PAYMENT BY RESULTS
EXTERNAL ADVISORY GROUP

MINUTES OF MEETING ON WEDNESDAY 11 JULY 2012
SKIPTON HOUSE, LONDON

1. Introductions and apologies for absence

Present:

George Agathangeiou (GA)	Ernst & Young
Leela Barham (LB)	Royal College of Nursing
Alan Betts (AB),	Dorset PCT
Paul Betts (PB)	Foundation Trust Network
Sarah Butler (SB)	DH PbR
Martin Campbell (MC)	DH PbR
Nigel Campbell (NC)	Monitor
Janice Fawell (JF)	Project Diamond
Hayley Fenton (HF)	DH PbR
Janet Gallear (JG)	DH PbR (minutes)
Tabitha Gardner (TG)	Wirral University Teaching Hospital NHS FT (obo Russell Favager)
Andy Hardy (AH)	HFMA representative, University Hospitals Coventry and Warwickshire NHS Trust
Jane Hazelgrave (JH)	Bradford and Airedale PCT
Phil Heywood (PH)	North West Specialist Commissioning Group
Suzanne Ibbotson (SI)	DH PbR
Tom Kane (TK)	BMA Consultants Committee
Tom Margham (TM)	NHS Commissioning Board Authority
John McIvor (JM)	Lincolnshire PCT (Chair)
Eleanor Monaghan (EM)	DH PbR
Paula Monteith (PM)	NHS Information Centre
Ian Newton (IN)	DH PbR
Sue Nowak (SN)	DH PbR
James Peskett (JP)	Audit Commission
Eileen Robertson (ER)	DH PbR
Lee Rowlands (LR)	Central Manchester University Hospitals NHS FT
Ian Rutter (IR)	DH Clinical Advisor
Peter Saunders (PS)	PbR Data Assurance Framework
Sohin Shah (SS)	Monitor
John Shepherd (JS)	Ramsay Health Care UK (deputising for Tom Fellows)
Ivy Wong (IW)	NHS Commissioning Board Authority
Vicki Woodhead (VW)	NHS Commissioning Board Authority

Apologies:

Russell Favager	Wirral University Teaching Hospital NHS FT
Tom Fellows	Nuffield Health
Jane Hazelgrave	Bradford and Airedale PCT
Jonathan Storey	North East SHA

2. Minutes of the meeting held on 9 May and matters arising

2.1. The minutes of the meeting on 9 May 2012 were accepted as an accurate record.

2.2. Action 3:15: Best Practice Tariffs (BPTs) for 2013-14 was included on today's agenda.

2.3. Action 5.8: A review of PbR CAP membership was undertaken recently. SB pointed out that after 2013-14, DH PbR would not be responsible for setting the tariff, so Monitor and the NHS Commissioning Board Authority (NHS CBA) would need to consider for future years.

2.4. Action 5.10: An update on outpatient procedure tariff development was included at today's meeting.

2.5. Action 8:1: JG had circulated the long-term conditions year of care presentation and other relevant papers.

2.6. Action 11.5: The proposal to use PLICs data to inform the tariff calculation for chapter H (orthopaedic HRGs) in 2013-14 would be raised at the next HFMA Special Interest Group meeting.

3. Update on PbR in 2013-14

3.1. MC introduced paper EAG30-02, and gave a presentation offering an update on the development of the following aspects of the PbR package for 2013-14

- Reimbursement of diagnostic imaging in outpatients
- Outpatient procedure tariffs
- Neurology/neurosurgery outpatient attendances
- Setting prices for orthopaedic HRGs
- Cystic fibrosis
- Cherry picking
- Exclusions
- Innovation payments
- QIPP LTC year of care
- Recovery, Rehabilitation and Reablement (RRR)

3.2. MC reminded EAG members of the need to hand over a sustainable package to Monitor and the NHS CBA.

3.3. JP referred to the QIPP long-term conditions (LTC) year of care presentation at the last meeting, and asked how it fit with the year of care BPT proposals. MC explained that the year of care BPTs were for specialised services, for example, paediatric diabetes, cystic fibrosis and paediatric epilepsy, whereas the long term conditions programme was concentrating on more generic LTCs. MC acknowledged that how LTC tariffs would fit with the national PbR

tariff, and the scope of what LTC tariffs would cover in terms of planned and unplanned treatment, was still to be determined.

