west midlands
ACADEMIC HEALTH SCIENCE NETWORK

West Midlands Academic Health Science Network Board Meeting held on Wednesday 27th January 2016 09:00-11:00 in the Board Room, Institute of Translational Medicine

Present: Michael Sheppard (MS), Christopher Parker (CP), Tony Davis (TD), Jo Chambers (JC), Sue Ibbotson (SI), Mandy Shanahan (MS2), Gavin Russell (GR), Andy Taylor (AT), Andy Garner (AG), Jeremy Kirk (JK), Tim Jones (TJ) on behalf of Dame Julie Moore, and Blair Davis (BD).

Apologies: Andy Hardy (AH), Peter Winstanley (PW), Dame Julie Moore (JM), David Adams (DA) and Peter Lewis (PL).

Agenda Item 1: Welcome/opening remarks/apologies

MS welcomed Board members and apologies were given from those listed.

MS wanted to formally congratulate PL with regards to the MH test bed being successful. It is a great achievement for PL personally as well as all others involved in the submission. MS also thanked those present who had played a role in making it happen.

Agenda Item 2: Minutes of the last meeting

MS identified that many of the action points will be addressed in the Executive update and suggested going through the minutes for corrections and alterations. On the last line of the first page the sentence should read 'WMAHSN will propose RAID, StarTback and Flo'.

AT highlighted that the top of page 3 refers to the Industry reference group, which has now not met for a long time. However AT is working with his ABPI counterpart and Robin Vickers to try and look at how this can be improved. AT hopes to have a proposal for the next Board meeting.

CP added that there is a typo on the fourth line at the top of page 3 where it should say 'it' and not 'IT'.

ACTION: BD to make corrections to the minutes and post the corrected version online.

Agenda Item 3: Actions arising

All actions from the last meeting had been completed.

Agenda Item 4: Executive team report

General. CP reiterated congratulations to the Mental Health test bed. The WMAHSN will continue to offer support as well as to those test beds that were unsuccessful.

At the last Board meeting the collated review that was sent to NHSE was discussed and the spreadsheet has been shared with the Board.

There have been good Spoke Council meetings since the last Board, and in particular some good discussions around Vanguards. However,

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attendance has been falling. CP had scheduled a meeting with the Spoke chairs for immediately after this Board meeting to discuss the way forward. Unfortunately AH is now unable to attend but the meeting will go ahead with JC and GR.

Membership Key Leader Engagement and Simplification of Message. With regards to membership, CP and TD have been visiting regional Academic Institutions, Providers and CSUs. Their briefs have been well received, with only one visit proving marginally less positive. However CP and TD have been asked to return and speak to a larger group at that particular Trust. CP felt that it has helped that the message has been simplified and to that end he reiterated that we are here to 'facilitate the adoption of proven, beneficial innovation'. Of the original four core objectives that were stipulated for all AHSNs that is in effect 'the specified task'. The others can be regarded as 'implied tasks'. CP stressed the adjectives 'proven' and 'beneficial' – proven in that the AHSN looks to spread things that are ready now and will not take a long time to develop; beneficial to make sure they reflect value for money rather than being perceived as costly. Key is that innovations promote greater health or care outcomes as well as improved patient satisfaction; with that comes greater staff satisfaction.

As in other AHSNs it has also been noted that there is no shortage of entrepreneurs and innovators. The difficulty seems to be getting innovations to land. The current approach is to take this forward with both commissioners and providers, getting the right people together to identify where there are challenges and seeking a joint pull for innovative solutions. The rationale is that if both commissioner and provider are saying these are areas where we would like you to source some innovation, the WMAHSN can use its 'Meridian' platform as well as its Spokes and Networks to source solutions for them to consider. If providers and commissioners work together from the beginning there is a greater chance of innovations being accepted and brought into practice.

Also of importance is an area picked up by TJ, namely an apparent disconnect with industry business models. The level of return they often seek in years one to three does not fit with the NHS. There is a need to do more work with the companies to come up with business models that fit with the way the NHS operates. CP noted that the Industry Reference Group should provide guidance for the WMAHSN to develop.

TD confirmed that there have been discussions about pushing innovation. Some interactions have already started but TD was in agreement with TJ that there is a piece of work to be done around what a new agreement between providers and companies should look like. There is a whole piece of work that could be done if we repurpose the Industry Reference Group on informing industry as to what the receptive messages are from the service at the moment. AT agreed and felt that this is something that could be helped by MedilinkWM.

SI felt that the sharpening of the message is really helpful from a prevention point of view. The translation and the spread and the adoption are the real issues. There is a potential opportunity through the new NHS planning framework. There is a need from the service point of view to systematically look at prevention at scale. Now that Public health is hopefully more involved in the Spokes it may be time to look at a more strategic approach to prevention and how to support spread and adoption.

