

PAYMENT BY RESULTS CLINICAL ADVISORY PANEL

MINUTES OF MEETING ON TUESDAY 26 JUNE 2012 HELD AT SKIPTON HOUSE, LONDON

Present:

Professor Mahmood Adil (MA), DH National QIPP Advisor- Clinical & Finance Engagement
Dr Bill Aylward (BA), Chair of EWGs and Consultant Ophthalmologist
Dr Jonathan Brown (JB), Gloucestershire Hospitals NHS FT
Sarah Butler (SB), DH PbR
Martin Campbell (MC), DH PbR
Nigel Campbell (NC), Monitor
Adrian Davis (AD), Office of the Chief Scientific Officer
Janet Gallear (JG), DH PbR (minutes)
Dr Tom Hughes (TH), College of Emergency Medicine
Virginia Jordan (VJ), NHS Information Centre for Health and Social Care
Professor Ian Lewis (IL), Consultant Paediatric and Adolescent Oncologist
Helen Marlow (HM), Pharmaceutical Adviser, NHS London
Ian Newton (IN), DH PbR
Sue Nowak (SN), DH PbR
Professor David Oliver (DO), National Clinical Director for older people
Dermot O'Riordan (DOR), Royal College of Surgeons
Catherine Pollard (CP), Monitor
Eileen Robertson (ER), DH PbR
Dr Ian Rutter (IR), Chair
Andy Taylor (AT), Association of British Healthcare Industries
Professor Lynne Turner-Stokes (LTS), Chair of Rehabilitation, Kings College London
Dr Graham Venables (GV), Consultant Neurologist
Professor Keith Willett (KW), National Clinical Director for trauma care

1. Introductions and apologies for absence

1.1. IR welcomed all to the meeting. The following apologies were received:

Dr Amit Arora, British Geriatrics Society
Lloyd Barker, East Sussex Healthcare NHS Trust
Dr Una Coales, Royal College of General Practitioners
Dr Patrick Cadigan, Royal College of Physicians
Clare Gerada, Royal College of General Practitioners
Professor Ursula Gallagher, Royal College of Nursing and Ealing PCT
Mike Henley, BMA Central Consultants and Specialists Committee
Ian Higginson, College of Emergency Medicine
Lisa Hughes, (LH) DH Allied Health Professions
Dr Chaand Nagpaul, BMA General Practitioners Committee
Dr Donal O'Donoghue, National Clinical Director for kidney care
Sian Rees, NICE
Dr Tim Richardson, National Association of Primary Care
Dr Bohdan Solamka, Royal College of Psychiatrists
Ivy Wong, NHS Commissioning Board Authority

2. Minutes of the meeting of 17 April 2012, and matters arising

- 2.1. The minutes were agreed as a true record of the meeting and actions arising were discussed.
- 2.2. Paragraph 2.2: the PbR team had liaised with LH and DOR regarding publishing articles on clinical engagement in appropriate bulletins, and details had been included in an edition of the Medical Director's bulletin.
- 2.3. Paragraph 2.3: arrangements for a meeting of IR and a delegation of CAP members with Kathy McLean had still to be finalised. **Action: Secretariat**
- 2.4. Paragraph 3.2: ER will send the final evaluation report on BPTs to George Batchelor when completed. **Action: Eileen Robertson**
- 2.5. Paragraph 3.3: BPT team and LH will meet to discuss the development of BPT proposals. **Action: Lisa Hughes/Eileen Robertson**
- 2.6. Paragraph 4.6:– VG agreed to share the report with CAP members, and circulate the questionnaire to allow members to offer feedback. This topic would then be included on the next meeting agenda for more detailed discussion. **Action: Virginia Jordan.**
- 2.7. Paragraph 6.1: NC reported that Monitor was considering their clinical engagement strategy, and will share their proposals with this group as soon as possible. **Action: Nigel Campbell**
- 2.8. Paragraph 8.1: ER confirmed that information on PET scans had been shared with MH.
- 2.9. Paragraph 8.2: no comments on the exclusions paper had been received.
- 2.10. IR reflected that in recent times, the minutes of this group had moved away from the style initially agreed, and the group agreed that future minutes should revert to group discussion and agreement, with more limited attribution in minutes to individual members.