3.4. The group discussed the reimbursement of diagnostic imaging in outpatients. TK shared his support of a move to an unbundled tariff, and IR reported that the PbR Clinical Advisory Panel (CAP) was also largely supportive of this approach, but reflected that commissioners were not generally in favour. JM agreed that from his observations, commissioners were generally resistant to unbundling, but others broadly supportive. The group debated the feasibility of expanding direct access tariffs as an alternative to unbundling, but accepted that there was a significant national variation in what was allowed in direct access. MC added that there had been calls to expand the list of direct access to include plain film x-ray. The consensus of the group was that the list should be expanded, especially as more complex imaging, for example MRI and CT scans, was now routine. MC replied that if the decision was in favour of unbundling, rules would be issued to manage known risks, and JM concluded by stressing that rules would be essential to ensure that hospitals could not generate money from inappropriate medicine.

3.5. JS asked if guidance relating to cherry picking would be strengthened, to help commissioners assess whether individual NHS and independent sector (IS) providers, were selecting an unfair casemix, and whether a statistical model would be provided. MC replied that there had been no negative feedback to the content of this year's guidance (paragraphs 703-705 refer[1]), and the draft 2013-14 guidance document would be published as part of the annual PbR road-test package, when all feedback would be welcome, and fully considered ahead of the publication of the final tariff package. The group agreed that it was important for flexibilities to be applied equally for both NHS and IS organisations, and the balance must be right between commissioners and providers. JM concluded that any practical examples or comments on how the guidance could be improved should be sent to in writing MC, and urged EAG members to offer feedback during the road-test exercise.

3.6. MC asked for EAG views on feedback which had reported issues in reaching agreement on innovation payments, and whether it would be useful to list in the PbR guidance, technologies, devices and drugs that should be considered for innovation payments. These would have been proposed for exclusion, but rejected on the grounds of low volume, and have NICE guidance with no significant concerns over efficacy or safety. The group broadly agreed that this would be useful, and PB asked if there would be a process for putting forward suggestions. ER explained that there was an existing portal for suggestions for exclusions on the PbR website[2], and as a result of this, there was a list of things not accepted as an exclusion, mainly due to low volume, but which were potentially suitable for innovation payments.

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1 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133585.pdf

2 http://www.dh.gov.uk/health/2012/03/high-cost-drugs/

3.7. JM asked for a further update on Recovery, Rehabilitation and Reablement (RRR) to be shared with this group in due course, and MC agreed to include on a future agenda.

4. Reimbursement of specialist activity

4.1. ER introduced paper EAG30-03 which updated EAG members on the status of a number of work streams that relate to the reimbursement of specialist activity.

4.2. JM asked that when looking at funding, whether market forces and MPET were also considered. ER confirmed that this was the case, and added that a working group was to be established to look at the issues raised by the Shelford Group of trusts[3]. The group will include representatives from the Department, the Shelford Group of hospitals, the NHS CBA, and Monitor, and the aim was to extend the remit of the working group to cover all teaching hospitals.

4.3. JF then gave some background to Project Diamond, stressing that the project was not limited to the London area. GA then gave a presentation, which summarised key findings from recent analysis, and which examined whether there were systematic features of the national tariff that lead to under-funding of complex and specialist care.

4.4. JM asked what lessons the Department was taking from this project. ER replied that the PbR team was in discussion with the Project Diamond group of trusts and Ernst & Young, to review the findings, and was currently trying to establish whether there was indeed systematic under costing of specialist activity, and if so, the scale of it, what impact it could potentially have, and the extent to which some of the other mechanisms in the system (e.g. top-ups) were compensating, or whether there was a residual problem thereafter.

4.5. PS asked how this work was feeding in to the review of costing being undertaken by Monitor. JF replied that Monitor was keenly interested in this project, and had regularly attended the PLICs user group. NC added that Monitor had published a *Strategic Option for Costing* report, which included this work. This was available on their website[4] and views were invited via the online response form, or by email to pricing@monitor-nhsft.gov.uk. Following consideration of feedback, Monitor intended to produce a costing strategy later in the year.

