

Item 6.6 Minutes of the ICMS Board meeting Held at Liverpool Heart & Chest Hospital, 30th January 2017

Present:

Ms Jane Tomkinson (JT) (Chair)
Professor Lawrence Cotter (LC)
Dr Andrew Vallance-Owen (AV-O)
Professor Sir Munir Pirmohamed (MP)
Professor Kim Fox (KF)
Mr Bob Bell (BB)
Mr Chris Colecci (CC) (via dial-in)

In attendance: Professor Rod Stables (RS), Dr Jay Wright (JW), Dr Mark Jackson (MJ), Dr Jenny Rivers (JR), Ms Gill Hamblin (GH), Mr Piers McCleery (PMcC)

Apologies: Professor Dame Carol Black (Chair) (CB)

1. JT opened the meeting and welcomed members of the Board, recording apologies from Dame Carol Black. JT asked that all Board members complete the declaration of interest form provided and forward these to PMcC.
2. The minutes of the previous (May 2016) Board meeting were presented, and were accepted as accurate and approved. In relation to the actions arising within these minutes:
 - The ICMS website – the website address was discussed, with KF maintaining that the website did not rank highly if searched for (eg via Google). RS responded that the Exec Committee and the Liverpool web team had concentrated on restructuring the website, following the Board's comments in the previous Board meeting, and had not yet carried out a process of building in links to other websites and other linking mechanisms, which would increase the odds of internet search engines giving the ICMS website a high position in their listings. BB suggested searching using the name of the parent Trust hyphenated with the ICMS name. Given the inconsistencies of how the ICMS is described on both Trusts' websites, RS proposed that both Trusts' hospital websites standardise their approaches by automatically redirecting to the ICMS site, to which the Board agreed. **Action 1: RS / PMcC to ask respective Trusts' web teams to make this change.**
 - All the other actions arising were to be picked up within the current agenda.

3. PMcC presented the finance report, highlighting the reduced cost of the symposium through holding it at the National Heart & Lung Institute (NHLI) rather than at the more expensive venue of the Royal College of Physicians. Sponsorship income for this event had not been sought because of the ongoing negotiations with industry partners around a strategic partnership and funding agreement(s): once this / these agreements had been made, other industry providers could then be targeted for more tactical funding opportunities such as the symposium. PMcC proposed that because annually the ICMS incurred around £30k of purely administrative expenses (eg travel, audit, insurance), it would be not appropriate for these to be covered by strategic partnership funding, and that instead the Trusts should provide an annual subscription of £15k each to cover these administrative expenses.
- KF warned that Imperial College (owners of the NHLI) would seek to take a 50% share of any sponsorship income in support of any event within the NHLI.
 - RS added that at the last Board meeting an amount of £25k had been discussed as each Trust's subscription, but that in the light of the partnership funding secured from Medtronic we had reduced this to £15k. BB stated that as RB&H are very much committed to the ICMS, hence £15k was not an undue amount. KF asked whether this commitment was to be open-ended: BB's view was that as long as the ICMS exists, RB&H as a founder member is committed to paying a membership fee to support administrative costs, hence this subscription is guaranteed. JT stated that a subscription such as this is a way of signifying that ICMS is a going concern, and that it is also an important signal to Medtronic and other funding partners that the two Trusts are committed to the ICMS. BB agreed, saying that the subscription should not be tied down to a particular timeframe. JT summarised that this subscription would be a rolling commitment, to be reviewed by Board prior to signing off on the annual budget.
 - The Board approved the proposed subscription on this basis.
4. PMcC presented the operating budget. Given the difficult financial climate for both Trusts, the importance of ensuring that each of the ICMS's activities will have a clearly attributable source of funding, and also the uncertainty as to whether strategic funding from a pharma partner would be forthcoming, the budget focuses on one year. An updated three year strategic plan will be produced, once there is confirmation as to whether the pharma funding will be provided or not. The budget is divided into a core budget, covering the ongoing administrative costs and the salary-related costs associated with the ICMS Research Lead post, and a budget for strategic initiatives, several of which are itemised within the existing 3 year strategic plan.
- KF asked how the research projects that are going to be initiated at the working group meetings, and launched by the Research Lead, will actually be

funded. RS replied that each project should attract funding of its own, and that the role of the Research Lead is to connect people, catalyse the ideas, facilitate/support proposals for external funding, and take the first steps to setting up the relevant database or register. KF – understood, but at the start of every project it is essential to have an idea of where the ongoing funding to run that project (eg support a research fellow's time) over 1-3 years will come from. JW cited a joint ICMS cardio-oncology project that has been going for a while, which now has been able to secure £55k of funding from Boston Scientific to support data collection.

- BB – the value of a dedicated Research Lead is clear, but where will he / she be based, who is employing them etc? RS explained that post-holder will be employed by LHCH but would work across all three hospitals. KF stressed that it was important that RS has dedicated time to supervise this person. JT said that she was comfortable that the benefits from the post outweighed the risks. AV-O asked whether the job description was sufficiently compelling to be able to attract the right candidate. JR replied that there had been a lot of discussion within the Exec Committee as to the right balance of activities – doing their own research, but also doing administrative and organisational tasks too. But post-doc positions of this kind are rare, so the position should attract good candidates.
- JT asked whether the Research Lead would have time, over and above her / his work on the core activities, to be able to support some of the strategic initiatives. If not, then both partner Trusts may need to consider underwriting the cost of some of these initiatives, if a lack of resources delays them, in order to get them under way. BB agreed with JT, saying that everything the ICMS does is wholly aligned with RB&H's core mission. Many of the strategic initiatives are sufficiently small that they should be seen as opportunities not cost pressures, but that the Research Lead will need more help / resources from each Trust. KF added that it will help if the Research Lead's research interests are aligned to those of the ICMS, and that he / she must be regularly visible at all three hospitals – hopefully over time the role would be sufficiently successful so as to justify the ICMS being able to afford a second such position. JR pointed out that it would be important to market the role in a targeted way, using our existing networks of contacts (eg via MP to University of Liverpool). **Action 2: PMcC to refresh operating budget, and prioritise and accurately cost the strategic initiatives, and determine which initiatives might require underwriting from the Trusts.**

5. RS talked through his paper on strategic funding partnerships. He has secured a £50k per year funding commitment from Medtronic for three years, with Medtronic also engaging on several initiatives with likely costs over and above the core grant amount.