TD stated that what is surfacing around the work on prevention is a need to ensure that there is a robust evidence base around the prevention case as well as the proven savings.

AG was in agreement, especially regarding the restatement of a very clear message as to what the WMAHSN is about.

TD stated that we have a regional business case template. There can be some generic guidance as to what a business case should look like. However, it is mainly on a case-by-case basis. There needs to be a balance between generic guidance offered by 'Meridian', as well as the WMAHSN acting as an honest broker if a Trust is in discussion with a company to work with that company to adapt their business model.

TJ suggested surgeries for companies at a very early stage of development and that they could sign an NDA and get advice. CP felt that this would be a good offer from the Commercial Hub and this was agreed.

CP observed that it would be good to see the WMAHSN simplified message reflected in business plans of regional partner organisations such as the CRN, HEE, CN, PHE etc and that he will seek to arrange this.

GR stated that in regards to the Spokes the North has two Directors of Public Health that attend regularly. There is a need to keep all messages simple and uniform across the Spokes and important for the DPHs to be involved in that message.

MS2 discussed the importance of identifying what Commissioners are looking for by looking at the challenges in the Five Year plan and to get their buy in from the outset of looking for solutions. Reinforcing the notion of simplicity, the advantage was emphasised of having only a small number of things on which to focus.

West Midlands Genomic Medicine Centre (GMC). Regarding the GMC, CP and Dion Morton have been visiting Phase 2 and 3 Trusts to bring the Chief Executives on board. CP and NM also accompany the Operational team when Trusts are briefed on what will be involved in recruiting patients for the 100k Genome Project.

The Board was reminded that in November the WMAHSN hosted an event at short notice for NHSE to shape initial ideas for a personalised medicine strategy for England. It was thought that the findings would be discussed at the December NHSE Board, however that did not happen. The topic is also not on the agenda for their meeting on 28th January. However, CP has been asked to take part in a phone-call to follow up on this topic as the WMAHSN has been asked (with the other two AHSNs that hosted events) to assist in moving forward the personalised medicine agenda.

WMAHSN Recruiting. On the matter of recruiting to the executive posts that were previously agreed by the Board, there are a large number of applicants to be shortlisted this week.

Actions arising from Item 4:

> **ACTION:** Industry Reference Group to provide guidance on obtaining a better fit between industry and NHS business models.
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> **ACTION:** WMAHSN CD to consider staging surgeries for early stage companies.

Agenda Item 5: Items tabled for discussion

There were 2 items tabled but these generated discussion on a number of points:

Quarter 2 Assurance – NHSE Response. The Q2 Assurance visit was briefed at the last Board meeting as being successful with all presentations being well received. Subsequently the MD received a letter on 26th November from the NHSE regional team saying there were some issues they wished to discuss.

MS informed the Board that it had been a surprise to receive a letter saying that in spite of what was covered at the assurance meeting the NHSE team found it hard to establish what had been achieved to date or to be confident on deliverables and milestones. (This despite WMAHSN being asked to share exemplar projects with another AHSN.)

Board Assurance. One apparent concern is whether the Board has a sufficiently robust approach to assuring delivery of programmes. There were also questions about the 2015 Stakeholder survey that the Board had discussed, although admittedly to a limited extent. In addition, NHSE wanted reassurance about the PSC programme – whether it was adequately resourced and that its importance is recognised by the Board. When MS and CP met with the NHSE regional medical director on 8th December 2015, MS had personally given the necessary assurance that the latter most certainly is the case. For that meeting the Chairman and MD presented a good deal of documentation dealing with the issues raised. At the meeting MS was clear about the quality and expertise of Board members and their strong leadership profiles. Budgets and case studies were discussed and it was felt that the meeting was successful. However, on 18th December another letter thanked the WMAHSN for the information provided, but stated that NHSE still found it difficult to be sure as to how the Board is assured of progress. It also suggested the WMAHSN look to appoint a senior level programme manager. CP went back to them with further information in a discussion on 14th January. Another letter on 19th January said that they still wanted further statements on the Board's oversight of assurance processes and financial management. NHSE is therefore awaiting the outcome of today's Board, which CP will feed back to them. MS went on to say that CP has a copy of all correspondence if any members of the Board would like to see it.

(It was mentioned that during the period in which these letters were exchanged, all AHSNs were advised that there is to be an uplift in Q4 to each network of just over £120k. This is the subject of another issue note for this Board (see later discussion).)

