PAYMENT BY RESULTS
EXTERNAL ADVISORY GROUP

MINUTES OF MEETING ON WEDNESDAY 9 MAY 2012
SKIPTON HOUSE, LONDON

1. Introductions and apologies for absence

Present:

Leela Barham (LB)	Royal College of Nursing
George Batchelor (GB)	Monitor
Alan Betts (AB),	Dorset PCT
Sarah Butler (SB)	DH PbR
Martin Campbell (MC)	DH PbR
Russell Favager (RF)	Wirral University Teaching Hospital NHS FT
Paul Fenlon (PF)	DH PbR
Janet Gallear (JG)	DH PbR (minutes)
Jane Hazelgrave (JH)	Bradford and Airedale PCT
Peter Huskinson (PH)	EMPACT Commissioning Support
Suzanne Ibbotson (SI)	DH PbR
John McIvor (JM)	Lincolnshire PCT (Chair)
Ian Newton (IN)	DH PbR
James Peskett (JP)	Audit Commission
Mark Redhead (MR)	Foundation Trust Network (deputising for Paul Betts)
Eileen Robertson (ER)	DH PbR
Lee Rowlands (LR)	Central Manchester University Hospitals NHS FT
John Shepherd (JSh)	Ramsay Health Care UK (deputising for Tom Fellows)
Lorna Sinclair (LS)	DH PbR
Jonathan Storey (JSt)	North East SHA
Simon Tither (ST)	DH PbR
Jacquie White (JW)	DH QIPP LTC Workstream

Apologies:

Paul Betts	Foundation Trust Network
Tom Fellows	Nuffield Health
Andy Hardy	HFMA representative, University Hospitals Coventry and Warwickshire NHS Trust
Phil Heywood	North West Specialist Commissioning Group
Paula Monteith	NHS Information Centre
Ian Rutter (IR)	DH Clinical Advisor
Peter Saunders	PbR Data Assurance Framework
Ivy Wong	NHS Commissioning Board
Tom Kane	BMA Consultants Committee
Alan Maynard	University of York

2. Minutes of the meeting held on 14 March and matters arising

2.1. The minutes of the meeting on 14 March 2012 were accepted as an accurate record.

2.2. The actions for EAG members to send comments on the draft FIMS form had been completed, and SB confirmed that it was not possible to collect the readmission rate on the FIMS collection form.

2.3. Action 3.5: SB confirmed that PbR guidance states that clinical staff must be included in the review of readmissions, and a link to the appropriate paragraphs had been included in the minutes.

2.4. Action 7.3: LS explained that guidance does not suggest that drugs used alongside excluded drugs should also be excluded.

2.5. The QIPP LTC year of care presentation had been circulated by JG.

3. Best practice tariffs

3.1. IN referred to paper EAG29-02 offering an update on the areas proposed for inclusion in the 2013-14 Best Practice Tariff (BPT) work programme. Members were invited to comment on the proposed incentive models for introducing some of the proposed BPT areas.

Avoiding hospital admissions for long-term conditions

3.2. IN reported that whilst the PbR Clinical Advisory Panel (CAP) was generally supportive of some of the proposals, the PbR Technical Working Group (TWG) voiced concerns about the likely additional administrative burden of introducing these BPTs. IN asked the group for suggestions of how to address that concern, and for views on the proposal to link payment of BPTs that do not flow through SUS to achievement of benefits, such as reductions in admissions.

3.3. RF made the point that some admissions were beyond the control of the provider organisation. JM agreed and added that where the entire pathway was covered by a year of care tariff, the majority of care was provided in primary care, and costing was therefore difficult.

3.4. ER added that the key was to find indicators in available data that will show whether best practice was being met by the organisation that received the funding.

3.5. PH agreed that the principle of finding things that directly map was good, but looking at relative rates of admission was fraught with difficulty and could lead to perverse incentives, such as not investing in alternative care options, which was the opposite of what the year of care was hoping to define.

3.6. LR asked whether more treatment function codes would be required. IN confirmed that the PbR team was looking at this issue, in particular for paediatric epilepsy and diabetes.

3.7. JM acknowledged that this was a complex area, and summarised that the principle of trying to do it was right, but indicators needed to be more aligned to those doing the work and receiving the payments. The key to success might lie with localising to a limited number of patients, but this might be a significant and time-consuming challenge. Year of care was an excellent concept, but within a pathway split system it would be very difficult to implement.

