PAYMENT BY RESULTS CLINICAL ADVISORY PANEL

MINUTES OF MEETING ON TUESDAY 6 NOVEMBER 2012
HELD AT SKIPTON HOUSE, LONDON

1. Introductions and apologies for absence

Present:

Mahmood Adil (MA), DH National QIPP Advisor- Clinical & Finance Engagement
David Allen (DA), NHS Information Centre for Health and Social Care
Amit Arora (AA), British Geriatrics Society
Jonathan Brown (JB), Gloucestershire Hospitals NHS FT
Sarah Butler (SB), DH PbR
Martin Campbell (MC), DH PbR
Dennis Cox (DC), Royal College of General Practitioners
Adrian Davis (AD), Office of the Chief Scientific Officer
Stephen Fenton (SF), DH PbR
Chris Foster-McBride (CFM), DH PbR
Ursula Gallagher (UG), Royal College of Nursing and Ealing PCT
Janet Gallear (JG), DH PbR (minutes)
Tom Hughes (TH), College of Emergency Medicine
Virginia Jordan (VJ), NHS Information Centre for Health and Social Care
Andrew Lloyd-Kendall (ALK), BMA
Helen Marlow (HM), Pharmaceutical Adviser, NHS London
Sue Nowak (SN), DH PbR
Dermot O'Riordan (DOR), Royal College of Surgeons
Catherine Pollard (CP), Monitor
Tim Richardson (TR), National Association of Primary Care
Eileen Robertson (ER), DH PbR
Ian Rutter (IR), Chair
Sohin Shah (SS), Monitor
Bohdan Solamka (BS), Royal College of Psychiatrists
Andy Taylor (AT), Association of British Healthcare Industries
Vicki Woodhead (VW), NHS Commissioning Board

Apologies

Bill Aylward, Chair of EWGs and Consultant Ophthalmologist
Lloyd Barker, East Sussex Healthcare NHS Trust
Patrick Cadigan, Royal College of Physicians
Nigel Campbell, Monitor
Clare Gerada, Royal College of General Practitioners
Mike Henley, BMA Central Consultants and Specialists Committee
Ian Higginson, College of Emergency Medicine
Lisa Hughes, DH Allied Health Professions
Ian Lewis, Consultant Paediatric and Adolescent Oncologist
Tom Margham, NHS Commissioning Board
Chaand Nagpaul, BMA General Practitioners Committee
Donal O'Donoghue, National Clinical Director for kidney care
David Oliver, National Clinical Director for older people
Sian Rees, NICE
Meera Sookee, DH Sector Regulation
Lynne Turner-Stokes, Chair of Rehabilitation, Kings College London
Graham Venables, Consultant Neurologist
Keith Willett, National Clinical Director for trauma care

2. Minutes of the meeting of 26 June 2012, matters arising, and an update on actions

2.1. The minutes were agreed as a true record of the meeting and actions arising were discussed.

2.2. Paragraph 2.3: A meeting was to be arranged in November for IR to meet with Dr Martin McShane from the NHS Commissioning Board's (NHSCB) Medical Directorate. IR was asked whether he needed a delegation of CAP members to attend. IR said that he was content to meet Dr McShane alone in the first instance, but if any CAP members wanted to volunteer to attend, he would be pleased for them to join him.

2.3. Paragraph 2.4: the final evaluation report on BPTs had not yet been published. ER explained that the PbR team had just received the report, and a link to the publication would be shared with the group when available. **Action: PbR team.**

2.4. Paragraph 2.5: Ian Newton, DH PbR team had been in touch with Lisa Hughes to discuss the development of BPT proposals.

2.5. Paragraph 2.6: The report on the findings of a consultation relating to the use of diagnosis in outpatients grouping was included at item 10 on the agenda.

2.6. Paragraphs 2.7 and 12.12: CP would include an update on Monitor's clinical engagement strategy, and plans for the future of CAP under item 12 on the agenda.

2.7. Paragraph 3.5: MA would include examples of good practice from acute care under item 3 on the agenda.

2.8. Paragraph 5.5: It was agreed to defer an update from the best practice tariff research team to a future meeting. **Action: PbR team.**

2.9. Paragraph 9.4: Graham Venables had sent detail on intracranial clot retrieval devices to the PbR team for them to consider adding to the exclusions list.

