ACRA(2013-14)16

Health Premium Incentive Advisory Group (HPIAG)

Recommendations to the Advisory Committee on Resources Allocation (ACRA)

Interim report 1

15 October 2013

Note from the Chair

I was honoured to be asked by the Department of Health to chair the Health Premium Incentive Advisory Group (HPIAG), a subcommittee of the Advisory Committee on Resource Allocation (ACRA) to make recommendations for a robust formula driven health premium incentive scheme.

We were asked to review which of the indicators in the Public Health Outcomes Framework (PHOF) were suitable for inclusion in the Health Premium Incentive Scheme (HPIS). The PHOF indicators were developed through consultation and underwent rigorous selection criteria, and we are confident they are robust. However, given the specific requirements of developing an incentive scheme to reward local authorities for progress made over a short period, HPIAG developed additional criteria to decide which Indicators were most suitable for this particular task. This document sets out how we approached our work, and our recommendations.

This is new territory with a complex task and very short deadlines in order to meet ministerial commitment to launch the scheme in 2014/15 with the first payments in 2015/16. The progress we have made will provide a good foundation for future developments.

The Advisory Group has undertaken a large amount of work and given careful consideration to the interim recommendations. I am grateful to all members of the Advisory Group for their valuable support and expert input and to their organisations for allowing these experts to participate.

Dr Janet Atherton (Chair)
President at ADPH & DPH at Sefton Council

Content

1.0 Acknowledgements

These recommendations are based on the consensus reached by the members of the Health Premium Incentive Advisory Group (HPIAG) and other specialists who have contributed their time and expertise.

We are grateful to the Advisory Group members for their valuable contribution and to their organisations for allowing them time to participate in the project despite their extremely busy schedules.

Members of the HPIAG

Dr Janet Atherton (Chair)	*President at ADPH & DPH at Sefton Council*
Ben Barr	*University of Liverpool- Academic*
Tim Baxter	*Department of Health*
Prof Chris Bentley	*Association of Directors of Public Health*
David Buck	*Kings Fund- Academic*
Michael Chaplin	*NHS England*
Dr Ann Marie Connolly	*Public Health England*
Kate Davies	*NHS England*
Dr Paul Edmondson-Jones	*York Council/Association of Directors of PH*
Justine Fitzpatrick	*Public Health England*
Prof Peter Goldblatt	*UCL Institute of Health Equity*
Ian Gray	*Chartered Institute of Environmental Health*
Paul Lincoln	*National Heart Forum*
Dr Stephen Lorrimer	*NHS England*
Alyson Morley	*Local Government Association*
Rob Poole	*Reading Borough Council (LGA)*
Dave Roberts	*Health and Social Care Information Centre*
Dr Mike Robinson	*Faculty of Public Health*
Prof Matthew Sutton	*Manchester- Academic*
Dr Steve Watkins	*British Medical Association*

2.0 Background

The development and the high level design for the health premium was set out in the White Paper, *Equity and excellence: Liberating the NHS, July 2010*[1],

> *"……a new "health premium" designed to promote action to improve population-wide health and reduce health inequalities".*

A subsequent document, "*Healthy Lives, Healthy People: Update on Public Health Funding, June 2012*[2], stated*:*

> "*We recognise that the significant data lag on many of the indicators in the public health outcomes framework would mean that if it was paid in 2013-14 we would be rewarding local authorities for decisions taken by PCTs. We are therefore planning to delay the first payments until 2015-16, the third year of local authority responsibility for public health responsibilities*".

This report set out the Government's approach to developing the Health Premium Incentive Scheme (HPIS), including a commitment to convene an expert group to assess the indicators in the Public Health Outcomes Framework (PHOF) for their suitability as an incentive measure. The update also set out a number of potential criteria for selecting the candidate indicators for the HPIS.

In March 2013, the Advisory Committee on Resource Allocation (ACRA) established the Health Premium Incentive Advisory Group (HPIAG) as a sub-committee with the aim of developing recommendations for a robust formula driven Health Premium Incentive Scheme (HPIS). The Advisory Group consisted of academics, experts in Public Health and stakeholders with public health experience.

The Advisory Group's terms of references were to:

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

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

c) Consider how to set incentives for progress.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf
[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213684/dh_134580.pdf

The Advisory Group met three times and had three sub-groups to look at specific aspects of the scheme. Various interim meetings also took place between the Department of Health, NHS England and Public Health England to review the PHOF indicators selection criteria, definition and data readiness.

Local priorities will inform flexibilities. These will be determined by local authorities based on local priorities agreed by the Health and Wellbeing Board (H&WBB) in their Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS) with support from Public Health England and the Department of Health. This will determine which areas local authorities wish to consider based on local priorities.

3.0 Summary of recommendations

3.1 The HPIAG reviewed and amended the criteria for selecting PHOF indicators for inclusion into the HPIS provisionally published in the June 2012. The selection criteria applied to all the PHOF indicators to assess inclusion into the HPIS were as follows:

- Indicator definition and data source fully developed and ready,
- Technical criteria applied to the data – reliability, robustness collection taking into account modelled estimates, and if improvement was measurable,
- Availability of published robust baseline data at upper tier local authority level.

In recommending the indicators for inclusion in the incentive scheme, the Advisory Group reviewed the 66 indicators with all the sub - indicators contained within the Public Health Outcomes Framework (PHOF). 28 indicators or 49 indicators and sub-indicators passed the underpinning criteria. These are set out in table 1 below.

The smoking, substance misuse and alcohol indicators are still being reviewed with the policy teams. The Advisory Group recognises that a credible scheme should include measures related to smoking, substance misuse and alcohol.

The indicators in tables 1 and 2 are interim and may be subject to change based on further technical analysis of data. ACRA will recommend technically suitable indicators for inclusion in the

scheme, from which the Secretary of State and local authorities will select a small number for the final scheme

The Department of Health recognises the need to review the HPIS indicators as better understanding of the incentive scheme is gained and as more PHOF data is published.

Details of the methodology used to select the criteria are set out in annexes 1-4.

