Quality Improvement Project Application Form

Salford Innovation and Improvement Fund Locality Call 2022/2023

Each question in this application form is very specific about the information required. **Please ensure that you read the Application Guidance document carefully, complete all sections of this form and provide all of the information requested**. Please ensure that any abbreviations/acronyms are explained at the start of the application; they may then be abbreviated throughout the remainder of the application.

SUBMISSION DETAILS

SUBMITTED BY *(name, role, org.)*	Nicole Vourliotis and Ashley Marsh
CONTACT NUMBER	0161 2064497
EMAIL ADDRESS	Nicole.vourliotis@nca.nhs.uk Ashley.marsh@nca.nha.uk
SUBMITTING ORGANISATION	Salford Care Organisation
SERVICE NAME	Dietetics
DATE SUBMITTED	30/08/22

Details of how to complete each section of this form correctly are found in the Application Guidance document. Please confirm that you have followed this guidance	☑ I have read and followed the Improvement Project Application Guidance document

SECTION ONE: PROPOSAL OUTLINE

1) NAME OF PROPOSED PROJECT

Please provide a name for the proposed project that you wish to be considered

Implementing a dietetic discharge pathway led by dietitians to minimize risk of malnutrition and dehydration at all stages of a service users' journey (treatment + recovery)

2) WHAT IS THE PROJECT RATIONALE?

What is the problem situation / rationale for this Quality Improvement Project?

SCO currently uses the universal malnutrition screening tool (MUST) to identify nutritional risk of all patients admitted to hospital. This tool is widely used nationally and has been validated in several clinical environments to detect malnutrition. In Salford we have introduced MUST care plans according to nutritional risk (as per trust policy) to meet patients nutritional needs in hospital. Nutritional screening is a nursing task and all patients should be screened within 12 hours of admission.

Local data and audits continue to show a delay in starting a care plan and/or referral to a dietitian has per current system where nurses screen, start MUST care plan and refer to dietitians. Whereas placing patients on a nutrition care plan/referral to dietitian in a timely manner may minimize the risk of malnutrition.

Moreover, a previous project on EAU highlighted no patients with a low to medium MUST scores received a nutritional discharge plan to prevent any risk of developing nutritional deficits at home. This could increase people's risk of readmission to hospitals unless they had been referred to dietetics. This does not follow the nutrition discharge pathway which had been put in place on that ward (See Appendix). Frequent hospital admission can cause adverse effects on quality of life, independence, and someone's nutritional status by entering the spiral of malnutrition and frailty which is not always addressed on the way into hospital or on the way out to hospital.

Dietetic services have been challenged over last 3 years with caseloads increasing for reasons such as deteriorating mental health and long COVID, increased frailty likely due to home isolation and lack of family/friend support. There used to be dietetic attendance at Multi-disciplinary team meetings (MDTs) where dietitians were able to identify nutritional risk whilst patients were in hospital and during discharge planning without solely relying on nurses using the MUST criteria. However, staffing pressures have meant this is no longer possible, so improving MUST care planning can mitigate for this and allow dietetic care to be used more efficiently.

The Ageing and Complex Medicine (ACM) dietetic team currently manages 13 wards, 380 beds, including two new medical wards (L7,L8). Staffing levels have been added to the risk register due to increasing complexity and high demand of dietetic care and this lack of resource means dietetic time needs to be used as efficiently and effectively as possible and routine accurate screening and care planning by ward staff can allow for this.

Therefore, we propose to establish a better discharge system using ward L7 and 8 as example wards to ensure all patients are accurately screened, placed on most suitable dietetic care plan as an inpatient and receive optimal dietetic care plans on discharge as required.

3) WHAT IS THE AIM OF YOUR PROJECT?

Overall aim is to increase the number of dietetic discharge care plans based on MUST on ward L7/8 by 80% by the end of the 12 month project period.

Secondary aims are:

1) **To reduce readmissions linked to malnutrition, dehydration and frailty to L7/8 by 20% in 12 months**

2) **To reduce LOS on L7/8 by 10% in 12 months**
3) **Enhance patient experience by involving them in dietetic discharge planning**

4) WHAT QUALITY IMPROVEMENT METHODOLGY WILL YOU BE FOLLOWING?

