes to develop a simple guidance sheet to support wider adoption and enable benchmarking across services.

Conclusion:

By identifying the most appropriate tools for measuring movement, this project has ensured that every step of progress for people with Parkinson's is recognised and built upon. Rachel's work shows that consistent, sensitive assessment is key to delivering effective, person-centred rehabilitation.

Good vibrations: exercise to music in rural Aberdeenshire

Dr Isobel Sleeman, geriatric and internal medicine registrar, NHS Grampian

The challenge:

Living with Parkinson's in rural areas presents unique challenges. Limited access to physiotherapy, exercise classes, and community support can lead to deconditioning, isolation, and loss of confidence. In Aberdeenshire, geography and transport barriers meant that many people with Parkinson's were unable to attend in-person rehabilitation or exercise groups, leaving a clear gap in ongoing physical and social engagement.

The project:

Dr Sleeman developed "Good vibrations", an innovative exercise-to-music programme designed to make movement enjoyable and accessible to people living in rural areas. The project involved:

- Creating a structured exercise-to-music class incorporating rhythm, balance, and coordination activities tailored for Parkinson's.
- Partnering with a local community hall to host sessions within reach of several rural villages.
- Using familiar, upbeat music to enhance motivation, rhythm, and enjoyment.
- Embedding warm-up, stretching, and relaxation routines to cater for varied ability levels.
- Gathering participant feedback to evaluate physical and emotional outcomes.

The results:

Attendance grew steadily as word spread through local networks. Participants reported improved balance, stamina, and mood, as well as a renewed sense of community and purpose. Many described the sessions as "uplifting" and appreciated the chance to exercise in a social, supportive environment.

The impact:

The programme demonstrated that rural rehabilitation can be both engaging and effective when designed creatively. It improved access to physical activity, reduced isolation, and fostered peer support among participants. The rhythmic element of music also supported movement coordination and confidence in daily tasks.

The future:

Dr Sleeman plans to evaluate the project's outcomes more formally using balance and wellbeing measures. She is exploring partnerships with local Parkinson's groups and community centres to expand the model to other rural locations across Grampian.

Conclusion:

"Good vibrations" highlights how small, community-led innovations can overcome barriers to access and transform the rehabilitation experience. By combining music, movement, and social connection, the project enhances both physical and emotional wellbeing for people with Parkinson's in rural areas.

The power of breath: managing symptoms with functional breathwork for people with Parkinson’s and carers

Angela Fong, advanced Parkinson's nurse specialist, Salisbury NHS Foundation Trust

The challenge:

Non-motor symptoms such as anxiety, fatigue, and breathlessness often undermine quality of life for people with Parkinson’s. Carers, too, experience significant stress and tension, yet few non-pharmacological approaches are routinely offered to manage these shared challenges.

The project:

Angela developed a functional breathwork intervention to help patients and carers manage breathlessness and anxiety through practical breathing techniques. The project included:

- A structured breathwork class teaching diaphragmatic breathing, relaxation, and gentle movement.
- Joint participation by carers to foster shared learning and mutual support.
- Collaboration with therapy colleagues to integrate posture and voice control exercises.
- Qualitative evaluation of changes in wellbeing, confidence, and symptom control.

The results:

Participants reported improved awareness of breathing patterns, reduced anxiety, and better control during moments of breathlessness. Carers described feeling more confident in supporting their loved ones. Clinicians observed improved posture, relaxation, and calmness during subsequent consultations.

The impact:

This low-cost, patient-centred intervention addressed a neglected area of Parkinson’s management. It promoted self-awareness, relaxation, and resilience for both patients and carers, and strengthened therapeutic relationships by empowering participants to take an active role in symptom control.

The future:

Angela plans to formalise the programme with measurable outcomes (such as anxiety scales and breathing control questionnaires) and explore opportunities for integration into community therapy or wellbeing hubs.

Conclusion:

This project demonstrates that small, holistic interventions can have a powerful impact on quality of life. Functional breathwork offers a sustainable, inclusive approach to managing non-motor symptoms and supporting emotional wellbeing in Parkinson’s.

