



UNAPPROVED Minutes of the ICMS Board meeting **Held at Liverpool Heart and Chest Hospital, 4th September 2015**

Present:

Professor Dame Carol Black (Chair)
Ms Jane Tomkinson
Mr Robert Bell
Mr Chris Colecchi (via teleconference)
Professor Lawrence Cotter
Dr Andrew Vallance-Owen
Professor Sir Munir Pirmohamed
Professor Kim Fox

In attendance: Dr Rod Stables, Dr Jay Wright, Dr Dhiraj Gupta, Dr Mark Jackson, Dr Margarita Perez-Casal, Mr Piers McCleery

1. Professor Dame Carol Black (CB) opened the meeting and welcomed Members of the Board, in particular Professor Sir Munir Pirmohamed (MP) and Dr Andrew Vallance-Owen (AV-O) as new Members, and also Mr Chris Colecchi who was joining the meeting via teleconference.
2. Professor Kim Fox (KF) presented the first paper on the reconfiguration both of the ICMS Board and the Executive Committee, and the rationale behind the changes. Having a single academic partner (Imperial College) for the ICMS had not proved workable, hence the invitation to Liverpool University to become a second academic partner. With Professor Sir Ian Greer moving to Manchester, MP is therefore the representative of Liverpool University on the ICMS Board, with KF the representative of Imperial College in place of Professor Sir Anthony Newman-Taylor who has stepped down. With Richard Hunting finishing his term as non-executive director on the Royal Brompton & Harefield (RB&H) Board, AV-O has joined the ICMS Board in Richard's place. In terms of the composition of the Executive Committee, Dr Rod Stables (RS) has taken over the chair from KF. With the number of working groups being reduced from four to two, Professor John Pepper and Dr Jay Wright will lead the two working groups (Vascular Biology, formed from Interventional Cardiology and Aorta & Valves) and Heart Failure and Arrhythmias respectively. All Board Members were content with this reconfiguration.
3. Dr Mark Jackson (MJ) presented a number of papers that together laid out a comprehensive governance framework for the ICMS, including updates to the ICMS's original Articles of Association and Heads of Terms, a Scheme of Reservation and Delegation (SORD), a declaration of interests policy, and the work plans for the

working groups, the Executive Committee and the Board. Ms Jane Tomkinson (JT) asked what should be the financial threshold for a project or initiative decided upon by the ICMS Executive Committee that then required approval by the Board. After discussion a limit of £25,000 was determined as the relevant threshold. The amended Heads of Terms was approved and signed by the Chief Executives of both member Trusts. Following MJ's clarification that the declaration of interests will be circulated to all members of the ICMS faculty, working groups, exec committee and board, with records to be kept at LHCH and report to be presented once a year, MP asked if the academic partners needed to provide a declaration of interests. MJ assured MP that only he and KF from our academic partners, in their capacity as ICMS Board members, needed to do so. RB suggested that the Executive Committee should draft a Freedom of Interest policy for the ICMS, since, as the ICMS is not a public body, its FOI policy should be different from that of its member Trusts. **ACTION: MJ to draft an FOI policy for discussion at the next Executive Committee meeting.** Members also discussed whether, as recommended by the paper on working groups, the Board should meet three times a year. After discussion, it was decided that the Board should meet twice a year, although this should not preclude further meetings if circumstances warranted it. The dates of these meetings need to allow for the ICMS's annual budget to be approved and for the annual accounts to be signed off before filing with Companies House. **ACTION: PMcC & MP-C to confirm dates of next two Board meetings.**

