NHS England

Putting Patients First

The NHS England business plan for 2013/14 – 2015/16

DIRECT COMMISSIONING

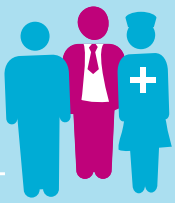
SUPPORTING, DEVELOPING AND ASSURING THE COMMISSIONING SYSTEM

EMERGENCY PREPAREDNESS

PARTNERSHIP FOR

QUALITY

STRATEGY, RESEARCH AND INNOVATION FOR OUTCOMES AND GROWTH



CLINICAL AND PROFESSIONAL LEADERSHIP

WORLD CLASS CUSTOMER SERVICE: INFORMATION, TRANSPARENCY AND PARTICIPATION

DEVELOPING COMMISSIONING SUPPORT UNITS

THE NHS CONSTITUTION
the NHS belongs to us all

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Foreword

Our goal is high quality care for all, now and for future generations.

This document builds on *Everyone Counts: Planning for Patients 2013/14*, the planning guidance for commissioners. Here, we set out in detail how we will support commissioners to use their valuable public resources to improve quality and secure the best possible outcomes for people. The plan covers a three-year period, but the major emphasis is on the work we will undertake in 2013/14. It will be reviewed in Autumn 2013 and an update published in Spring 2014.

This plan provides detail of NHS England's operating model, explaining how we will deliver our mandate from the government and fulfil our own duty to improve outcomes for people. We will do this through listening, publishing and sharing information, and enabling staff to operate in an environment of trust and transparency.

Recent events have demonstrated the stark realities when standards of care fall woefully short. We in the NHS must all remain vigilant to ensure that patients are never again subjected to such poor quality of care. This is why we must, and will, put people at the heart of everything we do. The overarching theme from the report from Robert Francis QC is clear: a fundamental cultural change is needed in order to put people at the centre of the NHS. This business plan is oriented, in its entirety, towards supporting this cultural change.

We also demonstrate how we at NHS England are committed to transparency, how we will assess our own progress and how we will be accountable for our actions. We set out an 11-point scorecard reflecting our core priorities, against which we will measure our performance and within which two measures take precedence – firstly, direct feedback from patients and their families and secondly getting direct feedback from NHS staff. The friends and family test will ensure patients' and their families' voices are heard and used to help us to deliver better services and guarantee no community is left behind or disadvantaged. Our guiding principle for success is receiving positive feedback from patients and NHS staff on whether they would recommend treatment at their hospital to their friends and family.

Our staff will make NHS England an excellent organisation: an exemplar in customer focus, professionalism, rigour and creativity. Grounded by the values and principles of the NHS Constitution, we will share ideas and knowledge, successes and failures, and listen to each other carefully and thoughtfully.

Our key measures of success will be satisfied patients, and staff who feel positive about what they are doing. We want to make the service we provide in the NHS truly world class, and to do this we must strive to design and deliver care based on the needs and choices of each patient.

Professor Malcolm Grant
Chair

Sir David Nicholson
Chief Executive

1 Our priorities and measuring progress – the NHS England Scorecard

1.1 The year 2013/14 is a critical one for the NHS. The only acceptable legacy of the Francis report is that the NHS changes as a result of its findings. The Department of Health has published the response to the Francis report, and we will play our full part in delivering the actions described in it. We will put patient care at the centre of all we do through our focus on patient satisfaction and outcomes. The healthcare system is also facing the challenge of significant and enduring financial pressures. People's need for services will continue to grow faster than funding, meaning that we have to innovate and transform the way we deliver high quality services within the resources available.

1.2 We have been on a journey to establish a new and more responsive system of healthcare commissioning which will continue into 2013/14. New organisations are now taking on new responsibilities and operating in new ways to shape better health services for local areas. In underpinning the move to a new system, where quality is at the heart of everything we do, we have a set of clear core priorities. We will measure progress against these to produce an **11-point NHS England Scorecard**:

Priority	Description	Scorecard measurement
1 – Satisfied patients	**Establishing the Friends & Family test for patients, updated and published monthly**	**Net score of positive versus negative feedback (scale -100/+100)**
2 – Motivated, positive NHS staff	**Establishing the Friends & Family test for NHS staff, updated and published monthly**	**Net score of positive versus negative feedback (scale -100/+100)**
3 – Outcomes Framework – Domain 1	Preventing people from dying prematurely.	Progress against Improvement areas 1.1 – 1.7 of the Outcomes Framework
4 – Outcomes Framework - Domain 2	Enhancing quality of life for people with long term conditions.	Progress against Improvement areas 2.1 – 2.6
5 – Outcomes Framework – Domain 3	Helping people to recover from episodes of ill health or following injury.	Progress against Improvement areas 3.1 – 3.6
6 – Outcomes Framework – Domain 4	Ensuring that people have a positive experience of care.	Progress against Improvement areas 4.1 – 4.9
7 – Outcomes Framework – Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm.	Progress against Improvement areas 5.1 – 5.6
8 – Promoting equality and reducing inequalities in health outcomes	Promoting equality and inclusion through NHS services. Highlighting and reducing inequalities in health outcomes across all Outcome domains. This will include parity of esteem for people with mental health issues.	Progress in reducing identified health inequalities on all indicators for which data are available
9 – NHS Constitution rights and pledges, including delivery of key service standards	Direct commissioning and support and assurance of CCG processes will ensure continued delivery of the NHS Constitution rights and pledges. Carrying out work to embed the NHS Constitution in everything we do.	The proportion of people for whom NHS England meets NHS Constitution standards
10 – Becoming an excellent organisation	Ensuring the staff of NHS England understand their roles, are properly supported and are well motivated. Seeking comprehensive 360 degree feedback from local and national partners.	Staff survey results 360 degree feedback
11 – High quality financial management	Living within our means whilst delivering our priorities.	Actual spend versus budget

Measuring patient and staff satisfaction – *Scorecard priorities 1 & 2*

1.3 Our touchstones of success above all others will be if patients would recommend their local NHS care and if individual NHS staff members have faith in the service they are contributing toward. We know there is good academic evidence of a relationship between patient experience of care and staff feeling supported and valued in their work. It is these indicators that will tell us if all others are amounting to genuine quality where it matters.

Improving health outcomes – *Scorecard priorities 3-7*

1.4 Central to the work of NHS England is our objective to improve health outcomes for people. The NHS Outcomes Framework covers five domains of care against which the performance of the NHS is measured. These domains are:

- ***Scorecard priority 3*** – Preventing people from dying prematurely; progress on reducing Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare; and increasing life expectancy.
- ***Scorecard priority 4*** – Enhancing quality of life for people with long-term conditions; improving health-related quality of life for people with long-term conditions
- ***Scorecard priority 5*** – Helping people to recover following episodes of ill health or after injury; reducing emergency admissions for acute physical and mental health conditions that should not usually require hospital admission and emergency readmissions within 30 days of discharge from hospital
- ***Scorecard priority 6*** – Ensuring that people have a positive experience of care; improving patient experience of primary and hospitals and community mental health care
- ***Scorecard priority 7*** – Treating and caring for people in a safe environment and protecting them from avoidable harm; comprehensive reporting and reduction of patient safety incidents. Reducing hospital deaths attributable to problems in care.

1.5 Our aim is to deliver improvements in each of these domains and all indicators assigned to them. Success will be measured not only on overall improvement but also on progress in reducing inequalities.

Promoting equality and reducing health inequalities – *Scorecard priority 8*

1.6 Equality lies at the heart of the NHS, its values, processes and behaviours. People have a right to high quality services, irrespective of who they are, where they live, or what condition they have. There is clear evidence that people from disadvantaged communities are at greater risk of early death than the average population. Those with mental health problems have worse outcomes for their physical healthcare with people who have severe mental illnesses dying on average 20 years earlier than the general population. Therefore we will make a particular effort to ensure that people with mental health problems receive the same care and outcomes as the rest of the population.

1.7 The high quality benchmarked information we provide will highlight inequalities and support CCGs in developing their priorities; our assurance processes will focus on the progress made. We will also be

accountable for making progress in reducing health inequalities in access and across all domains of the Outcomes Framework where inequalities are identified, through the services we commission directly and in our work to support local commissioners.

1.8 We will be systematic and evidence-based. As a first step we will measure, assess and publish information on each of the protected characteristics (as set out in the 2010 Equality Act) and inequalities dimensions across all the domains and indicators in the NHS Outcomes Framework for which information is available. We will also improve our understanding of health inequalities across the breadth of the Framework and identify the measurable progress which we can expect to make on health inequalities across the Framework. We will implement the Equality Delivery System (EDS) and will support CCGs to adopt the EDS where they have not already done so. Both our increasing understanding of health inequalities across the Framework and the EDS will inform our priorities and strategy.

1.9 We will work in partnership to promote equality and address health inequalities. Nationally, Public Health England, the Commissioning Assembly, Royal Colleges, Local Government Association and the Department of Health will be key partners.

1.10 Promoting equality and narrowing inequalities in access and outcomes will be highly challenging and we will need to deepen our understanding of the role the NHS can play across the breadth of its remit. We will publish an equality and health inequalities strategy which will form part of the Board's broader strategy.

The NHS Constitution – *Scorecard priority 9*

1.11 The NHS Constitution sets out the values and principles of the NHS and the rights and responsibilities of patients, staff, and the public. For the Constitution to have real effect, it is vital to raise awareness and embed it at every level in the NHS.

1.12 We are seeking a sustained improvement across the NHS through a coordinated, system-wide approach. We are working with partners and stakeholders to co-develop and implement a joint strategy for promoting and embedding the Constitution in everything that the NHS does, including appropriate means of monitoring progress and impact.

1.13 Patients and the public consistently tell us that timely access to services is important to them. Our assessment will include performance against key access standards such as 18 weeks referral to treatment, accident and emergency waiting times, elimination of mixed sex accommodation and cancer waiting times.

An excellent organisation – *Scorecard priority 10*

1.14 We can only achieve the aims of NHS England if our own employees are positive, supported and well-motivated. We will gather and publish feedback via staff surveys and comprehensive 360 degree stakeholder feedback to ensure that we are creating the right environment, values and cultures as this new organisation develops.

High quality financial management – *Scorecard priority 11*

1.15 The economic outlook for England remains extremely challenging. The resources that the NHS receives will be under unprecedented pressure if we are to meet the rising demands of the population. We therefore need to continue to improve efficiency and transform the way that services are delivered.

1.16 Our commitment to put quality at the heart of everything we do must be in the context of the need to spend resources wisely. Excellent financial management is a foundation for maximising improvement in outcomes for patients. Through enhanced professional leadership, and rigour in our investment decisions, budget monitoring and financial assurance systems, we shall ensure that the NHS remains in financial balance and spends every pound for the benefit of patients.

2 What we stand for – becoming an excellent organisation

2.1 The Francis report made clear the impact that organisational culture and values can have on care: a top down management system driven by national targets can skew priorities and cause us to lose sight of what is most important. Evidence suggests that good staff support and management are fundamental to a healthy organisational culture, and are directly related to patient experience of care. Our aim is to exemplify the behaviour and values that we expect from all organisations in the healthcare system. Our ambition is to enable an open, transparent, participative and inclusive NHS that delivers high quality care to every patient, every time.

2.2 The NHS is a unique social movement and therefore people working in the NHS must share a common set of values if we are to be successful in our ambitions. These values are clearly stated in the NHS Constitution and we will demonstrate these values in the work we do every day. We will work to uphold the NHS Constitution and to make sure that everything we do is based on the understanding that the NHS puts people first, whether that is saving lives or improving the quality of life for people with a long term condition. This means we will design and deliver care around the needs and choices of each individual patient and will do this by delivering the best customer service we can. We will give people control of their own health information to help them say what kind of care they want. This, and a desire by doctors and nurses to improve the quality of care they deliver, will lead to improved outcomes for every patient.

2.3 We will ensure that every person who comes into contact with the NHS is treated fairly and equally, and with dignity and respect. Our work to address health inequalities will help to identify groups or areas that are not getting a fair deal. When we know that someone, or a group of people, is not getting the health care and support that is their right, we will put in place measures to help them.

2.4 We will focus relentlessly on the needs of people in every decision we make, always asking ourselves what implication our actions will have on our patients, both as individuals and as groups in society. To really understand this we need to be accountable and make it possible for people to easily and regularly tell us how they feel about their treatment, and demonstrate how we are using this feedback to make improvements.

2.5 We will share ideas and knowledge, successes and failures. We believe in innovation and we will learn from our mistakes. We will encourage staff to speak up when they have an idea and promote positive workplaces in which people thrive. And we will ensure that there is transparency of information that allows the public

themselves to judge the quality of service they receive.

