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NHS Standard Contract 2023/24

Summary of key changes in response to consultation feedback

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Introduction

Following our consultation which ended on 27 January 2023, NHS England has now published the final NHS Standard Contract and Contract Technical Guidance for 2023/24.

This document describes the material changes we have made in the final full-length Contract in response to stakeholder feedback received during the consultation process. Changes have been carried over to the shorter-form version of the Contact where relevant.

Overall consultation feedback

We received feedback from 158 organisations or individuals in relation to the specific changes we proposed in the draft 2023/24 Contract. Most responses received were from providers (67%); Integrated Care Boards and Commissioning Support Units accounted for 22%.

For each of the proposed changes, the consultation feedback demonstrated majority support, by a significant margin, amongst those responding with a view on that specific change. In most cases, therefore, we have retained in the final Contract the wording we had proposed in the draft version.

In a small number of areas, consultation feedback has prompted us to make minor changes in the final version of the Contract. In other cases, the feedback indicates that – whilst the specific changes to the Contract which we had proposed are appropriate and should proceed – it may be helpful if we provide further clarification as to their rationale and intent. Our detailed response is set out, issue by issue, below.

(Throughout this document, where we quote a percentage of respondents to our consultation who either supported or opposed a particular proposal, the percentage stated is the proportion excluding any respondents who marked that particular proposal as “not applicable” in their response.)

National Quality Requirements

We proposed changes to bring various of the National Quality Requirements set out in Annex A of the Service Conditions into line with the revised expectations in the 2023/24 Priorities and Operational Planning Guidance (the "Planning Guidance"). The changes affected maximum RTT waits, A&E waits, ambulance response times and cancer waits, as set out in Annex A of the Service Conditions.

Maximum RTT waits

There was very strong support (97%) in the consultation feedback for the proposed change in this area, which was to amend the maximum wait to 65 weeks, to be achieved by March 2024.

However, there were a number of detailed comments in the responses which have made us consider further.

- In their response to the consultation, DHSC asked us to include in the Contract a requirement for maximum waits to be no higher than 78 weeks from April 2023 onwards. This was not specifically referenced in the Planning Guidance, but it has always been the expectation set out in the national Elective Recovery Plan, and a recent letter from NHS England to Trusts and ICBs has emphasised the continuing importance of achieving this milestone. We have therefore added a requirement around 78 week waits to Annex A.

- At the same time, a number of respondents pointed out that the Planning Guidance allows some leeway, in relation to maximum RTT waits, for "patients who choose to wait longer or for specific specialties". We have added caveats to the 78- and 65-week requirements in Annex A accordingly.

- DHSC asked us to make clear that providers are "recommended to prioritise waiting lists according to clinical need and then in chronological order from the longest waiting patient". Clinical validation of surgical waiting lists Framework and operational guidance provides detailed guidance on validation and prioritisation.

- Making the most efficient use of outpatient capacity will be essential in the drive to cut RTT waits. NHS England has now published Reducing did not attends (DNAs) in outpatient services, covering how providers can effectively reduce their DNA rates to release capacity for elective recovery and improve patient experience. We have not built into the Contract a specific requirement to follow this new guidance at this stage, but providers will wish to study it carefully.

Coverage of the RTT waiting times requirement

As described in the RTT Rules Suite, the RTT requirements apply to all consultant-led elective treatment. That includes consultant-led elective care for both physical and mental health services.

To date, we have included the RTT requirement only in the full-length version of the Contract, which must always be used for hospital-based elective care. But it was pointed out to us in consultation feedback that some consultant-led services will be based in community settings and may therefore be commissioned using the shorter-form version of the Contract.

This will happen only rarely, but it is important to ensure that RTT requirements do apply to community-based consultant-led services, whether for physical or mental health conditions. We have therefore now included the relevant provisions in the final shorter-form version of the Contract, at Service Condition 6 and in Annex A of the Service Conditions. To be clear, this does not mean that the RTT requirements apply to all community services – just to the small number of consultant-led elective services which are provided in community settings.

A&E, ambulance and cancer waits

The changes we originally proposed in these three areas were in line with the Planning Guidance. Under them,

- the contractual requirement for four-hour A&E waiting times would be set at 76% (to be achieved by March 2024), rather than 95%;
- the contractual requirement for Category 2 ambulance response times would be set at a mean of no more than 30 minutes (to be achieved across 2023/24), rather than no more than 18 minutes; and
- the contractual requirement for 28 day waits from urgent cancer referral to diagnosis would continue to be set at 75%, but to be achieved by March 2024.

