

Health Survey for England

HSE 2016-2019: Approval to procure

Bethan Thomas, Alison Neave, Steve Webster, Julie Stroud

February 2014

Contents

Contents	- 2 -
Introduction	- 3 -
1.1 Purpose of document	- 3 -
1.2 Background	- 3 -
1.3 Standard HSE timetable	- 4 -
1.4 Current contractual position	- 4 -
1.5 HSE Budgets	- 5 -
2 How is HSE used?	- 5 -
2.1 Government	- 6 -
2.2 Academia	- 7 -
2.3 Charities	- 8 -
2.4 Private Companies	- 8 -
2.5 Science Museum	- 8 -
2.6 International	- 9 -
3 Why is the HSE important?	- 9 -
3.1 Physical and Biological measures	- 9 -
3.2 User Demand	- 10 -
3.3 Ethnic Boosts	- 11 -
3.4 Data Linkage	- 12 -
4 HSE 2016 – 2019	- 12 -
4.1 Option 1	- 13 -
4.2 Option 2	- 14 -
4.3 Option 3	- 15 -
4.4 Option 4	- 15 -
4.5 Option 9	- 15 -
4.6 Option 10	- 16 -
5 Recommendations	- 17 -
6 Next Steps	- 17 -
Annex A Table of possible options for HSE 2016-2019	- 17 -

Introduction

1.1 Purpose of document

- To gain Board approval for the procurement of the Health Survey for England (HSE) 2016-19.
- In November 2012, the HSCIC Executive Directors Group approved the commencement of the procurement process for a new contract to cover the delivery of the annual Health Survey for England (HSE) for four years - HSE 2016, HSE 2017, HSE 2018 and HSE 2019 to be funded via Grant in Aid (GIA).
- The purpose of this document is to get this decision ratified under the new HSCIC approval processes.
- On Dec 19th 2013, EMT confirmed their continued support for the HSE, endorsed option 1 and recommended the proposal be put to the HSCIC board for final approval.

1.2 Background

- The Health Survey for England (HSE) is a series of annual surveys about the health of people living in England. The HSE began in 1991 and since 1994 the survey has been carried out under contract by the Joint Health Surveys Unit of NatCen Social Research (NatCen) and the Research Department of Epidemiology and Public Health at UCL (University College London).
- The survey was originally commissioned by the Department of Health and the responsibility was transferred to the HSCIC as a GIA function in 2005.
- Its purpose is to provide reliable information about various aspects of the population's health and to monitor selected health targets. All surveys have covered the adult population aged 16 and over living in private households in England, and children have been included in every year since 1995. As such, it provides unique information at a national level about lifestyles, attitudes and disease prevalence that cannot be gleaned from operational data sources. From survey year 2011 the HSE has been renamed the 'Health Survey for England: Health, Social Care and Lifestyles' to reflect the inclusion of questions on social care within the survey.
- The survey combines questionnaire-based answers with physical measurements (blood pressure, height and weight) and the analysis of blood samples, urine and saliva. Blood pressure, height and weight, smoking, drinking, general health and wellbeing are covered every year. An interview with each eligible person in the household is followed by a nurse visit which includes the biological measures. For HSE 2011 onwards, the core sample size is approximately 8000 adults and 2000 children.
- The survey design, particularly because of the inclusion of physical and biological measurements and analytes, is regarded internationally as a "gold standard" for population health surveys.
- A number of core questions are included every year but each year's survey also has a particular focus on a disease, condition or population group. Topics are brought back

at appropriate intervals in order to monitor change; for example, ethnic minority boosts have been carried out in HSE 1999 and HSE 2004 and the boost allows the HSE core sample to be augmented by an additional sample of specific ethnic groups.