Recommendation 1 – Indicators for inclusion in the incentive scheme

HPIAG recommends indicators listed in table 1 below as a basis for selecting a small number of PHOF indicators for inclusion in the health premium incentive scheme.

Table 1 : Recommended indicators

Indicator ref	Indicator Descriptor	Indicator No	Sub No
0.1 ii	Life Expectancy at Birth	1	1
1.01	Children in poverty - Percentage of children in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs)	2	2
1.03	Pupil absence - Percentage of half days missed by pupils due to overall absence (including authorised and unauthorised absence)	3	3
1.04 i	First-time entrants to the youth justice system - Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population	4	4
1.05	Percentage of 16-18 year olds not in education, employment or training (NEET)	5	5
1.06 i	Percentage of all adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family	6	6
1.12 i	Age-standardised rate of emergency hospital admissions for violence per 100,000 population	7	7
1.12 ii	Rate of violence against the person offences based on police recorded crime data, per 1,000 population		8
1.13 i	Re-offending - % of offenders who re-offend from a rolling 12 months cohort	8	9
1.13 ii	Re-offending - Average no of re-offenders committed per offender from a rolling 12 month cohort		10
1.15 ii	Statutory homelessness / Household in temporary accommodation	9	11
2.01	Percentage of all live births at term with low birth weight	10	12
2.04	Under 18 conception rate per 1,000 population	11	13
2.06	Excess weight in 4-5 and 10-11 year olds	12	14
2.07i	Hospital admissions for unintentional and deliberate injuries in children age 0-14	13	15
2.07ii	Hospital admissions for unintentional and deliberate injuries in		16

Indicator ref	Indicator Descriptor	Indicator No	Sub No
	young people age 15-24		
2.13i	Physically active adults	14	17
2.13ii	Physically inactive adults		18
2.20 ii	The percentage of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period	15	19
2.22 i	Percentage of eligible population aged 40-74 offered an NHS Health Check in the financial year	16	20
2.22 ii	Percentage of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check in the financial year		21
2.24 i	Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population	17	22
3.03 i	Hepatitis B vaccination coverage (1 and 2 year olds)	18	23
3.03 iii	DTaP/IPV/Hib vaccination coverage (1, 2 and 5 year olds)		24
3.03 iv	MenC vaccination coverage (1 year olds)		25
3.03 v	PCV vaccination coverage (1 year olds)		26
3.03 vi	Hib/MenC booster vaccination coverage (2 and 5 year olds)		27
3.03 vii	PCV booster vaccination coverage (2 year olds)		28
3.03 viii	MMR vaccination coverage for one dose (2 year olds)		29
3.03 ix	MMR vaccination coverage for one dose (5 year olds)		30
3.03 x	MMR vaccination coverage for two doses (5 year olds)		31
3.03 xii	HPV vaccination coverage (females 12-13 year olds)		32
3.03 xiii	PPV vaccination coverage (aged 65 and over)		33
3.03 xiv	Flu vaccination coverage (aged 65 and over)		34
3.03 xv	Flu vaccination coverage (at risk individuals from age six months to under 65 years, excluding pregnant women)		35
4.01	Crude rate of infant deaths (persons aged < 1 year) per 1,000 live births	19	36
4.03	Age-standardised rate of mortality from causes considered preventable per 100,000 population	20	37
4.04 i	Age-standard rate of mortality cardiovascular diseases (including heart disease and stroke) < 75 years of age per 100,000 population	21	38
4.04 ii	Age-standard rate of mortality preventable cardiovascular disease (including heart disease and stroke) < 75 years of age per 100,000 population		39
4.05 i	Age-standardised rate of mortality from all cancers in persons less than 75 years of age per 100,000 population	22	40
4.05 ii	Age-standardised rate of mortality that is considered preventable from all cancers in persons less than 75 years of age per 100,000 population		41
4.06 i	Age-standardised rate of mortality from liver disease in persons less than 75 years of age per 100,000 population	23	42
4.06 ii	Age-standardised rate of mortality that is considered preventable from liver disease in persons less than 75 years of age per 100,000 population		43
4.07 i	Age-standardised rate of mortality from respiratory diseases in persons less than 75 years of age per 100,000 population	24	44
4.07 ii	Age-standardised rate of mortality that is considered preventable from respiratory diseases in persons < 75 years of age per 100,000 population		45

Indicator ref	Indicator Descriptor	Indicator No	Sub No
4.08	Age-standardised mortality rate from certain infectious and parasitic diseases per 100,000 population	25	46
4.10	Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population	26	47
4.11	Indirectly standardised percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital after admission	27	48
4.14 i	Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 65 and over per 100,000 population	28	49

Recommendation 2 – Additional indicators

Table 2 : Other recommended Indicators for inclusion.

Smoking			
2.03	Smoking status at the time of delivery	50	Indicators under discussion with tobacco policy team
2.09	Smoking prevalence – 15 Year old	51	
2.14	Smoking prevalence – Adults (over 18)	52	
Drugs			
2.15	Successful completion of drug treatment	53	Indicators under discussion with drugs policy team
2.16	People entering prison with substance dependence issues who are previously not known to community treatment	54	
Alcohol			
2.18	Alcohol-related admissions to hospital (placeholder)	55	Indicator under discussion with alcohol policy team

3.2 In order to operationalise the incentive scheme, the Advisory Group set up specialist sub-groups to research, evaluate and discuss details of how the incentive scheme might work in practice. The areas discussed were:-

- **Local flexibilities**

HPIAG recommended that the Health Premium Incentive Scheme should include some local flexibility to select measures that are relevant to a particular local authority, but may not be included in a small number of nationally prescribed measures.

Recommendation 3 – Local Flexibilities
Local Authorities should have flexibility to select a small number of local indicators from the proposed indicators for the HPIS. Alternatively, where a PHOF indicator has not passed the technical criteria for acceptance into the incentive scheme, but a relevant local dataset exists that would pass the technical criteria, it should be possible for the relevant local authority to propose its inclusion in the health premium incentive for that area. The local authority will need to demonstrate that it meets the technical criteria. Local indicator test for robustness, monitoring and delivery of the proposal should be considered together with its impact on resources based on the overall expressions of interest and final take up of flexibilities offered.

