**TAGRA Acute MLC Sub-group**

**Minutes of 10th meeting – 18th August 2015 – Waverley Gate, 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)
David Garden (NHS Highland)
Lynne Jarvis (NHS NSS) (Minutes)Alisdair McDonald (NHS Lothian) Chris Mueller (NHS NSS)Paudric Osborne (Scottish Government)Tom Russon (Scottish Government)Sarah Touati (NHS NSS)

**In attendance**

**Apologies**

Frances Elliot (Scottish Government)

Fiona Ramsay (NHS Forth Valley)

Diane Skåtun (University of Aberdeen)

Judith Stark (NHS NSS)

Matt Sutton (University of Manchester)

**Apologies from equality leads**

Jackie Erdman (NHS Greater Glasgow & Clyde)

Colin Fischbacher (NHS NSS)

Elisabeth Smart (NHS Highland)

Emma Doyle (NHS Health Scotland)

Ali Jarvis (NHS Health Scotland)

Andrew Waugh (Scottish Government)

1. **Welcome and apologies**

KF welcomed Ali Jarvis and Andrew Waugh who were attending the meeting to provide expert critique on inequalities issues. KF, TR, LJ, ST and PC had held a pre-meeting with them to brief them regarding NRAC and the Acute MLC review.

1. **Minutes from previous meeting**

Some changes were to be made to the minutes to explain how we made the decision around datazones and geography. KF will email the revised version round the group for approval.

***ACTION 1 – KF to circulate revised minutes for approval***

1. **Matters arising**

It was agreed that all items in the Matters Arising paper (TAMLC31) were adequately addressed.

1. **Health inequalities impact assessment (HIIA)**

PC presented a briefing paper for the HIIA, providing a reminder of the sub-group’s process for integrating an HIIA into the whole process of the committee’s work. She reminded the committee that this covered issues of health inequalities, health impacts and human rights. The Chair noted that today’s discussion would inform predictors of need and approaches to evaluating unmet need.

Then ED led the committee in a shortened HIIA scoping workshop. She presented a range of issues for consideration in the HIIA Workbook summary (Appendix 1) and it was agreed that section 2 should be considered in detail as outlined in Appendix 2.

The committee discussed whether the groups outlined were likely to have a different relative need for services in a datazone and if they had been considered in the development of the formula. AJ noted that a risk assessment approach should be used considering the most important issues.

Following a wide ranging discussion (Appendix 3) it was agreed that older people living alone should be considered as a predictor of need, It was noted that this would also address an issue raised in the last meeting about special consideration of older people.

The equality leads had read the upcoming papers for the meeting and noted that looking at ethnicity in terms of ‘white’ and ‘non-white’ groups is too crude as individual ethnic groups will show different relationships with health outcomes.

1. **Revised Potential Candidate Variables**

ST presented paper TAMLC34 which provided updates on the further investigation of potential candidate variables. AST agreed to check previous papers to check the decisions made in relation to use of SPARRA and specification of supply variables.

The Committee agreed that the indicators proposed in the paper were all appropriate and that following the HIIA discussion, older people living alone should be added.

There was a discussion about the relevance of some Census data where individuals’ situation may change. The stability of indicators can be examined later if a Census variable is shown to be significant.

***ACTION 2 – AST to check previous meeting papers for decision made regarding supply variables and the use of SPARRA as a potential indicator.***

***ACTION 3 – AST to add information from the Census on older people living alone (and consider definition of ‘older people’, unpaid care, general health, mental health, education and employment to potential variable list.***

1. **Unmet need analysis**

At the last meeting it had been agreed that a simple shortfall method will be used to investigate unmet need. TR presented paper TAMLC33 - a methodology paper describing how this investigation of unmet need will be undertaken.

The group discussed whether it wanted to pursue analyses of unmet need just based on the acute index or on the basis of deprivation, ethnicity and rurality as well, as had been done for the NRAC report. The group agreed that it is valuable to look at these, but noted the issues about the specification of ethnicity raised by the equality leads. It was also noted that SIMD 2012 will be used at the 2001 datazone level as the 2011 datazone level data will not be available until August 2016.