- The core for HSE 2011-2014 has been kept consistent to allow the 4 data sets to be combined, thus increasing their value and usability.
- Core content is funded by the HSCIC via administrative GIA. Contributions from other organisations are required to fund anything in addition to this (see section 1.5).
- The survey is overseen by a steering group, whose members include HSCIC, NatCen, UCL, DH, PHE, Academics, local authority representation and a Director of Public Health. This group reports into SPAG, the Survey Programme Advisory Group which is chaired by the HSCIC Head of Population Health & Social Care.
- As part of the development of each HSE, we review the content of the survey, considering ways to innovate whilst ensuring we are achieving value for money.
- For dissemination, this means improving access to, and understanding of, the information that is available from HSE in order to help people make greater use of the data and reports that we publish. One way we will do this is by responding to feedback to the data visualisation tool that NatCen are developing for HSE 2012 and exploring the potential to expand the methods of disseminating data and piloting new publication techniques through more interactive web-based products to meet a wider range of user needs.

1.3 Standard HSE timetable

- For a standard year of the HSE, for example with the HSE 2016, the time table is as follows:

Timetable for the Health Survey for England 2016	
Phase	Timescales
Questionnaire Development, testing, ethical approval and interviewer training.	Jan 2015 – Dec 2015
Fieldwork	Jan 2016 – Dec 2016
Data cleaning / report production	Jan 2017 – Dec 2017
Publication of the report	Dec 2017
Archive of the data set	April / May 2018

1.4 Current contractual position

- The current contract covers HSE 2011 to HSE 2014 with an option to extend for the HSE 2015 and HSE 2016.
- In November 2012, the HSCIC Executive Directors Group approved the extension of the existing HSE contract to cover HSE 2015. HSCIC have agreed the extension of

the contract for HSE 2015 with NatCen, as the lead contractor for the Joint Health Surveys Unit. This was ratified by the HSCIC Board on Oct 23rd 2013.

- The HSE contract allows for a negotiation of an annual inflationary uplift, which is renegotiated for each survey year. The current agreed methodology is the 12 month average rate of CPI reported by ONS in the preceding 12 month period Nov-Oct.

1.5 HSE Budgets

- Prior to HSE 2011, the HSCIC budget for HSE was in the region of £5m. However, due to funding constraints, this was reduced to approximately £3.5m from HSE 2009. This reduction in the central funding for the HSE has had a number of impacts:
- In earlier surveys the HSE alternated between large ('full') and smaller ('half') samples. The last full sample was in HSE 2008 and was drawn from 16,056 randomly selected addresses (resulting in 15,102 adults and 3,473 children being interviewed). In HSE 2010, this was decreased so that only a half sample was drawn from 8,736 randomly selected addresses, resulting in 8,420 adults and 2,074 children being interviewed.
- From HSE 2009 onwards, the reports have only had 10 chapters rather than 12 and no hard copies are made available to users.
- From HSE 2011 onwards, 2 core topics each previously covered every year are covered on an alternating basis to reduce costs. Fruit and vegetable consumption (HSE 2011) is alternating with Mental Health and Wellbeing (HSE 2012).
- The HSCIC GIA funded HSE budget has remained relatively consistent from HSE 2009 – HSE 2015, only rising in line with the agreed annual inflationary uplift, which is the 12 month average rate of CPI reported by ONS in the preceding 12 month period Nov-Oct.
- The GIA funded costs of the HSE 2014 is £3.66m.
- We anticipate the GIA funded costs of HSE 2015 to be in the region of £3.67m.
- Additional content within HSE 2011, 2012, 2013 and 2014 increased the value of the contract by £1.57m, which is approx. £370K per survey. This was funded entirely by external organisations including DH, DWP, HPA (now part of PHE), the Health and Safety Executive, the Gambling Commission and academic institutions.
- No sample boosts took place during this contract period (HSE 2011 – HSE 2015).