Tariff linked to achieving accreditation

3.8. JSh raised the point that achieving accreditation typically takes18 months to two years, and until accreditation had been obtained, organisations would be unable to provide services. IN replied that the majority of organisations were already accredited or working towards accreditation, and only a small number had not yet begun the process.

3.9. LB emphasised the need for good quality accreditation schemes to be in place.

3.10. PH felt uncomfortable about it being seen as a financial lever for accreditation, and suggested an alternative was to include in CQUIN.

3.11. RF offered a positive view on the proposal, as at present there is no financial incentive to offset the cost of achieving accreditation, and therefore, those not engaged with the process were financially advantaged.

3.12. JM summarised that the accreditation system must be one which the NHS Commissioning Board (NHSCB) believes is appropriate for the population of England, unlike some other accreditation systems that were excessively onerous.

Other

3.13. PH suggested the need for more information on the band of year care tariffs, in particular the flow between different levels of care. JSt recommended clear definition of what events were covered by a year of care tariff, to avoid potential double payment, which was a key risk especially for diabetes care.

3.14. JM concluded that, as work moved forward, this group would welcome wider and more detailed discussion on year of care tariff, as perversities in the system may be a concern.

3.15. IN confirmed that the PbR team would continue to work with stakeholders to develop and finalise BPTs for 2013-14, which will be presented to EAG in July for agreement and sign-off. **Action: Ian Newton**

4. Tariff price volatility

4.1. ST introduced paper EAG29-03 which updated EAG members on work done, following EAG advice at the last meeting in March, to further investigate price volatility.

4.2. ST summarised discussion at the recent PbR Technical Working Group (TWG) meeting, which had concluded with TWG acknowledging that volatility was an inevitable consequence from the annual recalculation of prices, and contrary to EAG advice, that volatility of individual tariffs was not a significant issue, given that changes to the tariff are generally managed at an organisational (rather than service) level.

4.3. ST outlined the recommendation to build on existing processes rather than introduce a systematic policy for one year, including provision of more detailed analysis and supporting data for the PbR pre-sense check process. The PbR team would also explore the provision of more information as part of the sense check package. ST asked for EAG views on whether this approach for the 2013-14 tariff met concerns raised at the last meeting.

4.4. The group discussed. LR commented that although he was in favour of the recommendation, it would be sensible for the PbR team to be mindful of volatility at chapter-level when undertaking detailed analysis, and he suggested that outpatient tariffs were also an area at risk from volatility. ST agreed that although the paper focussed on admitted patient care, any policy would be introduced across all tariff prices. PH welcomed this approach, reflecting on the fact that changes to the A&E tariffs can have a significant impact, especially for minor injury units.

4.5. JM summarised that EAG members were supportive of the recommendation in the paper not to introduce a systematic policy to manage volatility for the 2013-14 tariff, but to consider as part of the existing process, quality assurance of draft tariff prices, and working towards greater granularity.

5. Outpatient procedure tariffs

5.1. LS referred to paper EAG29-04 and asked for EAG views on the outlined approach, and advice on the list of procedure-driven HRGs for which there will be mandatory outpatient tariffs in 2013-14.

5.2. LS asked for views on whether the current list should be expanded. PH commented that as clinical practice was continually evolving, he was in favour of expanding the list slightly (in line with the volume criteria suggested), and JH agreed that input was essential from clinicians on the treatments which could safely and appropriately be delivered in an outpatient setting. The group agreed with this approach.

5.3. LS explained that the analysis had identified an issue where the HRG title can sometimes mask the activity going to it, and that this may explain some

instances of large difference in costs reported in different settings for the same HRG. LS explained that we would work closely with the NHS Information Centre to identify whether there are problems with iso-resoucivity in some HRGs, and therefore better inform when tariffs should be combined across different settings. The further analysis may indicate some HRGs where the tariff can be combined across settings where we do not already do so.

5.4. MC reported that sense check and road test feedback had included comments on the differential between outpatient and day case prices, and asked if this might be a reflection of the way in which costs were apportioned, and the difference in overhead costs. If this was so, MC suggested it should not matter if reference costs were different if the activity mix was broadly similar, the starting point should be to combine outpatient and day case procedures to incentivise treatment in an outpatient setting.

5.5. AB emphasised that clinical advice on appropriate setting was essential to ensure the tariff did not over-reward those providing care in an inappropriate setting.