➢ Role of innovation

The "Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS" report[3], December 2011, on innovation in the NHS set out 3 stages in the innovation process (invention, adoption and diffusion). The sub-group discussed how innovation could be built into the HPIS. Its conclusion was that the key challenge is largely one of diffusion as there is unwarranted variation in the rate of spread of new proven interventions and service models. The Group agreed that promoting innovation is very important, but concluded that this scheme was not an appropriate tool for doing this.

Recommendation 4 – Role of innovation
The HPIS is not appropriate for promoting innovation in public health. PHE will take the lead to establish a group to investigate ways of promoting innovation in public health with support from HPIAG members.

➢ Reward on progress

The stated purpose of the new HPIS is to promote action to improve population-wide health and reduce health inequalities.

Recommendation 5 – Reward for progress
The reward for progress and how progress is measured should reflect the

3 http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_134597.pdf

level of challenge faced by the local authority. One option would be to use the target allocation to scale the reward, i.e. "areas with greater challenge would get a proportionately greater reward". The HPIAG would welcome further input from the Technical Advisory Group (TAG), a sub-group of ACRA on determining exactly how rewards could be distributed.

➢ Measuring inequality

The government's vision is to improve the health of the poorest, fastest. Targeting resources to the areas of high deprivation will lead to the reductions in inequalities.

For most authorities the slope index of inequality will be the best measure of inequality although there are some technical difficulties with this especially for authorities with very little internal inequality, for authorities with several distinct populations, authorities which are highly polarised or where the most serious inequality is not associated with deprivation. In those cases it may be more sensible to focus on differences between specific populations and the average. For this reason, and due to local variations in the situation, we have not added an inequality indicator to the recommended set but authorities who wish to suggest one using local flexibilities will be encouraged to do so in conjunction with relevant stakeholders to assist the development. If it is necessary for resource reasons to restrict the scope of local flexibility this should not preclude proposals for indicators relating to inequality.

Recommendation 6 – Measuring inequalities
Local authorities to incentivise the reduction in inequality using Slope Index of Inequality (SII) for life expectancy for their area. Where this is not appropriate, LAs should consider building an inequity indicator in partnership with its stakeholders as one of its local indicator/priorities. Input from the Technical Advisory Group (TAG) is required to test the appropriateness on this proposal.

➢ Choice of indicators

HPIAG believes that the incentive scheme should be constructed from a mixture of a small number of,

- nationally chosen indicators agreed by the Secretary of State.
- locally selected indicators, total numbers to be agreed as part of the scheme.

The number of indicators should be small and the exact configuration needs to be agreed. However, it is important that the selection of indicators ensures good coverage across the four PHOF domains.

Recommendation 7 – Choice of indicators
The indicators chosen should reflect both national and local indicators across the four domains.

This approach will allow local authorities to select their own indicators based on their local population needs identified by the local JSNA from the recommended set of indicators or locally agreed indicators that meets the selection criteria agreed by HPIAG.

Recommendation 8 – Benefits and evaluation criteria
Benefits criteria and an evaluation methodology to be developed in conjunction with key stakeholders for the final basket of indicators after a period of operation. The review will include actual evidence around how the scheme is working and how it is supporting improvements in public health outcomes and reduction in inequalities.

4.0 Methodology for selecting indicators

A systematic and robust methodology was developed for selecting PHOF indicators for inclusion in the HPIS.

Details are available at annex 1, however in brief the methodology included,

i) Defining essential criteria,

- PHOF Indicator definition and data sources readiness,
- Geographical availability of data,
- Technical criteria for data,

ii) Defining desirable criteria.

iii) Reviewing the number of indicators that passed the criteria (annex 2).

iv) Revising the technical criteria for HPIS in the light of iii) above (annex 3).

v) Reviewing the number of indictors that passed the revised HPIS criteria (annex 4).

vi) Including additional desired indicators consistent with the governments public health commitments with additional caveats

5.0 Role of innovation

A sub-group was convened to discuss the role of innovation in the HPIS. Members of the Advisory Group recognised that innovation was very important and had a key role in public health. There is a risk that an incentive scheme may deter innovation, as failed initiatives may lead to a loss of income. The consensus in the group was that the health premium incentive scheme needs to be simple and proportionate, and so an explicit incentive for innovation was not appropriate. However, the approach to local flexibilities may make a contribution towards innovation.

The importance of innovation as a key strand needs to be highlighted and there needs to be other routes to stimulate innovation. This is a possible role for PHE.

Annex 5 shows a range of support mechanisms, research work and evaluations available for the NHS and public health. This is not an exhaustive list.

6.0 Addressing health inequalities

A sub-group was formed to look at inequalities both within and between local authorities. The Advisory Group concluded that within area inequalities could be reflected in the incentive scheme through a single measure of the slope index of inequality (SII) applied to life expectancy.

This is a challenging issue and the SII was the best available measure that is recognised and widely accepted. However, it is only been published for life expectancy. While in principle it could be applied to other measures in the PHOF this would require considerable technical work, and so is probably not appropriate at this point.

In addition, the SII looks only at inequality in relation to deprivation differences. Other possible dimensions, such as ethnicity, are not captured directly although they may themselves be correlated with deprivation. The interpretation of the SII may also be problematic in areas with very distinct populations, whereas the SII is based on an assumed continuum across deprivation groups.

Given these issues, close attention needs to be paid to developments in the understanding and measurement of inequalities to ensure the incentive scheme continues to exploit the best available methodologies.

A scheme that incentivises local authorities cannot directly incentivise the reduction of inequalities between them; that is the role of other policies, including the core allocations. However, the incentive can be weighted so that it offers a greater incentive to those areas facing the greatest health challenge. This would then offer support to the wider range of inequalities policies.

The Advisory Group has briefly considered some options for weightings. These have focused on continuous variables, rather than categorical approaches. This avoids 'cliff-edges', where two similar local authorities see different incentives because they fall either side of a boundary.

