Proceedings of the Bevan Commission
9 May 2012

This was the second Bevan Commission meeting since the Health Minister, Lesley Griffiths AM, requested the Commission to reconvene. The meeting was chaired by Professor Sir Anthony Newman Taylor CBE, as the usual chair, Professor Sir Mansel Aylward CB was still overseas, having been invited to be the inaugural Ko Awatea Visiting Chair at Auckland University and Counties Manukau District Health Board, New Zealand.

The meeting was attended by the following Commission members:

- 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
- 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 Jennie Popay, Professor of Sociology and Public Health, Lancaster University (by telephone)

Apologies were received from:

- Professor Sir Mansel Aylward CB (as noted above)
- Lt General Louis Lillywhite CB, MBE, QHP, former Surgeon General of the British Armed Forces
- Professor Allyson Pollock, Professor of Public Health Research and Policy at Queen Mary, University of London.

Abigail Harris, Director of Strategy and Policy, Department of Health, Social Services and Children, Welsh Government, also attended the meeting.

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

The Commission also welcomed a presentation from Richard Bowen, Director of Operations, NHS Wales and a video conference briefing from Cathy Shoen, Senior Vice President, Policy, Research and Evaluation, The Commonwealth Fund. A discussion of the 'Delphi Exercise' undertaken since the previous meeting was facilitated by John Bullivant, Director of the Good Governance Institute.

The meeting was conducted under Chatham House rules and so these proceedings do not denote the contributions of individual members, except where members presented or led a discussion. The discussions were conducted with a high degree of consensus and agreement, and the salient points have been collated and summarised in the following pages. Some points have been re-ordered to improve the narrative flow of this report.

Accountability and Public Engagement

The meeting started with a discussion over the role of the Bevan Commission and the possibility of greater transparency and public engagement. The discussion was prompted by the Minister's review of organisations and boards that provide advice to the Welsh Government.

The National Advisory Board was set up by the previous Minister, during the reconfiguration of NHS Wales into integrated health boards in 2009, and is currently under review. Its primary role was to provide a reference and stakeholder group to the Minister during this transitional period. It contains representatives from key bodies and from the third sector, appointed though the public appointments system.
The Commission members were asked if they felt the Bevan Commission could take on some of the roles of the National Advisory Board, particularly regarding engagement with the public. This could mean some Commission meetings being held in public.

The general consensus was that the National Advisory Board and the Bevan Commission have quite different remits. The Commission is composed of members selected for their expertise, rather than representing particular constituencies. It is an expert group or 'think tank' that is able to independently provide advice. At the moment it has a broad remit to 'observe, interpret, analyse, scrutinise and comment on health-related matters in Wales and outside, and advise the Minister on actions to address this'.

Members recognised that the Commission would benefit from greater public engagement, transparency and accountability. This would increase public awareness and show that the Commission's expertise is drawn from experience of working in and alongside healthcare organisations and staff.

The following points were also raised about taking on the functions of the National Advisory Board (NAB):

- Unlike the NAB, the Bevan Commission does not have a formal advisory role, which allows it greater freedom to scrutinise NHS Wales, and comment independently on Welsh Government policy.
- Advisory bodies tend to be reactive, but the Bevan Commission has been reconstituted as a forward-looking body, proactively seeking out better practice and assessing how NHS Wales can improve.
- The Bevan Commission is not disconnected from Wales; it currently has six of its 13 members based in Wales, and is highly informed of developments in the nation.
- The present Minister has a number of advisors and it may be that the NAB is not needed.
- Legitimacy and transparency are issues. Aneurin Bevan would probably have favoured some element of public accountability, and it would be worth the Commission considering ways to engage the public.
- Conducting Commission meetings under Chatham House rules is vital for genuine, fruitful discussions to take place, and this should not be jeopardised in the quest for transparency.

Members of the Bevan Commission felt that it had a special role in advising the Minister which should not be confused with the role of NAB However, greater transparency and public engagement would be of benefit. This could be addressed in the terms of reference for the Commission, a reformulated version of which follows.

Terms of Reference for the Bevan Commission 2012

- The Bevan Commission is independent from the Welsh Government. Its role is to observe, interpret, analyse, scrutinise 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 2011 report.

