Has Britain solved its teenage pregnancy problem?

Teenage pregnancy rates have been falling dramatically for several years. **Sophie Arie** looks at why—and whether the trend will last

In recent years, although many public health problems have been growing, Britain's notoriously high teenage pregnancy rates have suddenly dropped. The number of 15-17 year olds getting pregnant in England and Wales started to fall significantly in 2008, and by 2010 it had fallen to the lowest level since records began in 1969. The rate continued to fall over the next two years with the result that by 2012 it was 40% down from 47.7/1000 girls in 1998 to 27.9/1000 (fig 1).[1]

The implications in terms of maternal and child health are huge. At least 40% of teenage mothers leave school with no qualifications, and both teenage mothers and their children have poorer health outcomes and an increased chance of living in poverty.[2 3]

Yet not everyone agrees on what brought about this turnaround or how to bring the rate down further (it is still the highest in western Europe according to the latest published comparative data, fig 2).[4] Many would say it's obvious. In 2000, the Labour government launched a 10 year teenage pregnancy strategy, which pumped over £250m (€300m; $415m) into a multipronged approach that aimed to halve the rate of conceptions among under 18 year olds by 2010.

The strategy included advertising campaigns, providing better information and access to contraceptives, encouraging good sex education, and more discussion of sexual health with general practitioners, youth services, and in specialised clinics. National and regional

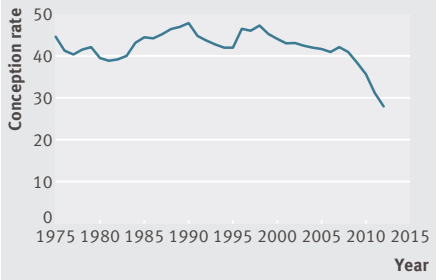

Fig 1 | Conception rate among girls aged 15-17, per 1000, 1975 to 2010[1]

boards were set up to oversee the progress, and all 150 local authorities appointed local teenage pregnancy coordinators as the contact point for all those involved from local health services, education, social services, youth services, housing, and the voluntary sector.

"These [latest figures] are the dividends we are reaping from a big concerted effort," said Alison Hadley, who was in charge of the strategy as head of the specially created teenage pregnancy unit within the Department of Health. "It's an illustration of how long it takes to have an impact on such a big public health issue. You don't get quick fixes overnight. But in time you can see services and culture changing."

Advocates of improved access to contraception point out that for every £1 spent on free contraception, the NHS saves between £11 and £12.50.[5]

But social conservatives argue studies show that encouraging children to talk to experts about sex and making contraceptives easily available to them may in fact encourage early sexual activity. They point out that promotion of the morning after pill, in particular, had led to an increase in the incidence of sexually transmitted infections.[6]

Loss of funding

When the coalition government came to power in 2010 it closed the teenage pregnancy unit, shelved a bill to make sex and relationships education compulsory in primary and secondary schools, and invited pro-life groups LIFE and CARE to participate in a new government forum on sexual health. The government says it remains committed to reducing teenage pregnancy and has made it one of four priority areas in its Sexual Health Improvement Framework, but it has not allocated funding to a specific, national strategy.

At the same time, reorganisation of the NHS, including making public health the responsibility of local government, and severe budget cuts across the NHS and all public services, mean that many of those who received training and had key roles at local level during the first decade of this century have now moved on or lost their jobs. An investigation by the *Guardian* newspaper found that 56 teenage pregnancy coordinator jobs had been axed by August 2011.[7] In the past year, the budget for youth services—which are the main contact point for teenagers not attending school—has been cut by up to 50% by many local authorities.

