West Midlands Academic Health Science Network
Board Meeting

9 - 11am
Wednesday 30 April 2014

Medical School, Keele University

Present: Michael Sheppard (MS) Chair, Christopher Parker (CP), Tony Davis (TD), Gavin Russell (GR), Peter Winstanley (PW), Janice Stevens (JS), David Adams (DA), Andy Garner (AG), Andrew Riley (AR), George Tadros (GT)

In Attendance: Neil Mortimer (NM)

Apologies: Dr Peter Lewis, Jeremy Kirk, Blair Davis, Dame Julie Moore, Andy Hardy

Agenda Item 1: Welcome/Opening Remarks/Apologies

MS welcomed attendees. Apologies were received from those listed.

Agenda Item 2: Minutes of the previous meeting

The minutes of the previous meeting were accepted as a true and accurate record.

Agenda Item 3: Matters arising

CP took the Board through matters arising from the previous meeting:

Minutes will continue to be published within 2 weeks of each Board.

Theme Directors meetings have now been scheduled with the second taking place next week, and at this they will discuss the scheduling of updates to the main Board.

Spoke Council Terms of Reference (TORs) were accepted at the last Board. The North Spoke has met, the South Spoke is due to meet (2nd May), the Central Spoke will follow and the TORs can be revisited if experience dictates that revisions are needed.

Following the hurried preparation of this year's Business Plan, in future this will be a more deliberate process. Furthermore, timely consultation with major, regional stakeholders should permit cross-referencing of respective drafts before they are due.

Agenda Item 4: Executive Team Report

CP said the AHSN has received some high profile visitors: Steve Fairman plus a team from NHS England, and Sir Malcolm Grant, Chairman of NHS England who had discussed the need to influence a cultural shift. CP and MS used both opportunities to discuss the need for realistic funding to avoid a 'hand to mouth existence' in advance of the AHSN establishing a self-sustaining model. This has

also been the line taken with NHS England by the wider AHSN MD/CEO community.

Budget for 2014/15 now confirmed as £4.15M, which means only minor adjustments will be needed in the business plan. One amendment is the expectation by NHS England that part of the budget (£3M nationally) will be used for Patient Safety, but clarification needed from NHS England about how much will need to come from existing budget, and how much may attract central funding (believed to be £8M nationally).

Patient Safety Collaboratives

JS had heard about Patient Safety Collaboratives, and asked if these would run alongside NHSIQ. CP said that this was yet to be clarified. JS suggested a collaborative led by a partnership of AHSN & HEWM. GR asked if this could be based in Stafford. JS suggested that such a collaborative would be seen as a commitment to change culture. GR said that the University Hospital of North Staffordshire is working up to be a patient safety centre. CP said that the ambition for cultural shift goes wider than patient safety, but JS suggested that patient safety could be an important way of testing our ability and proving our commitment to effecting cultural change. DA felt it important for any proposed collaborative to be practically focused. JS advised that it could be targeted towards specific practical aspects of patient safety, such as skills, tools, data etc. AG raised the risk that cultural change can be nebulous, and is dependent on leadership, so if this proposal goes ahead, it will need to be a discreet, explicit piece of work to avoid the risk of diverting attention from our wider agenda. PW felt that it would need Public Health involvement to capture non-acute care. JS clarified that this depends on the specific remit of the proposed collaborative. The timescale is to be 'up and running' by July, but we need a definition of what 'up and running' means. JS outlined an approach that involved service improvement methodology and leadership support. MS asked if there is specific guidance on what type of Collaboratives are being sought. CP said that he is seeking clarity from NHS England. GR suggested an approach could factor in our existing work on Drug Safety etc.

MS concluded that the Board is broadly supportive of submitting a proposal as it could present a real opportunity, subject to clarification on the funding and scope from NHS England. PW cautioned that this must be seen as an integrated AHSN activity, rather than a 'bolt-on'.

ACTION: CP & JS to explore the possibilities.