Outline the planned approach to delivering the QI project e.g. IHI Model of Change, Lean Thinking, Six Sigma, Total Quality Management, Theory of Constraints, PDSA cycles

3-4 PDSA cycles to help guide the test of change for 12 months period.
These are likely to be split into 3 phases:

Phase 1 – baseline (PDSA 1)
Compare and contrast current standards of MUST screening, dietetic assessments and discharge planning and how well our nutritional policy is embedded into daily practice. This will then lead to developing training pack and how nutritional status can be improved.

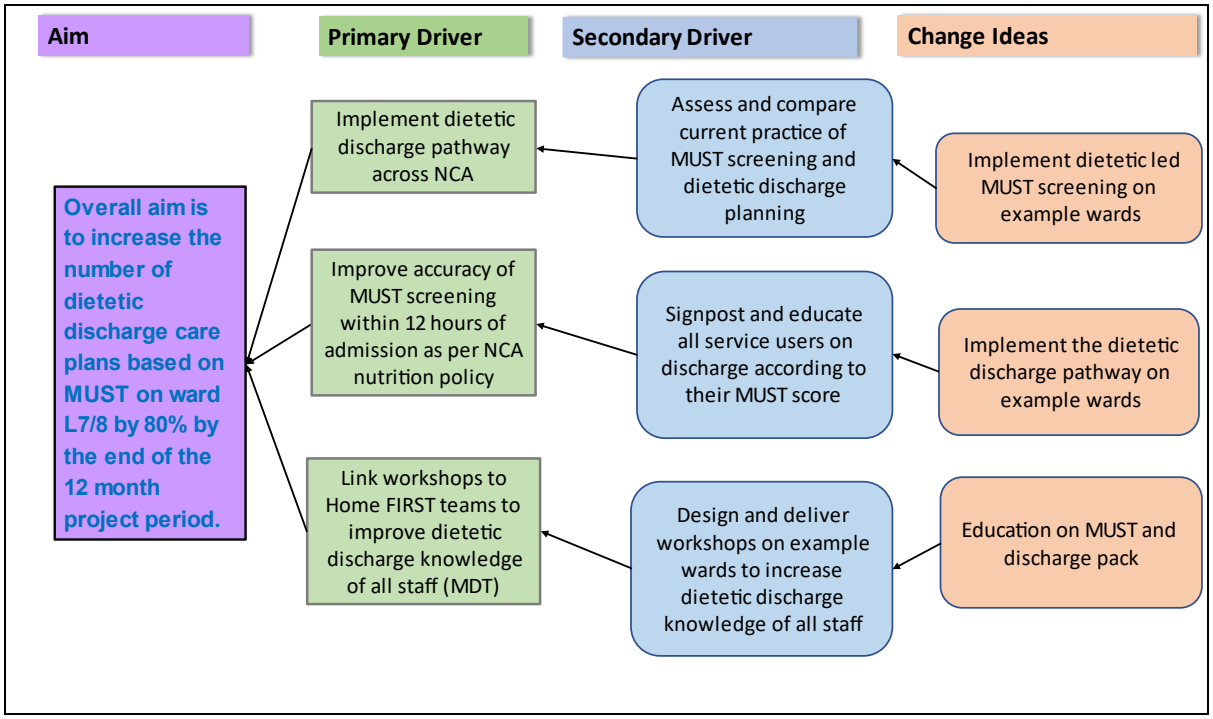
Phase 2 – intervention (PDSA 2)
During this phase the dietitians will help support with MUST screening, implement ting correct care plans and assessing those scoring MUST 2+. All patients will get a dietetic discharge careplan according to nutritional risk by using the pathway (appendix). Alongside relevant training that will be delivered by the project dietetic Band 3. The discharge pack contains social prescribing and the use of local resources; therefore, project lead will build strong relations with AGE UK Salford and hospital after care.

Phase 3 – sustainability (PDSA 3)
During this time the dietitians will step away from screening and will concentrate on complex dietetic assessments. The training of ward staff will remain to ensure new staff, bank staff and temporary workers are able to follow the MUST screening, care planning and dietetic referral systems as well as prepare for correct discharge plans.

