west midlands
ACADEMIC HEALTH SCIENCE NETWORK

West Midlands Academic Health Science Network Board Meeting
Wednesday 28th September 2016, 9:00 – 10:40
Board Room, Institute of Translational Medicine

Present: Andy Hardy (AH), Tim Jones (TJ), Sue Ibbotson (SI), Peter Lewis (PL), Mandy Shanahan (MS2), Gavin Russell (GR), Andy Garner (AG), Jeremy Kirk (JK) Richard Deveraux-Philips (RD-P), Andy Williams (AW), Christopher Parker (CP)

Apologies: Michael Sheppard (MS), Julie Moore (JM), David Adams (DA), Richard Lilford (RL), Tony Davis (TD)

Agenda Item 1: Welcome/opening remarks/apologies

GR opened the meeting on behalf of the acting chair. A particular welcome was extended to AW (Accountable Officer for the large Sandwell and West Birmingham CCG) who was attending for the first time. AW gave a brief résumé of his background of over 30 years of NHS management experience, with some time spent in Wales and 8 years in the West Midlands. His roles have covered human resources and organisational development but his background is predominantly commissioning. All present welcomed the addition of his particular expertise.

Apologies were noted from MS, JM, DA, RL and TD.

Agenda Item 2: Minutes of the last meeting

These were reviewed and accepted as an accurate record.

Agenda Item 3: Actions arising

AG briefed that Midlands' medical deans will meet again on 9th November and that a one-day conference is to be staged jointly by East and West Midlands on 31st March. He suggested the Board be given a formal update after the November meeting.

Action: CP to schedule this as an agenda item for the November board.

There had been no comments raised since the last meeting regarding the Industry Focus Group paper. Approval was given for its recommendations to be implemented.

Action: TD to task Medilink WM to take this forward.

Whilst it has been questioned of other AHSNs whether any have achieved 'best practice' in regard to the Matrix of Metrics, different approaches and 'asks' by the various NHSE regional teams have precluded development of any that can be identified and shared.

All other actions had been completed or formed part of the agenda.

Agenda Item 4: Executive team report

CP addressed some of the matters that were covered in the update sent out prior to the meeting.

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Re-licensing of AHSNs.

Latest understanding is that AHSNs may be considered for a research consultancy role, rather than this being a procurement exercise. AHSNs' directors wish to demonstrate collective impact and are working to achieve this. A central coordination function will facilitate this work. CP mentioned that the CEO of ABPI believes that the Accelerated Access Review (AAR) will underscore the need for AHSNs and that delivery of its objectives will be reliant on them. RD-P cautioned that the change in Prime Minister and Downing Street staff might result in an altered date for publication of the AAR.

Stakeholder survey

All were thanked for promoting this. Frustrations were expressed that the YouGov survey was not accessible from so many NHS IT systems. The WMAHSN achieved one of the highest response rates (commensurate with the size of the region). Draft reports for each AHSN are due on 30th September and the national final report on 7th October.

Quarterly assurance

Q1 went well. The next reports and returns will be compiled as at 30th September. The Matrix of Metrics will be circulated to board members once updated. Members will need to review this out of committee and provide comment/guidance/direction prior to the Q2 assurance visit scheduled for 3rd November.

STPs and Membership Innovation Councils (MICs)

CP updated on meetings past and planned with STP leads and dates for MICs. MIC(C) will avail itself of the Pfizer Excellence in Health offer on 13th October in order to finalise its priority areas and task and finish requirements. GR plans to use this offer at the MIC(N) in the autumn. This opportunity will be made known to MIC(S) members on 10th October.

Meridian update

The board considered the Meridian update sent out with the Executive team report. Discussions ensued on the possibility of more qualitative descriptions of Meridian's impact, of there being a breakdown between use by regular and enhanced members. MS2 asked if there is anything comparable and it was explained that Meridian is a more comprehensive package than models that have been introduced by some other AHSNs. JK specifically asked if more could be done on signposting, especially to organisations such as the West Midlands Clinical Research Network. TJ suggested an 'abandoned' category would help innovators to learn lessons as much from what had not worked as well as from successes. TJ also enquired in regard to the Midlands engine bid for which an update will be sought from Pam Waddell. Some felt the site could be more intuitive (although it was acknowledged that familiarity and understanding grows with use). GR asked how the process could be more transparent and it was agreed that it would be helpful to know if common themes emerge. PL asked if it could be made explicit what is meant by 'approved' and 'implemented'.

