Bevan Commission meeting report, 20 January 2012

This was the first Bevan Commission meeting since the Health Minister, Lesley Griffiths AM, requested the Commission to reconvene in a reconstituted form. The meeting was opened by the Chair, Professor Sir Mansel Aylward CB.

The meeting was attended by all those invited to join the Commission. These were:

- Professor Bim Bhowmick OBE, Consultant Physician for the Elderly in Community Care, Anglesey
- Dr Tony Calland, Chairman, BMA Medical Ethics committee.
- Sir Ian Carruthers OBE, Chief Executive, NHS South of England.
- Dr Jo Farrar, Chief Executive, Bridgend County Borough Council
- Lt General Louis Lillywhite CB, MBE, QHP, former Surgeon General of the British Armed Forces
- Professor Marcus Longley, Director, Welsh Institute for Health and Social Care, University of Glamorgan.
- Professor Ewan Macdonald OBE, Head of Healthy Working Lives Group. University of Glasgow
- Professor Donna Mead, Professor of Nursing and Head of the School of Care Sciences, University of Glamorgan.
- Professor Sir Anthony Newman Taylor CBE, Principal, Faculty of Medicine, Imperial College.
- Professor Ceri Phillips, Professor of Health Economics and Head of Research, College of Human and Health Sciences, Swansea University.
- Professor Allyson Pollock, Professor of Public Health Research and Policy at Queen Mary, University of London.

Full biographies of Commission members are included in appendix 2.

Jonathan Davies, Special Advisor to the Minister for Health and Social Services, attended the opening session on behalf of the Minister.

In addition the following support staff attended: Eleanor Higgins (Public Health Wales), Helen Howson (Welsh Government), Jon Matthias (Public Health Wales), Dr Chris Riley (Welsh Government), Dr John Watkins (Public Health Wales)

The Commission also welcomed presentations from David Sissling, Director General, Health, Social Services and Children in the welsh Government and Chief Executive of NHS Wales and Dr Judith Greenacre, Director of Health Intelligence, Public Health Wales.

Re-launching the Bevan Commission

The Commission began with a short round- table introduction. This was followed by a brief PowerPoint presentation by Jon Matthias outlining the previous work of the Commission. The former Commission culminated in the publication of a final report called *Forging a Better Future*. This was well-received by the Welsh Government and informed the most recent NHS strategy document, *Together for Health*'.

*Toge*ther for Health and the current governmental direction regarding NHS Wales were set in the wider context of the past ten years, in a presentation by Dr Chris Riley. The key elements that have driven government policy have been the desire for 'world class' services

in Wales and also a firm rejection of market economics in the structure and delivery of health services.

Today's NHS Wales structure consists of seven geographically integrated health boards responsible for all health services for their local population, in addition to three NHS trusts, the Ambulance Service, Public Health Wales, and Velindre NHS Trust (a specialist cancer services trust). The structure is deemed to be sound and there are no plans to reorganise.

The Commission were informed that the new Welsh Government is focused on delivery, with a determination to make a measurable difference in the lives of the people of Wales.

The initial draft terms of reference given by the Minister for Health and Social Services to the Chair, regarding the role and purpose of the Bevan Commission were discussed (see appendix 3). The Commission decided to amend the terms of reference to strengthen the suggestion to "advise the Minister on how to achieve" change. It also chose to keep the scope of the Commission open-ended, removing the list of conclusions from *Forging a Better Future* to allow the Commission to raise new issues as it sees fit. The Commission believe this change will give them greater flexibility in addressing all issues that face NHS Wales and those that may arise in future.

It was agreed that the Commission would operate under Chatham House Rule.

The Commission would develop its own website and would no longer be hosted on the Welsh Government website.

The Chair introduced several paradigms of working methods and proposed that papers and advice be created corporately. On a practical level, this could be through use of an online document sharing tool, which will enable papers to be added to and edited by members of the Commission. Witnesses and experts could be invited to contribute through papers, or in person. Enough time needed to be given to fully discuss evidence brought by witnesses.

It was agreed that the Commission needed to have a focus on outcome, with decisions made at the end of each meeting about who would prepare initial frameworks for papers. There was the possibility of smaller working groups meeting between full Commission meetings. Literature reviews could probably be commissioned through Public Health Wales if needed.

The Commission would have a role as a scrutineer, as a change agent and in providing 'thought leadership'. It could have a major impact on the Welsh Government's and NHS Wales' delivery culture. It would be independent, but it should aim to assist the Minister to drive forward change.

It was suggested progress in a thematic way would be preferable. A work programme would be essential, with activities geared to that programme. But the Commission would need to be flexible and responsive if and when events happen. The terms of reference may need to change if the wider agenda changed.

Regarding the role of the Bevan Commission, it would be helpful to have in mind what 'success' would look like for the Commission, when looking back from five years in the future.

Points were raised by Commission members throughout the opening discussions, usually with a high degree of consensus and agreement. The points are summarised in the following pages.

The 2012 situation

The Commission were informed that the Welsh Government has a duty to support sustainable development which is now central in its thinking. This in effect requires it to take a long-term view of policy, with the impacts of policy decisions being carefully considered. In this context the Commission agreed that health improvement could be seen as part of collective ministerial responsibility and that therefore the health needs of the nation need to be taken into account in all policy decisions.

Together for Health explicitly addressed issues raised by the Bevan Commission. Health Inequalities are being taken seriously. Progressive reform, the ongoing quality agenda, transparency as a driver of performance, the complex relationship with the public and the financial pressure faced by NHS Wales are all covered in the document. Financial control is crucial.

The Commission agreed the appropriate relationship between NHS Wales and the people it serves is hard to define. In the system in England the service was largely market-driven, but in the Welsh model, the relationship was different. The health service needed to be supported by the public, but how this should be worked out precisely is unclear. In *Together for Health,* the Minister spoke of making a 'compact' with the public. A suite of strategies are being developed to make this 'compact' happen, with clear commitments to the public so they know what they can reasonably expect from the health service, and what the service can expect of them.