2.10. Paragraph 11.1: no suggestions had been received on how sense check might be improved.

3. Update on clinical engagement in cost collection

3.1. MA delivered a presentation on clinical and financial engagement, and offered an update on four levels of clinical and financial engagement:

- **Level 1:** Engagement is only at board/strategic level.
- **Level 2:** There is some joined-up, collaborative work between clinical and finance teams but only on an ad hoc basis.
- **Level 3:** Joined-up collaborative working between clinical and finance teams is the norm in at least one clinical specialty/directorate.
- **Level 4:** Joined-up collaborative working between clinical and finance teams is the norm across all clinical specialties/departments.

3.2. MA outlined policy levers that helped to move this agenda forward, and shared key findings from the DH 2012 Reference Cost survey, which included evidence of the increased use of PLICs, and had collected for the first time, details of clinical and financial engagement in trusts, based on the 4 levels described.

3.3. An action point from the previous meeting was for MA to share examples of good practice (para 2.7 refers), and MA gave four examples of trusts that had clearly demonstrated how they used PLICs effectively. MA offered to share contact details at the trusts with individual CAP members who were interested in finding out more.

3.4. MA outlined details of a forthcoming workshop for level 4 organisations, being planned in collaboration with the DH, HFMA and Monitor. The aim of the workshop was to review and refine the four levels of clinical engagement; develop an assessment toolkit; and to collate examples of best practice.

3.5. HM enquired whether MA was working with clinical professional groups other than doctors. MA confirmed that he had engaged with a range of clinical groups, including pharmacists and nurses.

3.6. The group reflected on the different communication styles of finance and clinical colleagues, and acknowledged there was a need for each to better understand the needs of the other. MA explained PLICs could be a useful tool to get clinicians and finance people to talk and work together.

3.7. A question was asked about how many trusts feed in to the reference costs which then determine the PbR tariffs. SB replied that all trusts submit data.

3.8. MA thanked the group for their input, offered a commitment to providing another update at a future meeting, and asked CAP members to send any further ideas or comments to him via SB/SF in the PbR team. **Action: CAP members**

4. Sense check feedback

4.1. SF gave a presentation covering feedback from the sense check of the draft 2013-14 tariff, focussing on areas not covered as separate items on the agenda.

4.2. SF explained that the sense check exercise had been similar in scope and structure to previous years. Parallel sense check exercises were undertaken for chemotherapy and radiotherapy prices, and for cystic fibrosis, to seek advice from relevant experts. SF reported that a good cross-section of feedback had been received.

4.3. SF outlined the general themes emerging from sense check feedback, and offered detail of feedback in key areas such as:

- Best practice tariffs
- Cystic Fibrosis
- Chemotherapy delivery and external beam radiotherapy
- A&E and major trauma
- Maternity pathway payment system
- Specialised services and exclusions

4.4. SF explained that a common question was why elective prices were provided for certain procedures which would ordinarily be non-elective. He explained that having a price was not an endorsement of undertaking the procedure, but it was more to ensure the spell grouped to an appropriate HRG, which would lead to correct reimbursement for the treatment. ER added that some unusual circumstances could generate an HRG which would not be expected, for example, if someone was admitted for an elective procedure, but had a heart attack before the procedure had been undertaken, this could show up as an elective heart attack, and this was why elective prices were in place.

4.5. The group discussed the best practice tariff proposal to link an element of payment for endoscopy to having achieved, or being in the process of achieving, JAG accreditation. The up to date underlying cost data had resulted in a reduction in the price, and if organisations failed to meet the best practice criteria, there was potential for further reduction. Feedback was offered from The British Society of Gastroenterology (BSG) that the rewording of the BPT should stipulate that organisations need to be engaged with JAG rather than have achieved JAG accreditation. Feedback was also reported from the Royal College of Physicians (RCP) that a similar process of accreditation for radiology would be welcomed, to ensure that all providers delivered the same quality of radiology service. The group expressed some concern about the price differential for different procedures, and asked for further consideration to be given to this by the PbR team. Members suggested that complex endoscopies were time consuming and not adequately rewarded, and this could lead to a perverse incentive. The PbR team was asked to consider this further.

4.6. The group agreed that BPTs were meant to be stretching, with organisations having to strive to meet best practice, and the PbR team should retain that principle for all BPTs.