3. Update on clinical engagement in costing

- 3.1. SB gave a presentation summarising what had been done in previous years to improve the quality of cost collection. She outlined the encouragement given to organisations to implement PLICs, and how this had resulted in 71 organisations using PLICs data to inform reference costs in 2010-11 (40% of acute providers), compared to 13 in 2006-07.
- 3.2. SB explained that the Department handed over the responsibility for Clinical Costing Standards to HFMA in 2010. HFMA would develop the standards for use in 2013-14 and will look at how to address known issues such as the costing of specialist care.
- 3.3. SB emphasised that the objective to improve quality of the collection would remain, including encouraging further clinical engagement.

- 3.4. MA then delivered a presentation on creating effective clinical and financial engagement in the NHS. He outlined survey objectives and results; the benefits of PLICs and the increase in implementation; levels of clinical and finance engagement, and the main barriers; and the lessons for both clinical and finance teams in using PLICs to create value-based healthcare.
- 3.5. The group discussed the content of the presentations. TH asked if MA knew of any examples of good practice from acute care. MA replied that he had participated on HFMA and HSJ reward panels, and would share examples with TH outside this meeting. **Action: Mahmood Adil**
- 3.6. The group reflected on the importance of engaging clinicians, and that different PLICs systems could give very different results. They acknowledged that there were ways other than PLICs to effectively engage clinicians, so the process should not wait until a PLICs system had been implemented.
- 3.7. CAP members were interested in the relationship between PLICs and quality measures (as opposed to activity) that were demonstrable in terms of benchmarking and bench costs. They asked what evidence had been found of good practice in relation to clinical quality and outcomes that related to this methodology rather than counting alone. MA advised that last year HFMA had organised an event for software providers, who had indicated that systems were so far unable to link quality with cost. At this event, MA had emphasised the need to work with clinicians to find other ways to collect this information. He shared an example from one trust where a review had been undertaken of orthopaedic services, looking at variations in cost, which had resulted in improved outcomes and profitability.
- 3.8. The group acknowledged that there was a difference in what value meant in an organisational context, and value from a patient/population perspective, and agreed on the importance of looking at the whole pathway.

4. Update on PbR in 2013-14

- 4.1. MC introduced paper CAP24-02, and offered an update focussing on the following areas:
 - Maternity pathway payment system
 - Reimbursement of diagnostic imaging in outpatients
 - Neurology/neurosurgery outpatient attendances
 - Spinal surgery outpatient attendances
 - Outpatient procedures
 - Setting prices for orthopaedic HRGs
 - Cystic fibrosis
 - Cherry picking
 - RRR/LTC year of care – update on request for early implementers to test LTC year of care funding model.
- 4.2. Clarification was sought on whether the intention was for the tariff to be independent of setting. MC replied that the plan in 2009-10 was to introduce a planned same day tariff, but there had been some difficulty in respect of the amount of coding required

for outpatient procedures. There were also significant cost differentials between same activity reported in day case and outpatient settings, and a different mix of activity being done in each setting. The aim was therefore to move to a position that where appropriate, prices were independent of setting. ER added that for this year all the endoscopy tariffs were the same across setting, and the team had been looking at activity where there was a significant amount of outpatient procedures to see if more tariffs could be established across setting. Experience had indicated that this needed to be done on a case-by-case basis. There would be an opportunity through sense check to offer feedback on what was proposed for introduction next year. MC reported that previous sense check feedback had indicated that there was huge differential between the outpatient and day case prices for some activity, which might be a reflection of how overheads were allocated to activity. In this instance, there was the associated difficulty in determining where to set the price.