In each case, consultation feedback showed majority support for the changes as proposed; 91% supported the change on cancer waits, 85% supported the change on A&E waits and 70% supported the change on ambulance waits. Comments in the feedback from those opposing the changes revealed conflicting views – some respondents were concerned that allowing longer waits would adversely affect patient care, for example, others that delivering the revised requirements would be very challenging.

We believe that it is important for the Contract to be as consistent as possible with the Planning Guidance under which the NHS is expected to operate each year. In the final Contract, therefore, we have retained the changes in the areas highlighted in the Planning Guidance as originally proposed. But – as the NHS continues to

recover its performance post-pandemic – NHS England will of course review, with Government, requirements on access and waiting times for future years.

Other changes

In response to consultation feedback and otherwise where required, we have made a small number of changes in the final version of the Contract.

Integrated Care Strategies (Service Condition 4.7)

As originally drafted, the Contract required commissioners and providers to contribute towards the implementation of, and perform any specific obligations under, the Joint Forward Plans to be put in place in each local NHS system. At the suggestion of DHSC, we have broadened this requirement in the final version of the Contract to refer also to the Integrated Care Strategies being developed by each Integrated Care Partnership.

Hospital visiting (Service Condition 17)

In its response to the Contract consultation, DHSC asked us to include a new provision, requiring relevant providers to operate a clinically appropriate policy for visits to, and accompaniment of, Service Users in hospital settings. DHSC asked that local policies should be no more restrictive than the position described in existing NHS guidance. Clearly, it is important that patients are able to be visited / accompanied by their families and others, and the existing guidance is something to which providers should already have regard under the general duty in Service Condition 1. We therefore do not consider that it would be a substantial change to add a specific requirement on visiting / accompaniment to the Contract, and we have accordingly included a new provision at Service Condition 17.11.

Use of desflurane (Service Condition 18)

The draft Contract included a revised requirement for providers to achieve a reduction in the proportion of desflurane to all volatile gases used in surgery to 2% or less by volume, and this change received strong support in the consultation feedback. Since the draft Contract was published, NHS England has committed, with the support of the Royal College of Anaesthetists and the Association of Anaesthetists, to the more ambitious goal of decommissioning desflurane by early 2024. We have therefore clarified in the final Contract that the “2% or less” requirement is to be delivered across 2023/24 as a whole, and we have added a reference to the expectation that use of desflurane will be eliminated, broadly, by 31 March 2024. NHS England and the Royal College of Anaesthetists / Association of Anaesthetists will publish further guidance in due course setting out what exceptions, if any, will apply in terms of where desflurane can continue to be used from 1 April 2024 onwards.

Patient safety (Service Condition 33)

We proposed changes to the draft full-length version of the Contract to reflect the requirements of the new national Patient Safety Incident Response Framework (PSIRF), and these received strong support in the consultation feedback. A number of respondents commented that we should set out a clearer requirement on this issue in the shorter-form version of the Contract. We have therefore amended the final shorter-form version to include a specific reference to the adoption by the provider of PSIRF – but on a lighter-touch basis than in the full-length version, allowing the provider discretion over the timing of its transition from the (current) NHS Serious Incident Framework to the (new) PSIRF.

Use of the shorter form version of the Contract for Trusts (Service Condition 36 and various other sections)

In our draft Contract Technical Guidance, we advised that the shorter-form version of the Contract could no longer be used in any circumstances for Trusts. This was because of changes to the rules in the draft 2023/25 NHS Payment Scheme which meant that Trusts would always operate under Aligned Payment and Incentives (API) arrangements, including CQUIN – neither of which are accommodated in the shorter-form Contract.

It has now been agreed in principle that the final 2023/25 NHS Payment Scheme will create a new exception to the API Rules, covering a situation where "the service provided is a single non-acute service procured by an ICB from an NHS provider". This will mean that the shorter-form Contract can continue to be offered to Trusts in these limited circumstances, with local prices applying rather than API / CQUIN. Further detail is set out in paragraph 9 of our final Contract Technical Guidance.