One option is to use the target allocation, which is intended to be an estimate of public health need. This is also weighted for the size of the population, another desirable feature. But other options might be considered, such as weighting in line with health outcome or deprivation measures. The Advisory Group would welcome Technical Advisory Group's views on these issues and have asked the secretariat to take a paper to a future meeting.

7.0 Flexibilities for local authorities in choosing indicators

The Advisory Group members set up a working group to bring findings back to the main group. The Advisory Group recommends that some local flexibility should be offered, consistent with the issues highlighted in the PHOF.

- Local authorities should be free to select additional measures from the 'menu' of acceptable measures that have passed the technical assessment.
- Additional flexibility should be offered where there is a placeholder or a national measure that did not meet the HPIS technical criteria.
- This additional flexibility should only be offered if DH/PHE can identify sufficient resources to make a thorough assessment of the suitability of the local proposal.
- Local authorities may be in a better position to make suitable local proposals once the scheme has been running for at least a year. This would also give the opportunity for an assessment to be made of the interest in local measures.

8.0 Recommendation for payment

The Advisory Group recommends that the payment scheme be based on targeting resources to the areas with the most challenge. This could be based on the target allocation with points awarded to successfully meeting the required target / threshold. Two authorities achieving the same progress on an indicator will mean that the one with the greater challenge will receive a higher incentive. The Advisory Group recommends TAG carry out further work on this proposal.

Payment should be made on some form of trend rather than absolute annual data to smooth out any unexpected or unintended fluctuations. Annex 6 shows the data availability for the chosen indicators

Due to the population size of City of London and Isles of Scilly population, they will receive either full payment or the average payment as if they had achieved the target.

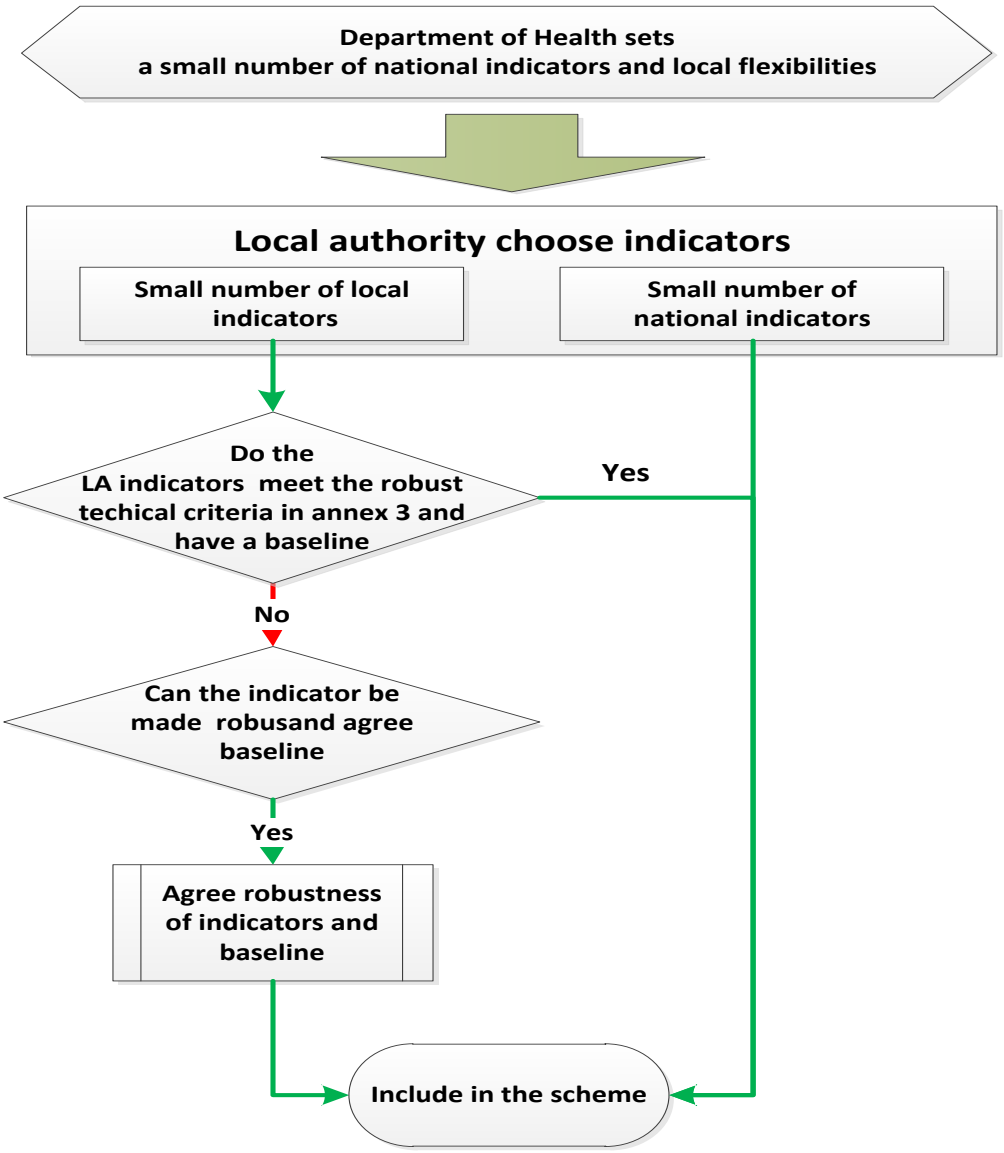
9.0 Selection of Indicators

The Advisory Group discussed the process of implementing the incentive scheme. They envisaged a combination of a small number of national and local indicators, the latter might, as discussed above differ from the selected indicators in the PHOF. The locally derived indicators will need to be as robust as the national ones and will need to be agreed with PHE in advance. The ability of local authorities to adopt such locally-derived indicators will depend on the capacity of PHE to support their development and monitoring.

This will mean practically, the local authority will advise PHE whether they wish to propose a locally derived indicator for consideration.