Strength in every stretch: introducing a yoga and pilates class for people living with Parkinson’s

Coral Mannion-Morris, Parkinson's clinical nurse lead, Rotherham Doncaster and South Humber NHS Foundation Trust

The challenge:

Many people with Parkinson’s wish to remain active but struggle to find suitable and accessible exercise opportunities tailored to their condition. Existing physiotherapy services were limited by time and resources, and there were few structured exercise programmes offering physical and emotional support.

The project:

Coral launched a specialist yoga and Pilates programme designed specifically for people living with Parkinson’s. The class combined gentle stretching, core strengthening, balance work, and mindfulness in an inclusive, social environment. The project involved:

- Collaboration with a trained instructor experienced in neurological conditions.
- A progressive class structure that allowed individuals to participate safely at their own pace.
- Education on posture, breathing, and relaxation to complement medical care.
- Ongoing feedback from participants to refine exercises and address individual needs.

The results:

Participants reported improved flexibility, coordination, and balance, with reduced stiffness and anxiety. Many continued practising exercises independently at home and felt more confident engaging in physical activity. The group also provided peer support, helping participants feel connected and encouraged.

The impact:

The project has created a safe, sustainable exercise model that bridges the gap between clinical therapy and community activity. It has demonstrated improvements in both physical and emotional wellbeing, empowering people with Parkinson’s to take ownership of their condition.

The future:

Coral aims to expand the programme to additional localities, train more instructors in Parkinson’s-specific adaptations, and evaluate outcomes using balance and wellbeing measures. She also plans to collaborate with local Parkinson’s UK branches to secure ongoing funding.

Conclusion:

By introducing yoga and Pilates into the Parkinson’s care pathway, this project has offered an accessible and holistic approach to rehabilitation. It illustrates how inclusive exercise can enhance movement, confidence, and community for people living with Parkinson’s.

Developing a support pathway for carers of people with Parkinson's

Siobhan Coulter, geriatric medicine specialty trainee, The Newcastle upon Tyne Hospitals NHS Foundation Trust

The challenge:

Carers play a crucial role in supporting people with Parkinson's, yet many report feeling isolated and unsupported, especially as responsibilities grow. Within Siobhan's service, there was no structured framework for carer education or emotional support, leaving families struggling to navigate complex systems alone.

The project:

Siobhan developed a comprehensive carer support pathway to ensure carers were recognised and supported throughout the Parkinson's journey. The project included:

- Mapping key stages of the carer journey to identify when support is most needed.
- Designing tiered interventions, from written resources and signposting to group sessions and peer support.
- Creating educational materials on medication management, recognising "off" symptoms, and promoting self-care.
- Running monthly carer drop-in sessions, co-facilitated by psychology and occupational therapy colleagues.
- Building partnerships with voluntary organisations, including Parkinson's UK, to extend community-based support.

The results:

Carer engagement increased significantly, and participants reported improved confidence, reduced stress, and greater understanding of Parkinson's progression. Staff noted better communication with carers and earlier identification of burnout or crisis.

The impact:

The pathway improved continuity and collaboration across health and social care, promoting a holistic, person-and-carer-centred approach. It highlighted the essential contribution of carers to rehabilitation and overall wellbeing.

The future:

Siobhan plans to extend the pathway across her Trust and create an online resource hub for carers in rural areas. Long-term evaluation will include wellbeing and satisfaction metrics for both carers and patients.

Conclusion:

Siobhan's project positioned carers as active partners in the Parkinson's care pathway. By creating a sustainable framework for education and emotional support, it strengthened resilience and enhanced quality of life for both carers and those they support.

Theme 6: education, training and workforce development

A confident, knowledgeable workforce is the foundation of high-quality Parkinson's care. As services become more integrated and multidisciplinary, ensuring that all staff — from community nurses to care home workers and students — understand the complexities of Parkinson's is essential for safe, person-centred practice.

These projects highlight how education can transform outcomes: improving medication safety, communication, and confidence across all levels of care. From community upskilling to undergraduate training, each initiative demonstrates how learning translates directly into better lives for people with Parkinson's.