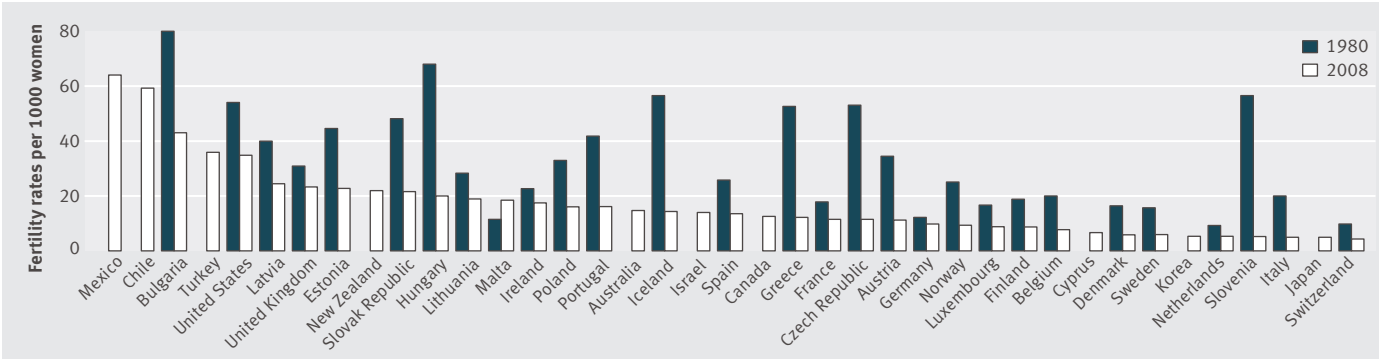

Fig 2 | Births to teenagers by country, according to an OECD 2013 report[4]

Future prospects

So will Britain's teenage pregnancy rate continue to fall? Or is it inevitably going to start rising again now that the national strategy has been dismantled? Those who led the strategy until 2010 are concerned but hopeful.

"We're in a slightly fragile place at the moment," says Hadley, who now runs the Teenage Pregnancy Knowledge Exchange, created at the University of Bedford in 2013. "The pegs are in the right place. But all the regional health structures have changed and the networks (we had created) have gone. The risk is that people who know things move on and that knowledge gets lost."

Simon Blake, who heads the sexual health services charity Brook, says an emphasis on good sex education and access to contraceptives has shown that given support, teenagers make sensible choices. "There's been a shift in our culture, a change of mindset that has made people recognise that our [high teenage pregnancy] rate is not inevitable," he says.

Reports from individual local authorities suggest that where the structures and philosophy of the teenage pregnancy strategy have been maintained, teen pregnancy rates are still falling.[8] A teenage pregnancy coordinator in the West Country recently suggested this may have a lasting effect in the region because there is now a stigma attached to being a teenage mother among young women who previously might have assumed they would leave school and have a family early.[9]

But in some areas, access to contraceptives has become more difficult. In 2012, an advisory group on contraception, made up of leading sexual health clinicians and charities, found in 2012 that access to all forms of contraception had been significantly reduced for a third of all women of childbearing age because of clinics closing, reduced opening hours, and lack of availability of some forms of contraception.[10 11]

International confirmation

Scientific consensus is that improving access to contraception reduces teenage pregnancy rates.[12] Research by John Santelli, public health expert at Columbia University, concluded that contraception was 75-85% responsible for the substantial fall in the rate in the US in recent years and abstinence accounted for the rest.[13]

The US has seen a dramatic drop in teenage pregnancy rates at almost exactly the same time as the UK,[14] and Santelli remarks that while better condom use, promoted by the anti-HIV campaigns, reduced teenage pregnancies in the 1980s and 1990s, recently teenagers have become more sophisticated in their knowledge and use of contraception.[15]

CHRIS ROUT/ALAMY

The pegs are in the right place. But all the regional health structures have changed and the networks (we had created) have gone

"What we think is going on is an increase of contraceptive use, with people shifting to methods that are more effective," he said. "IUDs are much more effective and more teenagers are now using them. We are also seeing increases in dual use of contraceptives—more than one type of contraceptive at once, which clearly gives greater protection."

Research shows that long acting reversible contraceptives (LARCs) are more effective than the pill or condoms, and in the UK the National Institute for Health and Care Excellence (NICE) recommended greater use of LARCs for all age groups.[16]

Santelli explains, however, that so far there is not sufficient evidence to establish just how much LARCs or dual use of contraceptives may be behind the recent change in the US.[17]

Many conservatives argue instead that it is a tightening of abortion laws in the US that has discouraged teenagers from taking risks. Although the US abortion rate has not fallen significantly in recent years, the teen pregnancy rate fell by at least 15% in all states apart from West Virginia and North Dakota between 2007 and 2011 at a time when many US states tightened their abortion laws. Rates in Arizona, Colorado, Idaho, Nevada, and Utah fell by 30% or more.[18]

Education

NICE has just advised that the UK's rates would fall further if the morning after pill was made available through schools for teenagers to stockpile should their chosen method of contraception fail.[19]

