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The incentives framework for ACOs

Accountable Care Organisation (ACO) Contract package - supporting document

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The incentives framework for ACOs

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Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Introduction

1 The Accountable Care Organisation (ACO) Contract represents a new approach to contracting, including a wide scope of services for a population and a longer duration than a Standard NHS Contract. As such, it is appropriate that each contract incorporates an appropriate incentives framework, including a greater focus on long-term population and system outcomes that reflect the longer term aims of new care models.

2 As described in the explanatory notes to the Contract, we expect ACO Contracts to specify, at an appropriate level of detail, the care model to be delivered and a balance between a revised form of service specification and outcomes, agreed between commissioner and provider. This recognises that there remain a number of practical challenges associated with creating outcomes-based financial incentives. This includes difficulty in attributing changes in outcomes to provider interventions, difficulties in standardising for different populations in order to compare and reward performance and difficulties in how to stagger payments for outcomes which will be realised over multiple years. There will remain an important role for proximal process measures that indicate progress.

3 This document sets out the first steps of a journey from an incentive system based primarily on processes, to one which incorporates a greater degree of population and system-level outcome measures. It starts a dialogue about outcomes for an ACO and it recognises that different solutions could be appropriate for different areas. It sets out how performance based payments will function in the short term for ACOs and how this could evolve over time.

4 The indicator set is not intended to operate as an additional and separate performance framework, or at this stage to create new data flows. The national bodies are working to streamline provider oversight in a way that reflects that some areas of performance are primarily of interest to commissioners, some to regulators and some to both but that interactions with providers should be as co-ordinated as possible.

5 This framework reflects for completeness a number of measures in which regulators and commissioners have a joint interest. However, we have focused on distilling a list of the measures that commissioners procuring an ACO might choose to focus on, including a specific focus on longer term measures that reflect the aims of the new service models. As work progresses on the alignment and streamlining of oversight for both accountable care systems (ACSs) and ACOs, the approach set out here will evolve accordingly to maximise effectiveness and minimise burden.

6 In parallel, business intelligence systems across the NHS are growing in maturity and our capability to understand the efficacy of care provision for a given community will improve. Some areas are already taking huge steps forwards in this area. Over time, the sophistication of measures used to understand provider and system performance will increase, and this will also be reflected.

7 The selection of indicators provides a core framework, which will provide a degree of national consistency so areas benefit from opportunities to benchmark and compare achievement. However, there is flexibility for local areas to supplement additional indicators and thresholds, which are applicable for their own local circumstances.

8 Where areas are seeking to supplement the core metrics within this incentives framework, we would recommend that they are designed consistent with the following eight principles:

i) Aligned with system-wide objectives e.g. Five Year Forward View

ii) Consistent with structure of payment system and other financial flows

iii) Aligned with non-financial incentives e.g. professional regulation standards

iv) An evidence based understanding of what drives value in the local health system

v) Co-created with strong patient and clinician involvement, so that objectives are clearly visible and shared with the frontline

vi) Benefits of implementation out-weight the burden

vii) Based on a limited set of well-targeted indicators

viii) Clear process and timeline for evaluating impact and revising/ phasing out

The structure of the framework

9 The framework will provide commissioners with a view of the overall performance of the ACO and the contribution that the ACO is making to the wider health economy. It will provide commissioners, and the populations on whose behalf they commission care, with an overview of the performance and impact of the ACO. It should be made accessible to the public, in order to provide transparency to the population served.

10 The threefold purpose of the framework is to:

a) provide a consistent data set for ACO benchmarking purposes and evaluation of impact, enabling best practice to be identified, shared and adopted;

b) assist in improving the quality of out-of-hospital data sets, as it evolves; and

c) use payment to incentivise performance improvement across a small number of priority areas.

11 Through a combination of financial and non-financial incentivised indicators, the incentives framework for ACOs is being designed to signal and encourage change across a range of priority areas that meet the NHS ambition of closing the three gaps outlined in the Five Year Forward View – the health and wellbeing gap; the care and quality gap; the funding and efficiency gap.

12 This national framework cannot provide a comprehensive safeguard against any potential unintended consequences of contracting services under ACO Contracts. The commissioner, locally, will need to ensure that the Contract addresses local population needs, including those of marginalised and minority groups, and continue to liaise and co-ordinate with regulators to ensure that standards are met.

