Local Government Association *Association of Directors of Public Health (UK)*

The Association of Directors of Public Health & Local Government Association – submission to the technical consultation on the Health Premium Incentive Scheme 2014/15 & Public Health Allocations 2015/16

The **Association of Directors of Public Health** (ADPH) is the representative body for Directors of Public Health (DsPH) in the UK. It seeks to improve and protect the health of the population through DPH development, sharing good practice, and policy and advocacy programmes. www.adph.org.uk

ADPH has a strong track record of collaboration with other stakeholders in public health, including those working within the NHS, local authorities, government and other sectors.

Directors of Public Health (DsPH) across the UK are the frontline leaders of public health, working across health improvement, health protection, and health care service planning & commissioning.

The **Local Government Association** (LGA) is the national voice of local government. It works with councils to support, promote and improve local government.

We are a politically-led, cross-party organisation that works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems.

In total, 415 authorities are members of the LGA. These members include 351 English councils, the 22 Welsh councils via the Welsh LGA, 31 fire authorities, 10 national parks via corporate membership and one town council.

ADPH and LGA submission - overview

ADPH President Dr Janet Atherton Chairs the Advisory Committee on Resource Allocation's Health Premium Incentive Advisory Group.

ADPH and the LGA have - and continue to - work closely with the Department of Health to secure appropriate levels of funding for public health within local government. We have welcomed the progress made so far, but would emphasise that there is more to do to achieve a real and strategic shift in the pattern of spend to prevention.

ADPH welcomed the early announcement of the 2015/16 PH allocations in advance of the main Local Government settlement, thereby enabling Directors of Public Health in England to accelerate planning with partners to get the best from investment in health and well-being across the whole public sector. We also look forward to the additional public health 0-5 financial settlement being made in due course.

However, we are disappointed that the opportunity has not been taken to increase investment in public health and prevention – and thereby relieve pressures on other health and care services in the future. The case for spending more on preventative services has been well made for some time and overwhelmingly accepted. Attached in the Appendix below is the 2013 ADPH Business Case for increased investment in local public health - which shows clearly that any increased funding could be spent efficiently and effectively by Local Authorities and would deliver outcomes that improved health whilst reducing premature mortality and health inequalities.

Association of Directors of Public Health (UK)
● Tel. 020 7832 6945
● E-mail: president@adph.org.uk ● www.adph.org.uk

We are aware that there has been significant differential between Councils in the amount that is allocated to public health and we would welcome a commitment from government to increase the proportion of health spending to be given to local authorities. ADPH believes that there should be increased funding allocated to those Local Authorities that have had historically low public health expenditure to allow them to increase their commitment to the level of at least the average per capita.

In relation to the Health Premium Incentive Scheme, whilst acknowledging that any increase in Public Health funding is welcome, we are concerned that:

- it would be more appropriate for such funding to be applied to core allocations rather than incentive schemes;
- it is not clear whether the Health Premium is the best use of scarce resources for public health. The overall sum of £5m is limited and when broken down, the level of the 'incentive' locally will be too low to make a significant difference or have a marked impact on outcomes. Indeed in some cases, the resources that would have to be committed to attain increases in performance would be disproportionate to the financial incentive offered;
- concerns and uncertainty remain over the robustness of indicators for judging progress and how sensitive they are at a local level;
- there are concerns that the Scheme design will disadvantage some local authorities, and will also tend to penalise past good performance – as those areas that are already doing well will struggle to get much better and reach the target when compared with areas currently performing less well.

ADPH and the LGA would welcome the opportunity to provide further advice to the Health Premium team on the issues raised in our response.

Below we set out detailed responses to consultation questions 1, 2, 4 and 6, following consultation with ADPH members.

Consultation Q. 1: *Do you agree that successful completion of drug treatment should be used as the pilot national incentive measure?*

We recognise that, due to high direct costs of drug treatment and the high indirect costs to society of not successfully treating drugs users, the successful completion of drug treatment is an important outcome for one of the most significant Public Health commissioned services, and is also strongly related to areas of deprivation and the associated health inequalities.