2 How is HSE used?

- The HSE is a huge resource of information and is analysed and reused in numerous different ways by a wide range of organisations and individuals.
- Publications of the survey's results are one of the most popular on the HSCIC website and are regularly accessed by users, in addition to the examples of usage shown below:

2.1 Government

The need for annual HSE data

- HSE has a direct influence on health policy development and monitoring and also in funding allocations in England and is widely used by DH, PHE and NHSE each year, as the following examples show:
- HSE data are a significant component in the formula allocating public health grants annually from DH to each upper-tier and unitary local authority; particularly the data on cigarette, alcohol and fruit & vegetable consumption. A bi-annual HSE would mean DH would have less up to date data.
- DH have also indicated a wish to have other modules (e.g. social care, general health, longstanding illnesses) on an annual basis rather than less frequently as now.
- HSE data are used annually by both PHE and DH to monitor the Public Health Outcomes Framework indicator 2.21, Proportion of adults classified as overweight or obese
- HSE is the data source for part of the subjective wellbeing indicator in the Public Health Outcomes Framework indicator 2.23, giving a national figure annually for mental wellbeing. HSE data are used to explore the relationship of wellbeing to many other health behaviours and conditions.
- PHE also use annual HSE data to create estimates of behavioural risk factors in their published Health profiles to provide data on adult binge drinking and adult eating indicators. Annual data are essential to provide reliable time series and provide large enough samples over time.

Keeping the survey annual retains its flexibility to meet changing customer demand for new and repeat topics.

Other uses of HSE data

- HSE data also inform ongoing policy for tobacco control, obesity, respiratory disease, chronic kidney disease, diabetes, and other issues.
- The measurement of serum creatinine (analysed from the HSE collected blood sample) and ratio of urine albumin to creatinine (analysed from the HSE collected urine sample) were used to assess the national general population prevalence of chronic kidney disease for the first time, and showed the levels of undiagnosed kidney disease are significantly higher than the official diagnosed levels. This issue, highlighted to government, inspired action to tackle this problem.
- HSE provided measured height and weight data used to forecast future trajectories of obesity and quantify the magnitude of this problem in a report by Foresight. Foresight is headed by Professor Sir Mark Walport, the Government Chief Scientific Adviser, who reports directly to the Prime Minister and Cabinet. It is a part of the Government Office for Science within the Department for Business, Innovation and Skills and advises government about how to ensure today's decisions are robust to future uncertainties.

- HSE height and weight measures are the basis for the calculation of excess calorie intake by the population, and used to set a target in the Department of Health's Public Health Responsibility Deal.
- Risk factors for cardiovascular disease were used in economic modelling for the vascular risk checks.
- Government targets for a population fall in systolic blood pressure of 5 mm Hg by 2005 were based on HSE data and subsequent monitoring through HSE data showed achievement of this target.
- HSE salivary cotinine data were used to assess the effect of the smoke free legislation on passive smoking in the children of smokers, showing that the then minister's concerns that smokers who were unable to smoke at work would expose children to more smoke at home were unfounded.
- Another use of HSE data is in the local area diabetes prevalence model produced by what is now Public Health England. The prevalence provides estimates of total (diagnosed and undiagnosed) diabetes prevalence for people aged 16 years and over for 2009, 2010, 2015, 2020, 2025 and 2030 at a PCT level.
- PHE uses the HSE data extensively in the Global Burden of Disease (GBD) work in order to construct time series of risk factors and covariates for the burden of disease model – there are 30+ variables they use to do this. They also use the cross-sectional estimates of different disabilities and measures (e.g. hypertension, self-report diagnoses etc.).
- The survey design, with a core and space for varying additional questions or biological measures enables us to respond flexibly to government needs. Questions on a particular topic can be put into the survey for one or more years and this gives government a cost effective way of getting data for policy analysis or less frequent monitoring of specific diseases or health or social care policies.

2.2 Academia

- The HSE has been referenced in at least 450 research projects, which are often picked up by the press.
- One recent example is the call to put a tax on soft drinks to reduce obesity (based on HSE 2010) and that obesity in England is rising at a slower rate (based on data from HSE 1992 – 2010) . This was covered by the BBC, Daily Mail, and Telegraph amongst others.
- UCL researchers compared alcohol sales data from HMRC to consumption estimates in HSE to point out that much more alcohol is bought than is reported as consumed. They found there was a significant shortfall with almost half of the alcohol sold unaccounted for in the consumption figures given by drinkers. The BBC highlighted this report and DH took it into account in their alcohol consumption review.
- A recent report by Nuffield Health and the London School of Economics, "12 minutes more..." showed that if people did just 12 minutes more exercise a day they could save the NHS £257million a year and free up 80,000 hospital beds. They analysed data from HSE and showed 70 per cent of British adults do not meet the target of five 30-minute exercise sessions a week, with the average person exercising just four

days a month. The figures also show that in England, more than 40 per cent of men and 30 per cent of women are classified as overweight or obese, costing the NHS £5billion every year.