4.6. SB offered additional background that a key finding from the *Options for the Future of PbR* consultation was that costing needed to improve. It was widely acknowledged that organisations were at different stages of development, and

[3] University Hospitals Birmingham, Cambridge University Hospitals, Central Manchester University Hospitals, Guy's and St Thomas', Imperial college Healthcare, Oxford University Hospitals, Sheffield Teaching Hospitals, Newcastle upon Tyne Hospitals, University College Hospitals, King's College Hospital.

[4] http://www.monitor-nhsft.gov.uk/about-monitor/monitors-new-role/strategic-options-costing

much work had been done in recent years to facilitate improvement, including the Healthcare Financial Management Association (HFMA) taking responsibility for the development of costing standards. The PbR team was now liaising with Monitor regarding what data would be collected in the future, and would continue to work with HFMA to determine how best to improve costing overall, and costing for particular issues being identified by the Project Diamond and Shelford Group work. The results of this work would inform the costing guidance for 2013-14.

4.7. PM reflected that there was variability in the usefulness of patient level costing, and the group discussed the reasons behind this, and the resulting difficulties. NC shared his ambition to work towards a system where data was used for a trust's own purposes, as this was likely to result in improved quality, and a system that was both taking and using data that was produced for the setting the tariff, and which also enabled benchmarking decisions.

4.8. PH reminded the group of the work being done to prepare for the NHS CBA taking responsibility for commissioning specialised services. Clinical Reference Panels (CRPs) comprising of clinicians and other professionals, had been set up to redefine specialist commissioning and services, which Ministers would approve. JF confirmed she was engaged with this work.

4.9. JM thanked JF and GA for attending today to share their useful presentation.

5. Chemotherapy and radiotherapy

5.1. MC presented paper EAG30-07 which offered an update on work to develop tariffs for external beam radiotherapy and chemotherapy delivery.

5.2. MC asked for views on three options available for progressing the development of tariff for chemotherapy delivery and external beam radiotherapy.

- Option 1: continue to mandate the use of the currencies for external beam radiotherapy and chemotherapy delivery for 2013-14.
- Option 2: mandate prices for 2013-14.
- Option 3: mandate prices for 2013-14 for 50% of contract activity on a transitional basis, ahead of full mandation in 2014-15 (mirroring the approach to renal dialysis in 2011-12).

5.3. The group discussed the pros and cons of each option, and agreed support for option 3.

5.4. MC added that regular day attenders were currently excluded from PbR, but as part of this development, regular attenders for chemotherapy may be brought into the scope of PbR.

6. Best practice tariffs

6.1. ER explained that the PbR team had recently received a draft final version of the BPT evaluation report. The Executive Summary was being shared (paper EAG30-04a) in confidence, in advance of the final version of the report, which would be published following peer review. The PbR team planned to devote an agenda item at the EAG meeting in November to a presentation and discussion of the findings. ER added that the report had been done by the same team that was commissioned to evaluate CQUIN, which offered a helpful overlap, and allowed them to compare and contrast with the impact of CQUIN. ER outlined the main findings in the draft report, and the group discussed.

6.2. PB thanked ER for early sight of this and indicated that the FTN was in favour of BPTs, but the burden of collection, going outside regular data flows, and determining effectiveness was significant, so when introducing new BPTs, similar reviews would be most helpful. He enquired what was happening with the CQUIN evaluation. ER agreed to find out and inform EAG members. **Action: Eileen Robertson**.

6.3. AB sought reassurance that following publication of the report, action would be taken in response to report recommendations, to make necessary changes to specific BPTs. JP informed the group that The Audit Commission was also doing two pieces of work on BPTs; looking at the local level of individual organisations to benchmark how they perform clinically, and to understand the financial impact and incentive, and looking at assurance of data which underpins BPTs. JP offered to share findings with EAG, and the group agreed this would be a useful item for a future agenda. **Action: James Peskett/secretariat**

6.4. IR cautioned that making assumptions on one year of data carried risks, and a trend over a period of time should be identified before making judgement.