Many believe, however, that without making sex and relationship education compulsory Britain will not achieve the deep cultural shift it needs to bring its pregnancy rates in line with those of its neighbours. "If we'd had statutory sex and relationship education from the start of the 2000-2010 strategy, we'd have made more progress," says Hadley. "We are a society still hidebound by a lack of openness. We have extreme sexualisation of things, but young people would still say they'd feel embarrassed about asking about contraception." She points to the Netherlands and Sweden, which have some of the lowest teenage pregnancy rates in the developed world, as examples of societies where young people are more able to discuss sex and as a result less likely to engage in it or more likely to use contraceptives effectively. In the Netherlands, teenagers have sex younger and more often than Americans, and Rik van Lunsen of the University of Amsterdam has argued that this education had been crucial to the Dutch success.[20] A study of US, UK, the Netherlands, and Sweden showed that family planning services work closely with schools in the Scandinavian countries, with support from parents and from government.[21]

Currently age appropriate sex education is recommended in schools in the UK, but it is not obligatory and different schools teach it in very different ways. While there is consensus across the political spectrum that education is important, there is disagreement on what it should cover. Sexual health charities recently published guidance for schools on issues such as online porn, "sexting," and sexual violence after the government decided not to update official guidance that dates from 2000 and does not mention the internet.[22]

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Competing interests and references are in the version on bmj.com.

Provenance and peer review: Commissioned; not externally peer reviewed.

Cite this as: *BMJ* 2014;348:g2561

GSK faces accusations of bribing doctors in Poland

The company may have broken US and UK bribery laws, says Shelley Jofre

GlaxoSmithKline (GSK) recently announced that by 2016 it will end direct payments to doctors for promotional talks and stop setting individual targets for its sales reps.[1] The announcement by GSK, which last year made profits of £6.6bn (€7.9bn; $11.0bn), was broadly welcomed in an industry that has long been tarnished by accusations of corruption and aggressive marketing.

But just as Britain's largest drug company attempts to rebuild its image a BBC *Panorama* report, entitled "Who's paying your doctor?" has found that GSK is under investigation in Poland for allegedly bribing doctors there.

It is alleged that GSK sales reps in the region of Lodz, Poland's third largest city, paid doctors as recently as 2012 to boost prescriptions of some of the company's best known drugs.

A spokesman for the Lodz public prosecutor's office, Krzysztof Kopania, told *Panorama* that one GSK regional manager and 11 doctors have been charged in connection with corruption allegations for offences committed in 2010-12.

One doctor has already admitted guilt, been fined, and given a suspended sentence. He told *Panorama* he took money but only under pressure from a GSK drug rep. The investigation is ongoing.

A former sales rep for GSK in Lodz, Jarek Wiśniewski, told *Panorama* that money from the company's £1m annual marketing programme for GSK's blockbuster asthma drug, fluticasone (which it markets as Seretide), was used to bribe doctors to boost sales of the drug.

"There is a simple equation," Wiśniewski told *Panorama*. "We pay doctors, they give us prescriptions. We don't pay doctors, we don't see prescriptions for our drugs."

Doctors understood clearly that they must produce a certain number of prescriptions in return for the money

Payments for "educational services"

The whistleblower explained that the bribes were disguised as fees for "educational services."

"We cannot go to doctors and say to them, 'I need 20 more prescriptions'," said Wiśniewski. "So we prepare an agreement for them to give a talk to patients—we pay one hundred pounds, but we expect more than a hundred prescriptions for this drug."

Wiśniewski confirmed that the doctors understood clearly that they must produce a certain number of prescriptions in return for the money. It's a bribe, he said.

The Polish investigation has established, independently of former employees, that contracts were signed and payments made to doctors in at least a dozen different health centres across the region of Lodz where there was no evidence that "patient education" had taken place.

The payments were often small by UK standards—according to the prosecutor most were for several hundred zloty, but some were for several thousands (100 zloty = £20 (€24; $33)). But for Polish doctors, who earn around £700 a month, the sums are considerable.

Another former GSK rep in Poland, who spoke to *Panorama* on condition of anonymity, confirmed the payments influenced doctors' prescribing:

"This worked on the principle of a kind of obligation. The doctor feels obliged and he tries to a greater or lesser degree to fulfil that obligation. I think that—as with many colleagues—my feelings were very negative and unpleasant but such was the working culture. It is not easy to find a job."