- Anyone can register to use the HSE data published on the UK data archive, either through customised tabulations on the website or by downloading the anonymised data sets to do their own more detailed analysis. There is extensive use of this facility by academia, with the datasets having been downloaded around 10,000 times over the last 10 years.

2.3 Charities

- “Give us time to cross” – This is a major new campaign that has been launched based on HSE data, asking the Department of Transport to extend the amount of green-man time at crossings. HSE data showed that on average 3 additional seconds of green-man time is needed to make crossings fit for purpose and 75% of all people aged 65+ struggle to cross the road in time on the current green-man times. The campaign is fronted by Living Streets, and supported by Age Scotland, Brake, Guide Dogs, Independent Age, Leonard Cheshire Disability, RNIB, Sustrans and Transport for All. Within a day of the campaign being launched it had already been picked up by media outlets including the Telegraph and BBC Breakfast.
- British Heart Foundation – Their campaigns on heart disease and high blood pressure, predominantly focussing on the undiagnosed levels of each condition, are based on HSE data.
- Rethink – HSE data was used as part of their recent campaign to stop the thousands of people who die needlessly each year due to a failure to take their mental health issues seriously.
- Blood Pressure UK – They have cited data from HSE in their campaigns that shows 16 million adults in the UK have high blood pressure, yet a third (5.3 million) are unaware of this.

2.4 Private Companies

- Lloyds Pharmacy – In 2012, they launched a major campaign about managing blood pressure. This was based on the HSE data on undiagnosed levels of high blood pressure and was used to promote the products and support that Lloyds Pharmacy offered. This campaign was heavily trailed in the media, shop windows, the internet and email mailshots.
- CACI – CACI are leading experts in information systems and marketing solutions. They have developed a consumer geographical classification system that segments the UK population, called ACORN. They used HSE data in the research, development and validation of these codes.

2.5 Science Museum

- The Science Museum permanent gallery “who am I?” was revamped and re-launched in June 2010. As part of their redevelopment they ran a competition looking for the

average British man and woman to become sculptures in this gallery. “Average” was based on the height, weight, waist circumference and hip span as shown by HSE 2008 data and the competition was launched to coincide with the publication of the 2008 report.

2.6 International

- The HSE is used widely in policy development and is used as a standard and example of best practice for health interview and health examination surveys across the world. For instance, when Eurostat decided to implement a European wide health examination survey they based theirs on our nurse visit model, used our data for validation, and travelled to England to spend time with the team to learn more about how the nurse visit processes work.

3 Why is the HSE important?

3.1 Physical and Biological measures

- What is particularly unique about the HSE is its ability to identify the unknown prevalence of conditions. This cannot be obtained from routine administrative data, i.e. QOF only measures diagnosed prevalence, which greatly underestimates true prevalence.
- For example, data from GPs will give the number of patients who have diabetes. However only HSE estimates how many people within the population of England could have undiagnosed diabetes, and the proportions of these who are obese, their smoking habits, their drinking habits, their mental wellbeing and what type of family and home they live in.
- HSE routinely does this for diabetes, kidney disease, cardiovascular disease, high blood pressure and exposure to second hand smoke. These data are obtained via the physical and biological measures captured as part of the nurse visit, combined with data obtained during the interview. There is no other source of data within the UK that gives reliable estimates of undiagnosed conditions in this way.
- Different options for collecting physical and biological measures have been considered but are not considered to be satisfactory substitute. For example:
- Height and Weight measures replaced by self-reported height and weight – HSE 2011 contained both self-reported height and weight and actual measurements. Analysis proved the self-reported values to be unreliable as the data showed that (on average) men and women over-reported their height by 1.7cm and 1cm respectively, and under-reported their weight by 1.4kg and 2.4kg respectively. This means that people were under estimating their BMI: 17% of men and 20% of women were obese based on self-reported estimates, but the actual measures showed this to be 24% and 26% respectively, a noticeable difference of 6-7 percentage points. A similar pattern can be seen for those that are overweight.
- Nurse collected venous blood samples replaced with a blood spot sample taken by an interviewer – the Health Survey for Scotland has implemented this change. Results of