The impact of these variables cannot be examined simultaneously so they will have to be analysed individually. In 2007, some significant results were found for deprivation, ethnicity and rurality for certain diagnostic groups at various spline percentage cut-offs. After consideration of the core criteria and consistency of effects, NRAC decided that deprivation was the most important factor and only made adjustments for unmet need on that basis.

TR explained the three scenarios and how the analysis would be affected by these:

1. No significant unmet needs effects found – no need to adjust the formula
2. Significant unmet need effects found in one additional factor – adjust the formula for that factor.
3. Significant unmet need effects found in multiple additional adjustments – this is more difficult as the excluded sub-cohorts of the population for testing for unmet need will be different for e.g. deprivation and rurality. In 2007, the method used in this scenario was to pick one of the two adjustments and apply that to the formula. This raises the question of what criteria is used to make this decision.

SB suggested that some sort of combined score could be produced and then make the exclusion based on that. Some assumption would have to be made about the relative importance of each component. It was agreed that this was a good solution that would be investigated when the unmet need analysis is undertaken.

1. **Report outline**

ST presented the outline of the TAGRA Acute MLC report, which was accepted by the committee. .

***ACTION 3 – AST to start writing the first four chapters of the report to TAGRA.***

1. **Work plan**

LJ described the current status of work in the Acute MLC work plan (TAMLC35). It was confirmed that there have been no major changes to the work plan. LJ also introduced CM, a student on placement from Glasgow University who is continuing the Acute MLC analysis work started by Petya Kindalova.

The Chair asked PC to review how the HIIA work was featuring in the work programme and check the timing of the various activities to ensure timely deliver of the whole report to TAGRA.

***ACTION 4 – PC check placement of HIIA activities in the work plan.***

1. **Date of next meeting**

The next meeting will take place on 1st December 2015 at Gyle Square, Edinburgh, 1.30pm (lunch provided from 1pm).

**Appendix 1 – HIIA Workbook summary (NHS Health Scotland 2015)**

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1. **Who will be affected by this policy\*?** Keep this brief, such as ‘Children aged 5–12’.

**2 How will the policy impact on people?** Think about people, not characteristics, such as how the policy will impact on the right to health of a disabled older man with low literacy who lives in a deprived area.

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| **Population groups and factors contributing to poorer health** |
| **Age:** older people; middle years; early years; children and young people.**Gender:** men; women; people undergoing gender reassignment; pregnancy and maternity; experience of gender-based violence.**Disability:** physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions.**Race and ethnicity:** minority ethnic people; non-English speakers; gypsies/ travellers; migrant workers.**Refugees and asylum seekers****Religion and belief:** people with different religions or beliefs, or none.**Sexual orientation:** lesbian; gay; bisexual; heterosexual.**Marriage:** people who are married, unmarried or in a civil partnership.**\*** The word ‘policy’ represents any option, procedure, practice, strategy or proposal being assessed. | **Looked after and accommodated children and young people****Carers:** paid/unpaid, family members.**Homelessness:** people on the street; staying temporarily with friends/family; in hostels/B&Bs.**Involvement in the criminal justice system:** offenders in prison/on probation, ex-offenders.**Addictions and substance misuse****Staff:** full/part time; voluntary; delivering/ accessing services.**Low income****Low literacy****Living in deprived areas****Living in remote, rural and island locations****Discrimination/stigma****Any other groups and risk factors relevant to this policy.** |

1. **How will the policy impact on the causes of health inequalities?** You may have discussed some of these issues when considering question 2.
* **Income, employment and work:** e.g. availability of good quality jobs and the price of basic commodities such as food and fuel.
* **The physical environment and local opportunities:** e.g. air and housing quality, availability of affordable transport and leisure opportunities.
* **Education and learning:** e.g. availability and quality of pre-school education, availability of life-long learning.
* **Access to services:** e.g. availability and accessibility of services, as well as the ability to access and navigate them (both physically and financially) and the quality of service provided/received.
* **Social, cultural and interpersonal:** e.g. opportunities for community engagement and co-production, reducing experience of stigma and discrimination. How does the policy help foster good relations between different groups?
1. **How will the policy impact on people’s human rights?** Think about the potential impacts you have identified and consider whether these could help fulfil or breach legal obligations under the Human Rights Act.
* The right to life
* The right not to be tortured or treated in an inhuman or degrading way
* The right to respect for private and family life
* The right not to be discriminated against
* The rights to freedom of expression, thought, conscience and religion
* The right to a fair trial
* The right to liberty

Can you think of any actions that might promote positive impacts or mitigate negative impacts?

