**TAGRA Acute MLC Sub-group**

**Minutes of 11th meeting – 20th January 2016 – Gyle Square, Edinburgh**

**Present**Sarah Barry (University of Glasgow)
Roger Black (NHS NSS)
Angela Campbell (Scottish Government)Pauline Craig (NHS Health Scotland)

Andrew Daly (NHS GG & Clyde)
Karen Facey (Chair)
Lynne Jarvis (NHS NSS) (Minutes)Alisdair McDonald (NHS Lothian) Chris Mueller (NHS NSS)Paudric Osborne (Scottish Government)
Evan Williams (Scottish Government)Sarah Touati (NHS NSS)
Fiona Ramsay (NHS Forth Valley)
Diane Skatun (NHS Borders)

**Apologies**

Matt Sutton (University of Manchester)

David Garden (NHS Highland)

Frances Elliot (NHS Fife)

1. **Welcome and apologies**

KF welcomed the group and in particular, two new members, Evan Williams and Peter Martin.

1. **Minutes from previous meeting**

The minutes from the meeting on 18th August 2015 were provisionally approved. Karen requested that the group check Appendix 3 of the minutes as this will be a formal record of the HIIA process. Karen drew attention to the list of questions on the penultimate page, which will be particularly important at a later stage. Any comments to be sent to Lynne by Friday 12th February.

**Action 1: Read appendix 3 of minutes of 18 August meeting and send any comments to Lynne by Friday 12th February.**

1. **Matters arising**

It was agreed that all items in the Matters Arising paper (TAMLC37) were adequately addressed. All actions are complete other than the ongoing writing of the final report to TAGRA, and to check with Pauline Craig about the timing of the next stages of the HIIA, which will be dealt with in a meeting over the next couple of weeks.

1. **Model structure (*reference model and supply model papers*)**

ST presented papers TAMLC38 which describes the work to update the reference model using 2011 datazones. She explained that the model looks similar at the updated datazones and the relationship between the cost ratio and the needs index does not change significantly. Outlier analysis also shows similar results, with slightly fewer residual outliers at the new geography, suggesting the model may fit slightly better.

The two biggest outliers were examined and were found to include prisons. Due to the difference in needs and relationships with the needs indicators in these populations, it has been suggested that the outliers which are datazones dominated by prison populations are excluded.

There was a further discussion of the issue of prisons. It was clarified that prison funding is separate only in terms of primary care. Acute care will come under the NRAC allocation formula. It was also clarified that only prisoners with a stay of longer than 6 months (which represents a minority of prisoners) will be recorded under the prisons datazone, otherwise the home datazone is used.

There was a suggestion of using dummy variables for datazones including a prison. This would allow an average increase in the predicted cost ratio for all datazones with a prison. The possibility of this will be explored.

**Action 2: AST to look into using dummy variables for datazones including a prison.**

Sarah also presented paper TAMCL39 which focuses on supply models, taking into account suggestions from the group following the circulation via email of TAMLCL36 in December. The paper explains the purpose of supply variables, that is to control for the effect of healthcare availability and accessibility. It was agreed that the paper was very helpful in improving the Subgroup’s understanding of supply variables.

The various options for supply variables were explained, including detailed explanation of how each is constructed and what they represent.

The analysis of supply variables correlation with cost ratios were explained. Each supply variable option was considered along with the TAGRA core criteria, as shown in table 8 of paper TAMLC39.

It was agreed to use IPACX for inpatient diagnosis groups and OPACX for outpatients. For the ‘All acute’ option, IPACX will be used, since inpatient data makes up the majority of this group.

It was noted that changes to primary care services in the future will affect which measures of primary care supply are appropriate and this should be kept in mind.

1. **Indicator selection results**

Lynne Jarvis presented paper TAMLC40 which gives an update of the initial analysis on the final potential candidate variable list.

The first part of the selection process was to remove variables for which over 30% of datazones have zero values. The two ethnicity variables (Gypsy / Traveller and Pakistani) would be excluded under this criteria which prompted concerns that some measure of ethnicity should be included in the needs index.

It was agreed to further investigate the ethnicity variables, including the possibility of using intermediate zone averages to get around the large number of zeros at data zones, and creating variable(s) using broader groups. Karen Facey, Lynne Jarvis and Pauline Craig will meet to further discuss the ethnicity variables.

**Action 3: AST to investigate analysing ethnicity variables at intermediate zone level and also creating broader ethnicity groupings.**

**Action 4: Lynne Jarvis to arrange a telephone meeting with Karen Facey and Pauline Craig to discuss ethnicity and HIIA work.**

The next section of the paper looked at the current diagnostic groups and whether ‘outpatients’ should be split between the other 6 groups (Cancer, Heart, Digestive, Injury, Respiratory, Other) and whether there is a suitable way to do this. In the absence of diagnostic information on outpatient data, it was agreed to look into the possibility of applying the diagnosis / specialty mapping in SMR01 (inpatients and daycases) to SMR00 data (outpatients).

**Action 5: AST to look at whether there is a feasible way to assign the outpatients to the other 6 diagnostic groups.**

The group were reminded that there has already been some discussion around the ‘Other’ diagnostic group and whether this could be improved. It was explained that the only code group within ‘Other’ that was comparable in size to the existing diagnostic groups was ‘Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified’, which did not seem a good candidate for a separate diagnostic group.

It was agreed to look at the performance of the indicators using the separate diagnostic groups and also a ‘Whole acute’ group.

The first stage of the indicator selection methodology and results was described. This produced an initial list of variables, which were approved by the Subgroup as being suitable to be taken forward for the next stage of analysis. This includes the ethnicity variables, which will be determined after actions 3/4.

1. **Work plan**

Lynne Jarvis went over the current work plan. The results of the next stage of the analysis of indicators will be reported at the next Subgroup meeting in March. A first draft of the final report to TAGRA will be available at this meeting.

1. **Timetable of future meetings**

We will now be in a phase of more frequent meetings as results of the analysis and drafts of the report are available to present. The next meeting is planned for Tuesday 15th March, with further meetings to be arranged for May, June and July.

1. **AOB**

No-one in the group had anything further to add.

1. **Date of next meeting**

Tuesday 15th March PM. Exact times and location TBA.