2.6 The NHS does not exist in isolation so we will build coalitions with partners to work together with common purpose and as close as possible to the communities we serve. We also understand the significant positive contribution that the NHS can make to wider society and will develop a comprehensive corporate social responsibility framework to maximise our positive impact in this area.

2.7 We will be successful by making NHS England an excellent organisation: an exemplar in customer focus, professionalism, rigour, transparency and creativity. We will encourage collaborative working to maximise the resources that can be spent on care and to promote truly patient-centred care.

3 Our operating model – NHS England's eight key activities

3.1 Having set out the 11 scorecard priorities by which people can judge our overall progress, this section explains the means through which NHS England will go about achieving them. NHS England does of course have a more detailed set of requirements with this government set out in its Mandate. These are captured in Annex 2 of this plan as part of our public accountability. NHS England will deliver better outcomes for patients in eight ways.

a. Supporting, developing and assuring the commissioning system

b. Direct commissioning

c. Emergency preparedness

d. Partnership for quality

e. Strategy, research and innovation for outcomes and growth

f. Clinical and professional leadership

g. World class customer service: information, transparency and participation

h. Developing commissioning support

3.2 Through these eight core work areas we will lead the commissioning system in shaping the climate for success. We will deliver on the ground as commissioners ourselves and we will help develop the entire commissioning system to be in the best possible position to make a difference to the people of England. Through matrix working, every member of staff working for NHS England will be contributing to at least one of these areas in their roles.

3.3 The following sections set out the scope of our activity towards our objectives to improve patient outcomes in everything we do. At the end of each section we set out a small number of deliverables that will act as strong markers of our overall success.

a. Supporting, developing and assuring the commissioning system

3.4 High quality, clinically-led commissioning will be a mainstay of the new healthcare system. Commissioning will focus on issues that matter locally, underpinned by robust public and patient involvement. We will stand alongside CCGs as commissioners of healthcare services, and provide the leadership and support to help them to become excellent commissioners.

3.5 CCGs are new organisations and we will continue to support their development as they move through authorisation and beyond. The authorisation process provided an assessment of how each CCG is developing against a set of core commissioning competencies. The results of this will shape the support and development we provide for CCGs. During 2013/14 we will:

> Identify development needs for all CCGs, and establish development programmes from support organisations

- Establish a maturity model for CCGs, and assessment criteria to monitor progress
- Establish network arrangements to meet CCG needs for adoption and spread of best practice
- Establish a programme for collaborative commissioning between CCGs with area teams, local authorities and Public Health England
- Support CCGs to deliver the plans that they have developed with local communities

3.6 As a direct commissioner of a range of services, NHS England will have its own development needs. We will work to understand our area team development requirements for primary care and specialised commissioning in order to establish an effective development framework.

3.7 We will establish a process to assure that CCGs are effectively carrying out their commissioning duties. This assurance will include an assessment of commissioning plans, followed by in-year monitoring and an annual assessment of delivery against the agreed plan. *Everyone Counts* sets out seven steps that constitute robust local planning:

- Ensuring all local partners are contributing to the strategy
- Understanding how local performance compares with that of peers
- Understanding which groups of people within the community are getting a raw deal
- Engaging in open and creative ways with local communities to identify what matters most to them about their health and care, particularly disadvantaged groups
- Using information to develop shared priorities based on outcomes that are in greatest need of improvement
- Considering where and how commissioning budgets can be integrated whenever it will advance shared priorities
- Aligning contracting around the shared priorities and putting in place mutual accountability across partners

3.8 We will work with CCGs to ensure that these steps are followed and where necessary, we will provide more active support.

3.9 Next year's planning guidance will further develop our approach and expectations for the planning of healthcare services for CCGs. This guidance will continue to maximise CCG freedom and autonomy to develop plans and, where appropriate, devolve national objectives to a local level. We will provide and publish high quality, benchmarked information to help local systems understand their current performance and health inequalities, and to inform the development of their strategies. During 2013/14, we will develop new measures for access and outcomes for mental health services. These measures will aim to reintegrate mental and physical health rather than treating them as separate entities, and support CCGs to understand and tackle unwarranted variation.

3.10 The Quality, Innovation, Productivity and Prevention (QIPP) challenge will remain a key priority for the commissioning system over the next three years. Set within a common, significant set of challenges including an ageing population, integrating services locally and the financial pressures in the public sector, the NHS needs to develop innovative ways to commission the best services for its local populations. From

2013/14 we will support CCGs to meet the QIPP challenge in the following ways:

- By building on the authorisation process which will provide confidence that each CCG can articulate its own QIPP challenge and has a solid platform for delivery
- By adopting the 'assumed liberty' approach rather than performance-manage the achievement of milestones. Through our area teams, we expect to see assurance from each CCG that its governance processes are robust enough to identify and respond to its own QIPP challenges and milestones over the next two years
- By ensuring that our direct commissioning does not sustain out-dated service models when CCGs have identified the need for improved delivery methods
- By triangulating activity, quality and cost data, and using this intelligence to provide overall system assurance
- We are in the process of establishing the initial areas of focus where we should provide leadership and support for commissioners – both in CCGs and NHS England – to innovate and achieve transformational change in services to meet the increasing demand, while still delivering high quality services that offer the best value for money.

3.11 As a direct commissioner of services, we will operate a similar planning process for area teams involved in direct commissioning. This process will work to similar timelines as the CCG planning process, and area teams will work in partnership with CCGs and other local commissioners to ensure alignment and integration of their strategy.

3.12 In carrying out this support and assurance role, we will establish mutual accountability between ourselves and local commissioners, and we will measure our success by the way that we are able to support CCGs to achieve their objectives. Through NHS clinical commissioners, we will seek and publish 360 degree feedback from CCGs and other key stakeholders on how we are promoting autonomy in local organisations, and how effectively NHS England is building relationships.

The NHS Commissioning Assembly

3.13 The NHS Commissioning Assembly is the community of leaders for NHS commissioning, comprising the clinical leader from every CCG in the country and the leadership in NHS England. The purpose is to create shared leadership nationally and locally, co-produce national strategy and direction, embed principles for working together and create a common voice, and to connect leaders both within the NHS commissioning system and beyond. It is based on the principle that we will undoubtedly maximise the impact of commissioning on outcomes by working together rather than individually. The work of the Assembly is overseen by a joint NHS England-CCG Steering Group. Already a number of Assembly Working Groups have been established to support the co-production between NHS England and CCGs to implement many aspects of the business plan during 2013/14.

Tools, guidance and incentives

3.14 NHS England is responsible for producing of a number of tools and enablers to support the commissioning process. These resources will support commissioners in both improving outcomes and value for money. NHS England will provide guidance

for commissioners based upon an agreed framework that will support statutory responsibilities, development needs and knowledge sharing.

Choice & Competition Framework

3.15 Choice and competition can be an important lever for commissioners to improve the quality and efficiency of services. Choice can help ensure people get services that best meet their needs, and competition can be an important lever for driving up quality and innovation. Competition is not an end in itself and will only be used as a means of improving outcomes. It needs to be applied appropriately by commissioners as part of a wider approach to improvement, and should never impact negatively on the ability to join up services around people's needs. The application of choice and competition will be guided by the following principles:

- Patients come first, and choice and competition should be used as a tool to benefit patients.
- The use of choice and competition should be evidence based rather than ideology based. It should be applied where there is clear evidence of patient benefit.
- Choice and competition should be commissioner led, and commissioners will decide how and when it should be applied.
- The commissioner led approach will not be a reason to let poor quality providers continue to perform poorly, and we expect commissioners to consider how best to use these levers to tackle poor performance where appropriate.
- Commissioners should think innovatively about how it is applied for the benefit of patients.

3.16 We are working in partnership with Monitor, the independent regulator of NHS foundation trusts, and with CCG and provider representatives to develop a Choice and Competition Framework. The Framework will offer practical tools, guidance and evidence so that commissioners and providers are able to deliver improved outcomes for people through more effective use of choice and competition.

The NHS Standard Contract

3.17 NHS commissioners use the NHS standard contract to specify and purchase the services they are buying from acute, community and mental health providers. The standard contract provides a clear framework for commissioners to help them define a consistent set of service requirements across all the domains of care in the NHS Outcomes Framework. During 2013/14 we will work with the Commissioning Assembly and other key stakeholders to design the standard contract. The contract will be issued alongside our planning guidance in December 2013, ready for commissioners to use in the 2014/15 financial year.

The quality premium and Commissioning for Quality and Innovation (CQUIN) scheme

3.18 We have established the Quality Premium for 2013/14. We will continue to work with CCGs and other partners, including local clinicians and patients, to ensure that the Quality Premium for 2014/15 continues to reward improvements in quality, outcomes and inequalities in a range of national and local measures. In 2014/15 the quality premium will include a measure for mental health outcomes.

3.19 We are also designing the 2014/15 CQUIN scheme; this is a way of linking the payments made to hospitals (and other healthcare providers) to ambitions for improvement in outcomes.

3.20 We will continue to publish an outcomes indicator set for CCGs that will demonstrate to CCGs and the populations they serve the quality of the health services they commission and associated health outcomes. CCGs can use the CCG outcomes indicator set to demonstrate to local people and their health and wellbeing board that they are targeting their commissioning to meet the needs of the patients they serve.

Key deliverables: supporting, developing and assuring the commissioning system	Timelines
80% of outcomes improvements identified in CCG plans delivered	April 2014
Overall positive CCG satisfaction with NHS England development support	Annual survey
Choice and competition framework (and supporting documents) published	July 2013
Overall positive CCG satisfaction with resources, tools and guidance provided by NHS England	Annual survey

b. Direct commissioning

3.21 NHS England is responsible for directly commissioning £25.4bn of healthcare services including primary care, specialised services, secondary care dental services, some public health services, offender health and armed forces health. These services will be commissioned by the 27 area teams of NHS England.

3.22 Much of our early focus will be on embedding a number of single operating models for how we will carry out our direct commissioning responsibilities. These operating models will seek to address inequalities in access and outcomes, to take account of unmet need for access to high quality services right across the country and to allow us quickly to apply learning and best practice to different geographical areas. At the same time, we will focus on patient safety, giving clear guidance on how to commission a safer service, manage serious incidents and use safety reviews to support commissioning for improvement.

3.23 Where services we commission directly need to join up with locally commissioned services, we will co-ordinate with CCGs and other partners, to ensure people experience a seamless and integrated service.

Primary care

3.24 Primary care has a key role to play in improving health outcomes and reducing health inequalities. We know that good primary care has a positive impact across the whole of the health and social care system. Evidence shows that strong and effective primary care services are vital for health economies and for delivering high quality, best value health services and healthy populations.

3.25 As a single commissioner of primary care services, we have the unique opportunity to redefine the role of primary care in an effective healthcare system and to take steps to address inequalities of access to primary care services, whilst improving the quality of care and outcomes for patients across the country. We aim to do this by:

- Developing and reviewing contract levers to ensure that maximum benefits are achieved through rewarding quality services and better outcomes for patients.
- Managing the smooth transition from Primary Care Trust (PCT) commissioning to NHS CB area teams. The single operating model we will develop will include developing a single approach for effective performance management of primary care
- Improving the skills of practitioners in primary care through the development of robust workforce planning
- Developing and maintaining mechanisms to enable revalidation of GPs, ensuring that skills are up to date and clinical standards remain high

3.26 We will establish a Primary Care Patient Safety Board and develop a comprehensive primary care patient safety strategy that will feed into the overall primary care strategy.

3.27 Some patients find it more convenient to access GP services away from home. We will evaluate the results of the GP choice pilots and consider how we can apply successes more widely. We will move towards a more equitable system of GP practice funding to support patient choice. We will continue to support and incentivise practices to offer greater access to services through digital means.

Specialised services

3.28 Specialised services are those services, often provided in relatively few hospitals, accessed by comparatively small numbers of patients, but with catchment populations of more than one million. These services tend to be located in specialist hospital trusts that can recruit staff with the appropriate expertise and enable them to develop their skills. Examples include long-term conditions such as renal dialysis, complex interventions such as liver transplants, rare cancers and secure forensic services.

3.29 At present, these services are commissioned in a range of different ways leading to variation across the country. Our focus for 2013/14 is to create a consistent, robust and evidence-based approach to the way these services are commissioned across area teams, regardless of where the services are provided. We will also establish a specialised services innovation fund to support innovative practice locally.

3.30 National service-specific clinical reference groups have supported the development of five national programmes of care through wide and expert engagement across clinical and patient stakeholders. Improved patient outcomes will be delivered through quality standards incorporated into the new contracts.

3.31 We will develop outcome measures for all specialised services in line with the Outcomes Framework. This will build on previous work to develop and implement outcome measures, for example, the current measures of survival rates in rare cancers, survival post-transplant in transplant services and the percentage of patients with severe intestinal failure who are discharged home without any need for tube feeding, and the percentage patients with psychosis who can be discharged back to primary care after NICE recommended treatment.