Timescale
Each PDSA cycle will be split into equal time scales for easy comparison. Same data will be collected and compared, this will be presented as run charts to see if change in practice and staff education is causing a shift.

5) WHAT ARE YOUR CHANGE IDEAS?

Please list these, or attach an image of your Driver Diagram if you have completed one



6) HOW WILL YOU KNOW WHETHER YOUR CHANGE/S MAKE AN IMPROVEMENT? *(I.E. WHAT IS YOUR MEASUREMENT PLAN?)*

Please include the data collection method you plan to use

Compare pre and post data using Microsoft Excel using data from electronic patient records

Using Statistical Process Control (SPC) Charts to enable process performance monitoring over time with the support of NCA QI team

Aim for as many patients as possible to have a dietetic discharge plan in place by end of project. We use an SPC chart to run over months, splitting in baseline phase (likely only patients under dietitian have a discharge plan), intervention phase (aim: 80% of patients have a d/c plan) and sustainability phase (where dietitians pull back and let nursing team to follow dietetic discharge pathway, aim for 80% of patients having a d/c plan) so we can monitor the change in practice over time.

Secondary aims are to see if above implementation (dietetic led screening, implementing care plans and d/c action plans as per pathway) will lead to improved clinical and operational outcomes such as reduced LoS, reduced number of readmissions, improved nutritional status.

Sustainability: within the 12 months we aim to develop a training pack to allow other areas to introduce the dietetic discharge pathway.

Identifying outcome, process, balancing measures as part of PDSA cycle 1.

This project is very economical, the intervention is free as the pathway includes a discharge pack using local resources that are already available.

7) WORK ALREADY UNDERTAKEN

In this area, or in development of these ideas

This project is in line with ongoing improvement work across within Salford ACM, across the NCA and nationally.

1) Dietetic Discharge pathway

To help with more accurate discharge care planning we can implement an existing dietetic nutrition dietetic discharge pathway that has been trialed on EAU and helps to sign post patient to the correct discharge pack according to MUST score (see appendix).

1) Project lead/management

Both project leaders also have QI experience, Nicole completed a QI hydration project in collaboration with Kings College in 2021 (summary poster attached) and Ashley is part of the NCA Leadership QI model

2) Baseline data
   We have already collected baseline data to see how well nurses screen, implement and discharge patients using MUST on L7/8.

3) Home First project (See below for detail)
4) Government strategies are supporting national scheme to provide better living at home and out of hospital.

8) FURTHER INFORMATION

Close working relationships with Malnutrition task force, the ACM dietetics team have liaised with MTF for many years and contributed to recent Salford's story 22969_Salford Story - Report_OP.pdf (salfordcvs.co.uk). This project will align with their goals and strategies to reinforce the bigger picture to ensure we can meet nutritional and hydration needs in our community. As part of the QI project methodology, we would send regular reports to help ongoing collaborations, however we can also discuss ongoing challenges that arise within PDSA cycles in monthly MTF meetings for quick actions and accessible information for service users.

Age friendly City of Salford Age Friendly Salford (ageuk.org.uk) is available to us for sign posting and accessible resources that we want to imbed in daily discharge practice for a consistent message to our patients and their carer's. It's important we recognise the available help that is already to hand for our patient during this project to reiterate the importance of existing services that aim for healthy ageing and promoting an independent life in Salford community.

Salford Hospital after care (HAC) team can be accessed as part of the discharge pack for additional help at home. This has been an ongoing dietetic aim for wards to update this service, however currently only patients known to dietetics seem to benefit from this service when leaving the hospital.

Home first project – discharge to assess

It is a national scheme to providing short-term care and re-ablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means people no longer need to wait unnecessarily for assessments in hospital. The aim is that this process in turn may reduce delayed discharges and improve patient flow. This QI projects wants to ensure that any NCA wide HOME FIRST projects include the importance of nutritional education and care plans on discharge. It is important that we ensure patients can meet their nutritional and hydration needs at home and that care packages, written material, training sessions are adequate for people to access food and drink and can prepare meals/drinks consistently before they can be discharged. This QI project gives a perfect opportunity to highlight the importance of all patients to have a dietetic discharge care plan and not just patients already malnourished, frail or who are post operative. The patients that are vulnerable but currently eating, drinking with normal weight and body mass index (BMI), would still benefit from nutritional education on discharge to prevent risk of malnutrition or dehydration in future which can occur very quickly due to adverse effects such as social, mental, and physical determinants.

