Health and Wellbeing Board

14 May 2015

Health Premium Incentive Scheme 2014-15

Report of Anna Lynch, Director of Public Health County Durham, Children and Adults Services, Durham County Council

Purpose of the Report

1. The purpose of this report is to provide an update on the Health Premium Incentive Scheme for public health 2014-15.

Background

2. The White Paper "Equity and Excellence: liberating the NHS" published in July 2010 set out the policy direction that resulted in the Health & Social Care Act 2012 being implemented. Equity and Excellence stated that a new health premium designed to promote action to improve population wide health and reduce health inequalities would be introduced.

3. The public health finance update, *Healthy Lives, Healthy People: Update on Public Health Funding,* published in June 2012, included a high level design summary of the health premium incentive. In summary the premium would be:

    - Innovative.
    - Based on Public Health Outcomes Framework (PHOF) indicators.
    - Have national indicators set by the Government, supplemented by locally chosen indicator.
    - Be weighted to areas facing the greatest challenges.
    - Be formula driven to minimise bureaucracy and maximise transparency and
    - Be introduced from 2014-15 with the first payments being made in 2015-16, reflecting improvements made in 2014-15.

4. The Advisory Committee on Resource Allocation (ACRA) was commissioned to make detailed recommendations about how the scheme should operate and established a technical sub group with the appropriate expertise – the Health Premium Independent Advisory Group (HPIAG).

5. In summary, HPIAG recommended that:

    - Fifty one PHOF indicators or 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 have the potential to include indicators in relation 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.
- The health premium incentive was not the right mechanism for promoting innovation.
- Progress should 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.

6. Following the consultation Department of Health and Public Health England informed Local Authorities and Directors of Public Health that the scheme would be piloted for 2014-15 and of the following regarding the indicators:

    - "Successful completion of drugs treatment" with combined data for opiate and non-opiate users is confirmed as the national indicator. Though this measure is not straight forward to use, the majority of responders were supportive of its inclusion as the national indicator, recognising that it provides a litmus test of local authorities capacity to improve the change of recovery of some of the most vulnerable in our society and success in working with a wide range of partners. The measure reinforces and supports the new grant condition which requires LAs to have regard to the need to improve the take up of, and outcomes from, their drug and alcohol misuse treatment services.
    - The majority of respondents did not support smoking prevalence as the default local indicator. Various issues were raised in terms of its use in an incentive scheme. As a result of the feedback received it was decided to 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.

7. Local Authorities (LAs) were requested through Directors of Public Health (DsPH) to choose which local indicator from a basket of 33 from the Public Health Outcomes Framework they want to be measured against as part of the pilot scheme (attached as Appendix 2).

8. The local indicator selected and submitted was:

    - 1.03: pupil absence – percentage of half days missed by pupils due to overall absence (including authorised and unauthorised absence).

9. This indicator was selected as performance against the PHOF baseline in 13-14 is good and shows an improving trend.

10. For those local authorities that did not submit a return the Department of Health (DoH) / Public Health England (PHE) will use the NHS Health checks indicator as the default indicator.

Financial implications

11. The financial implications to the council of achieving the health premium incentive is unclear. It is unlikely that the confirmed national indicator, successful completion of drugs treatment with combined data for opiate and non-opiate users will demonstrate improvement in County Durham. It is expected that the local indicator identified in Paragraph 9 will demonstrate the required improvement although the threshold methodology is unclear.

12. The incentive payment is from a fixed pot of £5m and is dependent on the number of local authorities showing improvement against one or both of the indicators. It is therefore not possible to estimate the likely payment in any meaningful way.

13. The timing of the payment (if any) is also unclear due to the time lags for the receipts and analysis of 2014-15 data.

14. PHE will analyse the data from each Local Authority on the improvement made in 2014-15 against the 2013-14 baseline position. There will not be any need for local authorities to submit any additional data. All data is collected via the normal Public Health Outcomes Framework data collection route and any additional statistical analysis will be done centrally within PHE with support from the technical sub group of the Advisory Committee on Resource Allocation. The data used to assess payment will be that presented in the Public Health Outcomes Framework.

15. The level of payment will depend on the total number of authorities that achieve the necessary level of improvement based on the threshold methodology. Payments will be made in quarter 4 of 2015-16 and will be proportional to target allocations.

16. In order to understand further detail in relation to the methodology of the Health Premium Incentive Scheme 2014-15, the Director of Public Health, County Durham will contact Public Health England to seek clarification.

Recommendations

17. The Health and Wellbeing Board is recommended to:

- Note the progress and pilot phase of the Health Premium Incentive Scheme.
- Note the submitted local indicator as per paragraph 9.
- Note the uncertainty regarding incentive payment value.
- Note the delayed timescale for payment.
- Note that the Director of Public Health, County Durham will contact Public Health England to seek clarity on the methodology of the Health Premium Incentive Scheme 2014-15.

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Appendix 1: Implications

Finance
To be confirmed

Staffing
No implications

Risk
No implications

Equality and Diversity / Public Sector Equality Duty
No implications

Accommodation
No implications

Crime and Disorder
No implications

Human Rights
No implications

Consultation
No implications

Procurement
No implications

Disability Issues
No implications

Legal Implications
No implications