General Discussion. There followed a full discussion of each issue raised by NHSE with considerable input from all Board members. During this, members were made aware that TJ had been involved in related discussions because the host trust, as the legal entity for the WMAHSN, has contractual concerns arising from some letters. However, he and CP were agreed it would be beneficial and preferable if these various matters could be resolved without escalation. Discussions therefore centred around the concerns on governance, assurance, the stakeholder survey, the executive structure and the perceived burden of responsibility and workload on certain staff. CP explained that his most recent feedback to the regional medical director included several recommendations for today's Board and appeared to enjoy provisional approval by the assurance team.

Matrix of Metrics. The matrix of metrics was distributed to the Board and consulted during the meeting. MS2 asked whether the WMAHSN needed to demonstrate governance or was it a case of NHSE being unhappy with delivery? CP felt there is a need to address both, and to capture successful innovations as case studies so that we can demonstrate the effect that we are having. MS agreed that it is important that we demonstrate what we are achieving. The WMAHSN must also work on communication, a point the MD has already been reinforcing. Following comprehensive discussions in regard to assurance and oversight, the Chairman directed that the matrix of metrics used in the assurance process will henceforth be sent to board members before all future meetings for prior scrutiny and subsequent deliberation. The MD explained that he had checked meeting dates for the coming year and, with the sole exception of the September/October period, Clinical Leads' and Board meetings fall nicely before planned assurance calls. This means that any issues can be worked up and discussed in a logical and sequential fashion. A board member asked if the executive had been given an example of good practice. In response CP and TD confirmed that the regional team had shared with them another region's matrix of metrics that they regard as better. The WMAHSN will therefore adapt its matrix over the next couple of rounds to better reflect the example given. As has always been the case, the Board will continue to be

involved in development of all business plans and the approval of annual reports. The Chairman also stressed the importance of maintaining regular board meetings, ensuring their alignment with assurance visits and that there should be no alteration to their frequency.

2015 YouGov Survey of AHSNs. CP took members through last year's YouGov survey, using a synopsis that TD had produced at the time the results came out. This showed a breakdown of the factors assessed, highlighting ones on which the WMAHSN needs to improve and others on which it can build. Whilst the Board noted that the WMAHSN had enjoyed a comparatively greater response from business than the other AHSNs (and also did better than many on wealth creation objectives) it observed that regional responses for all AHSNs were low. JK also queried whether we had allowed people to develop unrealistic expectations of the AHSN and what it can deliver. Re-focusing and simplifying the message will help with managing expectations. MS felt that there are a couple of messages here to work on, however we also need to reflect on the positives. MS2 stated that we need to push for more responses next time and better promote the survey. If we want to understand more we need a larger number people to respond to have confidence in the findings. TD advocated that through the membership manager post that is being created, the WMAHSN could conduct its own survey that was specific to our development and aspirations. He felt that the YouGov survey encourages comparison between AHSNs, which is not necessarily objective since all are very different. What is needed is to understand what our own population thinks and not necessarily comparing with other AHSNs. MS summarised what had been discussed. He observed that the synopsis constituted a useful basis for an action plan and directed that the necessary tasks be built into the 2016/17 Business Plan. All were in agreement. JC also queried whether the membership visits to CEOs have captured any additional information. TD confirmed that they had and this is helping to write the Business Plan.

WMAHSN Workload and Structures. On the matter of workload and structures, CP informed the Board that he and TD had drafted some options. During the previous week these had been discussed with the Theme Directors, Clinical Leads and also with the host trust. Option 1 was essentially no change; Option 2 saw the removal from the structure of the Theme leads (although the theme functions will remain and be procured through contract), the compensating reduction in salary permitting the creation of a full time Operations officer; Option 3 was identical to Option 1 but with the addition of one more business manager. Of these options, the host trust and the Clinical Leads'/Directors forum had favoured Option 2 and recommended this to the Board, subject to clarification of the SOPs that must underpin it. These options were presented to the board along with a narrative that had been created. JK queried how we compare to other AHSN's on size as well as infrastructure size. TD confirmed that this is an equitable approach in comparison to Yorkshire and Humberside as they are very similar with regards to size. Overall, our head count is smaller than many other AHSNs. GR felt that we need to work out how we support the Spokes. AG commented that from a Northern Spoke point of view engagement is not a problem and activity is good. The frustration is the push from elsewhere and what is happening in the rest of the patch. This is where programme manager brought that support to the North. GR also queried if the concern is around the workload for TD as he was unsure whether Option 2 really addresses workload for the Commercial Director. However, TD was adamant that the recommended structure would address that point. Throughout subsequent discussions the importance of spokes was continually reinforced, along with the significance of the executive working with those spokes and maintaining continual communication across the whole network. As with the simplified core message, several Board members were keen that the overall WMAHSN structure and operating procedures should also be as

simple as possible to aid understanding. TJ emphasised the need for more around the Operating Officer's performance management role and the need to be clear on how this structure addresses engagement, assurance and performance management. TD agreed to develop the detail that must be included.