6.5. ER asked whether EAG would find it helpful to invite the research team to the next meeting. EAG members suggested PbR should decide if this would be useful, or whether they would be able to offer a succinct overview.

6.6. IN then presented paper EAG30-04b which offered an update on the areas selected for inclusion in the 2013-14 BPT work programme, and sought EAG advice on the additional BPT areas proposed for inclusion in the 2013-14 sense check exercise, and the case for expanding the list of scenarios covered by the BPT for same day emergency care.

6.7. EAG members discussed the proposal that activity for Parkinson's and early inflammatory arthritis be excluded from the payment grouper. AB wondered whether a longer-term aim for coding diagnoses in outpatients would help with some of these areas, reflecting that the volume of activity had previously been a barrier, but as more best practice tariffs were developed in outpatient areas, there would be more of a reason for doing it. LR suggested patients could be mapped to a treatment function code rather than excluding them. IN replied

that they did not meet some of the criteria, for example in terms of them being discrete clinics. JM concluded that EAG agreed with the proposal, but Monitor and the NHS CBA would need to take a future view around diagnoses in outpatients. MC added that PbR CAP had discussed a paper on coding diagnosis in outpatients, tabled by Virginia Jordan from the IC.

6.8. IN raised the proposal to link payment of tariff to achieving relevant endoscopy accreditation, and asked for views on delaying the introduction of the BPT until part way through the financial year, or to have a managed transition for those who had opted to engage in the process.

6.9. AB asked that if a provider chooses not to engage in accreditation, would they be paid less than those who had achieved accreditation, otherwise organisations may be able to offer endoscopies at a cheaper price than corresponding organisations who have achieved JAG accreditation[5]. The group discussed, and agreed that it would depend on the difference in tariff. AH suggested that if an organisation was not accredited, they should not be offering the service. JM summarised discussion that there was a consensus from EAG in favour of accreditation, but the period of delay should be checked with JAG. EAG members were happy to proceed on this basis.

6.10. IN asked for EAG views on how to address the possible perverse incentives and barriers to engagement. JP suggested that a solution might be to publically report a list of accredited organisations. He advised the group that there was some evidence from the USA that combining public reporting with financial incentives was powerful, and professional peer to peer rivalry was a promotion in itself for accreditation. IN replied that details of accredited organisations were available on the JAG website, which JAG had indicated would be updated on a monthly basis, and this information would be made available to commissioners.

6.11. IR questioned the use of the term accreditation, as it could lead to people assuming a standard was involved, and concern over accepting treatment at a non-accredited unit.

6.12. JM reflected that using JAG accreditation did set a precedent, and questioned how the decision was made, and who would control their costs. ER responded that the national clinical director for endoscopy, and representatives from royal colleges had been consulted, and were keen on the proposal. SN reminded the group that the government was very keen on accreditation, as it reduced the regulatory burden of inspection. JS commented that accreditation did not necessarily improve quality, and non-accreditation did not signify lower standards.

6.13. JM summarised that the group had raised a number of issues, and it was important to ensure that JAG accreditation did not cause perversities nor create precedence for the future. He suggested more work was needed to check on accreditation itself, and its future place in the system.

[5] http://www.jagaccreditation.org/Page.aspx?ID=7

6.14. IN then asked for views on expanding the list of scenarios covered by the BPT for same day emergency care, and he delivered a presentation on the findings of a survey conducted in conjunction with the NHS Institute. MC explained that following sense check feedback, a list of conditions available to expand had been created. LR expressed concern at the focus on admitted patients, and suggested that if organisations set up patient flows which managed some of this in A&E departments; they would be disadvantaged, thereby creating a perverse incentive. The group agreed with this concern, and the need to consider settings.

6.15. JM summarised that there was general support, but a need to be aware of possible perversities, because good practice and innovation already existed in the system. He emphasised that clinically relevant treatment in an appropriate setting was essential.

