PAYMENT BY RESULTS CLINICAL ADVISORY PANEL

MINUTES OF MEETING ON TUESDAY 17 APRIL 2012 HELD AT SKIPTON HOUSE, LONDON

Present:
Dr James Adams (JA), British Geriatrics Society
Dr Bill Aylward (BA), Chair of EWGs and Consultant Ophthalmologist
George Batchelor (GB), Monitor
Sarah Butler (SB), DH PbR
Martin Campbell (MC), DH PbR
Stephen Fenton (SF), DH PbR (minutes)
Professor Ursula Gallagher (UG), Royal College of Nursing and Ealing PCT
Mike Henley (MH), BMA Central Consultants and Specialists Committee
Lisa Hughes (LH), DH Allied Health Professions
Virginia Jordan (VJ), NHS Information Centre
Andrew Lloyd-Kendall (ALK), BMA General Practitioners Committee
Helen Marlow (HM), Pharmaceutical Adviser, NHS London
Sue Nowak (SN), DH PbR
Dermot O’Riordan (DOR), Royal College of Surgeons
Tongtong Qian (TQ), DH PbR
Sian Rees (SR), NICE
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
Ivy Wong (IW), NHS Commissioning Board special health authority

1. Introductions and apologies for absence

1.1. IR welcomed all to the meeting and reminded members of their role in providing broad-based clinical input rather than representing the interests of specific specialties. The following apologies were received:

Dr Amit Arora, British Geriatrics Society
Dr Jonathan Brown, Gloucestershire Hospitals NHS FT
Dr Patrick Cadigan, Royal College of Physicians
Dr Una Coales, Royal College of General Practitioners
Adrian Davis, Office of the Chief Scientific Officer
Dr Ian Higginson, College of Emergency Medicine
Dr Tom Hughes, College of Emergency Medicine
Professor Ian Lewis, Consultant Paediatric and Adolescent Oncologist
Dr Chaand Nagpaul, BMA General Practitioners Committee
Dr Donal O’Donoghue, National Clinical Director for kidney care
Professor David Oliver, National Clinical Director for older people
Dr Tim Richardson, National Association of Primary Care
Dr Bohdan Solomka, Royal College of Psychiatrists
Professor Keith Willett, National Clinical Director for trauma care
2. Minutes of the meeting of 28 February 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 – A note had been shared with CAP members setting out the requirements in the reference cost collection guidance relating to clinical engagement. The note also contained draft text for a forthcoming edition of the Medical Directors’ bulletin. LH suggested that it would be useful for similar articles to appear in other bulletins. The PbR team will discuss with LH which bulletins to target. **Action – PbR team.** DOR suggested ways in which the piece for the Medical Directors’ bulletin could be strengthened, and said that he would be happy to help. The PbR team will follow-up on this offer of assistance. **Action – PbR team.**

2.3. Paragraph 5.2 – IR reported back on the discussion that he had with Kathy McLean, who was receptive to concerns raised by CAP members about clinical engagement going forward. Due to time pressures on Sir Bruce Keogh, Kathy would be happy to meet with IR and a delegation of CAP members, perhaps by videoconference, to discuss this further. **Action – Secretariat.**

2.4. Paragraph 7.4 – Colleagues from Monitor had been invited to attend the meeting.

2.5. Paragraph 10.1 – It had not been possible to arrange a telephone or web link for the meeting.

2.6. MC gave an update on work undertaken since the last meeting on the issue of reimbursement for diagnostic imaging in outpatients. DOR raised concerns that some commissioners might ‘cherry pick’ certain tests, IR said that he could see opportunities for joint working through unbundling diagnostic imaging. MC said that the next step would be to set out the issues for David Floy’s consideration.

3. Best practice tariffs

3.1. ER introduced her paper and explained that advice on the long list of best practice tariff (BPT) proposals for 2013-14 had been sought from members of the PbR External Advisory Group and Technical Working Group as well as CAP. The shortlisted BPT proposals will now be subject to further analysis. It is not guaranteed that all of the proposed BPTs on the short list will make the final cut.