their feasibility study into the use of dry blood spots have shown that it is not a viable alternative for the nurse visit. Although there was some correlation between the results, the values were very different from those taken by a venous sample and resulted in a large proportion of people being assigned to different risk groups for cardio-vascular disease. The Scottish Government are now considering reintroducing the nurse collected blood sample.

- Nurse collected saliva or urine samples replaced with collection by an interviewer – it would be possible for this to be done, as there is precedent set by the introduction of this protocol in the Health Survey for Scotland. However their study shows it takes approx. 30 minutes per recipient for the whole biological module and only a proportion of recipients agree to do the module at the first visit, with others requesting a 2nd visit. A 2nd visit reduces the potential cost saving. Also, in Scotland they found that a lower percentage of respondents agreed to do the biological module with an interviewer than agreed to it in the nurse visit.
- These results show that the separate nurse visit has a strong influence on the quality and volume of the information and samples collected and supports our recommendation to continue the nurse component of the HSE.

3.2 User Demand

- A public consultation of the future of the HSCIC survey programme was run in 2008. The overwhelming response from this was a desire to continue the HSE as an annual survey with a nurse visit and a sample size of 16,000 adults and 4,000 children.
- A new public consultation on the future of the HSE was launched on the HSCIC website in October 2013. Feedback from key customers (DH, PHE and NHSE) shows that there is very strong support for continuing the HSE with at least the current sample size or larger. This is essential to provide sufficient data for their analyses and statistical modelling of local estimates as noted in para 2.1.
- The consultation also highlighted the continued demand for externally funded non-core topics, principally from DH and PHE but also noted by LAs and NHS bodies. To meet this demand and keep the survey at an acceptable length for respondents strongly implies a continuing need for annual surveys. The topics include:
 - physical activity and exercise
 - well being
 - diabetes
 - cardiovascular disease
 - kidney disease
 - respiratory health
 - chronic pain
 - falls and fractures
 - sexual health
 - end of life care

- hearing
- HSE is an essential and critically important resource for Public Health England, providing high quality national data for monitoring health trends, some Public Health Outcomes Framework indicators, and to map health inequalities. PHE use HSE data in statistical modelling to estimate local disease prevalence, and are committed to large scale quantitative modelling of future health relying on current and past distributions of risk factors, only available to any degree of accuracy from the HSE. For example, there is a continuing critical need to measure the population distribution of adult BMI and systolic and diastolic blood pressure.
- Stakeholders and key customers use the survey data for informing policy making, monitoring and evaluating policy, monitoring changes in health and/or lifestyles and in the prevalence of health or illness, national and regional benchmarking, comparing local indicators with national figures and in planning services. The HSE provides them with data they cannot get from other sources. In addition to the government uses described in section 2, stakeholders said that having the HSE:
 - Enables them to look at how various risk factors lead to medical conditions over time.
 - Means they are able to fill a gap in data on sight loss. If the Survey did not exist they would not have been able to collect this information elsewhere, as the cost would have been too much, or data would not have been representative enough.
 - Gives data on average weekly alcohol consumption enabling them to monitor 'compliance' with drinking guidelines and to calibrate models used to assess policies and plan services.
 - Gives them the ability to examine the relationships between different risk factors and morbidity to help develop 'holistic' policies and to make the financial case for interventions such as the alcohol screen in the health check.
 - If the HSE were stopped, lack of information on cotinine levels (from the nurse visit) would prevent understanding the effects of, and making the case for, policies to reduce exposure to second-hand smoke.

