The NHS Quality, Innovation, Productivity and Prevention Challenge: an introduction for clinicians

Department of Health

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Policy HR/Workforce Management Planning/Performance Clinical	Estates Commissioning IM&T Finance Social Care/Partnership Working
Document purpose	For information
Gateway reference	13551
Title	The NHS Quality, Innovation, Productivity and Prevention Challenge: an introduction for clinicians
Author	Department of Health
Publication date	11 Mar 2010
Target audience	Medical Directors, Directors of Public Health, Clinical Staff working in the NHS. Clinicians include those staff who provide clinical care to patients and the public, including doctors, dentists, nurses, midwives, healthcare scientists, pharmacists, allied health professionals, clinical support workers and paramedics.
Circulation list	
Description	This booklet explains the context of the current financial situation for the NHS and the Department of Health's plan for responding to this challenge by focusing on improving quality and productivity while making efficiency savings.
Cross ref	The NHS Operating Framework; NHS 2010 – 2015: from good to great: productive, people-centred, preventative; High Quality Care for All
Superseded docs	
Action required	N/A
Timing	N/A
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For recipient's use	

Summary letter

Dear colleagues

Ten years ago we worked in a very different NHS. Significantly less was spent on our healthcare than in most other developed countries. As a result, the improvements in care we delivered were in spite of, rather than because of, the system we worked in.

That has changed over the last decade as the annual budget for the NHS in England has more than doubled to over £102 billion.[1] Today £1 of every £13 (7.7% GDP) produced by the UK economy is spent on healthcare – a level that matches most other European countries. Making sure that this investment is used as effectively as possible is a key responsibility for us all.

You have used this increased funding to accelerate your work to improve care for patients. But, as we face up to the consequences of the worldwide recession and the need to cut the national debt, we must focus on how to continue to make these improvements in a tighter fiscal climate. Spending on public services, including the NHS, will no longer grow at the rate we have become used to.

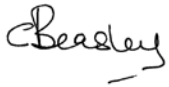
To meet increasing demand, stemming partly from the fact that our population is ageing, and to absorb increasing costs, we need to concentrate on improving productivity and eliminating waste while focusing relentlessly on clinical quality. The NHS needs to identify £15-£20 billion of efficiency savings by the end of 2013/14 that can be reinvested in the service to continue to deliver year on year quality improvements. We need to start now to achieve this aim. This is a huge challenge but one we believe we will be able to meet.

1 In 1999/2000 the total budget for the NHS in England was £40 billion. In 2009/10 it is over £102 billion.

You may think that money is someone else's business but we believe that addressing financial inefficiencies is a key personal, professional and moral responsibility because it allows us to free up resources which can then be used to treat more patients, more effectively.

This booklet describes how we will support clinical teams and NHS organisations to meet this challenge and the ways in which we can all get involved in shaping the response locally. We want you to talk to your colleagues about how you could continue to improve the quality of care you provide, and do so more efficiently. We want you to learn from listening to patients and to work closely with managers to make sustainable improvements.

We know that NHS clinicians are among the best in the world and we are confident that you have the imagination, commitment and innovation to meet this challenge.



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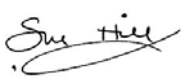

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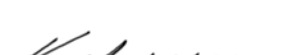

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Chief Health Professions Officer

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Chief Pharmaceutical Officer

Improving quality in the current financial context

Investment in the NHS in England in 2010/11 will be £102 billion. The NHS Operating Framework, which sets out the priorities for the year ahead, confirms that in the 2010/11 financial year healthcare spending will increase by 5.5% – but after that financial growth will be limited for the foreseeable future. We will use this year of guaranteed growth in spending to prepare for the years ahead by focusing on quality and identifying big efficiency savings.

The Pre-Budget Report announced that frontline NHS investment will grow in line with general inflation in 2011/12 and 2012/13. However, the demand for healthcare from a growing and ageing population, new technology and ever higher patient expectations mean there is increasing pressure on the NHS budget. The NHS needs to identify £15-£20 billion of efficiency savings by the end of 2013/14 that can be reinvested within the service so that it can continue to deliver year on year quality improvements. The money will be kept in NHS budgets.

> Efficiency savings of £15–20 billion by 2013/14 will be needed to realise the vision of *High Quality Care for All*.