However, our members have highlighted concerns in relation to this proposed national incentive measure, including:

- as the Health Premium was designed to focus on prevention / health inequalities, it seems perverse to award it for success in treatment services, rather than for more upstream measures;
- there will be difficulties for those areas that are performing well already, and there is a lack of clarity as to how the measure might be fairly applied. The baseline details aren't set out in the proposal, and nor is the detail of the level of improvement needed, and it would be helpful to know what the alternative might look like if this indicator isn't used;
- although nationally this has some merit, as stated this will apply more readily in some areas than others. For some this may be a retrograde step. Great strides have taken place to accommodate alcohol treatment and its performance in measuring the success of treatment to maximise the population helped. There is evidence that a significant number of people successfully completing 'drug' treatment will transfer their substance misuse to alcohol. PHE performance is now taking this in to account, managing performance less on primary substance of use to successful treatment of the individual's dependency issues. This measure would negate this progression;

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- rural areas have significant challenges in providing treatment services due to the dispersed nature of their population and the large number of towns and villages as well as the limited public transport links available. In comparison urban areas can provide centralised services with better access to both treatment and rehabilitation support. As rural areas generally have lower per capita allocations than their urban counterparts, the proposed premium will disadvantage rural areas further;
- this measure is narrowly focused on a small cohort of people in population terms; relates to a small part of overall public health responsibilities; and is not necessarily a key priority for many Health & Well-being Boards. Alternative approaches could be considered such as: a national incentive measure with an overarching indicator (such as life expectancy), or relating to a more universal public health service with a greater reach; or an approach based on locally determined targets, with priority setting through the local Health & Wellbeing Board, and aligned with health inequality priorities identified through JSNA, (enabling local flexibility to determine priority areas for improvement);
- Year-on-year variations are evident due to relatively small numbers and the resultantly wide confidence intervals will make threshold setting and outcome related payments problematic, particularly for smaller local authorities. Thorough checks of data quality and consistency across local authorities will be required to ensure that payments are based on accurate data;
- there are concerns that additional financial incentives at this stage may dis-stabilise newly commissioned treatment services, those that are in the procurement phases, or in the first year of a new provider - and make establishing a secure and improved service more difficult;
- whilst it notes within the technical consultation that opiate and non-opiate success rates are to be combined (they are currently reported separately on PHOF 2.15i opiates and 2.15ii non-opiates), and that performance will be monitored to ensure that there is no incentivising of treatment provision to low complexity substance users in order to boost successful completion figures, there is no mention of re-presentations being used within the calculation (which is currently within the PHOF measure). As the indicators discussed within this document are taken from the PHOF are we to assume that the same methodology is to be used for what will be a combined opiate and non-opiate successful completions percentage (drug users that left treatment successfully who do not re-present to treatment within 6 months)? If it is to be solely based upon successful completions rather than successful completions and non-representations to treatment, then surely there should be as much concern about how robust the exits from treatment will be if there is to be no monitoring and reporting of re-presentations to treatment, as is noted within the technical consultation re. prioritisation of low complexity clients.

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

As highlighted above, there are concerns over this proposed national incentive measure and the ability to have a marked impact on outcomes given the limited sums available at local level.

ADPH members have highlighted the following specific concerns in relation to setting a threshold:

- as highlighted in the response to Q.1, it will be difficult to identify a fair evaluation scheme that will recognise the differences between urban and rural areas;
- the measure should not penalise those areas that have historically good performance for whom further improvement would be difficult, especially compared to areas with historic poor performance;
- incentive payments should relate to the absolute number of people completing treatment. The PHOF measure reports completions as a proportion of all those in treatment. Using this in allocation of health premium payments would create a perverse incentive that would reward local authorities for service systems that fail to engage with more challenging clients

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who will require a longer time in treatment and may have several treatment episodes before successful completion;

- a review of one area's local data on successful completions over the last six years shows that achieving outcomes that represent a statistically significant improvement on 2013/14 would require a 45% increase in completions by opiate users and a 37% increase in completions by non-opiate users. The picture is likely to be similar for other local authorities, reflecting the relatively small number of completions at individual local authority level and the sizeable fluctuations that may take place from year to year. Achieving increases of this magnitude is unlikely;
- a more reasonable 'reward' threshold would be to make payments to authorities whose performance in 2014/15 is above the average for the past three years. Whilst there would still be a risk that authorities' receipt of the premium would be affected by random factors, this would be more acceptable given the relatively small sums on offer, and it would provide a modest incentive for improved performance;
- another potential approach would be rewarding on 2 levels – e.g. lower reward for direction of travel (i.e. any improvement on previous year's outturn); and a higher reward for scale of relative improvement over previous year's performance – say 5% [i.e. if last year's smoking prevalence was 20% a 5% relative improvement would be a 1% reduction i.e. 19% prevalence];
- the development of a threshold would be very challenging, particularly in the current context of local service developments – for example moving services in line with greater numbers of non-opiate clients and away from a traditional clinical service for opiate users;
- the percentage measure is flawed. Successful completions can improve, but if this combines with engaging increased numbers in treatment this will reduce the 'successful' percentage measure. It is also perverse to combine the opiate and non-opiate successful completions arbitrarily, as the numbers in opiate or non-opiate treatment should reflect the identified need of the population;
- in terms of demonstrating progress, this is achieved over a reasonable period of time and on the basis of a clear trend (e.g. five successive data points, five quarters). Data may be subject to random sampling variation which needs to be considered;
- payment should be based on improvement against a set threshold based on historical performance and agreed between local authorities and Public Health England in a similar way to how the Better Care Fund operates;
- the threshold should be mapped against LA baseline (i.e., distance travelled).

