Minutes of the WMAHSN Board Meeting held in the Board Room, Institute of Translational Medicine on Wednesday 22nd March 2017

Present: Michael Sheppard (MS) Chair, Chris Parker (CP), Helen Duffy (HD), Tony Davis (TD), Gavin Russell (GR), Richard Devereaux-Phillips (RP), Peter Lewis (PL), Tim Jones (TJ), Andy Hardy (AH), Sue Ibbotson (SI), David Adams (DA) Laura Boddy (LB) minutes.

Apologies: Kevin Dunn (KD), Andy Williams (AW), Richard Lilford (RL), Neil Mortimer (NM), Pauline Walsh (PW)

Agenda Item 1: Welcome/opening remarks/apologies

MS welcomed all to the Board Meeting and apologies were given from those listed. Helen Duffy was attending on behalf of Pauline Walsh, whose apologies were provided.

Agenda Item 2: Minutes of the last meeting

The following errors were noted and corrected for the 25th January 2017 Board Minutes:

- Peter Jones is listed as present. This should be corrected to Peter Lewis
- Andy Taylor is listed as present. This should be corrected to Andy Hardy.
- Chris Parker is not listed as present. This should be corrected to enter CP into the list of present attendees.

Agenda Item 3: Actions arising

Actions from page 1
Completed

Actions from page 2
The AHSN is arranging for some formal training packages for Meridian for the AHSN team, which will then be made available to enhanced members and then all members.

CP confirmed that AW discussed sponsoring a Meridian presentation with the commissioners, with a date to be confirmed.

Actions from page 3
The Business Plan forms part of the agenda for today's meeting. The draft Plan was circulated to the Board last week.

Actions from page 4

The draft Annual Report to be circulated to the Board before the 26th April meeting.

Agenda Item 4: Executive Team Update

CP provided the Executive Team update.

Relicensing: As there have been no further NHS England oversight panels since 16th January and nothing further from NHS England other than a request for a self-assessment, which has been completed, there is little to report. The self-assessments had been well-received.

The two issues highlighted with regard to lack of news were that there might be a sudden short-term deadline to be met alongside the continuing uncertainty about the terms of relicensing.

Membership: It was clarified that the new enhanced member was Coventry University.

Annual Report: CP outlined the vision for the Annual Report. The aim is that it will utilise technology such as videos and animated infographics to showcase, but will not be gimmicky. Videos will be from iCentrum and the Meridian Live event. SI queried whether the Report had Prevention case-studies?

ACTION: CP to provide update to SI on prevention case-studies for the Annual Report.

It was discussed that some of the topics that the AHSN deals with, such as wealth creation and digital, are not easily understood by those outside of the network. Therefore, focusing on concrete achievements over aspirations should be a priority in the Annual Report. The lack of understanding amongst some Chief Executives was also raised as a concern and it was suggested that they should receive an update on the WMAHSN.

ACTION: CP to contact Richard Kirby to get a slot on Provider CEOs agenda.

The consensus of the Board is that AHSN is not 'selling' itself. The impact of AHSNs on the economy needs to be more widely recognised so that rather than focusing on the costs of the NHS, the benefits to the economy are highlighted. It was noted that the UHCW has created about 200 jobs, that QEH and other large Trusts are the biggest employers in the area, but unlike other companies who create jobs, e.g. JLR, this is not widely publicised. The NHS has not joined up the narrative between health, jobs and the economy and there is a frustration with the inability to engage the NHS with industry nationally. This could be an area for AHSNs to focus on and sell themselves on.

CP noted that to include this within the Business Plan would be an adjustment, not a rewrite. In drafting the focus has been towards members and pulling in funders, but this doesn't play well to NHSE and NHSI, as they perceive this as less relevant to them. This was cited as a reason for their apparent lack of engagement on this.

CP also mentioned that since the Executive report was drafted and sent out there had been a meeting of the Birmingham Health Partners' GMC Executive Group. TJ had told that meeting that Sue Hill, Chief Scientific Officer, has asked that he attend the next NHSE Board meeting to brief on the approach taken by the WMGMC as it is considered much more transformational and forward leaning than that of other GMCs. TJ confirmed

that he has been asked attend this month's NHSE Board and that this would present an excellent opportunity to promote the AHSN's involvement and influence.

TD provided the Commercial Director's update. In the West Midlands Combined Authority update, TD noted that a lot of mayoral candidates are polarised by the politics of healthcare, but that all are aware of economic needs and drive that the NHS can provide.

Agenda Item 5: Items Tabled for Discussion

A. Issue Note on WMPSC

GR presented. The issue is the risk to the programme due to not having correct resources in place, which might hamper the ability of the PSC to deliver its programmes next year. In effect it has a core team of just one wte, with other necessary staff brought in either through Service Level Agreements or on secondment and this is part of the problem. Both present challenges. Either people are not willing to do a secondment, or their line manager is not supportive in the current environment. SLAs are also time consuming and can be slow to execute. Third parties can be used but this is expensive e.g. for Board work on safety, the third party AQuA was used at a cost £25,000 for each training cohort.

