Department of Health

Establishment of Health Premium Incentive Advisory Group (HPIAG)

Document Number : HPIAG 2013/14-02 (v12)
Revision : 12

Restricted

20 May 2013

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Contents

Section 1 - Background

1 *Healthy Lives, Healthy People: Update on public Health Funding*, published in June 2011[1] set out the Government's ambitious vision to help people live longer, healthier and more fulfilling lives, and to improve the health of the poorest, fastest.

2 From April 2013, there will be major changes to the public health system in England and local authorities will take the lead for improving health and coordinating local efforts to protect the public's health and wellbeing, and ensuring health services effectively promote the population's health. Local political leadership will be central to making this work.

3 The Public Health White Paper, *Healthy Lives, Healthy People*,[2] gave a commitment to Ensuring that local authorities are adequately funded for their future new public health responsibilities and that any additional net burdens will be funded in line with the Government's New Burdens Doctrine.

4 This document outlines,

- The health premium incentive scheme (the element of non-mandated expenditure that is dependent upon the local authority making progress against certain public health indicators),
- The approach to establishing a "Health Premium Incentive Group" (HPIAG),
- Proposed terms of reference, roles and responsibilities.

[1] http://data.parliament.uk/DepositedPapers/Files/DEP2012-0993/PQ112036-1.pdf
[2] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127424.pdf and http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129334.pdf

Section 2 - Health Premium Incentive (HPI)

5 Establishment of Health Premium Incentive scheme is in line with the Government's commitment in the *White Paper, Liberating the NHS*[3], page 5 to introduce "…. a new health premium to promote action to reduce health inequalities".

6 The consultation on the new commissioning arrangements demonstrated support for an incentive scheme. Responses highlighted,

a) Concern about the precise working of any scheme,

b) The risk of perverse incentives – an area which improved its health outcomes might find its core allocation reduced,

c) The problem of time lag before the impact of public health interventions appear,

d) The impact of population churn in some areas.

7 The Department of Health have reflected carefully on how best to introduce the health premium incentive. Recognising that the significant data lag on many of the indicators in the public health outcomes framework[4] would mean that if it was paid in 2013-14 we would be rewarding local authorities for decisions taken by PCTs. Therefore, it is planned to delay the first payments until 2015-16, the third year of local authority responsibility for public health responsibilities.

8 This delay will also give the Advisory Committee on Resource Allocation (ACRA) time to develop further the public health allocation formula to be driven by the underlying drivers of need for public health services. This will be important in avoiding the perverse incentive identified above. A local area that is rewarded under the health premium incentive risks seeing a penalty in the core allocation as its SMR<75[5] improves.

9 While much of the detail of the scheme will built on the recommendations of HPIAG, the update on public health funding[6] did however set out some of the key high level design features including:

a) the scheme will reward progress not the achievement of a target;

b) it will reward progress against indicators based on the elements of the PHOF; and

c) areas facing the greatest challenge will see the greatest rewards.

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[3] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf
[4] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358
[5] SMR<75 (Standardised mortality ratio) is an indicator of the health of the whole population4, and hence the need for public health. The SMR<75 is a measure of how many more or fewer deaths there are in a local area compared with the national average, having adjusted for the differences between the age profile of the local areas compared with the national average. It is available at the MSOA level. A higher SMR<75 number represents a higher relative number of deaths. SMR<75 is recommended by ACRA as an indicator of the whole population's need; it should not be interpreted that the formula does not reflect the needs of those aged over 75 years or that morbidity is unimportant.
[6] Ibid 4

Section 3 - Establishment of a Health Premium Incentive Advisory Group (HPIAG)

10 It is important to give local authorities as much certainty about the basis of the "Health Premium Incentive Scheme" as early as possible. The Department of Health is convening a group **(Health Premium Incentive Advisory Group (HPIAG))** to begin the task of assessing the indicators in the Public Health Outcomes Framework[7] for their suitability as an incentive measure. The group will make recommendations to ACRA on how incentives for progress should be set, ie what PHOF indicators should be used as the basis for an incentive and what formulae or other approach should drive the awarding of payments. This group will need to consider a range of factors, including,

a) The availability of data for local areas.

b) The possible lag between local authority action and the impact on the indicator.

c) Any local characteristics that would mean making progress is more challenging.