Action: It was agreed that a broader update would be useful and the board requested a 'live demo' be scheduled for their benefit.

Commercial Director's update

TD's update in the Executive report was structured around the WMAHSN 7 point growth plan that was launched in October 2014. The content was well received.

At the conclusion of the report MS2 asked that abbreviations be avoided or explained.

Action: Executive to make clear acronyms and abbreviations.

Agenda Item 5: Person Centred Care (PCC) Network proposal

CP introduced the item, mentioning that the Executive had circulated its preferred option for review in early September for questions to be raised by members. MS2 had raised helpful comments around connectivity with related work streams and networks and how the WMAHSN PCC network might link with the various new alliances as well as the well-established integrated care workforce transition theme. It was proposed that whatever the decision with regard to the supplier, these could be stipulated as contract conditions.

It was confirmed that the other considered bid came from a WMAHSN member organisation. It was explained that the other proposal was more 'grass roots' in nature and there was concern that it might become conflated with a deliberately separate network of health, social enterprise and voluntary organisations that is being delivered by that bidder.

CP reinforced the fact that the preferred bid would allow the candidates to build on the excellent work that had been done during the first 2 years of the licence by Rhian Hughes at the Research Institute for Primary Care and Health Sciences at Keele University. He also observed that there was barely any difference in the quoted costs in both tenders and he sought the board's approval for the preferred bid.

TJ raised the issue of value for money, questioning whether the £82k even included the proposed conferences, although CP responded that it did. GR also raised the related matter of a PCC service for enhanced members that will be required. AG expressed mixed feelings, reinforcing that it would be remiss not to exploit and expand on work undertaken by Rhian Hughes (noting that there was little capacity left now to do this in Keele) whilst recognising that it would also be costly to complete a replacement. He felt that the issue would lie more with delivery and stressed the importance of monitoring any contract to ensure value for money. AH and MS2 asked for greater clarity on outputs, with harder deliverables etc in order to be able to demonstrate the required value for money. TJ agreed he would like to see a list of deliverables; JK would like some clarity regarding clinical champions (given that these exist in other organisations) and AH summed up that more clarity was required with regard to confidence in the bid. GR proposed that it would be helpful to raise this at the MIC(N).

Action: TD to address the points made.

Action: GR to add to agenda for MIC(N).

Agenda Item 6: WMAHSN Title

CP introduced this item by mentioning constraints under which the Executive feels it operates. NM gave a presentation explaining the rationale for a new title, the perceived benefits, how it might be used to qualify membership categories and that the proposal would be commensurate with moving to more purposeful delivery language.

The proposal generated much comment and the widespread view was that this should not happen. Numerous reasons were given. Some related to original discussions and title selection preceding the formation of the WMAHSN; that members were not convinced that the change of name by other AHSNs was especially successful; that with re-licensing the more important factor is convincing NHSE of overall national AHSN impact; that a better route and focus should be on improving and perfecting Meridian – stick with this first and work on regional impact without diluting that. Whilst some acknowledged that the name is unfortunate, it did originally make sense and the WMAHSN is after all achieving traction; that the approach is a triumvirate one and whilst indifferent about the name any relegation of 'academic' would not be acceptable; that

conversations are increasingly place focused and the option presented did not speak to 'place' or 'people'. It was agreed that there would be no change.