NCA frailty collaborative
Please see dietetic input with our frailty collaborative, its key to liaise with this team as nutritional screening goes hand and hand with frailty screening to ensure nutritional needs and defects are identified and the correct education and care plan is provided on the way out of hospital. Frailty dietetic slides available on request.

Name and Role

Nicole Vourliotis, Clinical lead dietitian in Ageing and Complex Medicine (ACM).

Tell us something interesting about yourself

I have always been interested in food (I love cooking and baking) and over the years my passion about sharing the study of nutrition & lifestyle and its relation to health and well-being grew. During my academic journey I developed a keen interest in understanding the ageing process more.

Why is frailty important to you and your area of work?

As a dietitian I am aware of the increasing detrimental health impact of frailty on older adults as well as the high prevalence of malnutrition in an ageing population. I want to raise awareness and focus on both conditions simultaneously, because focusing on just frailty can lead to possible gaps or missed opportunities in understanding the effect of complementary interventions on malnutrition. I enjoy all forms of improvement work, my motto is "driving patient focused small changes to create big impacts".

What are you hoping to achieve through the frailty collaborative?

I hope we can identify patients risk early to optimise dietetic intervention by implementing multidisciplinary assessments, ideally with robust front door screening pathways. Frailty is a condition with multiple causes, I am hoping to highlight the risk of malnutrition, frailty and sarcopenia and raise awareness of each condition to understand the overlapping features to increase opportunities for nutrition interventions and aid clinical outcomes.

Patient experience and volunteering
ACM already work closely with our mealtime volunteer teams and patient experience is extremely important to us. Therefore, as part of this project we aim to gather patient and carer's feedback which will help the design of suitable training packs and educational resources for our patient group, and most of all involve patients and carer's in discharge planning for fair and individualized care plans.

9) FINDINGS AND DISSEMINATION

The findings will be shared NCA wide to allow for dietetic discharge plans to be followed at larger scale. The training and screening methods used to initiate the pathways will be designed for self-explanatory implementation and can be followed by MDT including nurses, medical and AHPs etc.

The project team will report to NCA nutrition & hydration steering group on a monthly basis.

The project team will include patient and experience team to ensure we can meet the needs of the service user.

10) IMPLEMENTATION

Do you have your organisation's support to enable recommendations from this work to be taken forward?

Yes

If **YES,** provide details below:

Natalie Garratt, Head of Innovation, NCA supports the application

Kate Grimshaw, Dietetic Manager, Salford Care Organisation has had input into the project application and will provide regular operational support to the project team.

11) WHICH CITIZENS / PATIENTS / COMMUNITIES / VULNERABLE GROUPS WITHIN SALFORD WILL SEE A BENEFIT OF THIS PROPOSAL?

Group/s	What benefit/s will be realised for this particular group?
Older adults	This initiative addresses the challenges and outcomes of frailty and supporting ageing well in Salford by collaborations with Age UK Salford and hospital after care services as well as joining current Frailty collaboratives.
Dementia, cognitive impaired, Learning disabilities, autistic spectrum	Improved screening and dietetic referral criteria by using proposed pathway to enhance dietetic care on the way into hospital, during admission and on the way out to ensure staff and service users are aware to optimise nutritional stages at all stages of their treatment and recovery. For those that are unable to voice or understand what is in their best interest a robust nutrition pathway will ensure that all patients receive best possible dietetic care.
Carers	Discharge packs will help carers to continue dietetic care plans at home and signposting to local community groups will help carers and all service users to keep well in the community.

Mental health illness	Signposting to most suitable local help groups and providing written advice on discharge to encourage people to make better living choices and seek help when necessary. On discharge all patients and their carers receive nutrition education according to their risk of malnutrition.