11 The Department of Health remains committed to a formula driven model to keep bureaucracy to a minimum and maximise transparency. To manage costs, this may need to be complemented by an overall cap on the total amount paid out under the incentive scheme, but again we would be clear before the payment year about how we expected this to operate.

12 Drawing on the advice and recommendations from ACRA, the final selection of indicators and decisions about the underlying formulae to drive payments will be made by the Secretary of State for Health. Some indicators will be chosen to apply to all local authorities in support of national strategies, HPIAG will also explore ways of allowing some local choice in the measures used, so that the incentive can reflect local strategies, provided bureaucratic overheads can be kept to a minimum.

[7] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

Section 4 - Proposed Terms of Reference for Health Premium Incentive Advisory Group (HPIAG)

13 Government's Ambition

The Government's ambitious vision is to help people live longer, healthier and more fulfilling lives, to improve the health of the poorest, fastest and improve public health through strengthening local actions.

14 Aim of HPIAG

The aim of HPIAG is to make recommendations to the Secretary of State around October / November 2013 for rollout in 2014/15 with payments in 2015/16, on what a robust formula driven "health incentives premium scheme" might look like.

15 Objective of HPIAG

The objective of the HPIAG will be to

a) Assess the indicators in Public Health Outcomes Framework for their suitability as an incentive measure.

b) Develop "indicator measuring criteria" for national strategies and local flexibilities.

c) Considering how to set incentives for progress.

16 Reporting Arrangements

a) The HPIAG will report to the Advisory Committee on Resource Allocation (ACRA). Refer annex 1 for arrangements.

b) The Chair of ACRA shall have a standing invitation to HPIAG meetings.

17 Membership

a) The Chair and Members of HPIAG shall be appointed by the Secretary of State.

b) The Department of Health and the Chair of HPIAG shall discuss and agree the balance of expertise required for the group. The group shall broadly consist of representatives from,

- Department of Health,
- Academia/Think Tank,
- Local Authority Finance,
- Data Expert,
- Patient representatives,
- Public Health England,
- NHS Commissioning Board,
- Marmot Report team member,
- British Medical Association (BMA),
- Faculty of Public Health

Refer annex 2 for details. The range of expertise may change over time.

c) Members shall be invited to join the HPIAG for a period of 12 months after which the Department of Health and the Chair will review the membership composition. The date of the membership will take effect from the first meeting.

d) Membership of the HPIAG is offered in a personal capacity to individual experts to ensure continuity. Substitutes during meetings will only be allowed at the discretion of the Chair. Members shall advise the Chair / Secretariat if they are not able to attend a meeting. The members are encouraged to submit written views / comments on agenda items.

e) The membership shall be regularly reviewed to ensure the balance of expertise is adequate to achieve the vision and aims of the group.

18 Time commitment

HPIAG is expected to meet around six times before the end of the year, potentially with some topic-specific subgroup meetings to make initial rapid progress. It is likely that face-to-face meetings will mainly be held in London and last for up to 4 hours, although it will be for the group itself to decide if, for instance, their discussions can be effectively conducted by a telephone or video conference. Members may wish to host some meetings at their own premises. Members will be expected to read papers and other material in advance to enable full participation. Some email communication will also be required.

19 Proceedings of meetings

a) Each member shall have the right to be fully heard as equal partners. There will be genuine dialogue.

b) On tough and difficult issues, members shall adopt a win / win frame of mind and fully exploit the synergy such a team brings.

c) Whilst achieving consensus should be the aim, HPIAG should not seek unanimity at the risk of failing to recognise different views or approaches on an issue. Once a position (or major/ minor positions) is established by the group, the members shall support that decision and recognise their responsibility not to undermine the authority of the group.