7. Monitor and NHS Commissioning Board Authority updates

7.1. IW introduced two new colleagues: Tom Margham, clinical adviser and G.P., and Vicki Woodhead who had joined the NHS CBA to lead on tariff transition. IW then offered a verbal update to EAG members on behalf of the NHS CBA.

7.2. IW thanked EAG members for their comments on the proposed scope, which had helped inform the final plan, and also thanked the PbR team, with whom they were working closely, for the help and support they were receiving. Work on evidence and analysis would commence in July. Communication would be made shortly regarding the forward work plan, and outlining ways in which individuals and groups can be involved. IW explained that the NHS CBA was also working closely with Monitor, to ensure a joined up approach to their work streams and responsibilities. The initial deliverable around pricing strategy was expected to reach a conclusion by the end of 2012. IW offered commitment to keep EAG members informed of progress, and indeed hoped some members would volunteer to be involved.

7.3. JM asked what the immediate key deliverables and timescales were for the NHS CBA, as opposed to the work the PbR team would continue to do. IW explained that the King's Fund and Nuffield had agreed to help them produce an evidence pack within the next 6-8 weeks, drawing on work that the PbR team and Monitor had already done, and international comparisons. Following this, around September there would be a formal commencement of the four main workstreams: self-management of long-term conditions; centralisation; innovation**,** and productivity and efficiency, working towards the development of a strategy. IW asked any EAG members willing to help to send expressions of interest direct to: ivy.wong@nhs.net. **Action: EAG members**

7.4. NC then offered a verbal update on behalf of Monitor, and began by confirming they were also working very closely with PbR and the NHS CBA, and would continue to work very closely with the NHS CB in future years.

7.5. NC reminded the group of the publication of *Strategic Options for Costing,* and their aim to publish a costing strategy in the autumn. He confirmed that Monitor would continue to work with PbR on reference costs. NC encouraged responses to the PwC recommendations.

7.6. NC referred to the publication of the *Evaluation of the reimbursement system for NHS-funded care* report. A summary of stakeholder responses had recently been added to Monitor's website.[6] *Enablers and Barriers to Integrated Care and Implications for Monitor* had also been published.[7]

7.7. NC explained that a number of interviews had been conducted across the health sector to help inform direction. A limited consultation on licence conditions had been undertaken, and responses received, and Monitor expected to publish licence conditions for statutory consultation around the end of July/early August.

7.8. NC reported that Monitor had found attending both CAP and EAG very useful. They were currently working on governance arrangements between the PbR team and NHS CBA, and would then decide on the best ways to obtain input and important advice from clinicians, providers, commissioners and other relevant parties. They anticipated being able to comment on clinical input at the PbR CAP meeting in November, and as soon as possible afterwards for others.

7.9. LB mentioned that at a previous EAG meeting George Batchelor had mentioned the development of a pricing strategy and the group had discussed issues around getting costing to tariff, local modification, and risk, fall and failure regime. LB asked whether Monitor would be seeking input into this strategy development, and how it linked with other components. NC replied that the strategy development was likely to conclude around the end of the year, and Monitor would seek views from existing governance groups, as well as from others. In terms of the risk pool, NC explained that he was not responsible for continuity of service, and would find out more from his colleagues who were leading on this area, and report back to this group. **Action: Nigel Campbell.** In terms of local modifications, NC explained that Monitor would take responsibility for the tariff from 2014-15, and work was being done on local modifications, with a view to sharing emerging thinking around late autumn.

7.10. NC emphasised that timescales for the development work outlined in his update were aspirational and not yet set.

7.11. AB asked whether Monitor's engagement would be widened to encourage feedback from emerging organisations, for example CCGs, and others now more involved in PbR than in previous years. NC confirmed that they were keen to maximise responses, especially from providers and commissioners.