3.3 Ethnic Boosts

- The HSE sample is randomly picked based on postcodes with the aim that the demographic profile of the sample is broadly similar to that of the overall population of England. However this then means that the sample size for ethnic minorities is so small that it is impossible to produce analysis at a detailed level. HSE 2011 showed that 24% of men are obese but this figure cannot be broken down by all ethnic groups as numbers are too small. To be able to do this, we have to carry out an Ethnic Boost to HSE, which means targeting the sample in such a way as to ensure a minimum number of respondents in each of the ethnic groups being reported on. The last time this was done was HSE 2004.
- The Department of Health is looking to fund an ethnic boost in HSE 2017, at a cost to them of approximately £3million.

- If a boost were to take place, we would not need to increase the HSCIC GIA funding to support it.
- An article published in the BMJ in September 2013 looked at changes in risk factors in relation to ethnic inequalities and mortality from HSE 1999 to HSE 2004, and stated that the HSE ethnic boost data is the best available in Europe to allow comparisons over time, and that another HSE ethnic boost is essential for this type of analysis.

3.4 Data Linkage

- In addition to the information collected via the two interviews, the HSCIC also funds data linkage by linking the NHS number to existing admin data sources, mainly HES, cancer and mortality.
- This is a way of further enriching the dataset and we continue to look at further opportunities to innovate and develop the survey in this way.

4 HSE 2016 – 2019

- In November 2012, the HSCIC Executive Directors Group approved the commencement of the procurement process for a new contract to cover HSE 2016, HSE 2017, HSE 2018 and HSE 2019.
- As part of getting this decision ratified under the new HSCIC approval processes, on Dec 19th 2013, EMT confirmed their continued support for the HSE, endorsed option 1 and recommended the paper is put to the HSCIC board for final approval.
- We would include a standard clause within the contract to allow for the possibility for an extension for an additional 2 survey years.
- The new contract will include the standard one month's notice HSCIC termination clauses limiting our liability to reasonable costs; this is normal procurement practice.
- The cost profile for Option 1 is given below as an example - similar profiles can be applied to other options. It should be noted that inflationary uplifts would be applied each year which could increase the overall value of the survey, in this case by approx. £600k.

Survey Name	Estimated expenditure per Financial Year (£m)						Estimated expenditure per Survey to the HSCIC
	FY 2015/16	FY 2016/17	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	
HSE 2016	£1m	£2m	£0.8m				£3.8m
HSE 2017		£1m	£2m	£0.8m			£3.8m
HSE 2018			£1m	£2m	£0.8m		£3.8m
HSE 2019				£1m	£2m	£0.8m	£3.8m
TOTAL	£1m	£3m	£3.8m	£3.8m	£2.8m	£0.8m	£15.2m

- This would be funded from HSCIC GIA administrative monies.
- These figures do not include any external funding for additional content (historically an average of £370k per survey year), child sample boosts (historically at costs of £650k) or ethnic minority boosts (estimated costs for an HSE 2017 ethnic boost are £3million).
- As part of the development work for HSE 2016 onwards, we have considered many different options and permutations. Of the 17 options considered, we have rejected 11 due to cost or because they are impractical (see annex A for all 17).
- The pros and cons of the remaining 6 options are given below.

4.1 Option 1

- This is the baseline option and is what we currently do.
- An annual survey, with a sample of 8,000 adults and 2,000 children and a nurse visit.
- Estimated cost per survey year: £3.8m of GIA resource funding.
- Total estimated cost of a contract covering 4 survey years: £15.2m of GIA resource funding
- Pros:
 1. Proven model that is highly regarded by government and external users.
 2. Includes the nurse visit that makes the HSE unique and world class. This enables the monitoring of cholesterol for CVD, hypertension, cotinine for smoking and passive smoking and to provide measures of undiagnosed disease in the population.
 3. As noted in 3.2 above, it allows for annual updates of indicators and targets, i.e. two Public Health Outcomes Framework Indicators and monitoring health

behaviours such as smoking and alcohol consumption and compliance with drinking guidelines annually as DH and PHE want.