4.7. The group was in favour of incentivising emergency departments to carry out some procedures rather than admitting patients, and they would welcome the PbR team working towards bringing some of the tariffs into the emergency department, to facilitate patients receiving treatment in that setting. They cautioned however that it would be essential that accurate diagnosis had been determined.

4.8. Clarification was sought on procedures included for stroke patients in the BPT for interventional radiology. ER offered to check the detail of the BPT and offer further clarification. **Action: Eileen Robertson**.

4.9. A question was raised regarding whether clinical trials for chemotherapy and radiotherapy were chargeable, especially as patients taking part in trials may be seen more often in clinic. MC replied the general rule was that the drugs were paid for separately, but if there was activity associated with trials (the delivery of the drugs) that was within the scope of the tariff (unless explicitly included in the trial agreement)**.** MC referred the group to the rules included in the PbR guidance.

4.10. The group discussed the major trauma recommendation, and whether there was a need to define what type of consultant should be present within 5 minutes of arrival in at the major trauma centre, and emphasised the need for a **relevant** consultant to see the patient. The group agreed that existing documentation was thorough and

robust, and part of the Trauma Audit & Research Network (TARN) system, so they were content to endorse the proposal.

4.11. There was recognition that the maternity pathway payment system was challenging, but the group agreed that it was a move in the right direction, and that the many organisations that were ready to implement should not be held back to wait for those not yet ready.

4.12. SF explained that the PbR team was reviewing feedback on the draft exclusions list, and would circulate an updated version to CAP members for comment by correspondence **Action: PbR team**

4.13. IR concluded by reminding the group that there was still opportunity for CAP members to share any additional comment, and encouraged them to do so.

5. Patient / procedure selection

5.1. ER explained to the group that the PbR team had a commitment to strengthen the guidance around patient / procedure selection for 2013-14.

5.2. ER referred to the analysis presented to this group earlier in 2012 to try to identify the procedures most at risk of patient or procedure selection. A list of procedures had resulted from the analysis which was being sense checked by the Information Centre's (IC) expert working groups (EWGs). Once the list was available, the PbR team would draft the guidance. Some feedback had indicated that it might not be helpful to have a list, but the overwhelming feedback was that it would be useful. The list would be published as part of the PbR road test package in December. ER would circulate beforehand to seek feedback. **Action: Eileen Robertson**.

5.3. The group discussed the issues surrounding patient / procedure selection, and emphasised that some providers may not provide the full spectrum of procedures for appropriate clinical safety reasons.

5.4. The group also agreed that price differential was a key element, and could negate the need for guidance. ER explained that the PbR team would discuss potential future HRG redesign with the IC, and would in particular revisit the endoscopy pricing to see if price relativities should be adjusted.

5.5. A question was raised about whether the key was to get the casemix right, but MC explained that the focus was more on ensuring the provider was appropriately reimbursed for the casemix they provided.

5.6. The group discussed various options, and IR summarised that there were a number of things to take forward to try to strengthen the national approach to this, including:

- looking at cost relativities, particularly in the area of endoscopy.
- strengthening the guidance.
- asking the IC to amend HRG design where necessary.
- asking Monitor to work with the PbR team on patient/procedure selection, with particular reference to tariff flexibilities.

6. Emergency readmissions

6.1. CFM introduced paper CAP25-02, to share findings from the collection of data in Quarter 2 on the operation of the policy of non-payment for some emergency readmissions, and to seek CAP members' views on recommendations for 2013-14.

6.2. The group asked whether there was clear evidence that re-investment had reduced emergency readmissions. CFM replied that analysis had not yet been undertaken, but that was the fundamental aim of the policy. CAP members suggested that organisations should need to provide assurance that the money was being spent to reduce the risk of patients being readmitted.

6.3. There was discussion about the clinical review process. There had been a range of experiences, and some members reported that it had not helped to develop relationships in a productive way. Whilst the group welcomed the transparency, there was some doubt over whether the process would indeed prevent readmissions, and despite clinical review groups agreeing that some readmissions could have been avoided, there was no way to ensure additional funds would be invested to ensure the same issue did not recur.

6.4. IR suggested that, as a small percentage of the population accounted for significant healthcare spend, there might be some merit in considering individual financial solutions for these high cost patients.