20 Quorum and Decision making

a) There shall be a minimum of 40% HPIAG members in attendance for the meeting to proceed.

b) For a voting, there shall be at least 50% HPIAG members in attendance.

c) If there is less than 50% attendance, the decision will be in abeyance until subsequently ratified though quorate meeting or by correspondence.

d) In the event of a tie, the Chair will have a casting vote.

e) Special attendees, guests and secretariat are not eligible to vote.

21 Communication and Transparency

a) The main communication route will be via agendas, minutes of meetings and supporting documents circulated in advance. These will be approved by the Chair, circulated to all members and copied to various key personnel at the Department of Health.

b) Intranet site (internal network accessible externally by a password) shall be set up showing agendas, minutes, background documents and other useful and supporting documents.

c) Regular updates, progress and minutes of the HPIAG meetings shall be published on the Department of Health's website. The minutes shall clearly show firm agreements and areas under discussion. Certain parts of the minutes may be withheld at the discretion of the Chair and the Department of Health as policy development or awaiting wider ministerial announcements.

d) In general, work in progress that has not been finalised shall not be published unless the HPIAG membership feels otherwise.

e) Arrangements shall be made to draw the attention of key stakeholders when new items have been published on the website and superseded documents shall be properly archived.

f) All external communications shall be carried out through existing Department of Health channels.

22 Confidentiality

a) Due to the sensitivity of this project, all HPIAG members shall agree not to discuss or share any documents external to the group, nor shall any work be replicated in any form. All correspondence will only be via the Department of Health, NHS Commissioning Board and the Chair of ACRA.

b) HPAIG will strive to strive to be as transparent and open as it can be by publishing documents on websites as and when HPIAG believes is appropriate.

23 Supplementary Working Groups

The Chair and the members may agree to form "Supplementary Working Groups (SWGs)" on an ad hoc, voluntary basis for specific issues. Summary terms of reference shall be agreed by HPIAG.

24 Performance Review

It is important to review the relative effectiveness of HPIAG as a team and the contribution of each stakeholder and identify any performance and progress gaps on a regular basis in light of these terms and conditions. Reviews will be undertaken by DH and the HPIAG Chair. The review may include but not limited to,

- Stakeholder feedback
- Commissioner feedback
- Subcommittee feedback
- Individual feedback

The findings of this review shall be shared with the members.

25 Remuneration of Expenses

HPIAG members will be eligible to claim the cost of travel and subsistence expenses in line with the Department of Health's policy. Members are entitled to fair and prompt repayment provided they follow the rules governing the submission of claims and their timing.

26 Declaration of Interest

Chair and members shall declare any interests[8] that are relevant to the overall work of HPIAG and the specific agenda item under discussion. Secretariat shall review and maintain such declarations and publishing details as part of routine progress update. Members shall withdraw from discussion of matters in which they feel that they cannot act impartially. Where this occurs, it shall be reflected in the official record of the meeting.

27 Liabilities and Indemnities of Members

a) Legal proceedings by a third party against individual members of advisory groups are very exceptional. An advisory group member may be personally liable if he or she makes a fraudulent or negligent statement which results in a loss to a third party; or may commit a breach of confidence under common law or criminal offence under insider dealing legislation, if he or she misuses information gained through their position.

b) If legal proceedings are brought against any HPIAG member by a third party, the Department of Health will meet any personal civil liability that is incurred in the execution of their functions, unless they acted recklessly and provided that they have acted honestly, in good faith and without negligence.[9]

28 Early Identification of Issues and Risks

In order to ensure successful completion of this work, HPIAG shall keep under review current and potential future threats and opportunities, internal and external risks together with mitigation strategies. An up-to-date register of issues and risks shall be maintained by the Secretariat.

