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Health Premium Incentive Scheme 2014/15

Response to Technical Consultation

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Consultation responses to the Health Premium Incentive Scheme consultation exercise and resulting changes to the 2014/15 pilot scheme.

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Local authorities:

- Directors of Public Health
- Directors of Finance
- Chief Executives

Contact details:

Healthpremiumincentivescheme@dh.gsi.gov.uk

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Health Premium Incentive Scheme 2014/15

Response to Technical Consultation

Prepared by
Head of Public Health Policy and Strategy Unit
Public and International Health Directorate
Department of Health
Quarry House,
Leeds
LS2 7UE

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Introduction

1. In September 2014, the Department of Health (DH) and Public Health England (PHE) carried out a technical consultation on the introduction of the Health Premium Incentive Scheme (HPIS) developed by ACRA [1]. The scheme incentivises local authorities to take action to improve the health of their population and reduce health inequalities. It is based on selected Public Health Outcomes Framework (PHOF) indicators. This report summarises the feedback from the consultation.

2. The consultation was mainly aimed at local authority commissioners, directors of finance, directors of public health and local representative bodies such as Health and Wellbeing Boards. We sought the views on the high-level design of the scheme as recommended by ACRA and other area outside its remit.

3. The Department is running a pilot scheme during 2014/15 to ensure the learning feeds into any future scheme, subject to ministerial decision.

4. The main feature of the HPIS is to reward LAs for health improvement rather than attainment of a target against a number of indicators. The scheme has been designed to be transparent, formula driven to minimise bureaucracy and non-burdensome. The main recommendations of the high level design of the HPIS is as summarised below:

    - Fifty-one Public Health Outcomes Framework indicators (including sub-indicators) were deemed suitable for use as part of the incentive scheme, based on a set of criteria;
    - Notwithstanding technical difficulties with measuring progress on smoking, alcohol and substance misuse, any credible scheme should include indicators relating to these areas;
    - Alongside nationally set indicators, local authorities should have the flexibility to select a small number of indicators from those meeting the criteria, different to that selected nationally;
    - Local authorities should have further local flexibility to select locally relevant indicators, provided they could demonstrate they were suitably robust;

[1] Advisory Committee on Resource Allocation, an independent expert committee comprising Directors of Public Health, GPs, academics and NHS managers. It is also supported by the Health Premium Incentive Advisory Group (HPIAG) and a Technical Advisory Group (TAG).

- Progress would be considered to have been made if a threshold is met. Ideally this would be set at a statistically significant level, but this might not always be possible;
- Local authorities should seek to incentivise the reduction in health inequalities;
- Indicators chosen should cover the four PHOF domains; and
- Benefits criteria and an evaluation methodology to be developed in conjunction with key stakeholders.

5. During 2014/15, the pilot scheme will be measured against two indicators, one national indicator (successful completion of drug treatment) and one locally selected indicator. Responses from the technical consultation exercise have informed the pilot scheme and it will shape the overall scheme going forward subject to ministerial decision.

6. We would like to take this opportunity to say **thank you** to all those who took the time to respond to this consultation exercise. A total of 69 responses were received of which 61 were from Upper Tier Local Authorities out of 152 and 8 were from health system leaders and the voluntary sector.

7. The responses to the six questions showed a high level of agreement on the design of the scheme. The only significant deviation was that responders wanted “NHS Health Checks” as the local default indicator rather than the “smoking” indicator. We have taken this on board and the scheme has been amended accordingly.

Consultation

8. During the consultation we asked six questions as follows:

1. Do you agree that successful completion of drug treatment should be used as the pilot national incentive measure? If you have answered no, please explain why

2. What threshold should we adopt for demonstrating progress, balancing statistical significance with robustness for successful completion of drug treatment?

3. Which PHOF measure from the approved list, would you be likely to select for a local measure of attainment when the scheme is formally launched, or would you accept the default adult smoking prevalence?

4. Do you agree that smoking prevalence adults over 18s' should be used as the default indicator where no choice has been made from the list of approved indicators?

5. For future years, LAs will have additional flexibilities to develop their own local indicator. Would you have developed your own local indicator and progress measure this year, had this flexibility been available?

6. Do you agree that we should adopt an approach based on point shares from a fixed pot, maximising the amount we can pay for progress, even though this means a lack of certainty on exactly how much the incentive for progress will be for each local authority?