6.5. The group felt that a good way to promote integrated care would be to direct some of the reinvestment towards a local pool of clinical staff, or on specialist nurses, who could work between trust and community, managing chronic conditions that often resulted in readmissions.

6.6. IR summarised that whilst the aims of the policy were positive, there was a clear message from clinicians that there should be a modified process, with an emphasis on incentivising integrated care.

7. Reimbursement for diagnostic imaging in outpatients

7.1. LS introduced paper CAP25-03, and sought members' views on the feedback from sense check on the proposal to have separate tariffs for diagnostic imaging in outpatients.

7.2. CAP members considered the proposal and commented that there was some doubt over whether clinicians would know how a scan would be paid for if it was organised in a clinic, so the behaviour of clinicians in referring patients for imaging would be unlikely to change whether or not the payment process altered. The view was that the changes in the way clinicians would refer patients would be due to improvements in imaging, and not related to financial gain. Imaging was continually evolving, and clinicians needed to keep up to date with improvements, without having to worry about monetary flows. Concern was expressed over the degree of the reduction of the outpatient tariff, and how essential it would be to calculate the correct change in price to compensate for the cost of the imaging. However, it was felt that this approach may reduce pressure on outpatient departments, as it would allow more imaging to be requested from primary care, which would benefit patients in terms of

earlier diagnosis. The group reflected on the role of radiologists, who had a significant role in recommending tests or modifying investigations, and how this proposal could incentivise the promotion of preferred tests.

7.3. It was acknowledged that there was significant clinical variation between clinicians in both primary and secondary care, and concern was expressed about the lack of granular information about what diagnostic imaging was being ordered.

7.4. Feedback was offered from a recent EWG meeting that if the process did not change, it would reinforce the existing multiple appointment system, whereas having separate tariffs for diagnostic imaging in outpatients would encourage diagnostic testing before the outpatient appointment. This would offer the opportunity for some patients not having to attend an outpatient clinic, especially if the guidance allowed for flexibilities such as telephone consultations.

7.5. A question was asked about whether the proposal covered reporting on the image as well as the image itself. LS confirmed that it covered both, and that would be clarified in the guidance. It was reported that some AQPs routinely just sent a written report, and a question was raised about whether JAG accreditation for radiology would include the imaging films. IR explained that at a recent EWG meeting, Erika Denton (ED), National Clinical Director for imaging, had emphasised that all contracts for radiology had to include the provision of the film, and it was a breach of contract if this did not happen. LS agreed to liaise with ED in the drafting of the guidance.
Action: Lorna Sinclair

8. PbR currencies for 2013-14

8.1. SN introduced paper CAP25-04 and updated the group, and invited comments on the status of the following work streams:

- HIV outpatients
- Specialist rehab
- Renal transplants
- Mental health
- Looked after children's health assessments

8.2. It was reported that the Royal College of Psychiatrists (RCPsych) had compared the mental health clustering mechanism, consisting of 20 clusters that combine diagnosis, complexity and severity, to ICD-10 diagnosis, which was a more granular spread of diagnoses. The RCPsych favoured a diagnostic led approach, particularly as NICE guidelines were based on diagnoses. SN explained that the team was considering piloting work around broad diagnostic categories in relation to the clusters and the cost drivers that might occur from treating that particular group of service users. There was discussion about how patients might prefer functionality above a diagnosis, which might feel like labelling them with a mental health condition, and how diagnosis did not always predict cost. ICD-10 did not always offer the same level of complexity or co-morbidity that a cluster potentially could. A question was raised about potential difficulties created by the clusters in relation to the integration of health and social care. MC reassured the group that the PbR team was aware of social care concerns about the cluster approach for mental health, and SN added that consideration was being given to whether to continue to move to a national tariff for some elements of mental health services because of the close links with social

care, and issues related to separating the funding streams. SN explained that there were some positive examples where social services were using the clustering tool effectively for their needs assessment and funding requirements. The PbR team would look for opportunities for these organisations to share this with other local authorities. IR reminded the group that this was a gradual process, and if prices were to be mandated, it would be sometime in the future.

8.3. A question was raised on why the proposal for looked after children's health assessments was only for looked after children placed out of area. SN replied that there had been significant variability in the type of assessment undertaken, and there were known issues with providers being reimbursed, so the initial proposal was to address this funding problem, which was a bigger issue in the parts of the country with a concentration of out of area looked after children. MC added that consideration would be given to introducing a national currency in the future.