If the indicator is a locally-derived one, then the local authority will present supporting documentation and data on how the indicator meets the revised criteria in annex 3. Once PHE is satisfied that the indicator is robust and agrees the baseline, the indicator will be accepted for inclusion into the incentive scheme.

Periodic monitoring / return will be agreed by PHE. At the end of the year progress will be reported with sample assurance audits carried out by PHE, as illustrated in the flow chart below.



How the incentive scheme would function

10.0 Resources requirements

The main resources required to implement these recommendations will be determined by;

a) Number of local authorities choosing to use their own indicators which will need assessing against the agreed criteria.

b) The level of assurance required to ensure progress should be consistent with achievements.

11.0 Next steps

The key next steps will be as follows;

i.	Publish this report on DH Website	Mid October
ii.	Data analysis (TAG)	Mid / End October
iii.	Joint HPIAG / TAG meeting	Early November
iv.	HPIAG agree final report	Early November
v.	HPIAG final meeting	Early / Mid November
vi.	Finalise recommendation from ACRA	Mid November
vii.	Recommendations to Secretary of State	Early December

Annex 1 – Methodology for selecting indicators

A systematic methodology was developed for selecting PHOF indicators for inclusion in the HPIS. This included,

a) Defining essential criteria

The essential criteria were as follows:

i. Indicator definition and data sources must be ready.

Each indicator has been rated in the Public Health Outcomes Framework in terms of their readiness for use as of November 12. This assessment considered the readiness of both the indicator definition and the data source, as both are required for an indicator to be acceptable for a HPIS.

Ratings were allocated to indicate the readiness of the indicators. The table below summarises the status of the 66 indicators including the 2 overarching indicators.

Based on the assessment, 39 indicators (38 + 1 overarching) had both a definition and data source that were ready for use. This indicated that over half of the PHOF indicators were ready for the framework without any further development work being necessary as at November 2012.

HPIAG agreed that only those indicators that have data definition ready, indicated by "1" and have their corresponding data sources ready indicated by "A" should be considered for the health premium.

Readiness of Indicators

			Data Sources		
			A	B	C
			Ready (Yes)	Needs further development	New data sources required
Definition	1	Ready (Yes)	39	8	1
	2	Needs further development	4	14	0
	3	New definition required	0	2	0

Indicator and data source readiness status

ii. Geographical availability of data.

An initial assessment has been made of whether **national and upper tier local authority level breakdowns** are currently available for each of the indicators included in the Public Health Outcomes Framework.

iii. Technical criteria for data

These were developed in conjunction with Department of Health, NHS England and Public Health England. These were ratified by the Advisory Group members. These criteria included.

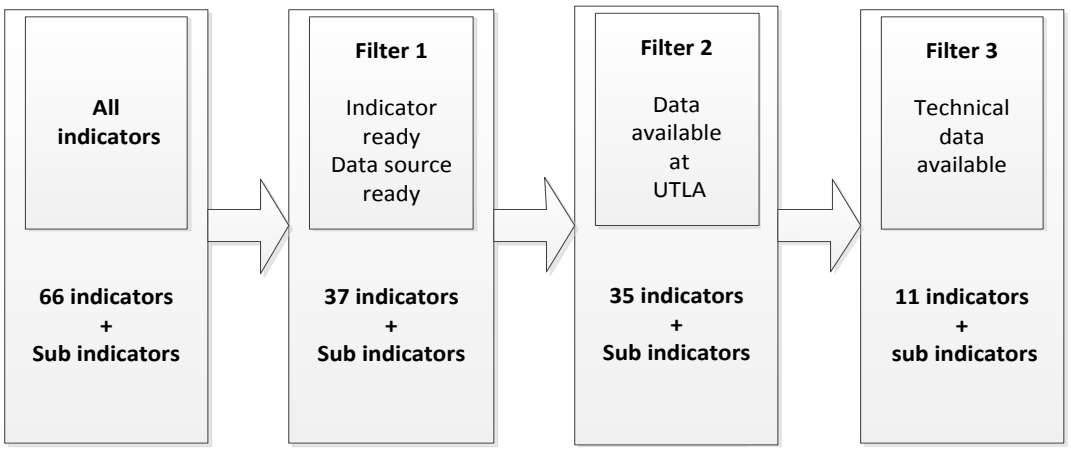
	Criteria	Remarks
1	Data should be available for all UTLA except City and Isles of Scilly[4]	Many indicators are not available for these two areas as they have very small populations. Data will also need to be available for the base year as well as the performance year. City of London and Isles of Scilly are too small for reliable data to be available. The proposal is that for incentive purposes both areas should be assumed to have made progress in all measures.
2	Data should be reliable enough to measure progress annually	Ideally need -yearly for monitoring progress. 3 years rolling average can only be used in the year new data is available
3	Data should be produced annually.	This is important for paying the LA. However, where data are produced less frequently a measure could be included in the year data is available
4	Data should not be a synthetic estimate	Anything that is not real data will not suffice e.g. modelled estimate. It may be possible to use an estimate interpolated from PCT data with caution.
5	The measurement should not be vulnerable to perverse incentives that might lead to undesirable public health behaviours	If LAs are paid for successful treatment of a condition this could encourage them to stop treating that condition.
6	Need to know whether an increase in the indicator is good or bad	If diabetes prevalence goes up we do not know whether that is due to an increase in disease (bad) or an increase in recording (good).