1. **Will there be any cumulative impacts as a result of the relationship between this policy and others?** Consider the potential for a build-up of negative impacts on population groups as a result of this policy being combined with other policies.
2. **What sources of evidence have informed your impact assessment?**

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* **Population data:** e.g. demographic profile, service uptake.
* **Consultation and Involvement findings:** e.g. any engagement with service users, local community, particular groups.
* **Research:** e.g. good practice guidelines, service evaluations, literature reviews.

**Appendix 2 – Inequalities assessment discussion guide.**

**TAGRA- Acute MLC subgroup**

**Inequalities assessment discussion guide**

**Have all of the groups and factors below been considered fully? Do we have enough data? Is there anything else we could include?**

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| **Protected under equalities legislation but unlikely to change the formula** |
| **Marriage:** people who are married, unmarried or in a civil partnership. | **Religion and belief:** people with different religions or beliefs, or none. |
| **Population groups to think about though data may not be available** |
| **Sexual orientation****Carers:** paid/unpaid, family members.**People with limited literacy**  | **Staff:** full/part time; voluntary; delivering/ accessing services.**Looked after and accommodated children and young people** |
| **Priority groups that it is important to consider carefully** |
| **Refugees and asylum seekers****People experiencing addictions and substance misuse** | **Homeless:** people on the street; staying temporarily with friends/family; in hostels/B&Bs.**Criminal justice system:** offenders in prison/on probation, ex-offenders. |
| **Groups where data has already been captured- is there anything missing?** |
| **Gender:** men; women; people undergoing gender reassignment; pregnancy and maternity; experience of gender-based violence.**Disability:** physical impairments; learning disability; sensory impairment; mental health conditions; long-term medical conditions.**Low income and deprivation** | **Living in remote, rural and island locations****Race and ethnicity:** minority ethnic people; non-English speakers; gypsies/ travellers; migrant workers.**Age:** older people; middle years; early years; children and young people. |

**Appendix 3 - Health inequalities impact assessment (HIIA)**

# Background

The MLC sub-group aims to integrate the principles of health inequalities impact assessment (HIIA) with the whole process of the group’s work in order to ensure that issues related to seeking equity are considered throughout the review. The discussion reported in this paper contributed to scoping the potential impact of the formula on equality, inequalities and human rights and included co-opted guest equality advisors. The discussion was designed to take stock of the ways in which equity has already informed the review at the half-way stage and to identify any gaps or areas where further analysis may be useful. In particular, the discussion aimed to consider the challenges of relying on routinely collected data which risks missing out knowledge of the particular needs of small but highly disadvantaged groups who may be particularly high users of acute services.

The intention was also to test some of the assumptions underpinning the formula and to consider the implications of increasing diversity and complexity of need for services in the future.

# HIIA materials used

The discussion used HIIA scoping workshop materials in order to provide a systematic framework for consideration of equality, inequalities and human rights. The usual scoping workshop questions had to be adapted to take into account that the resource allocation formula differed from the usual strategies examined by HIIAs by being a step removed from impacting directly on people, in that it is mediated through Health Boards. Therefore, a modified version of a HIIA scoping discussion format was used, with a focus on question 2 which is about specific population groups. However, the group was given an opportunity to read through all of the workshop questions and to bring in other elements as they felt appropriate.

# Consideration of human rights

Direct human rights impacts are difficult to envisage in relation to the formula, but the group agreed that there may be opportunities in the sub-group’s final report to discuss the right to health and the underpinning rights-based principles of healthcare being accessible, affordable, acceptable and of good quality. It was also suggested that the application of human rights principles could be highlighted to the broader TAGRA committee to demonstrate the ways in which the principles of equity and the right to health are at the heart of the review of the resource allocation formula.