[6] http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/about-monitor/monitors-new-role/evaluation-the-re

[7] http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/latest-press-releases/monitor-publishes-independent-report-enabler

7.12. LB asked for more detail on sampling. NC understood the current confusion, as it was not yet clear what everyone would need to do. He explained the current position regarding the coverage and quality of reference costs and PLICs, and the pros and cons of using either collection, or a mixture of both to set prices in future years, with the main aim of setting prices based on the best possible costs. If a sample was to be used in the future, it would be essential to ensure that it was representative. LB asked whether there would be a move towards a mandated data collection from a smaller proportion of trusts. SB added that in the immediate future, organisations would need to continue to complete reference costs, as they had uses other than to inform PbR, and the PbR team was keen to drive up the quality. An example of this is asking organisations during the 2011-12 reference cost collection to volunteer their materiality and quality score (MAQS)[8], and this may become part of the mandatory collection for 2012-13. This will help inform Monitor in tariff development from 2014-15 on. NC confirmed reference cost collection would remain mandatory, and it was not yet prudent to mandate PLICs collection, as organisations were not all ready to implement, and this would lead to poor results.

7.13. JM thanked the NHS CBA and Monitor for their useful updates.

8. Maternity pathway payment system

8.1. SN introduced paper EAG30-05, offered background, outlined the purpose of the questionnaire at annex A, and gave a presentation to summarise the work stream. SN agreed to share today's presentation with the group, and a link to additional information on the DH website.[9] **Action: Sue Nowak/secretariat**.

8.2. EAG members were asked to comment on:

- readiness to implement the pathway payment system on a mandatory basis in 2013-14.
- whether they were aware of any significant issues that need to be overcome prior to the pathway payment system being mandated, and if so, were any so great that they posed a risk to the implementation of the pathway payment system on a mandatory basis from April 2013.
- whether they were aware of any best practice areas of implementation that may help others in implementing the system.

8.3. LR commented that it was proving to be an operational challenge for most providers to collect information in such a different way.

8.4. TG shared concern that her organisation had not been notified of the minimum dataset change, and whether it would be notified in time for April, and

[8] MAQS – a score that indicates the accuracy or quality of the costing process. The calculation takes account of the actual level of financial resources within each cost pool, the quality of the allocation method and number of records matched to patient level.
[9] http://www.dh.gov.uk/health/tag/maternity-pbr/

therefore how information exchange would happen. TG reported that they were still completing the handwritten forms, which was an onerous task.

8.5. AH asked why there was a price covering a caesarian section where there were no complications. PM replied that there was an assumption that some planned c-sections would be undertaken where there were complications in a woman's pregnancy history or personal health, and it was not an indication that unnecessary surgery should be anticipated. MC confirmed that there were different prices for c-section with and without complications.

8.6. The group discussed the challenges related to monitoring postnatal services, and the number of patients being followed up post delivery. Some difficulty had been encountered in the receipt of payment for patients who had been transferred, and cross charging was very difficult for patients who received services in more than one area.

8.7. JM summarised that impact and data collection had been identified as the group's current key issues.

9. A&E tariff

9.1. MC introduced paper EAG30-06, and asked whether EAG was supportive of the recommendation to implement the 11 HRG structure for A&E in 2013-14. The group agreed with this proposal.

9.2. MC then outlined the slight misalignment between PbR rules and the data dictionary definition of A&E departments, and the proposal to therefore amend the PbR definition. This would ensure that all type 1 and 2 A&E departments could be paid on the full range of tariffs, regardless of whether or not they operated on a 24-hour basis. The group discussed, and concluded that they were in agreement with the proposal, but that guidance might need to be reinforced in relation to a definition of a consultant led service, and what constituted the different types of A&E departments, as different types of hospitals (e.g. major teaching hospitals and DGHs) could report as the same type when they provided different services.

10. Sense check arrangements

10.1. SB introduced paper EAG30-08 and explained that the purpose and process of sense check would be similar to previous years, but the PbR team intended to make it more CCG relevant in terms of nominations and involvement, and had sought input from PbR CAP and Keith Willett**.** Commencement of sense check was anticipated mid to end of September, following sign off from David Flory. Suggestions of how we might improve the sense check process were welcome to stephen.fenton@dh.gsi.gov.uk. **Action: EAG members**

10.2. JS asked whether representation from the independent sector would be included in the sense check exercise. SB said that the PbR team would

consider nominations. JS replied that his organisation would be able to respond in the same way as an NHS organisation. ER and SB explained that as part of the quality assurance process, we compared whether PbR assessment of the impact on both providers and commissioners matched with the local impact, and this was more difficult to do within the IS. JM suggested JS discuss this further with the PbR team outside this meeting.