3.2. IR urged caution in not trying to pre-empt NICE guidance. GB said that it would be helpful to understand more of the background, and so IR asked ER to send GB a note setting out the criteria used to determine whether or not BPT proposals are progressed. **Action – Eileen Robertson.** ER noted that the evaluation of BPTs is complete and the final report is expected during the week commencing 23 April. She undertook to give GB early sight of the report. **Action – Eileen Robertson.**

3.3. DOR asked about the status of a BPT proposal relating to radiotherapy. ER said that it was felt that this was not sufficiently well-developed to include in plans for 2013-14. It was proposed to proceed with the endoscopy proposal and leave radiotherapy for the future. GV noted that there were regional initiatives which the PbR team needs to
be aware of, and LH said that she would contact ER off line to share useful information. **Action – Lisa Hughes.**

3.4. IR summarised the discussion and asked ER about next steps, which is to work up the proposals and come back to the next CAP meeting in June with an update. ER said that Monitor and the NHS Commissioning Board will be played in as this work progresses.

4. **Analysis of outpatient procedure activity**

4.1. TQ introduced her paper and presented some slides which set out the provisional findings of an analysis of the data underpinning outpatient procedure tariffs. TQ said that whilst there are no plans for a significant expansion in the number of HRGs which will have an outpatient procedure tariff, there are issues with the current approach which need to be better understood. Further analysis is required, and any proposals for action will be brought to a future meeting.

4.2. BA said that it would be important to look at the ratio of day cases and outpatients across trusts, and said that there was a possibility of ‘gaming.’ IR said that looking solely at historic data is unlikely to provide the answers, and suggested that local bottom-up costing should be used and local prices allowed to emerge.

4.3. MH said that the current HRGs used are not sufficiently descriptive, and questioned the robustness of the activity data, which suggested that one trust was undertaking a particular procedure an average of 134 times per week, which was unrealistic. LTS said that the issues with the historic data need to be understood and then the focus needs to switch to prospective data collection. HM noted that there have been discussions at the High Cost Drugs Steering Group about medicines used in outpatients and the use of codes, which appears to be inconsistent.

4.4. MC noted that the analysis had revealed large differences in the reported cost for day cases and outpatients for the same HRGs, and the PbR team needs to try to understand whether this is real or a reflection of the way in which costs are apportioned. Whilst the PbR team would like to set combined day case / outpatient prices wherever possible, it is difficult to do so whilst these issues remain unresolved. MC asked whether it is the case that the outpatient procedure costs being reported are lower than the actual costs being incurred. BA said that some cost differences are legitimate, for example with laser eye surgery where setting does influence cost. ER said that we need to understand whether different procedures are being reported under the same HRG and whether procedure codes are mapping to the appropriate HRG.

4.5. GV said that it would be helpful to have better definitions for procedure codes. LTS noted that there is limited comorbidity coding in outpatients. MC asked whether it would be appropriate to move to combined day case / elective prices where there is similar casemix, LTS said that in this scenario it would be appropriate. BA raised the risk of providers being under or over reimbursed depending on their position on the cost spectrum.

4.6. VJ said that the Health & Social Care Information Centre Casemix team had conducted a survey to identify benefits of collecting diagnosis in the outpatient
setting, and would like to bring an update to a future meeting. **Action – Virginia Jordan.** IR thanked TQ for her presentation and asked that the group be kept informed of progress.

5. **Cherry picking**

5.1. ER introduced her paper and presented some slides which demonstrated the outcome of some analysis recently undertaken. ER briefly explained the basis on which the HRGs for analysis had been selected, and BA noted that for one of the HRGs (cataracts) there are often additional procedures undertaken.

5.2. SF read out comments submitted via e-mail from Tom Hughes of the College of Emergency Medicine, in which he made the case for age being used as a good surrogate measure of comorbidity and for there to be better recognition in the tariff of the higher costs associated with more complex cases.