The Welsh Government had recognised that change was a necessity. Services could not be propped up. The challenge was not to do things differently, but to do different things. Those new areas of work would be decided on evidence – and the Welsh Government had a clear commitment to drawing on an evidence base.

The lack of integration with the Third Sector was raised as an issue. The Commission heard that lessons could be learned from the Third Sector's understanding of how to engage best with the public. The Third Sector was diverse and not all relationships between the Third Sector and health services were fully integrated. The Minister met with representatives from the Third sector biannually and had invited them to contribute knowledge and ideas.

It was agreed that integration between healthcare and local government was a challenge. There were 22 Local Authorities (LAs) in Wales. There was a shift in focus among local authorities with some services being delivered nationally and regionally, rather than locally.

The Commission agreed that Local Service Boards could be better exploited and have proved successful in many areas. For example, a complex families unit based in a police station has drawn in and enabled coherence across social services.

The Commission also discussed how tribalism could be a barrier to integration. A more personal approach could overcome this, with a champion drawing grass-roots people on board and motivating them. Increased communications can enhance integration. All services, and Third Sector organisations, would need to be involved and know they were valued.

A number of members of the Commission felt that information had been repeatedly highlighted as a problem in Wales. Sharing information across services would be beneficial to people. The core of information needed to be person-centred not organisation-centred. There were issues with security, confidentiality, over-sharing, what professionals do need to know, who has access, and why people would have access. Without addressing these

issues information, for example, could be passed on with good intentions which could subsequently lead to vulnerable people being overwhelmed by multiple contacts from different health and social services teams.

However, some members identified where progress has been made. Individual health records existed and public access to their own records was being proposed through 'my health online'. There was access to secondary care data and integration between out-of-hours services and primary care. Test results were available to professionals working in any arena. There was a framework for sharing across services – the Wales Accord on the Sharing of Personal Information (WASPI).

The Commission also discussed that at a population level, the SAIL database developed in Swansea University pulled together anonymised primary care data in a powerful epidemiological tool. It could also provide case studies of life events to give a picture of patient experiences. SAIL could go beyond health and social care, and could also link to school records, for example, to show the impact of premature birth on subsequent educational achievement.

Resources and manpower were identified as an issue, but SAIL could be made available to health boards, which could provide the additional time resources to expand the database. The challenge was how SAIL could inform service delivery – at the moment it is, primarily used in academic study.

Scope of the Bevan Commission

The Commission was asked to advise the Minister about health and health services. The Commission confirmed this gave a wider scope than just a focus on health services, i.e. the provision of healthcare through NHS Wales. Feasibly, the Commission agreed they could comment on anything that could have an impact on health. Improving the health of the people of Wales to be comparable with the best health enjoyed by citizens of any other country in the world would require looking beyond the narrow confines of healthcare.

The Commission agreed they needed to be aware of what was often missed out from discussions about health, and indeed what was missed from the Commission's draft terms of reference, e.g. the Third Sector and enterprise. Efficient and effective health services were not seen to be the sole driver and determinant of gaining a step-change in the health of the people of Wales. Policies that would change the health of the nation more broadly were primarily socio-economic. The Commission should comment on these other drivers for health if there was to be a step-gain in the population health.
Discussion took place on how NHS Wales can increase wealth in Wales to tackle the socio-economic causes of poor health. Further discussion took place on how the Welsh Government should relate to the private sector. It was agreed that public services need to be seen as wealth creators, not a drain on finances. If NHS Wales could become a wealth creator, then it would make a powerful case for its ongoing resourcing needs.

A 'collective' responsibility within the Welsh Government towards health was recognised, but there should be to be two-way dialogue between departments. The health department should be able to offer advice on economic policy and enterprise, as economic status is a primary determinant on an individual's health outcomes.

Comparing health and health services in Wales with the best in the world was discussed and it was agreed that this required an understanding of the context and whether a system could be translated or modified for Wales. Several factors that would need to be considered in any comparison were identified:

- The social landscape of other countries (e.g. post-industrial, democratic).

- The way healthcare services are provided, remembering that NHS Wales has firmly rejected the non-market system.
- The 'starting point' of other systems – percentage improvements in healthcare maybe misleading in countries that start from a very low baseline.
- The levels of integration in the compared system.
- The robustness of outcomes

The Commission were informed that there is an emphasis on delivery in the Welsh Government. They heard that NHS Wales has had more money in the past than others who have delivered more with less. The main challenge was highlighted as supporting the First Minister and the Welsh Government as a whole to change the pattern of the way things are done.

Most countries have a market system operating in healthcare, whereas the Welsh system is based on non-market values. If the Welsh system were to fail it would be the failure of the non-market model. The Commission agreed that there is a requirement of NHS Wales to succeed to show that a non-market system can work to deliver comparable-best healthcare to citizens. The ramifications of failure would therefore be significant.

The Commission will be helped in its task of comparing healthcare in Wales through a thorough needs assessment for Wales and knowledge of what is the best elsewhere. The 'needs' could simply be 'whatever is wrong with health'. The Commission would need to define the metrics it wants to capture from other countries and determine what constitutes 'best'. However, while Wales could learn from anywhere in the world, it should adapt and use the knowledge it could gain.

The Commission agreed that any findings they make will need to have practical implementations attached. The 'Welsh trap' of good analysis and poor implementation must be avoided. The Commission's advice should be framed according to desired outcomes and how to achieve them. *Forging a Better Future* (June 2011) highlighted intractable problems that have been discussed many times before – can the Commission conceptualise solutions in ways that have never been done before?

