1. Introductions and apologies for absence

Present:
Dr Paul Anderson (PA), Central Consultants and Specialists Committee, BMA
Dr Bill Aylward (BA), Chair of EWGs and Consultant Ophthalmologist
Sarah Butler (SB), DH PbR
Martin Campbell (MC), DH PbR
Una Coales (UC), Royal College of General Practitioners
Stephen Fenton (SF), DH PbR (minutes)
Jennifer Field (JF), NICE
Professor Ursula Gallagher (UG), Royal College of Nursing and Ealing PCT
Jake Gommon (JG), DH PbR
Dr John Heyworth (JH), College of Emergency Medicine
Lisa Hughes, Allied Health Professions, DH
Suzanne Ibbotson (SI), DH PbR
Virginia Jordan (VJ), NHS Information Centre
Professor Ian Lewis (IL), Consultant Paediatric and Adolescent Oncologist
Helen Marlow (HM), Pharmaceutical Adviser, NHS London
Dr Chaand Nagpaul (CN), General Practitioners Committee, BMA
Sue Nowak (SN), DH PbR
Professor David Oliver (DOL), National Clinical Director for Older People
Dr Donal O'Donoghue (DOD), National Clinical Director for Kidney Care
Dermot O’Riordan (DOR), Royal College of Surgeons
Dr Tim Richardson (TR), National Association of Primary Care
Eileen Robertson (ER), DH PbR
Dr Ian Rutter (IR), Chair
Dr Bohdan Solomka (BS), Royal College of Psychiatrists
Professor Lynne Turner-Stokes (LTS), Chair of Rehabilitation, Kings College London

Apologies:
Amanda Allen, Allied Health Professions, NHS South East Coast
Dr Patrick Cadigan, Royal College of Physicians
Katherine Fenton, Chief Nurse, UCLH NHS Foundation Trust
Dr Clare Gerada, Royal College of General Practitioners
Dr Kathy McLean, Medical Director, NHS East Midlands
Dr Graham Venables, Consultant Neurologist
Dr Amit Arora, British Geriatrics Society
Jonathan Brown, Gloucestershire Hospitals NHS FT

1.1. IR welcomed members to the meeting and received apologies.
2. Minutes of the meeting of 13 March 2011, and matters arising

2.1. LTS requested a number of changes be made to paragraphs 3.6 and 9.4.

2.2. UC pointed out that Clare Gerada’s name had been miss-spelt.

2.3. Paragraph 3.5: PA had fed back comments on some of the best practice tariff nominations. Paragraph 5.3: IR noted that the maternity pathway tariff casemix template had been circulated with the meeting papers. MC said that the PbR External Advisory Group had advised that the pathway tariff should be introduced on a shadow basis initially. Paragraph 10.1: PA said that his concerns regarding the neurology tariffs relate to tertiary referrals, and suggested that the relevant Expert Working Group should look into this further.

2.4. IR noted that the minutes of the 19 April meeting of the PbR Children’s Sub Group had been circulated to CAP members. IL said that the work done by the University of York had not taken into account all of the patients treated in children’s trusts. ER said that York were re-running the top-up analysis. MC said that work was underway, the outcomes of which would be shared with CAP members following the Sub Group’s next meeting on 7 July. Action: Martin Campbell.

3. Best practice tariffs

3.1. JG referred members to the paper which set out plans for the full package of best practice tariffs in 2012-13. The presentation focused on three specific service areas on which advice from CAP was sought; ambulatory emergency care, payment for outcomes with hip and knee replacement and paediatric diabetes.

Abulatory emergency care

3.2. PA said that presentation late in the day, and the prevalence of some social factors, mean that it is difficult to treat some emergencies as ambulatory. The presence of some complicating underlying conditions also means that for some patients ambulatory care may not be appropriate. In summary, PA said that although the list of proposed conditions is sensible, some may not lend themselves to this approach.

3.3. DOR welcomed the direction of travel, but warned of the risk of perverse incentives being introduced. He pointed out that for some conditions diagnosis does not take place quickly after the patient presents, and asked what proportion of patients with the conditions set out on the list stay in for one night. It was agreed that it would be more appropriate to use the term ‘assessment’ rather than ‘diagnosis.’ DOD welcomed the proposals, but would like to see more clarity on how the payment
mechanism will work. TR said that he supported the concept, though
acknowledged that it was not without issues.