4. DH allocate Public Health grant funding each year to Local Authorities and this option enables the data used to be updated each year and to be as recent as possible improving the quality of this process.
 5. Keeping the survey annual retains its flexibility to meet changing customer demand for new and repeat topics (see 2.1 and 3.2 above).
 6. No increase in the current HSCIC GIA levels of funding.
- Cons:
 7. Sample size is not as large as users would ideally like – technically it is still a “half” sample (see paragraph 1.5).
 8. Sample size isn’t large enough for some analysis to be done every year. Instead 2 year’s worth of data has to be combined to produce a “full” sample, e.g. with the GIA funded Social Care module.

4.2 Option 2

- An annual survey, with a sample of 8,000 adults and 2,000 children but **NO** nurse visit.
- Estimated cost per survey year: £2.8m of GIA resource funding
- Total estimated cost of a contract covering 4 survey years: £11.2m of GIA resource funding
- Pros:
 1. It is cheaper than the baseline option because we collect fewer items of data.
 2. It allows for annual updates of indicators and targets that are based on only interview data.
- Cons:
 3. Without a nurse visit, there would be no biological measures and all the associated data would be lost, including medication and disease data. HSE would not be able to provide measures of undiagnosed disease in the population, e.g. diabetes or kidney disease, and any information about diseases or conditions requiring venous blood samples for diagnoses. We would also lose the ability to monitor cholesterol for CVD, hypertension, cotinine for smoking and passive smoking, significantly reducing the information value of the survey.
 4. Sample size is not as large as users would ideally like – technically it is still a “half” sample (see paragraph 1.5).
 5. Sample size isn’t large enough for some analysis to be done every year. Instead 2 year’s worth of data has to be combined to produce a large enough sample, e.g. with the GIA funded Social Care module.

4.3 Option 3

- An annual survey, with a sample of 16,000 adults and 4,000 children and a nurse visit.
- Estimated cost per survey year: £6.4m of GIA resource funding
- Total estimated cost of a contract covering 4 survey years: £25.6m of GIA resource funding
- Pros:
 1. As in Option 1 points 1-5 above plus;
 2. Would return the HSE sample to a “full” sample size, increasing the precision of survey estimates and making more detailed breakdowns possible, e.g. annual reporting on the GIA funded Social Care module would now be possible.
- Cons:
 3. Significantly more expensive than the baseline option in paragraph 4.1.

4.4 Option 4

- An annual survey, with a sample of 16,000 adults and 4,000 children but **NO** nurse visit.
- Estimated cost per survey year: £4.3m of GIA resource funding
- Total estimated cost of a contract covering 4 survey years: £17.2m of GIA resource funding
- Pros:
 1. Would return the HSE sample to a “full” sample size which would increase the precision of survey estimates and makes more detailed breakdowns possible, e.g. annual reporting on the GIA funded Social Care module would now be possible.
 2. It allows for annual updates of indicators and targets that are based on only interview data
- Cons:
 3. Significantly more expensive than the baseline option.
 4. If there was no nurse visit, there would be no biological measures and all the associated data would be lost (see option 2 above), reducing the information value of the survey.

4.5 Option 9

- A survey **every other year**, with a sample of 16,000 adults and 4,000 children and a nurse visit.

- Estimated cost per survey year: £6.4m of GIA resource funding
- Total estimated cost of a contract covering 4 survey years: £12.8m of GIA resource funding
- Pros:
 1. Would return the HSE sample to a “full” sample size which would increase the precision of survey estimates and makes more detailed breakdowns possible, e.g. annual reporting on the GIA funded Social Care module would now be possible.
 2. It is cheaper than the baseline option
 3. Includes the highly regarded nurse visit that makes the HSE unique and world class.
- Cons:
 4. It means the users would only get the data every 2 years, rather than annually. This would not be acceptable to many users as consultation has shown that they require the data ASAP and find the current annual outputs the minimum they need.
 5. It would not allow for annual updates of indicators and targets, a key requirement of PHE and DH.

4.6 Option 10

- A survey **every other year**, with a sample of 16,000 adults and 4,000 children but **NO** nurse visit.
- Estimated cost per survey year: £4.3m of GIA resource funding
- Total estimated cost of a contract covering 4 survey years: £8.6m of GIA resource funding
- Pros:
 1. Would return the HSE sample to a “full” sample size
 2. It is cheaper than the baseline option
- Cons:
 3. It means users would only get the data every 2 years, rather than annually. This would not be acceptable to many users as consultation has shown that they require the data ASAP and find the current annual outputs the minimum they need.
 4. It would not allow for annual updates of indicators and targets, a key requirement of PHE and DH.
 5. If there was no nurse visit, there would be no biological measures and all the associated data would be lost (see option 2 above). This reduces the “information value” of the survey.