- 4.3. A question was raised regarding the potential unbundling of diagnostic imaging, where if a G.P. requested diagnostic imaging directly from secondary care, would the funding come from the G.P. or would the commissioner pay direct to the provider. MC replied that if a G.P. directly referred a patient for diagnostic imaging, mandatory tariffs would apply, and the commissioner would pay for the service. If that patient was then referred for an outpatient appointment, there was flexibility for the commissioner to reclaim some of the money for the outpatient attendance. There was recognition that this flexibility did not always work well, which was one of the key drivers for unbundling diagnostic imaging from outpatient attendances. MC reflected that mixed advice had so far been received from different advisory and professional groups, and the challenge would be to strike a suitable balance. This advice, together with feedback during sense check would be key to the direction chosen for road test of the 2013-14 tariff package.
- 4.4. The group discussed the proposals for a maternity pathway payment system. Some concern was expressed that a potentially major element of maternity was the public health aspect of midwifery care, and how this would be incentivised if public health moved out of the NHS. If the incentive was to move away from providing public health interventions, this may pose a risk especially for high-risk groups. Feedback from the screening committee echoed the point that the incentivisation was partly around medical and not public health issues, and in moving to this pathway, would screening, some of which is currently dependent on health visitor input, be included. MC replied that some screening elements were included in the pathway. This was the first time these public health issues had been raised, and he would review outside this meeting. IR asked whether a definition of complex and standard had been agreed. MC replied that a set of diagnoses determined the category (simple, intermediate or complex), which had been worked up with a wide range of stakeholder groups, including tertiary centres.
- 4.5. The group discussed the setting of prices for orthopaedic HRGs, and advised that if done for elective orthopaedics, it was important to ensure that the trauma element was not penalised. There was suggestion that getting accurate information on the prosthetic cost as a component of the HRG would potentially offer a lever to drive down the cost. MC reassured the group that these points would be fully considered.

5. Best practice tariffs

- 5.1. 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 CAP24-03a) in confidence, in advance of the final version of the report, which would be published following peer review.
- 5.2. The group discussed, and raised concerns about the reference to gaming in terms of listing patients as planned day cases when they were not all treated as such. This was occurring because it was not possible to get credit for a day case if it had not been planned in advance, so the default option for many providers was to initially book day cases, so if patients were discharged same day, they would be credited. Organisations had improved day case rates through this incentive, but also defaulted to booking day cases.
- 5.3. Concern was expressed about the pathway of the BPT for stroke, which incentivised the front end of pathway, but had a disincentive on direct admission from emergency services to a stroke unit. There was significant financial loss where people presenting as suspected stroke patients, went into the BPT pathway, were given the necessary scans and admitted to a unit, but were then determined as non-stroke. Another concern was the lack of incentive for early supported discharge.
- 5.4. The group agreed that national clinical audits were important for BPTs.
- 5.5. The group agreed to devote an agenda item at next meeting and invite the researchers to attend to present. **Action: Eileen Robertson**
- 5.6. The group also agreed that it would be useful at a future meeting to have an extended discussion about what makes a good best practice tariff, as a legacy for the NHS CBA and Monitor.
- 5.7. IN then introduced paper CAP24-03b, and gave a presentation updating CAP members on the areas proposed for inclusion in the 2013-14 BPT work programme. IN asked for advice on whether there were any issues associated with the underpinning guidelines or evidence behind each of the BPTs, or the proposed structure of the BPT.
- 5.8. The group suggested that it would be helpful to add additional detail, including the number of spells, the number of patients, and outcome indicators of what the BPT was expected to improve, as this would be very useful for Monitor and the NHS CBA to determine future direction.
- 5.9. The group agreed that the BPT for diabetes needed additional detail to differentiate the ongoing year of care work from more urgent intervention, and needed to be specific about acute care in a hospital setting, as the majority of adult diabetic care was managed in a primary care setting. The group also encouraged good transitional care arrangements between children and adult services to be built into this BPT, and any other BPT for chronic conditions.
- 5.10. The group agreed that rheumatoid arthritis was a good option for a BPT, as there were clear outcomes.

- 5.11. In relation to endoscopy, the group reported that many units were failing to meet, or losing JAG accreditation¹ purely on waiting times, and if non-accredited units were to be paid less, this would not help to remedy the situation. Whilst CAP acknowledged that JAG was a good global rating of the whole department, they felt there was little emphasis on the skill of individual clinicians. The group agreed that there was a perverse incentive for commissioners to choose non-accredited providers, as they would pay less for the endoscopies.
- 5.12. The group discussed the evidence bases available to inform selection of BPTs, and IR summarised that BPTs were part of a suite of incentives, they should be focussed on patient needs and not just diagnosis, and NICE guidance should be followed. He emphasised that being focused on outcomes and having national datasets was crucial. IR encouraged CAP members to share information with relevant colleagues, as it would be helpful for wider comments to be shared directly with the PbR BPT team.