In meeting this financial challenge, it is crucial that we do not lose momentum in improving the standard of care we deliver. We need to protect and promote quality while releasing savings everywhere. In doing so we will continue to ensure that NHS values are at the heart of what we do and we remain committed to tackling inequalities and promoting equality.

As clinicians we make the decisions that, every day, have an impact on how the NHS budget is spent. Our duty is to do this in a way that makes the best use of NHS resources and taxpayers' money. It is more important than ever that each pound we spend is focused on maximising the quality of healthcare we provide and on improving the experience of patients and the public.

CASE STUDY

Enhanced recovery programme

Yeovil District Hospital NHS Foundation Trust

The enhanced recovery programme in elective surgery is reducing patients' return to normal from weeks to just days and, if adopted nationally, has the potential to save 200,000 bed days. Mr Nader Francis, consultant colorectal surgeon at Yeovil District Hospital, says it has transformed the way patients recover from major operations.

"The Yeovil team have experience of nearly a thousand cases for elective bowel surgery through this programme. The first day after major bowel surgery, you see most patients in excellent shape back on the ward, eating and drinking normally, mobilising and living pain free. That is the revolution of enhanced recovery.

The programme works by involving the entire clinical team – from dietitians and surgeons to anaesthetists and ward staff – to get the patient in the best possible condition, optimise their nutrition and minimise the stress of surgery, promoting faster healing and recovery. One of my priorities is to ensure the patient feels very positive and motivated, converted from the shock and devastation of hearing they have cancer, to a positive view that most likely it will be cured by the surgery and they will be fully informed about every single step of recovery, so there are no surprises.

There are three essential features of this approach:

- Pre-operative care and education ensure that the patient is in optimal condition for surgery.
- Minimally invasive techniques are used during surgery and the patient is managed very carefully during the operation to minimise gut dysfunction and maintain optimum fluid levels.
- Patients are mobilised early, and oral fluids and nutrition re-started as soon as possible after surgery.

One of my patients just three minutes after the anaesthetic tube was removed in recovery was able to give me his wife's mobile number. The recovery we see in patients is astonishing but it is multi-factorial – it is not just the surgeon's work.

At Yeovil, the average length of stay is now just five days, with only 5% readmission rates. The quality and speed of patients' recovery is much better and that is our primary motivation, but it has also produced productivity improvements.

We do more surgery; we don't have empty beds. In the three years from 2006, our cancer referral operations have increased significantly. We could not have done that without enhanced recovery."

The NHS Operating Framework 2010/11

The NHS Operating Framework is published each year. It clarifies the priorities for NHS organisations and explains how the system will act to support them.

This year's Operating Framework sets out a number of changes to national policies to support commissioners to lead change locally and help providers move care out of hospitals and into the community, with the aim of increasing quality and productivity.

The NHS Operating Framework makes clear that significant quality and productivity gains can be made by looking at the interface between organisations – for example, between health and social care, or primary and secondary care. In some cases, integration of services may be appropriate. Given that so many emergency admissions could be preventable with better community services, we have reduced the tariffs for these admissions to encourage hospitals to work with primary and community care to improve out-of-hospital care. Organisations need to work together to put patients' interests first and manage risk across the system, rather than just within organisational boundaries.

The NHS Operating Framework explains that we need to develop a new system. To be successful, the NHS in five years' time will have more services closer to home and therefore less investment and activity in the acute sector.

As the NHS Operating Framework makes clear, delivering this vision means change for NHS staff. It may mean working in a different place and in a different organisation. We are committed to supporting staff through these changes. The NHS Constitution,[2] published last year, sets out the rights and responsibilities of staff as well as certain pledges to staff where the NHS is committed to going above and beyond the normal legal responsibilities of employers.

The full NHS Operating Framework is available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107

2 The NHS Constitution for England, Department of Health, January 2009 www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm

CASE STUDY

Fractured neck of femur – rapid improvement programme

South Tees Hospital NHS Foundation Trust

Senior nurse Glynis Peat was the pathway leader for a multi-professional group at South Tees Hospital NHS Foundation Trust that transformed the patient pathway for fractured neck of femur. Their improvements have speeded recovery for this vulnerable group, saving money and freeing valuable orthopaedic bed days.

"Patients with hip fractures are probably one of the most vulnerable groups admitted to orthopaedics. Most of them are over 65 and have a lot of other conditions. They may have been stuck where they fell for several hours before admission. As a result, we see a lot of complications and long hospital stays.