As a result, we have made a number of changes to the final 2023/24 Contract, reinstating a small number of Trust-specific provisions from the 2022/23 version which we had originally intended to delete.

NHS Talking Therapies for Anxiety and Depression (Annex A to the Service Conditions and Schedule 2Aii)

We have changed references in the Contract to the Improving Access to Psychological Therapies programme (IAPT) to reflect that IAPT is now known by the new title "NHS Talking Therapies for Anxiety and Depression".

Payment of sub-contractors (General Condition 12)

We consulted on a change to strengthen GC12.6 of the full-length version of the Contract in relation to prompt payment by the provider of any sub-contractors (within 30 days, in accordance with the Government's Prompt Payment Policy). On further reflection, we believe that these requirements on payment of sub-contractors should also be included within the shorter-form version of the Contract, and we have made this minor change accordingly.

Clarifications in response to feedback

The section below deals with areas in which we have retained, in the final Contract, changes which we originally proposed in the draft version – but where we think it is helpful for us to offer some clarification.

Workforce Race and Disability Equality Standards (Service Condition 13)

In relation to the Workforce Race and Disability Equality Standards, we proposed to amend the Contract wording to create a clearer focus on improvement in the experience of staff (through development of provider action plans to improve performance against the Standards) and on transparency (through publication on provider websites of Board-approved annual performance reports and action plans). Overall, this proposal was strongly supported (92%). A small minority of respondents were concerned that, by moving away from the previous "comply with" wording, we were reducing the importance of these Standards. That is not in any way our intention. Our view remains, simply, that the "comply with" wording was not fully appropriate; the two Standards contain metrics or indicators against which providers are to assess themselves, relating to the workplace and career experiences of staff in the NHS, but they do not set absolute measurable requirements which providers must comply with in full. But we emphasise that improving performance against WRES and WDES metrics will assist any provider in complying with its obligations under the Equality Act.

Antibiotic usage (Service Condition 21)

Since 2019, the Contract has required acute providers to make year-on-year reductions in their per-patient usage of antibiotics from the "Watch and Reserve" categories, in line with the ambition for a 10% cumulative reduction set out in the UK 5-year action plan for antimicrobial resistance 2019 to 2024. To date, the Contract requirement for annual reductions has been expressed against the 2018 baseline of actual usage. For consistency with the UK 5-year AMR National Action Plan target, we proposed to amend the Contract wording so that the requirement would be for a 10% cumulative reduction by 31 March 2024 against the 2017 baseline (instead of a 6.5% reduction against a 2018 baseline).

This re-basing does not, of itself, make the target harder to achieve at national level, but it does change the position of individual providers against the target – and it has prompted a response from some providers about whether they can realistically achieve the target reduction.

The threat to public health posed by antimicrobial resistance is significant, and there is strong evidence that providers can substantially reduce use of antibiotics from the "Watch and Reserve" categories by switching the treatment choice to antibiotics from the "Access" category wherever possible and safely using shorter courses where "Watch" and "Reserve" drugs are unavoidable. So, we have retained the requirement for a 10% reduction as set out in the draft Contract.

However, in Annex A to this document, the NHS England Antimicrobial Resistance Programme team has set out some of the challenges which providers may face in delivering the target and possible solutions to them. We hope that this will help commissioners to support providers in achieving the maximum possible reduction, consistent with good clinical care for patients.

Non-compliance with Evidence Based Interventions Guidance (Service Condition 29)

Our proposal to remove the provision under which commissioners can withhold funding from providers for breaches of Evidence Based Interventions Guidance at individual patient level attracted support from a large majority of respondents (92%). But there were some voices of dissent.

- Some respondents (commissioners) simply did not agree with the proposal. They accepted that, for Trusts, the issue could be dealt with instead under the Aligned Payment and Incentive rules within the NHS Payment Scheme, but believed that a provision for non-payment would still be appropriate for non-NHS providers. Our view is that non-compliance with Evidence Based Interventions Guidance by a non-NHS provider can be appropriately dealt with through the contract management provisions at General Condition 9.

- Other respondents (providers) felt that the change did not go far enough and urged us to remove other provisions for financial withholding by commissioners, covering non-compliance with local Prior Approval Schemes under Service Condition 29 and Information Breaches under Service Condition 28. We have not made changes to the Contract wording for 2023/24 in line with these requests, but these are issues we will consider further as part of the fundamental review of the role and content of the Contract which we plan to undertake later in 2023.

