west midlands
ACADEMIC HEALTH SCIENCE NETWORK

West Midlands Academic Health Science Network
Theme Directors and Clinical Leads Meeting Minutes
2 – 4pm
26 May 2015
4 Greenfield Crescent, Edgbaston, Birmingham, B15 3BE

Present: Christopher Parker, Chair (CP), Tony Davis (TD), Lucy Chatwin (LC), Ruth Chambers (RC), Jeremy Kirk (JK), Neil Mortimer (NM), Theo Arvanitis (TA), Emma Patterson (EP) for Peter Lewis and Sarah Millard, minutes (SM)

Apologies: Rhian Hughes (RH), Marie Moore (MM), Jamie Coleman (JC), Tim Jones (TJ), Peter Winstanley (PW), Andrew Rose (AR), Peter Lewis (PL) and Susannah Goh (GH)

Agenda Item 1: Welcome and apologies

CP welcomed members and apologies were received from those listed.

Agenda item 2: Minutes of the last meeting

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

Agenda item 3: Matters arising

TA confirmed that he was attending the AHSN Informatics Meeting on 1 June and would report back at the next meeting.

RC and SM confirmed that communications around integrated care (IC)/long term conditions was ongoing, especially supported by the WMAHSN newsletter and new website.

LC confirmed that she and MM had met with colleagues at CLAHRC West Midlands.

All Theme Directors (TDs) and Clinical Leads (CLs) confirmed that they had fed back to MM on the prioritisation matrix.

There has been ongoing discussion about the engagement in the review process between TDs and Heads of Programmes (HoPs). Reassurance was given about inclusivity in the review process going forward. Attendees agreed that the process appears to be going well.

It was noted that there were some good examples of inter-AHSN working emerging e.g. informatics group, impact report.

Agenda item 4: Executive update

CP gave a brief on the links across WMAHSN priorities and themes, as evident at the Annual Stakeholder Event on 28 April. CP then talked about proving the system during the move from set-up to operational delivery. There are several processes and services to support this e.g. opportunities for innovation process, the Innovation and Adoption Service. The group was asked to take more responsibility for operational delivery and agree a way

forward, linking with each other and making use of the various mechanisms.

The WMAHSN executive team recently held a successful away day to look at restructuring during the move to becoming a self-sustaining organisation. Services are a key part of the membership offer. The Business Plan 2015/16 reflects this; HoPs will become Business Managers, managing networks and services.

There is a need to redraft the terms of reference (TORs) for this meeting to reflect the greater operational role of the TDs and make better use of their time and expertise.

JK agreed: he pointed out that while he had rolled out some pre-existing programmes – good for the "push" element – there was a need to do more on "pull". Some mechanisms e.g. the industry portal will help once on-stream. Work should be organic and build on strengths pulling together, rather than in individual cells. He would like to see the "quick win" work of the first year taken forward and more pull activity.

RC agreed: this is much more about application, wealth creation and taking it forward. She used the example of some pertinent work of the Strategic Clinical Networks (SCNs) and the Clinical Senate. CP pointed out that the direction of the WMAHSN reflected that of NHS England (NHSE), which envisages more joint working with SCNs/Senate. It also supports the NHS Outcomes Framework and the Five Year Forward View. We are a strong agency to support this thinking.

RC pointed out that work should be impact-focused (compare with the AHSN Network Impact Report). She stated that she had recently attended an Innovation Summit, which helped to clarify thinking around innovation and wealth creation impacts, which should be reflected in our work.

NM pointed out that "we don't know what we don't know", and we are not always sighted on touch points across the network, although LC pointed out that the WMAHSN is a growing network and as we are getting established and linking people, this should improve. She suggested a more strategic view, with a mapping exercise to identify gaps.

EP stated that feedback from the innovation workshop at the Annual Stakeholder Event included the issue of going separately for intellectual property; this needs to be brought into one service. TD confirmed that the AHSN was working on this.

LC fed back from the West Midlands Innovation Leads' meeting and stated that they clearly don't want stuff "done to" them – we are here to support.

NM pointed out that the more explicit visibility of some networks e.g. WIN provides tangible, structured places to tap into. TA agreed; WIN has matured and is becoming an important communication channel/forum for discussing policy and the push and pull mechanism. We now need to see individual projects consolidate and spread across other themes and priorities.

RC said that while it would be great to replicate WIN for IC, this would require investment.

TD stated that the model was based around the learning from last year. Evidence showed that WIN was the most effective as it has been resourced, so forthcoming networks would be based on the WIN model. There would be announcement around these soon. He added

that if we harness the capacity of the public and private sectors, we will deliver the next generation of healthcare. However, both sides need to change behaviours, and we are working with industry to see how we can create a genuine collaboration and partnership channel, not just another sales channel for them. The public sector needs to be more receptive when there is a genuine opportunity to collaborate. This also helps weed out those that are a waste of time. JK agreed that it needs a change in attitude - that the private sector is not “evil” - while recognising that we are in competition with other regions on this.