Our Chief Executive was very keen to focus on improving the pathway of these patients. It is a pathway that is high cost both to the NHS and to the patient. If we could deliver rapid treatment and care it would help avoid complications, aid speedy recovery, free beds and improve the patient experience. Our aim was to systemise excellent care across the entire patient pathway from time of injury to discharge.

We set ourselves an objective to actively involve patients and carers in evaluating and designing the service. There were an enormous number of specialties involved – the ambulance service, nursing home managers, cardiology, the discharge team and social services to name a few. That reflected the complexity

of the patient pathway for fractured neck of femur. What strikes me now is that everybody did something to make a change.

Our key priorities were to reduce waits in A&E, to reduce time to theatre and the time before patients were up and on their feet. Patients' key concerns were pain management, having clear information at each step and support after discharge. We listened and responded to them.

We developed a fast track through A&E and we went from 50% of patients through in two hours to 70%. We worked with anaesthetists and geriatricians to establish 'fit for surgery' criteria. The patients having their operation within 48 hours went from 62% to 72%. Our length of stay reduced from 18 to 14 days, and the number discharged home went from 42% to 70%. Crucially, patients benefited from improved patient information that we developed with them and better pain management pre- and post-operatively.

We wrote a strong business case for improving the pathway for this group of patients, which we presented to the Trust Board. We received funding for additional theatre lists because we were able to demonstrate improvements to our productivity. The work of the physiotherapists mobilising patients early was a key part of their recovery and discharge. Because of this, the Board also gave us funding for a new dedicated weekend physiotherapy service.

We now have faster times to theatre, reduced length of stay and fewer readmissions. The improvements we made are now part of our normal business.

Each year 70,000 people over 60 suffer a hip fracture and, with an ageing population, it is estimated these figures will grow by 2% each year. That means this is an important group of patients for many acute trusts and focusing on their pathway has the potential to improve quality for patients and improve efficiency for the trust."

How we plan to respond to this challenge

In *High Quality Care for All*[3] Lord Darzi reflected clinicians' desire to place quality at the heart of the NHS. A high-quality service can only be delivered if there is a focus on three key dimensions of quality: clinical effectiveness, safety and patient experience.

It is crucial that the economic challenge does not change this focus. We need to support innovation in our clinical practice and develop pathways that improve effectiveness and enhance the patient experience as well as providing value for money.

We realise that this is a challenge but there is good evidence that concentrating on delivering high-quality care, prevention and early intervention can improve efficiency and save NHS resources. The case studies included in this booklet show where this has been done.

In our plans to meet these aims we will focus on four core components:

Quality

Innovation

Prevention

Productivity

(QIPP)

3 Lord Darzi, *High Quality Care For All: NHS Next Stage Review final report*, June 2008
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

QIPP national workstreams

To help us succeed in this challenge, a national programme of workstreams has been set up to support clinical teams and NHS organisations. Workstreams focusing on **long-term conditions**, **urgent care** and **end-of-life care** look at improving quality and productivity across care pathways.

The programme will also identify the next wave of **safety challenges**, including tackling priorities such as venous thromboembolism and pressure ulcers. A workstream on **right care** will involve clinicians in identifying high- and low-value treatments in different specialties and in reducing variation in referral thresholds.

The national programme will also help providers **improve staff productivity** and **support key changes in procurement, medicines use and management, staffing and back-office clinical support**. It will also look at how to improve the way the NHS commissions primary care.

Innovation (especially the widespread adoption of best practice) and prevention (in the medium term through secondary prevention, and, over the longer term, through primary prevention) will be key enablers for achieving quality and productivity gains.

You can find out more about these workstreams and how they are able to assist your local service delivery at www.dh.gov.uk/qualityandproductivity

CASE STUDY

Engineering simpler, safer and more efficient blood transfusion systems

Oxford Radcliffe Hospitals

Mike Murphy is Professor of Blood Transfusion Medicine at Oxford University and consultant haematologist, NHS Blood and Transplant at Oxford Radcliffe Hospitals. He pioneered the 're-engineering' of hospital blood transfusion using an electronic system. It has made transfusion at the Oxford Radcliffe Hospitals safer for patients, simpler for staff and is reducing costs for the trust.

"Blood transfusion is a complex and time-consuming process involving numerous steps that culminate in a series of bedside checks. Thankfully, errors resulting in the wrong blood being transfused are rare but, when they do occur, most are due to patient misidentification and they can be fatal.