6. A&E tariff

- 6.1. MC introduced paper CAP24-04, and asked whether CAP was supportive of the recommendation to implement the 11 HRG structure for A&E in 2013-14. The group discussed this proposal, and agreed that a more granular structure was better, especially as emergency care had become more complicated in the last few years.
- 6.2. The group was keen that plans did not lead to perverse incentives, and felt that the more complex treatments in an emergency setting were not adequately remunerated. The suggestion was to reduce the tariffs for the more minor procedures, and increase tariffs for the more intensive care patients, and this might also incentivise more treatment outside the hospital setting.
- 6.3. The group discussed options for addressing issues relating to payment for the use of high cost drugs in A&E. A suggestion was made for a top up payment in A&E for expensive drugs.
- 6.4. MC confirmed that these points would be considered as part of the sense check exercise.
- 6.5. Following discussion, CAP members agreed with the proposal to slightly amend the PbR definition to align it with the data dictionary to ensure that type 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.

7. Chemotherapy and radiotherapy

- 7.1. MC introduced paper CAP24-05 which provided CAP with an update on developments relating to external beam radiotherapy and chemotherapy, and outlined plans for future tariff development.

¹ <http://www.jagaccreditation.org/Page.aspx?ID=7>

- 7.2. CAP members considered the proposal for PbR to review pricing options for external beam radiotherapy and chemotherapy delivery, and were in agreement with this approach.
- 7.3. The group was also content with the removal of the regular attendance exclusion for external beam radiotherapy, chemotherapy and renal dialysis.
- 7.4. MC agreed to offer a further update on plans for the mandation and pricing of chemotherapy and radiotherapy at the November meeting.

8. Reimbursement of speciality activity

- 8.1. ER introduced paper CAP24-06 and updated the group on the status of a number of work streams that related to the reimbursement of specialist activity. The PbR team was trying to identify very high cost outlier cases that impacted differentially on this group of providers, and how existing funding arrangements could be used in a way that could deal with them rather than taking out and reimbursing separately.
- 8.2. ER offered additional background to the work being done by Project Diamond, and the Shelford Group of trusts.²
- 8.3. The group expressed some anxiety over this issue. They acknowledged that there were some expensive aspects of specialist care, and complexity did need to be recognised, but should be based on outcomes, as some providers could achieve the same outcomes for a fraction of the price of the specialist units for the same casemix. It was suggested that this might partly be a result of a widespread misunderstanding of PbR, where an HRG covers an average price, and in any HRG group there were procedures more expensive than the tariff and some less expensive. The group reported instances where individual consultants were being discouraged from performing some procedures where the cost was more than the tariff price, without looking at the HRG as a whole.
- 8.4. A number of group members referred to models that had been developed in their own areas where the HRGs did not adequately account for complexity, which were transparent and put complexity against outcomes, and suggested these models could be applied elsewhere to help others to manage similar issues.
- 8.5. Feedback was offered from the PbR children's sub-group on external evaluation undertaken by the University of York and KPM that showed 20% of costs for specialist children's providers was due to approximately 1% of cases. A recommendation was made to explore whether one of the underlying issues for adult services was that a small number of cases might account for a high proportion of the cost.
- 8.6. The group was interested to hear whether the Project Diamond trusts were doing a similar casemix to other trusts that was costing them more, or whether they were undertaking an unusual casemix. HM advised that spend on PbR excluded high cost

² 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.

drugs in secondary care in London was significantly higher than the rest of the country, which suggested London performed more specialist care.