5.6. JM added that some procedures were now carried out in primary care, and CCGs were likely to continue to shift these procedures into primary care surgical schemes, the data for which is not currently captured.

5.7. LS reflected on dental HRGs, where it was difficult to determine whether some seemingly minor activity had been provided in an outpatient setting due to clinical need, or whether it should have been provided elsewhere.

5.8. JM recommended the PbR team consider representation on PbR CAP for clinical areas outside the acute setting. **Action: PbR team**

5.9. JM summarised the group discussion that there ought to be more equalisation and combination, but with clinical input from all clinical areas involved.

5.10. LS confirmed that next steps would be to undertake further analysis focussed on a narrower list of HRGs, and share proposals with EAG at a future meeting. **Action: Lorna Sinclair**

5.11. LS asked how the level of the procedure tariffs compared to the outpatient attendance tariff that would be applied if the procedure were not coded, especially in relation to HRGs where the activity is relatively minor. Sense check feedback compared those procedure tariffs to first attendance tariff, indicating that it might be better not to have a separate tariff, but to cover by the outpatient attendance tariff. LS asked whether organisations would be likely to stop recording that data just because there was not a dedicated tariff.

5.12. RF commented that it would not be appropriate to stop recording activity, as there could be unintended consequences to doing so. PH questioned the incentive for organisations to code more if the result was less money. JSh advised that this would work against providing see and treat services, and PH suggested constructing an enhanced tariff for treatment carried out at first

attendance. MC agreed that if we can incentive treatment as part of a first attendance, then we should.

5.13. JM asked LS to offer a further update at the next meeting.

6. Chemotherapy and radiotherapy

6.1. SI presented paper EAG29-05, which offered information on proposals for developing chemotherapy delivery and external beam radiotherapy, and asked for advice from EAG on pricing methodology alongside consideration of mandating prices for 2013-14.

6.2. SI explained that a questionnaire had been issued, and feedback was expected over the next month from providers and commissioners on how they had used the currency, and whether they had used the local prices or the published non-mandated prices and associated impact. Following consideration of feedback, a recommendation on next steps regarding mandation and price setting will be offered to this group for comment.

6.3. SI added that alongside this the PbR team was looking at pricing options including using a subset of data, and ways to improve the accuracy of coding. ST acknowledged that there had been some issues with the quality of reference costs, which had been a barrier to mandating prices. Options would be discussed with the working group led by the National Cancer Action Team (NCAT), and a proposal would be shared with EAG members in July.

6.4. AB commented that it was good practice to exclude outliers, and suggested a 50% transition approach (as with renal dialysis), and the group agreed.

6.5. MC reminded the group that there was no proposal to mandate chemotherapy procurement for 2013-14, as this remained a difficult area to code and report, and despite a considerable amount of work to improve this area, more work still needed to be done. ER added that an additional complication was with high cost drugs, and there would be a great deal of complexity involved to include these drugs in the process.

6.6. Following group discussion, JM summarised that, as information was now up to date, more accurate and granular, there was more of an opportunity to consider doing it than before. As work continued in this area to get greater granularity, a decision would be easier, therefore it should not be ruled out, but considered for future years, and EAG would welcome an update and the opportunity to comment on next steps.

7. Cherry picking

7.1. ER introduced paper EAG 29-06, which provided a summary for EAG members of the PbR Clinical Advisory Panel's (CAP) views and proposed next

steps on cherry picking. ER asked for EAG comments on the paper and advice on the proposed way forward.

7.2. JSh expressed his concern that the independent sector (IS) had been unfairly targeted, and emphasised that it was just as likely to happen in the NHS. ER answered that the PbR team had so far used the IS as a proxy for treatment centres. JSh insisted that the PbR team needed to include NHS hospitals, and said that unless guidance was issued, direct statistical methodology needed to be applied to assess whether cherry picking was taking place, rather than assume the IS was mostly responsible. He emphasised that his organisation accepted all patients.

7.3. JSh also suggested that the PbR team had used out of date data, and therefore the fundamental analysis was flawed, whereas his organisation had looked at more recent data and found no evidence. ER replied that it was not possible to use 2011-12 HES data, as it was not yet available. JSH explained that they had received part-year HES data for 2011-12, which was sufficient. He emphasised that analysis could not be based on older data, when different rules applied, which included the IS not being allowed to provide complex treatments.