Responses

9. The following responses were received. Further details of the responses can be found at Annex A.

Question 1: National indicator

Do you agree that successful completion of drug treatment should be used as the pilot national incentive measure? If you have answered no, please explain why Style using the style sheets provided.

10. From those who responded, 62% agreed to the national indicator "successful completion of drug treatment with combined data for opiate and non-opiate users". However, there were concerns about the robustness of the data and the population coverage, refer to annex A table 2 for further details. ACRA recognised this early at the design stage, they increased the data numbers by combining opiate and non-opiate users in the measure to reduce some of the data issues as well as assuring a monitoring process to ensure access to services does not deteriorate.

11. The national measure was chosen as it provides a litmus test to local authority's capacity to improve the chances of the recovery for some of the most vulnerable in our society; the outcomes will impact on a number of other PHOF indicators. The measure reinforces and supports the new addition to the grant conditions that requires LAs to have regards for the need to improve the take up of and the outcomes from the drug and alcohol misuse treatment services.

Question 2: Payment threshold

What threshold should we adopt for demonstrating progress, balancing statistical significance with robustness for successful completion of drug treatment?

12. A threshold will be set for all the indicators included in the pilot scheme to ensure that an improvement has been made before payment is awarded. For the Drugs indicator it is two percentage points above the first interquartile range for all the LAs. Threshold for improvement will be calculated for the local indicators chosen by LAs.

13. We received a number of responses "for" and "against" the thresholds proposed for the national and default local indicators, refer annex A table 3 for further details. Only five LAs did not support the proposed threshold. A number of LAs also commented on the variation in LAs and the risk in awarding LAs who had met their threshold by chance and issues relating to LAs who have already achieved major improvements against the national indicator and therefore plateaued. We will ensure that the threshold calculation methodology is consistent and statistically robust across all locally chosen indicators.

Question 3: Local indicator

Which PHOF measure from the approved list, would you be likely to select for a local measure of attainment when the scheme is formally launched, or would you accept the default adult smoking prevalence?

14. Feedback shows that majority of LAs will choose their own local indicator, annex A table 4 shows the range of indicators selected by LAs as their preferred indicator. The NHS Health Checks is the most preferred local default indicator for the pilot scheme. Three indicators stood out from the responses, these are:

    - 44% of respondents preferred NHS Health Checks;
    - 11% selected under 18 conception rate per 1,000 population and
    - 8% percentage of 16-18 year olds not in education, employment or training (NEET).

    As a result of the feedback received we will use "Cumulative % of the eligible population aged 40-74 who received an NHS Health Check" as the default local indicator, in line with the refined indicator for NHS Health Checks in the Public Health Outcomes Framework.

15. Although DH and PHE would prefer LAs to select their local indicator based on JSNA and other local priorities to ensure local plans are linked to the HPIS for maximum benefits, failing to select a local indicator will mean that LAs will be measured against the default local indicator selected for the pilot scheme, the "NHS Health Checks". In future years, subject to ministerial decisions there may be other indicators to ensure all the PHOF domains are included in the scheme.

Question 4: Smoking indicator

Do you agree that smoking prevalence adults over 18s' should be used as the default indicator where no choice has been made from the list of approved indicators?

16. Majority of respondents (73%) did not support the default indicator "smoking prevalence for aged 18 and over". Numerous issues were raised around the data measure and its robustness, see summaries in the annex A table 5 below for further details. As a result of your feedback, we have changed the local default indicator to NHS Health Check. We would hope that LAs will actively select a local indicator of their choice. NHS Health Check will be allocated to LAs that do not submit their local measure for the scheme.

Question 5: Future flexibilities

For future years, LAs will have additional flexibilities to develop their own local indicator. Would you have developed your own local indicator and progress measure this year, had this flexibility been available?

17. One of the ACRA recommendations was to offer additional flexibilities for LAs to develop their own indicators. Subject to ministerial decision, this could be offered in the future. This was broadly accepted by LAs with mixed responses on developing new indicators or using the selected PHOF indicators, refer annex A table 6. LAs were particularly concerned about the time and resources required in developing a local indicator and if the incentive was large enough to cover the cost. Rather than developing a new indicator from scratch that could stretch resources, we would encourage LAs to focus on health inequalities or to adapt the PHOF indicators to produce a local indicator that supports local plans with maximum benefit. All locally developed indicators would be tested for robustness and measurability against the technical selection criteria developed for the HPIS indicators.