The Commission discussed a need for cultural change, and agreed this may be one of the conclusions of *Forging a Better Future* that would be hardest to pursue. Public aspirations towards health, and a host of other policy agendas including education, need to be raised. Worklessness, with all its attendant health issues and impact on mortality must be something the Commission addresses. Social security is not devolved, but would be integral to any discussion of work and worklessness.

The members were asked to suggest subjects they would regard as a priority for the Bevan Commission to focus on. (These have been summarised in the appendix 5.) The following notes expand on this summary:

1) Demographics
The ageing population and increased number of emergency admissions for the elderly, combined with delayed discharge of elderly patients is already a noteworthy pressure on the system, and without action, this pressure will only increase. It has consequences on the ability of NHS Wales to reconfigure health services.

NHS Wales needs to reduce avoidable admissions to hospital and provide more services at home. Services need to be better, faster and more co-ordinated. A full audit on how NHS Wales cares for the elderly, particularly those with dementia, would be helpful.

The ‘demographic issue’ is only really a problem if old age is associated with poor health – people are living longer with more health conditions that need treatment. This has a huge impact on quality of life alongside the exponential growth in healthcare costs. Delaying the onset of chronic age-related illness and infirmity will help alleviate the pressure on the system. This will require significant public health input earlier in life.

2) Information / transparency
Information is core to everything, but there are still doubts over whether professionals have the data they need to hand. The formation of the NHS Wales Informatics Service (NWIS) and the development of SAIL are positive moves, but there are issues around capacity. Transparency means indicators of performance will help track improvements. However, a strategic overview of the availability and use of information would seem to be essential.

Accountability towards the citizens of Wales need to be strengthened and structures to enable such accountability should be supported, for example, Community Health Councils. Accountability is more than just responding to complaints.

3) Service reconfiguration & integration
From 2000-2010 there has been a large increase in admissions to hospital, and also of patient-driven use of hospital services through attending Accident & Emergency departments. The reasons for these changes need to be fully explored and these user-patterns will have an impact on any configuration of services.

The integrated healthcare structures are still very new, and a truly integrated structure that is broader than healthcare exists only in theory. From the inside, services may appear integrated, but they might not appear that way to the patient / service user / citizen.

A stock-take on the primary care strategic delivery plan would be a worthwhile exercise for the Commission. When discussing the barriers to integration, it is important to include practical steps forward. This is an area where greater involvement of the Third Sector in delivering health services and working on preventative interventions can be discussed.

Courage is needed to advocate putting resources into other (non-health) services that deliver health benefits. This is more than just money; other resources such as staff, capital assets, and so on could be made available across traditional funding borders.

4) Public health
Obesity is becoming an even more serious public health problem in Wales. The difficulty is that deprivation causes poor nutritional choices (low quality, but expensive food), and the deprived lack the skills to source and cook better quality, cheaper food. With a higher proportion of income spent on food, the expense of convenience food keeps poor people poor.

The less deprived tend to eat better quality, more nutritious food, which has an impact on health generally, but also may impact on educational achievement while young, and the ability to hold down employment when older, with fewer periods of sickness, for example.

5a) Culture
Communities are very important, but people are still reliant on services and not each other. How can NHS Wales help to build resilience and self-reliance in people and also in community relationships? De-medicalising society should be targeted to decrease dependency and boost autonomy and self-reliance, recognising there are numerous social determinants to health, which must be addressed.

People's limited aspirations for their own health and other areas of personal responsibility should be challenged. The idea that education 'isn't for the likes of me' needs to be gently but firmly challenged. Poverty, worklessness, crime, illiteracy and poor health are not inevitable and the passive acceptance of these outcomes by both the people who experience them, and sometimes the professionals who try to help them, should be vigorously challenged.

Increasing the skill-base and working skills, linked to enterprise policy will impact on health. Changing the culture requires the Welsh Government to act as a cohesive whole. Decreasing health inequalities should be a priority and deliberations and guidance offered by the Commission should aim to have an effect on the lives and outcomes of people in the lowest social sectors.

5b) The relationship with the public
This is linked to changing the culture, but specifically relates to the way NHS Wales interacts with the citizens of Wales. Communication with the public has to improve to i) rationalise expectations regarding the limits to what NHS Wales can do, and ii) establish more effective behavioural change and to improve health.

6) Costs
NHS Wales needs to get a handle on costs, which means a true assessment of what things actually cost in the current configuration of services. The system-costs and, importantly, the opportunity costs of the day-to-day need to be calculated. The citizens of Wales pay for the service and they need to get value for money – this is an important facet of quality (see point 7, below).

7) Service quality
The Commission will advise the minister on what it means to be 'world-class', and the quality of the services provided by NHS Wales is an essential feature.

There is a danger that NHS Wales will be a low quality working environment, despite the hard work of the good people employed in it. There are several aspects of quality that the Commission should focus on:

- Dimensions of patient safety
- Effectiveness of treatment
- Patient experience, with services integrated around the patient
- Timely access
- Productivity and value for money
- Implementation strategies (and evaluation)
- Making safety a priority at board level
- Possible external reviews, such as ISO accreditation
- Commitment to research and development
- Efficiency – although this needs to focus on the right efficiency, e.g. allocative efficiency

There is a need to use money and measure the outcome at the same time. Efficiency is more than just moving money around between budgets. It should focus on creating public value. Efficiency is not an end in itself – NHS Wales needs to get value for the citizen, but this is rarely measured, if at all. Citizens want the best outcomes possible form the deployment of resources. The public sector needs to make better use of money spent in complex situations. From a health point of view the question of quality could be: 'what is the best clinical outcome for the citizen based on the use of this resource'.

8) Creation of a common purpose

The whole public sector needs to have a common purpose, which could be to maximise the functional capability of the citizen. This links into points made about cultural change above, recognising that education and literacy affect employability, which in turn affects life expectancy.

Services need to be aspirational, with an aim to maximise the functionality of the person they are working with. In healthcare this would result in a commitment to total rehabilitation of those receiving treatment. NHS Wales needs the self-belief that it can achieve and it can deliver.