3.4. LH asked that links with the 30-day post discharge policy be borne in
mind, and that the College of Paramedics be consulted as appropriate.
UC expressed the concern that one unintended consequence may be an
increase in the number of patients being ‘bounced back’ to their GP. UG
said that the proposed approach has the potential to deliver real
benefits, but asked that interfaces with other aspects of the tariff are not
overlooked. LTS said that a consequent increase in demand for imaging
would require careful resource planning, and would like to see an
increased emphasis on risk assessment to mitigate the likelihood of
patients being inappropriately discharged.

3.5. BA said that there remained a perverse incentive to admit patients and
attract a higher tariff. HM referred to work undertaken in London on
admission from care homes, which had highlighted a need for more
training for care home staff. LH was concerned that multi-disciplinary
care was not specifically mentioned.

3.6. In summary, IR said that whilst there was general support for the
concept, it might be more appropriate initially to focus on a smaller
number of conditions. It was also recognised that there is a need to get
the financial incentives right, and that there is potential through this BPT
to promote a setting-independent approach to tariff.

Payment for outcomes – hip and knee replacements

3.7. JG set out the work that has been done with the National Joint Register
and British Orthopaedic Association. He asked CAP members for views
on the use of Patient Reported Outcome Measures (PROMS) to inform
an element of tariff payment.

3.8. CN advised caution around measuring outcomes on the basis of
symptom relief, stating that from a commissioner perspective there are a
broader range of outcomes that warrant consideration. BA noted that
outcome data can be difficult and expensive to collect. LTS said that an
important outcome was whether the patient had attained the level of
recovery that had been anticipated. TR noted that with hips and knees,
around 20 per cent of patients reported that they had not realised
expected benefits. LH said that a far better measure would be to also
consider post discharge recovery, such as length of time before the
patient was able to return to work. UC raised a concern about the
outcome measures being too subjective in nature. IL said that despite
the concerns raised, the outcomes data collected were clearly validated.

3.9. DOD said that in orthopaedics, good progress is being made in the use
of PROMS and Patient Decision Aids. DOR said that it was appropriate
for trusts to be rewarded where they focus on improving patient
outcomes.
3.10. JF questioned whether CQUIN might be a more appropriate vehicle for linking some payment to PROMS. IR asked whether both a CQUIN and BPT approach could be used.

**Paediatric diabetes**

3.11. IL and LF welcomed the BPT proposals for paediatric diabetes, saying that they had been thoroughly developed and the proposed approach to implementation was helpful. TR also welcomed the proposal, but said that further work was needed on the detail, and questioned why there was no mention of prescribing. DOD asked whether there would be a burden of collection. IL suggested that transitional care should be included, independent of setting, and that further discussions with the diabetic community would be helpful. UC raised concerns about the proposed tariff rate, comparing this with the payment that GPs receive.

4. **Emergency readmissions and post discharge support**

4.1. SN gave a presentation summarising activities since the previous CAP meeting.

4.2. DOL made the point that non-payment for readmissions and post discharge support are separate issues. He recognised that trusts are unable to mitigate the risk of readmission in many cases. He welcomed the renewed emphasis on integration and resources for step-down services. He gave a flavour of discussions at a recent senior expert panel meeting to discuss post discharge support, at which there had been a debate as to whether tariff is the most appropriate way to deliver policy objectives. The conclusion was that an alternative approach should be sought, and this was endorsed by CAP members.

4.3. NC said that readmission rates should not necessarily be seen as an indicator of the quality of care provided by a hospital. He called for better unbundling of resource and greater recognition of the role of GPs in enabling patients to better manage conditions. IR noted that in the US, some hospitals with high readmission rates lose a proportion of their income. TR raised concerns about tariff acting as a perverse incentive to drive patients to hospital with subsequent disinvestment in community services. LTS said that the development and introduction of community service commissioning currencies was vital.

4.4. MC said that at the end of the first quarter of 2011-12 the PbR team will work with SHAs to assess the financial impact of non-payment for some emergency readmissions.
5. **Proposed exclusions and NICE**

5.1. ER summarised the issues covered in the paper.

5.2. PA queried why the numbers of PET CTs was low. ER said that when an item is included in the reference cost collection, the numbers reported in the first year can be small. Where this data is intended to underpin tariff, feedback at sense check will inform whether any price adjustments need to be made. IR asked whether guidance could be clarified on what tariff covers with regard to drugs provided on discharge. ER said that there is variation in practice which will be reflected in reference costs, and therefore in tariff. TR raised the issue of some trusts reporting drugs in outpatients and others not doing so, which suggests further clarity is needed in reference cost collection guidance.