In response to *Panorama*'s questions about the case, GSK confirmed that it ran a programme in Poland in 2010-12 to help improve diagnostic standards and medical training for the benefit of patients with respiratory disease.

"[Some] sessions were delivered by specialist healthcare professionals who, based on contracts signed with GSK, received payments appropriate to the scope of work as well as their level of knowledge and experience. The provision of sessions under this programme was agreed with the Polish healthcare centres.

"Following receipt of allegations regarding the conduct of the programme in the Lodz region, GSK has investigated the matter, using resources from both inside and outside the company," the company added. "The investigation found evidence of inappropriate communication in contravention of GSK policy by a single employee. The employee concerned was reprimanded and disciplined as a result. We continue to investigate these matters and are cooperating fully with the CBA [the anti-corruption bureau in Poland]."

GSK said it agreed that "there is a need to modernise interactions between the pharmaceutical industry and healthcare professionals to ensure patients' interests are always put first and to eliminate even a perception of a conflict of interest. This is why we have made, and will continue to make, fundamental changes to our business such as opening up access to our clinical trial data, changing how we pay our sales representatives and stopping payments to healthcare professionals for speaking engagements and for attendance at medical conferences."

Meanwhile, in Poland, doctors face jail sentences of six months to eight years if they are found guilty of giving or accepting bribes, and GKS's Lodz manager faces one to 10 years if found guilty of bribery.

Wiśniewski first raised his concerns with his bosses at GSK in Poland in May 2011. He says they carried out an investigation, then he was moved to another department. In September 2012 he was eventually fired for "poor performance" even though he says he had been singled out as a high flier in previous years. He is now unemployed.

GSK did not respond to questions about how the whistleblower was treated.

Other cases

The details of the case emerge as GSK attempts to rebuild its image after pleading guilty in 2012 to criminal charges in the United States and paying $3bn (£1.8bn) in fines for promoting some of its best selling antidepressants for unapproved uses, bribing doctors, and failing to report safety data about its drug for the treatment of diabetes.[2] The allegations dated to the mid-2000s, and Andrew Witty, who took over as chief executive in 2008, claimed the behaviour dated from a different era.

Similar allegations emerged last year in China, where authorities have accused GSK of funnelling substantial sums in expenses to doctors and officials in 2007-10 to encourage them to use its drugs. GSK's funding for all advertising, promotional, and training activity in China during the relevant period was around ¥3bn (£288m; €350m; $483m). The extent to which this funding was used fraudulently remains under investigation. The company again said such behaviour was not sanctioned at a corporate level and claimed that senior executives of GSK China had "acted outside of our processes and controls."[4] GSK has said it is "cooperating fully with the investigation in China."

The head of GSK China was replaced in 2013,[3] and GSK has reportedly just sacked more of its Chinese staff.[4]

GSK confirmed recently that it is also investigating bribery accusations in Iraq.[5]

Sydney Wolfe, founder of US campaign group Public Citizen, is sceptical of GSK's recent pledge to change its ways. He recently analysed all the fines paid out by the drug industry in the US over the past 21 years and says that GSK is a repeat offender that tops the list.[6]

"Glaxo was the number one with $7.6bn in these penalties and the number one company in the world in terms of total criminal and civil penalties. The penalties are not large enough to deter these illegal activities. They keep doing it over and over again, and in one year Glaxo makes more money in terms of profits than all the penalties they've paid over the 21 years."

GSK challenged Public Citizen's calculations, however, telling *Panorama* that they included $3.4bn, which was "not a penalty or a fine and did not relate to sales and marketing practises." GSK said the sum was "from a resolution we reached in 2006 with the US Internal Revenue Service (IRS) to pay tax related to transfer pricing."

If the new allegations are shown to be true, then GSK might have violated both the UK's Bribery Act and the US's Foreign Corrupt Practices Act (FCPA). In both countries it is illegal for companies based there to bribe government employees abroad. In the US, some drug companies have already paid out settlements after allegations they contravened the FCPA.

The Bribery Act came into force in the UK only in 2010, and there have not yet been any drug company prosecutions.

The US has taken a tough stance in recent years on drug industry corruption at home and abroad, making extensive use of whistleblowing legislation, which rewards employees who come forward with information about law breaking.

It was evidence from some of GSK's former employees in the US that resulted in the $3bn payout in 2012. Blair Hamrick, a GSK sales rep in Colorado for seven years until 2002, told *Panorama* he often made large payments to doctors for "educational" talks that were, in reality, purely promotional:

"We would have these Continuing Medical Education programmes that would get CME credit for the doctors, and they were nothing but a commercial," he said.

