



The full document is [here](#)

“This revision to the NHS Operating Framework 2010/11 makes significant changes in-year, and signals substantial changes in future years as to how the NHS will function as it develops to drive up standards, support professional accountability, deliver better value for money and creates a healthier nation.

Increasingly NHS staff will be freed from central micro-management and become more accountable to the patients they serve.”

Revisions to the operating framework for 2010/11 – Main Points

Four key areas:

Revisions to Vital Signs and Existing Commitments; new rules on reconfiguration; future direction and next steps on transforming community services; finance and efficiencies; accelerating development of the payment by results system.

- Performance management of the 18 weeks waiting times target by the Department of Health will cease with immediate effect.
- Access to primary care will no longer be performance managed.
- The four-hour A&E standard will continue to apply during 2010/11. However, on clinical advice, the threshold will now change from 98 per cent to 95 per cent with median times in A&E to be performance managed.
- The Health Protection agency will publish weekly data on MRSA and *c-difficile*
- Ensure military veterans receive appropriate treatment. Here, ensuring a smooth transition for injured personnel into NHS care is important as well as providing priority treatment for conditions relating to their service.
Dementia; NHS organisations should be working with partners on implementing the National Dementia Strategy.
- Mixed-sex accommodation needs to be eliminated, except where it is clearly in the overall best interests of the patient.

- A moratorium is in place for future and ongoing reconfiguration proposals
.....and a new test:
 - # GP support
 - # Strengthened public and patient engagement
 - # Clarity on the clinical evidence base
 - # Consistency with current and prospective patient choice
- Separating PCT commissioning from the provision of services remains a priority.
This must be achieved by April 2011, even if this means transferring services to other organisations while sustainable medium-term arrangements are identified and secured. PCTs should therefore continue to develop and review proposals for the divestment of their directly-provided community services
- The £15-20 billion efficiency challenge up to 2014, which the NHS is planning to meet, remains absolutely critical for the future.
- The expectation is that most of the management cost reductions need to be realised in 2010/11 and 2011/12
- The payment mechanism (PbR) will be an increasingly vital means of supporting quality and efficiency; to achieve this, payments for performance must be structured around outcomes, be capable of aggregation along patient pathways, extend across service sectors, be benchmarked for quality and cost; and incentivise for quality.
DH working to develop contractual quality requirements, expanding the number of best practice tariffs where payment is linked to best practice care, and expanding the list of never events so that no payment is made for services which compromise patient safety.
- Hospitals are responsible for patients for the 30 days after discharge. If a patient is readmitted within that time, the hospital will not receive any further payment for the additional treatment.

■ “The overall ceiling for Management Costs in PCTs and SHAs will now be set at two thirds of the 2008/09 Management Costs (£1,509 million), the ceiling will therefore be £1,006 million.”

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