- 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 are comparable with the best anywhere.

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

- The Commission will usually operate under the Chatham House rule, but also recognises the need for transparency and accountability. Meeting proceedings and reports will therefore be made public through the Commission's website, which it will maintain independently of Welsh Government.

- It may commission papers, request advice and seek further input and information from others, including members of the public.

- It may also hold meetings in public.

The current performance of NHS Wales

Richard Bowen, Director of Operations, NHS Wales, presented on 'Where is Wales now and where is Wales going?' NHS Wales performed well in 2011-12 against the targets set in key priority areas, including the number of emergency admissions for chronic conditions, readmissions, average length of stay, dignity audits, quality metrics (including reduced healthcare associated infections), mortality rates, waiting times, stroke care, and efficiency targets.

There have also been significant reductions in bed capacity in acute care and especially in private sector use. The scale of NHS Wales' financial challenge is also significant – a real terms reduction of 1.8% in 2011-12 compared to 2010-11. This

reduction will rise to 3.9% in 2012-13 and 6.2% in 2013-14, according to figures prepared by the Wales Audit Office. This is the actual impact of 'flat funding'. This is having an impact on long-term investment. NHS Wales currently invests 1-1.5% of its budget in IT. This is about half the investment figure found in high-performing healthcare systems, worldwide.

Sustainability is important for change to really make an impact. There are pockets of best practice throughout the country and variation in the quality and delivery of services remains a key challenge. Demand and capacity are rising – in orthopaedic care demand is increasing at a level of 5-6% per year. Cost is shaping decision-making at the moment.

There is a growing sense that a focus on quality can produce savings. This has caused a gradual movement away from process measures towards outcome measures. Clinically led quality improvements will be more effective at driving down costs than financially-led cost improvements.

There is good news to report in terms of clinical improvements, with stroke care in particular improving in the past year. This improvement should be replicable in other areas. Mortality indicators show there has been some, limited improvement across the whole system.

Together for Health identified key areas in which NHS Wales must move forward, namely:

- Transparency on quality, delivery, patient experience and cost.
- A 'compact' with the public about expectations.
- Building on the benefits of the Welsh system (such as integration and joint working).
- Service reconfiguration and genuine transformation.
- Adopting world class efficiency measures /outcomes.
- Increasing the pace and adoption of best practice /efficiency.

NHS Wales may need to consider different service models, while also looking for ways to drive improvement. Getting the processes right, for example in clinical triage, can prevent people getting 'sucked into secondary care'. There need to be reasonable alternatives to admissions that will produce superior clinical outcomes.

The Commission welcomed Richard's presentation and particularly discussed means of driving improvement across the system. Some suggestions included:

- Evaluating primary and community care, despite the difficulty in instituting effective metrics, could help give a 'downstream' view to assess long-term outcomes of acute care treatment.
- Creating 'Tsars' in certain specialties and resourcing them to lead change.
- Challenging health boards to move from a hospital-centric view and to focus on the 'suppliers of the hospitals business' i.e. primary care.
- Giving GPs alternatives to sending people to hospital, with proper 'step up' and 'step down' care in community settings.
- Whole workforce planning so that relocated secondary care staff are properly trained for community care.

- Recognising the problem with boundaries, for example good services attract people across boundaries.
- Developing shared outcomes and services between local authorities and health organisations.
- Genuine commitment to a 'care system'. There are currently lots of different places where care is given, but they are still not necessarily joined up.
- While achieving its own targets is positive, NHS Wales also needs to look at how it is doing compared to best practice in each area. It also needs to set standards that are acceptable, for example, is a 26 week wait for anything acceptable?
- It is time to 'stop tinkering'. The real terms reduction in money means the pace of change and improvement must be stepped up.

The case for change in Wales

Commission member, Professor Marcus Longley was invited to introduce the Welsh Institute for Health and Social Care (WIHSC) report 'The Best Configuration of Hospital Services for Wales: A Review of the Evidence', which he had authored. The Commission were asked to discuss both the WIHSC report and the 'NHS in Wales Response' produced by the Welsh NHS Confederation. The report was uniquely focussed on Wales. It may also precipitate significant reorganisation.