13 There are two components of the framework. The first component is a dashboard which will include the totality of indicators in the framework. It will be published and include benchmark information about provider performance on outcomes, although in the early years there may be a limited number of comparable providers holding these contracts. The benchmarking and public reporting is designed to act as an additional incentive for ACOs to deliver the underlying transformation needed.

14 The second component is the Improvement Payment Scheme (IPS). A subset of the Dashboard indicators will be linked to payment as part of the IPS. The IPS payment constitutes a portion of the contracted integrated budget value and is paid upon delivery against targets for agreed metrics. The purpose of the IPS is to use payment to incentivise performance improvement across a small number of priority areas and to help mitigate the risk that introduction of a population budget could result in access to and/or quality of care. Whilst the scheme will initially be aligned to the existing CQUIN scheme, the metrics are intended to evolve to become more sophisticated over time.

15 The service scope of the ACO models will vary. We are designing this framework so that commissioners can flex it according to the service scope of the ACO, for example opting in or out of parts of the framework related to mental health and social care. The applicable scope for each indicator can be seen in the tables in section 23.

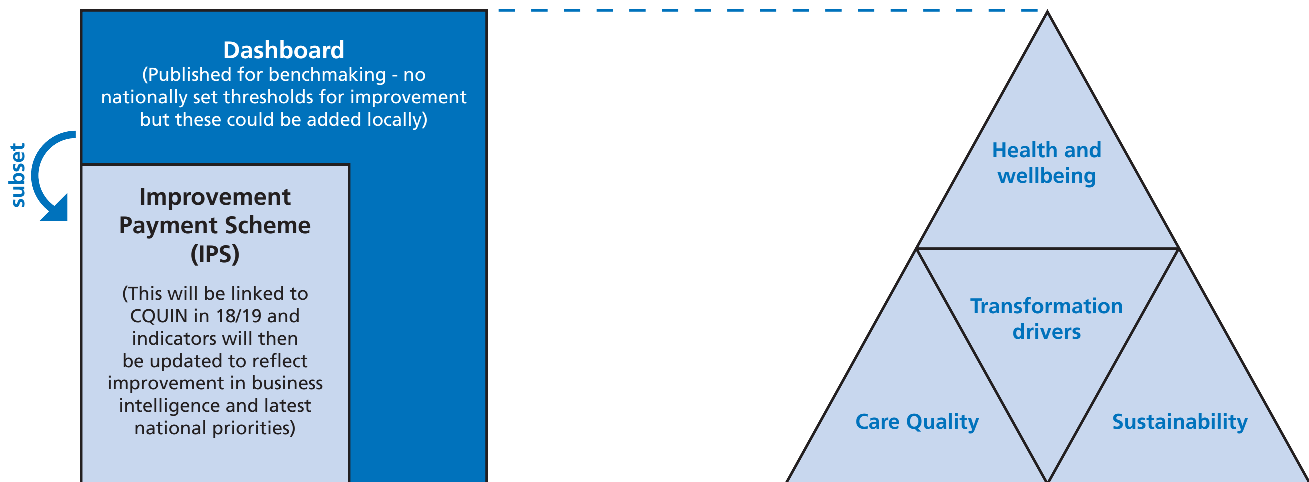
16 The quantum for the national element of the scheme will be designed to replicate the balance of financial risk and incentives that exist in the current national performance pay schemes. The implication of this is that the national IPS will be worth c. 2.5% of a partially-integrated ACOs contract value.

17 If the ACO is commissioned to deliver local authority services and thus the integrated budget includes local authority funding in a pooled budget, the minimum quantum of the IPS would be calculated in proportion to the NHS contribution to the integrated budget. The ACO would be free to spend the integrated budget and IPS payments it receives as it sees fit in order to meet the terms of the contract. This means the minimum level of system funding at risk through the IPS would not change, but that risk would be shared across the services for which the ACO was responsible. Initially, the indicators within the mandatory IPS would relate to health services only (as they reflect current commissioning for quality and innovation CQUIN), but our intention is to move to system-wide measures over time. Locally, commissioners may choose to increase the quantum of the integrated budget at risk through the IPS and, in doing so, may opt to add indicators that relate to other services.

18 We have divided this framework into four parts, which reflect the three gaps highlighted within the Five Year Forward View and Next Steps and the transformation needed to address these gaps.