3.32 At the time of writing, there is a judicial review on the re-organisation of paediatric heart surgery across England. A priority for 2013/14 will be to take forward

this work in light of the outcomes of the review to ensure safe sustainable services.

3.33 Further information on the approach and commissioning intentions for specialised services can be found at: http://www.commissioningboard.nhs.uk/files/2012/11/comm-int.pdf

Public health

3.34 Public health is about helping people to stay healthy, changing lifestyle behaviours and preventing disease. Campaigns and interventions are used to promote healthy choices, while disease prevention helps people to avoid getting ill and enables early diagnosis through screening. Public Health encompasses a wide range of services such as immunisation, nutrition, tobacco and alcohol, drugs recovery, sexual health, pregnancy and children's health.

3.35 In the main, these services will be commissioned by Public Health England (PHE). We will work in partnership with PHE so that we mutually support our common goals of improving health outcomes promoting equality of access. The NHS Act 2006, Section 7a, sets out the important role we have in relation to the commissioning of screening and immunisation services, health intervention services for children aged 0-5 years and sexual assault services.

3.36 The 0-5 years programme in particular demonstrates the value of delivering public health programmes in partnership with other statutory agencies that have a responsibility and budget, in this case for the commissioning of children's services. The programme will strengthen the co-ordination of the link between needs assessment and strategy and provide a clear line of sight from the commissioning process through to the delivery of services. The 0-5 years programme includes the continued expansion of numbers of health visitors and family nurse practitioners (FNPs).

3.37 Screening programmes will be extended during 2013/14 for bowel cancer, breast screening and Human Papilloma Virus triage in cervical screening. New vaccines will be introduced for rotavirus in infants and for shingles in the elderly, reducing the incidence of painful and unpleasant conditions for sufferers whilst simultaneously reducing the burden on urgent care services.

Dental health

3.38 NHS England will be responsible for commissioning all NHS dental care; across the hospital (secondary), community (e.g. care for people with special needs), and primary dental care settings, and managing some 10,000 contracts with 'high-street' dental practices. Our aim is to deliver excellence in commissioning NHS dental services including improvements in quality and patient satisfaction, and reductions in inequalities of access and outcomes.

Offender health

3.39 With commissioning of offender health services, NHS England will be responsible for planning, securing and monitoring an agreed set of services for prisons, young offenders Institutions (YOIs), immigration removal centres, secure training centres, police custody suites, court liaison and diversion services and sexual assault services.

3.40 In 2013/14, our focus will be to align the justice commissioning intentions with those of the NHS England offender teams and local partnerships, particularly for children and young people. This will mean developing a

single operating model for offender health, setting commissioning standards that reduce the potential for variation in outcomes and inequalities of access to services that prisoners currently experience across England. We will also focus on mental health services in prisons and detainee settings.

Armed forces health

3.41 NHS England will focus on developing core requirements in new contracts and delivering on a number of commitments such as increasing and improving access to mental health services for serving personnel and veterans, as well as improving prosthetic care for veterans.

Key deliverables: Direct commissioning	Timelines
All area teams will have contracts in place with providers that reflect the requirements of the single operating model for specialised services	June 2013
80% of all commissioning intentions implemented in full	April 2014
All area teams will implement primary care quality assurance for all four contractor services	From April 2013

c. Emergency preparedness

3.42 The NHS needs to be able to plan for, and respond to, a wide range of incidents and emergencies that could have an impact on health or patient care. These incidents could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. They often require a co-ordinated response at national and local level. The development of the capability and capacity to provide this response is a central element of NHS England's role in safeguarding the public.

3.43 In 2013/14, NHS England will implement new arrangements for effectively handling these incidents and emergencies, ensuring safe transition from existing organisations. These arrangements will include new Local Health Resilience Partnerships (LHRPs), which bring together NHS England's area teams with other local partners, to provide on-going surveillance and a co-ordinated multi-agency response, where necessary.

3.44 Emergency preparedness resilience and response (EPRR) is critically dependent on effective multi-agency working. This directly contributes to our mandate objectives relating to partnership working across organisations, by ensuring that single databases and websites for EPRR planning and incident response functions are joined-up, that strong working relationships are fostered between delivery partners and that new structures and ways of working are embedded. This work also contributes to our objectives of improving on all outcomes framework indicators, by ensuring that we minimise the adverse impact of these incidents. "Safe-system" assurance will ensure on an annual basis that the new model remains fit for purpose from April 2013 and beyond.

Key deliverables: Emergency Preparedness	Timelines
Conduct further exercises in each of the NHS England regions to ensure incident response plans and reporting arrangements are aligned with key partner agencies and implement findings	December 2013
Publish updated NHS Pandemic Influenza Guidance in preparation for the Cross Government Pandemic Influenza Exercise (September 2014)	October 2013

d. Partnership for quality

3.45 Improvements in health and care are linked and the NHS and its public, private and voluntary sector partners can only provide the best and most effective service for patients and public when we work together to achieve their objectives.

Francis and Winterbourne View reports

3.46 The Francis and Winterbourne View reports described major failings in the delivery of care. In December 2012 the Department of Health published *"Transforming Care: A national response to Winterbourne View Hospital"*. The report laid out clear, timetabled actions for health and local authority commissioners working together to transform care and provide support for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. The report outlined our shared objective to see the health and care system get to grips with past failings by listening to this very vulnerable group of people and their families, meeting their needs, and working together to commission the range of services and support which will enable them to lead safe and fulfilling lives in their communities.

3.47 The Francis report on events at the Mid Staffordshire Foundation Trust made 290 recommendations, but its single, overarching theme is clear: that a fundamental culture change is needed in the NHS to put people first. Robert Francis highlighted five themes when he presented his report. These were:

> A structure of fundamental standards and measures of compliance

> Openness, transparency and candour throughout the system underpinned by statute

> Improved support for caring, compassionate, and considerate nursing

> Stronger healthcare leadership

> Accurate, useful and relevant information

3.48 The Department of Health has published the full response to the Francis report; we commit to supporting all the actions described in this response and to fulfilling every single one of those for NHS England.

3.49 NHS England is also committed to promoting and upholding the values, rights and pledges enshrined within the NHS Constitution and to putting patients and the public at the heart of everything we do. How we respond to the Francis report will be both a test of our commitment and an opportunity for the Board to work with its partners to drive the required cultural change in the NHS.

3.50 We already have a number of work programmes underway in line with the Francis report recommendations. Key examples include:

- Through our work with the Civil Society Assembly we will test the credibility of our work plans with the right people, and take direction from them on how we can improve
- Effective planning across local organisations to ensure that of actions and commitments are embedded in local systems, as set out in 'Everyone Counts'
- Putting care courage and compassion and other qualities that are of critical importance to nursing first, as part of the vision and strategy for nursing as set out in the Chief Nursing Officer's vision and strategy for nursing, 'Compassion in Practice'
- The implementation of NHS England's Organisation Development Strategy, as a key driver of cultural change

3.51 However, every aspect of NHS England's work programme is now being reviewed to identify what more needs to be done. Key elements of our response will include promoting a culture of safety and quality, including putting the improvement of quality and outcomes at the centre of our organisation and the wider commissioning system.

Quality Surveillance Groups and the National Quality Board

3.52 In 2013/14, we will work with partners to implement Quality Surveillance Groups. We will review all of the existing agreements, in the light of organisational developments and, following the recommendations of the Francis report, we will ensure that we remain focused on the right priorities. We will support board to board meetings to set the strategic direction for these relationships.

3.53 Through our membership and secretariat, we will support the National Quality Board to bring the national elements of the system together to ensure that it is aligned to drive improvements in quality and outcomes, and to maintain the essential standards of quality and safety. We are supporting the work to develop a Quality Dashboard that offers a richer, shared and more holistic view of information on quality.

Safeguarding

3.54 Safeguarding is the multi-disciplinary work we undertake to minimise and manage the risk of harm to vulnerable adults and children. The accountability and assurance framework sets out clearly the responsibilities of each of the key players for safeguarding in the future NHS. The framework has been developed in partnership with colleagues from the Department of Health (DH), the Department for Education (DfE) and the wider NHS and social care system. The NHS CB's regional and local area teams will each have a Director of Nursing who is responsible for supporting and providing assurance on the safeguarding of children and adults at risk of abuse or neglect.

3.55 We will work with CCGs to support them to fulfil and excel in their safeguarding role. We will implement the national safeguarding IT infrastructure and mobilise the professional support required to realise the benefits.

Partnership working

3.56 We will work alongside other organisations at national and local level to achieve our goals of improving outcomes and reducing inequalities, meeting the requirements of the Mandate and achieving

our financial obligations and statutory duties. This includes working alongside partners to jointly commission integrated health and social care packages for people. The Francis report and Winterbourne review have shown how important it is to protect vulnerable people and ensure they receive the highest quality services. All parts of the NHS system must work together to achieve this.

3.57 We have developed a concordat with the Local Government Association (LGA). NHS England has chosen to prioritise the concordat with the LGA for early agreement because of the unique nature of the relationship between health and local government. The concordat provides an important strategic framework for the operational relationship between local authorities and NHS England's area teams. This partnership will be enacted at local and national level, the local dimension of this will be particularly important, as NHS England works with other commissioning partners as part of the health and wellbeing boards to ensure joined up commissioning and services. The three priorities are:

> Facilitating shared system leadership through Health and Wellbeing Boards

> Supporting local mechanisms for joint planning of services

> Creating sector led improvement and innovation

3.58 NHS England has a shared interest in improving outcomes with national organisations, including the National Institute for Health & Clinical Excellence (NICE), the Care Quality Commission (CQC), the NHS Trust Development Agency (NTDA), Monitor, Health Education England (HEE), and Public Health England (PHE). We have partnership agreements with each of these organisations that will formalise the way we work with them on shared priorities and objectives, as follows:

> NICE – we share ambitions for high quality care, improved outcomes for people and cost effective practice. Partnership will help to drive improvement across all five domains of the NHS Outcomes Framework and particularly to support equality of access and reduce inequalities in health outcomes.

> CQC – we have the common objective of supporting and promoting delivery of safe care for everyone

> NTDA – working in partnership will help to improve service quality, outcomes for people and integration of services

> PHE – our partnership will help to reduce inequalities and enhance population health

> Monitor – we are collaborating on sector regulation, tariff for service integration, and choice and competition

> HEE – we are aligning programmes that will help deliver NHS England's medium term strategy, including our vision for nursing

National Institute for Clinical Excellence (NICE) Quality Standards

3.59 NICE will take forward the development of around 30 quality standards for commissioners each year. They will develop related resources, tools and guidance for commissioners to support these quality standards.

3.60 We will ensure that the resources, tools and guidance that we commission or produce are aligned with quality standards, so that they support commissioners in

delivering high quality care as described by the relevant quality standards. In particular we will ensure that there are sufficient quality standards on cross-cutting topics, and that the library includes topics relating to patient safety and experience. We will work with CCGs to agree the appropriate timescales and mechanisms for implementation of these standards.

3.61 We will also work to align topics across the NHS, public health and social care libraries of quality standards and any supporting guidance, resources or tools and workforce skills sharing and competency development.

Integrated care and support

3.62 Care is at its best when it is centred round the needs, convenience and choices of people and their families and carers. Many individuals have multiple needs, and these often span organisational boundaries. Their experience should be of care and support services that are as seamless as possible.

3.63 Through health and wellbeing boards, we will work with local commissioning partners to develop plans for integrated care in line with the requirements set out in *Everyone Counts* and implement plans for integration in each health and wellbeing area by April 2014.

3.64 As a system leader we are tasked in our Mandate from the government to promote integration and seek to remove barriers to it. We are developing with partners a Common Purpose Framework, which will be published in May 2013. This will set out how we will promote, enable and encourage better integrated care and support across health and social care, including primary and secondary care, mental and physical health, and adult and children's services. Our aim is for person-centred and co ordinated care and support to become the norm for everyone. Some localities are further advanced than others. We are therefore, enthusiastic in our support for Ministers' proposals to identify 'pioneers' from examples of integrated care across the country, with the, with the emphasis on identifying and spreading learning for wider, rapid adoption.