[4] Many indicators are not available for these two areas as they have very small populations. Data will also need to be available for the base year as well as the performance year

Annex 2 - First sift based on initial criteria

Recommended indicators for inclusion in the health premium scheme

After applying the initial technical criteria the following results were obtained



First Criteria Sift

Since only 11 indicators met the criteria, the Advisory Group members reviewed the criteria and amend as shown below in annex 3,

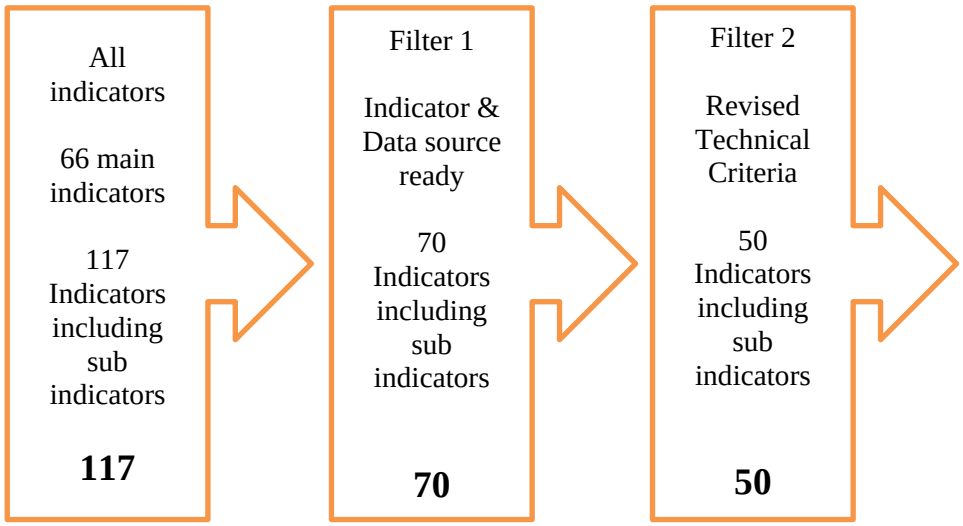
List of PHOF indicators meeting the initial criteria.

No	Indicator ref	Indicator descriptor	Mandatory
1	1.01	Children in poverty	
2	1.04i	First-time entrants to the youth justice system	
3	1.05	16-18 year olds not in education, employment or training	
4	1.13	Re-offending	
5	1.15 ii	Statutory homelessness / Household in temporary accommodation	
6	2.01	Low birth weight of term babies	
7	2.06	Excess weight in 4-5 and 10-11 year olds	yes
8	2.20 i	% of women eligible for breast screening who were screened adequately	
9	2.24 i	Falls and injuries in the over 65s	
10	4.11	Emergency readmissions within 30 days of discharge from hospital (Placeholder)	
11	4.14 i	Hip fractures in over 65s	

Annex 3 – Revised criteria

No	Criteria (revised)	Discussion	Rational for change	*Comments*
1	**Data should be available for all UTLA except City and Isles of Scilly**	*Many indicators are not available for these two areas as they have very small populations. Data will also need to be available for the base year as well as the performance year*	n/a	*Nil*
2	**Data should be reliable enough to measure progress ~~annually~~ periodically**	*~~Ideally need data midyear for monitoring~~. 3 -5 years rolling data will be acceptable*	We may be able to pay on progress on rolling averages	*Need to ensure if 3 year averages are used then performance is only assessed every 3 years. We cannot make annual payments on three year data*
~~3~~	~~**Data should be produced annually.**~~	~~*This is important for paying the LA*~~	Deleted based on 2) above	*Deleted*
4	**Data should not be a synthetic estimate**	*Estimated ~~from a PCT figure~~, figures will be considered. Modelled estimate ~~anything that is not real data~~ will not suffice*	At the HPIAG meeting there was a consensus that estimated / extrapolated REAL data may be used. Modelled data is problematic due to high levels of uncertainties	*Some estimated data may be Okay. In some cases we have PCT level data and have estimated the LA level data. Where 2 LA make up a PCT, they will both have the same values. If a PCT value changes we will not know which LA the improvements was in. This criteria may not apply to any indicators due to PVT abolition , however the criteria needs to stay*
~~5~~	~~**The measurement should not be vulnerable to perverse incentives that might lead to undesirable public health behaviours**~~	~~*if LAs are paid for successful treatment of a condition this could encourage them to stop treating that condition*~~	This can be managed.	*Put in technical exclusions and heavy caveats case by case by basis.*
6	**Need to know whether an increase in the indicator is good or bad**	*If diabetes prevalence goes up we do not know whether that is due to an increase in disease (bad) or an increase in recording (good).*	n/a	*Nil*

Annex 4 – Second sift Following technical criteria revision



Revised criteria sift

Based on the revised technical criteria the following indicators met the criteria.

No	Indicator ref	Indicator Descriptor	Caveats	Mandatory
1	0.1ii	Life Expectancy at Birth	*This is an overarching indicator used to determine the level of inequalities in HPIS. Data not published, however indicator meets HPIS criteria*	
2	1.01	Children in poverty - Percentage of children in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs)		
3	1.03	Pupil absence - Percentage of half days missed by pupils due to overall absence (including authorised and unauthorised absence)		
4	1.04i	First-time entrants to the youth justice system. Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population		
6	1.05	Percentage of 16-18 year olds not in education, employment or training (NEET)		
7	1.06 i	Percentage of all adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family		
8	1.12 i	Age-standardised rate of emergency hospital admissions for violence per 100,000 population		
9	1.12 ii	Rate of violence against the person offences based on police recorded crime data, per 1,000 population		
10	1.13i	Re-offending - % of offenders who re-offend from a rolling 12 months cohort		
11	1.13 ii	Re-offending - Average no of re-offenders committed per offender from a rolling 12 month cohort		
12	1.15 ii	Statutory homelessness / Household in temporary	*Indicator relevant to certain LAs e.g. in*	