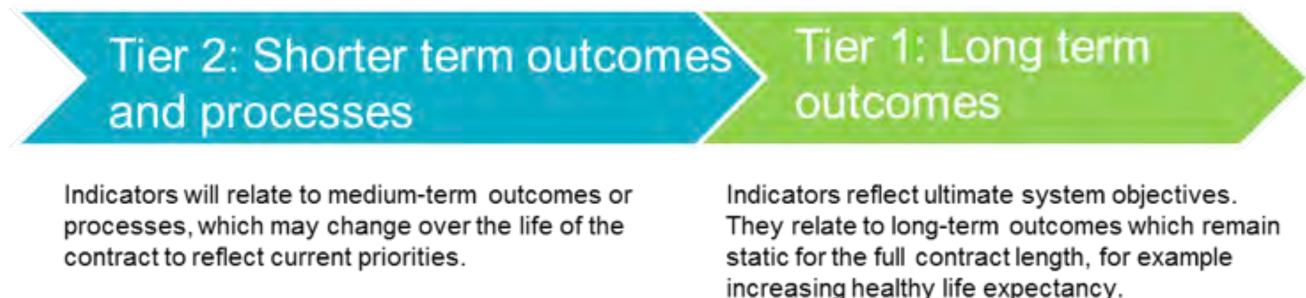
- **Health and Wellbeing:** Indicators linked to population health outcomes and lifestyle factors;
- **Care Quality and Experience:** Indicators linked to positive patient experience, safe and effective care;
- **Sustainability:** Indicators focusing on the impact of the ACO on financial and clinical sustainability of services (note that the incentives to improve sustainability are largely within the integrated budget and gain/loss mechanism; please see the finance and payment approach for ACOs for more detail); and
- **Transformation Drivers:** This category includes measures that will help to drive long-term improvements in the other outcome areas.

Figure 1: Framework Structure



19 A local ACO Contract may last up to 10 years. Over this time period we can expect that clinical best practice will change, new technologies will become available and the public's expectations will change. We are therefore taking a tiered approach to the selected indicators. Tier 1 indicators will relate to long-term outcomes which remain static for the full contract length, for example Potential Years of Life Lost. They signal a shared set of objectives for the system. Tier 2 indicators can be expected to change over shorter periods, and will be updated throughout the life of the contract. These updates should not be expected to change the average earnability of the scheme.

Figure 2: Indicators tiered approach



Indicators will relate to medium-term outcomes or processes, which may change over the life of the contract to reflect current priorities.

Indicators reflect ultimate system objectives. They relate to long-term outcomes which remain static for the full contract length, for example increasing healthy life expectancy.

20 Indicators for tier 1 have been selected by applying a systematic set of criteria to existing indicators, established through engagement with sites and experts. We are not proposing to initiate new data collections at this stage. The criteria applied are as follows:

- The indicator should be aligned with the Five Year Forward View priorities of Health and Wellbeing, Care Quality and Sustainability.
- The indicator should not be too narrowly focused and should fill a significant gap in the framework with minimal overlap with other indicators.
- The indicator should align with the MCP or PACS care model ethos and ambition.
- The provider should have the ability to influence the indicator within the life of the contract.
- The indicator should not generate any perverse incentives or risk 'gaming' e.g. be capable of being manipulated to influence the measured outcome without the intended improvement actions taking place.

21 All existing CQUIN indicators have been included in the IPS for 2018/19. These indicators will be updated for April 2019 and as business intelligence systems mature further the types of indicators will change to reflect the higher value information which can be extracted from these systems. Ultimately, we are aiming to select measures which provide insight into the value of the healthcare delivered by the ACO, taking account of patient outcomes and cost for individuals across the population.

22 The proposed dashboard indicators for a partially integrated ACO are shown below. In a partially-integrated ACO the practices remain on their core contract, and are therefore expected to remain on the Quality and Outcomes Framework (QOF). However, they will also be significant contributors to the overall performance of the ACO and their contribution may be formalised through local additions to the Integration Agreement. We are engaging on these proposed metrics, and welcome comments, as set out at the end of this document.

23 Proposed indicators fall into three types:

Tier 1 indicators:

These indicators reflect the shared long-term objectives of the system and will last the length of the Contract. National thresholds will not be set, but commissioners may choose to agree these, and any associated payment, locally.