The pre-transfusion safety checks have become so complex that they may be self-defeating. It has been observed in some clinical studies that only 30% of pre-transfusion bedside checks are carried out correctly. We needed to do something to make the process simpler and safer.

Together with my team, we aimed to re-engineer the entire process, and to replace the old manual process with end-to-end electronic control. We introduced hand-held electronic devices that guide staff at every stage of the transfusion process.

Making transfusion as safe as possible is our guiding principle, but we have also simplified it to some degree, creating significant savings in staff time. Under our new system:

- the patient's identification details are encoded within a barcode on their wristband, and are applied by the laboratory to the blood unit to be transfused;
- a small hand-held computer is used to prompt staff through the process for collection of a blood sample for blood grouping and compatibility testing, and to ensure that the blood is transfused to the right patient;
- if there is a mismatch between the barcodes on the wristband and on the blood unit, the nurse is alerted so that transfusion does not take place;
- blood is stored in 'smart' refrigerators controlled by a computer linked to the information system in the laboratory.

We have found many proven benefits to the system, including better use of blood, less wastage, a simpler process for staff and much-reduced staff time. The new system saved the trust £940,000 in 2008.

We have developed a national specification for an electronic transfusion management system so that others can benefit from our experience in Oxford."

Developing a sustainable health service entails making widespread changes to the structure of the NHS.

We already know that too much care is focused around hospitals. Inpatient care will still be needed for the sickest patients but best practice shows that far more care should be delivered in a patient's home or community. This will mean that the role of hospitals and some of the services within them will change.

We will also need a greater focus on primary and secondary prevention along with early identification of disease. Our NHS in the future will see a greater role for patients managing their own health, often through the use of new technology or through the application of scientific advances.

It will mean we need to form better partnerships between primary, community and secondary care to support people with long-term conditions. Pharmacists and healthcare scientists will also need to ensure that we have the most effective processes and best evidence for diagnostics and treatment.[4]

The NHS needs a collective response at local, regional and national level with each part of the system doing what it is best placed to do. As clinicians working on the frontline we are able to see the best opportunities for combining improved quality with improved value. We will be central to this response and must lead it.

4 *NHS 2010–2015: from good to great. Preventative, people-centred, productive*, December 2009 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109876

What do we need to do?

We understand that it is often easy to feel disempowered in a system of 1.4 million employees but our ability to continue delivering high-quality care to our patients will depend on what actions we take now to prepare for a more constrained economic future.

Every region, local health economy and NHS organisation is currently planning how it will respond to the QIPP challenge.

Our national QIPP programmes are there to support this change but it is crucial that, as clinicians, we are at the heart of this transition. We have the best understanding of how high-quality care can be delivered on the frontline.

If we do not respond to this challenge there is a real risk that the need to cut costs will overtake all our best intentions to improve care for our patients.

CASE STUDY

Rapid response community assessment and management of dysphagia in end-of-life care

Sandwell Community Healthcare Services

Ruth Williams is a speech and language therapist and acting manager for rehabilitation services in Sandwell Primary Care Trust (PCT). Ruth led a programme to improve the assessment and management of dysphagia, allowing more patients to remain at home during end-of-life care and reducing hospital admissions.

"This project started because we wanted to improve what was happening towards the end of our patients' lives. Many have conditions such as Parkinson's, stroke and dementia; they would develop problems with feeding and swallowing, leading to aspiration pneumonia, they were admitted to hospital, treated, discharged, then the same thing would happen two months later.

The other key issue we identified was to do with our response times. Our team of speech and language therapists was following our professional recommended response times for dysphagia assessment – two days. But if an elderly person in a nursing home developed dysphagia towards the end of their life, this wasn't fast enough. Staff would panic and the patient would be admitted to hospital, where they would die.

The situation wasn't good for anyone: the patient, their family, the nursing home staff or our therapists. We thought we had to do something to break this cycle.

We took a two-pronged approach. First, we developed a rapid response service to assess urgent patients within four hours, reducing hospital admissions.

Second, we developed an extensive training programme for nursing home staff to ensure they could manage dysphagia in their patients. It means they have other strategies and skills to manage feeding and swallowing difficulties as a frontline community service, whenever they happen, and hospital admission is no longer the only option.

They now have the confidence to identify when someone is at the end of life and to put them on a palliative care pathway in collaboration with the family, the GP, dietitians and our team.