"There was what's called an ROI analysis [return on investment] about six months after a specific speaker programme. So if we spent $5000 on a speaker and we spent $20 000 on tickets and food, that's $25 000 invested. They would take all those physicians and they would track their prescription volume, and they would want to see an increase in prescriptions greater than $25 000 worth of business."

Whistleblower Jarek Wiśniewski says he lost his job after reporting his concerns over bribery

Hamrick adds, "The abhorrent behaviour that was going on, it was not only condoned, but we were compensated heavily for doing it."

More transparency in future

GSK announced in December that it is going to scrap the link between its reps' pay and drug sales targets globally by 2016.

A Washington lawyer who represented two other GSK whistleblowers, however, points out that this was something the company had already agreed to do in the US, as part of a Corporate Integrity Agreement drawn up during negotiations for the $3bn settlement.

Erika Kelton of law firm Philips and Cohen told *Panorama*: "There were prospective requirements for ongoing compliance that were imposed on Glaxo. In the past, GlaxoSmithKline had compensated sales representatives by paying them bonuses based on the amount of revenue that they generated. That kind of incentive compensation that's geared to how much revenue you're bringing in encourages off-label marketing, encourages borderline or over the line practices to get more sales."

The latest allegations against GSK are likely to prompt further debate over how little is known about industry payments made to doctors in the UK, even if they are not breaking the law.

In the US, GSK was forced to detail exactly how much it pays individual named doctors, and the company's payments to US physicians have since plummeted by 75%, from $56.7m in 2010 to $14.6m in 2013. A similar effect has been seen with many other drug companies that have been forced to publish such details in the US.

Since 1 April 2014, when the Sunshine Act came into effect, all pharmaceutical companies must now detail their payments to named physicians in the US. By contrast, drug companies in the UK have been obliged only since last year to supply an aggregate total. There is no way of finding out which individual doctors are being paid or how much.

The latest UK figures published by the ABPI (Association of the British Pharmaceutical Industry) on 3 April show that payments from the pharmaceutical industry to healthcare professionals last year totalled around £38.5m, roughly level with the previous year.

Stephen Whitehead, ABPI's chief executive, told *Panorama*: "You need to work with healthcare professionals to get understanding of the new science coming through, and that is a legitimate relationship. What you need to have to maintain confidence in these relationships is absolute crystal clear transparency about the money that changes hands. Then let people make their own judgment as to whether they think that's appropriate."

Whitehead says the ABPI is committed to full disclosure of payments in the UK by 2016 and is currently developing a searchable, centrally hosted register for payments in collaboration with the medical community.

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The *Panorama* programme "Who's Paying Your Doctor?" was broadcast at 8.30 pm on Monday 14 April on BBC 1.

References are in the version on bmj.com.

Cite this as: *BMJ* 2014;348:g2768

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DIABETES TEAM AWARD

Clinicians and patients working together

The Diabetes Team award category recognises an innovative project or initiative that has measurably improved care. **Adrian O'Dowd** presents the shortlisted teams

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Competing interests: I have read and understood the BMJ policy on declaration of interests and have no relevant interests to declare.

The BMJ Awards are sponsored by MDDUS. The awards ceremony will take place on 8 May at the Park Plaza Hotel, Westminster. To find out more go to http://thebmjawards.bmj.com.

Provenance and peer review: Commissioned; not externally peer reviewed.

Cite this as: *BMJ* 2014;348:g2708

3 Dimensions of care for diabetes

Diabetes affects patients in many ways, and a team at King's College Hospital NHS Foundation Trust, London, found an innovative approach that took into account the fact that a third of patients with diabetes have a psychiatric comorbidity—usually depression, but sometimes diabetes related psychological distress, anxiety disorder, or cognitive impairment—

Norwood Surgery, Southport

Taking a hands-on approach to patients' weight and its effect on diabetes has proved to be a winning approach at the Norwood Surgery in Southport, Merseyside. The practice wanted to tackle the epidemic of obesity and diabetes known as diabesity. It came up with the idea of pairing a new psychological, solution focused approach in evening group sessions with a lower carbohydrate diet.