5.3. GB said that it was important to bear in mind that the analysis was looking at activity within HRGs, and that the variation seen in the charts in the paper could be due to a number of factors such as patient choice. LTS asked whether the findings were consistent with the outputs of the work done by Andrew Street’s team at the University of York, and in relation to next steps whether the PbR team would focus on the clear outliers in the analysis. MH stressed the importance of protecting services which can be more difficult to provide.

5.4. IR suggested that some cherry picking can be beneficial, with the more pressing question being around how activity can be reimbursed in a way that appropriately reflects costs incurred. ER said that we are not yet at the stage of identifying solutions, but are trying to identify areas where action may be required. UG stressed the importance of promoting more accurate and granular pricing, and suggested that CCGs might need some support in understanding some of the ‘big picture’ issues being addressed.

5.5. DOR raised the possibility of the issue being addressed through guidance, and MC asked whether this could be done through a strengthened flexibility in 2013-14. DOR said that he would like to see providers given the option to trigger an investigation where they felt this was necessary.

5.6. ER noted the group’s view that it was not necessary to do further work to try to prove the existence of cherry picking, and said that the PbR team would focus its work accordingly and report back at the next meeting. If issues are identified with HRG design, then there may be scope to fast-track a change to the grouper.

6. **Update from Monitor on PwC and Frontier Economics reports**

6.1. GB set out the background to the reports recently published, and in response to questions about clinical involvement he referred to a medical advisory group that Monitor has and whose membership is drawn from foundation trusts. MH asked GB if he could provide a written summary of his comments and would be interested to know the roles of the members of Monitor’s medical group and FTs are represented
on the group. SN also asked if GB could share the group’s terms of reference.

**Action – George Batchelor.**

6.2. DOR said that whilst FTs have been Monitor’s focus to date, this is changing and will need to be reflected in their clinical advisory arrangements. HM asked about the involvement of clinical staff other than doctors, and UG and LH stressed the importance for Monitor to have access to a broad range of advice. GB said that the group will change as Monitor’s role changes. GB noted that the PwC evaluation report had been informed in part by clinical input, and he offered to pull together a list of the clinicians that had been involved, though he noted that some contributions may have been submitted in confidence. DOR suggested that Monitor make use of existing expertise within the DH PbR team, and IR noted the links between the PbR team and the NHS IC in relation to HRG design.

6.3. GB said that a pricing strategy project had been launched, which will help to build a picture of where Monitor wants to be in the medium to long term. This project will involve significant stakeholder engagement, through targeted interviews and wider engagement. GB said that he would welcome CAP members’ involvement in this, and IR said that he was sure that many CAP members would be happy to be involved. LTS said that her rehabilitation Expert Reference Panel would be happy to share with Monitor information on the approach that they have been pursuing.

6.4. SR said that it might have been sensible for Monitor to have engaged with CAP members at the start of this engagement process. DOR said that he was unclear about what would happen after the conclusion of the interview and workshop phases of the engagement. VJ noted that the NHS IC has a strong record on clinical engagement, with over 300 clinicians involved in HRG design through the Expert Working Groups. VJ gave an overview of ongoing work, including production of a specialist services commissioning grouper and input into the RRR workstream.

6.5. GB gave a brief overview of the local tariff modification report produced by Frontier Economics, which set out what the Act permits and on which further work will be needed to identify how it might work in practice. HM said that there has for some time been confusion as to how medicine costs are reflected in tariff. ER recognised that this is a common query and is a matter on which there is variety in custom and practice. UG said that a key issue is how tariff can be more transparent and help drive improvement.

6.6. IR thanked GB for his contribution and looked forward to increased engagement between Monitor and CAP members.

7. **NHS Commissioning Board (NHSCB) strategy**

7.1. IW presented some slides setting out the scope of a project to look at the NHSCB’s approach to tariff over the longer term, and invited feedback from the group.