The outcome has been that a lot of nursing homes have been able to keep patients in the home for the end of their life. We found that in the six months from April to September 2009, we avoided 75 hospital admissions, saving £225,000.

We are all really proud of the programme because we can see the benefits every single day. GPs are confident they can get rapid assessment, nursing home staff have new skills to manage dysphagia and there is more choice for patients at the end of their life, and for their families."

Your personal practice

On an individual level, we each need to look at our daily clinical practice and identify where making changes will lead to better care for patients as well as eliminating waste and inefficiencies. We also need to consider the wider care pathway and contribute ideas about how to improve efficiency and the quality of care beyond the boundaries of our own organisation.

Your local clinical service

Where you believe there is an opportunity for improvement, it is crucial that you make your views heard. Locally, you should approach your professional lead. Regionally, it could be the clinical lead for your clinical pathway or the QIPP lead who has been appointed in each strategic health authority (SHA), or professional and workforce leads. You can find details of your QIPP lead at www.dh.gov.uk/qualityandproductivity. It is their responsibility to listen to your ideas.

The QIPP programme also extends outside the NHS. It may be that your Royal College or professional organisation is involved in consultations or is directly involved in supporting projects. Find out how they are contributing and help shape their response too.

NHS Quality Observatories and Innovation Leads and Funds

In addition, every SHA is establishing a Quality Observatory and an Innovation Fund. These are designed to help clinical teams identify the best opportunities for improving quality and productivity.

The Quality Observatories (www.qualityobservatory.nhs.uk) are intended to become a first port of call for anyone seeking comparative information on quality of care in their region.

SHA Innovation Leads are in place to help your service make a wider contribution to meeting the QIPP challenge by, in some cases, resourcing and implementing your ideas through their Innovation Fund, but also to help you find the appropriate support for taking your innovation forward.

Next steps

Throughout this document you can see examples of where clinical teams like your own have improved the quality of care they provide while making funding go further. We hope you will use these ideas to stimulate changes in your own practice. There are further resources at the end of this document to help you.

We do understand that you cannot do this alone. In addition to the national workstreams, we are working on ways to get clinicians, senior staff and managers to work together more closely in the future and we hope you will embrace this. We will also need to engage patients and the public, and ensure that we learn from their experience, to provide shared leadership for the changes that are needed.

This economic challenge presents us all with a reason to evaluate the quality of care we deliver and to make major changes which will increase our efficiency, reduce waste and improve the experience for patients. Putting these considerations at the forefront of our daily practice will allow us to secure a great future for the NHS founded on the principles of best value and quality of care for all.

CASE STUDY

Antibiotic stewardship

Southampton University Hospitals NHS Trust

At Southampton University Hospitals NHS Trust pharmacists and medical microbiologists work together to support clinical teams' treatment decisions. Consultant pharmacist for anti-infectives Kieran Hand says this systematic approach to antibiotic prescribing is helping to reduce the rates of *C. difficile* infection, supports effective and safer patient care and saves money for the trust.

"Antibiotic prescribing practice clearly has a big effect both at an individual patient level, at trust level and also much wider in terms of public health by selecting for resistant microbial strains.

When I took up my post at Southampton, pharmacists and medical microbiologists were already collaborating to tackle complex infection management problems through weekly ward rounds and reporting back the results of their patient reviews to clinicians.

An evaluation of the effectiveness of the microbiology ward rounds estimated a reduction of 48% in the use of intravenous antimicrobials and a net saving of 42% in antimicrobial acquisition costs in the medical directorate alone.

I sought to build on this in several ways. We established an antibiotic management team to oversee the way antibiotics were used across the hospital. The aim was to support clinicians to access guidelines for first-line treatments and to prescribe more prudently and conservatively.

A common complaint from doctors was that they couldn't easily find Trust guidelines when they needed them. We created a dedicated microsite for infections on the hospital intranet; our aim was for clinicians to find the guidance they needed in just three mouse clicks.

We created a pocket-sized version of the guidelines with information on key treatment issues: salvage treatments for patients with life-threatening infection; which antibiotics to avoid so as not to predispose patients to *C. difficile* and MRSA; clear dosing instructions to avoid complications, such as kidney damage, and a clear guide to avoid allergic penicillin reactions – with penicillin-related antibiotics coded red.

We have used the pharmacy computer system to collate data on trends in antibiotic use in the hospital and feed this back to doctors. When we started, the ratio of use of high-risk to low-risk antibiotics was approximately 50:50 – but over two and a half years, this has gone to something like 65% low risk and 35% high risk, thanks to clinician engagement and a change in prescribing behaviour.