Key deliverables: partnership for quality	Timelines
Delivery of 100% of actions set out in the Winterbourne View concordat and Francis response	June 2014
Integrated care proposals implemented in every health and wellbeing board Area	By April 2014
Quality Surveillance Groups operational in every region and area team	From April 2013
Ensure that there is a capable system of safeguarding that is resilient to the transition and linked to quality assurance	From April 2013

e. Strategy, research and innovation for outcomes and growth

3.65 In order to deliver our core objectives, it is essential that we develop a strategy for sustained, long-term, service improvement to ensure that the NHS continues to deliver for everyone, whatever their background, against the backdrop of low financial growth and rising demand for healthcare service. We will place much greater emphasis on innovation in healthcare by providing the space and support for local systems to adopt

innovative practice. The key elements to our approach in 2013/14 will be:

A ten year strategy for the NHS

3.66 We will lead a national and local debate with service users, clinicians, the public and key partner organisations to develop a medium term strategy for the NHS. We will align the strategy with the five domains of the NHS Outcomes Framework, identifying evidence-based, optimum, clinical pathways and changing services where necessary. This work will be underpinned by economic modelling to ensure we develop and deliver financially sustainable services for the future.

3.67 The strategy will consider and address unmet needs and inequalities in outcomes and access to services, commit the NHS to a fairer deal for all, and confirm patient rights outlined in the NHS Constitution. It will also focus on the commissioning system itself. This will cover cohesive development and support for clinical commissioning, future direction for commissioning support services and the development of high-impact levers and tools.

3.68 We will focus on the development of primary care in the light of changing populations and medical models of delivery. We will consider what practical changes, data, market management, workforce development and contract mechanisms will deliver continuous improvement.

Service change

3.69 Over time, the way services are delivered will evolve in line with new technology and clinical practice. It is important that these opportunities are anticipated and managed well, with full stakeholder and clinical involvement and with a singular focus on improving outcomes. We will develop and oversee a framework for major service reconfiguration that will set out the roles, responsibilities and interfaces between the different organisations across the health and care system that will operate from April 2013.

3.70 A key part of this work will be to ensure that there is full clinical input and ownership of service changes to ensure that improved patient outcomes and reducing inequalities are at the heart of all decisions.

Allocations

3.71 Clinical commissioning groups receive funding in proportion to the size and needs of the populations they serve. From 2013/14, NHS England takes on formal responsibility for the development of the resource allocation methodology, and making allocations to CCGs and its own area teams.

3.72 The way that we distribute resources is critical to our objectives on health outcomes, to promoting equality and to tackling health inequalities. During 2013/14 we will carry out a review of the approach to resource allocation, which will inform future allocations. In particular this will be an opportunity to consider the full breath of NHS England funding to make sure it is allocated in the best way to address inequalities and improve outcomes.

Pricing

3.73 In 2013/14, the production and dissemination of the tariff will remain a DH responsibility, with NHS England and Monitor taking joint responsibility thereafter.

3.74 Our work in 2013/14 is primarily focused on working with Monitor to design and set the 2014/15 tariff and we expect formal engagement to begin from June onwards. We also intend to agree priorities for the medium-term, and as part of NHS England's longer term strategy work, to develop a long-term approach to the development of the tariff. In all of this we are working closely with Monitor, and so part of our work programme in 2013/14 is to put in place robust governance arrangements for this unprecedented partnership. In addition, we want to build new and more inclusive arrangements for working with CCGs and others, to ensure that we use pricing as effectively as possible to drive better outcomes for people.

Innovation

3.75 Innovation must become integral to the daily work of every member of staff, in providing high quality and compassionate care. Innovation is as much about designing new ways of doing things, as it is about taking up new technologies. We will deliver programmes for rapid diffusion and adoption of innovative ideas, products and services so that everyone can benefit from proven best practice, including disadvantaged groups. In 2013/14, our primary focus will be to embed *Innovation, Health and Wealth* across the new commissioning system, deliver NHS England's contribution to the UK Genomics Strategy and lead the NHS's contribution to the UK Plan for Growth.

This will include:

> Supporting CCGs to identify and drive innovation locally

> Embedding the new NICE compliance regime

> Establishing a Centre of Excellence to spread innovation at pace and scale

> Delivering progress on the six high impact changes identified in *Innovation, Health and Wealth* across the NHS

> An Innovation Expo – the largest event of its kind in Europe – bringing together the NHS, industry and academia to share and showcase new ideas and innovations

3.76 NHS England will lead the NHS contribution to the UK Genomics Strategy, developing detailed research proposals for 100,000 genome sequences in the UK over the next three years initially focussing on cancer and rare diseases and infectious disease. The NHS England Genomics Strategy Board has established three work streams for 2013/14:

> Benefits realisation – to identify how to exploit existing scientific and research data for clinical use in the NHS to deliver better patient outcomes

> Procurement and intellectual property – to develop the processes for managing the establishment of contracts for genome sequencing

> Clinical, public and media engagement – to develop a shared plan for public engagement about the value, rationale and benefits of the genomics strategy

3.77 The NHS is a major investor in UK science, technology and engineering, contributing to economic growth by exporting innovation and expertise internationally. NHS England will have a key role in supporting the Small Business Research Initiative and strengthening partnerships between the NHS and international healthcare systems through Healthcare UK. This a joint venture between

NHS England, the Department of Health and UK Trade and Investment (UKTI). Healthcare UK will boost the value of the UK's trade in healthcare products and services, generating revenue for the NHS that can be redirected back into improving patient care.

3.78 NHS England will also establish a new Industry Council to identify and work through issues of mutual interest to NHS England and the UK life sciences industry, where this will generate benefits for both patients and taxpayers, and support economic growth in the UK.

3.79 The innovation programme will ensure that the new commissioning system promotes and supports participation of the NHS in research, translating scientific developments into benefits for patients.

Research and Development

3.80 NHS England has a mandate commitment to "ensure that the new commissioning system promotes and supports participation by NHS organisations and NHS patients in research funded by both commercial and non-commercial organisations, to improve patient outcomes and contribute to economic growth."

3.81 To carry forward this commitment NHS England is developing a research and development strategy early in 2013/14 which will largely focus on two key aims:

1. To seek, coordinate and prioritise the research priorities coming out of NHS England and working with the National Institute for Health Research (NIHR) and other large research charities. This will involve a receptive mode for incoming proposals and an active search strategy working across the breadth of the NHS fields of delivery.
2. To improve and develop the interface with both primary and secondary care providers to ensure research is recognised and facilitated in local contracting in collaboration with key partners.

3.82 There are five key work streams underpinning these aims:

> A 'responsive-receptive' function whereby we will advertise a process to receive calls from the NHS commissioners NHS Improving Quality (NHS IQ) and providers as they identify gaps in evidence or knowledge during their development or redesign of services. This will include health systems, and qualitative and quantitative clinical research to meet the requirements of both providers and commissioners. We will seek to prioritise research in these identified areas

> We will have an 'active search' function whereby we will carry out regular research priority-setting exercises, probably on a 3-year rolling cycle. This will include NHS Commissioners and providers. We will use the NHS Outcomes Framework as the basis for these exercises and are likely to have one priority area, per domain, per year in the cycle

> We will act as a facilitator of research – for example, we are planning to investigate a system of 'presumed consent' to take part in research studies for all patients treated in teaching hospitals

> We will have a role in supporting the implementation of research and the spread of known evidence-based best practice. This might be through effective use of national clinical audits, peer review

processes, possible links to the revalidation process and the use of tariffs as incentives

> Resolution and establishment of NHS England policy in a number of research-related activities, such as the payment of excess treatment costs related to research participation.

Academic Health and Science Networks (AHSNs)

3.83 We will establish AHSNs to be the local centres for innovation within the NHS. These networks will bring together expertise in education, research, informatics and innovation to translate research into practice in mental and physical health.

3.84 AHSNs will have strong links with clinical research networks, academic institutes and the commercial sector to identify, evaluate and test innovative practices locally and support their adoption. They will also act as a catalyst for rapid diffusion of other nationally designated innovations.

Sustainable Development

3.85 We will develop, in partnership with Public Health England, a Sustainable Development Strategy to be launched in January 2014 for the health, public health and social care system.

Key deliverables : Strategy, Research and Innovation	Timelines
NHS Publication of a long term strategy for the NHS, including a comprehensive primary care strategy	Products throughout 2013/14
Oversee the priority service reconfigurations to ensure outcomes for people are improved	Throughout 2013/14
NHS England flexible procurement programme for genomics strategy in place to sequence 100,000 genomes in UK in the next three years.	Quarter 4 2013/14
Review of NHS allocations	Interim outputs July 2013 Final outputs July 2014

f. Clinical and professional leadership

3.86 Strong and diverse clinical and professional leadership is essential for high quality commissioning. CCGs have been established to ensure that clinical leadership is at the heart of local commissioning. NHS England will work to ensure that there is the right level of clinical and professional leadership in everything we do.

3.87 Clinical and professional leadership will contribute directly to the delivery of all of our mandate objectives, in particular the objectives relating to the NHS Outcomes Framework. Domain Directors for each of the five domains of the NHS Outcomes Framework, supported by National Clinical

Directors, will provide clinical leadership at a national level.

3.88 Medical and Nursing Directors in the area and regional offices, working alongside clinical networks and senates, will provide clinical leadership to NHS England activities locally and regionally and to the wider commissioning system.

3.89 We will develop and publish strategies as to how we believe we can have the greatest impact on each of the five domains of the NHS Outcomes Framework. These will set out where we believe improvements in pathways will lead to improvements in outcomes for people.

3.90 The key elements of our approach are as follows:

The NHS Nursing Strategy: Compassion in practice

3.91 *Compassion in Practice* sets our shared purpose for nurses, midwives and care staff to deliver high quality, compassionate care, and to achieve excellent mental and physical health and wellbeing outcomes. It builds on the enduring values of the NHS, and the rights and pledges of the NHS Constitution.

3.92 The strategy sets out six areas for action to be implemented over the next three years:

Staying independent, maximising wellbeing & improving outcomes

> Develop resources to support the *Dementia Challenge*

> Develop policy & programme for *No health without Mental Health*

Improving patient experience

> Identify patient experience measures that can be used between settings and sectors

> Support the roll out of the Friends & Family Test in all care settings

> Rollout of the public reporting of pressure ulcers, falls, patient & staff experience and the Safety Thermometer

Delivering high quality care & measuring impact

> Early piloting and development of the Safety Thermometer in mental health, learning disability, children and young people

> Identify metrics & indicators which reflect compassion & effective care

> Publish information from acute trusts and mental health and community providers that identifies the quality of care

Building & strengthening leadership

> Develop a set of tools that enable organisations to measure their culture

> New leadership programme for ward managers, team leaders and nursing directors based on values and behaviours of the 6Cs (care, compassion, competence, communication, courage, commitment)

> Support DH on implementation, roll out and embedding of the Leadership Qualities Framework for adult social care

Right staff, right skills, right place

> Develop evidence based staffing tools for mental health, community, learning disability care and support services

> Support effective value based recruitment, induction, training and appraisal of nursing

staff and support workers, led by Health Education England (HEE) & NHS Employers

> Embed the 6Cs in all nursing and midwifery education and training, led by HEE

Supporting positive staff experience

> Ensure health employers aim for 90% coverage of all staff with their local appraisal system

> Develop a plan to support care staff in the workplace

> Review the suitability of the 'Cultural Barometer' once pilot completed

> Review the 'Image of Nursing' work and develop actions for implementation

The 7 day services review

3.93 Our aim is to promote a comprehensive health service, increasing access to the right treatment and coordinating care around the needs, convenience and choices of patients, their carers and families – rather than the interests of organisations that provide care.

3.94 *Everyone Counts* set out plans to move towards routine services being available seven days a week. The first stage objective is to establish a forum and publish a report, in the autumn of 2013, identifying how there might be better access to routine services seven days a week. In this first phase, the review will focus on improving diagnostics and urgent and emergency care. It will include the consequences of the non-availability of clinical services across the seven day week and provide proposals for improvements.

3.95 We will then design and offer a programme of support for clinical commissioners as they implement recommendations of the report.

Urgent and Emergency Care Review

3.96 The Urgent and Emergency Care Review aims to develop a national framework to enable clinical commissioning groups (CCGs) to commission high quality urgent and emergency care services across NHS England for April 2015. The first stage of the Review is to publish high level principles in 2013. The most serious emergencies require rapid access to highly specialised skills and equipment; however, many less serious cases can be safely treated in community settings. The aim is to provide care as convenient to the patient's home as the urgent care specialism allows.

3.97 Starting, with the patients' perceptions of urgent need, NHS England will engage on the high level design principles for services and the changes needed to create a national framework and the associated guidance for 2015. We will determine how best use to use resources, particularly skilled staff and information, to improve decision-making and outcomes. We will also ensure that the proposed models of care are sustainable, capable of meeting the challenges arising from advances in clinical technology and workforce and are consistent with the duty to live within the allocated resources for the health service.