18. A key design feature of the HPIS is that it is a payment for progress. It does not reward the meeting of an arbitrary target. There is no need for local authorities to submit any additional data. Data submitted for the Public Health Outcomes Framework will be analysed by Public Health England for payment.

Question 6: Sharing the incentive pot

Do you agree that we should adopt an approach based on point shares from a fixed pot, maximising the amount we can pay for progress, even though this means a lack of certainty on exactly how much the incentive for progress will be for each local authority?

19. Respondents indicated a desire to understand the share of the incentive pot their local authority would be likely to receive, refer annex A table 7. As the payment is from a fixed pot and is dependent on the number of local authorities showing improvement against one or both of the indicators and the target allocation for each LA, it is difficult to estimate the likely payment for local authorities.

20. Respondents also raised the issue of payment being made late in the financial year and the risk around underspend. We recognise this is an issue, however we would need to have received and analysed data returns for all the indicators including the locally chosen ones to enable us to calculate the proportion of the fixed pot for awarding 2014/15 improvements by LA. With the data lag of some of the indicators, it is likely that payment will be made towards the end of the 2015/16 financial year.

21. The HPIS payments will be subject to the same conditions as the ring fenced public health grant. If funds paid to LAs are not spent at the end of the financial year they can be carried forward into the next financial year. Funds carried forward should be accounted for in a public health reserve.

Future design of the health premium incentive scheme

22. The future of the HPIS will depend on ministerial decisions. Evaluation of the pilot will thoroughly examine the lessons learnt and this will be incorporated in future schemes.

23. This consultation has shown that:

- There needs to be a combination of national and local indicators based on the PHOF.
- The national indicator(s) will be chosen by ministers and local indicators selected by LAs. A default indicator will be set where LAs do not select their own.
- LAs have shown a strong preference for flexibility to develop their own local indicator within the set criteria developed by ACRA or to adopt the PHOF indicator to local needs.
- All indicators need a threshold for payment based on robust and transparent methodology for rewarding improvements achieved.
- A point shared from the fixed pot will be adopted for rewarding LAs for improvement achieved in proportion to their public health target allocation.
- The scheme should run from April to March, within the financial year with payments made in the following financial year. The exact timing of payment will be determined by data availability.
- Public Health England will lead on delivering the scheme with support from DH.
- PHOF indicators will be continually assessed to ensure that as PHOF data and definition improves these indicators are added to the scheme.

Annex A: Details of responses

Table 1 - Summary of results

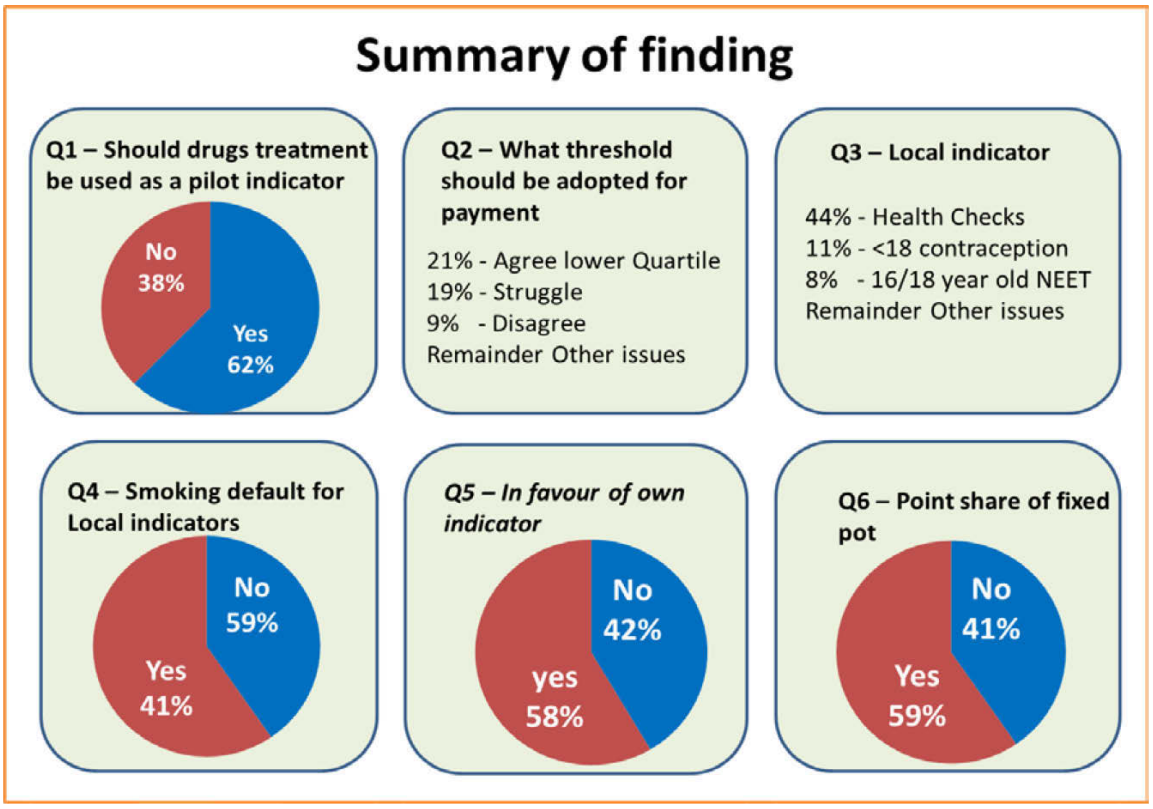
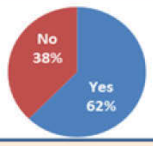