5.3. ER said that whilst reference cost data is available for some exclusions, these are global costs. UG asked whether there is any evidence from audit that exclusions from tariff have incentivised perverse clinical behaviour. ER said that there might be merit in bringing a paper to a future CAP meeting on how the exclusions regime sits in the PbR system going forward. **Action: Eileen Robertson.**

5.4. IR summarised that the group was content with the proposed exclusions lists going forward for sense checking.

6. **ICD-10**

6.1. VJ gave a presentation on how the Casemix team plans to implement changes arising from the update to the ICD-10 classification system.

6.2. TR raised a question about whether the use of large volumes of ICD-10 codes was appropriate, to which VJ responded that there are occasionally examples of clearly nonsensical coding combinations. BA asked about the relationship between ICD-10 and SNOMED CT, which is due to be implemented in 2015. VJ said that in developing ICD-11 (due for implementation in 2014-15), the World Health Organisation is working closely with the SNOMED group. BA said that it was important to build better working between coders and clinicians.

7. **Chemotherapy and radiotherapy**

7.1. SI introduced the paper, covering issues such as problems with the recording and flowing of activity data and options around the implementation of currencies and tariff for chemotherapy and external beam radiotherapy. It was noted that the Cancer Strategy had called for acceleration in currency development.
7.2. IL asked for clarity around the definitions used in the paper with regard to chemotherapy. SI provided further background on how the chemotherapy HRGs are currently structured. IL said that he was content with the proposal to mandate the currencies for radiotherapy in 2012-13 and take a more gradual approach for chemotherapy, but asked what the long-term plan is. MC said that the aim is to bring these services into the scope of PbR in a managed and sensible way.

7.3. MH asked that some thought go into how the tariff can be made more flexible in terms of reflecting changes in medicine prices. She gave examples of where a medicine comes off patent or where there is a sudden change in clinical practice that leads to a change in the medicines used. TR could see possibilities for bringing more standardisation to an area where there is currently variation in price.

7.4. In summary, IR said that there was support for mandating external beam radiotherapy currencies for contracting in 2012-13, with a more gradual approach to the introduction of currencies for chemotherapy.

8. **Cystic fibrosis**

8.1. SN introduced the paper, which set out progress towards the goal of introducing a mandatory tariff from April 2012. Views were sought on two issues; the scope of the year of care tariff, and the extent to which there have been changes to clinical practice since 2007, which was the year in which data was collected which informed the banding.

8.2. UG expressed strong support for the proposal, though asked that there be an explicit exclusion for transplantation. ER asked whether CF would appear as the primary diagnosis for a transplant patient, UG said that yes it would. PA said that he was not aware of any significant changes in clinical practice since 2007, though he suggested that the PbR team contact the group which undertook the 2007 cost collection exercise to verify the basis on which they collected the data. **Action: PbR team.**

8.3. IL could see a potential conflict between a year of care tariff designed to incentivise best care and instances where more frequent interventions are needed. He also asked to what extent drugs are an issue for consideration, as with chemotherapy. DOD said that whilst he supported the year of care approach, it is perhaps more appropriate for ‘stable’ patients. SN said that the seven-band structure and in-built review reflected the fact that the CF Trust and others have considered this issue.

8.4. DOD said that it would be advantageous if payment could follow the patient across organisation boundaries, and that the transition from paediatric to adult CF care should not be overlooked. PA said that such an approach might work well for COPD and paediatric diabetes, but noted that most CF care takes place in an acute setting and CF patients
are used to very individualised care. LTS said that for most CF patients
the movement between bandings is likely to be one-way, as the
condition worsens.

8.5. In summary, IR asked the PbR team to take on board the comments
raised in preparing the CF tariff for sense checking.

9.  HIV outpatient services

9.1. SN introduced the paper, which provided an update on the development
of a tariff for HIV outpatient services, which it is anticipated will not be
implemented before 2014-15. SN noted that the Health Protection
Agency, which currently has responsibility for datasets, is taking forward
some information governance work with the NHS Information Centre and
others.