Supporting staff wellbeing when caring for people with Parkinson's

Dr Ambreen Sadiq, consultant geriatrician, University Hospitals Birmingham NHS Foundation Trust

The challenge:

Delivering high-quality Parkinson's care requires not only clinical expertise but also emotional resilience. Parkinson's is a long-term, progressive condition, and clinicians often build deep relationships with patients and families as they navigate deterioration, loss of function, and complex decision-making.

Dr Sadiq recognised that many members of the multidisciplinary team were experiencing emotional fatigue, moral distress, and burnout when supporting people through advanced stages of the disease. Heavy workloads, staffing pressures, and the emotional demands of end-of-life discussions were taking a toll on staff wellbeing, yet there were few formal mechanisms for reflection or peer support within her trust.

The project:

Dr Sadiq designed and piloted a staff-wellbeing initiative to create protected space, peer connection, and psychological safety for Parkinson's teams. The project combined structured reflection, education, and practical self-care strategies. Key elements included:

- Monthly reflective practice sessions for the Parkinson's multidisciplinary team, facilitated by a clinical psychologist, providing a confidential environment to share challenging cases and emotions.
- Workshops on compassion fatigue and moral injury, offering tools to recognise early signs of stress and adopt evidence-based coping techniques.
- Creation of a staff-support resource hub, including contact details for occupational health, counselling, and local wellbeing champions.
- Embedding "wellbeing check-ins" at the start of team meetings, normalising conversations about stress and emotional load.

The results:

Feedback from participants was overwhelmingly positive. Staff reported feeling more valued, supported, and connected to their colleagues. Self-reported stress levels fell, and many noted improved ability to compartmentalise work-related distress. The reflective sessions were credited with enhancing empathy and communication within the team, particularly after difficult consultations or patient losses.

Attendance at the sessions remained high throughout the pilot period, and other departments expressed interest in replicating the model. Line managers observed fewer sickness absences and improved morale among Parkinson's service staff.

The impact:

Dr Sadiq's project reframed staff wellbeing as a core component of clinical quality, not an optional extra. By prioritising emotional support, it strengthened team resilience and reduced burnout risk. In turn, staff felt better equipped to deliver compassionate, patient-centred care even in emotionally demanding situations. The initiative also encouraged open dialogue about the psychological impact of long-term care, reducing stigma and promoting a culture of kindness.

The future:

Building on its success, the wellbeing model will be rolled out across the wider Older People's Medicine directorate. Dr Sadiq plans to incorporate wellbeing education into Parkinson's induction training and to evaluate outcomes through validated measures of staff satisfaction and burnout. Longer-term, she aims to present the framework nationally to encourage adoption across other neurological and geriatric services.

Conclusion:

Dr Ambreen Sadiq's project highlights that caring for those with Parkinson's must include caring for the carers themselves. By embedding reflection, peer support, and wellbeing awareness into everyday practice, she has helped to sustain a resilient, compassionate workforce — one better equipped to provide outstanding, person-centred care for people living with Parkinson's.

Improving confidence of care home staff in the management of Parkinson's disease among their residents

Dominic Carter, Parkinson's clinical nurse specialist, Bedfordshire, East London NHS Foundation Trust

The challenge:

People with Parkinson's living in care homes often experience complex symptoms, multiple medications, and a high level of dependency. However, care home staff typically receive limited training in Parkinson's disease, leaving them uncertain about symptom recognition, medication timing, and escalation of concerns.

Dominic identified that this gap in knowledge frequently led to missed or delayed medication doses, inconsistent management of "off" periods, and unnecessary hospital admissions. Staff confidence was low, and communication between care homes and specialist services was inconsistent.

The project:

Dominic launched a care home education and empowerment programme to improve the confidence and competence of care staff supporting residents with Parkinson's. The project was designed to be accessible, practical, and relevant to the daily challenges faced in care settings.