Patient safety (Service Condition 33)

In its response to the Contract consultation, the Medicines and Healthcare products Regulatory Agency (MHRA) has asked us to remind providers of the need to ensure that their staff are encouraged to report to the MHRA, via its long-standing Yellow Card scheme, suspected side effects to medicines, vaccines, e-cigarettes, medical device incidents, defective or falsified (fake) products.

Palliative care co-ordination (Service Condition 34)

We proposed to remove a reference requiring compliance with a specific guidance document relating to the implementation of electronic palliative care co-ordination systems (EPACCS). There was strong support (98%) for this removal in the consultation feedback, but a small number of respondents urged us to remind commissioners and relevant providers that implementation of EPACCS continues to be encouraged as part of the general move to shared electronic records, as set out for instance in Palliative and End of Life Care Statutory Guidance for Integrated Care Boards

Charging of overseas visitors (Service Condition 36)

There was overall support (71%) for our proposal to change the arrangements for financial risk-sharing between commissioner and providers in relation to the recovery of charges from chargeable overseas visitors. In general, those objecting to the change did so because they understood that NHS England was wholly abandoning financial risk-sharing in this area. That is not what we are seeking to do. Rather, we are moving away from the specific risk-share arrangement which has been required under Improving Systems for Cost Recovery for Overseas Visitors and is reflected in the 2022/23 Contract – because it is a relatively burdensome arrangement which requires complex transactions at individual patient level between commissioners and providers. Instead, we are replacing it with broadly equivalent, but much less burdensome arrangements under the Aligned Payment and Incentive rules within the NHS Payment Scheme. Further details are set out in paragraphs 96-99 of the Revenue finance and contracting guidance for 2023/24.

Procurement of medicines via national frameworks (Service Condition 39)

We proposed changes so that Trusts would be required, in certain circumstances, to ensure that they purchased medicines under national frameworks put in place by NHS England. Our proposed changes in this area were supported by over 75% of respondents, and on that basis we have retained those changes unamended. Some key points in response to detailed consultation feedback are set out below.

- There was general acceptance of the proposed regime in relation to medicines funded on a pass-through basis, but less so in relation to medicines paid for through fixed payments under API rules. Many Trusts suggested that they should be entitled to seek their own deals in those circumstances. However, leveraging NHS England's purchasing power on a national scale and maximising use of national Frameworks results in better value for the NHS and taxpayers overall.

- Some respondents cited concerns that drugs available from Frameworks might not always be clinically suitable – but our wording in Service Condition 39.2 addresses such concerns by allowing for purchase off-Framework where no clinically appropriate product is available via a Framework.

- Concerns were expressed over potential problems with availability and lead times for medicines via Frameworks, which might justify purchase off-Framework in extremis. We believe these concerns are adequately addressed, as Service Condition 39.2 requires the clinically appropriate product to be available at time of purchase: if it is not, then purchase by another route is permissible.

- Some respondents asked whether these Contract provisions are to apply to Patient Access Schemes. The answer at this stage is no; the provisions apply only to Frameworks available via https://pharmacycatalogue.cmu.nhs.uk/pharmacycatalogue/. However, the

same general principle applies to Patient Access Schemes – it is in the public interest for their use to be maximised, as this ensures cost-effective use of NHS resources as determined by NICE. We will review for 2024/25 whether the scope of the Contract provision should be expanded to cover Patient Access Schemes.

To address other detailed issues, NHS England's Commercial Medicines Directorate will shortly circulate FAQs relating to the detailed operation of the Frameworks.

Procurement of high-cost devices used in specialised services (Service Condition 39)

We proposed a change to require that Trusts should purchase high-cost devices for use in specialised services via NHS Supply Chain, rather than through other routes. Support for our proposed change in this area was very strong, with over 82% of respondents supporting it, and on that basis we have retained the changes as originally proposed. Amongst those objecting, there was some degree of misunderstanding about the application of the proposed regime; we can confirm that it applies only to devices funded on a pass-through basis.

FAQs on NHS England's Specialised Services Devices Programme are available here on FutureNHS and may be helpful for providers.