During related discussions, GR stated that he had discussed with CP his analysis of what has been going on with PSCs in other AHSNs together with improvement. GR has a concern that the performance regime within NHSE will zone in on patient programmes. Other AHSNs have concentrated on that and have quite large faculties around such topics. We need to balance sorting out the governance aspects as well as doing what AHSNs were set up to do.

JK queried whether there is a once a year forum where the three Spokes meet. TD confirmed that this is not currently in place, however all were in agreement that this should happen.

TD felt that some of the learning from this is that we need to make sure we adequately communicate to NHSE as well as to the regional team throughout the assurance process to ensure accurate representation. Related to this, CP has extend an invitation to John Holden to visit as he now has responsibility for AHSNs and it would be helpful for him to see at first-hand what the WMAHSN has achieved.

AHSN Exemplar Programmes. Towards the end of these discussions, CP informed the Board that the WMAHSN has recently put its 3 exemplar programmes into a spreadsheet of programmes collated from across all fifteen AHSNs. This resulted in a total of 44 proposals that the AHSN Improvement Directors discussed last week. Of the 3 WMAHSN programmes that were submitted, the Improvement Directors placed 2 in the top 10 for potentially wider spread across England. Thus, despite challenges that need to be addressed, WMAHSN outcomes are being recognised as having the desired effect.

Various Matters of Board Direction. At the conclusion of this part of the proceedings, the following points were also raised:

> MS felt in terms of assurance to the Board at a simple level we can look at timing of reports and the details that are put before the Board.
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> MS2 asked that the Board receive reports in writing.
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> MS agreed that we need to look further at the role and responsibilities of the Commercial Director and how the Operating Officer will aid assurance. We need to be clear on how those responsibilities lie.
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> There was general support for the Operating Officer role with the caveats highlighted by MS. JC felt that if Executive feels that this is the most appropriate way then she is supportive of this.
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> All were in agreement to create an Operating Officer role.
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> All were supportive of the role of the Spokes, however MS identified that the functionality needs to be discussed further on how the Spokes should be supported.

[Board after note: the WMAHSN core executive team has started to address these points and further meetings are scheduled to complete the work.]

Contract Variation. The other issue note that had been sent to the Board prior to the meeting was in regard to a contract variation. An email relating to this was circulated to the Board during the meeting. This breaks down how the uplift is to be spread between

core AHSN programme funds, support to test beds and the PSC. This is shown in a table in the email. These amounts have been included in the matrix of metrics: £32k for PSC; £60k for test bed support; main programme funds £31k (primarily for mental health due to the successful test bed proposal). The £60k is to support the unsuccessful test beds as well as to aid them or other potential test beds for the next round. The Board noted and supported these allocations.

As this will come under Q4 payment this may need to be carried over to the next financial year.

WMAHSN 2016/17 Business Plan. The final matter mentioned under this item was with regards to the Business Plan. CP felt that case studies and the feedback gained from the membership visits are extremely beneficial. This Board meeting had also given CP and TD a good feel of what needs to be included. CP will go out to the Board before the next meeting for further feedback.

In conclusion the consolidated actions from Item 5, which the Board approved, are:

ACTION: WMAHSN Board meetings to align with assurance programme.

ACTION: WMAHSN Executive to ensure reports to Board are in writing.

ACTION: WMAHSN MD to secure an improved response in the 2016 Stakeholder survey.

ACTION: WMAHSN MD and CD to develop actions from the 2015 survey and build into the 2016 Business Plan in order to improve survey results.

ACTION: WMAHSN Executive team to develop Option 2 as the future structure and ensure clarity on the roles of the CD and Operations Officer as well as responsibilities for engagement, assurance, performance management and support to spoke councils.

ACTION: WMAHSN Executive team to accept the latest contract variation and attribute funds as agreed.

Agenda Item 6: Risks and Issues

The risks and issues log was discussed and the following actions agreed:

ACTION: R006 will need reworking but it was suggested that this is stalled until after Q3 meeting

ACTION: R007 needs to be updated

ACTION: TDCL001 needs to be updated as three Ambassadors are now in post and phase three Trusts are coming on board.

ACTION: TDCL004 update reflecting the Board discussion

ACTION: TDCL006 needs more work and attention but will be updated after CP has had further discussions with MS2.

Agenda Item 7: Any other business

No other business was discussed.

Agenda Item 8: Date and venue of next meeting

Wednesday 23rd March 09:00-11:00, ITM Board Room.