Key components included:

- Interactive, scenario-based training sessions tailored to local care homes, focusing on recognising symptoms, managing fluctuations, and understanding the critical importance of medication timing.
- A concise Parkinson's information booklet created with input from speech and language therapists and physiotherapists, outlining medication administration tips, swallowing precautions, and signs of deterioration.
- Direct collaboration with care home managers to establish clear lines of communication between care homes, Parkinson's nurses, and GPs.
- Pre- and post-training confidence surveys to evaluate impact and identify ongoing learning needs.

The results:

Post-training evaluations demonstrated a marked increase in staff confidence and understanding of Parkinson's management.
Care homes reported fewer incidents of delayed medication administration, and staff expressed improved awareness of when to contact the Parkinson's nurse or GP for support. Feedback from participants described the sessions as "eye-opening," "reassuring," and "practically useful."

The impact:

Dominic's project strengthened the partnership between care homes and specialist Parkinson's services, creating a more joined-up approach to long-term care. The initiative improved safety and wellbeing for residents while fostering a sense of professional pride and empowerment among care staff.

The project also served as a model for how nurse-led outreach and education can extend specialist expertise beyond the hospital, ensuring that people with Parkinson's receive high-quality care wherever they live.

The future:

Following the success of the pilot, Dominic plans to develop a sustainable rolling education programme, combining in-person and virtual sessions for new and existing care home staff. He also aims to introduce Parkinson's Care Champions within each participating home to maintain awareness and serve as local points of contact for ongoing training.

Conclusion:

Dominic Carter's project highlights the vital role of nurse-led education in improving care for people with Parkinson's in residential settings. By investing in staff knowledge and confidence, he has enhanced safety, communication, and quality of life for residents — turning everyday care into truly specialist practice.

Final reflections

The Parkinson's Advanced MasterClass 48.2 cohort has once again demonstrated how education can translate directly into impact — not only within individual services but across the wider neurological care landscape. Each project represents a tangible commitment to doing things better: finding creative solutions, challenging established norms, and improving life for people living with Parkinson's.

What unites these 28 projects is a shared belief that change does not always require large-scale reform. Instead, it begins with one person noticing a gap in care, asking the right questions, and bringing others along to solve it. From new pathways and multidisciplinary collaboration to exercise classes, anticipatory planning, and workforce education, every project has contributed to a collective drive for progress.

The themes emerging from this year's work reveal a service community that is increasingly **proactive, integrated, and person-centred.**

- **Proactive care** is becoming embedded as standard, with teams developing tools and frameworks to identify need earlier and prevent crisis.
- **Integration and communication** across boundaries — between neurology, geriatrics, psychiatry, and primary care — are improving coordination and continuity.
- **Education and empowerment**, both of healthcare professionals and care partners, are strengthening the foundations of quality care.

This cohort's work reflects the ongoing evolution of Parkinson's services across the UK. There is a growing shift from reactive to anticipatory care, from fragmented systems to joined-up pathways, and from professional silos to shared ownership. Importantly, these projects show how leadership at every level — whether from a specialist nurse, registrar, therapist, or consultant — can spark meaningful change.

The projects also highlight the value of the Parkinson's Academy model: creating a space where learning is immediately translated into action, supported by mentorship, and shared across disciplines. The outcomes presented here show the ripple effect of that model — from individual confidence to system-wide improvement.

As these ideas move forward, the challenge now is one of sustainability and spread. The innovations showcased in this report deserve to be adopted, adapted, and amplified within other regions and services. Many of the approaches — such as RAG-based caseload tools, care home education, and multidisciplinary pathway design — have potential for national adoption.

Above all, this body of work reminds us that progress in Parkinson's care is driven by people: clinicians who listen, collaborate, and lead with compassion. Their work ensures that people with Parkinson's — wherever they live and whatever stage of the condition they are in — receive care that is timely, equitable, and truly person-centred.

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Neurology Academy is an innovative educational provider for healthcare professionals including consultants, specialist nurses, pharmacists, therapists and other allied health professionals. Our courses are developed by practising specialists who combine their experience and expertise into case-based learning designed to create specialists in their field with confidence in effecting change.

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