# Prioritisation of population groups for discussion

There was a consideration of which population groups to prioritise in the discussion and a paper was tabled with some suggestions. The paper noted all population groups covered by the HIIA process, which include those protected under the Equality Act (2010) and other groups known to have specific health needs or poorer than average health outcomes.

# *Population groups/ issues not discussed in detail*

The group agreed that the legally protected characteristic of **religion and belief** is unlikely to be a useful indicator for the formula and that it would not be discussed further. It was also suggested that the characteristic of **marriage and civil partnership** would not be a useful indicator, although it was noted that there is evidence that people who are married live longer than those who are not. It might be useful to check the data on marriage and to understand how it might predict health outcomes, though it may be subsumed in ‘life expectancy’ which is already considered as an indicator of need.

The group considered that suitable data on need or service use was unlikely to be available for **sexual orientation**, **literacy**, or **looked after and accommodated children and young people**, so these issues were not considered further at this point. It was noted that issues relating to **staff** are already considered as part of the excess costs element of the formula.

It was noted that **gender**, **age**, **deprivation** and **rurality** are already considered in the formula, although the issue of age was considered to need further thought and this is returned to below. **Ethnicity** is also already being considered as an indicator but again some questions were raised about this which are outlined below.

# *Carers*

**Carers** were identified by the group as being a high profile group in current policy. Consideration of carers is relevant for their own healthcare needs and for the costs to the NHS if they become unable to care. ISD has recently produced a report on the available data about carers. For example, there is some data available from the census on how much unpaid care people provide. This suggests that about 750,000 people in Scotland identify as carers and around 120,000 are eligible for Carers’ Allowance which means that they provide more than 35 hours of care per week. Data is also available from the Scottish Health Survey and the Scottish Household Survey which have questions about the impact of caring on health, although these surveys are based on smaller samples. All surveys give different prevalence rates of caring, especially at lower hours of care.

The impact of caring on use of acute services is not currently known, but it was suggested that this could be tested in the model.

It was also noted that the absence of a carer could have an impact on acute services for example in exacerbating delayed discharges. The census contains data on numbers of **elderly people living alone**. It was suggested that an area with many elderly people living alone may have greater demand for acute services. However, this additional use may already be reflected in the cost for that datazone. It was noted that **older people** are not yet considered adequately within the formula. There is an issue in that there is no obvious age split and the formula probably reflects younger people better. It was suggested that looking at, for example, those over 75 living alone could be a potential indicator.

There has been an increase in the prevalence of **long-term limiting conditions**, and this continues to change. The formula needs to take account of changing demographic patterns over the next ten years. There is a danger that by basing it only on what we know to be true now, we are perpetuating systemic norms and not reflecting changing circumstances. There is a possibility that carers are currently masking unmet need.

# *Extremely disadvantaged and marginalised groups*

The discussion turned to those groups who are most marginalised and are likely to be high users of acute services rather than routine and preventative care but whose specific needs are unlikely to be reflected in routine data. This includes **refugees and asylum seekers**, people experiencing **addictions and substance misuse**, those who are **homeless**, those who are **involved in the criminal justice system**, and **Gypsy/Travellers**.

Case level records on homelessness are available from local authorities, though postcodes are only available for about two thirds of cases as many homeless people have no fixed abode. This means that there is a difficulty in mapping homelessness to datazones. The homeless population is diverse and includes people with many complex needs. Around 10% of homeless people are prison leavers and, in Glasgow, refugees who have been granted leave to remain are also included in this population. At Health Board level, health care provision for homeless people is usually coordinated through dedicated GP practices (there are seven or eight such practices across Scotland). There are urban/ rural differences in levels of homelessness and need for services.