[8] http://www.civilservice.gov.uk/about/resources/public-appointments
[9] http://www.civilservice.gov.uk/wp-content/uploads/2011/09/public_appt_guide-pdf_tcm6-3392.pdf Para 11.6

Section 5 – Health Premium Incentive Advisory Group (HPIAG) Roles and Responsibilities

29 Probity and Accountability

a) HPIAG members shall be appointed for their specialist expertise and the contribution they will make to the vision and aim of HPIAG.
b) HPIAG members may be subject to "Freedom of Information" legislation[10] and therefore under a statutory requirement to disclose certain information on request and to abide by commitments set out in a Department of Health's Freedom of Information Publication Scheme[11]. Those that are not subject to Freedom of Information legislation are expected to abide by the spirit of Freedom of Information legislation[12].
c) HPIAG members shall abide by the Data Protection Act 1998[13]. Data protection legislation is based around eight common sense principles Refer annex 3.

30 HPIAG Role and Remit

The Role of HPIAG is to make recommendations through ACRA to the Secretary of State. The terms of reference have been developed by the Department of Health, agreed by the Chair and the HPIAG membership. They shall ensure these terms of reference are adhered to. Any clarification of the role of HPIAG must take place prior to commencing work.

31 Responsibilities of the Chair

a) The Chair shall be responsible for,

i. Report back to ACRA

ii. Effectively chairing meetings

iii. Ensuring HPIAG is effective

iv. Operation and output of HPIAG.

v. Ensuring every member has a fair opportunity to be heard and that no views are ignored or overlooked.

vi. Allowing genuine dialogue to take place and diversity fully explored and discussed.

vii. Endeavour to achieve a consensus of opinion.

viii. Ensure the secretariat accurately documents the proceedings and there is clear audit trail showing how decisions were made.

[10] http://www.ico.gov.uk/for_organisations/freedom_of_information.aspx
[11] http://transparency.dh.gov.uk/2012/07/20/freedom-of-information-publication-scheme/
[12] http://resources.civilservice.gov.uk/wp-content/uploads/2011/09/annex_i-pdf_tcm6-3389.pdf
[13] http://www.ico.gov.uk/for_organisations/data_protection.aspx

ix. Ensure there is a right balance of skills to fulfil the aims of HPIAG.

x. Ensure voting is carried out fairly, should it be necessary to vote on an issue.

xi. Ensure all members have a good grasp of the underlying subject matter expertise and if necessary arrange training to enable them to fulfil their roles and ensure records are kept of member's performance as necessary.

xii. Ensure good knowledge management principles are adhered to.

32 Member's Roles and Responsibilities

a) Members will be expected to abide by the "Seven Principles of Public Life" (sometimes referred to as the Nolan Principles (refer annex 4)[14].

b) Members of HPIAG shall ensure they understand why they have been appointed and in what capacity, and the role they are expected to play on the group. Members shall understand the nature of any expertise that they are asked to contribute. Members with a particular expertise have a responsibility to make the group aware of the full range of opinion within the discipline.

c) Members shall confirm before accepting an invitation to serve on a HPIAG that they are clear about the period of appointment and that they can fulfil the commitment required in terms of continuity, meeting attendance, group's business and preparation for meetings.

d) A member's role on the HPIAG shall not be constrained by the expertise or perspective they were asked to bring to that group. Members shall regard themselves as free to question and comment on the information provided or the views expressed by any of the other members, notwithstanding that the views or information do not relate to their own area of expertise. If members believe, the group's method of working is not rigorous or thorough enough they shall raise this initially with the Chair and subsequently the Senior Responsible Officer at the Department of Health. They have the right to ask that any remaining concerns be put on the record.

e) Members joining HPIAG for the first time shall undergo an induction process. This shall cover the following issues,

i. Explanation of the group's vision and aim.

ii. The role of the group.

iii. Basis of decision-making.

iv. The groups work plan.

v. The role of the secretariat and other officials.

vi. Roles and responsibilities of members.

vii. Conflicts of interest.