Clinical senates and networks

3.98 Clinical senates will bring together a range of professionals to take an overview of health and healthcare for local populations and provide CCGs, health and wellbeing

boards and NHS England with strategic, independent advice and leadership on how services should be designed. They will draw on a variety of health and wider care perspectives to provide the best overall care and outcomes for people, including those of professionals who sometimes go unheard. There will be 12 clinical senates covering England.

3.99 NHS England will also host four Strategic Clinical Networks, these are as follows:

> Cancer
> Cardiovascular
> Maternity and children
> Mental health, dementia and neurological conditions

3.100 These are service areas where large scale change is required across very complex pathways of care involving many professional groups and organisations, and a co-ordinated, combined improvement approach is needed to overcome healthcare challenges.

3.101 In 2013/14, we will work to ensure that networks and senates are developing resilient and effective arrangements. This will include:

> Ensuring that the twelve clinical senate plans are fit for purpose each year
> Providing development support for all types of networks through the NHS Improvement Body
> Developing and agreeing national clinical priorities for strategic clinical network improvement programmes for 2014/15
> Holding national development events for clinical senate chairs to share learning and experience
> Reviewing national cancer and mental health peer review arrangements, and consider extensions and develop appropriate plans

Leadership on health inequalities, equality and diversity

3.102 There are still too many longstanding and unjustifiable inequalities in access to services, quality of care, health outcomes and patient experience. It is our ambition that everyone receives excellent care, which takes account of their background, who they are and where they live.

3.103 During 2013/14, we will re-launch the Equality Diversity Council (EDC) with a structured work programme, embedded within each of the NHS England directorates, which will support the promotion of equality and the reduction of health inequalities across society. Within this period, the Equality Diversity System (EDS) will also be refreshed to embody the values of the NHS Constitution and help NHS organisations to reduce inequalities in health. The EDS will be rolled out to the NHS to help promote equality and reduce health inequalities. It will form the basis of NHS England's equality objectives for the forthcoming business planning period, in collaboration with the NHS EDC. We have also established an Equality and Diversity Group to improve the diversity of NHS England itself.

3.104 We have set ourselves three interim Equality Objectives for April to October 2013 which will ensure that its own policy making, decisions and activities are compliant with the public sector Equality Duty, and provide system leadership to Clinical Commissioning Groups and other parts of the NHS. These are as follows:

- NHS England will ensure that the public sector Equality Duty is embedded and reflected within all of its core business processes, including direct commissioning and workforce development.
- NHS England will implement the Equality Delivery System (EDS) and use it to help it deliver on the general and specific duties of the public sector Equality Duty
- NHS England will ask Clinical Commissioning Groups to adopt the EDS where they have not already done so, and will support CCGs to meet the public sector Equality Duty and to publish their own Equality Objectives by October 2013.

3.105 From April to October 2013, NHS England will carry out engagement with its staff, NHS organisations, patients and the public, and other stakeholders including the third sector, in order to reflect on the conduct and achievement of the interim Equality Objectives, and to agree its strategic Equality Objectives from October 2013. These strategic Equality Objectives will not focus on processes as the interim Equality Objectives do; rather, they will focus on outcomes for patients and/or staff, and be specific and measurable.

The NHS Leadership Academy

3.106 The NHS Leadership Academy is a system wide body, whose vision is to be recognised as a national centre of excellence for leadership development and talent management in the NHS. Its mission is to develop outstanding leadership in health to improve the quality of services and outcomes for everyone.

3.107 It is a partner in providing leadership development expertise and capacity to support the delivery of NHS England's internal strategy, and in building the organisation's overall capability and capacity to deliver. It is also a partner in supporting wider commissioning system development, providing leadership development support to CCGs, Commissioning Support Units (CSUs) and others, and serves as a vehicle for connecting and supporting leadership and system development.

3.108 This will be done by:

- Broadening, and where necessary changing, the leadership behaviour in the health system
- Professionalising leadership: raising the profile, performance and impact of health system leaders
- Working in partnership to make leadership in the health system more inclusive and representative of the communities it serves
- Developing leaders who can create a climate where innovation can flourish

3.109 The Leadership Academy will also take forward the deliverables for improving leadership as part of the government response to the Francis report.

NHS Improving Quality

3.110 NHS Improving Quality (NHS IQ) has two overarching priorities; to drive the implementation of the NHS Outcomes Framework through effective improvement programmes, and to build improvement capacity and capability across the whole of NHS England. The aims of NHS IQ are to:

- Support the delivery of the priorities of the 5 Domains of the NHS Outcomes Framework by designing and commissioning improvement programmes

- Ensure that NHS England has a single improvement methodology to enable it to continuously improve its own processes and be the most effective commissioner of health care services
- Support the regional and area teams of NHS England in driving improvement and transformation of local health systems
- Ensure that the improvement requirements of CCGs, commissioning support services and Strategic Clinical Networks are met
- Support the wider NHS system, in particular the NHS Trust Development Authority and Academic Health Science Networks, in delivering improvement goals to support transformation
- NHS IQ will work alongside the Local Government Association to deliver a sector-led improvement approach, so that CCGs and local authorities have an effective, clear and consistent approach to improvement and innovation for the benefit of patients, users and the public. Priorities will be Winterbourne View, and supporting the implementation of integration proposals and the development of Health & Wellbeing Boards

3.111 The establishment of NHS IQ creates for the first time the alignment of an improvement body with the commissioning priorities of the NHS. It also offers the opportunity to build greater improvement capacity and capability across NHS England and the wider system at a time of unprecedented change and challenge in the NHS.

Key deliverables: Clinical and professional leadership	Timelines
7 day service review report published	Autumn 2013
Urgent and Emergency Care Review: high level principles published	Spring 2013
Commencement of 70% of the actions set out in 'Compassion in Practice' (our three year nursing strategy)	By April 14
Delivery of Leadership Academy core programmes to 2,000 clinical and non-clinical staff	March 2014

g. World class customer service: information, transparency and participation

3.112 Transparency and participation are key to transforming customer service in health and care – patients, professionals and citizens need far better information on local services and need to be able to take control of their health when they want to. They need to be able to offer feedback on local services and know that those comments will be acted upon. They need to be able to make use of the latest digital technologies to improve the safety, outcome and experience of care.

3.113 In 2013/14 NHS England is committed to transforming the way information is made available to the public and wider healthcare system. We will improve data and information availability to better support public and patient participation.

Intelligence: supporting decision making and choice throughout the service

3.114 Health and care data represents one of our greatest public assets and putting it to work is key to improving outcomes for all people. We will build a modern data service, through the *care.data* programme, which will provide timely, accurate data linked across the different components of the patient journey and the outcomes resulting from treatment.

3.115 This programme is a ground-breaking step that will underpin the rights and pledges set out in the NHS Constitution, including the right to choose the most appropriate provider and setting of care. Part of this will include the *Everyone Counts* offer of publishing consultant level quality and outcomes information for 10 key specialties by summer 2013.

3.116 We will deliver an integrated business intelligence tool which will provide the robust information needed for evidence based, insightful decision making for all parts of NHS England.

3.117 We aim to improve people's experience of care by enabling information to be exchanged securely across the health and care system, through the publication and adoption of national standards that support the integration of local information systems.

Patient and public voice: putting the citizen at the heart of the NHS

3.118 Our aim is to create the conditions for an equal, balanced and reciprocal relationship between citizens and the NHS. We will encourage collective participation by establishing the Civil Society Assembly, which will: create a forum where patients and the public can be heard; give citizens greater ownership of the healthcare agenda; and inform NHS England's decision-making.

3.119 We will give citizens the knowledge, skills and confidence to manage their own health by developing a coherent, linked package of shared-decision making aids so that people can actively participate with their clinicians in making choices about their care and treatment. We will make available personal health budgets for people who could benefit from them, subject to evaluation of the national pilot programme.

3.120 Building on the achievements made to date, we will enable patient & public voice and insight to be routinely used in the planning and delivery of services. We will do this by providing high quality advice, tools and training on evidence-based methods of gathering and using insight to gain a better understanding of the wants and needs of people from across society and a range of groups, including disadvantaged groups.

Patient insight, including roll out of the friends and family test

3.121 A deeper understanding of how users of NHS services view aspects of the care they receive is essential to make services better. National staff and patient surveys facilitate the benchmarking of services, and are particularly valuable in helping improve the experience of groups who may be socially disadvantaged.

3.122 As set out in the government's NHS Mandate, one specific aspect of this will be the roll out of the Friends and Family Test. This will enable staff and patient feedback to be gathered in a more responsive and granular way, allowing care providers

to make rapid improvements in patient experience at local level. This test and the other patient survey measures we also have, represent a starting point in understanding patient feedback on services. We will continue to develop measures to improve our understanding of patient experience.

3.123 We will use modern techniques such as social and digital media to supplement other forms of insight, so that we hear views from all sections of society and understand what people are saying about the health services they want to receive.

Customer relations: Giving people control and choice when they want it

3.124 To be a truly patient centred service, we need to maximise the choice and control that we offer to people in the services they receive. We will work to make the NHS Constitution a reality, including the right for people to make fully informed decisions about how, when and where they access healthcare. This includes choice both at the point of GP referral and along the care pathway.

3.125 In order to improve both outcomes and efficiency, NHS England must make best use of digital channels to offer people more convenience, choice and control. We will launch the Customer Services Platform, a public-facing service that uses telephone, smartphone applications and the internet, across the NHS, public health and social care.

3.126 This programme will start with *MyhealthLondon*, which will drive improvements in care and customer experience in London through transparency of information and open feedback. Furthermore, to ensure we do our utmost to reduce inequalities in access to online health services, we will develop a programme to support those people that currently do not, but could if they wished, use the internet.

3.127 We will gain insight into public views and perceptions of the NHS to enable us transform services in line with people's needs and expectations, delivering a better service and driving up quality.

Strategic systems and technology: digital first

3.128 The Health Online Programme makes use of modern technology to transform the service offer of the NHS, empowering patients and citizens to take control and make informed choices. As part of this, people will have online access to their health records if they want it, by 2015. The 'Paperless NHS' programme includes the re-launch of Choose and Book which aims to make electronic referrals universally and easily available to patients and their health professionals for all secondary care services by 2015.

3.129 NHS England will set the direction for NHS technology and informatics so that commissioners, providers and suppliers can make informed investment decisions and, in co-production with key strategic partners and in consultation with stakeholders, we will develop and publish an evidence-based NHS Technology Strategy and Roadmap.

3.130 Through the Informatics Services Commissioning Group we will bring together key organisations from across health and social care to ensure that benefits to patients and citizens are central to all commissioning decisions about national information and technology services.

Communicating patient and public values

3.131 We will put in place the essential communications infrastructure to support NHS England's national, regional and local teams. Commissioning Support Units will provide a joined-up communications service on behalf of NHS England's regional and area teams, so that we engage effectively with local stakeholders, public and media. We will deliver a programme of stakeholder and learning development events to share key information, motivate and engage with key audiences. As part of this, we will build a website that is robust and engaging for both the public and our staff.

3.132 We will develop a clear purpose and vision for NHS England, which will be at the heart of a knowledge service for staff, connecting people across the organisation.

Key deliverables: World class customer service: information, transparency and participation	Timelines
Publish outcomes data from national clinical audits for every consultant practising in the ten surgical specialties set out in *Everyone Counts*	Summer 2013 (10 specialties), all by March 2015
Roll out of friends and family test and an increase in the % of trusts improving their score	Acute and A&E services – April 2013; Maternity – October 2013
Online primary care: 100% providing patients with a facility to order repeat prescriptions, access their records and book appointments	March 2015
Reducing inequalities: 100,000 citizens trained in basic online skills to boost health literacy	April 2014
Civil Society Assembly demonstrates over 80% satisfied with the involvement of patients and the public in the planning and commissioning of NHS services by NHS England.	Baseline 2013/14
100% of CCGs will be able to deliver personal health budgets, including direct payments, for patients receiving NHS Continuing Health Care.	April 2014

h. Developing commissioning support

3.133 Locally designed, clinically-led commissioning will be at the core of the healthcare system. Success will depend on clinicians focusing on the differing needs across their local population and able to devote time and clinical leadership to addressing those needs. This will require access to excellent and affordable commissioning support services.

3.134 Developing a robust market for the provision of commissioning support services should widen the skills and resources available to commissioners and create efficiency in the marketplace. We will design and publish in June 2013 a strategy to develop affordable and sustainable commissioning support services, setting the standard for excellence. This strategy will also include a quality regulation framework to ensure sustainability of the market.

3.135 The current NHS England-hosted CSUs are likely to form a key part of this market and will be supported and developed to become commercially viable by March 2016.

3.136 There are currently 23 NHS England-hosted CSUs across England, providing a broad range of services including business intelligence, service transformation, back office functions and procurement.