Published literature and experiential knowledge from service providers suggests that there are some behavioural similarities in terms of homeless people, refugees/ asylum seekers and recent migrants, prison leavers, Gypsy/Travellers and people experiencing addictions in terms of their high use of acute services. However, these are comparatively small population groups and often highly mobile, which poses problems in terms of data capture. In some cases, they may be included in other indicators; however it was noted that, for example, the homeless and Gypsy/Traveller populations are quite young and have higher healthcare needs so a standard age distribution won’t capture their additional resource use.

A new project is starting which will link homelessness data with hospital admissions and mental health data to compare use amongst homeless people with those in the most deprived and least deprived data zones. This data is not yet available but once it is it will help to quantify the extra use of acute services amongst homeless people.

The group discussed the possibility of using data on people who are not registered with a GP, as this may capture a number of population groups who rely more on acute services and less on routine or preventative care. However, it was determined that the GP registered population is actually larger than the GRO population because of multiple registrations and people not deregistering when they leave a practice. Therefore this data is not reliable.

It was then discussed whether data on take-up of routine and preventative care such as childhood immunisation or screening would be a suitable indicator as low take-up may indicate high acute resource use (and hard to reach groups). Childhood immunisation data is available, as is data on uptake of particular screening programmes, and some of these things have already been looked at as potential indicators. However, data on uptake relies on people having been invited in the first place and so is not a good measure for transient groups. Also, programmes such as bowel cancer screening are targeted at the over 50’s but the homeless population is much younger than this.

The coding of ‘no fixed abode’ used by services was considered as a data source. However, there is also a ‘not known’ postcode that some services use which includes both homeless people and those whose postcode is just not known.

The group returned a number of times to the issue of these populations being proportionately very small, and it was asked if measures could be grouped together in some way. It was discussed that as we are dealing with such small numbers of people, it may not be proportionate to change the formula to include them, but it was recognised that these are often high resource use individuals and that there may be a need for other ways to think about health care provision. It was considered that it might be more relevant to focus on the provision of specialist primary care practices for the most excluded groups through the Scottish Allocation Formula (SAF) for GP practices. There are very high levels of need and a lot of additional work is being done across the country by NHS staff, for example with Gypsy/Travellers, that is not being captured in any way and is often not being specifically resourced.

# *Ethnicity*

Although **ethnicity** has already been discussed as an indicator, it was suggested that there is a need to think a bit more carefully about it, and particularly the proposal to group together all ‘non-white’ ethnic groups. It was considered that this is potentially too crude as ‘non-white’ won’t capture many Gypsy/Travellers and migrant workers who have some of the poorest health outcomes. Also, evidence on the health needs of non-white ethnic groups is more complex than ‘all non-white groups have greater healthcare needs’. Some non-white ethnic groups have better health outcomes than average, others have worse, for different reasons, not all of which are necessarily directly related to ethnicity (for example, they may be more related to poverty). The ethnic profile of Scotland is changing very fast and there is a need to be clear about what this indicator is doing. It was noted that the main NRAC report shows that areas with higher proportions of ethnic minorities also have higher values of the main indicators of need. However, it is important to understand the context of data around ethnicity. For example, new immigrant populations often settle in the most disadvantaged areas but as they become more settled, by the second or third generation, they may no longer be concentrated in poorer areas - so the health correlations change.

It was argued that ethnicity should be included as an indicator in some form because there are inequalities linked to ethnicity; however, with the indicator as it stands it’s not obvious what it is doing or telling us and we need to test the assumptions being used.

It was noted that some diagnostic groups (sub-groups of care) are more socially patterned than others, including some that show clear patterns in relation to ethnicity. It was asked how much room for weighting there is within these categories. It was explained that regressions are fitted separately for each diagnostic group, so they have different slopes. The results are combined and weighted by expenditure. It would be theoretically possible to use different indicator variables for each diagnostic group, for example using SMR for all of them but also using ethnicity for some (e.g. using south-east Asian ethnicity as a measure in the ‘diabetes’ category as there is evidence of association). This hasn’t previously been considered and there would be a need to be confident in establishing robust, statistically significant relationships. There would also be a need to monitor changing patterns of illness over time. This would be quite burdensome in terms of work, but it could be done.