- 8.7. The group was uncertain of the merits in putting more resource to this issue, and in establishing another working group, although recognised that lobbying had occurred, and would probably continue from a small number. The group reflected that from next year ministers would not be responsible for the tariff, so lobbying might not be as effective as it had been in the past.
- 8.8. IR summarised discussion that this year lobbying had continued in different formats, and therefore had to effectively deal with. There were some options of models to draw from, but in the past working groups had been established who reported through established governance structures, including CAP and EAG, and we should continue with this this year, but in the future safeguards needed to be established in the new arrangements, especially around the transparency of lobbying. CAP was broadly happy with proposals outlined, but would like recommendations to be tabled at a future meeting for further discussion and validation.

9. Exclusions and NICE adjustments

- 9.1. LS introduced paper CAP24-07 and asked for feedback on proposed changes to the exclusions list.
- 9.2. LS asked for views on removing the exclusion of pelvic reconstruction. Having defined the exclusion better last year, the proposal was to remove the exclusion for 2013-14, as the HRGs sufficiently reimburse the procedure. CAP members were content for PbR to proceed on that basis.
- 9.3. LS outlined potential updates for high cost drugs and devices, CAP members agreed with proposals, and advised that bone anchored hearing aids were included in specialist national commissioning, and recommended the PbR team talked to the Clinical Reference Group (CRG).
- 9.4. GV suggested the PbR team might want to add intracranial clot retrieval devices to the list, and agreed to send additional detail to LS. **Action: Graham Venables**
- 9.5. LS explained that the PbR team worked closely with NICE on forthcoming appraisals and guidance. LS explained that the PbR team comes under pressure to add more exclusions, and used tight criteria for selection of what is excluded. NICE guidance was not always available, and we were reluctant to include something on the exclusions list without evidence. The route therefore available to providers and commissioners for paying for things that were expensive, but did not meet our criteria, was the flexibility of innovation payments, but we get feedback that they are not easy to put into practice. One suggestion was that a list could be created of some things that might be appropriate for innovation payments where NICE guidelines exist, but the criteria was not met due to low volumes.
- 9.6. The group agreed a list might be useful, but emphasised that only where NICE guidance existed.

9.7. LS welcomed additional feedback on email after this meeting, and confirmed that the PbR team would seek further advice on these proposals at sense check.

10. PbR currencies in 2013-14 – Integrated Sexual Health and HIV

10.1. PF introduced paper CAP24-08a, and explained that integrated sexual health (ISH) and HIV needed to be considered separately, as they would follow different paths in the future.

10.2. CAP members asked for additional clarity on how ISH development would facilitate a single service, and whether the NHS would pay for all sexual health services, or whether some elements would not be included, and be the responsibility of local authorities. PF explained that the mandate between Public Health England (PHE) and local authorities was not yet clear, and would be defined within secondary legislation. Whilst some funding would transfer to local authorities, commissioning arrangements were still somewhat vague and still to be defined.

10.3. The group was interested in where specific conditions would be treated, and expressed concern over conditions such as viral hepatitis, where some local preference currently existed for patients to be sent to the sexually transmitted disease block contract sector, where clinicians did not necessarily have the expertise to manage, and should the structure proposed be implemented, this problem could increase. The group also asked how local authorities would be accountable for their part of the service, and how gaps would be avoided. PF reminded CAP that development of the currencies was in the early stages, and much had still to be decided, which would take some time.

10.4. IR summarised that the long-term consequences and cost of not doing this right were vast, and asked for a progress report at the next meeting in November.

10.5. PF then introduced paper CAP24-08b updating on progress towards the introduction of HIV adult outpatient currency. A number of clinical seminars were being organised for autumn 2012. PF referred CAP members to the information published on the DH website.³

10.6. The group asked whether PF was working with the CRGs. PF confirmed that this work was indeed informing CRGs, and that Simon Barton, chair of the HIV CRG was a member of the HIV national reference group.

11. Sense check arrangements

11.1. SB referred to paper CAP24-09, which alerted CAP members to the plan to commence the sense check the draft 2013-14 tariff mid to end of September, following sign off from David Flory. SB thanked CAP members for their help and support during previous exercises, and asked for suggestions of how we might improve the sense check process to be sent to stephen.fenton@dh.gsi.gov.uk
Action: CAP members.

³ <http://www.dh.gov.uk/health/2012/04/pbr-sexual-health/>

11.2. A suggestion was made that specialised commissioning CRG leads and CCGs should be engaged in sense check, and as some participants may be unfamiliar with the process, a robust explanation of what was required would need to be given.