4. KF presented the annual report on the ICMS's activities, touching upon the completed higher degrees and publications and the opportunities to obtain new grant funding from BHF and similar such sources. KF also focused on the achievements of the arrhythmias working group, before RS, Dr Jay Wright (JW) and MP-C summarized the past year's activities of the Interventional Cardiology, Heart Failure and Aorta & Valves working groups. CB asked what the next steps for the PhD fellows might be following completion of their degree, and how the ICMS might benefit. KF responded that the fellows would be expected to move into academic positions, by obtaining their CCST through their academic clinical lecturer post and then apply for senior research fellowships, ideally (though there are not many opportunities) at one of our two Trusts and / or universities. **ACTION: Executive Committee to determine how fellows can be encouraged to maintain links even if they move into positions at other Trusts / universities.** KF recommended that in future the heads of the two working groups should themselves attend each Board meeting so as to report on. RB suggested that a summary of progress achieved to date by the ICMS in layman's language should be captured in brochure format so that it can be presented to different audiences (eg Governors' council meetings). MP agreed and suggested something like this should be presented to the Liverpool Health Partners. KF wondered if a similar summary could also be prepared but for clinical audiences, perhaps for publication in a journal such as Heart. MP suggested that at the right time we could build on our shared genomics knowledge and activities by putting together genomics-related education and training materials to be targeted to all levels of staff, not just those working on research. AV-O asked what level of engagement in the ICMS's activities there was from clinicians at both Trusts: RS, MJ, JW, MP-C and PMcC confirmed that the level of engagement is very 'patchy' (ie significant from a few clinicians, very minimal from most clinicians) and therefore needs continued focus from the Executive Committee to broaden the base of

participating clinicians. **ACTION: RS and the Executive Committee will take these suggestions on board and determine the best mechanisms to disseminate the ICMS's achievements within and outside both Trusts.**

5. PMcC presented a report on the financial position of the ICMS, both in terms of the performance during the 12 months to April 1st 2015, and a budget for the financial year to April 1st 2016. A similar size deficit (£60k) was recorded as in the previous year, but much greater than in the preceding years due to increased expenses in three areas (travel, pay and conferences) and a lack of sponsorship income, especially in relation to the annual symposium. The two Trusts have recently injected an additional £50k each into the ICMS, providing a cash balance of just under £50k as of April 1st 2015. For the operating budget going forward, there are three possible sources of income, of which industry sponsorship has to be the principle source, such that it more than covers the costs of the annual symposium. There is an opportunity to derive income from ICMS educational events which currently are free of charge for delegates. However the calibre of the ICMS faculty is very high, and we are not maximizing this. Although at some events the majority of the delegates are nurses, therefore limiting what we can charge, we should look closely at how we might recoup a small surplus from each event. Finally there is potential to derive income from the carefully planned use of data from our shared 'big data' repository, in that pharmacos and devicecos may be willing to pay (probably in the form of funding for a research fellow) in exchange for access to some of this data. In terms of expenditure, pay costs have been high, since we have allocated two days a week historically for an IMCS business manager role, but we believe we will derive more value from this manager if he worked on ICMS business only one day per week, with his main focus on the website. In terms of travel expense, we will ensure that our external academic leads / mentors, now that they have contracts with Imperial College, should combine their visits to working group meetings with other commitments. We will also look to choose a different location for the annual symposium at close to half the cost of the Royal College of Physicians.

JT questioned the format of the financial statement within the report, both in terms of its overall layout and the terminology relating to particular items on the statement. She suggested that perhaps the LHCH finance director meets with someone at RBH to ensure the format of statement is clearer. JT observed that, while from a financial perspective it may not be easy at the moment to determine whether this is a going concern, taking into account all the worthwhile projects and plans in place, there is clearly considerable income potential. RB concurred with JT's observation and suggestion. RS asked whether there was scope for the ICMS to engage with industry partners on a broader basis than just through sponsorship of the symposium. PMcC referred to Boston Scientific's response last year to an initial approach where they indicated that they would prefer to work with the individual trusts rather than the ICMS. RS wondered if we would get a more positive response if we could understand what might be of value to Boston & other suppliers and then put together a relevant package of benefits (eg education, staff exchanges, research, access to data) that might also bring income to the institute ICMS. RB suggested that at the formation of ICMS we had envisaged the notion only of adding clinical partners (as opposed to commercial partners). We should exploit our strengths in knowledge dissemination and scientific and clinical discovery in a different direction, and think

less in terms of sponsors and more in terms of partners who could facilitate a business model which can bring in recurring income from a package of activities, and who might pay an annual fee or have a seat on the ICMS board etc. KF (and other members of the Board) agreed with this suggestion, pointing out that ICMS could be a politically attractive partner for pharmacos / devicecos because as a joint venture it carried out no procurement activities itself: KF pointed out that it would be important from a competition standpoint that more than one commercial partner was sought, and that this should not in any way compromise clinically-based choices / preferences for particular suppliers in particular sub-specialties. JW cautioned that we should first quantify how much support we get currently and from what supplier sources, national or international, as there may wider strategic implications if existing arrangements are compromised. ***ACTION: The Executive Committee should develop and promote a 'value proposition' / package in collaboration with two or more potential partners.***