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SECTION TWO: ALIGNMENT WITH SALFORD LOCALITY PRIORITIES

12) WHICH PRIORITY AREA DOES YOUR PROPOSAL ALIGN TO?

*(The 2022/23 Innovation and Improvement priorities are summarised below. (Please tick the **ONE** relevant box for the priority area your proposal aligns with.)*

2022-23 Innovation and Improvement Themes	
☐	Neighbourhood based care
☐	Safer Salford Care Homes and Domiciliary Care
☐	Workforce Transformation
☐	Sexual Health
☒	Frailty and ageing
☐	Screening
☐	Tackling vaccine / immunisation hesitancy

A full breakdown of these themes is available in the Application Guidance document.

NONE / OTHER	☐	*Please select this option if your proposal does not clearly align to any of the above topics, but you believe it addresses a current un-met need*

13) WHICH OF OUR CORE INNOVATION PRINCIPLE/S DO YOU BELIEVE YOUR PROPOSAL EVIDENCES?

(Please tick all that apply)

☐	*Exploiting the use of **Technology and Digital** Innovation*
☒	***Partnership Working** - Developing links between Health & Social Care and external organisations that are looking to test and evaluate innovative solutions in this field*
☒	***Neighbourhood Working** - Developing, delivering and structuring Health & Social Care within the 5 Salford Neighbourhoods / GP Networks*
☒	*Addressing **Health Inequalities and Wider Determinants of Health***
☐	*Improving the **Environmental Sustainability** of care*

SECTION THREE: PROJECT DELIVERY

14) PROJECT TIMESCALES

(What is the proposed length of your project? Please tick the ONE relevant box below

☐	3 Month (e.*g.* 90 day improvement cycles)
☐	6 Months
☒	12 Months

15) HOW IS THE PROJECT GOING TO BE MANAGED?

0.6 wte Band 7 will lead on the project, collect baseline data, identify training needs, carry out MUST screening and analyse PDSA outcomes and final data alongside the project lead

1.0 wte Band 3 dietetic assistant will collect data, support training and be a dietetic support to ward staff regarding MUST training.

Monthly meetings with dietetic lead to support project and monthly/quarterly meetings with project stakeholders including Salford Malnutrition Taskforce, Salford Hospital Aftercare, Salford community dietetics and other Stakeholders identified in the project

16) WILL THE PROJECT REQUIRE A CHANGE TO AN ESTABLISHED CARE PATHWAY?

If you are currently unable to assess if the activity will require a change to an established pathway, please indicate so using the Don't Know option. Applications selected to progress will be able to work with their sponsor to establish this.

☐ Yes
☒ No
☐ Don't Know

If Yes, please provide details of the existing care pathway and explain how your project will require a change to this.

17) WILL YOUR PROPOSED PROJECT ACTIVITY REQUIRE ACCESS TO, CHANGES TO, OR INTEGRATION WITH, EXISTING IT INFRASTRUCTURE OR SYSTEMS TO ENABLE DELIVERY?

☐ Yes
☒ No
☐ Don't Know

Please only select the 'Don't Know' option if you are currently unable to assess whether the activity will require access or changes to IT systems or infrastructure. If selected for progression, you will need to engage the relevant IT departments of pilot sites to establish these requirements prior to achieving final sign-off for funding.

If Yes, please answer the below questions:

A) Which system/s or infrastructure will you require access to, changes to, or integration with?

B) What changes / integrations are required, and the timescales needed for this?

C) Who owns or manages this system / infrastructure?

D) How have you engaged with the relevant system owners / managers / IT departments so far to determine the feasibility of making these necessary changes?

18) WHAT RISKS HAVE YOU IDENTIFIED, AND HOW WILL YOU MITIGATE THEM?

Potential risks are

i) that a dietetic led screening method may increase overall dietetic workload, especially considering increased admissions during winter months e.g. flu/COVID risk. This can be mitigated to some extent by the project staff. Additionally, by following the discharge pathway there is likely to be a reduction in referrals for patients who can be managed without dietetic intervention

ii) Potential risk of increasing community dietetic workload by screening for appropriate dietetic referrals and continuation of care post hospital admission. However this is likely to be mitigated by reducing the number of patients who are inappropriately referred to dietetic for follow-up after discharge who would not need this if given appropriate nutrition discharge pack based on the discharge pathway

iii) potential delay in recruitment in backfilling ACM staff, this can be mitigated by skill mixing or using the bank.