9. RRR / LTC year of care update

9.1. CFM gave an update to the group on progress since the last CAP meeting. He explained that the PbR team was working extensively with the early implementer sites, and data was due to be reported for the first time in mid-November. The early implementer sites were reviewing logistics, such as information, governance, and confidentiality between organisations at a local level.

9.2. CFM reported that the PbR team had commissioned a piece of work with the IC to identify a statistical methodology in relation to a list of HRGs for long-term conditions. The IC would finalise the methodology, which they would present to clinicians and colleagues from the early implementer sites at a workshop.

10. Using diagnosis in outpatients

10.1. DA introduced paper CAP25-05 in response to an action arising at the last CAP meeting. He outlined the findings of two online questionnaires, designed to consult with key stakeholders on the development of the introduction of recording diagnoses in an outpatient setting, and the different options available for the utilisation of ICD-10 codes within the Casemix Classification system for activity within the outpatient setting.

10.2. DA was seeking views on whether the approach taken seemed appropriate, whether the proposal was practical from a coding perspective, whether it was moving in the right direction, and whether it should be tested initially by pilot sites. The IC would continue to work closely with their EWGs. They had secured input from clinicians, finance and information staff, and intended to consult with coders. DA was interested in CAP views on whether other NHS expertise would be required.

10.3. The group reflected that it would not be easy to collect all the necessary data, and enquired what the data would be used for. An added complication was that diagnosis occurred at different stages, and was often not possible at an early outpatient appointment, so it was difficult to know when to apply a code. Also, the consultant did not always see the patient at the outpatient appointment to be able to offer a diagnosis. IR suggested the IC engage with GPs, as their systems did not allow

diagnosis coding, but were symptom based, which were then linked as an integral part of a diagnosis, which only key people could determine. He cautioned that there were also legal issues relating to this. VJ asked if CAP members could help the IC to extend their engagement with the GP community.

10.4. The group was interested to know whether the IC was linking with the Connecting for Health (CFH) SNOMED CT outpatient subset coding project. VJ confirmed that the IC had been working closely with CFH around both discharge letters and the SNOMED subset.

10.5. The group reflected that outpatients had changed much over the last few years and would continue to evolve, and fewer patients would have an in-patient episode which would result in a discharge letter, at which point a diagnosis might be made. There was concern that any further delay in recording diagnoses in an outpatient setting might stifle new models of care delivery; and new abilities to deliver different sorts of procedures in outpatients. The group therefore urged this project be taken forward as a key priority.

11. Consultation on 'pricing objection' process

11.1. Meera Sookee was unable to attend to deliver this item. ER therefore gave a brief summary to the group.

11.2. ER referred to the new arrangements for the tariff for 2014-15 onwards, where Monitor would be required to publish a final draft of the National Tariff, and allow 28 days for commissioners and providers to object to the proposed methodology for calculating tariff prices. If a sufficient number were to object to the arrangements, Monitor would either have to reconsider the proposed methodology and re-consult on revised proposals; or refer the proposed methodology to the Competition Commission for a decision on whether it was appropriate.

11.3. A consultation on proposals for objecting to proposed pricing methodology "*Fair and transparent pricing for NHS services"* had been published[1], and CAP members were encouraged to offer feedback.

11.4. The consultation proposes that the objection percentage thresholds be set at 51% of the total number of commissioners, and 51% of the total number of providers. A 'share of supply' threshold would take account of providers who were most affected by tariff pricing, and therefore offer them a proportionate weight to the NHS services that they deliver. A provider not providing a service would not be able to object to it.

11.5. IR emphasised that a mechanism needed to be in place to avoid compromising patient care. ER explained that was why the threshold had been set relatively high at 51%.

11.6. The group reflected on existing lobby groups, and the bar being set so high that the only groups able to trigger an objection would be large groups such as those representing providers, or every hospital with a specific department. ER explained that the aim was to have as much consultation and agreement beforehand as

[1] http://www.dh.gov.uk/health/2012/10/pricing-consultation/

possible, so when the tariff was published, the majority would be signed up, although it was recognised that complete agreement was unlikely to be achieved.