Tier 2 indicators:

a) Associated with national payment: These indicators will reflect the current CQUIN scheme until April 2019 and will then be updated.

b) Associated with NHS Constitution standards: These indicators reflect some of the core performance standards for which the NHS is publicly accountable. These are of shared interest to commissioners and regulators.

We have also included example tier 2 indicators which we feel are pertinent to ACOs and that commissioners may wish to include as local additions.

Core = likely to be applicable with a minimum ACO service scope.

Health and Wellbeing

	Goal	Indicator	Source	Service scope
Tier 1				
H1.1	This indicator measures how successfully the ACO is supporting people with long-term conditions to live as normal a life as possible. This indicator helps people understand whether health-related quality of life is improving over time for the population with long-term conditions.	Health related quality of life for people with long term conditions.	GP Patient Survey from Ipsos MORI	Core
H1.2	This indicator seeks to capture how successfully the provider is supporting carers to live as normal a life as possible. This indicator helps people understand whether health-related quality of life for carers is improving over time.	Health-related quality of life for carers	CCG IAF 108a	Core
H1.3	This indicator captures gains in life expectancy at birth, which can be attributed to a number of factors, including rising living standards, improved lifestyle and better education, as well as greater access to quality health services.	Healthy life expectancy at birth	public health outcomes framework (PHOF) 0.1i	Core
H1.4	This indicator is a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation. It takes account of health inequalities across the whole range of deprivation.	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area	PHOF 0.2iii	Core

Health and Wellbeing

	Goal	Indicator	Source	Service scope
Tier 2				
H2.1	This indicator is a measure of whether the provider is effectively identifying and, where required, providing advice and offering referral to specialist services to patients displaying high use of alcohol and tobacco. Preventing ill health through smoking cessation and reductions in alcohol consumption can significantly reduce the burden on the NHS; premature mortality and morbidity; and will help to reduce health inequalities.	Preventing ill health by risky behaviours – alcohol and tobacco	CQUIN 9	Core
H2.2	This indicator aims to support NHS England's commitment to reduce the 15 to 20 year premature mortality in people with severe mental illness and improve their safety through improved assessment, treatment and communication between clinicians by measuring improvements in the identification and managing of physical risk factors for patients with severe mental illness.	Improving physical healthcare to reduce premature mortality in people with serious mental illness	CQUIN 3	MH, GP
Additional measures which could be applied locally				
H2.3	This is a measure of the number of respondents aged 16 and over, with valid responses to questions on physical activity, doing at least 150 "equivalent" minutes of activity each month as physical activity has a significant impact on overall health and well-being along with obesity rates.	Percentage of physically active and inactive adults – active adults	PHOF 2.13	Core

Health and Wellbeing				
	Goal	**Indicator**	**Source**	**Service scope**
Additional measures which could be applied locally				
H2.4	This is a measure of smoking during pregnancy, which can cause a range of serious health problems, including placental complications and perinatal mortality and an increased risk of miscarriage, stillbirth, low birth weight, premature birth.	Maternal smoking at delivery	CCG IAF 101a	Core
H2.5	This is a measure of the proportion of children aged 4-5 years classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile. Obesity is associated with increased risk of premature death.	Child excess weight in 4-5 and 10-11 year olds	PHOF 2.06	Core
H2.6	This is a measure of the percentage of working age people who have a long-term condition (includes learning disability and mental health) who are employed, compared to the percentage of all working age people employed. There is strong evidence of a link between employment and good health and wellbeing.	Employment of people with long-term conditions	PHOF 1.8	GP, Community, Mental Health
H2.7	This measure draws on self-reported levels of social contact as an indicator of social isolation for service users and carers. There is a clear link between loneliness and poor mental and physical health.	Proportion of people who use services, and their carers, who reported that they had as much social contact as they would like	adult social care outcomes framework (ASCOF) 1I (NHS Digital)	Social Care

Health and Wellbeing				
	Goal	**Indicator**	**Source**	**Service scope**
Additional measures which could be applied locally				
H2.8	This measure reflects experience of access to information and advice about social care. Information is a core universal service, and a key factor in early intervention and reducing dependency.	The proportion of people who useservices and carers who find it easy to find information about services	ASCOF 3D (NHS Digital)	Social Care
H2.9	This is a measure of how able patients are to access therapies for common mental health conditions, these can have a significant in improvements in physical health and also overall health and wellbeing.	Increase the proportion of people with a common mental health problem accessing improving access to psychological therapies (IAPT) treatment.	IAPT data set	Core