[14] http://www.public-standards.org.uk/

viii. The commitment required for meeting attendance, group business and preparation for meetings.

ix. Confidentiality of proceedings and papers.

x. How members shall deal with media enquiries.

xi. Disclosure of members' personal details to the public, bearing in mind personal security and other considerations.

xii. The rules governing declarations of outside interests, potential conflicts of interest, and gifts and hospitality.

xiii. How conflicts of opinion are resolved.

xiv. Terms of appointment of the Chair and members,

xv. Remuneration of expenses, and

xvi. Personal liability.

33 Role of the Secretariat

The secretariat shall,

i. Support the HPIAG members by assembling and analysing information and recording conclusions of meetings.

ii. Advise members on relevant process and procedure.

iii. Bring to the attention of the HPIAG Chair and members emerging issues of concern to the Department of health so as to inform the group's deliberations.

iv. Arrange regular briefing meetings with the Chair.

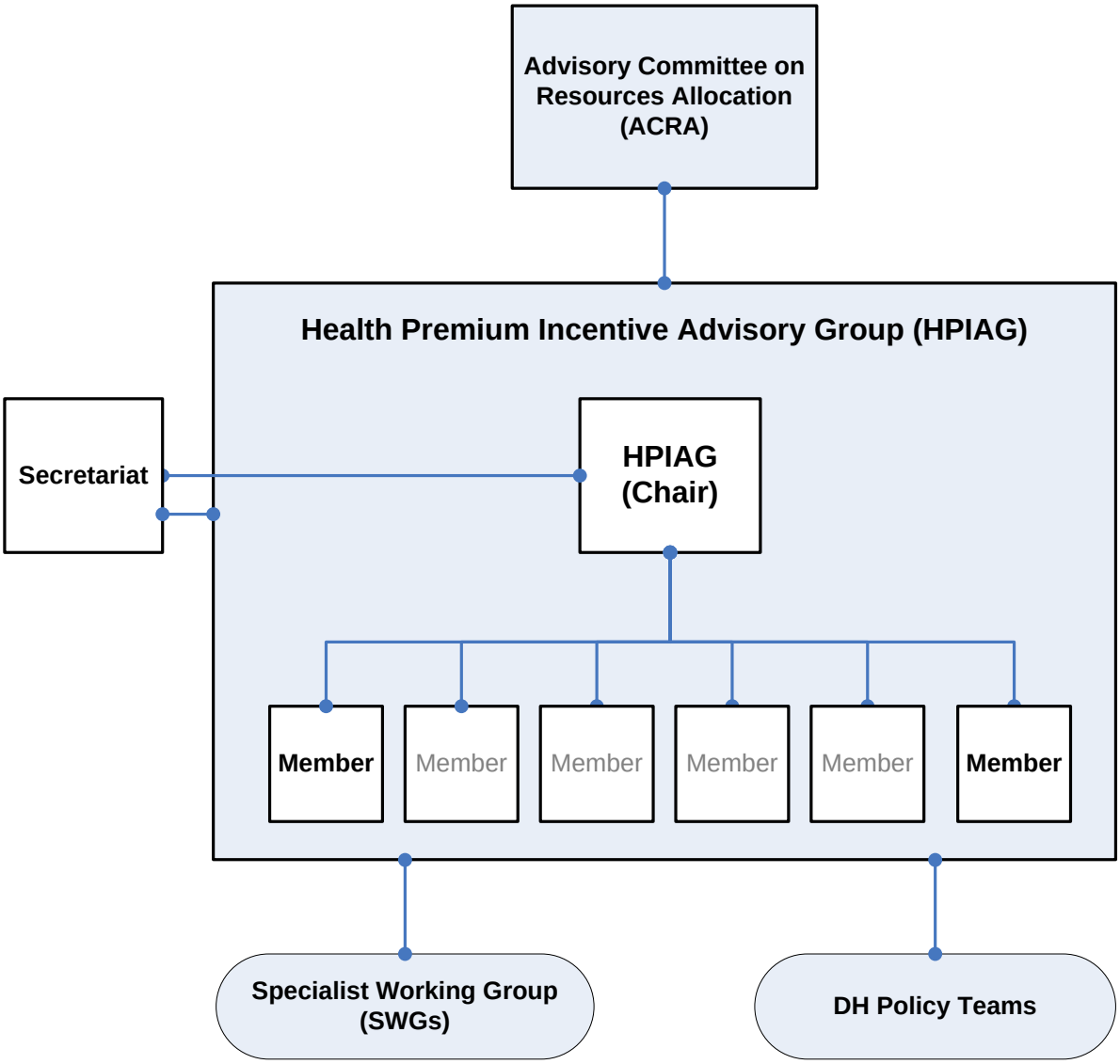
v. Be an impartial facilitator and guard against introducing bias during the preparation of papers, during meetings, or in the reporting of the group's deliberations.