No	Indicator ref	Indicator Descriptor	Caveats	Mandatory
		accommodation	*London.*	
13	2.01	Percentage of all live births at term with low birth weight		
14	2.04	Under 18 conception rate per 1,000 population	*It is suggested that 3 year rolling average is considered for this indicator*	Yes
15	2.06	Excess weight in 4-5 and 10-11 year olds	*mandatory function*	Yes
16	2.07i	Hospital admissions for unintentional and deliberate injuries in children age 0-14	*Data agreed in August 13*	
17	2.07ii	Hospital admissions for unintentional and deliberate injuries in young people age 15-24	*Data agreed in August 13*	
18	2.13i	Physically active adults	*Data agreed in August 13*	
19	2.13ii	Physically inactive adults	*Data agreed in August 13*	
20	2.20 ii	The percentage of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period	*Accepted and would be taken into consideration when we look at the reward measure]*	
21	2.22 i	Percentage of eligible population aged 40-74 offered an NHS Health Check in the financial year*	*Data will be LA level from 2013/14. OK with threshold*	Yes
22	2.22 ii	Percentage of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check in the financial year	*As above*	Yes
23	2.24 i	Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population		
24	3.03 i	Hepatitis B vaccination coverage (1 and 2 year olds)	*Currently PCT level but should change to LA of responsibility for 2013/14. Data not available for all local authorities.*	
25	3.03 iii	DTaP/IPV/Hib vaccination coverage (1, 2 and 5 year olds)*	*Currently PCT level but should change to LA of responsibility for 2013/14.*	
26	3.03 iv	MenC vaccination coverage (1 year olds)*	*Currently PCT level but should change to LA of responsibility for 2013/14.*	
27	3.03 v	PCV vaccination coverage (1 year olds)*	*Currently PCT level but should change to LA of responsibility for 2013/14.*	
28	3.03 vi	Hib/MenC booster vaccination coverage (2 and 5 year olds)*	*Currently PCT level but should change to LA of responsibility for 2013/14.*	
29	3.03 vii	PCV booster vaccination coverage (2 year olds)*	*Currently PCT level but should change to LA of responsibility for 2013/14.*	
30	3.03 viii	MMR vaccination coverage for one dose (2 year olds)*	*Currently PCT level but should change to LA of responsibility for 2013/14.*	
31	3.03 ix	MMR vaccination coverage for one dose (5 year olds)*	*Currently PCT level but should change to LA of responsibility for 2013/14.*	
32	3.03 x	MMR vaccination coverage for two doses (5 year olds)*	*Currently PCT level but should change to LA of responsibility for 2013/14.*	
33	3.03 xii	HPV vaccination coverage (females 12-13 year olds)*	*Currently PCT level but should change to LA of responsibility for 2013/14.*	
34	3.03 xiii	PPV vaccination coverage (aged 65 and over)*	*Currently PCT level but should change to LA of responsibility for 2013/14.*	
35	3.03 xiv	Flu vaccination coverage (aged 65 and over)*	*Currently PCT level but should change to LA of responsibility for 2013/14.*	
36	3.03 xv	Flu vaccination coverage (at risk individuals from age six months to under 65 years, excluding pregnant women)*	*Currently PCT level but should change to LA of responsibility for 2013/14.*	
37	4.01	Crude rate of infant deaths (persons aged less than 1 year) per 1,000 live births	*Need to group several years of data together if included in HPIS*	
38	4.03	Age-standardised rate of mortality from causes considered preventable per 100,000 population		
39	4.04 i	Age-standard rate of mortality cardiovascular diseases (including heart disease and stroke) < 75 years of age per 100,000 population		
40	4.04 ii	Age-standard rate of mortality preventable cardiovascular disease (including heart disease and		

No	Indicator ref	Indicator Descriptor	Caveats	Mandatory
		stroke) < 75 years of age per 100,000 population		
41	4.05 i	Age-standardised rate of mortality from all cancers in persons less than 75 years of age per 100,000 population		
42	4.05 ii	Age-standardised rate of mortality that is considered preventable from all cancers in persons less than 75 years of age per 100,000 population		
43	4.06 i	Age-standardised rate of mortality from liver disease in persons less than 75 years of age per 100,000 population		
44	4.06 ii	Age-standardised rate of mortality that is considered preventable from liver disease in persons less than 75 years of age per 100,000 population		
45	4.07 i	Age-standardised rate of mortality from respiratory diseases in persons less than 75 years of age per 100,000 population		
46	4.07 ii	Age-standardised rate of mortality that is considered preventable from respiratory diseases in persons less than 75 years of age per 100,000 population		
47	4.08	Age-standardised mortality rate from certain infectious and parasitic diseases per 100,000 population		
48	4.10	Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population		
49	4.11	Indirectly standardised percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital after admission		
50	4.14 i	Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 65 and over per 100,000 population	*Should not choose both this and 2.24 (age 65 and over injured due to a fall) as both closely related*	

Note'*' data at PCT level, population boundary from PCT to LA are the same for most LAs. Indicator are available for those LAs that have the same population boundaries at PCTs.

Annex 5 - Collection of innovative ideas in the health system

Item	Website	Description
NHS Evidence – Quality, Innovation, Productivity and Prevention	http://www.evidence.nhs.uk/qipp	Collection of real examples of how health and social care staff are improving quality and productivity across the NHS and social care. The collection also has Cochrane topics drawn from systematic reviews by the Cochrane Collaboration that may help inform local initiatives to address the quality and productivity challenge.
NHS South Central Directory of Leadership and Management Development eLearning and Online Resources	http://www.networks.nhs.uk/nhs-networks/innovation-south-central/resources-1/directoryof-leadership-and-management-development-elearning-and-online-resources	Provides details (together with direct links) of a range of leadership and management development eLearning programmes, online journals and databases of journal articles, recommended books and articles, online resources, recommended websites and Business School resources, as well as the change agent resource directory for business skills, improvement, information and innovation. Nearly all of these resources are free.
NHS Networks	http://www.networks.nhs.uk/	Promotes the development of networking in the health service to support innovation and improvement in health and care, and the role of networks in promoting learning and change. This is a free resource helping people get together to share ideas and improve the health service for all those who work in and use it.
Innovations in Healthcare	http://www.innovationinhealthcare.org/	Public health England Website Bringing new healthcare products and interventions to life
NHS institute for innovations and improvements	http://www.institute.nhs.uk/ - Site no longer updated	The NHS Institute was established in July 2005 to support the transformation of the NHS, through innovation, improvement and the adoption of best practice. We enable and support the NHS system to transform health and healthcare for patients through a strategy of creating inventive, clinically-led and tested practical ideas which will build skills and capability for continuous improvement
NHS Improving Quality	http://www.nhsiq.nhs.uk/	NHS Improving Quality works to improve health outcomes across England by providing improvement and change expertise
Welcome Trusts	http://www.wellcome.ac.uk/index.htm	Our vision Our vision is to achieve extraordinary improvements in human and animal health. In pursuit of this, we support the brightest minds in biomedical research and the medical humanities. We focus on three key areas of activity, reaching across five major research challenges. Focus areas Our funding focuses on supporting outstanding researchers, accelerating the application of research and exploring medicine in historical and cultural contexts.
The Health Foundation	http://www.health.org.uk/about-us/	The Health Foundation is an independent charity working to improve the quality of healthcare in the UK.
Book	Creating the culture for innovation : a practical guide for leaders (2010)	Maher, Lynne
Article	http://www.innovation.cc/scholarly-style/omachonu_healthcare_3innovate2.pdf	Innovation in Healthcare Delivery Systems: A Conceptual Framework