7.2. It was suggested that IW might want to include an explicit reference to personalisation and personal budgets. LH asked for clarification around what is meant by clinical or professional advice, and suggested that it would be helpful to have clarity on what coverage of funding models there is at present. GV said that there are issues around when it might be appropriate to promote particular
technologies, and IR noted that historically diffusion has not been pushed ahead of NICE guidance. MH said that trusts with high MFF values tend to be better at innovating than trusts with a lower MFF.

7.3. LTS said that she would like to see a greater emphasis on outcomes. She would like the NHSCB to focus on the perennial problem of measuring complexity, and would be happy to talk about this outside the meeting. UG said that the presentations by both Monitor and the NHSCB demonstrated a need for there to be a consistent approach and overarching narrative and a more explicit link between architecture and outcomes. SR questioned how the approaches outlined would shift the commissioning landscape, and GV said that he would like to see some reference to health inequalities. SN suggested that a link with the service user perspective would be beneficial, and GB noted that Monitor is doing some work on patient choice and involvement.

7.4. IR noted that often specialist knowledge doesn’t flow upstream, IW said that she will rely on input from experts to help take this work forward. DOR noted that the NHSCB’s timescales for the project seem very ambitious, and warned of a degree of cynicism across the wider service. ALK asked whether the NHSCB was looking for national or local solutions.

7.5. LTS noted that people have competing demands on their time, and UG said that there is a need for realism in relation to what can be achieved and by when. LH questioned the need to commission work from academics at this stage, and urged the NHSCB to tap into the knowledge and expertise that already exists within the Department. GV referred to the 57 clinical reference groups as another valuable source of information. GB stressed the importance of joint working between NHSCB and Monitor in taking this work forward.

7.6. IR thanked IW for her contribution.

8. Exclusions

8.1. ER introduced her paper and summarised that the proposed HRG and outpatient attendance exclusions are broadly unchanged, but that the latter may be influenced by the outcome of the work on reimbursement of diagnostic imaging. MH raised the issue of the bundling of PET scans, which ER said she would pick up outside the meeting. Action – Eileen Robertson.

8.2. ER invited CAP members to send in any comments about the Exclusions paper via e-mail to Stephen Fenton. Action – CAP members.

9. Any other business

9.1. MC gave a brief update on the recent PbR Children’s Sub Group meeting, at which there had been a discussion on the specialist rehabilitation and RRR work, with a request that this be included as an item on the agenda for the next Sub Group meeting.

Date of next meeting: Tuesday 26 June 2012, 11.15am, Skipton House.
## Actions

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<th>Ref.</th>
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<tr>
<td>2.2</td>
<td>Follow up with Lisa Hughes possible bulletins for further articles on clinical engagement in costing</td>
<td>PbR team</td>
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<td>2.2</td>
<td>Liaise with Dermot O’Riordan about the article for the Medical Directors' bulletin</td>
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<td>2.3</td>
<td>Set up meeting for Ian Rutter and a number of CAP members with Kathy McLean</td>
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<td>3.2</td>
<td>Provide George Batchelor with a background note on best practice tariffs and a copy of the evaluation report</td>
<td>Eileen Robertson</td>
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<td>3.3</td>
<td>Provide Eileen Robertson with information to help inform development of best practice tariff proposals</td>
<td>Lisa Hughes</td>
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<td>4.6</td>
<td>Bring an update to a future meeting on work to identify benefits of collecting diagnosis in the outpatient setting</td>
<td>Virginia Jordan</td>
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<td>6.1</td>
<td>Provide a written summary of comments and details of Monitor’s medical advisory group</td>
<td>George Batchelor</td>
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<td>8.1</td>
<td>Pick up issue of bundling of PET scans with Mike Henley</td>
<td>Eileen Robertson</td>
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<td>8.2</td>
<td>Send in via e-mail to Stephen Fenton any comments on the Exclusions paper</td>
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**CAP attendance**

**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.