By influencing prescribing practice across the hospital, over time we have begun to reap the benefits. Over the last two and half years, the rate of *C. difficile* infection has gone from 60 to 10 cases a month. This has been the result of a multi-disciplinary effort on infection control, but with antibiotic stewardship playing an important part.

Each case of infection prevented saves more than £4,000. And we have seen no adverse effects on either mortality rates or length of stay.

So the bottom line is: by pharmacists, medical microbiologists and clinicians working together we have seen a safe and effective change in practice that reduces infections, lowers costs for the trust and benefits patients."

Resources

There are many tools available to help you and your organisation identify opportunities for quality and efficiency improvement, and for spreading best practice. This list is not comprehensive but offers some examples of resources you can draw on.

NHS Evidence – Quality and Productivity	A new Quality and Productivity section on the NHS Evidence website will act as the national evidence base on how to improve quality while making cash-releasing savings. The aim is to create a national resource which is drawn on locally. The website contains a selection of the best evidence available – real examples submitted by healthcare professionals of how staff are improving quality and productivity across the NHS.	www.evidence.nhs.uk/qualityandproductivity
NHS Institute for Innovation and Improvement	The website includes hundreds of quality, safety and cost improvement tools and approaches, as well as details of powerful improvement programmes that have been developed by clinicians including the Productive Series of strategies for improving 'high volume' care.	www.institute.nhs.uk

NHS Evidence – Innovation and Improvement	The Innovation and Improvement section of the NHS Evidence website provides information resources including best available evidence, tools and techniques, case studies and policy on all aspects of innovation and improvement of health and social care services.	www.library.nhs.uk/Improvement
High Impact Actions for Nursing and Midwifery	The website contains 600 submissions from nurses and midwives describing actions that can help to transform the care that patients receive as well as reducing costs. Eight areas are set out in more detail in the downloadable document and more work is under way to explore these and further quantify their potential impact.	www.institute.nhs.uk/building_capability/general/aims/
NHS Quality Observatories	Each SHA has established a formal Quality Observatory, building on existing analytical arrangements, to facilitate local benchmarking, the development of metrics and the identification of opportunities to help frontline staff innovate and improve.	www.qualityobservatory.nhs.uk

NHS Better Care, Better Value indicators	The quality and value section of the NHS Institute for Innovation and Improvement website provides information about high-level indicators of efficiency that identify potential areas for improvement.	www.institute.nhs.uk/quality_and_value/high_volume_care/better_care_better_value_indicators.html
NHS Comparators	A free comparative analytical service which enables providers and commissioners to improve the quality of care they deliver, by helping them to investigate in detail variations in activity, costs and outcomes at a local, regional and national level.	www.ic.nhs.uk/nhscomparators
Transforming Community Services	Guides covering six service areas developed with community practitioners that support the ambitions of delivering high-quality personalised health services for patients as close to home as possible.	www.dh.gov.uk/en/Healthcare/Primarycare/TCS/index.htm
The NHS Constitution	The aim of the Constitution is to protect and renew the enduring principles of the NHS. It empowers staff, patients and the public by setting out existing legal rights and pledges for the first time in one place and in clear and simple language. The Constitution also sets out clear expectations about the behaviours and values for all organisations providing NHS care.	www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093419

Programme Budget Atlases	The Programme Budget Atlases enable PCTs to: • link programme budgeting expenditure data with a wide range of outcome and activity data; • use maps, distribution and correlation plots to provide an illuminating and user-friendly way of analysing and presenting data.	www.nchod.nhs.uk
Programme budgeting tools	The tools enable PCTs to identify: • how they spend their allocation over 23 diseases and subcategories; • how their expenditure distribution pattern compares with those of other PCTs; • how their expenditure distribution has changed over time.	www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743
National Institute for Health and Clinical Excellence (NICE) guidance	NICE's cost-saving guidance, costing tools, recommendation reminders and commissioning guides are designed to support service providers to make the best use of their money by setting out the case for investment and disinvestment, and to help organisations to deliver quality care for patients.	www.nice.org.uk/aboutnice/whatwedo/niceandthenhs/UsingNICEGuidanceToCutCostsInTheDownturn.jsp

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www.dh.gov.uk/qualityandproductivity
DH External Gateway reference: 13551