7.4. JM agreed that this was a fair point, and reflected that some people were appropriately excluded from some facilities on clinical safety grounds. MC agreed that selection of patients should not always be seen negatively, and the activity that a unit treats should be appropriately reimbursed, and sub-HRG if different groups of patients cost different amounts to treat, then the reimbursement system should reflect that.

7.5. The group then discussed the term cherry picking, and agreed that the term was unhelpful, and did not describe the real concern. MC explained that the PbR team had not chosen the wording, the NHS Future Forum had first used the term, saying that the private sector should not be able to cherry pick patients. SJB added that CAP had also concluded that cherry picking was not a helpful description, and had agreed that it was not just an IS issue.

7.6. JSh emphasised that care should be taken in how guidance was worded in terms of organisations, and MC confirmed that guidance referred to the type of contract and not the type of provider.

7.7. JM concluded that cherry picking was not a helpful description, this issue was not specific to the IS, and the same rules should apply to all organisations, whilst recognising that organisations have different capabilities and capacities, and it was therefore appropriate for some patients to be excluded from some facilities. EAG were supportive of further work to drill down into procedure level to see if this was a real issue, and EAG would welcome an update and the opportunity to comment further at a future meeting.

8. Long term conditions year of care update

8.1. JW offered a presentation, building on the presentation offered by Keith Willett at the last meeting, which gave EAG members an update on development. JW agreed to share her presentation and other relevant papers with the group. **Action: Jacquie White/Janet Gallear**.

8.2. JM reflected that the plans seemed incredibly ambitious, and it might be difficult for organisations to meet the necessary criteria. JW explained that 90 expressions of interest from different health and social care economies had been received so far, and a selection process was anticipated. The two areas presenting as the biggest challenge were community data, and how established the integrated teams were.

8.3. JM commented that there was a lack of national community data, and asked whether it had been decided what data would need to be provided, and how collection could be mandated. JW said they had been pleasantly surprised at the amount of data available, but acknowledged that there were gaps in many areas.

8.4. AB reflected on the introduction of the post discharge tariff, and the amount of work necessary to obtain costs first, and asked whether learning had been taken from that project, especially in how to obtain data from non-NHS sources. JW confirmed that learning had indeed been taken from post discharge, as well as other projects, for example; mental health and 18 weeks.

8.5. JH asked what support pilot sites would receive. JW advised they would receive a suite of support including funding of up to £95k; central support for analysis, ongoing coaching and site visits, and the pilot sites would be encouraged to buddy up and participate in group learning. Those unable to apply as they do not meet the required criteria will be offered the opportunity to become fast followers. These organisations would not receive funding, but would have access to materials, and be matched with other organisations to accelerate learning and development. The enthusiasm for the project had lead to many organisations indicating that they want to participate, irrespective of the funding.

8.6. PH asked how it would be determined whether treatment was within the scope of the long-term condition (LTC), and urged the need for clear definition. JW explained that the proposal was to only include treatment directly related to the diagnosed LTC, and to exclude unrelated planned care and unrelated acute treatment, but this would be tested by the early implementers before a definition was determined.

8.7. PH asked if the LTC team would centrally design how funding would flow to each individual provider, or would individual organisations be expected to design locally. JW advised that this would also be tested with the early implementers, as the LTC team was looking to learn from pilot sites and better understand what they feel would be better dealt with locally.

8.8. MC asked whether it was the intention to use the early implementers to collect data, and then develop shadow currencies early 2013. JW confirmed the aim was to provide local currencies for 2013-14, as there will be a limited quantity of data available to do more.

8.9. JM thanked JW for her useful presentation, and offer to share other information with this group via the secretariat.

9. Development of currencies for HIV outpatients and integrated sexual health

9.1. PF referred to paper EAG29-07, which offered an update on progress towards the introduction of HIV adult outpatient and integrated sexual health (ISH) tariffs.

9.2. RF asked whether tariffs would be mandated for HIV adult outpatients in 2013-14, and PF responded that the proposal was to introduce a mandated currency from April 2013 with local pricing.

9.3. JH asked if the HIV dataset would become the responsibility of Public Health England, and PF confirmed that this had been agreed.

9.4. JM asked if sexual health services would become the responsibility of local authorities, and PF replied that promotion and prevention would, but outpatient services could be retained in the NHS. JM and JH observed that this was not clearly defined, and clarity was required on what had been agreed and what was transferring where. PF confirmed that HIV services were part of the NHSCB clinical resource groups, but arrangements for ISH were still to be finalised.