Table 2 - Responses to Question 1

1 Do you agree that successful completion of drug treatment should be used as the pilot national incentive measure? If you have answered no, please explain why



Responses	Yes	No
	38	23

	Comments	Freq Yes	Freq No
25 Measure - Data robustness / population coverage	Small numbers, population coverage	4	7
	Combine opiate and non opiate to overcome small numbers or alcohol users / To link to other outcomes like employment / training / education / housing	1	2
	Useful measure but not priority for LA/ aligned to national PH priorities	2	2
	Robustness of the measure	1	2
	Drug use has decline, eg class A drugs, alcohol, obesity remains high	0	1
	Time lag in data. Rewarding on historical data	0	1
	Annual fluctuation in data values are enormous	0	2
		8	**17**
9 Threshold measure	Penalising highly performing LA as they may already be above the national average	1	2
	How much money per indicator for each LA	1	
	Achievement of the measure is not solely for LAs		2
	Time lag in data. Rewarding on historical data		1
	Risk of manipulating data to increase performance		1
	Concerns on methodology	1	0
		3	**6**
4 Inequalities / complexity to be considered in payment measure	Recognition of the length and time in treatment and wider health issues	1	0
	Good proxy for measuring health inequalities	1	0
	Not useful in reducing or tackling health inequalities/or whole population health improvement	0	3
		1	**3**

Table 3 - Responses to Question 2

2 What threshold should we adopt for demonstrating progress, balancing statistical significance with robustness for successful completion of drug treatment?

Responses	Total response	comments
	53	All respondents

We proposed :

2.0% pts – lower quartile

2.5% pts – median quartile

3.2 % pts – upper quartile

Comments	Freq
Support the suggested thresholds	11
Percentage points challenging - variability in LA means some will struggle with lower quartile	10
Do not support the Threshold	5
Risk in awarding undeserving LAs who met their threshold by chance	4
Data issues – fluctuation in numbers/time lag	4
Risk penalising LAs already performing	4
Complexity of Opiate client (link to employment, housing, training, etc) – fair reward for LAs with higher prevalence of hard to reach drug users. Reward should reflect this	4
Trajectory should be set locally	3
Suggest absolute number not % points	3
3 year average- data robust	2
Median or higher threshold achievable	1

Table 4 - Responses to Question 3

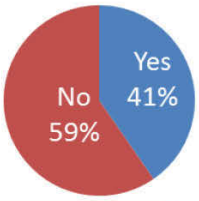
3 Which PHOF measure from the list at Annex A, would you be likely to select for a local measure of attainment when the scheme is formally launched, or would you accept the default adult smoking prevalence?