Professor Longley highlighted some key parts of the report that would be of particular interest to the Commission. In general terms, acute care in Wales was not performing as well as in England. There was significant variability between hospitals and also between weekday and weekend admissions. The report questioned the view that there is a link between the time it takes for a patient to reach hospital and better outcomes. In fact, the report made clear that the time it takes to access *appropriate* care is a more important influence on outcomes.

The Commission questioned some of the report's findings, particularly regarding staffing levels. Were there to be poor medical education in Wales, which may result in complaints from junior doctors to the General Medical Council, could result in the loss of many students. There is a vacuum due to problems in overseas recruitment. Most medical specialties are understaffed and this may result in unplanned withdrawal of services.

Although there is no evidence of greater levels of dependency on the health service among the population, a higher proportion of people are admitted to hospital. The Commission questioned whether community care in Wales was of a lower quality compared to the rest of the UK. Care before and following surgery is often sub-optimal.

NHS Wales may need more 'specialist generalists' to deal with the pressures at the hospital door and in the community. However, better assessment and a commitment to treat all co-morbidities would also help alleviate some pressures. Just treating one problem and then trying to treat all the others through out-patient clinics can result in readmissions. 'Today's problem is not dealt with today – it is put off until tomorrow.'

The Commission concluded that the WIHSC report was a timely reminder of the necessity of change. This necessity was also highlighted in the Bevan Commission's own report of 2011 and also acknowledged in Together for Health, published by the Welsh Government in 2011.

Defining 'world class' health services

Following the meeting of the Bevan Commission in January, A 'Delphi' exercise had been undertaken to help identify the key measures and outcomes that would help the Commission fulfil its remit to identify whether NHS Wales was living up to its intention of providing healthcare 'comparable with the best anywhere'.

John Bullivant joined the Commission members to look at the results of the exercise and also to assess whether the areas identified were the correct areas to focus on, and how the Commission could make a difference in those areas.

The Delphi exercise had asked Commission members to rank eight dimensions of world class healthcare systems, as identified by The Commonwealth Fund, in order of importance. Members were also asked to propose possible measures that could be used to evaluate NHS Wales' performance on each area. The summary report of the Delphi exercise is included as an appendix.

The Commonwealth Fund's eight dimensions are:

1. Healthy Lives
2. Right care
3. Co-ordinated care
4. Safe care
5. Access to care
6. Patient-centredness
7. Efficiency
8. Equity

A detailed discussion was held regarding the exercise, which included the following points:

On The Commonwealth Fund's elements

- The elements identified are quite broad and could stretch to include almost everything raised in the discussion. Commission members noted this was confusing and concepts could be interpreted differently.
- There are several areas of overlap between the dimensions – right care will naturally be safe care, for example. Access and equity are similarly linked.
- They are primarily about a health service, not about health generally. The Bevan Commission's remit is broader, as it is about health, although they do include healthy lifestyles with high level outcomes related to mortality and life expectancy, for example.
- It was recognised that if all eight dimensions were evident in NHS Wales would mean we would have a world class service.

What else needs to be considered

- Collective engagement is important when considering whether the people of Wales can collectively shape the direction of their health services. People's sense of control over decisions has an impact on health, so community and individual control over their care does need to be included as a dimension.
- Functionality / functionability is a crucial part of 'health' in the wider sense. The health service is only a small part of ensuring every person can achieve high levels of functionality within society.
- Functionality is still individualistic and needs to be allied to analysis of social cohesion and relationships, which have a significant impact on health.
- The extent of the 'gap' needs to be monitored. Variation and inequality shows deficiencies in social cohesion.
- The Bevan Commission also needs to look at what impacts on the Welsh nation's health, not just the health service.
- A health service that does not address the social and other determinants of health will be unsustainable.
- It would be useful to assess how well Welsh Government is performing on the 'health in all policies' concept.
- The patient's perception of their influence on the process, not just their satisfaction with their care.