How requirements under the Contract are expressed

Some respondents commented on our use in the Contract of terms such as "have regard to" or "use reasonable endeavours to"; their view was that these terms might be viewed as weak or imprecise. We believe that these terms are appropriate in the contexts in which we use them. We provide clear definitions in paragraph 5 of our Contract Technical Guidance of the different ways in which the Contract describes obligations on either commissioner or provider and what each particular expression means.

Annex A – reducing antibiotic usage

The NHS England Antimicrobial Resistance Programme team has provided the information below to support providers and commissioners in achieving maximum progress in reducing per-patient usage of antibiotics from the “Watch and Reserve” categories, in a way which is consistent with providing good clinical care for patients.

The World Health Organisation groups antibiotics into three broad categories – Access, Watch and Reserve – and has set a global goal to reduce the use of Watch Group and Reserve Group antibiotics (the antibiotics most crucial for human medicine and at higher risk of resistance) [https://adoptaware.org]. The WHO global goal is expressed in the UK AMR National Action Plan as a commitment to reduce prescribing of Watch and Reserve antibiotics in hospitals by 10% between 2017 and 2023/24.

The NHS Standard Contract for 2019/20 and 2021/22 included a requirement for acute providers to reduce total per-patient antibiotic consumption by 1% and 2% respectively. For 2022/23 the Contract requirement was changed to focus on the UK AMR National Action Plan commitment by requiring a 4.5% reduction in use of Watch and Reserve antibiotics from a 2018 baseline and indicating that a further 2% reduction would be required for 2023/24 (to continue on a trajectory towards meeting the National Action Plan commitment). Data have recently become available for the National Action Plan baseline year of 2017, leading to a decision to align the Contract requirement for 2023/24 precisely with the UK AMR National Action Plan commitment to reduce use of Watch and Reserve antibiotics in hospitals by 10% from 2017, in order to minimise the risk that this National Action Plan commitment will not be met.

It is important to recognise that the 2023/24 Contract requirement to reduce per-patient use of antibiotics from the Watch and Reserve categories is not a requirement to treat fewer patients, but instead to promote initiation, continuation or switch to antibiotics from the Access category wherever possible and safely using shorter courses where Watch and Reserve drugs are unavoidable.

Evidence that there is room for improvement comes from data demonstrating significant variation in use of Watch and Reserve antibiotics for NHS acute providers, ranging 40% from the median; from 1.5 standard treatment days per admission (10th Centile) to 3.2 standard treatment days per admission (90th Centile) [2022-23 Q2 performance]. Recent research findings for surgical inpatients suggest up to 16% of antibiotic treatment days may not be necessary [Hearsey D 2022]. Some acute providers are on track to achieve the Contract requirement. By Quarter 2 of 2022/23, 45 providers had already met the 2022/23 target for a 4.5% reduction from 2018 – and there may be an opportunity to deploy more widely some of the solutions used successfully by these acute providers (see below).

There is no doubt that the target is challenging, however. Potential local challenges received on consultation – and some contextual information – are set out below. Commissioners and providers are encouraged to discuss these in their local context.

- Secular trends in patient demographics and acuity due to ageing and co-morbidities creating increased demand for antibiotics – this challenge pre-dated the National Action Plan and is faced by all acute providers and affects demand for all categories of antibiotic.
- The COVID-19 pandemic had an impact on hospital bed occupancy and case mix, and bacterial co-infection with COVID-19 created additional demand for antibiotics – but data aggregated from English hospitals do not indicate any sustained impact of the pandemic on use of Watch and Reserve antibiotics and concerns about bacterial co-infection have not been borne out by research evidence. [Calderon M, 2023]
- The increased incidence of Group A streptococcus infections in November and December 2022 resulted in an increased use of antibiotics – but this increase in use affected predominately primary care and antibiotics from the Access group, with relatively few patients hospitalised and a prompt return to usual levels of prescribing which is not expected to impact 2023/24 performance.
- NHS staffing pressures compromising the maintenance of high standards of infection prevention and antimicrobial stewardship – digital systems may offer a partial solution by helping to identify patients prescribed Watch and Reserve antibiotics or to prompt review of prescriptions (see below).
- Changes to European laboratory guidelines on the reporting of antibiotic resistance, leading to pressure to use higher doses of certain antibiotics – there is variability in adoption of European guidelines (see below).
- Changes to acute provider case mix due to mergers/de-mergers or consolidation of services – acute providers taking on a new cohort of cystic fibrosis patients, for example, or expanding critical care or haematology/oncology beds during the period since 2017 may create an increase in demand for antibiotics from the Watch and Reserve categories.
- Data quality factors – Contract performance is measured from dispensing records from hospital pharmacy systems and admissions data from HES and changes to circumstances such as mergers/de-mergers can lead to data anomalies.