12. Update from Monitor and the Commissioning Board

12.1. Apologies had been received for this meeting from the NHS Commissioning Board Authority (NHS CBA). MC reported that the NHSCB had four main workstreams: self-management of long-term conditions; centralisation; innovation, and productivity and efficiency. Tom Margham, a G.P. had recently joined the NHS CB as a clinical adviser, IR had made contact with TM and had invited him to attend a future CAP meeting.

12.2. Representatives from Monitor offered an update on their work.

12.3. A *Strategic Options for Costing*⁴ report, which had been commissioned independently by Monitor, had been published on their website. Monitor was considering the recommendations and would publish a costing strategy in due course.

12.4. Following publication of the *Evaluation of the reimbursement system for NHS-funded care* report, a summary of stakeholder responses had very recently been added to Monitor's website.⁵

12.5. Monitor was due to publish its licence conditions for consultation in August. The licencing conditions for pricing would cover recording and the submission of the relevant cost data. Alongside those conditions, in due course, would be costing guidance, and an opportunity for Monitor to use the licence as an enforcement mechanism around costing and costing standards.

12.6. As Monitor continued work on its internal strategy, they were seeking clinical input, and welcomed volunteers from this group. Monitor had established two medical advisory groups for advice on authorisation and compliance functions, and were looking to broaden representation.

12.7. A suggestion was made that with the different performance levels amongst trusts, Monitor should stratify on the population with age as a surrogate for the co-morbidity profile, social deprivation, and urban/rural split, as they were factors which could distort costing data for medical conditions, and stratifying on NHS services alone may compound inherent variation.

12.8. Monitor referred to the recent publication of the independent report into *Enablers and Barriers to Integrated Care and Implications for Monitor*,⁶ integrated care being one of Monitor's secondary duties. The Act says that: *Monitor must exercise its functions with a view to enabling health care services provided for the purposes of the NHS to be provided in an integrated way where it considers that this would (a) improve the*

⁴ <http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/about-monitor/monitors-new-role/strategic-options>

⁵ <http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/about-monitor/monitors-new-role/evaluation-the-re>

⁶ <http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/latest-press-releases/monitor-publishes-independent-report-enabler>

quality of those services (including the outcomes that are achieved from their provision) or the efficiency of their provision, (b) reduce inequalities between persons with respect to their ability to access those services, or (c) reduce inequalities between persons with respect of the outcomes achieved for them by the provision of those services. The Act however does not define what integration is. Monitor was therefore beginning to consider integrated care, the benefits for patients, the enablers and barriers, and what Monitor could do to fulfil its duty to enable integrated care. A licence condition would be included on integrated care, and views would be welcome during the consultation period. In relation to pricing, the report suggested that Monitor work with the NHS CB on currencies that might deliver integrated care, and consider the payment system, and incentives or disincentives it puts in place that might impact or support the fragmentation or the coordination of it.

12.9. The group discussed the difficulty in defining integrated care, and the complexities around delivering a fully integrated service, especially as costing data was limited for areas such as community services.

12.10. CP thanked LTS for her offer to share information with Monitor outside this meeting about her organisation's research in this areas, and details of the costing tools they had developed for comparing costs in different settings.

12.11. CAP members enquired about future governance arrangements, and the potential lifespan of this group. Monitor confirmed their intention to continue with existing clinical governance arrangements in the near future, and were keen to avoid any risk of a gap between existing arrangements and whatever new arrangements were put in place. It was anticipated that this group would be asked to continue until at least April 2013.

12.12. IR stressed the importance of CAP members being given adequate notice of any request for continued commitment to this group beyond April 2013, as members had significant pressures on their time, needed to plan diary commitments well in advance, and were frequently invited to be involved in other things. CP would endeavour to offer more certainty regarding future arrangements to this group at the November meeting. **Action: CP**

13. Any other business

13.1. CAP members reflected on their different experiences of clinical review meetings for readmissions. Mixed feedback was shared on how well groups were working together. The group agreed that lessons should be learned from where it was working well, and suggested these examples could inform future guidance. MC and DO agreed to discuss in more detail outside of this meeting.