In a citizen-based model, the common vision for a common outcome provides clarity and focus to everyone working in the public sector and to politicians.

The pursuit of a quality, citizen-focused health service must not provide a battlefield for local political agendas.

View from the top

The Commission welcomed David Sissling, Director General, Health and Social Services and Chief Executive, NHS Wales, who introduced his view of NHS Wales. In an interactive session with members of the Commission, the following points were made or reaffirmed.

- The structural architecture of NHS Wales is not going to change. The system has been shaken up, but is now positioned to deliver.
- There is a compelling vision in Together for Health.
- NHS Wales is not settling for mediocrity. It wants to attain world-class status.
- The key drivers are: legislation, benchmarking / performance management, the desires of the public, leadership, and partnership.
- The approach to change could be 'centralist', although experience shows this doesn't work.
- Accountability and transparent outcomes are going to be key in driving NHS Wales forward.
- NHS Wales needs evidence that it can deliver. Some evidence is already available, for example eliminating pressure ulcers in hospitals.
- NHS Wales needs to get serious about quality.
- Improvements can happen despite unfavourable financial terms.
- There are already improvements in managing demand and cross-working.
- The current state of play still feels like 'visiting yesterday'. It doesn't feel like a transformational moment. It's still very much hospital-based and doesn't focus on population health.
- Reconfiguration is a big issue. The hospital system is unsustainable.
- The mantra at the moment is 'progress with pace'.

The Director General also raised some questions that he said he was personally hoping the Bevan Commission would help answer.

- How do we change the population's view of healthcare?
- How do we move from health promotion campaigns to other solutions to the problems with population health – maybe solutions that lie outside the NHS?
- How do we achieve a balance between standardised care and diversity? How many versions of 'good' do we allow?
- Could the Bevan Commission be more interactive with Chief Executives, as both advisors and also as a sounding board?

There are benefits to the Bevan Commission acting as an independent source of advice. For example, when it comes to reconfiguration and infrastructure issues it can take an

independent view and say the hard things that need to be said. It will be more influential if it is commenting on the issues that are the main priorities for NHS Wales. The Commission's words have weight and can give practical advice to fuel progress in healthcare and across the public sector.

The inequality gap

For its final session, the Commission welcomed Dr Judith Greenacre, Director of Health Intelligence, Public Health Wales, who presented on the recent work of the Public Health Wales Observatory in assembling health inequality profiles for Local Authority areas across Wales, alongside a national picture.

The findings revealed significant divergence for both life expectancy and life without disability (or 'quality life expectancy') both geographically and between the most deprived and least deprived segments of the population. In some areas the difference between the richest and poorest segments of society was over 20 years in terms of good quality life. The full findings were available on the Public Health Wales website.

There were some caveats to the research. While mortality data was secure, some of the other data was admittedly 'soft' and reliant on self-disclosure of information. Generally, though, reviews by other public health observatories and other research conducted in Wales have confirmed the overall reliability of the findings. This means health boards could access comparable data and decide where to allocate resources to tackle health inequalities, with some confidence.

The overall trend was for a widening gap in equalities between the most and least deprived communities. On average, people in the most deprived sections of society would live 7 (males) or 9 (females) years longer with poor health and die earlier. Projections were difficult, but it was reasonable to believe the gap would continue to increase.

The Commission's response to the trends presented by Dr Greenacre was overall positive, and the hard work of the staff at Public Health Wales was commended. The Commission thought that the findings were interesting, but not surprising. There were known problems with the poorest communities in Wales, and the slightly depressing message of the presentation was that despite deploying resources in the poorest areas, the gap still seems to have increased.

Possible causes were discussed. There may be a cohort problem, with the legacy of post-industrial disease skewing the trends. The gap may therefore close naturally but was considered to be unlikely. However, the cohort effect was not present throughout the UK, but similar research seemed to show similar patterns of a widening gap. Also, it was unlikely that there was a substantial legacy effect in a cohort of older people who worked in mining or heavy industry, given the length of time since the de-industrialisation of Wales.

It was suggested that there could be an inter-generational effect of industrial disease on children born into families where people worked in heavy industry and mining; the 'in utero' effect. However, determining this, or any other genetic trend, would be very difficult. The health profiles did show trends for smoking and other lifestyle influences on health and some action could be taken on this. But even without smoking or alcohol indicators, significant differences remain.

Could the gap be closed? Life expectancy overall had increased, just not at the same rate across socio-economic groups. The level of the poorest could be raised, but the richer parts of society would always accelerate faster. Perhaps the only way to close the gap would be to

take money off the rich, but that is a questionable policy that does not improve the situation for the poorest members of society.

The gap is, however, the subject of political interest. Is it acceptable that it is widening? The determinants of ill-health are greater in the most deprived fifth of society, so appropriate action should be taken. In places the worst gap has been in areas where schools produce very few children with any examination qualifications. Again, the health services cannot fix health problems without a creative, and concerted approach across platforms.

In conclusion, the disparity may be the wrong focus for improvement. Improving the 'absolute' – the rates of mortality and morbidity – could be of greater benefit to the poorest than trying to close the gap. A macro-economic view is needed. Unemployment needs to decrease and wealth increase and this may well have an impact on the inequality gap.