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SECTION FOUR: BUDGET & FINANCE

19) WHAT IS THE TOTAL AMOUNT OF FUNDING YOU ARE REQUESTING?

£53,026-00

Payment schedules for successfully funded projects will be finalised prior to sign-off. The typical arrangement is to pay 50% of awarded funds up front, with the remaining 50% released upon receipt of a successful 6-month project update report. If you would require any different payment schedule or arrangement, please give details below

20) PLEASE PROVIDE A FULL BREAKDOWN OF HOW THE REQUESTED FUNDS WILL BE UTILISED

	£
Staffing (inc enhancements)	
0.6 wte Band 7 Dietitian	31,666-00
1.0 wte Band 3 Dietetic Assistant	21,360-00
TOTAL	**53,026-00**

21) HOW WILL THE PROJECT ACHIEVE A RETURN ON INVESTMENT / COST BENEFIT?

By reducing the rate of malnutrition (https://www.bapen.org.uk/screening-and-must/78-media-centre/economic-report/471-new-data-reveals-increased-cost-of-malnutrition-in-england)

We would like to highlight the malnutrition link to readmission, LoS and adverse patient clinical outcome e.g. risk of falls (caused by dehydration), increased frailty (limited knowledge and access to food/drink), pressure sores, sore mouth, muscle wastage/weakness, immobility, fatigue, low mood/changes in mood.
This project can highlight how a deteriorating nutritional status can worsen any health condition (short term e.g. surgery, fracture, mild infection) or long term condition e.g. diabetes, dementia, cancer and therefore appropriate, timely and effective dietetic discharge care planning for every patient is crucial to either prevent malnutrition, slow it or correct for a better quality of life.

22) WHAT COMES NEXT AFTER THIS QUALITY IMPROVEMENT PROJECT? HOW WILL YOU ENSURE THAT THE LEARNING FROM THE PROJECT OR ITS RESULTS ARE SUSTAINABLE AFTER THE FUNDING PERIOD HAS ENDED?

The 12 months will be used to find a way how nursing staff are able to implement the nutrition discharge pathway and any new training modules will be shared across the NCA

for easy implementation. Sustainability is high as this project doesn't introduce a new screening/referral criteria, however can highlight how the current system can be embedded across the NCA if MUST is implemented in a way that staff know how to follow the nutrition policy and the dietetic discharge pathway (linked to MUST and discharge information pack using local resources).

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SECTION FIVE: DATA PRIVACY IMPACT ASSESSMENT

23) WILL THE PROJECT COLLECT / USE / PROCESS PERSONAL CONFIDENTIAL DATA?

☒ Yes
☐ No

If 'yes', please tick below which of the personal and sensitive data items the asset / system /project will process.

Personal Data Items	Sensitive Data Items
☐ Forename(s) ☐ Surname ☐ Address ☒ Postcode ☒ Date of Birth ☐ Home Telephone Number ☐ Mobile Telephone Number ☐ Other Contact Number ☐ GP Name and Address ☐ Legal Representative Name (Next of Kin) ☒ NHS Number ☐ National Insurance Number ☐ Photographs / Pictures of persons ☒ Other – please state below: Hospital number	☒ Gender ☐ Religion ☐ Ethnic Origin ☒ Medical Information ☐ Occupation / Employment ☐ Other – please state below:

A Data Privacy Impact Assessment (DPIA) form will need to be completed if your proposal is shortlisted to Interview.