12. PbR in 2014-15

12.1. Catherine Pollard from Monitor and Vicki Woodhead from the NHS Commissioning Board (NHSCB) delivered a joint update.

12.2. CP outlined preparations for the new pricing regime, and emphasised that during development, consideration would be given to how to use tools for best effect in order to drive benefits to patients. CP explained that Monitor was working closely with the NHSCB on future strategy, and they anticipated being in a position to bring firmer arrangements to this group early in 2013.

12.3. VW explained that the NHSCB was undertaking work looking at the long-term approach to tariff design, and how tariff could be developed to be consistent with, and promote the NHSCB's strategic aims. They were looking at whether payment mechanisms could incentivise the four key workstreams: self-management of long-term conditions; centralisation & specialisation; innovation; and productivity and efficiency. VW outlined emerging themes from stakeholder discussions to date, and reported that the NHSCB had strengthened over the last 6 months, and was now working on their future long-term strategy, but acknowledged that the full strategy would take some time to develop, so they were keen have shorter-term priorities agreed.

12.4. CP outlined the vision for the partnership agreement between Monitor and the NHS CB. Interim governance was in place, to focus on immediate and urgent decisions which were needed in the next few months. A more robust agreement, setting out new governance arrangements for clinical and expert advice, was planned for early 2013. She reassured the group that both Monitor and the NHSCB would ensure robust clinical guidance was in place, and asked that suggestions from CAP members be sent to CP and VW by e-mail. **Action: CAP members**

12.5. CP said that the approach for 2014-15 would be to avoid adding unnecessary complexity, provide stability, and allow some degree of local flexibilities, whilst creating an environment that would allow beneficial change for the patient.

12.6. The group asked for more detail on the intended local flexibilities, and emphasised that information needed to be shared with the NHS as early as possible to avoid organisations potentially having to alter their planned direction. CP referred to the recently published Kings Fund report[2] *How can payment systems help deliver better care?* which set out a number of options for Monitor and the NHSCB. She emphasised that Monitor and the NHSCB's duties were tightly defined around benefits for patients, and they would therefore be setting the same expectations for organisations around any use of flexibilities.

12.7. A question was asked about plans for integration, and how Monitor and the NHSCB might think about best practice with respect to risk sharing for financial flows in the context of trying to deliver stability whilst driving change. CP reported that Monitor

[2] http://www.kingsfund.org.uk/publications/payment-results-0

and the NHSCB had duties around integrated care, and were giving much thought to how best to proceed, and what they would want to prescribe, or allow to happen locally.

12.8. CAP members expressed some concern that the reorganisation was taking some time to progress, and whilst there were some worrying risks, there were also opportunities to improve patient experience. CP and VW agreed to keep CAP members updated on progress.

13. Any other business

13.1. None raised.

14. Date of next meeting

14.1. The PbR team would need to be guided by Monitor and the NHSCB regarding future meetings. SF explained that, if the cycle from previous years was to flow into 2013, and Monitor and the NHSCB wanted this group to meet to discuss 2013-14 arrangements and to begin preparation for the 2014-15 tariff, the PbR team had tentatively pencilled in 29 January and 16 April as potential dates for the next two meetings.

14.2. MC reflected that January meetings had usually focussed on new BPTs, and if, for example, the decision was made not to introduce any new BPTs in 2014-15, would a meeting in January be needed.

14.3. CP and VW agreed that the usual pattern of meetings should continue until they had finalised their future governance arrangements.

Actions

Ref.	Action	Owner
2.3	Alert CAP members when the evaluation of best practice tariffs is published	PbR team
2.8	Invite the best practice tariff evaluation team to attend a future CAP meeting	PbR team
3.8	Send ideas/comments on clinical engagement in cost collection to SB or SF in the PbR team.	CAP members
4.8	Clarify procedures included for stroke patients in the BPT for interventional radiology.	Eileen Robertson
4.12	Circulate an updated version of the draft exclusions list to CAP members for comment by correspondence.	PbR team
5.2	Circulate an updated version of the draft list of procedures most at risk of patient or procedure selection to CAP members for feedback.	Eileen Robertson
7.5	Liaise with ED in drafting guidance referring to radiology films remaining with the patient	Lorna Sinclair
12.4	Suggestions on future governance arrangements to be sent to CP/VW	CAP members

CAP attendance[3]

Key

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

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

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