3.137 Over the past 18 months, CCGs have been working with CSUs to define and specify their requirements. NHS England's role in hosting these organisations includes assuring they are viable, supporting their development as well as developing a future market for commissioning support services.

3.138 We need to provide assurance that CSUs are commercially robust, and that potential commissioning and financial risks are well-managed. At the same time we need to maximise their ability to become freestanding, responsive commercial enterprises. We are developing fair, balanced frameworks for monitoring and assuring that CSUs are as effective as possible.

3.139 We want to encourage leadership and innovation in the ways clinical commissioning can deliver improvements in quality, outcomes, tackling inequalities and value for money. Good commissioning support will help CCGs translate the priorities for their local health systems into frameworks and incentives that deliver better health and care for people.

3.140 We are launching a development programme to support CSUs to become effective and efficient organisations. This programme will focus on leadership development, data and information management and the procurement of potential delivery partnerships.

Key deliverables: Developing commissioning support	Timelines
Robust processes are in place to assure the performance of all CSUs (service quality and financial)	From April 2013
Final strategy for the development of commissioning support services published	November 2013
CSUs commercially viable and externalised	March 2016
Creation of a diverse and responsive commissioning support market	March 2016
Positive feedback from customers on services provided by CSUs	Twice a year

4 Developing NHS England

4.1 NHS England takes on its full responsibilities from April 2013, however 2013-14 will be a year of transition in a number of areas. As a new organisation there is a considerable focus for the first year on establishing and investing in its most vital resource – its people. This section sets out how we aim to achieve this.

Staffing

4.2 NHS England has eight directorates from which to draw resources to help deliver improved outcomes for people. The majority of our functions will be carried out at a local level through four regional teams and twenty seven area teams, supported by the operations directorate. The area and regional teams are supported by the national directorates, who are based at the national support centre in Quarry House, Leeds with an additional presence at Maple Street, London. Our structures are available at www.commissioningboard.nhs.uk/about/structure. We will work to complete our recruitment process as soon as possible in 2013-14.

Organisational development

4.3 Our approach to organisational development will be central to our success. It is important that we reinforce and develop a single organisational culture and build a shared vision of improving outcomes for people.

4.4 A detailed organisation development strategy is in place, which aims to deliver the following objectives:

> To attract and retain the best people, from diverse backgrounds, with values which are congruent with our vision

> To develop the core policies, systems and processes which support the NHS England vision and objectives

> To develop working patterns and behaviours which support NHS England's vision and objectives

> To develop NHS England's leaders to enable them to support all our employees

> To develop collectively and communicate a strong, shared sense of purpose, organisational culture, brand and reputation

> To build employee morale and commitment through real and meaningful engagement.

4.5 Development activities under each of these objectives will help us deliver a shared common purpose and vision, and a single organisation focused on improving outcomes for patients, promoting equality and reducing health inequalities. This includes the delivery of a corporate induction programme to communicate our purpose and values to all our staff around the country. It also includes a set of clear strategies to make significant improvements in the diversity of our workforce; to support the health and wellbeing of our staff; to develop high performing matrix and functional teams; and to implement a values-based performance development review scheme for all staff, designed to reinforce the patient-focused culture we are developing. We will also develop a staff engagement strategy underpinned by research and evidence.

4.6 Work will also continue to develop our senior leaders to provide the leadership needed to be successful, particularly through the NHS England Leadership Forum, across a single organisation with cross-boundary working and behaviours, which ensure a relentless focus on people in everything we do.

4.7 During this year, we will also develop a patient-led training and development strategy, to help us build a corporate curriculum for staff, so that we can build a number of core capabilities within the organisation.

NHS England Governance

4.8 Delivering NHS England business is a large-scale complex task. A corporate programme office has been established to provide a resource to the organisation in terms of project support, as well as providing assurance to the Board regarding corporate performance and business plan delivery. Risk identification and mitigation is an important element of this and will be managed and reported on using the Board Assurance Framework.

4.9 NHS England's operating model will be underpinned by exemplary governance arrangements. The new corporate governance framework will set out how we will be governed and held to account for our objectives and the way we conduct our business. We will have a clear scheme of delegation to enable the NHS England board and staff to make transparent, robust decisions that support our functions, and agreed approaches to managing clinical risks and providing assurance on the quality and safety of services for patients.

4.10 We will be open and transparent about our governance, and will regularly hold our board meetings in public in a range of venues across the country. Those who cannot attend will be able to watch the proceedings via live streaming or watch later through YouTube. We will continually review how Board meetings drive a focus on patients, and we will provide a variety of opportunities for the public to provide feedback to the Board.

Public and Parliamentary accountability

4.11 NHS England is accountable for delivering the mandate set for us by the government to respond to correspondence, Parliamentary questions and complaints, and as a statutory body we have formal duties to respond to Freedom of Information and Data Protection Act requests. Teams have been established to respond to briefing requests

from various stakeholders, and FOI requests and calls from the public. A formal protocol has been agreed with the Department of Health setting standards for timeliness and quality that we will meet. All directorates in NHS England will have a part to play in managing our responsibilities to respond to requests for information from Ministers, Parliament and the public.

Equality and Health Inequalities Strategy – including the Equality Diversity Council and the Equality Diversity System

4.12 One of our central commitments is to promote equality across the NHS and reduce health inequalities in access to, and outcomes from, healthcare services. It is our ambition that everyone receives care that takes account of their background, who they are and where they live. We referred to the Equality Diversity System (EDS) in our section on leadership (paragraph 3.106). We will publish equality data and information using EDS, that demonstrates how NHS England is meeting the Public Sector Equality Duty (PSED) and performance against its agreed equality objectives. We will also include an assessment in the NHS England annual report of how well NHS England and CCGs have met their legal duties regarding health inequalities.

4.13 We have also established an equality and Diversity Strategy Group, which is a committee of NHS England, set up to improve the diversity profile of our own organisation.

Assessing our success in building the new organisation

4.14 It will be important to measure how successfully we have met the objectives outlined above. We will do this through a range of measures, including feedback from all our partners. We are already working with NHS clinical commissioners to co-produce an independent 360 degree survey to provide feedback to NHS England from every CCG in the country which will form part of these measures, along with a regular staff survey; and other indicators under development.

Annex 1: Budgets and resources

Securing value for money

NHS England has a £95.6bn commissioning budget. We are responsible for using this money wisely and fairly to secure the best possible outcomes for both patients and the taxpayer. We also have a clear role to play in promoting innovative approaches to service delivery; in the current economic climate it is ever more important that the NHS can deliver better at lower cost.

The challenge of securing better services for people at a lower cost to taxpayers will continue over the three period of this operational plan. By the end of 2014/15, we aim to have completed delivery of the NHS's first QIPP (Quality, Innovation, Productivity and Prevention), challenge. From 2015/16, the same focus on driving quality improvements within a tight financial envelope will be required. We have an overarching duty to stay within our budget and demonstrate transparency in its deployment by publishing our financial position.

Resources

The government's mandate, set out the amount of funding the NHS Commissioning Board (NHS CB, now renamed as NHS England) would receive in 2013/2014. It stated that:

"The NHS Commissioning Board's revenue budget for 2013/2014 is £95,623 million (of which £1,843 million is for delivery of the section 7A agreement with the Secretary of State) and its capital budget is £200 million"

Table 1 provides a summary of the 2013/14 mandate funding.

Table 1: Summary of Mandate funding 2013/2014

	£m
Programme Costs	88,040
Running Costs	2,014
Social Care Funding	859
Central Commitments/ Reserves	1,023
Total core funding 2013/2014	**91,936**
Technical Allocations	
Annually Managed Expenditure	300
Technical Accounting	360
Total technical allocations 2013/2014	**660**
Carry Forward from 2012/2013	1,184
Public Health Section 7a	1,843
Total other allocations 2013/2014	**3,027**
Total mandate funding 2013/2014	**95,623**

Distribution of mandate funding

On 14 December 2012, the board of the NHS CB approved the distribution of £88,040m core health programme costs to the commissioning system, in addition to the separate allocations for social care and public health.

As can be seen in table 1, the NNHS England running cost budget has been set at £2,014m. The allocations of running cost allowances to CCGs were approved by the Board in November and account for £1,345m of this total, the remaining £669m of running costs (£527m recurrent/£142m transitional) is allocated to the NHS England for its own administration costs.

Table 2 below provides an analysis of how the Commissioning Board has distributed its 2013/2014 mandate funding between the different elements of the commission system:

Table 2: Analysis of mandate distribution 2013/2014

	£m	£m
CCG programme allocations	63,355	
CCG running cost allowance	1,345	
Total CCG allocations		**64,700**
Social care		**859**
National Commissioning:		
GP Services	6,408	
Other Primary Care	4,691	
Specialised Services	11,987	
Other	885	
Growth uplift	475	
Sub-total		24,446
Cost of Specialised Services convergence		240
Running costs		669
Total national commissioning		**25,355**
Central programmes		1,023
Technical allocations		660
Carry Forward from 12-13		1,184
Section 7a from Public Health England		1,843
Total mandate sum 2013/2014		**95,623**

The CB's central budgets are therefore made up of the following items:

> Running costs of £669m (of which £527m is recurrent and £142m is transitional)

> Programme costs of £1,023m

Directorate Budgets

It is vital that NHS England uses its limited resources to deliver maximum benefits in line with its mandate objectives and to get the greatest value out of every pound it spends.

Budget setting has been carried out as part of the overall business planning process with the guiding principle that resources must be used to support our strategic and operational priorities and that we must derive maximum advantage from matrix working across NHS England and its hosted bodies.

An overall summary of the funding allocations to directorates, hosted bodies and other cost areas is shown in Table 3.

Table 3: NHS England Budgets 2013/14

Directorate budgets	Running cost budgets	Discretionary running costs	Total running costs	Programme costs	Total
	£m	£m	£m	£m	£m
Innovation, health and wealth		0.0	0.0	75.0	75.0
Improvement body	12.7	0.0	12.7	53.5	66.2
Medical (other)	12.3	0.2	12.5	34.9	47.4
Nursing	7.8	3.0	10.8	4.1	14.9
Clinical networks and senates	7.2		7.2	32.0	39.2
Operations	250.9	12.7	263.6	60.7	324.3
Commissioning Development	5.5	2.3	7.8	5.0	12.8
Patients & Information	15.5	6.0	21.5	45.4	66.9
NHS Direct/111	0.0	78.7	78.7	78.7	78.7
Finance	10.2	0.5	10.7	2.5	13.2
Policy & Corporate	5.3	5.5	10.8	0.0	10.8
Human Resources	5.6	2.4	7.9	0.0	7.9
Leadership Academy			0.0	46.7	46.7
Other:					
Clinical excellence awards				174.0	174.0
Other central budgets		2.1	2.1	309.6	309.6
	333.0	**34.6**	**367.5**	**922.0**	**1,289.6**
Corporate/Outsourced functions	36.2		36.2		36.2
Directorate Budgets	**369.2**	**34.6**	**403.7**	**922.0**	**1,325.8**
Non Pay costs – fixed	72.8		72.8		72.8
Non Pay costs – discretionary	34.6	(34.6)			0.0
Contingency reserve	20.5		20.5	100.9	121.4
Ring-fenced depreciation	30.0		30.0		30.0
Total NHS CB budget	**527.0**	**(0.0)**	**527.0**	**1,023.0**	**1,550.0**
Non recurrent transitional running costs			***142.0***		
Total 2013/14 running costs (Inc. non-recurrent element)			***669.0***		

Annex 2: Deliverables against key accountabilities

NHS Mandate objectives

1. Demonstrate progress against the five parts of and all of the outcome indicators in the framework *Mandate introduction paragraph 11*	
> Clinical leadership will underpin all of our work to ensure sufficient focus on outcomes. We will produce vision statements for each Outcomes Framework domain by May 2013 setting out the high level approach the commissioning system will take to improve outcomes and reduce health inequalities.	National Medical Director/Chief Nursing Officer
> We will produce and embed single operating models for all directly commissioned services by June 2013. These will deliver improved outcomes by driving up standards in mental and physical health service provision and address unwarranted variation in current practice. At least 80% of direct commissioning intentions delivered to time by April 2014.	Chief Operating Officer
> Our oversight and leadership of the commissioning system will ensure robust planning and delivery of outcomes improvements that make sense locally and take account of health inequalities. At least 80% of outcomes improvements identified in CCG plans delivered by April 2014.	Chief Operating Officer
> Our 10 year strategy will develop a framework for sustainable improvements in outcomes and addressing health inequalities over the medium term. Strategic documents will be published throughout 2013-2014.	National Director: Policy
> 'We will undertake an Urgent and Emergency Care Review, to develop a national framework that will enable clinical commissioning groups (CCGs) to commission high quality urgent and emergency care services across NHS England for April 2015. The first stage of the Review is to publish high level principles in 2013.	National Medical Director'
> We will deliver a range of programmes throughout 2013-14 that will support rapid diffusion and adoption of innovative practices and ideas to support outcomes improvement.	National Medical Director