Care Quality

	Goal	Indicator	Source	Service scope
Tier 1				
C1.1	This indicator measures the proportion of people who feel supported to manage their long-term condition.	People with a long-term condition feeling supported to manage their condition(s)	CCG IAF 105d	Core
C1.2	This is a measure of premature deaths that should not occur in the presence of timely and effective healthcare.	Potential years of life lost (PYLL) from causes considered amenable to healthcare.	PHOF (4.4 to 4.7; 4.9 to 4.10 & 2.19)	Core
C1.3	This is a measure of the culture around safety reporting and how well the provider is able to learn from mistakes.	Fairness and effectiveness of procedures for reporting errors, near misses and incidents	NHS Staff Survey (KF30)	Core
Tier 2				
C2.1	This is a measure incorporating the timely identification and treatment for sepsis and a reduction of clinically inappropriate antibiotic prescription and consumption	Reducing the impact of serious infections	CQUIN 2	Acute
C2.2	This indicator measures the number of full wound assessments for wounds which have failed to heal after 4 weeks. Failure to complete a full assessment can contribute to ineffective treatment which therefore delays the rate of wound healing.	Improving the assessment of wounds	CQUIN 10	Comm, GP

Care Quality

	Goal	Indicator	Source	Service scope
Tier 2				
C2.3	This is a measure of people presenting at A&E with mental health needs, who could have these met more effectively through an improved, integrated service, reducing their future attendances at A&E	Improving services for people with mental health needs who present to A&E	CQUIN 4	Acute, Comm, MH
C2.4	There is strong evidence that good staff wellbeing is associated with delivery of high quality care. This indicator measures staff engagement through the staff survey results, food supplied on premises and improving flu vaccine uptake.	Improving staff health and wellbeing	CQUIN 1	Core
C2.5	The aim is to identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them. This measure is about developing effective systems to deliver personalised support.	Personalised care and support planning	CQUIN 11	Comm
C2.6	This measure is constructed so as to encourage greater collaboration between providers spanning the care pathway. The aim is to improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services	Transitions out of Children and Young People's Mental Health Services	CQUIN 5	MH, Comm
C2.7	NHS Constitution requirement, patients have the right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions.	Maximum 18 weeks from referral to treatment - incomplete standard	NHS Constitution	Acute

Care Quality

	Goal	Indicator	Source	Service scope
C2.8	NHS Constitution (waiting time pledges) Patients can expect to be treated at the right time and according to their clinical priority.	Maximum four hour waits in A&E departments Standard	NHS Constitution (Pledge)	Acute
C2.9	NHS Constitution (waiting time pledges) Patients can expect to be treated at the right time and according to their clinical priority.	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	NHS Constitution (Pledge)	Acute
Additional measures which could be applied locally				
C2.10	This is a measure of improvement in access to general practice, which is a fundamental component of new care models, as an enabler to a more preventative model of care.	GP extended access - % registered patients with full provision	General Practice Forward View Dashboard	Core
C2.11	This measure reflects whether the proportion of deaths in hospital is reducing. It is common for patients to prefer not to die in a hospital, but this is currently a frequent outcome.	Percentage of deaths which take place in hospital	CCG IAF 105c	Core
C2.12	This is a key measure of early years development across a wide range of developmental areas. Children from poorer backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life.	Children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) as a percentage of all eligible children	PHOF 1.02	Children's services

Care Quality

	Goal	Indicator	Source	Service scope
Additional measures which could be applied locally				
C2.13	Injuries are a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people. They are also a source of long-term health issues, including mental health problems related to experience(s) of injury. The inclusion of this indicator is key for cross-sectoral and partnership working to reduce injuries, including child safeguarding.	Hospital admissions caused by unintentional and deliberate injuries in children and young people under 25.	PHOF 2.07	Children's services