14. Date of next meeting

14.1. Tuesday 6 November 2012 11:15 – 15:00hrs Room 125A Skipton House, London.

Actions

Ref.	Action	Owner
2.3	Arrangements for a meeting of IR and a delegation of CAP members with Kathy McLean to be finalised.	Ian Rutter via Secretariat
2.4	Send the final evaluation report on BPTs to George Batchelor when completed.	Eileen Robertson
2.5	BPT team and LH to discuss the development of BPT proposals.	Lisa Hughes Eileen Robertson
2.6	Share report and questionnaire with CAP and update as a substantive item at the November meeting	Virginia Jordan
2.7	Monitor to share their clinical engagement strategy	Nigel Campbell
3.5	Share examples of good practice from acute care with TH	Mahmood Adil
5.5	Invite best practice tariff research team to attend next meeting	Eileen Robertson
9.4	Send detail on intracranial clot retrieval devices to the PbR team	Graham Venables
11.1	Send any suggestions of how sense check might be improved to Stephen Fenton	CAP members
12.12	Provide an update at the next meeting on plans for the future of CAP	Catherine Pollard

CAP attendance⁷

Key

Y = Yes attended, A = apologies, N = not a member

First name	Surname	Organisation	22/02/2011	14/04/2011	21/06/2011	08/11/2011	28/02/2012	17/04/2012	26/06/2012
Amit	Arora	British Geriatrics Society	A	Y	A	Y	Y	Y	A
Bill	Aylward	Chair of Expert Working Groups	Y	A	Y	A	Y	Y	Y
George	Batchelor	Monitor	N	N	N	N	A	Y	Y
Jonathan	Brown	Consultant Physican and Gastroenterologist	A	A	A	Y	A	A	Y
Patrick	Cadigan	Royal College of Physicians	A	A	A	Y	A	A	A
Adrian	Davis	Office of the Chief Scientific Officer	N	N	N	N	Y	A	Y
Sian	Rees	NICE	Y	A	Y	Y	Y	Y	A
Ursula	Gallagher	Royal College of Nursing and Ealing PCT	A	A	Y	Y	Y	Y	A
Clare	Gerada	Royal College of General Practitioners	A	A	Y	Y	Y	A	A
Mike	Henley	BMA Central Consultants and Specialists Committee	N	N	N	Y	Y	Y	A
Ian	Higginson	College of Emergency Medicine	N	N	N	N	N	A	Y
Lisa	Hughes	Allied Health Professions Officer	A	A	Y	Y	Y	Y	A
Virginia	Jordan	NHS Information Centre	A	Y	Y	Y	Y	Y	Y
Ian	Lewis	Consultant Paediatric and Adolescent Oncologist	A	A	Y	Y	Y	A	Y
Helen	Marlow	Pharmaceutical Adviser, NHS London	A	Y	Y	A	A	Y	Y
Chaand	Nagpaul	General Practitioners Committee, BMA	N	A	Y	A	Y	Y	A
Donal	O'Donoghue	National Clinical Director for Kidney Care	A	A	Y	A	Y	A	A
Dermot	O'Riordan	Royal College of Surgeons	Y	Y	Y	A	Y	Y	Y
David	Oliver	National Clinical Director for Older People	A	Y	Y	Y	Y	A	Y
Tim	Richardson	National Association of Primary Care	N	Y	Y	Y	Y	A	A
Ian	Rutter	Chair	Y	Y	Y	Y	Y	Y	Y
Bohdan	Solomka	Royal College of Psychiatrists	Y	Y	Y	Y	A	A	A
Andy	Taylor	Association of British Healthcare Industries	N	N	N	N	Y	Y	Y
Lynne	Turner-Stokes	Chair of Rehabilitation, Kings College London	Y	Y	Y	Y	Y	Y	Y
Graham	Venables	Consultant Neurologist	Y	N	N	N	A	Y	Y
Keith	Willett	NHS Commissioning Board	N	N	N	N	Y	Y	Y

⁷ The table takes account of changes to individuals representing member organisations, and where deputies attend in place of a named member.