9.2. HM said that in London some changes are being made that will lead to
lower drug prices. IR noted the public health benefits of better treatment,
in the form of less virus being shed.

10. Response to the NHS Future Forum report – safeguards against
price competition and ‘cherry picking’

10.1. DOR gave an insight into his role as a member of the Future Forum’s
Choice and Competition group. He said that the sensible and pragmatic
wording in the report reflected the fact that the focus of concern is on
where ‘cherry picking’ distorts the market. He raised the possibility of
commissioners being able to vary prices for some ‘cherry picked’
services. IR said that all ideas would be helpful for the PbR team to be
aware of as they develop the tariff.

10.2. MC noted that the Government response to the Future Forum report
envisaged the Royal Colleges taking forward work on this. He suggested
that CAP be the vehicle for this, as it comprises representatives of the
Colleges. It was agreed that this was a sensible approach.

10.3. TR declared an interest, as a director of an independent sector provider.
He set out examples of where it would be possible to provide a service
at a price below tariff, but made the point that tariff rules do not at
present allow this to happen. BA said that competition with the
independent sector wasn’t the issue in itself, it was that some providers
‘cherry pick’ a small subset of patients. CN quoted an example from
north London where they only found out that an IS provider could not
take a patient for clinical reasons after the referral had already taken
place, the point being that many IS providers ‘cherry pick’ on justifiable
safety grounds. He suggested that rather than try to address the issue
within current tariff structures, there be a more fundamental re-think.
10.4. UC said that some GPs may be concerned that commissioning groups may seek to exclude some groups of patients. DOD said that this issue had been addressed. LH said that at recent AHP listening events, examples were quoted of ‘cherry picking’, and she asked that the AHP federation be involved in discussions going forward. IL said that a key issue was with organisations that treat many complex patients operating on an average cost tariff. LTS pointed out that a ‘banding by complexity’ approach may help in this regard. She said that ‘cherry picking’ isn’t all one way, and quoted rehab as an area where often NHS trusts take the simple cases and IS providers the more complex.

10.5. IR asked whether this issue would be partially resolved by more granular HRGs, and suggested that it might be worth identifying a number of procedures prone to ‘cherry picking’, for which a price adjustment might be justified. SJB said that it was important to be clear about what we mean by ‘cherry picking.’ TR said that for some, bottom-up costing data might be available, and asked whether for some procedures the price difference between with and without complications and comorbidities could be increased. MC sought views on the merits of a potential business rule whereby the price paid could be varied if a particular provider did not have a full range of casemix.

10.6. In summary, IR said that it would be helpful to look into the feasibility of doing something for the 2012-13 tariff. Action: PbR team.

11. Sense check proposals

11.1. SF gave an overview of plans to sense check the draft 2012-13 tariff.

11.2. IR noted that in previous years comments were lacking on some HRG Chapters. PA said that the picture was mixed, but that it would helpful if efforts could be made to encourage some EWG Chairs to engage in this year’s exercise and provide feedback. LTS said that it would be helpful if the PbR team could be more explicit about the sections of the tariff that EWGs should focus on, and HM said that more clarity about what has changed from the previous year would be helpful. IR asked the PbR team to identify the HRG chapters for which little or no feedback was received at sense check last year. Action: Stephen Fenton.

12. Any other business

12.1 DOR asked if there was any guidance available on bilateral procedures. ER thought that this was covered in the PbR Guidance for 2011-12, but would check. Action: Eileen Robertson.

Date of next meeting: Tuesday 8 November 2011
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<td>2.4</td>
<td>Share with CAP members outcomes of the discussions at the PbR Children’s Sub Group on 7 July</td>
<td>Martin Campbell</td>
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<td>5.3</td>
<td>Bring a paper to a future CAP meeting on how exclusions sit within PbR going forward</td>
<td>Eileen Robertson</td>
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<td>8.2</td>
<td>Contact those responsible for the 2007 data collection which underpins the Cystic Fibrosis banding</td>
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<td>10.6</td>
<td>Consider whether ‘cherry picking’ can be addressed in the 2012-13 tariff and business rules</td>
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<td>11.2</td>
<td>Compile list of EWGs that provided little or no feedback at sense check last year</td>
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## Attendance

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**Key**

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

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