Sustainability

	Goal	Indicator	Source	Service scope
Tier 1				
S1.1	This indicator provides an indication of whether hospital bed usage following emergency admission is rising or falling, which will impact sustainability of services.	Population use of hospital beds following emergency admission	CCG IAF 127f	Core
S1.2	The measure provides an indication of whether there is successful co-ordination between hospitals, community and social care services in order to discharge patients.	Delayed transfers of care attributable to the NHS and Social Care per 100,000 population	CCG IAF 127e	Core
S1.3	This indicator provides a measure of acute activity that could be avoided through more effective management of ambulatory care sensitive conditions within the community.	Unplanned hospitalisation for chronic ambulatory care sensitive conditions	CCG IAF 128a	Core
Tier 2				
S2.1	This indicator is a measure of whether patients are enabled to get back to their usual place of residence in a timely and safe way.	Supporting proactive and safe discharge	CQUIN 8	Acute, community, adult social care
S2.2	This indicator is a measure of whether the GP has access to consultant advice prior to referring patients in to secondary care, in order to effectively target resources.	Offering Advice and Guidance	CQUIN 6	Acute, GP

Sustainability

	Goal	Indicator	Source	Service scope
Additional measures which could be applied locally				
S2.3	This indicator is a proxy measure for ensuring patients' prescription drug use is regularly reviewed and medicines are taken as intended, in turn ensuring overall efficiency of prescribing spend.	Number of Medicines Use Reviews (MURs) per 1,000 prescription items dispensed.	Medicines Optimisation Dashboard	GP
S2.4	Where care is provided in the most appropriate setting the proportion of outpatient attendances resulting from a referral from A&E departments should be minimised.	Proportion of first outpatient attendances from A&E	Hospital Episode Statistics (HES)	Core
S2.5	This is a measure of growth in outpatient attendances. Over the last few years outpatient usage has grown significantly and this has not represented the best experience for patients (who are passed around the system) or use of resources.	First outpatient attendances per registered patient, rolling 3 month growth rate relative to the same 3 month period in the previous year	General Practice Forward View Dashboard	Core

Transformation Drivers

	Goal	Indicator	Source	Service scope
Tier 1				
T1.1	This indicator is a measure of staff engagement, as how well staff are engaged will impact on whether the provider can make successful changes to care delivery models.	The proportion of staff receiving good communication between senior management and staff.	NHS Staff Survey (KF7)	Core
Additional measures which could be applied locally				
T2.1	To demonstrate whether the ACO is contributing to increasing the number of patients with a personal health budget, as this is a key objective of the 5YFV.	Number of personal health budgets in place per 100,000 CCG populations.	CCG IAF 105b	Mental Health, Community
T2.2	Designed to assess whether: a) The ACO understands the health needs of its population through population health segmentation, risk stratification/ case management /predictive modelling and wider actuarial analysis working in accordance with relevant information governance. b) Understanding the health needs of the population feeds into planning and tailoring services. c) There is a focus on preventative services based on predictive modelling of the population's disease burden.	Planning and tailoring services based on population needs	Local measure	Commissioners

Transformation Drivers				
	Goal	**Indicator**	**Source**	**Service scope**
Additional measures which could be applied locally				
T2.3	Designed to assess whether: the ACO is successfully meeting patients' ongoing care needs, particularly in the following areas: a) MDTs design and deliver shared care plans b) Team competencies are designed around the care needs of the group of patients sharing similar characteristics c) The MDT uses risk stratification tools and knowledge to registered patients to proactively identify those patients at greater risk of admission and complications	Multi-disciplinary teams for those with long term, life-limiting conditions	Local measure	GP, Community, Mental Health

24 In addition to the indicators listed, we propose that general practice is so fundamental to the ACO delivery model that an aggregate measure of QOF is considered. This would not draw out individual practice performance, but could highlight average achievement and the distribution of achievement across practices involved in the ACO. This would be updated with any future reforms to QOF.

25 The following indicators are examples of new indicator collections that we feel would be useful to develop for ACOs over time as performance approaches evolve:

- Patient experience for the integrated set of services across the ACO (Care Quality)
- A measure of relative spend on preventative services, which is under development as part of the Sustainable Development Unit Metrics (Sustainability)
- A measure of whether the ACO is providing high quality system leadership with partner organisations in the system (Transformation Drivers)

Wherever possible these measures will need to be collated at an ACO level, rather than for individual subcontracted providers, CCGs or Local Authorities. In time, as business intelligence capabilities mature we would expect the data to be available for the registered ACO population.