1. Demonstrate progress against the five parts of and all of the outcome indicators in the framework *Mandate introduction paragraph 11*	
> We will produce a range of support tools and guidance to help commissioners throughout 2013-2014 and beyond. For each product, we will ensure there is a direct connection to improving outcomes.	National Director: Policy/National Director: Commissioning Development
> We will use financial incentives to reward improvements in outcomes. The Quality Premium will be paid to CCGs that in 2013/14 improve or achieve high standards of quality for four key measures in the NHS Outcomes Framework.	National Director: Commissioning Development
> We will publish a strategy for promoting equality and reducing health inequalities by March 2014. Our aim for each domain is to deliver interventions that will address health inequalities, including meeting the needs of the most disadvantaged and demonstrating parity between physical and mental health care.	National Director: Policy
> We will measure improvements both at domain level for each of the five Outcomes Framework domains and at individual indicator level where data is available. Our aim is to deliver measurable progress on each area by March 2015.	All
> We will assess health inequalities across a range of dimensions both at domain level for each of the five Outcomes Framework domains and at individual indicator level where data allows. Our aim is to deliver continuing progress on each indicator reflecting that inequalities may be narrowing or widening. We will also broaden our understanding of health inequalities across the Framework and make progress in reducing identified health inequalities on all indicators for which data are available.	All

2. Make measurable progress towards saving 20,000 lives by 2016 by reducing mortality to the level of the best in Europe *Mandate paragraph 1.2*	
> The actions set out in the overarching objective relating to all five domains of the outcomes framework all apply to this objective which focuses specifically on domain one (preventing people from dying prematurely).	National Medical Director
> Our clinical vision for domain one (published in May 2013) will set out the approach the commissioning system will take to improve outcomes and tackle inequalities in relation to mortality. This will focus particularly on prevention and earlier diagnosis of illness.	National Medical Director
> Addressing premature mortality will be a focus of all directly commissioned services.	Chief Operating Officer
> As set out in *Everyone Counts*, there will be a particular focus on earlier diagnosis, improving management in community settings, improving acute and mental health services, and preventing recurrence after an acute event.	Chief Operating Officer

3. Make significant progress on supporting earlier diagnosis, particularly through appropriate use of primary care and supporting the roll out of NHS Health Checks; ensuring people have access to the right treatment at the right time, including NICE recommended drugs and treatments, and services for children and adults with mental health problems; reducing unjustified variation in hospital deaths, measuring and publishing outcome data for all major services by 2015; making every contact with patients count in health; promotion, and promoting the mental and physical health of the NHS workforce *Mandate paragraph 1.4*	
> We will comply with NICE guidance and standards in our direct commissioning activity. Building on the authorisation process we will support and assure CCGs to meet NICE requirements through their commissioning and contracting arrangements on an on-going basis.	Chief Operating Officer
> We will improve outcomes through our role as commissioners of screening and immunisation services, and of health intervention services for children 0-5 years.	Chief Operating Officer
> As commissioners of primary care in England, we will develop the GP contract to support improvements in outcomes, including risk stratification, earlier diagnosis and roll-out of health checks.	National Director: Commissioning Development
> We will develop new measures for mental health access and outcomes that aim to reintegrate mental and physical wellbeing during 2013-14. These will be used by CCGs to understand and tackle variation locally.	National Medical Director
> We will measure health and wellbeing of the NHS workforce through the staff friends and family test and staff sickness absence rates on an on-going basis.	National Medical Director/Chief Nursing Officer

4. Make measurable progress towards making the NHS the best in Europe at supporting people with long term health conditions *Mandate paragraph 2.3*	
> The actions set out in the overarching objective relating to all five domains of the outcomes framework all apply to this objective which focuses specifically on Domain two (enhancing the life for people with long term conditions).	National Medical Director

5. Ensure the NHS becomes dramatically better at involving and empowering patients and their carers. By 2015 more people will have developed the knowledge and skills to manage their own health; everyone with long term conditions including those with mental health problems will be offered a personalised care plan; patients who could benefit will have the option to hold personalised budgets; information and advice about support will be available to carers
Mandate paragraph 2.5

> We are developing information, advocacy and support services to empower use of information as a means of managing health. We will launch the Customer Services Platform, a public facing multi-channel customer response service spanning health and social care, by November 2013.	National Director: Patients and Information
> 80% of CCGs will be commissioning to support patients' participation and decisions over their own care or will have a plan to do so by December 2013. This includes information and support for self-management, personalised care planning and shared decision making within normal service planning and commissioning.	
> The Health Online Programme will improve the way in which people interact with health services, including online access to key elements of the care process. 100,000 citizens will be trained in basic online skills to boost health literacy by April 2014.	
> The re-launch of Choose and Book will make e-referrals available to patients and health professionals for all secondary care referrals by 2015.	
> Personalised budgets will provide a route for people to have more control over managing their health. Personal health budgets will be offered to those who would benefit by March 2015. 100% of CCGs will be able to deliver personal health budgets, including direct payments, for people receiving NHS Continuing Health Care by April 2014.	
> We will encourage collective and collaborative participation in the NHS by establishing the Civil Society Assembly. Feedback from the Voluntary/Community Sector and Civil Society Assembly demonstrates over 80% are satisfied with the involvement of patients and the public in the planning and commissioning of services by NHS England.	
> We will use the reported experience of people to assess whether they feel they are being supported to manage their conditions (outcomes framework indicator 2.1)	

6. Achieve a significant increase in the use of technology to help people manage their health and care. By 2015 patients will have online access to health records held by GP, there will be clear plans in place to enable secure linking of electronic health records and also clear plans for records to follow individuals through NHS or social care system. Ordering repeat prescriptions and booking GP appointments will be available online, secure electronic communication with GP practice and e-consultations will be more widely available. We will have made significant progress in availability of telehealth and telecare by 2017 ***Mandate paragraph 2.6***	
> We will continue the roll out of telehealth and telecare towards the 3 million by March 2017 ambition set out in Innovation Health and Wealth (IHW)	National Medical Director
> We will improve online access to primary care. 50% of practices will offer the facility to order repeat prescriptions and to book appointments by April 2014 with 100% achieving this by March 2015. 100% of practices will have the technical capability to allow people to access their records by April 2014 and 100% will be offering this option to patients by March 2015.	National Director: Patients and Information
> We will have a new NHS e-referrals service operational by December 2013 and 100% of referrals will be made electronically by March 2017.	National Director: Patients and Information

7. Drive a whole-system approach to providing integrated, patient-centred care across in all health and social care settings ***Mandate paragraph 2.9***	
> As set out in *Everyone Counts*, the integration of the provision of services, including where appropriate the pooling of budgets to reflect local need, is an explicit requirement in local area planning. Integrated care proposals will be implemented in every Health and Wellbeing Area by April 2014.	Chief Operating Officer
> We will publish a common purpose framework for integrated care with national partners by May 2013.	National Director: Policy
> We will measure progress in this area through the new outcomes framework indicator on patient experience of integrated care (indicator 4.9 – currently under development).	National Director: Policy

8. Make measurable progress by March 2015 towards being among the best in Europe at diagnosing, treating and caring for people with dementia. A national ambition for diagnosis rates will be built up from local plans ***Mandate paragraph 2.11***	
> *Everyone Counts* emphasised the importance of dementia diagnosis and care. We are collecting and assuring plans for improving dementia diagnosis rates and will monitor delivery throughout the year. The CCG plans will demonstrate ambition for significant improvements in dementia diagnosis rates.	Chief Operating Officer
> As part of our nursing strategy *Compassion in practice* we will publish a range of tools and resources aimed at supporting the nursing contribution to the dementia challenge. These resources will be published between April and July 2013.	Chief Nursing Officer
> Our clinical vision for domain two of the outcomes framework will be published in May 2013. This will include how the commissioning system can work to deliver improved outcomes for dementia.	National Medical Director
> A portion of the CQUIN payment from commissioners to providers will be linked specifically to improving dementia care.	National Director: Commissioning Development
> Through direct commissioning of general practice, we will provide appropriate incentives and rewards for improving dementia services, including a designated enhanced service for dementia.	National Director: Commissioning Development/ Chief Operating Officer

9. Highlight variation and unacceptable practice: a revolution in transparency. We will reporting results at the level of local councils, CCGs, providers and consultant-led teams; ensure systematic development of clinical audit and patient-reported outcome and experience measures and consider how to make it easy for patients and carers to give timely feedback *Mandate paragraph 3.3*	
> We will ensure that all NHS funded patients will have the opportunity to leave feedback in real time on any service by 2015.	National Director: Patients and Information
> We will publish outcomes data for all major services by March 2015. Our starting point will be the ten surgical specialties set out in *Everyone Counts* which will be published in Summer 2013.	National Director: Patients and Information/ National Medical Director
> A modern data service, Care.data in physical and mental health services and social care will be established to ensure infrastructure is in place to support collection, storage, validation and presentation of care data: – 95% of trusts will be using the NHS number as the prime identifier in clinical correspondence by January 2015 – 75% of GP practices will be providing the full extract to care.data by September 2013 – 75% of hospital trusts will be providing patient level prescribing data to care.data by December 2015 > We will collect a core set of clinical data from GP practices for 2013/14 > Mental health trust providers will achieve 100% completion of the mental health minimum data set, and will publish regular information on key indicators (use of mental health act, physical health assessments and treatments as well as the results of peer accreditation and national audits with the early focus on safety in medicines and services for people with schizophrenia) in 2013/2014	National Director: Patients and Information

10. Ensure that service reconfigurations meet four tests i) strong public and patient engagement ii) appropriate availability of choice iii) clinical evidence base iv) clinical support *Mandate paragraph 3.4*	
> We will introduce service change and reconfiguration policy and guidance, which will be implemented from April 2013. This will ensure that the four tests are appropriately applied in all service reconfiguration. We will receive systematic assurance by: – Each CCG providing confirmation it has carried out a clinically-led quality impact assessment – Use of local metrics and intelligence such as views of patients and staff, and other more clinically based tools such as the NHS Safety Thermometer – A line of sight on the clinical assurances that there has been no clinically inappropriate reduction in the availability of local services	National Director: Policy
> We will identify with the Local Government Association opportunities for closer alignment and integration to inform service reconfiguration	National Director: Policy
> We will identify and publish evidence-based optimum clinical pathways to support local reconfigurations.	National Medical Director

11. Put mental health on a par with physical health, and close the gap between people with mental health problems and the population as a whole. Extend and ensure more open access to IAPT by March 2015, particularly for children and young people, and for those out of work *Mandate paragraph 3.5*	
> 'Everyone counts' sets out the requirements on CCG to ensure sufficient emphasis on care for those with mental health issues.	Chief Operating Officer
> We will oversee the roll out of Improved Access to Psychological Therapy (IAPT), towards the Mandate objective for improving timely access for at least 15% of adults, with a recovery rate of 50% by March 2015.	Chief Operating Officer
> From 2014-15, the Quality Premium paid to CCGs for delivery of improved outcomes will include Mental Health measures.	National Director: Commissioning Development
> We will measure improvement against indicator 1.5 and 1.7 in the Outcomes Framework - excess under 75 mortality for those with a serious mental illness, and excess under 60 mortality rate in adults with a learning disability (indicator under development). During 2013-14, we will develop improved measures relating to parity of esteem.	National Medical Director
> We will work with partners to develop better mental health informatics and new measures for mental health access and outcomes that aim to support reintegration of mental and physical wellbeing during 2013-14. These will be used by CCGs to understand and tackle variation locally.	National Medical Director

12. Ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care *Mandate paragraph 4.5*	
> We will ensure delivery of all of the actions set out in the Winterbourne View concordat in 2013-14.	National Director: Policy/Chief Operating Officer
> We will deliver all of the actions set out in the response to the Francis report.	All
> We will work to ensure that the views of vulnerable people, their families and carers are routinely used in the planning and delivery of services.	National Director: Patients and Information
> We will support CCGs to improve outcomes across the full range of the NHS Outcomes Framework and act proactively, with our support when appropriate, should they identify or anticipate a quality or safety issue in a provider. That includes wider system responses, such as acting on the Winterbourne View and Francis reports.	Chief Operating Officer

13. Pursue the long-term aim that NHS is recognised globally as having the highest standards of caring, particularly for older people and at the end of people's lives *Mandate paragraph 4.6*	
> The majority of indicators within the NHS Outcomes Framework relate directly or indirectly to older people. Our domain visions we will ensure that there is sufficient emphasis and focus on older populations.	National Medical Director
> Our objectives in relation improving diagnosis and care for dementia services set out above will also support this objective.	
> We will support a delivery framework and enablers that promotes person centred co-ordinated care which addresses physical and mental health comorbidity and frailty.	
> We will use the common purpose framework to continue pioneering greater integrated working between health and social care and physical and mental health.	
> We will begin implemetation of 70% of the actions set out in 'Compassion in Practice' by April 2014. (Chief Nursing Officer).	
> We will deliver Leadership Academy core programmes to 2,000 staff by March 2014. (National Director: Human Resources).	

