**TAGRA Acute MLC Sub-group**

**Minutes of 13th meeting – 15th April 2016 – Atlantic Quay, Glasgow**

**Present**
Roger Black (NHS NSS)
Angela Campbell (Scottish Government)
Karen Facey (Chair)
David Garden (NHS Highland)
Lynne Jarvis (NHS NSS) (Minutes)Alisdair McDonald (NHS Lothian) Chris Mueller (NHS NSS)Paudric Osborne (Scottish Government)
Sarah Touati (NHS NSS)
Fiona Ramsay (NHS Forth Valley)
Diane Skåtun (University of Aberdeen)

**Apologies**

Matt Sutton (University of Manchester)

Frances Elliot (NHS Fife)

Pauline Craig (NHS Health Scotland)

Sarah Barry (University of Glasgow)

Andrew Daly (NHS GG&C)

Evan Williams (Scottish Government)

1. **Welcome and apologies**

KF welcomed the group.

1. **Minutes from previous meeting**

The minutes from the meeting on 15th March 2016 were approved.

1. **Matters arising**

It was agreed that all items in the Matters Arising paper (TAMLC46) were adequately addressed.

1. **Indicator selection results part 3 (paper TAMLC47)**

Lynne, Sarah and Chris presented paper TAMLC47 describing the results of the rerun analysis, following changes to the retained variable list agreed at the previous meeting. These were to invert the ethnicity variable to create a count of the populations with average to poor health, and to exclude the following variables: dementia prescriptions, high resource individuals and general health – bad or very bad.

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Following on from the analysis presented in the addendum to TAMLC43, it was agreed that the index options should be determined primarily by their performance as indexes (rather than their performance as separate variables), since an index will be used in the Acute MLC adjustment. The paper presented the best-performing index options for 1, 2, 3 and 4 variables.

The R2 and RSS values for the index options were presented and the three decisions required were discussed:

1. **Diagnostic groups v Whole Acute?**

KF reminded the group that the slope of the relationship between cost ratios and the needs index varies between different diagnostic groups.

DS suggested that the geographical distribution of activity within these diagnostic groups may not be constant, and that while Table 4 of the paper showed that modelling their costs separately does not improve the predictions overall, this may not be true for smaller regions.

The arguments for keeping diagnostic groups were, better face validity, in terms of being able to take into account geographic variation in the prevalence of certain conditions, better granularity and relevance to a range of stakeholders.

PM advised that the quality of diagnostic coding in SMR01 is not perfect, that only primary diagnosis is selected, and that the data is not a reliable measure of prevalence of certain conditions in the population. RB pointed out that the SMR01 data were regarded as ‘fit for purpose’ in the context of statistical analysis. It is certainly possible to find instances of miscoding (fewer than 5% of records) and misallocation of consultant codes, but these do not preclude the use of the data in investigating relationships between healthcare needs and costs

**It was agreed to keep the diagnostic groups and to note any data quality issues that required particular attention in the report.**

1. **Specific v common indicator sets?**

It was clear from the analysis that there was little gained from having separate needs indices for different diagnostic groups. A common index was considered more transparent and easy to understand.

**The group agreed to use a common needs index for all diagnostic groups.**

**iiI) Which components should be included in the needs index?**

There was some concern over including DNA rates in the needs index. It was originally included as a proxy for deprivation. However, it is a supply-side variable and so may not be suitable as an indicator of need, in an index with demand-side variables. Improving DNA rates is also a KPI for boards and so an improvement in DNA rates would affect the stability of the formula and lacks face validity.

**It was agreed to remove potential indices containing DNA for face validity reasons.**

Having agreed to ignore DNA, it was agreed to revisit the analysis, including a new four variable option containing LLTI, All-cause SMR <75, Ethnicity and Unpaid Care.

**ISD analysts to rerun the analysis excluding DNA and send a paper, initially to RB and AC in KF’s absence, and then round the sub-group. The aim is to get a decision within the week, via email, to allow next stage of analyses to be performed.**

1. **Work plan**

LJ went over the current work plan.

A draft report was emailed to the sub-group prior to the meeting and everyone was reminded that comments are welcome at any time. A new draft report will be available at the next meeting on the 5th May.

**AOB.**

Nothing was added.

**Date of next meeting: Thursday 5th May, 10am – 12pm, Gyle Square, Edinburgh.**