David Unwin (a GP at the practice) and his wife, Jen Unwin, a clinical health psychologist at Southport and Ormskirk Hospital NHS Trust, came up with the idea

"We feel our best hope for stemming the tide of diabesity lies in changing eating behaviour. The results have been dramatic." **David Unwin**, GP

Sheffield Diabetes Footcare Team

Focusing on one of the most feared complications of diabetes—amputation—has helped to reduce the number of diabetic patients in Sheffield who have had to undergo the procedure, massively improving their lifestyle.

Sheffield had one of the highest amputation rates in the country between 2007 and 2010— 4.4 amputations/1000 people with diabetes, compared with the national average of 2.7/1000.

Sheffield Teaching Hospitals NHS Foundation Trust took several steps to reduce this figure, including introducing a diabetes foot hotline staffed by a consultant diabetologist to give immediate advice to community healthcare professionals and enable fast-tracking to the multidisciplinary foot clinic; simplifying the footcare pathway with a single point of referral; improving access to training for primary

West Hampshire Community Diabetes Service

Changing the setting for diabetic management from hospital to the community has proved popular with patients in West Hampshire and improved health. The West Hampshire Community Diabetes Service, provided by Southern Health NHS Foundation Trust, was launched in 2010 to help the local health system manage growing

Whittington Joint Diabetes Thalassaemia Clinic, London

A pioneering approach at the Whittington Hospital NHS Trust in London has allowed clinicians to provide high quality diabetes care to patients with complex problems. Diabetes is a common complication of β thalassaemia major, but most diabetes teams have limited experience of β thalassaemia, and care can become fragmented without close liaison with other specialists involved.

"The thing that has been very evident right from the word go is the teamwork approach with the clinicians and the patients." **Maria Barnard**, consultant diabetologist

The trust set up a joint diabetes-thalassaemia clinic in 2005 in its diabetes department with the aims of providing high quality diabetes, endocrine, and haematology care; optimising metabolic control; supporting self management; and supporting partnership working

that interferes with self management of their diabetes.

3 Dimensions of Care for Diabetes (3DFD) is a model of integrated care that deals with patients' psychological and social problems as well as their diabetes. The 3DFD team consists of a liaison psychiatrist specialising in diabetes, who delivers mental health interventions such as cognitive behaviour therapy, and two community support workers who deal with social problems. The team shares the same clinic space as the diabetes teams across five hospital and community sites.

"Our project addresses not just the psychological and medical aspects of diabetes, but also incorporates the third dimension—the social support elements." **Anne Doherty**, locum consultant liaison psychiatrist

Since the project began, there have been clinically significant reductions in patients' haemoglobin A_{1c} levels and improvements in lipid levels, blood pressure, and weight control. Sixty per cent of patients received a new diagnosis of a psychiatric disorder, and there were significant improvements in psychological symptoms and social functioning.

In the year after the intervention was introduced, compared with the year preceding it, attendances at emergency departments were reduced by 45%, hospital admissions by 43%, and bed days by 22%.

and recruited patients with type 2 diabetes or impaired glucose tolerance.

Participants were advised to reduce carbohydrates and eat more healthy fats, vegetables, and protein and given a low carbohydrate diet sheet. Baseline measurements of weight, waist circumference, blood pressure, cholesterol, and liver, thyroid, and renal function were taken.

Patients were given a choice of attending either monthly, 10 minute individual reviews of progress with a GP or practice nurse or evening "low carb" group meetings.

Among 18 patients who participated in the project over nine months, there were clinically and statistically significant improvements in weight, waist circumference, HbA_{1c}, and γ-glutamyl transferase levels.

David Unwin says: "We feel our best hope for stemming the tide of diabesity lies in changing eating behaviour. The results have been dramatic: HbA_{1c} dropped by an average of one fifth and weight by approximately a tenth. There were also improvements in blood pressure, liver function, and cholesterol despite a diet higher in fat."

"By focusing on the patient's journey, we have eliminated unnecessary barriers and enabled the care we deliver to flow more effectively." **Rajiv Gandhi**, consultant in diabetes

care screeners; providing better education for patients; having closer liaison with microbiology; and developing a simple inpatient foot screening tool.

The various steps meant that while the number of people over 17 with diagnosed diabetes in Sheffield rose from 23 690 in 2008-09 to 27 895 in 2012-13 and there was an 80% rise in activity within the foot clinic, the number of people who had amputations fell by around a third to 3.2/1000.