Business Plan

CP had asked for comments on the business plan. GR said the North Spoke had sought greater clarity on the AHSN's future processes for reviewing, prioritising and supporting proposals in the future. TD acknowledged that the process last year had had to be hurried to meet deadlines, and while we are still awaiting details of the 2014/15 contract, there is more time this year, and the business plan can provide greater focus. Spoke Councils and Theme Directors will be involved in establishing the process for next year. DA suggested that the funding approach needs to be more widely communicated. TD agreed, and said that transparency was an important factor; this will be factored into designing the future process, which can then be promulgated by the newly appointed Head of Communications. CP added that this also relates to the AHSNs wider strategy, and use of the network's shared knowledge to target the most

likely areas for future success. AG supported this, and MS confirmed that this was the AHSN's agreed approach.

PW felt it important to talk about how the AHSN's funding can lever additional monies for research, and TD said that this would be a significant aspect of the AHSN's planning, and also needs to be part of our communications plan.

PW added that the strategy could benefit from clearer, explicit reference to academic research and suggested that an incentive for academia is the research impact case.

Action: TD to work with Heads of Programmes and Theme Directors to produce a paper for the next Board on the process for assessing, prioritising and approving proposals for the use of AHSN funding.

CP said that the Stakeholder Event had reinforced this appetite for greater clarity about how we operate, and was keen to involve stakeholders.

CP also announced that:

- Sarah Millard has been appointed as Head of Communications and is expected to take up her post in mid-May.

- TD's role is changing from Chief Operating Officer to Commercial Director, which is more consistent with his specific duties regarding the Wealth and Industry theme, and is consistent with other AHSNs.

- Theo Arvanitis & Tim Jones have been appointed as joint Theme Directors for Digital Health

Of the outstanding vacancies, CP is working towards joint appointments with HEWM for Education & Training, and LCRN for Clinical Trials, and revisiting the job description for the Adoption & Innovation theme. CP added that this theme needed a strong director with gravitas and credibility, as this person would be crucial to delivering success as an AHSN. In addition, he believed that Integrated Care will also attract strong candidates.

TD discussed the four AHSN Reference Groups – Patients & Carers, Local Authority & 3rd Sector, Commissioners & Senates, and Industry.

Work to establish the Patients & Carers Reference Group is being led by Lucy Chatwin (LC), who is meeting with HealthWatch and other bodies to establish the group.

TD is leading the establishment of Local Authority and 3rd Sector Reference Group, and CP has begun work on establishing the Commissioners & Senates Reference Group.

The Industry Reference Group has met and agreed its TORs. Its chair is Robin Vickers, MD of Digital Life Sciences. Members asked Andy Riley from the Association of British Pharmaceutical Industry (ABPI) and Andy Taylor from the Association of British Healthcare Industries (ABHI) to share a seat on the AHSN Board. AR described ABPI's ambition for a standardised approach to Industry's relationship with the NHS, and confirmed his and Andy Taylor's commitment to representing wider industry through the Industry reference Group.

AG commented that this gives the AHSN Board strong representation from Industry, as well as academia, but questioned whether NHS representation needed strengthening. MS did note that there was a shortage of senior NHS members present.

GR raised the question of patient representation on the AHSN Board and at Spoke Councils. NM explained that LC is drafting an approach that allows the Patients and Carers Reference Group to identify appropriate representation on the Board, Councils, Advisory Groups etc, once the Reference Group is established, and the requirements of the Board and other groups have been clarified. GR said this would be important in order to identify people with appropriate interest, knowledge and expertise for the relevant groups.

TD outlined the AHSN's financial position, which showed current expenditure (on core costs and contracted programmes), and committed funds (to programmes agreed, but not yet contracted). This balances with income, taking into account an agreed carry forward figure of £1.4M. Overall, this gives a year-end balanced budget.

Next year's core cost is projected at £1.1M but TD intends to scale this back to £1M.

For the coming year, the remaining available funds will be targeted at priorities that build on existing activity, and new activities that emerge from our agreed process. These will also need to include patient safety and the other 3 system priorities as well as the existing 6 enabling themes and 3 clinical priorities.

MS said it was important that people who have benefited from this funding are aware that it has come from AHSN. TD said he has currently held back any press releases on funding, but will task the new Head of Communications with communicating the AHSN's investments. He also said that effective use of allocated funds would be overseen by theme directors, and this would factor into consideration of any future support.