# *Disability*

There was discussion about the inclusion of an indicator related to **disability,** though it was noted that there would need to be some thought given to the definition of disability used and how to measure it. For example, some people with life-long limiting conditions or co-morbidities may be high resource users but also may be engaged in self-management. In addition, many conditions are age-related so there would be a need to distinguish between older people and disabled people who also happen to be older. It may be hard to disaggregate a number of cumulative factors all impacting on health such as disability, old age, living alone and living in a disadvantaged area.

# General comments

There was much discussion in the group about the purpose of the formula and the extent to which it can be sensitive to some of these issues. It was argued that data on specific needs is important for local service delivery and planning but that it may not be that useful for resource allocation in comparison with other factors at the macro-level. Local NHS boards are responsible for ensuring services meet the needs of many of the population groups covered by the discussion and must take account of inequalities in their delivery plans. However, it was pointed out that as there is no feedback loop on how boards spend the money that they’re allocated, there is no way to know if boards are meeting the needs of populations in an equitable way. Because all boards have to ration and make choices about service provision, it’s important to allocate funds on the basis of the best available information about need and costs of delivery. It was suggested that there should be a mechanism to test how well these calculations are validated by the actual experiences of boards.

There is work ongoing within the integrated resource framework to try to identify who uses services. However, it was emphasised that use of services is not a good measure of need. Also, not everyone is accessing services in the same way or at the same point in their illness trajectory and not everyone has the same requirements from services once they do access them. People with complex needs or additional support needs such as communication support or language needs will use services in a more resource intensive way in relation to both time and costs. How do we measure this, rather than just who’s using services?

Again, these are all small groups- so do we just ignore them because they’re so small, or is there some way of amalgamating some of these small numbers into something that’s meaningful and that picks up the very high need of the most disadvantaged and the most marginalised? As well as being small, these population groups are also very unequally distributed between boards, which makes it difficult to incorporate them into the formula.

It was suggested that rather than going down to small groups, it would be more useful to identify something that these groups experience disproportionately which can be measured, for example diabetes, respiratory conditions or alcohol misuse.

# Prisoner healthcare as a model

It wassuggested that there may be some useful learning from the way that **prisoner** healthcare is being managed since responsibility was transferred to boards. TAGRA is dealing with small numbers and limited data for prisoners, so it is difficult to include in the formula. As a result what will probably happen is that a sub-pot of money will be split off and allocated on the basis of a simpler formula. It was suggested that this could be a model that is used for some other population groups that are similarly unevenly distributed across the country.

It is worth looking more carefully at what can be learned and replicated from this example, though it is important to note that a specific budget was transferred to the NHS along with the care of prisoners, whereas funding for other high use groups has to come out of core budgets.

# Outcomes

There wasn’t time in the meeting to think about all of the population groups that could be included and not all of them were considered in enough depth; however the discussion prompted thinking that will continue during the remainder of the process.

The main question for the formula in seeking equity in meeting healthcare needs was: where routine data is inadequate, are there proxies that can be used to ensure the formula takes account of high-resource population groups?

The discussion identified some specific issues to explore further:

* Rights based principles
* Marriage and its impact on life expectancy
* Testing the impact of caring on use of acute services
* What indicators might be developed around the needs of carers?
* What indicators might be developed around elderly people living alone?
* Is disability being adequately picked up elsewhere in the formula?
* How is ethnicity being used and why?
* Prisoners as a model for dealing with other small and high resource population groups
* Formula for resource allocation to GP practices vs MLC Acute for small population groups
* A suggestion was made for exploring a risk assessment approach to consider the most important issues for equity.

It was noted that this is a macro formula and that boards have the responsibility to deliver services in an equitable way. However, a question still remains about small groups with high needs. Specific pots of money outwith core funding are often used for funding specialist services for disadvantaged groups or those with complex needs and are potentially at risk to funding cuts or disjointed service provision if funds have to be reapplied for every few years. It would be important for the group to be certain that high need groups are not being disadvantaged by not being included in the core allocation of resources. This has potential implications for TAGRA as a whole.

The questions will be further explored during the remainder of the review period.