Responses	Total response	comments
	58	52 respondents

		Actual indicator measure	Freq LA
Domain 1	1.5	16-18 year olds not in education employment or training	5
	0.1	Health life expectancy	1
	1.2i	School readiness	2
	1.15ii	Statutory homelessness	1
Domain 2	2.22i	% eligible in the financial year –NHS **Health Checks**	12
	2.22ii	% eligible and offered and received – NHS **Health Checks**	12
		Both 2.22i & 2.22ii - **Health Checks**	3
	2.4	Under 18 conception	7
	2.14	Smoking prevalence for adults over 18	3
	2.1	Low birth weight in term babies	1
	2.02ii	% of infants due a 6-8wks check that has been breastfed	1*
	2.3	Smoking status at time of delivery	1*
	2.24i	Injuries due to falls in persons aged 65 and over	3*
	2.6	Excess weight in 4-5 and 10-11 year olds	2
	2.7	Hospital admission caused by falls in children and young people 0-24	2
	2.13i	Physically active adults	1
	2.22iii	Cumulative 5 year total of % offered – **Health checks**	1*
Domain 3	3.3xv	flu vaccination population covered	1
Domain 4	4.4	Under 75 mortality rate from Cardiovascular disease	1
	4.16	Estimated diagnoses rate for people with dementia	1*

Table 5 - Response to Question 4

4 Do you agree that smoking prevalence adults over 18s' should be used as the default indicator where no choice has been made from the list of approved indicators?

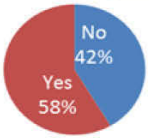


Responses	Total response	Yes	No
	59	24 LAs	35 LAs

	Detailed categories	Frequency of Yes response	Frequency of No response
36 Data measure	Data not robust, time lag, estimates, not age standardised	4	12
	Threshold unrealistic need to be scaled to LA area - decline in smoking prevalence	4	10
	LA data not reliable, estimates		6
		8	28
3 Threshold measure	Suggest a composite measure, e.g. a 3 yr rolling average/immunisation	1	1
	Agree to threshold 2% pts	1	
		2	1
1 Alternative measure	Locally agreed targets	1	
		1	0

Table 6 - Responses to Question 5

5 For future years LAs will have additional flexibilities to develop their own local indicator. Would you have developed your own local indicator and progress measure this year, had this flexibility been available?

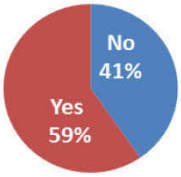


Q5 Responses	Total response	Yes	No
	53	31	22

	LAs	Examples of indicators	Frequency Yes	Frequency No
4 Burdensome	4	Time and resources burdensome		4
14 Develop own indicator	6	Based on JANA and JSWS	4	2
	2	Indicator that will improve inequality gap	2	
	1	Quit smokers from routine and manual groups over all quitters	1	
	1	Employability and mental health	1	
	1	Numbers accessing falls services		1
	1	Long term conditions and access to lifestyle improvement services	1	
	1	Blood pressure control for deprived wards	1	
	1	LARC's fitted	1	
25 Use indicators in PHOF	4	Take from PHOF and expand on it	1	3
	3	Health checks	3	
	3	Health weight 10-11yr olds	1	2
	3	% of women who smoke at delivery	3	
	2	Breast feeding prevalence	2	
	2	School readiness	2	
	1	Children engaged in physical activities	1	
	1	Healthy life expectancy	1	
	1	Chlamydia screening	1	
	1	Drug treatment around recovery, housing and employment	1	
	1	Reducing alcohol related hospital admission	1	
	1	Flu vaccination rates for under 65s	1	
	1	Wellbeing		1
	1	Employment	1	

Table 7 - Responses to Question 6

6 Do you agree that we should adopt an approach based on point shares from a fixed pot, maximising the amount we can pay for progress, even though this means a lack of certainty on exactly how much the incentive for progress will be for each local authority?



Responses	Total response	Yes	No
	51	30	21

		Detailed categories (LA may respond to one or more categories)	Freq Yes	Freq No
20	Certainty on amount of reward	Pot too small. A clear idea of how much the reward will be at the beginning to weight resource input	5	15
12	LA variance to be considered	Variance in reward(high deprivation an health inequalities): to reward local efforts and real improvements	1	11
3	Continuity of HPIS funding	Reward should be separate from core allocations	3	
3	Time in the year payment is made	When the money will be paid/to carry forward the money if not spent in year – time to spend money	2	1
1	Pace of Change	To exclude LAs above target allocation to support health inequalities and PoC		1
2	Don't understand	Do not understand the methodology		2