MS said that he had received a very positive letter from Sir Malcolm Grant, which made a clear distinction between AHSCs and AHSNs and the need for AHSNs to differ between regions. The letter also referenced West Midlands' manufacturing base and the AHSN's role in supporting this, along with the importance of our membership model.

MS said that Mark Newbold has stepped down as Spoke Chair for the Central Spoke, due to time commitments. MS has spoken to Jo Chambers, CEO at the Royal Orthopaedic Hospital, who has a previous background in community and primary care. A discussion followed about the value of a senior representative from a non-Acute NHS organisation and it was felt that there would be much merit in having on the Board the CEO of a Community Trust.

Action: MS to invite Jo Chambers to be Central Spoke Chair, and MS and Executive to explore additional non-acute NHS representation.

Agenda Item 5: Items tabled for discussion:

5.1 Draft WM AHSN Strategy

CP described the approach based on the Executive' visioning day and the May Stakeholder Event. He invited views from the Board on how we can strengthen the strategy. AG said it is often difficult to be clear about deliverables in a strategy

document, and PW suggested that references to Research Impact Case (strategy & calibration) might be an opportunity to make the role of academic research more visible in the document. TD said that information is already available from some academic partners, but has yet to obtain it from Warwick. PW offered to resolve this.

ACTION: Academic representatives agreed to put TD in touch with their Research Impact leads.

JS said that describing success criteria can be the hardest part of developing a strategy, and would share HEWM's strategy with CP.

TD explained that he is working with other AHSN Commercial Directors to define outcomes and value propositions. JS suggested mapping the various themes' impact on success in terms of health and wealth. GT suggested Dementia could be used for this. TD suggested StartBack (back pain) could also be a useful area.

AR suggested that the West Midlands' unique characteristics could be reflected more strongly and offered to support Head of Communications on this. MS said this also resonated with the need for AHSN's to have a regional 'brand'.

MS asked about the membership model. CP and TD said that communicating the value proposition was vital to this. Other AHSNs charged a membership from the outset; our Board agreed to use Year 1 to establish the value proposition and soon needs to agree our membership model to ensure sustainability. GR said that many parts of the NHS are facing growing financial pressures and would need to see real benefits to justify investment. PW suggested asking potential members about what value they would want from membership, but many Board Members were concerned about the risk that this would result in unrealistic expectations. GR said that the commissioners' perspective would be vital. AR described opportunities to learn from industry (especially focussing on productivity rather than raw costs).

MS asked if can we learn from other AHSN's. TD said that we can see their models, but they all came from different places, so learning is not readily transferrable.

Action: Board Members to send comments on the draft strategy to CP.

Action: CP and TD to work on the 'value proposition'.

5.2 Proposed Risk Template

CP wants a standardised process across the AHSN so a single format can be used for escalation. JS suggested a score for Post-Mitigation; GR warned of the risk that that can lead to complacency.

JS & AR suggested that the risks regarding sustainability and Spoke Chairs need clearer mitigating actions.

The Board approved the template, subject to the addition of a post-mitigation column which must clearly describe impact of mitigation and be subject to regular review.

ACTION: CP to add post-mitigation column to the template.

5.3 Framework for Annual Report

CP said that NHS England has asked us to standardise as far as possible. TD said that as an AHSN, we will want to produce an Annual Report that is more targeted at our stakeholders, but for now we will work within the NHS England format, while developing an approach for future versions. CP asked if Board members were happy with the proposed headings as a basis to draft the Annual Report. They were. MS also asked if members are happy to be identified as individuals? All confirmed that they are.

Agenda Item 6: Risks and Issues

Covered under Item 5.

Agenda Item 7: Any Other Business

MS discussed the frequency of meetings. Monthly meetings were initially agreed during establishment, but it is now proposed to move to meeting every other month, starting from the May meeting. After discussion, it was agreed, with a review in November, and the potential to extend the length of the meetings by an hour.

Action: BD to confirm the dates, venues and times of meetings for the remainder of 2014.

Agenda Item 8: Date & Venue of Next Meeting

Wednesday 21st May 2014, 10am until 12 noon
Board Room, Devon House, Heartlands Hospital