Annex 6 - Health Premium Incentive Scheme - Data availability

Indicator	Type of data	Set of data	Time Period								
			1998 - 2005	2006	2007	2008	2009	2010	2011	2012	2013
0.1ii - Life Expectancy at Birth											
1.01 - Children in poverty	annual data	1						a			
1.03 - Pupil absence	annual data	2						m	m	m	
1.04i - First time entrants to the youth justice system - Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population	mid-year estimate	3						a	a	a	
1.05 - 16-18 year olds not in education employment or training	mid-year estimate	2							a	a	
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	mid-year estimate	1							m	m	
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	mid-year estimate	1					m	m	m	m	
1.12ii - Violent crime (including sexual violence) - violence offences based on police recorded crime data	mid-year estimate	2						m	m	m	
1.13i - Re-offending levels - percentage of offenders who re-offend	annual data	1						a			
1.13ii - Re-offending levels - average number of re-offences per offender	annual data	1						a			
1.15ii - Statutory homelessness - households in temporary accommodation	mid-year estimate	2						m	m	m	
2.01 - Low birth weight of term babies	annual data	1						a			
2.04 - Under 18 conceptions	mid-year estimate	14	m	m	m	m	m	m	m		
2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	annual data	6		m	m	m	m	m	m	m	
2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	annual data	6		m	m	m	m	m	m	m	
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)		2						m	m	m	
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young		2						m	m	m	

people (aged 15-24)											
2.13i - Percentage of physically active and inactive adults - active adults		1								a	
2.13ii - Percentage of active and inactive adults - inactive adults		1								a	
2.20ii - Cancer screening coverage - cervical cancer	annual data	3						a	a	a	
2.22i - Take up of NHS Health Check Programme by those eligible - health check offered	annual data	2							m	m	m
2.22ii - Take up of NHS Health Check programme by those eligible - health check take up	annual data	2							m	m	m
2.24i - Injuries due to falls in people aged 65 and over (Persons)	mid-year estimate	2						m	m	m	
2.24i - Injuries due to falls in people aged 65 and over (males)	mid-year estimate	2						m	m	m	
2.24i - Injuries due to falls in people aged 65 and over (females)	mid-year estimate	2						m	m	m	
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	mid-year estimate	2						m	m	m	
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	mid-year estimate	2						m	m	m	
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	mid-year estimate	2						m	m	m	
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	mid-year estimate	2						m	m	m	
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (5 years old)	not available										
3.03iv - Population vaccination coverage - MenC (1 year old)	mid-year estimate	2						m	m	m	
3.03v - Population vaccination coverage - PCV (1 year old)	mid-year estimate	2						m	m	m	
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	mid-year estimate	2						m	m	m	
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old)	mid-year estimate	1							m	m	
3.03vii - Population vaccination coverage - PCV booster (2 years old)	mid-year estimate	2						m	m	m	

3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	mid-year estimate	2						m	m	m		
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	mid-year estimate	2						m	m	m		
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	mid-year estimate	2						m	m	m		
3.03xii - Population vaccination coverage - HPV (females 12-13 years old)	mid-year estimate	2						m	m	m		
3.03xiii - Population vaccination coverage - PPV (aged 65+)	mid-year estimate	2						m	m	m		
3.03xiv - Population vaccination coverage - Flu (aged 65+)	mid-year estimate	2						m	m	m		
3.03xv - Population vaccination coverage - Flu (at risk individuals)	mid-year estimate	2						m	m	m		
4.01 - Infant mortality	3 years rolling data	1					a	a	a			
4.03 - Mortality rate from causes considered preventable (provisional)	3 years rolling data	1					a	a	a			
4.04i - Under 75 mortality rate from all cardiovascular diseases (provisional)	3 years rolling data	1					a	a	a			
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (provisional)	3 years rolling data	1					a	a	a			
4.05i - Under 75 mortality rate from cancer (provisional)	3 years rolling data	1					a	a	a			
4.05ii - Under 75 mortality rate from cancer considered preventable (provisional)	3 years rolling data	1					a	a	a			
4.06i - Under 75 mortality rate from liver disease (provisional)	3 years rolling data	1					a	a	a			
4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional)	3 years rolling data	1					a	a	a			
4.07i - Under 75 mortality rate from respiratory disease (provisional)	3 years rolling	1					a	a	a			

	data										
4.07ii - Under 75 mortality rate from respiratory disease considered preventable (provisional)	3 years rolling data	1					a	a	a		
4.08 - Mortality from communicable diseases (provisional)	3 years rolling data	1					a	a	a		
4.10 - Suicide rate (provisional)	3 years rolling data	1					a	a	a		
4.11 - Emergency readmissions within 30 days of discharge from hospital	mid-year estimate	1						m	m		
4.14i - Hip fractures in people aged 65 and over	mid-year estimate	2						m	m	m	
2.03 - Smoking status at the time of delivery											
2.09 - Smoking prevalence – 15 Year old											
2.14 – Smoking prevalence – Adults (over 18)											
2.15i – Successful completion of drug treatment – opiate users											
2.15ii - Successful completion of drug treatment - non-opiate users											
2.16 – People entering prison with substance dependence issues who are previously not known to community treatment											
2.18 – Alcohol – related admissions to hospital (placeholder)											

midyear	m
Annual	a