Action Points

Number	Action	Who	Due Date
BCAP 01.01	Arrange future meetings of Bevan Commission	EH	March
BCAP 01.02	Produce paper regarding the links between the Third Sector and NHS Wales	HH	March
BCAP 01.03	Provide a summary of foci for the Bevan Commission	ML	March
BCAP 01.04	Set up and format website and Wiki	EH / JM	March
BCAP 01.05	Invite Ronan Lyons to present on SAIL database	EH / MA	March
BCAP 01.06	Begin Delphi exercise on 'What would we like Wales to be comparative to?'	MA / HH	March

Appendices

1. Meeting agenda
2. Members of the Bevan Commission biographies and areas of expertise
3. Initial draft Terms of Reference given by the Minister
4. Amended Terms of Reference to be returned to the Minister
5. Summary of foci for the Bevan Commission

Appendix 1
Agenda
Bevan Commission
Meeting 1

Date of meeting: 20 January 2012
Time of meeting: 09.30 – 15.30
Venue for meeting: Conference Room 24, Ty Hywel, Cardiff Bay.
Version: 1a

1.	09.30	**Welcome and Apologies** Professor Sir Mansel Aylward CB		Oral
2.	09.40	**Introductions** Professor Sir Mansel Aylward CB		BCP/12/01
3.	10.00	**Achievements of previous Bevan Commission** Mr Jon Matthias and Professor Sir Mansel Aylward CB		BCP/12/02 BCP/12/03 BCP/12/04 BCP/12/05
4.	10.15	**Current Context and Welsh Landscape** Dr Chris Riley		BCP/12/06 BCP/12/09
5.	10.35	**Task and Remit** Professor Sir Mansel Aylward		
		a	Terms of Reference and Minister's letter	BCP/12/07 BCP/12/08
		b	Role of the Commission	Oral
6.	11.35	**Ways of working** Professor Sir Mansel Aylward		
7.	12.30	**LUNCH**		
8.	13.30	**Summary of morning session** Professor Sir Mansel Aylward		Oral
9.	13.45	**Way forward / next steps** Professor Sir Mansel Aylward		Oral
10.	14.15	**Feedback from seminar** Professor Marcus Longley		Oral
11.	14.45	**Health Inequalities Profiles** Dr Judith Greenacre, Public Health Wales		Oral
12.	15.15	**Any Other Business**		

Appendix 2 – Members of the Bevan Commission

1. Dr Tony Calland – BMA, Ethics, retired GP

Dr Tony Calland has spent 34 years as a general practitioner in the Wye Valley on the Welsh Border. During that time he has also been a Non Executive Director of Gwent Health Authority and been the Chairman of the Welsh BMA GP committee and the Welsh BMA Council. He was a member of the BMA team that negotiated the 2003 GP contract and is still the Chairman of the BMA Medical Ethics committee based in BMA London. He retired from active general practice in 2006.

2. Sir Ian Carruthers OBE – Hospital Services Administration, Strategy

Ian Carruthers was brought up in Carlisle and attended Carlisle Grammar School. He commenced his career in the National Health Service (NHS) at Garlands Hospital, Carlisle, in 1969 as a trainee administrator, before subsequently holding posts in Barnsley, Blackpool, Southend, Portsmouth and Plymouth. From 1987 to 2006 Ian Carruthers held a succession of leadership posts with the Dorset, Somerset and Hampshire Health Authorities.

During 1994, Ian Carruthers was seconded to the South and West Regional Health Authority as Regional General Manager and Regional Director of the NHS Executive. He was seconded in 2004/5 to the Department of Health on a part-time basis as the Transitional Director of the NHS Institute for Innovation and Improvement.

Ian Carruthers received a Knighthood in the 2003 New Year's Honours List, for services to the NHS. In March 2006, Sir Ian took over as Acting Chief Executive of the NHS and was responsible for running one of the largest organisations in the world, having 1.3 million employees and a budget in excess of £100 billion.

Currently Sir Ian is the Chief Executive of the NHS South of England comprising South Central, South East Coast and South West Strategic Health Authorities. The NHS South of England covers a population of 13.4 million, has an allocation of £21.1 billion and comprises 13 PCT Clusters, 30 Primary Care Trusts, 39 Acute Trusts, 12 Mental Health Trusts, 4 Ambulance Trusts, 11 Social Enterprises, 66 Clinical Commissioning Groups and 4 Community Trusts.

In his 40 year NHS career, Sir Ian has transformed access to healthcare as well as the quality of services and financial performance in both national and local settings. He has overseen many major service changes and is a champion of change to deliver better outcomes for patients, staff and communities. He believes strongly in partnership working and this is demonstrated through the improvements that have seen the NHS in the South West achieve healthcare that is amongst the best in the United Kingdom.

He has recently undertaken a review of innovation in healthcare on behalf of the Chief Executive of the NHS in England culminating in the Innovation Health & Wealth Report which forms part of the Government strategy for improving the spread of best practice in healthcare as well as economic growth in the UK. He will be chairing the Innovation, Health and Wealth Implementation Board to oversee delivery.

Sir Ian is currently Chancellor of the University of the West of England, Chair of the Health Honours Committee, Non-Executive Director of Bioquell plc and a Trustee of the UK Charity ERIC.

He has been the lead author on several papers on reviewing and improving the NHS and is seen as an international expert on healthcare systems and service delivery.

3. Professor Ceri Phillips – Health Economist, Academic

Ceri is Professor of Health Economics at Swansea Centre for Health Economics and Head of Research at the College of Human and Health Sciences, Swansea University, Wales. He is a non-executive member of Abertawe Bro Morgannwg University Health Board and a member of the 1000 Lives+ Programme Board. He is also a member of the Management Board of the NICE Collaborating Centre for Cancer and has recently been a member of NICE Programme Development Groups on a range of public health issues.

He was appointed to the Bevan Commission in 2009 on the 60th anniversary of the NHS to advise and oversee the new configuration and structure of NHS Wales. Until 2011 he was the health economics member of the All Wales Medicines Strategy Group (AWMSG), which advises the Welsh Minster of Health and Social Services on matters relating to prescribing decisions and medicines management, and is the Vice Chair of its New Medicines Group, which appraises all eligible new, licensed medicines, available for use in the NHS, and which makes recommendations to AWMSG.