EP asked if we need to know where an idea has come from to look at it more effectively. TA pointed out that industry is now collaborating with academia and the NHS to change perceptions, which is great for wealth creation e.g. WMG at Warwick University. It leads to co-production, not just collaboration.

LC pointed out that while ideas could be submitted anonymously, this has to be balanced with the principle of transparency. We have to make sure it’s our role to put a challenge in if appropriate, looking at ideas from all sides.

NM stated that some ruses by industry to get through the door e.g. pro bono work/research, were really just a sales pitch. We have been screening out people but if it improves health indicators, we are interested. TA and TJ only get to see one in 10 ideas coming forward. In the services and networks model, WIN is the exemplar for pulling industry, academia and NHS together. Industry people are also working up how to work with NHS and academia on adding value to a product.

TA said that work is building on the transparent model of WIN e.g. will be visiting EMIS – not only a commercial opportunity but a commercial collaboration. Need to be open; perhaps training (particularly for academics) would help. JK agreed that we have the ability to work proactively with industry, tapping into our expertise.

TA said that we need to look differently at the mechanisms to bring in investment, so that investors become partners in the network.

LC explained that she has had to tell two parties that their proposals were too early-stage, but their response was fine as they saw value in the support of the network..

NM said that part of what we have been doing hasn’t been formal “training” but challenging assumptions from suppliers and clients. We are giving commercial value to organisations that aren’t private sector; co-production; and linking people with the same challenges; that is the value in what we do.

When TA pointed out that a lot of ideas have been lost as there has been no co-production, and this requires a cultural change, CP asked how we made this happen. TD stated that year one was primarily driven by operational imperative – to deliver what NHSE wanted. In year two, we can set direction and be proactive about what we want to do: champion our themes, not just our programmes, as a totality and show leadership around these areas. TA agreed that he would like the TDs and CLs to set strategy and have operational oversight, supporting each other. Digital, as an enabling theme, has to be more proactive in supporting others. The Business “Development” Managers can be filtering but also bringing in opportunities.

TD stated that the AHSN stopped short of business development managers. There will be three themes: patient-centred care, digital and innovation and adoption, with a network and opportunities process. They will create the pull and go to market, make sure that programmes come to fruition and support the new Opportunities/Programmes Manager role. We are building an infrastructure below TDs to support them. We are also rolling drug safety into patient safety.

TD then discussed the new structure in the Business Plan. He reiterated that there was no charge for institutions and listed the members: the West Midlands population, any businesses we have engaged with and West Midlands NHS, academia and industry. TD also explained the enhanced services proposition, the benefits of which will be articulated to selected members. The corporate partnership offering is for larger commercial organisations. TD confirmed that membership would remain free for the remaining term of the NHSE licence, the enhanced services would be run alongside and available for a fee. We will have one-to-ones with around 30 institutions to discuss the enhanced services. This is similar to the Academic Health Sciences Centre approach, whose members were invited. TD confirmed that the AHSN would identify whom to target.

JK pointed out that the challenge for the next year is do we wait for pockets of expertise to coalesce or are we more proactive and look for areas to support? TD replied that the AHSN is creating formalised networks rather than advisory groups, with TDs to articulate needs and challenges. They can be very granular.

JK stated that they need a list of six to eight areas on which they will be concentrating, to which CP replied that this group would be deciding on the direction and helping to shape next year's business plan, further exploiting the expertise of the TDs.

NM stated that e.g. the mental health priority will do things differently this year: they will be explicitly asking for ideas to be challenged. This group can further refine these, attracting a wider cohort of partners across other themes and priorities.

CP confirmed that TORs will be redrafted and circulated, to be affirmed at next meeting, along with the finalised Business Plan.

ACTION: Chair to redraft and circulate TORs before next meeting.

There was a discussion on technical channels to enable discussions between meetings.

ACTION: TA to set up virtual mechanism that all CLs/TDs can access, with SM as administrator.

It was agreed that CP and TD would have a more active role in the Spoke Councils, as would TDs and CLs, in collaboration with the Spoke Council Chairs, if there were relevant topics to be discussed.

<u>Agenda Item 5: AOB</u>

TD discussed the test beds programme, which sees a call for groups of organisations with a footprint of approximately 1million population with a challenge for a collaboration to address. There is a call for innovators e.g. to industry, social entrepreneurs. The AHSN will be responsible for matching the two together, aligned and supported by the AHSN. We are

expecting three or four ideas per AHSN, with five of six funded nationally. The deadline is 12 June for test beds.

JK gave his apologies for the next meeting and EP will represent PL.

Agenda Item 6: Date and venue of the next meeting

28 July 2015, 2 - 4pm, 4 Greenfield Crescent, Edgbaston, Birmingham B15 3BE (TBC)