On measurement

- There needs to be an emphasis on measuring outcomes not just process measurement.
- There are real problems with processes in how NHS Wales functions. People do not go through the system satisfactorily and are improperly or not fully dealt with, so this should be addressed and functional processes should be measured. If the processes are wrong, then the outcomes will be wrong.
- Measuring social dimensions will be helpful.
- There needs to be a means of comparing Wales to the performance of other countries.
- Metrics will not necessarily reveal how improvement happens.
- It would be useful to know what metrics top performing systems use. However, organisations often collect data in different ways and have different incentives to collect the data.

On high-performing healthcare systems

- The historical roots or contemporary performance need to be analysed. Looking at high performing systems does not always reveal the historical reasons or what has caused and enabled improvement.
- The improvements in England that are often ascribed to the market system also correlated with increased investment, increased staffing and the imposition of targets. This transformed outcomes for patients. Ideology needs to be distinguished from reality.

- Both market and non-market healthcare systems can deliver. The keys in both are investment, prioritisation and the energy given to the work. A definite focus usually leads to progress.
- It may be worth looking 'locally' to see where incremental improvements are happening in Wales or in Scotland, which has a similar system.
- Open information has a greater impact on provider behaviour than 'consumer' behaviour. Publishing Hospital Standardised Mortality Rates (HSMR) has resulted in cultural changes in poorly performing organisations and improvement.

On where to compare Wales against

- London has improved life expectancy against other areas in England, which is probably due to the restructured Accident and Emergency services.
- A new IT system in Scotland has improved diabetes care, leading to a much lower hospital admission rate and a 40% reduction in amputations.
- Torbay has demonstrated some good outcome based on integrated care.
- Italy has improved its comparative performance against other European countries through encouraging shared good practice.
- A study in Brazil, Thailand and Catalonia is assessing the impact of democratic involvement in healthcare systems.
- There are European networks assessing equality in healthcare access.
- In Holland there is a system where people are 'coached' through the healthcare system and then the coach is able to feed back to the healthcare organisations about problems in the system. This means every contact aids improvement.
- Every system probably has something that Wales can learn from, however it is important for the NHS in Wales to know what it wants to learn. It would be useful to identify five areas that would make the biggest impact and seek out systems that are performing well in those areas.

On areas to focus on

- Population health and lifestyle with a wider focus on 'healthy lifestyles' that goes beyond traditional public health messages and tackles issues of employment including 'life-enhancing' employment, unemployment, worklessness and functionability in society.
- The ageing population and healthy ageing.
- Dementia care (Wales has lower diagnostic rate for dementia than England).
- Diabetes – can examine outcomes through readmission rates, amputations, sight loss.
- Functionability and rehabilitation provision – every healthcare interaction needs to look at returning people to their maximum level of function. A long process of returning to work causes unemployment and increased mortality.
- Clinical engagement and leadership; empowering clinical teams to improve.
- System pressures and 'fire-fighting' in acute care.
- Quality and safety, accelerating the take up of better practice.
- Productivity, for example early access to rehabilitation / physiotherapy.

- Integration, with a focus on how to make things happen and recognising the interconnectedness of the system so that the impact of changes are measured across the entire system.
- Co-production and partnership, particularly to educate children and teenagers about healthy lifestyles and healthy eating.
- Patient-centredness, asking the question 'What is in the best interests of the patient?'
- Mental health and wellbeing.
- The life course of individuals needs to be looked at. Life expectancy is impacted by the age of 4 due to negative social circumstances. Looking at the life course would cover childhood, education, employment, healthy ageing and dignity at end of life. It would also tie in with a 'health in all policies' emphasis, the refocusing of Communities First programmes, the early years pathway and other key initiatives.

The Commission was then able to conduct a video conference with Cathy Shoen, Senior Vice President, Policy, Research and Evaluation, The Commonwealth Fund, enabling members to raise some of these points with her. The Fund has internationally benchmarked quality outcomes of healthcare organisations in the United States through the use of surveys among general populations, healthcare service users and physicians.

Cathy acknowledged the difficulties in international benchmarking. Data is collected and used differently across countries. She recommended picking a few indicators, ones that will definitely move if performance improves. Social and economic risks, for example, housing types, can be factored into benchmarking studies. Finding an area with poor demographic indicators that still benchmarks well can be especially helpful. She cited rural Pennsylvania, which has low average incomes and a health legacy linked to the mining industry as an area where the Fund had identified good practice.