He has undertaken commissioned work on the evaluation of programmes and interventions for a range of organisations, including the World Health Organisation, Welsh Government, Department of Health, Department of Work and Pensions and a range of health and social care authorities and pharmaceutical companies. He has published extensively in the field of health economics, health and social policy, with over 140 books and journal articles.

4. Professor Allyson Pollock – Public Health Policy, Academic, Health Inequities

Prof Allyson Pollock is professor of public health research and policy at Queen Mary, University of London. She set up and directed the Centre for International Public Health Policy at the University of Edinburgh from 2005 to 2011, and prior to that she was Head of the Public Health Policy Unit at UCL and Director of Research & Development at UCL Hospitals NHS Trust.
She trained in medicine in Scotland and became a consultant in public health medicine in 1991. Her research interests include globalisation; privatisation, marketisation and PFI / PPPs; health services; regulation and trade; pharmaceuticals and clinical trials; and childhood injuries.
She is the author of NHS plc and co-author of The New NHS: A Guide

5. Professor Donna Mead – Nursing, Academic

Donna is Professor of Nursing and Dean of the Faculty of Health, Sport and Science at the University of Glamorgan. In addition she is an Independent member of a Local Health Board, having served previously as a non-executive director of two NHS Trusts. She is also a Governor of a Further Education College.

Donna trained in Merthyr Tydfil in 1974. Following this she obtained qualifications from London University and Manchester University before returning to Wales to complete a PhD in the late eighties.

She has been involved in formulating health strategy in Wales for over 20 years – as a member/chair of statutory advisory committees and through involvement in key All Wales initiatives e.g. The All Wales Clinical Effectiveness Initiative.

Donna leads the team which wrote the Realising the Potential, A strategy for nursing care in the 21st century. This was written in 1997, to coincide with devolution. An evaluation of the strategy in 2007 demonstrated the strategy's longevity as it was deemed to remain current.

She is an active researcher. Currently Donna leads an All Wales Research Capacity Building Initiative which has resulted in 22 doctoral and 5 post doctoral qualifications. She is a member of the NISCHR Academic Health Science Collaboration and has been invited to join the advisory board for the NISHCR faculty.

Donna was awarded the OBE in 2009 New Years Honours for services to nursing and health care.

6. Professor Sir Anthony Newman Taylor – Secondary care, Academic

Professor Sir Anthony Newman Taylor is Principal of the Faculty of Medicine at Imperial College. He was, between 1977 and 2010, consultant physician at Royal Brompton & Harefield NHS Foundation Trust, where for several years he was Deputy Chief Executive, Medical Director and Director of Research. Since 2006 he has been a Non-Executive Director at Royal Brompton & Harefield NHS Foundation Trust. He has been Professor of Occupational & Environmental Medicine at National Heart & Lung Institute, Imperial College University of London since 1992. He was Head of National Heart and Lung Institute from 2006 to 2008 and Deputy Principal of the Faculty of Medicine at Imperial College from 2008 to 2010.

He was Advisor to Minister of Health, India, on the long term consequences of methyl isocyanate exposure to population of Bhopal in 1985 and Advisor to Dept of Health, Valencia, on epidemic of lung disease in textile spray workers in 1994. He was Chairman of the Industrial Injuries Advisory Council (IIAC), an expert advisory group to the Department for Work and Pensions between 1996 and 2008, and a member between 1982 and 1996. Between 1998 and 2009 he was Chairman of CORDA, Preventing Heart Disease and Stroke. He is currently the Chairman of the Independent Medical Expert Group of the Armed Forces Compensation Scheme, Chairman of the Colt Foundation and a Trustee of the Rayne Foundation.

His publications include, chapters in textbooks on respiratory disease and occupational and environmental lung disease and original papers in Lancet, British Medical Journal, Thorax, American Journal of Respiratory Disease and Critical Care Medicine; Journal of Allergy and Clinical Immunology.

7. Dr Jo Farrar – Local Government CEO, Social Services / Care, Public Health Wales Board member

Jo Farrar has been Chief Executive of Bridgend County Borough Council since January 2007 and is also Chair of the Bridgend Local Service Board. Jo is a Non-Executive Director for Public Health Wales. She is past Chair and currently the Health and Social Care Lead Chief Executive for the Society of Local Authority Chief Executives in Wales.

Since moving to South Wales in 2004, Jo has been the Assistant Chief Executive with Cardiff Council and worked with the Welsh Assembly Government on a programme of mergers.

Previously Jo lived in London and worked as an Assistant Chief Executive at Camden Local Authority and Deputy Director of Reform Strategy at the Cabinet Office.

Jo has held a number of positions with the Home Office including: Head of Opportunities, Training and Development; Head of the Home Office Health and

Welfare Service; Private Secretary to the Home Secretary; Head of Strategy, Performance and Planning for HM Inspectorate of Constabulary; and Leader of the Vehicle Crime Bill and Policy Team.

Jo has a PhD in Public Service Reform.

8. Professor Ewan Macdonald OBE

Ewan is an occupational physician who trained in occupational medicine in the coal mining industry and has since led UK and international services in industrial sectors as diverse as computing, textiles, aluminium production and health care. He is a former Dean of the UK Faculty of Occupational Medicine and founder and Past President of the Occupational Medicine section of the Union of European Medical Specialists. He retired from the Scottish NHS at the end of 2011, having developed the Salus service in NHS Lanarkshire. Salus is the largest NHS based occupational health and safety service which has a track record of innovation, of developing services for the workless, and of income generating for the NHS.

At the University of Glasgow he established Healthy Working Lives Group and proposed the Healthy Working Lives paradigm which became the strategy of Scottish Government in 2004. Subsequently he stimulated its review which led to the Health Works policy. During 2011 he chaired the implementation group of the first Health Works pilot to introduce a redesigned musculo-skeletal service in one health board. This will ensure a more patient centred faster service with a focus on return to maximum function including work where appropriate. His research has evolved from a focus on the health problems caused by work to the health problems caused by worklessness and he believes that worklessness rather than disease is the major contributor to morbidity, mortality, health inequalities and social exclusion in Scotland. He established with others, the Scottish Observatory for Work and Health which is based in his group at the University.