9.5. LR asked about HIV drug therapy costs, and PF confirmed that these were currently excluded.

9.6. PH was pleased to see the HIV dataset progressing alongside the currency, and asked about the linkage with primary care for ISH services, emphasising the need for clarity relating to exclusions and inclusions. JM enquired when further clarity could be anticipated, and PF indicated that more detail should be available around the end of July. The group was concerned that as budgets for public health were in the process of being set, more detail for ISH was needed at the earliest possible date.

9.7. JM shared concern about the potential to break apart an integrated service if care was not taken to ensure this did not happen.

9.8. PF agreed to further consider all points raised, and provide an update on HIV outpatient development at the next meeting. He did not propose to revisit integrated sexual health services with this group, as that was more relevant for local authorities. EAG members agreed with this approach.

10. Monitor future strategy

10.1. GB summarised Monitor's new role around pricing under the Health and Social Care Act 2012[1]. Work was currently being focussed on their primary duty set out in the Act: *to protect and promote the interests of people who use health care services by promoting provision of health care services which is economic, efficient and effective, and maintains or improves the quality of the services.*

10.2. GB confirmed Monitor was continuing to work closely with the NHSCB and the PbR team during transition and development, and was now considering the long-term vision for pricing strategy. To help inform the future direction of pricing, and what improvements might be made, Monitor was conducting extensive structured interviews across the sector, which would be followed by a structured workshop to test pricing options. Monitor was beginning to consider the common themes emerging from the feedback and responses to evaluation, including:

- avoiding obstacles to integrated care
- volatility, and to what extent the service could cope with yearly price changes, or whether it would be beneficial to have greater clarity about tariff prices over several years
- the pace of change, borne out of concern over sudden change and potential destabilisation
- clarity on future direction
- simplicity - not over complicating future development
- clear and unambiguous information
- outcome improvements – being clear about objectives and not having multiple objectives that pull organisations in different directions.

10.3. GB acknowledged that development of Monitor's future strategy was at a formative stage, and emphasised that they were open to listening to suggestions and comments. He encouraged EAG members to visit Monitor's website[2], which was being updated regularly, to leave feedback and views.

10.4. JM asked for clarification on who was responsible for price setting. GB replied that Monitor and the NHSCB jointly shared responsibility, on which they must agree. Monitor leads on price setting, the NHSCB leads on currency development and design.

10.5. JM asked that outside the acute sector, who would initiate the introduction of a price in other areas. GB replied that under the Act, the NHSCB had lead responsibility for expanding the scope of the tariff, so expansion into other areas would be their decision, but Monitor had lead responsibility for setting the rules for block contracting, and will therefore set the price, so there will need to be joint working between both organisations.

[1] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[2] http://www.monitor-nhsft.gov.uk/

10.6. RF enquired whether Monitor might want to set long-term prices, and if so, the likely timescales. GB confirmed that early feedback from stakeholders was indicating this would be a positive step, however it was recognised that expenditure limits and budgets commitments were difficult over a number of years. If setting multi-year prices was not feasible, the aim would be to offer clarity on direction for future years.

10.7. PH suggested that additional clarity was required regarding the boundaries between Monitor and the NHSCB, and who was leading on areas, and as transition proceeds, the individuals who will head up these areas. GB explained that the NHSCB was at an earlier stage in transition than Monitor, and were in the process of appointing their senior team.

10.8. LB asked whether Monitor would have a bail out fund. GB explained that if a commissioner requested a service that was uneconomical, the proposal was that the provider could ask for a local modification from the commissioner by providing evidence why additional funding was needed. If the commissioner refused, and the provider believed they had legitimate higher costs, they could apply to Monitor. If Monitor also refused, the commissioner had to accept that they could not force the provider to provide a service that they cannot afford. LB asked for further clarification, as she thought Monitor had a responsibility to ensure continuity of service for essential services, and that the Act included protection of essential services. GB explained that the local modification regime was in place to ensure essential services continued if the reward was not enough to cover costs, by providing a clear, transparent method-based approach to uplifting the price paid for those services. GB noted that the failure regime was unrelated. JM emphasised that the system was not there to reward inefficiency, but identifying whether inefficiency was part of the underlying reason was particularly challenging, and the group agreed.