5 Recommendations

- The HSE Steering Group (SG) made up of key stakeholders from the sponsor and user community are an advisory group that assist HSCIC to run the HSE contract but have no formal role in agreeing financial or contractual decisions. Within these constraints, we have thoroughly discussed with them all the possibilities for the future of HSE; SG support Option 3 as most closely meeting the continuing high demand for the survey and the user requirements for a larger sample.
- However the HSE Steering Group also recognised current pressures on HSCIC funding and as an alternative will support the less costly Option 1 which would have the benefit of maintaining HSE annually as now.
- On Dec 19th 2013, EMT confirmed their continued support for the HSE and endorsed Option 1 and recommended the proposal be put to the HSCIC board for final approval to procure on that basis.

6 Next Steps

- We are asking the Board for urgent confirmation they are happy with our recommended approach to reprocurement, and approval to proceed with procurement of HSE for 2016-19 on the basis of either Option 3 or Option 1.
- This early decision is needed as we need to start reprocurement by **March 10th 2014** to allow sufficient time for potential new contractors to get up to speed prior to the year of development, particularly to allow appropriate consideration of the proposed Ethnic Boost in 2017.
- Once we have agreement from the HSCIC Board to proceed, work will commence immediately on the HSE reprocurement exercise.

ANNEX A – Table of possible options for HSE 2016-2019

Option	Frequency of survey	Sample Size Adults & Children	Nurse Visit?	Cost per survey year	Total cost for a 4 year contract	Feasible?
<u>1</u>	Annual	10,000	Yes	£3.8m	£15.2m	BASELINE OPTION - What we currently do
<u>2</u>	Annual	10,000	No	£2.8m	£11.2m	Possible - Would depend on user demand for a nurse visit
<u>3</u>	Annual	20,000	Yes	£6.4m	£25.6m	Ideal - Increase the HSE sample back to HSE 2008 levels (technically known as a "full sample")
<u>4</u>	Annual	20,000	No	£4.3m	£17.2m	Possible - Would depend on user demand for a nurse visit but would increase the HSE sample back to HSE 2008 levels
5	Annual	100,000	Yes	£22m	£88m	No - Cost prohibitive , although it would ideal for meeting user's needs for data at a LA level
6	Annual	100,000	No	£14m	£56m	No - Cost prohibitive , although it would ideal for meeting user's needs for data at a LA level
7	Every other year	10,000	Yes	£3.8m	£7.6m	No - Dataset produced over the 4 year period would not be sufficient for user needs
8	Every other year	10,000	No	£2.8m	£5.6m	No - Dataset produced over the 4 year period would not be sufficient for user needs
<u>9</u>	Every other year	20,000	Yes	£6.4m	£12.8m	Possible - Dataset produced over the 4 year period could be sufficient for user needs
<u>10</u>	Every other year	20,000	No	£4.3m	£8.6m	Possible - Dataset produced over the 4 year period could be sufficient for user needs, but would depend on user demand for a nurse visit
11	Every other year	100,000	Yes	£22m	£44m	No - Cost prohibitive , although it would ideal for meeting user's needs for data at a LA level

12	Every other year	100,000	No	£14m	£28m	No - Cost prohibitive , although it would ideal for meeting user's needs for data at a LA level
13	Annual	5,000	Yes	£2.6m	£10.4m	No - Sample would be too small to be effective
14	Annual	5,000	No	£2m	£8m	No - Sample would be too small to be effective
15	Every other year	5,000	Yes	£2.6m	£5.2m	No - Sample would be too small to be effective
16	Every other year	5,000	No	£2m	£4m	No - Sample would be too small to be effective
17	Cease HSE	0	No	0	0	No - User demand is too great for this National Statistic to be dropped