9. Professor Jennie Popay – Health and Wellbeing, Social Science

Jennie Popay has been Professor of Sociology and Public Health at the Institute for Health Research since January 2002. She was previously at the Nuffield Institute, University of Leeds, the University of Salford and the Institute of Education, London University.

Jennie is also the Director of Health R&D North West.

Jennie Popay was born in Salford in the North West of England. She spent 5 years teaching in East Africa and studied social sciences in New Zealand before returning to the UK in 1974 to undertake postgraduate work. She began her research career at the Unit for the Study of Health Policy at Guy's Hospital in London and has worked as a sociologist in the public health field ever since. Her research interests include

social and gender inequalities in health, the sociology of knowledge, public/community engagement in health decision making and the evaluation of complex social interventions. She has used a range of methods in her work but has a particular interest in developing the role of qualitative research in public health including developing methods for the review and synthesis of qualitative research and mixed method studies. She was founding convenor of the Campbell Collaboration Process Implementation Methods Group and the Cochrane Collaboration Qualitative Methods Group.

10. Professor Bim Bhowmick OBE – Secondary Care, Integration, Elderly

Consultant Physician for the Elderly in Community Care, Isle of Anglesey, Emeritus Consultant Physician for the Elderly in Glan Clwyd Hospital Rhyl, ex-Clinical Director of Medicine, ex-Associate Postgraduate Dean Wales,.

He pioneered many services for Elderly in Wales and was awarded the OBE. He Chaired the Standing Committee of Postgraduate Medical Education for over a decade and played a pivotal role in shaping the education and training of junior doctors in Wales. He established the first in UK Academic Department of Geriatric Medicine in a small district general hospital. He initiated and led the development of Medical and Clinical Audit in Wales.

Cardiff University awarded him the Fellowship and a Personal Chair in recognition of his significant contribution for Post-graduate Medical Education in Wales. For his significant contribution to innovative Stroke Services, the Welsh Association of Stroke Physicians has created the Annual Bim Bhowmick lecture and Bim Bhowmick Bursary.

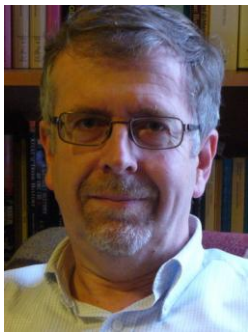
He has been a Councillor and first ever CENSOR from Wales of the Royal College of Physicians, London. He is a senior MRCP examiner and Ex-Chairman of the Equality and Diversity Committee.

He has been awarded the prestigious Founders Medal by the National British Geriatric Society – the highest honour for the most distinguished physician. He was awarded the Fellow of Glyndŵr University and was a Governor.

He has won the BUPA foundation Medical Charity UK award in recognition of his groundbreaking work in Intermediate Care in Pontypool in 2008. In 2009 he received the Lifetime Achievement NHS Wales Award, given for the first time ever. In 2011 he received the recognition achievement award from the Welsh Government for Health and Social Services Integration.

Professor Bhowmick is also the Deputy Lieutenant of Clwyd and Patron of Cronfa Betsi Fund.

11. Professor Marcus Longley – Health Policy Research



Marcus Longley is Professor of Applied Health Policy and Director of the Welsh Institute for Health and Social Care at the University of Glamorgan. He was educated at the universities of Oxford, Cardiff and Bristol, and worked in the NHS for 14 years, in a variety of managerial and planning posts, before joining the University in 1995. He has been a Specialist Advisor to both the House of Commons Welsh Affairs Committee and the Welsh Local Government Association, and to the Royal Pharmaceutical Society of Great Britain and the Older People's Commissioner for Wales. He is a Ministerial appointment on the Board of Consumer Focus Wales, and is a trustee/director of two third sector organizations working with young people. He was elected a Fellow of the Faculty of Public Health of the Royal Colleges of Physicians in 2008.

12. Lt General Louis Lillywhite CB, MBE, QHP – Veterans

Louis is the former Surgeon General of the British Armed Forces, a post he held from 2006 – 2009. He trained at the University of Wales College of Medicine and also began his TA training in Cardiff. He has held a number of distinguished posts including: Regimental Medical Officer 3rd Battalion Parachute Regiment; Second in Command, Commanding Officer 23 Parachute Field Ambulance; Commander Medical I (UK) Armoured Division (Gulf War - Mentioned in Dispatches, 1991); Director, Medical Personnel, Training and Clinical Policy; and Consultant Occupational Physician (since 1990). He is a Fellow of the Faculty of Occupational Medicine, Royal College of Physicians; Medical Society of London (Fellow); Royal Society of Medicine (Fellow); British Medical Association; and Society of Occupational Medicine.

Corresponding members

13. Professor Gregor Coster

His rural experience began with being a founding trustee and then Chairman of the New Zealand Institute of Rural Health, an organisation that is now supporting rural general practice and making a significant difference to rural health care. This was followed by appointment for four and a half years as Chairman of the West Coast District Health Board. This was an enlightening experience involving travelling from Auckland to the West Coast of New Zealand twice each month.

This was followed by appointment as Chairman of Counties Manukau District Health Board in December 2007, a position that he still holds. This is a leading health board in New Zealand, holding a budget of NZ$1.30billion (10% of the country's health budget). It is similar to a UK Primary Care Trust, except that in addition it owns and operates the hospitals in the district for a population of 500,000 people and so

integrates health care purchasing. There is a real opportunity to make a difference to the health of a deprived population that forms an important part of the community in New Zealand.