Commissioners will wish to work with their acute providers to ensure that everything possible is being done, in accordance with good practice, to promote antimicrobial stewardship and improve the quality of antibiotic prescribing, including but not limited to the following:

- Confirm the position of the acute provider in comparison to peers and other acute providers with regard to use of Watch and Reserve antibiotics [Fingertips], taking into consideration factors such as teaching hospital or tertiary referral centre status and any changes to high-risk patient cohorts such as critical care, haematology/oncology and cystic fibrosis that may increase clinical need for Watch and Reserve antibiotics.

- Confirm that Contract performance data are reported to acute provider Board meetings, benchmarked with peer organisations, and actions identified and taken forward in response to concerns over performance.
- Consider a formal documented review of antibiotic treatment guidelines, including comparison with peer organisations and NICE guidelines, and corresponding changes made so that antibiotics from the Access category are recommended first-line wherever safe and appropriate, guided by severity scoring systems such as CURB-65 for community-acquired pneumonia.
- Consider an audit of the appropriateness of prescribing for patients treated with Watch and Reserve antibiotics to establish whether local treatment guidelines are being adhered to.
- Ensure full implementation of CQUIN indicator 03 for 2023/24, to promote the timely switch from intravenous antibiotics to oral antibiotics in hospitals; this is expected to support a safe reduction in the use of Watch and Reserve antibiotics, many of which are administered exclusively intravenously.
- Consider an audit of discharge prescriptions to identify whether unnecessary additional days of treatment with Watch and Reserve antibiotics are prescribed on discharge prescriptions and action taken to address this if required.
- Consider a review of “pre-packs” of antibiotics, to ensure that pack sizes match local guidelines and appropriate oversight of choice of antibiotic when pre-packs provided to patients.
- Consider an audit of Emergency Department prescriptions to ensure that Watch and Reserve antibiotics are being used proportionately and only when necessary for patients who do not require admission to hospital
- Consider an audit of blood culture clinical practice to ensure that blood specimens, when indicated, are taken before antibiotics are started and that sample tubes are adequately filled and transported promptly to the laboratory to optimise yields and facilitate prompt de-escalation from initial treatment with Watch and Reserve antibiotics to targeted Access antibiotics.
- If an acute provider has changed local treatment guidelines to introduce higher dosing for specific antibiotics or infections, based upon European microbiology laboratory guidelines, has the provider estimated the anticipated impact on use of Watch and Reserve antibiotics and the significance of that impact for meeting the Standard Contract target?
- Ensure that functionality of digital systems has been exploited to promote the safe and appropriate use of antibiotics from the Access category.
- Ensure that sufficient resource is available for antimicrobial stewardship (AMS) to support monitoring of the appropriate use of antibiotics and review of patients prescribed antibiotics from the Watch and Reserve categories, for example on AMS ward rounds, to facilitate intervention when necessary to promote the use of antibiotics from the Access category.
- Ensure the target in the National Action Plan and the Contract to reduce use of Watch and Reserve antibiotics has been communicated successfully to all prescribers.
- Consider whether further action can be taken to promote the strategy of ‘review and revise’ of antibiotic prescriptions within 72 hours of initiation, including limiting prescription duration with automatic stops, as set out in the ARK Hospital study. [Llewelyn M 2023]

- Consider whether a Data Quality Improvement Plan is required to address problems with quality of antibiotic dispensing data reported to Rx-info.

Antimicrobial resistance is a significant threat to public health, evidenced by the global burden of resistant infections – associated with almost 5 million deaths worldwide in 2019 [AMR Collaborators, The Lancet 2022]. Acute providers and commissioners are encouraged to tackle this threat by working towards the Contract target to reduce the use of Watch and Reserve antibiotics. Stakeholders were encouraged to contribute to the Department of Health and Social Care call for evidence for the next UK AMR National Action Plan to influence the design of quality improvement measures and goals.

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This publication can be made available in a number of alternative formats on request

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