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

Yes/No. What threshold would balance attainability and robustness?

Whilst smoking prevalence is a very important population indicator for public health it is unclear how this would be applied fairly to allocate reward payments.

Below are some of the concerns highlighted by ADPH members in relation to the lack of reliable figures at a local level:

- for areas which have already achieved significant reductions in smoking prevalence further progress will be challenging given the gains that have already been made;
- for rural areas access to services will be a challenge as they are comparatively under-funded, therefore any factors being used should take into account and reward existing good performance otherwise areas that have poor performance will be rewarded in a perverse fashion;
- as a sample indicator, with a relatively small sample at local authority level, confidence intervals for the reported prevalence are relatively wide – approximately ±3%. It is unlikely that year-on-year changes for many authorities will show either a significant improvement or a significant deterioration. Thus, payment of rewards using this indicator would, in effect,

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be a random allocation. In addition, the most recent data available on this indicator relates to surveys undertaken between January and December 2012. If a reward payment were to be made in 2015-16, the most recent survey period it could cover would be from January to December 2014 – and that data would become available only late in the 2015-16 financial year. Thus, the 'reward' payment would be largely in respect of data that has already been collected, and it is thus of minimal use in incentivising improved performance. These difficulties could be overcome if there were an early announcement that this indicator would be used in calculating premium payments for 2016/17 onwards, with rewards being calculated upon the basis of aggregated survey results over a three year period.

- there is no measurement other than national survey evidence which is not robust enough to base payment on. Alternatively, maternal smoking would be better, looking for a sharp reduction between smoking prevalence (as measured by CO monitors) at booking in with smoking prevalence at delivery. Or alternatively (as this is harder in areas with late bookings) then an increase in the % of smoking quitters who are R and M as compared with all smoking quitters would be a health inequalities focus.
- as highlighted above, there are concerns over the statistical robustness of data linked to an indicator on smoking prevalence which is likely to be sourced from, e.g. modelled, synthetic, national survey-based estimates. Prevalence is a different measure to quit rates (or service provision) and, unlike the drugs completions, is not necessarily within the control of local activity as national action (or inaction) could have an impact. Also, would electronic-cigarette use count as smoking or not? It would be difficult to see how the prevalence rate could be measured accurately enough to detect local influence over a short period;
- alternatively Local Authorities should have the choice of choosing this over drug & alcohol uptake; or NHS Health Checks would demonstrate commitment to reducing LTCs.

Consultation Q. 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?*

Yes/ No. If no, what other methodology do you suggest.

Generally, ADPH members felt that this was a reasonable approach, although again there is a concern over penalising previous good performance and disproportionately rewarding areas for historic poor performance. Any point systems that are to be used must be demonstratively fair, recognising that some areas have already made good progress with the limited funding available and therefore should not be disadvantaged.

A progressive approach for achievement would be welcome - the indicator should balance reward for improvement and reward for overall performance.

It was felt that providing an indication of the overall sum available would be helpful to support local planning in terms of investment for success and creating a business case for action.

It was also highlighted that, given that the amount of the premium allocated locally will be relatively small, the level of the 'incentive' will be too low to incentivise major change. Indeed in some cases, the resources that would have to be committed to attain such increase in performance against the baseline would be disproportionate to the financial incentive offered.

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October 2014

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Appendix

The Association of Directors of Public Health

The Case for Additional Investment in Public Health

Executive summary

The paper *'The Case for Additional Investment in Public Health'* sets out the evidence that there is a health need that warrants additional investment, and that this can be invested in cost-effective, evidence based interventions to deliver improved population health and reduced demand on health care services whilst facilitating more efficient healthcare service delivery.