In the Pensylvanian example, the healthcare system had

- Intentionally focused on the 'sickest', including the oldest and most frail
- Emphasised a 'do it right first time' philosophy
- Linked discharge processes into community care
- Selected nurses as 'navigators' to guide people through the system
- Worked closely with primary care physicians, who often attended the emergency room to see 'their' patients

The results have been decreased costs and increased patient satisfaction. The initiatives in Pennsylvania are now being copied and adapted by other US organisations.

The Fund could help the Bevan Commission by directing it to best practice in other parts of the world. However, spreading better practice from one system to another requires adapting what works 'to fit'. Innovation usually comes from momentum built up over a number of years and so imitators or adopters need to know where they are starting from in order to successfully implement the initiatives developed in high performing organisations.

After the video conference concluded, the Bevan Commission members highlighted certain elements of the presentation as worth reflecting upon. The Pennsylvanian example had a similar demography and industrial heritage to Wales. The case manager 'navigator' was regarded as a good idea. Having more contacts with the outside world will be beneficial to Wales, as 'we don't know who is going to come up with what, and where they will come up with it.' The Commission could go back to the Fund with specific areas of work that it had identified Wales should be benchmarking itself against.

Benchmarking will not necessarily help the Bevan Commission identify those areas that are in need of the most change and where in the system NHS Wales could get the 'biggest bang for its buck' when investing in improvement. It is also important to consider the possible political fall-out of a benchmarking exercise if Wales performed poorly in all the areas it was compared in. Maybe a better way forward is to find out the best in the world and then find out why they are performing so well, rather than compare Wales against these systems.

Spreading the best practice we already have

The discussion about benchmarking acknowledged that there are currently areas in Wales that are performing well, but these are scattered. NHS Wales perhaps needs to focus on all clinicians in Wales introducing the evidence-based best practice that has been proven to work in isolated pilots. Once everyone is following best practice, 'then we can worry about where we are internationally.'

The 'big ticket item' is encouraging innovation and spreading it. Small changes in practice can make large differences. Improving safety and reducing variation is key. Learning from elsewhere is important, but it needs to be implemented in Wales, otherwise it is wasted time and resource. If NHS Wales was a company it would be strategically seeking to increase its capacity and knowledge base – i.e. introducing best practice and enabling it to adapt and spread. The system cannot be transformed with marginal gains. It relies on strategy, having the right people in place, and knowledge (data). The business should be to get the right knowledge of what works best and use it.

The existence of variation shows that there are some enthusiasts for best practice in Wales. Sir Muir Gray has published orthopaedic surgery rates and Wales has huge outliers in variation. The reason why needs to be explored.

Scale and pace are critical to spreading innovation. The Bevan Commission perhaps needs to question the ability of the current Welsh structure to enable pacey adoption of better practice. Another possible focus to study is incentives – which ones work to enable change? Open information has had an incentivising impact elsewhere.

NHS Wales needs a new environment which will give people confidence to change. People have often been told they cannot do things. A new culture that allows people to try and does not punish failure would help. Public sector management is primarily defensive leadership with people nervous to put their heads above the parapet.

Leaders can be risk averse, timid and unwilling to share best practice or learn from others. In a managed system leadership becomes even more important. In market systems other blunt mechanisms can be used to drive change, but they are not available in NHS Wales.

The clinical workforce needs to be engaged so that they acknowledge when their practice does not conform with known best practice, and they want to change. GPs in particular turn the 'flow' on or off in the system and if they are disaffected and disengaged, then there will still be problems. Engagement is about ownership, professional pride and encouraging those who want to pursue better practice.

Integration and co-ordination may be present at board level, but they are rarely present on the front line. There is still a sense of tribalism in health and social care in Wales.. No one can force health and social care to work together; both sides have to see it working elsewhere and want to make it work where they are.

Risk aversion is a problem because failure has consequences. This has contaminated the whole healthcare system. The Bevan Commission can be brave and take risks in what it recommends. This can empower decision-makers and politicians.

Connecting leaders is important on a local and national level. There has to be a common feeling that the problem is for everyone to solve. Local leaders should not be given the message that it is their problem to solve alone as this disconnects between local and national leaders. Chief executives need to feel free to act without having to receive permission.