11. Any other business

11.1. MC asked EAG members for feedback on the emergency readmissions policy, in particular the operation of the clinical review, sample of readmissions, and how it was working between providers and commissioners.

11.2. IR offered feedback from PbR CAP of a divergence of view dependant on the strength of the relationship and understanding between providers and commissioners, and suggested a needed to identify what lessons could be learned from those who had agreed a way forward on which both parties were agreed.

11.3. LR suggested the guidance might be strengthened by offering additional clarification around the threshold for readmissions.

11.4. AB observed that it seemed to be working well where a fully representative group participated in the audit, and it appeared to be especially important to involve G.P.s in the process. He acknowledged that some issues still existed, but overall, where strong partnership working had been developed, it worked well. LR added that it seemed to be improving communication between G.P.s and hospital clinicians. The group agreed with this observation, and JM summarised that relationships, behaviour and maturity seemed to be the key to success.

12. Date of next meeting

12.1. The next meeting will take place on Wednesday 21 November at 11:15 – 15:00 in room 124A, Skipton House, London.

ACTIONS

Para	Action	Owner
6.2	Share an update on the CQUIN evaluation with EAG members	Eileen Robertson
6.3	Share findings of work on evaluation of BPTs at a future meeting	James Peskett

7.3	Expressions of interest in assisting in any of the four work streams to be sent to Ivy Wong	EAG members
7.9	Share additional information on continuity of service to EAG members	Nigel Campbell
8.1	Circulate maternity presentation and a link to additional information on the DH website	Sue Nowak/secretariat
10.1	Comments on the sense check process to be sent to Stephen Fenton	EAG members

EAG attendance grid [10]

Y	Attended[11]	A	Apologies	N	Not a member

First name	Surname	Organisation	16/03/11	04/05/11	06/07/11	23/11/11	14/03/12	09/05/12	11/07/12
Leela	Barham	Royal College of Nursing	Y	Y	Y	Y	Y	Y	Y
Alan	Betts	Dorset PCT	Y	Y	Y	Y	Y	Y	Y
Paul	Betts	Foundation Trust Network	Y	Y	Y	Y	Y	Y	Y
Russell	Favager	Wirral University Teaching Hospital NHS Foundation Trust	Y	Y	Y	Y	Y	Y	Y
Tom	Fellows	Nuffield Health	A	Y	A	Y	Y	Y	Y
Andy	Hardy	HFMA and University Hospitals Coventry and Warwickshire NHS Trust	Y	Y	A	Y	Y	A	Y
Jane	Hazelgrave	Yorkshire & the Humber SHA	A	Y	Y	Y	Y	Y	A
Phil	Heywood	North West Specialist Commissioning Team	Y	Y	Y	Y	Y	A	Y
Peter	Huskinson	EMPACT Commissioning Support	Y	Y	Y	Y	A	Y	A
David	Jones	Monitor	N	N	N	N	Y	Y	Y
Tom	Kane	Central Consultants and Specialists Committee, BMA	A	Y	Y	Y	Y	A	Y
Kelly	Lin	Monitor	Y	Y	A	Y	Y	Y	Y
Alan	Maynard	The University of York	A	A	A	A	A	A	A
John	McIvor	Lincolnshire PCT (Chair)	Y	Y	Y	A	Y	Y	Y
Paula	Monteith	The NHS Information Centre	Y	Y	Y	Y	Y	A	Y
James	Peskett	Audit Commission	N	N	N	N	N	Y	Y
Lee	Rowlands	Central Manchester University Hospitals NHS Foundation Trust	Y	Y	Y	Y	Y	Y	Y
Peter	Saunders	Audit Commission/Capita	Y	Y	Y	Y	Y	A	Y
Jonathan	Storey	North East SHA	Y	Y	Y	Y	Y	Y	A
Ivy	Wong	NHS Commissioning Board	N	N	N	N	Y	A	Y

[10] The table takes account of changes to individuals representing member organisations.
[11] Including sent a deputy.