Alignment of payment to indicators

26 We have published a two year CQUIN scheme. Our intention is to align the IPS to the 2018/19 CQUIN package. By taking this approach now we do not introduce inequity in standards across ACOs and other NHS providers, nor create additional bureaucracy or dilute incentives in place for Trusts holding both standard and ACO Contracts. Over this period, we anticipate that most ACO providers which have been awarded a contract will be in the mobilisation phase; alignment to CQUIN rules and indicators which are already in the system will offer the ACO stability to deliver the IPS whilst also focusing on going live with the new service.

27 There are two parts to the CQUIN scheme. Assuming that all services are in scope of the ACO with the exception of ambulance and NHS 111 then the indicators that could apply to ACOs as well as the requirements relating to supporting local areas for 2018/19 are set out in figure 3.

Figure 3: CQUIN indicators for inclusion in the IPS

	Incentive	Proportion of contract value (%)
Part A CQUIN indicators potentially applicable to ACOs (commissioner to choose 6 most relevant indicators)	1. NHS Staff Health and Wellbeing	0.25
	2. Proactive and Safe Discharge	0.25
	3. Child and Young Person MH Transition	0.25
	4. Wound care	0.25
	5. Reducing the impact of serious infections	0.25
	6. Physical Health for people with Severe Mental Illness	0.25
	7. Improving services for people with mental health needs who present to A&E	0.25
	8. Preventing ill health by risky behaviours – alcohol and tobacco	0.25
	9. Offering Advice and Guidance	0.25
	10. Personalised Care Planning	0.25
Part B Supporting local areas	11. Engagement with STP	0.5
	12. Delivery of control total	0.5

28 The CQUIN indicators applicable to an ACO will be dependent upon service scope. In an instance where more than six indicators are applicable, the commissioner will need to choose those which are most relevant. The specifications for these indicators are set out in the CQUIN guidance. In relation to part B there is no opt out and ACOs will be expected to deliver this as per the CQUIN guidance.

Flexibility in the framework

29 Sites involved in the co-design of this framework have advised us that they would value flexibility to reflect local priorities and ambitions. There will be three mechanisms through which commissioners can flex the framework to meet their needs.

- Supplementing the dashboard measures: Commissioners could choose to add locally designed indicators to the Dashboard (these would be measured but not have payments assigned). These may include the examples listed in this document or different indicators, derived locally.
- Supplementing the IPS: Commissioners could, decide to increase the quantum assigned to the IPS by paying against additional indicators*.
- Service scope variations: ACO service scope may vary beyond the core elements. Indicators that do not apply to the service scope could be deselected locally by commissioners.

*Note: The additional financial risk borne by sites choosing to include local metrics and assign additional contract value to them will be assessed through the Integrated Support and Assurance Process (ISAP) run by NHS England and NHS Improvement. Commissioners will be expected, as part of their ISAP submission, to establish a clear narrative setting out how financial risk to the ACO is managed, for example through robust indicator design, cost-effectiveness considerations and thresholds set at levels that will be realistic for the ACO to deliver in the given time period. IPS indicators the ISAP panel believe inflate ACO financial risk beyond the level providers are able to bear could result in proposals being red-rated at the relevant ISAP checkpoint, with the details of the scheme recommended for review. Please refer to further guidance on the ISAP. (https://www.england.nhs.uk/wp-content/uploads/2012/03/isap-intro-guidance.pdf)

Conclusion:

30 This framework sets out a consistent structure for commissioners to use when procuring ACOs to deliver population care. It also describes how payment for performance will operate within these contracts.

31 We are committed to a joined up approach to oversight between commissioners and regulators and this framework will be updated over time to reflect that joined up approach.

32 Over time, as population analytics becomes more common place and business intelligence systems advance in their functionality, measures of system performance will equally become more sophisticated and this will be reflected in the framework for ACOs.

33 We are engaging on these proposals, and would welcome your response to the questions in our engagement survey, along with more general reflections. We will also work closely with the areas that are using the ACO Contract to further refine and develop this framework.

Please feedback by following our link to Citizen Space here. If you have questions please email england.newbusinessmodels@nhs.net.

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England
- Care Quality Commission
- Health Education England
- The National Institute for Health and Care Excellence
- NHS Improvement
- Public Health England

Our values: clinical engagement, patient involvement, local ownership, national support