- *If Yes is selected, a full DPIA will need to be completed*
- *If No is selected, the DPIA only needs to be completed up to Screen 5*

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SECTION SIX: EQUALITY, DIVERSITY AND INCLUSION

24) EQUALITY & DIVERSITY POLICY AND COMPLIANCE

A) Do you have an up-to-date Equal Opportunities (or equivalent) Policy in place?
☒ Yes
☐ No

B) Have you been involved in any Equality Act 2010 litigation breaches in the last 3 years?	
☐ Yes	*If Yes, please give details here*
☒ No	

25) PLEASE DESCRIBE HOW THIS PROJECT WILL ENSURE THE RIGHTS OF PROTECTED CHARACTERISTICS IN PARTICIPANTS, AND CONTRIBUTE TOWARDS TACKLING HEALTH INEQUALITIES IN SALFORD?

This project will not discriminate against the 9 protected characteristics under the Equality Act and aim to continually promote the NCA Trust Values (patient & people focus, continuous improvement, accountability, and respect) in respect to both patients and staff.
Within the methodology of the project all patients admitted to L7 & L8 will be screened, with appropriate dietetic care plan and discharge care plan put in place without any exclusion criteria relating to the 9 characteristics. Whilst nursing staff will be provided with education on MUST screening and discharge information.

26) ADDED SOCIAL VALUE: WHAT OTHER SOCIAL, ENVIRONMENTAL OR ECONOMIC BENEFIT/s WILL SALFORD RECEIVE THROUGH THIS PROJECT?

Reduced burden on NHS (financially & workforce) through reduction of readmissions related to nutrition and hydration.
Staff empowerment – autonomous working to calculate MUST and implement discharge pathway correctly.
Patient satisfaction, outcomes and safety by decreasing the risk of malnutrition and dehydration in hospital and in their communities.
Improved links to community welfare projects, resources and charities, instead of re-inventing the wheel by paying new leaflets we are using the local written educational materials, this also will help reinforcing the same messages to service users, carers and NHS staff, creating a solid educational preventative strategic care plan to promote healthy eating for every age and those living with chronic clinical condition.

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SECTION SEVEN: OPERATIONAL DETAILS

27) REGISTERED DETAILS OF BIDDING ORGANISATION/S

Name of Organisation	Registered Address	Organisation Type
Salford Care Organisation	Salford Royal Hospital, Stott Lane, M6 8HD	NHS Trust

28) WHICH ORGANISATION WOULD THE GRANT FUNDS BE PAID TO?

Dietetic Budget within Salford Care Organisation

29) WHO WILL BE THE INDIVIDUAL/s RESPONSIBLE FOR THIS PROJECT?

SENIOR LEAD *(overall accountability and oversight of project)*	
Name	*Nicole Vourliotis*
Job Title	*Clinical lead dietitian in ACM*
Organisation	*SCO*
Email Address	*Nicole.Vourliotis@nca.nhs.uk*
Telephone Number	*0161 2064497*

OPERATIONAL LEAD *(day-to-day delivery of project)*	
Name	*Ashley Marsh*
Job Title	*Specialist ACM dietitian*
Organisation	*SCO*
Email Address	*Ashley.Marsh@NCA.nhs.uk*
Telephone Number	*0161 2064497*

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SECTION EIGHT: APPLICANT AGREEMENT

30) PLEASE CONFIRM THAT IF YOUR PROPOSAL IS ACCEPTED YOU ARE AWARE OF, AND AGREE TO, THE FOLLOWING CONDITION:

Applicants must tick the box below to indicate that they agree to the condition

☒	Bidding organisation must be able to confirm a commencement date for the project within 2 months of receiving funding approval or approval may be withdrawn
☒	Completion of a mid-point project update report, presented to the Innovation and Research Oversight Group (IROG) and relevant Sponsoring Strategy Group
☒	Completion of a final evaluation report, presented to IROG and the relevant Sponsoring Strategy Group following the end of the project

31) PLEASE CONFIRM THAT YOU HAVE READ AND ACCEPT THE TERMS AND CONDITIONS

☑ I have read and accept the Salford Innovation and Improvement Fund Terms & Conditions

End of Application

Your completed application form, along with any requested additional information, should now be submitted via email to innovation.salfordccg@nhs.net

You will receive confirmation of receipt within three working days, along with a unique Bid Reference for managing your application and for on-going communication regarding your proposal.

Applications can be withdrawn at any time, for any reason, by contacting innovation.salfordccg@nhs.net with your Bid Reference

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