Quality of care also improved, as shown by the number of days in hospital for diabetic foot problems falling from 265.4 to 193.6 days per 1000 people with diabetes.

numbers of patients with diabetes and tackle an inequity of service provision locally.

Community service replaced all general medical diabetes outpatient appointments at two local acute trusts and expanded provision of education for patients and primary care staff.

The team is made up of a whole time equivalent community consultant, a team of specialist nurses, plus additional dietitian time and managerial support.

Various targets were set, including improving patient experience, improving availability of diabetes education for patients, and delivering a diabetes education programme for clinicians.

"I believe what sets us apart is our focus on encouraging activated and empowered patients who can inform and develop services." **Kate Fayers**, lead consultant

Improved pathways between the community service and primary care led to a reduction in the proportion of follow-up appointments by one third, despite an increase in the number of patients on the diabetes register by 14.5% over three years.

Non-elective admissions for hypoglycaemia and ketoacidosis fell by 8% and 7.4%, respectively, from 2010-11 to 2012-13. HbA_{1c} outcomes have improved. Patient feedback has been positive.

between the specialist teams and between patients and clinicians.

At the clinic, patients are seen by a multidisciplinary team comprising a dedicated consultant diabetologist, consultant haematologist, diabetes specialist nurse, and haematology specialist nurse. There is also access training for carbohydrate counting and adjusting insulin doses.

A retrospective analysis of data between 2005 and 2009 showed that performance on the key diabetes care processes such as rates of measurement of fructosamine/HbA_{1c}, serum cholesterol, serum creatinine, urinary albumin:creatinine ratio and weight/BMI were above average, as judged by the National Diabetes Audit. There were improvements in patients' glycaemic control, with a reduction in fructosamine over one year and an improvement in lipid profiles.

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GASTROENTEROLOGY TEAM AWARD

Working accross communities

The nominees for the Gastroenterology Team award have all improved services by making care more patient centred, finds **Chris Mahony**

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Competing interests: I have read and understood the BMJ policy on declaration of interests and have no relevant interests to declare.
The BMJ Awards are sponsored by MDDUS. The awards ceremony will take place on 8 May at the Park Plaza Hotel, Westminster. To find out more go to http://thebmjawards.bmj.com.
Provenance and peer review: Commissioned; not externally peer reviewed.
Cite this as: *BMJ* 2014;348:g2677

Supported self help and management programme for inflammatory bowel disease

In 2012 Luton and Dunstable Hospital became the first in the UK to use a remote, web based programme to manage patients with stable inflammatory bowel disease. The innovation grew from a 10 year review of the trust's treatment of the condition that showed the resource implications of treating around 2500 patients. With the aim of exploiting technology while improving education, community based care, and self management, the department began inviting hundreds of stable patients to transfer to its

"This programme has empowered patients by supporting them to self care at home." **Matt Johnson**, consultant gastroenterologist

Straight to test for lower gastrointestinal symptoms

The gastroenterology team at Barts Health NHS Trust adapted an existing pathway to ensure that almost all patients with lower gastrointestinal symptoms have endoscopy within weeks of referral rather than waiting for an appointment with a consultant.

Most patients referred to a consultant gastroenterologist

Gastroenterology and alcohol care team

Faced with a population in the highest quintile for alcohol related admissions and mortality, over the past 24 years Kieran Moriarty and his gastroenterology colleagues at Bolton NHS Foundation Trust have driven the development of a comprehensive alcohol care team that works across the trust and with primary care. "Alcohol has about 70 harmful effects on the body so it affects patients on every ward in the hospital. Taking account of its impact on our patients is part of the gastroenterology team's collaborative approach, which follows the British Gastroenterology Society commissioning guidelines to provide a comprehensive service," he said.

With around 60% of patients on the gastroenterology ward having an alcohol problem, the department continues to work closely with the alcohol care team. It has input from a psychiatrist specialising in addiction and is

Gastroenterology without walls

Sheffield Teaching Hospitals NHS Foundation Trust developed the "gastroenterology without walls" project to reduce pressure on acute services and remove barriers between hospitals and primary care.

Over nearly 20 years the trust's gastroenterology team, working with primary care, has responded to evidence that many patients

Nurse led ascites service

A pilot nurse led ascites service has been extended and given extra capacity after it cut non-elective hospital admissions and readmissions among patients with alcohol misuse problems. The service, at Blackpool Teaching Hospitals NHS Foundation Trust, also reduced the average length of stay and improved the patient experience.