GR also noted that Mike Durkin is positive about the progress made by the PSC, the issue is regarding how money is being spent. GR also noted that Mike is retiring in May. Mike's attitude was geared towards devolution and progressing appropriately, but there may be a heavier assurance emphasis in the future.

ACTION: Construct a risk for the risk register
ACTION: GR to update the board in a few months on secondments and whether programmes will be met. Such updates will be linked to Board meetings that are aligned to the forecast NHSE assurance meetings.

It was noted that other AHSNs have similar issues. The Board discussed the various solutions other AHSNs have adopted, including contracts with 3rd parties. The AHSNs should celebrate different approaches to problems.

Further discussion highlighted the fact that the AHSN needs to be more imaginative in from where it tries to bring in secondments. As academia is used to rolling contracts, the Board discussed the possibility of secondments from universities, rather than NHS organisations, which to date has tended to be the 'default setting'.

ACTION: AHSN to look at different sources of manpower to help deliver outputs.

B. Issue Note on Person Centred Care Network

A revised proposal was submitted and GR provided the update. Previous concerns with the original proposal had been that outputs were not very clear and the bid did not offer value for money. The new proposal focused on activities to date, such as Task and Finish groups created in the Innovation Exchange. It focused on the concerns of the AHSN regarding dissemination and spread, and getting Membership Innovation Councils to work together and support complimentary agendas. The proposed PCC Network

would also have support from existing programmes at Keele, e.g. StartBack. The work ties in with work that the PSC already does with atrial fibrillation.

The proposal was well received and the bid supported although during the discussions concerns were raised that potentially the AHSN is doing the work of the CCGs and instead the MICs should be persuaded to lobby the CCGs to correct this.

C. WMAHSN 2017/18 Business Plan

It was noted that we have already discussed one point that needs to be factored into the business plan and it was clarified that further work on layout and subsections needs to be completed to make it easier to follow the headings and sections in the plan. CP had also heeded advice from the previous Board and constructed an introduction that is starting to centre around the context in which the Business Plan is being constructed.

To avoid being seen primarily as a funding agency, it was pointed out that funding categories had been broken down into A, B, C depending on whether there were sources of funding and from where this was coming.

The Board desired to see a final draft before submission.

ACTION CP to negotiate so that Board can look at a revised draft before the April 26th Board meeting.

The Board made the following points re the Plan:

- If at all possible and if time permits, it might be worth inviting an external set of marketing eyes to look over the draft and the approach being taken.
- Genomics and Meridian have done really well and should be given much more emphasis in the report (citing examples such as the GENIE success and the roll out of a regional imaging platform). Also reference could be made to telehealth successes as well as the excellent initiatives surrounding Serendip at iCentrum.
- What are we measuring and how has success been achieved?
- The Plan should demonstrate what the AHSN is building on and what there is for members to buy into. It should stress things such as the IP offer and what else the AHSN can provide, especially for Premium members. (£35,000 is quite a lot of money so what is the return on that?)
- More should be made of Meridian and the extent of what it has to offer needs be made clear.
- The drafters were encouraged to make much more of the excellent way in which the AHSN so frequently creates the right environment in which collaboration can occur, leading to improvement.
- The sections on regional, supra-regional and (inter-)national impact were applauded and could be strengthened by demonstrating how local initiatives fit into this (with examples around Singapore, Texas etc).
- Could prevention re mental health also be mentioned under Wellness as well as long-term conditions and person centred care? Also how the priorities support the joint Public Health priorities.
- More could be made of the MIC Task and Finish groups and the message should be explicit to members regarding the opportunities these present to feed in their requirements.

- EIT is ‘undersold’; this needs strengthening. HD also offered to provide some advice.

Agenda Item 6: Risks and Issues

The WMAHSN Risk Issues were discussed. RN003 is not considered a continuing risk and can be retired.

After listened to GR, a new risk to be added around patient safety programmes given the large amount of funding needing to be allocated.

The IR35 problem was discussed. All public sector organisations must fall in line with IR35 and the AHSN needs to ensure the appropriate guidelines from the host trust are followed. The post-mitigation assessment column in the risk spreadsheet can’t be completed until more information has been received.

Agenda Item 7: Any Other Business

It is considered that the network of 15 AHSNs would be helped with a person acting as a national coordinator. Therefore, if there is something of national interest for the networks, or a go-between is required for AHSNs and NHSE/I there is a facilitator available. Mike Burrows is the first person appointed to this post. He is not replacing the Chair or Deputy for network of networks, but is there to support AHSNs as a collective group.

Agenda Item 8: Date and venue of next meeting

Wednesday 26th April 09:00 – 11:00 in the Board Room, ITM.