10.9. AB asked about ongoing stakeholder engagement, and GB replied that options were still to be agreed with the NHSCB, but reassured the group that existing governance arrangements would continue in the immediate future, and Monitor and the NHSCB would discuss how to build on the existing arrangements. SB welcomed this approach, and asked when Monitor was likely to complete their strategy. GB reported that Monitor was not intending to publish anything until they had had the opportunity to work closer with the NHSCB, who were not yet in a position to offer commitment.

10.10. JM thanked GB for his update, and encouraged EAG members to visit Monitor’s website for further information, and to offer additional feedback.

11. Any other business

11.1. ST shared details of a proposal to potentially use PLICS data to inform the tariff calculation for chapter H (orthopaedic HRGs) in 2013-14.

11.2. JSt asked what the underlying problem was with orthopaedic HRGs. MC replied that many organisations allocate cost around length of stay, but this did not work well for orthopaedics, where there are high device and theatre costs as part of the overall spell cost. Clinicians had also advised that the cost of the implant could sometimes account for most of the cost reported via reference costs. ER added that it was difficult to spot anomalies in this chapter, so sense checking was not straight-forward.

11.3. RF suggested that outliers should be removed from reference cost data, as not all trusts should be penalised for those who submit poor quality data. JH expressed surprise that trusts could submit costing data that had so obviously missed key elements of the treatment.

11.4. SB reassured the group that there was no intention to make any radical changes in 2013-14, but it was acknowledged that in this area, adjustments needed to be made to achieve a better evidence base.

11.5. LB suggested the HFMA special interest group would be interested in this issue, and EAG members agreed it would be useful to share the proposal with them. **Action: PbR team.**

11.6. JM summarised that this group was supportive of the proposed approach and looked forward to hearing more about what the ongoing analysis showed.

12. Date of next meeting

12.1. The next meeting will take place on Wednesday 11 July at 11:15 – 15:00 in room 136B Skipton House, London

ACTIONS

Para	Action	Owner
3.15	Present BPTs for 2013-14 to EAG for agreement and sign-off at the July meeting.	Ian Newton
5.8	Consider representation on PbR CAP for areas outside the acute setting.	PbR team
5.10	Undertake further analysis on outpatient procedure tariffs focussed on a narrower list of HRGs, and share proposals with EAG at a future meeting	Lorna Sinclair
8.1	Share long term conditions year of care presentation, and other relevant papers with EAG members	Jacquie White/Janet Gallear

11.5	Share with HFMA the proposal to use PLICS data to inform the tariff calculation for chapter H (orthopaedic HRGs) in 2013-14.	PbR team

EAG attendance grid [3]

Y	Attended[4]	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
Leela	Barham	Royal College of Nursing	Y	Y	Y	Y	Y	Y
Alan	Betts	Dorset PCT	Y	Y	Y	Y	Y	Y
Paul	Betts	Foundation Trust Network	Y	Y	Y	Y	Y	Y
Russell	Favager	Wirral University Teaching Hospital NHS Foundation Trust	Y	Y	Y	Y	Y	Y
Tom	Fellows	Nuffield Health	A	Y	A	Y	Y	Y
Andy	Hardy	HFMA and University Hospitals Coventry and Warwickshire NHS Trust	Y	Y	A	Y	Y	A
Jane	Hazelgrave	Yorkshire & the Humber SHA	A	Y	Y	Y	Y	Y
Phil	Heywood	North West Specialist Commissioning Team	Y	Y	Y	Y	Y	A
Peter	Huskinson	EMPACT Commissioning Support	Y	Y	Y	Y	A	Y
David	Jones	Monitor	N	N	N	N	Y	Y
Tom	Kane	Central Consultants and Specialists Committee, BMA	A	Y	Y	Y	Y	A
Kelly	Lin	Monitor	Y	Y	A	Y	Y	Y
Alan	Maynard	The University of York	A	A	A	A	A	A
John	McIvor	Lincolnshire PCT (Chair)	Y	Y	Y	A	Y	Y
Paula	Monteith	The NHS Information Centre	Y	Y	Y	Y	Y	A
James	Peskett	Audit Commission	N	N	N	N	N	Y
Lee	Rowlands	Central Manchester University Hospitals NHS Foundation Trust	Y	Y	Y	Y	Y	Y
Peter	Saunders	Audit Commission/Capita	Y	Y	Y	Y	Y	A
Jonathan	Storey	North East SHA	Y	Y	Y	Y	Y	Y
Ivy	Wong	NHS Commissioning Board	N	N	N	N	Y	A

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