JT has scrutinised and approved the contract. Support from a pharmaco has not yet been confirmed, but Astra Zeneca have indicated they would be interested in funding the Research Lead's salary and associated travel costs, and Sankyo may be interested in funding the symposium. This suggests at least 2 arrangements of varying size should be possible.

- BB - who signs the Medtronic contract? RS replied that it is important that the funding relationship is with the ICMS and not one particular Trust. BB stated that while it is within the delegated authority of the ICMS's Board directors to sign off on contracts, if RS as the Chair of the Executive Committee is to sign, we the Board need to delegate the authority to him to do so. Hence in this instance it would be quicker and easier if two Board directors sign off on the Medtronic contract, perhaps the two Chief Executives. For more day to day operational issues, perhaps the Board should assign authority to RS to sign. KF suggested that RS as an interventional cardiologist using Medtronic's devices might be conflicted, hence it would be better if the two Chief Executives signed. BB replied that it doesn't have to be the two Chief Executives, just any two ICMS Board directors, with which JT agreed. JT and BB subsequently then signed the Medtronic contract. **Action 3: a) the Exec Committee to determine appropriate standing order / signatory arrangements, and to revert with them at the next Board meeting for approval to be added to the ICMS's Articles of Association; b) PMcC to update CB on this matter**

6. The paper on the Big Data workstream was talked through by MJ, highlighting progress to date arising from the meeting at the symposium of the analytics teams from both Trusts, and also touching upon the potential Insite collaboration, the North West e-health approach to using routinely collected data to support prospective clinical trials, and a Brussels-based European initiative around the integration of health records and clinical trials' data.

- AV-O observed that engagement with consultants (especially) in collecting data is essential. MJ agreed, particularly in terms of quality of data being collected. RS stated that this was only feasible if the data being collected is part of routine clinical data collection. KF added that we need to capture the value of what we spend on servers and IT infrastructure as well.
- MP referred to the Digital Frontiers initiative in Liverpool – in which LHCH is taking part – which is trying to develop connected informatics for all healthcare providers in Liverpool to be able to pursue population level analyses. MP asked how the ICMS proposed to develop a predictive analytics capability in the long-term. BB answered that there was not a lot going on at Imperial College in this respect, other than a single possible initiative around lung cancer. PMcC added that with regard to predictive analytics at RB&H

there were some basic issues to overcome, such as ensuring all the clinical systems within the Trust were feeding into the Trust's clinical data warehouse, and then identifying (and supporting) the right clinicians to be given the right level of training. MP agreed that it was key to train clinicians to be skilled in informatics.

- BB observed that the Brussels initiative sounded promising: it would be important that we tailored ICMS involvement to suit the ICMS's particular needs, though RB&H staff should get involved too.

7. Working group presentations

- JW updated on heart rhythm, RS on vascular interventions. AV-O asked whether ICMS is being attributed on research publications - JW confirmed that if the Principal Investigator (PI) is a member of the ICMS faculty, then ICMS is attributed. KF pointed out that in some cases the activity was nearly entirely at one Trust, with little involvement from the other Trust. RS suggested that in future we should evaluate research projects / studies that have been attributed to the ICMS in (for example) two ways – eg a Class A project being one in which clinicians from both Trusts are involved in writing the grant application and performing the work; a Class B project being one in which one Trust is supplying only patient data / tissue; and a Class C project being one where all the activity is happening at one Trust, but where the PI is a member of the ICMS faculty. JR – there are two considerations: 1. where the funding goes/financial sustainability for ICMS, 2. the extent to which the grant application and the project delivery is a joint exercise and/or contributes to the wider research culture surrounding ICMS. **Action: Exec Committee to confirm a way of classifying ICMS-attributed research projects.**
- AV-O asked whether the ICMS is good at recruiting patients to studies: JW replied that we have struggled a bit on CASA-AF, but on RIPCORDER have done well.

8. MJ presented the risk register, covering the major risks (engagement of both Trusts in the ICMS, financial sustainability, translation of research into practice). JT asked whether some of the scores should be downgraded, and suggested that delivery of the CASA AF project should be placed on the register. JT proposed that the financial sustainability risk's score in terms of probability should be reduced to a 2, with which Board members concurred. Board members agree that the scores for engagement should be left as they are as we don't yet have the Research Lead appointed. AV-O suggested that this will be very different once appointment made. MJ confirmed that the aim is to have the Research Lead appointed by the next Board meeting.

9. AOB

- JT asked if any members had any other business to raise.
- KF asked where and when the symposium would be. RS said that the Exec Committee were keen to look at Liverpool. KF stated that as it would be a closed symposium (ie only for staff from both Trusts), it either Liverpool or London was fine. RS added that LHCH used research funding to support LHCH staff attending the last symposium at the NHLI. BB pointed out that if the symposium was in Liverpool he could see RB&H fellows and SpRs attending, but not consultants, because of private practice considerations. LC – the last symposium was excellent – it would be safer to leave it in London.
- The date of the next Board meeting – **PMcC / GH will organise**