- An additional £1.2 billion pounds investment in public health programmes in 13/14, increasing to £1.5 billion pounds in 15/16, would ensure delivery of the government's aspiration to improve health through its existing commitments to roll out the NHS Health Checks programme, reduce smoking prevalence, implement NICE recommendations in relation to alcohol brief interventions, meet cost pressures particularly in relation to GUM provision, build capacity in relation to school nursing and to tackle obesity.
- As well as delivering improved health outcomes for individuals a major beneficiary will be the NHS, with more cost efficient care delivery and a reduced burden of ill health.
- It would also allow local communities to embrace the public health agenda unfettered by inequity resulting from historical under-investment by the NHS in preventative services, whilst not reducing the allocation for those who have invested more in effective public health programmes.
- This amount whilst being significant for public health would have a marginal effect on the overall comprehensive health service budget (a 1% shift in the comprehensive health service budget to Public Health equates to £1 billion). It would also represent a reasonable proportion of the QIPP savings that we understand are to be re-invested in front-line services including public health programmes.
- Much of the investment would be used to develop and increase provision within programmes that are well established such as NHS Health Checks, tobacco control and GUM provision and therefore money can be committed immediately.
- There are however a number of areas of investment (school nursing, primary care, public health, leadership and community empowerment) where there will be a constraint on commitment of resources because of shortage of staff. In these areas capacity can be developed over a three year period in a similar way to that being undertaken currently with health visiting.
- In the case of alcohol misuse there is an increased level of investment in year 1 but as an increasing number of people are screened and receive a brief intervention there is a reduction in spend in future years.

Below are examples of programmes which would benefit from the investment and their health impact and value for money.

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Programme areas

Programme Area	Additional Investment	Health Impact	Financial Benefit
NHS Health Checks	£165 million	• 414 lives saved • 1,018 strokes and heart attacks prevented • 2,545 diabetes cases prevented • 12,727 diabetes and CKD (Chronic Kidney Disease) identified	£1.8 billion per annum
Tobacco	£110 million	• 7250 fewer deaths per annum • Reduced admissions for CVD (Chronic Vascular Disease), COPD (Chronic Obstructive Pulmonary Disease)etc	£600 million net revenue gain pa £69 billion over 50 years (Net Present Value)
Alcohol misuse	£292 million reducing to £75 million	• 4.9 million people identified for brief intervention • Reduced alcohol-related admissions • Additional 19,600 – 93,100 quality adjusted life years	£980 million – £4.6 billion
Sexual health	£186 million	• Reduction in HIV diagnosed late • Increased cases of HIV identified • Reduction in HIV transmission • 669,000 screened for chlamydia • 40,152 cases of Chlamydia identified and treated • Reduced cases of Pelvic Inflammatory Disease (PID), ectopic pregnancy, infertility and associated treatment costs	Every £1 pound invested in contraceptive and sexual health services saves the NHS £11 pounds.
Children's health	£382 million	Improved health through: • Implementation of Marmot recommendations • a full time school nurse for each secondary school and cluster of primary schools	

Other areas that will become the responsibility of the local authority that are likely to require some additional investment include:

- Obesity - The total annual cost to the NHS of overweight and obesity was estimated in 2001 at £2 billion, and the total impact on employment may be as much as £10 billion. By 2050 the NHS cost could rise to £9.7 billion, with the wider cost to society being £49.9 billion (at today's prices). It is difficult to assess what it would cost to put in place effective interventions across the country to achieve this but the costs are likely to be significant.
- Accidental injury prevention.
- Mental health promotion - by way of example, economic modelling shows a long term return on investment of 14:1 for school-based interventions to reduce bullying (these interventions are delivered/ facilitated through healthy schools programmes).
- Workplace health promotion programmes have been modelled to show a rate of return of 9:1 for the business, contributing to economic productivity. (There would be additional savings over and above this in health and care services).
- Social determinants – investment of PH funds in debt advice. Debt advice services show a rate of return on investment of 3:1 realisable over 2-5 years.
- Community safety, violence prevention and response.
- Fuel poverty / seasonal mortality.
- Wider determinants e.g. poverty, housing and overcrowding, homelessness, transport, health promoting environments and sustainable communities (e.g. green space, crime and road safety and noise levels), truancy and workless-ness.

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