6. PMcC then talked through a paper updating Board members on the ICMS's three year strategic plan. Several of the items (eg the 'big data' project, the cardiomyopathy service, the relationship with Liverpool University, partnerships with industry suppliers) had been or would be touched upon elsewhere in this Board meeting. A shared clinical genetics service is dependent on RBH's laboratory becoming accredited, although there have been three very positive reciprocal visits between LHCH clinicians and geneticists and the lead of the RBH laboratory (Dr Debbie Morris-Rosendahl). In terms of community cardiology, LHCH's proven model remains the one that RB&H wishes to adopt in NW London: participation in recent tenders of these services has proved difficult, owing to RB&H having to partner with other organisations, although the model that Harefield clinicians are developing in Hillingdon with the local CCG and Hillingdon Hospital is one that offers real potential as a 'recipient' for many aspects of LHCH's model. The Aortic tariff work done by an ICMS team has been complex but greatly influential with the NHS England Casemix office. We are cautiously optimistic that both Trusts will be significantly financially better off with the new tariff structure that has resulted from this team's work.
7. Dr Dhiraj Gupta provided an update on the CASA-AF research study, which is the first research grant-funded project that is jointly submitted and delivered by both Trusts as a result of the ICMS collaboration. The study is a randomized control trial funded by an NIHR EME grant to compare the efficacy and efficiency of surgical ablation vs catheter ablation in treating atrial fibrillation. The target patient cohort is patients with symptomatic AF but who have failed at least one drug therapy, with a primary endpoint of being free from AF after a single procedure after a year. Following surgeons at LHCH finishing a set of proctored procedures, the trial will begin recruiting in November, with results expected in 2019. RB observed that this is a perfect example of a project that individually each partner Trust would not be able to do on their own, but clearly can be done together through the ICMS.
8. MJ gave a presentation on progress to date in developing the ICMS's 'Big Data' ambitions. The principal challenge has come from aggregating data from two separate data repositories without breaking data governance rules. This challenge has been overcome by using (on a proof of concept basis) a federation server which brings together copies of the relevant data from both two warehouses in a 'cloud'

space in which the data is secure at that instant in time but is not stored. This now enables data to be combined from the three hospitals into one file. The current data being used is from aortic cases to analyze what is driving mortality in aortic surgery at all three hospitals, based on a dataset of more than three thousand cases already performed (elective and emergency) and planned. Initial analysis of the corrected data indicates that there is no significant statistical difference between the mortality between the three hospitals. This work will have significant benefits by making large datasets available from which insight at patient, service and organizational levels can be generated. The next step is to establish the federation server on a business as usual basis, although the cost of this may run to c.£75k. The business case for this will need to be approved by the ICMS Board. MP suggested that the Farr Institute could be worth talking to in relation to this project, and that he could link MJ to the relevant team at Liverpool University. A link to the Clinical Practice Research Datalink could enable the ICMS to generate income from this.

9. JW gave a presentation on the development of the inherited cardiac conditions' service at LHCH, which has been helped by input from RBH clinicians. The service now involves a number of recurring monthly channelopathy clinics and bimonthly cardiomyopathy clinics. The main need at the moment is for clinical genetic testing – LHCH currently use the Oxford lab, but the RBH lab will be LHCH's preference once it is accredited. The combined channelopathy and cardiomyopathy data sets from both LHCH and RBH should be potent sources of research opportunities and will help us develop new links with other partner organisations. MP suggested that we might consider linking with the Drug Safety Science Centre he is leading by involving the cardiovascular element.
10. MP-C gave Board members a quick tour round the ICMS website (www.theicms.org). The feedback from CB and other members was generally positive, but they suggested that the website could be made more 'lively' and interesting (eg by providing linkages to LinkedIn, Facebook, Twitter, etc); that it should be optimized for search engines; and that it needed to reflect the value proposition that we would be putting to potential commercial partners. ***ACTION: the Executive Committee will improve the website in line with this feedback before the next ICMS Board meeting.***