The Counties Manukau District Health Board has established Ko Awatea, (Centre for Health Services Innovation) which will be undertaking work in health workforce development, quality of healthcare delivery, innovation, and research. This is an exciting development and will involve working with the various university partners, and regional and international collaborators.

Gregor is Deputy Chair of Health Workforce New Zealand, a board responsible for advising the Minister of Health on education and training of the health workforce, with a budget of NZ$130million.

Gregor is an Accredited Fellow of the Institute of Directors with a particular interest in governance. In 2007 he was made a Companion of the New Zealand Order of Merit in recognition of his contribution to public health services.

14. Dr Don Berwick

Donald M. Berwick, M.D., M.P.P., is the Administrator for the Centers for Medicare and Medicaid Services (CMS). As Administrator, Dr. Berwick oversees the Medicare, Medicaid, and Children's Health Insurance Program (CHIP). Together, these programs provide care to nearly one in three Americans.

Before assuming leadership of CMS, Dr. Berwick was President and Chief Executive Officer of the Institute for Healthcare Improvement, Clinical Professor of Pediatrics and Health Care Policy at the Harvard Medical School, and Professor of Health Policy and Management at the Harvard School of Public Health. He also is a pediatrician, adjunct staff in the Department of Medicine at Boston's Children's Hospital and a consultant in pediatrics at Massachusetts General Hospital.

Dr. Berwick has served as Chair of the National Advisory Council of the Agency for Healthcare Research and Quality, and as an elected member of the Institute of Medicine (IOM). He also served on the IOM's governing Council from 2002 to 2007. In 1997 and 1998, he was appointed by President Clinton to serve on the Advisory Commission on Consumer Protection and Quality in the Healthcare Industry.

Dr. Berwick is the recipient of numerous awards and honors for his work, including the 1999 Ernest A. Codman Award, the 2001 Alfred I. DuPont Award for excellence in children's health care from Nemours, the 2002 American Hospital Association's Award of Honor, the 2006 John M. Eisenberg Patient Safety and Quality Award for Individual Achievement from the National Quality Forum and the Joint Commission on Accreditation of Healthcare Organizations, the 2007 William B. Graham Prize for Health Services Research, and the 2007 Heinz Award for Public Policy from the Heinz Family Foundation.

A summa cum laude graduate of Harvard College, Dr. Berwick holds a Master in Public Policy degree from the John F. Kennedy School of Government. He received his medical degree from Harvard Medical School, where he graduated cum laude.

Appendix 3 – Initial draft terms of reference given by Minister

- The Bevan Commission is independent from the Welsh Government. Its role is to observe, interpret, analyse and comment on health-related matters in Wales and outside and advise the Minister.

- In particular it will advise the Minister on
  - the performance of Wales in relation to the Bevan Commission principles
  - how to assess whether Wales is achieving its stated ambition of building health and health services Wales that meet the needs of Wales but match the best anywhere.

- In doing so, it should build on the conclusions in its 2011 report on the need to strengthen action to
  - reduce health inequalities and inequities;
  - promote a 'sea-change' in public attitudes towards NHS services
  - drive out waste in the health system
  - ensure effective partnerships between public health and local authorities, including in health and social care; and
  - seek solutions to health problems across all policy agendas and take into account government strategy.

- The Commission will operate under the Chatham House rule.

- It may commission papers, request advice and seek information.

- It will inform the Minister through its Chair of the work it is doing.

- It will be expected to maintain its own website where it can publish reports.

Appendix 4 – Amended Terms of Reference to be returned to the Minister

- *The Bevan Commission is independent from the Welsh Government. Its role is to observe, interpret, analyse and comment on health-related matters in Wales and outside and advise the Minister on actions to address this.*

- *In doing so, it should build on the conclusions in its 2011report*

- *In particular it will advise the Minister on*
  - *the performance of Wales in relation to the Bevan Commission principles*
  - *how to assess whether Wales is achieving its stated ambition of building health and health services in Wales that meet the needs of Wales but comparable the best anywhere.*

- *The Commission will operate under the Chatham House rule.*

- *It may commission papers, request advice and seek information.*

- *It will inform the Minister through its Chair of the work it is doing.*

- *It will be expected to maintain its own website where it can publish reports.*

Appendix 5 – Summary of foci for the Bevan Commission

Commission members generated a list of possible foci for future work when they met on 20th January 2012. The following is a slightly 'tidied up' version of that list:

Population health

1. "Burden" of ageing population (prevent avoidable admissions)
2. Cycle of health deprivation
3. Power of communities
4. Determinants of health
5. Aspirations (good health, education) - cohesive policies across WG

System development – specific topics

6. Better use of information:
   - Transparency of performance data
   - realising potential – e.g. sharing patient info to improve prevention/management of conditions (Scotland example)
   - gaps
7. Service reconfiguration – is it delivering Bevanite principles?
8. Stocktake on 1y/community care strategy
9. What does integration look like, and how is it being achieved?
10. Increased use of hospital services
11. Involvement of Third Sector
12. Audit dementia services

System development - generic

13. Incentives for change – alignment throughout the system
14. 10 things to make step change
15. Defining Quality of care – key parameters of safe, effective, patient experience, timely etc – to identify international comparators/good practice
16. Cost
    - socio-econ
    - system

Engage public
↳ improve
↳rationale exp. of capabilities of NHS
↳better ways to get behaviour change
Contribute to closing inequalities gap
↳new impact on most unhealthy
↳e.g. prematurity
Greater involvement of 3rd sector
↳prevention and services
Accountability to public
Show Welsh model works
Common public service purpose
↳make change reach patients

ISO disciplines ➲ NHS
Revisit Beecham, LSBs etc
World class = 5 defining characteristics
↳pop focus
↳quality
↳productive
↳integrated round pt.
↳people, leadership
↳research and dev.
How to de-medicalise society
Best value for money / long term return
Allocative efficiency (clinical outcome)

rank

Best in the world, created in Wales