vi. Ensure that the proceedings of the HPIAG meetings are documented in sufficient detail and within a reasonable period after a meeting so that there is a clear audit trail showing how the group reached its decisions.

vii. Project manage the work to ensure success completion (Refer Annex 5 for major milestones).

viii. Maintain an updated register of Issues and risks.

Annex 1- reporting arrangements



Annex 2 – Proposed Membership of HPIAG

	First Name	Role and Organisation
1	Janet Atherton (Chair)	President at ADPH and DPH at Sefton Council
2	Stephen Lorrimer	DH / NHS England Director / *SRO of Health Premium Incentive scheme*
3	Tim Baxter	DH Deputy Director Public Health Policy and Strategy / *SRO of Health Premium Incentive scheme*
4	Michael Chaplin	DH / NHS England – Economic Advisor
5	Mohammed Pandor	DH/ Public Health Policy and Strategy (Section Head)
6	Barbara Kyei	DH/ Public Health Policy and Strategy (Policy Manager)
7	Alyson Morley	Senior Adviser (Transforming Health) Local Government Association
8	Ben Barr	NIHR Research Fellow (Academic)
9	Chris Bentley	Public Health Consultant (ADPH)
10	Dave Roberts	Head of Primary Care Strategy- Health and Social Care Information Centre
11	David Buck	Senior Fellow, Public Health and Inequalities (Academic)
12	Dr Ann Marie Connolly	Director of Health Equity and Impact Public Health England
13	Kate Davies	NHS England Head of Public Health
14	Ian Gray	Principle Policy Officer Chartered Institute of Environmental Health
15	Justine Fitzpatrick	Assistant Director – Knowledge & Intelligence
16	Matthew Sutton	Health Economics (Academic)
17	Mike Robinson	Director of Public Health
18	Dr Paul Edmondson-Jones	Director of Public Health & Well-being
19	Paul Lincoln	Chief Executive UK Heath Forum
20	Peter Goldblatt	Deputy Director-Marmot Report Team & UCI Institute of Health Equity
21	Rob Poole	Head of Finance and Resources (Financial Planning)Council Services
22	Steve Watkins	British Medical Association & Director of Public Health

Annex 3 – Data Protection

Data protection principles require that personal information is:

1) Processed fairly and lawfully.

2) Processed for one or more specified and lawful purposes, and not further processed in any way that is incompatible with the original purpose.

3) Adequate, relevant and not excessive.

4) Accurate and, where necessary, kept up to date.

5) Data shall not be kept longer than necessary.

6) Processed in line with the rights of individuals.

7) Kept secure with appropriate technical and organisational measures taken to protect the information.

8) Not transferred outside the European Economic Area, unless there is adequate protection for the personal information being transferred.

Annex 4 - "Seven Principles of Public Life" (sometimes referred to as the Nolan Principles)

1) **Selflessness**
Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

2) **Integrity**
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

3) **Objectivity**
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

4) **Accountability**
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

5) **Openness**
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

6) **Honesty**
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

7) **Leadership**
Holders of public office should promote and support these principles by leadership and example.

Annex 5 – Major Milestones

Plan showing major milestones for HPIAG work