14. Make rapid progress in measuring, understanding and acting on patient experience; including the introduction of the 'friends and family test' . Increase the proportion of people, across all areas of care, who rate their experience as excellent or very good *Mandate paragraph 4.8*	
> The Friends and Family Test will be introduced for 100% of acute hospital inpatients and Accident and Emergency patients from April 2013 and for women who have used maternity services from October 2013. Our aim is that 30% of trusts improve their scores by 2014/15.	National Director: Patients and Information
> We will use financial incentives to reward performance in relation to the Friends and Family Test. In 2013-14, a portion of CQUIN funding will be linked specifically to the Test.	National Director: Commissioning Development
> The Quality Premium will be paid to CCGs that in 2013-14 improve or achieve high standards of quality for four key measures in the NHS Outcomes Framework. One of these measures relates to Friends and Family Test.	National Director: Commissioning Development
> We will measure improvements against domain 4 indicators of the outcomes framework which relate to patient experience of NHS services. Our aim is to deliver measurable progress on each area by March 2015.	National Director: Patients and Information/ Chief Nursing Officer

15. Improve standards of care and experience for women and families during pregnancy and children's early years, including choice, named midwife and addressing post natal depression *Mandate paragraph 4.11*	
> The Friends and Family Test will be introduced for women who have used maternity services from October 2013. We will use this, and indicator 4.5 of the Outcomes Framework (improving women and their families experience of maternity services) to assess overall progress against this objective.	National Director: Patients and Information
> We will host the Strategic Clinical Network for children and maternity services. In 2013-14 we will work to ensure these networks are developing arrangements to support local health systems to improve choice and outcomes.	Chief Nursing Officer
> We will for the first time have a National Clinical Director for Maternity and Women's Health to lead on clinical service improvement, reducing variation and generating information for the public on maternity services.	National Medical Director

16. Ensure that children and young people with special educational needs or disabilities have access to services agreed in their care plan, and that parents of children who could benefit have the option of a personal budget *Mandate paragraph 4.13*	
> Our vision statement for Domain 2 will be published May 2013 will include how the system we will deliver improved outcomes and reduced inequalities for children and young adults with special education needs or disabilities.	National Medical Director
> Personalised budgets will be offered to children and young people who would benefit by March 2015	National Director: Patients and Information/ National Medical Director

17. Uphold the rights and commitments in the NHS Constitution, including maintaining high levels of performance in access to care. Consider new standards and improve access for mental health services *Mandate paragraph 4.14*	
> We will uphold the NHS Constitution in both our direct commissioning, and oversight of CCG functions. *Everyone Counts* sets out the expectations on CCGs for continued delivery of the NHS Constitution. NHS England, through its area teams, will oversee CCG delivery of the NHS Constitution rights and pledges on an on-going basis, providing additional support and intervention where required.	Chief Operating Officer
> We will fulfil our duty to promote the NHS Constitution and seek sustained improvement through a coordinated, system-wide approach. We are working with partners and stakeholders (to co-develop and implement a joint system-wide strategy for promoting and embedding the Constitution, including appropriate means of monitoring progress and impact. This strategy will be available by September.	National Director: Policy
> We will develop new measures for mental health access and outcomes that aim to reintegrate mental and physical wellbeing. These will be used by CCGs to understand and tackle variation locally.	National Medical Director

18. Continue to reduce incidents of avoidable harm and make measurable progress by 2015 to embed a culture of patient safety in the NHS including through improved reporting of incidents *Mandate paragraph 5.3*	
> The actions set out in the overarching objective relating to all five domains of the Outcomes all apply to this objective which focuses specifically on domain five (treating and caring for people in a safe environment and protect them from avoidable harm). In addition to this:	National Medical Director/Chief Nursing Officer
> Quality surveillance groups (QSG) will be operational in every region from April 2013. They will bring together local commissioners regulators and other bodies to provide multi agency surveillance and response to quality and safety issues in all areas of healthcare.	National Medical Director
> We are introducing a zero tolerance approach to MRSA infections. We expect all cases will involve a Post Infection Review to identify why an infection occurred, and how future cases can be avoided. Reducing the incidence of MRSA and *Clostridium difficile* infections will be one of the national measures used to calculate the Quality Premium for CCGs.	Chief Operating Officer
> CQUIN payment by commissioners when providers deliver a level of quality over and above that stipulated in the NHS Standard Contract. A portion of the CQUIN funding will be linked specifically to improvement against the NHS Safety Thermometer.	National Director: Commissioning Development
> All area teams will implement primary care quality assurance for all four contractor services	Chief Operating Officer

19. Strengthen the local autonomy of Clinical Commissioning Groups, Health and wellbeing boards, and local providers of services *Mandate paragraph 6.2*	
> *Everyone counts* set out the framework by which we expect local health systems to plan. Our aim is to provide the freedom and support for CCGs to develop their own priorities through their input into the joint Health and Wellbeing Strategy.	Chief Operating Officer
> We have asked each CCG to identify local priorities against which it will make progress during the year – these will form part of our assurance of each CCG and will be taken into account when determining if the CCG should be rewarded through the Quality Premium.	Chief Operating Officer
> We will support the development of Commissioning Support Units through ongoing robust assurance processes. A future development strategy will be published in November 2013, and CSUs will be externalised and viable by March 2016. We will measure progress through CCG feedback on CSU services.	National Director: Commissioning Development
> We will assess how we are doing against this objective through comprehensive 360 degree feedback from national and local partners and stakeholders. We will aim to deliver positive overall feedback on our development support and tools resources and guidance provided to CCGs.	National Director: Human Resources/ National Director: Commissioning Development

20. Support the NHS to become more responsive and innovative: embed rights to choice and support AQP rollout to commissioning services, support the creation of a fair playing field between providers, extend and improve the scope of pricing *Mandate paragraph 6.5*

> A Choice and Competition framework and supporting documents will be published by July 2013. This will set out guidance for how CCGs can use choice and competition as levers to improve standards of care. This include guidance in relation to the use of Any Qualified Provider contracts.

National Director: Policy/ Chief Financial Officer

> NHS England is working in partnership with Monitor to develop a long term strategy for NHS pricing. This will expand the scope of the pricing where feasible and consistent with improving outcomes.

21. Promote and support NHS and patient participation in research to improve outcomes and promote economic growth *Mandate paragraph 7.2*

> We will establish a new Industry Council to identify and work through issues of mutual interest to NHS England and the UK life sciences industry, where this will generate benefits for patients and taxpayers, and support economic growth in the UK.

National Medical Director

> We will establish Academic Health Science Networks from April 2013 to bring together expertise in research, education, information, dissemination and implementation methods, and innovation to translate research into practice.

> Our flexible procurement programme for genomics will be in place by March 2014. It will throughput sequence 100,000 genomes in UK in the next three years.

> We will develop an R&D strategy to set out the key areas of focus for our activities related to research.

> We will establish a system to involve all NHS commissioners of healthcare in setting national R&D priorities.

> We will establish mechanisms to increase participation in research both by NHS organisations, and NHS patients.

22. Make partnership a success; including progress on improving services for disabled children and adults, improving safeguarding, multi-agency family support, the Armed Forces Covenant, reducing violence, helping people experiencing mental or physical ill health return to or remain in work, healthcare services for offenders, championing Time to Change campaign *Mandate paragraph 7.3*	
> Partnership agreements have been established for seven key national partners. These will be enacted from April 2013. In addition, we will consider whether this approach would offer a sensible way forward for formalising our relationships with other strategic partners.	National Director: Policy
> We will work closely with partners on key quality and safety issues through Quality Surveillance Groups from April 2013.	National Medical Director
> We are facilitating joined up planning locally. *Everyone counts* set out the requirements on CCGs and area teams to work with local partners to develop Joint Health and Wellbeing Strategy.	Chief Operating Officer
> We will ensure that there is a capable system of safeguarding linked to quality assurance.	Chief Nursing Officer
> We will continue and we worked with PHE and the LGA to issue benchmarking support packs for each health and wellbeing area – setting out performance and variation against the NHS, adult social care and public health outcomes frameworks to inform joint strategies.	National Director: Policy
> We will conduct further exercises in each region to ensure incident response plans and reporting arrangements are alignment with key partner agencies, and implement findings.	Chief Operating Officer
> We will publish an updated NHS Pandemic Influenza Guidance in preparation for the cross government Pandemic Influenza Exercise	Chief Operating Officer
> We will carry out comprehensive 360 degree feedback from national and local partners and stakeholders to measure our success.	National Director: Human Resources

23. Ensure good financial management and improved value for money across the NHS, and deliver the commissioning systems share of QIPP ***Mandate paragraph 8.1***	
> Our oversight and leadership of the commissioning system will ensure robust planning and financial management. We will assure CCGs QIPP plans as part of the planning process, and monitor CCGs financial performance throughout the year. Our annual assessment of CCGs will include an assessment of financial performance. We will apply the same approach to direct commissioning activity.	Chief Financial Officer
> We will review NHS allocations methodology to ensure it is as fair as possible and consistent with our objectives. Interim findings will be published by July 2013, and a final report by July 2014.	Chief Financial Officer
> We will develop a range of tools and guidance to support CCGs deliver transformational change in relation to their QIPP objectives. The first tranche of six of these resources will be published by September 2013.	National Director: Commissioning Development
> We will use financial incentives to reward good financial performance. A CCG will not receive the Quality Premium reward if it has overspent its approved Resource Limit in 2013/14.	National Director: Commissioning Development

24. Ensuring measurement and publication of information for both NHS England's direct commissioning and CCG commissioning (outcomes and value for money) including inequalities and unjustified variation ***Mandate paragraph 9.3***	
> As stated above, we will publish outcomes data for all major services, both directly commissioned and CCG commissioned by March 2015. Our starting point will be the ten surgical specialties set out in 'Everyone counts' which will be published in Summer 2013	National Director: Patients and Information

Offer	Key activities and measures	Lead directorate
Offer 1: NHS will move towards routine services being available 7 days a week.	> National Medical Director will establish a forum to identify how there might be better access to routine services seven days a week. > Stage one will focus on improving diagnostics and urgent and emergency care > The forum will report in Autumn 2013.	National Medical Director
Offer 2: More transparency, more choice	> The Healthcare Quality Improvement Partnership (HQIP) will publish activity, clinical quality measures and survival rates from national clinical audits for every consultant practising in the following specialties: – Adult cardiac surgery – Interventional cardiology – Vascular surgery – Upper gastro-intestinal surgery – Colorectal surgery – Orthopaedic surgery – Bariatric surgery – Urological surgery – Head and neck surgery – Thyroid and endocrine surgery > This information will be published by summer 2013, and from 2014/15 providers will be required to publish this information as part of the Standard Contract.	National Director: Patients and Information/ National Medical Director

Offer 3: Listening to patients and increasing their participation	> All NHS funded patients will have the opportunity to leave feedback in real time on any service by 2015 > The Friends and Family Test will be introduced for all acute hospital inpatients and Accident and Emergency patients from April 2013 and for women who have used maternity services from October 2013. > CCGs will demonstrate what action they have taken as a consequence of feedback from the Friends and Family Test and work with providers on further roll-out from 2014-15 > We will guarantee every patient the opportunity of online access to their own primary care record by the spring of 2015 > We will consult by June 2013, on plans for provision of patient access to interoperable records across that pathway of care. > Paperless referrals in NHS by March 2015, so patients and carers can easily book appointments in primary and secondary care	National Director: Patients and Information
Offer 4: Better data, informed commissioning, driving improved outcomes	> A modern data service, Care.data in health and social care will be established to ensure infrastructure is in place to support collection, storage, validation and presentation of care data > We will collect a core set of clinical data from GP practices for 2013/14. > Through 2013/14 commissioners must use sanctions if not satisfied over the completeness and quality of a provider's data on the Secondary Uses Service.	National Director: Patients and Information
Offer 5: Higher standards, safer care	> The concordat agreement in response to Winterbourne View will be implemented in full. > Quality Surveillance Groups will be operational in all regions and areas from April 2013. > Findings from the review of the 14 high mortality hospital trusts will be published by June 2013. > We will deliver 70% of the actions set out in Compassion in Practice by April 2014.	National Director: Policy/ Chief Nursing Officer/National Medical Director