Agenda Item 7: Update on national impact metrics/plans for Q2 report

CP briefed the board that work continues on the national metrics against which all AHSNs have to report in order to help NHSE garner a feel for the collective impact of the 15 networks. Of the original 15 metrics, one (Number 3) is being shed – it related to numbers of members in each AHSN but since some do not apply a membership model this was meaningless and did not add value. It is thought that a lot of others will be removed, refining the metrics to just the key ones required by NHSE. Work continues to improve the definitions of the remaining metrics so as to permit a truly standardised approach to their collection. Furthermore it is understood that national metrics for Patient Safety Collaboratives will soon be notified to AHSNs. These may cover several areas. [Board after-note. There are likely to be 3 sections – a maturity matrix (with Yes/No answers); metrics relating to the logic model; and a final section depending on a 'CMU' coming into play.]

Action: CP to ensure GR kept informed of any further updates.

Agenda Item 8: WMAHSN board dates 2017/18

CP covered the fact that quarterly assurance visits are easier to manage if they are linked to the timing of board meetings. To achieve the best outcomes and permit proper board scrutiny as well as comment and direction, board meetings should ideally occur after quarterly returns have been compiled and before assurance visits by NHSE regional staff.

A proposal was made to realign board meetings from 2017/18 onwards. This has the support of MS but the latter was also keen that the board continued to meet 6 times a year, not just 4. The proposal put to the board therefore included 4 meetings that link with assurance visits and 2 that link respectively with production and sign off of the annual business plan and the annual report. Members were content to support the change in annual rhythm and the plan was approved.

Action: Executive to issue board dates and key agenda topics for 2017/18. [Note: these are attached at the end of these Minutes.]

Agenda Item 9: Risks and Issues

The Board noted the Risks and Issues log. There were no candidate risks and no concerns were raised.

Agenda Item 10: Any Other Business

MS2 asked that Ruth Chambers (RC) contact her regarding the education agenda.

Action: Executive to arrange for RC to contact MS2.

TJ touched on the designation of University Hospitals Birmingham NHS Foundation Trust as a global digital exemplar and it's potential to the WMAHSN. He mentioned the relevance to supporting exemplars, local digital roadmaps, wider digital roadmaps, the digital workforce of the future and new innovations around digital. TJ will discuss this with TD.

AG mentioned its potential benefit for the Arab Health event and in the margins it was mentioned that UK Trade and Investment (UKTI) has been replaced by the Department for International Trade (this change took place in July 2016).

PL asked how many trusts have CCIOs. TJ replied that all should have them.

Agenda Item 11: Date, time and venue of next meeting

23rd November, 9:00 – 12:00 noon, ITM Board Room. AH pointed out to members that this next meeting is now scheduled for 3 hours to accommodate updates from the clinical priority leads. (This had been deferred due to the absence of MS for this September meeting.)

WMAHSN Board Dates 2017/18

Date[1]	Items for inclusion on the Agenda[2]	Remarks
2017		
25 Jan	1. Q3 Matrix of Metrics as at 31 Dec 2. Initial draft of 2017/18 Business Plan 3. Recommendations from Editorial Board on framework of 2016/17 Annual Report	Permits board endorsement/direction prior to Q3 assurance visit
22 Mar	1. 2017/18 Business Plan approval and sign off	
26 Apr	1. Q4 Matrix of Metrics as at 31 Mar 2. Draft Annual Report 2016/17	Permits board endorsement/direction prior to Q4 assurance visit
31 May	1. Board sign off 2016/17 Annual Report	
26 Jul	1. Q1 Matrix of Metrics as at 30 Jun	Permits board endorsement/direction prior to Q1 assurance visit
25 Oct	1. Q2 Matrix of Metrics as at 30 Sep 2. Clinical Priority Leads' updates	Permits board endorsement/direction prior to Q2 assurance visit
2018		
24 Jan	1. Q3 Matrix of Metrics as at 31 Dec 2. Initial draft of 2018/19 Business Plan 3. Recommendations from Editorial Board on framework for 2017/18 Annual Report	Permits board endorsement/direction prior to Q3 assurance visit
14 Mar	1. 2018/19 Business Plan approval and sign off	

[1] All meetings take place in the ITM Board Room from 0900 – 1100, except the October meeting, which is from 0900 – 1200 to accommodate Priority Leads' updates.

[2] These are in addition to the usual standing agenda items. Other items such as board approval for Meridian programmes will be added as necessary.