The surrounding culture is important too. The idea that if someone is ill they automatically have to go to hospital is very powerful and leads to increased demand. Services need to be delivered at home better, faster and smarter so that people feel they are experiencing superior care in the community setting. This has been done in Torfaen and is being introduced in Anglesey, and these exemplar sites show that giving people the attention they need when they need it solves most problems.

NHS Wales does need to consider handing some of the responsibility for health back to the people. The population needs to be engaged in sensible conversations regarding its own health and become genuine partners in the process of improving health outcomes. Self-management and self-triage are also ways of empowering people to take greater personal responsibility for their health.

Conclusions

To achieve its aims as defined in the terms of reference, the Bevan Commission needs to focus on key deliverables. The Commission may wish to identify three deliverables to focus on per year, although there are 'many ways to cut the cake', and the Commission could focus instead 'Life Course stages'.

It would be useful for the Commission to help the Minister by identifying:

- some early 'wins'

- longer term desirable outcomes that may take time to change (e.g. culture, leadership)
- demonstrable progress and improved outcomes
- potential barriers and delays to achieving effective integrated and co-ordinated care both within health and between health and social care providers
- ways in which 'health' is affected by the wider social context and to truly focus on health as opposed to treating illness

There is a need for clarity about the limits of the Commission and leadership role it is expected to have. It will need to focus on what is important and achievable, and where investment would reap the greatest rewards.

NHS Wales is looking to secure transformational change in a period of financial austerity where the real-term budget for Wales will be falling faster than in other parts of the UK. It will be important to increase the contribution of the NHS to the health and wealth of Wales.

One of the most important issues facing NHS is the variation in the quality and safety of healthcare provision in Wales. Introducing universal best practice across Wales in just 20 per cent of clinical areas will provide considerable benefit. Achieving this will require spreading good practice and innovation at pace and scale, which aligns with Aneurin Bevan's aspiration after the founding of the NHS: "now we need to universalise the best".

The real challenge for NHS Wales is to capitalise on its assets, in particular the advantages of a managed system of healthcare in achieving change, although this will be dependent on good leadership, supported by resources, and given permission to try new things with an acceptance from the powers-that-be that failure is an acceptable outcome in an innovation culture, as long as it engenders learning.

Transforming NHS Wales is necessary and will require:

- Connected leadership (national/local, clinical management etc) with the support and confidence to achieve change.
- Aligned incentives. These do not need to be financial – and in the absence of a market would probably not be.
- Transparent information – for both external and internal consumption as there is evidence this drives better provider behaviour.
- An environment which enables and supports brave leadership.
- Collective engagement – allowing patients and public to be involved in decision making.

To make this real the Commission needs to focus initially on some exemplars. Those suggested were:

- Dementia – This would include early diagnosis, appropriate treatment and care in the community and in hospital.
- Diabetes – Important and increasing in incidence.

- Rehabilitation – (restoration of maximal functional capacity) which of course includes access/return to work.

There are five important factors which should be considered in relation to each of these, when assessing the services provided by NHS Wales:

(1) Population health - including social and economic determinants of health
(2) Good service: quality, safety
(3) Productivity/efficiency
(4) Integrated care
(5) Leadership

Taking a 'life course' approach could help with this. These factors will form the basis of a paper to be prepared ahead of the next meeting.

Action Points

Number	Action	Who	Due Date
BCAP 01.05	Invite Ronan Lyons to present on SAIL database	EH / MA	To be agreed once forward work plan is in place.
BCAP 02.01	Invite Andrew Morris to present about Scottish IT system in Scotland that has improved diabetic care and reduced amputations by 40%.	MA	To be agreed once forward work plan is in place.
BCAP 02.02	Invite Sir Muir Gray to present on variation in orthopaedic surgery rates in Wales and why these exist.	MA	To be agreed once forward work plan is in place.
BCAP 02.03	Paper to be written on the 5 factors identified in the conclusion as vital to assessing the services provided by NHS Wales.	HH / ANT	08.06.12

Appendices

Summary report of the Delphi Exercise

Summary of Mirror, Mirror on the Wall