The pilot emerged from a study of 100 patients readmitted to medical wards within a month of discharge. It found that 12% of all readmissions were due to recurrent ascites.

Patients are now assessed, and if they show no adverse reaction to drainage and have good mobility and mental capacity they are offered a place with a service aimed at improving support. This includes an information leaflet

web based Supported, Self-Help And Management Programme.

By using telephone clinics and personalised websites with direct access to the hospital specialists if needed, the department has avoided routine six monthly hospital clinic visits.

Around 400 patients had joined the system by autumn 2013. And it is expected that more than 800 people will be registered by the end of 2014, with the figure potentially rising to between 1200 and 1300. With fewer clinic appointments, that could result in annual savings of around £250 000.

The clinical commissioning group has provided funding for two additional inflammatory bowel disease nurses to help run the project.

outpatient clinic with such symptoms are booked for endoscopy. However, even patients designated as "two week wait" faced an average time from general practitioner referral to testing of around six weeks. For those on the 18 week pathway the average wait was 14 weeks.

Ed Seward, a consultant gastroenterologist at the trust said: "Data from our own department showed more than 90% of patients attending consultants' clinics had gastrointestinal endoscopy so we decided to extend it and reduce consultant outpatient clinics. You don't know until you look."

The approach provides early diagnosis or reassurance. It also has generated savings and reduced the number of outpatient clinics

GPs are now able to arrange a telephone appointment for their patient with a nurse. The nurse takes the patient's medical history and gathers further information through a questionnaire before booking the patient for a sigmoidoscopy or colonoscopy. However patients aged over 80 with comorbidities continue to be given a clinic appointment.

The approach has generated savings and reduced the number of outpatient clinics. It also provides early diagnosis or reassurance for patients and relieves GPs of the burden of deciding whether a patient should be on the two or 18 week pathway.

admitted to hospital could be managed on more efficient and timely pathways. The change to processes has hastened over the past three years with the rise of community clinics and round the clock ambulatory care.

Sometimes healthcare seems to be organised in a way that hinders people's access to the right clinician at the right time

In each area the team has created templates for its alternative models that could be replicated elsewhere. The approach has helped to relieve pressure on emergency services, avoid admission to hospital, prevent avoidable death, and provide care closer to people's homes. For example, the results achieved by the haemorrhage unit, based around a team of alcohol specialist nurses. After the team contributed to a study that confirmed that alcohol specialist nurses saved 5-10 times their salary, the trust appointed four such nurses to provide a seven day service, ensuring that care was available for patients admitted at weekends.

The nurses introduced the Audit C Alcohol questionnaire and all inpatients are routinely screened—improving identification of dependent, harmful, and hazardous drinkers and patients with undiagnosed liver disease. The improved triage times and reduced time for patient detoxification produced savings of £250 000 across the trust. One stop multidisciplinary clinics improved waiting times and patient choice.

Improved triage times and reduced time for patient detoxification produced savings of £250 000 (across the trust)

with a daily weight management chart to encourage patients to self manage their condition at home.

After their first hospital admission patients are referred to the nurse led clinic where staff take a comprehensive health history, conduct a physical examination, and tell them how to self refer for drainage. On a longer term basis, patients' blood results are monitored and diuretic management is improved by altering medication, lifestyle changes, and a diet and fluid management programme. The clinic staff are also available for regular contact and support.

The three month pilot led to a fall in non-elective hospital admissions among the study group and reduced the percentage of patients readmitted. The clinic's patient group has more than doubled in six months, and it now operates five days a week rather than two. Mike Rolland, team leader and hepatitis C clinical nurse specialist, says, "A core team of dedicated staff . . . have designed and implemented a comprehensive nurse led service that is patient centred and quality driven."

set up to improve management of patients with gastrointestinal bleeding, contributed to the 2008 recommendation from the Scottish Intercollegiate Guidelines Network that all such patients should be managed in dedicated units. The unit is now associated with reduced mortality across Yorkshire.

"Sometimes healthcare seems to be organised in a way that hinders people's access to the right clinician at the right time. We feel very fortunate to have been supported both by our hospital trust and by primary care to develop exciting new services that break down such obstacles," says Alan Lobo, consultant gastroenterologist at Sheffield hospital.

The three month pilot led to a fall in non-elective hospital admissions among the study group and reduced readmissions