BOARD MEETING

Minutes of the meeting held on Thursday 21 July 2016

Intavent Suite, Association of Anaesthetists of Great Britain & Ireland

Members:	
Prof Monty Mythen	Chair, NIAA Board
Dr Andrew Hartle	Association of Anaesthetists of Great Britain & Ireland
Mr Dave Hepworth	Royal College of Anaesthetists Lay Committee
Dr Andrew Klein	*Anaesthesia*
Prof Mike Grocott	Royal College of Anaesthetists
Co-opted members:	
Ms Sharon Drake	Director of Clinical Quality & Research, Royal College of Anaesthetists
Prof Dave Lambert	NIAA Grants Officer, *British Journal of Anaesthesia*
Dr Ramani Moonesinghe	Director, Health Services Research Centre
Prof Rupert Pearse	Director, UK Perioperative Medicine Clinical Trials Network
Prof Rob Sneyd	Chair, NIAA Research Council
Dr S Walker	Specialist Society Representative
In attendance:	
Mr James Goodwin	Research Manager, Royal College of Anaesthetists
Ms Pamela Hines	Committee Secretary (NIAA Coordinator)
Apologies:	
Prof Nigel Webster	*British Journal of Anaesthesia*

NIAAB/07.2016/1 WELCOME AND APOLOGIES

The Chair welcomed members to the meeting and reiterated the changes in membership and meeting format that had taken place since the last NIAA Board with Board and Research Council meetings no longer taking place on the same day, and membership of the Board being streamlined to allow for more strategic discussions. The Chair stated that Prof Grocott had been invited by the RCoA President to be the RCoA Council representative on the NIAA Board going forward.

The Chair clarified that as per the terms of reference those listed as Members on the meeting agenda i.e. the Chair, representatives from the 4 Founding partners and the lay representative have full voting rights. It was pointed out that having six voting members could cause difficulties if there were to be a tied vote. After discussion it was agreed that the Chair would have the casting vote in these instances.

Apologies were noted as above. Prof Lambert clarified that he was representing the *BJA* for this meeting.

NIAAB/07.2016/2 MINUTES OF THE PREVIOUS MEETING

The confidential and non-confidential minutes of the meeting held on 4 February 2016 were approved, with the following amendment:

Mr Hepworth clarified that on pg. 5 under item *NIAAB/02.2016/11* the minutes should state that he had advised should Ms Drake see the Chair of the RCoA Lay Committee before the new lay members start; she might want to discuss with him recruitment of a new lay rep for the NIAA Board from among the newly joining members.

ACTION: NIAA Coordinator to amend and upload the non-confidential minutes of the meeting held on 4 February 2016 to the NIAA website.

Prof Pearse noted that one of the RCP NIHR Clinical Research Network trainee awards had just recently been awarded to an anaesthetist: one of his PhD students Dr Tom Abbott. It was noted as being a positive item to consider including in a future issue of both the RCoA President's News and the NIAA monthly newsletter.

ACTION: Prof Pearse to draft a short news item publicising Dr Abbott's award.

NIAAB/07.2016/3 MATTERS ARISING

3.1 ***NIAAB/02.2016/3 NIAA NIHR Clinical Research Network Award Scheme***

Prof Grocott provided an update, stating that there will be two awards made to research active NHS clinicians under this scheme – one each in anaesthesia and in critical care. Each will have two categories: trainee or consultant. The RCoA award will be presented at the RCoA Anniversary Meeting in March 2017. The awards are specifically not intended for career academics, or for University staff in substantive posts. The application process is currently being finalised, and the forms will ask applicants to state that they meet these criteria.

3.2 ***NIAAB/02.2016/5 NIAA Associate Research Fellowships***

Dr Moonesinghe reported that some work has been done on the proposal paper following the last meeting, which would go to the Training Committee in September. The issue of 25% of trainee time (day time) being spent on research work as a minimum was discussed with the working group following the last Board meeting. Dr Moonesinghe envisions that this work will be part of the new Academic Training Coordinator's role once they have been recruited.

Prof Grocott mentioned that the NIHR specialty group discussions have recently included the subject of career pathways. A document on this subject is currently being worked up which will be NIHR-badged and covers a lot of the same areas relating to trainees currently being looked into by Dr Minto and Dr Moonesinghe. The document is planned to be a form of national template which the NIAA will align with and possibly co-badge.

NIAAB/07.2016/4 GOVERNANCE

4.1 NIAA Strategy

The final version of the NIAA Strategy was presented for discussion and sign-off. Prof Sneyd mentioned it had been presented to the RCoA Council for information, and was received with no comments. There were no further comments from the Board so the document was declared as final.

4.2 NIAA Terms of Reference

The final version of the Terms of Reference was presented for discussion and sign-off. Following earlier discussion the document would be amended to reflect that the Chair will have the casting vote in the event of any tied voting, as agreed. Members were invited to submit any further comments to Ms Drake by Friday 29th July. There were no further comments on the document from Board members in the meeting.

ACTION: Ms Hines to amend the Terms of Reference to reflect the Chair's casting vote in the event of any tied voting.

NIAAB/07.2016/5 NIAA GRANTS AND RESEARCH COUNCIL

The minutes of the Grants Committee and Research Council meetings were presented for information. Prof Lambert noted R1 had been a very large round with approximately £600,000 in grants awarded.

Mr Hepworth commented that applicants had been aligning their research proposals to the JLA Priority Setting Partnership results and highlighting this in their applications, which was positive to note as it relates back to the NIAA Strategy.

Prof Mythen questioned whether there appeared to be any disadvantages for applicants who couldn't align their work with these priorities. Prof Lambert responded that the benefit of the NIAA system is the number of funding partners and the wide variety of criteria, allowing researchers to align their proposals with any number of priorities or funders.

NIAAB/07.2016/6 ACADEMIC TRAINEES

6.1 Academic Training Coordinator update

Dr Moonesinghe discussed recent correspondence with the NIAA Trainee representatives Dr Owen and Dr Highton, voicing concerns over academic training in general likely to be linked to the ongoing junior doctor contract negotiations. They had noted that the NIAA stand and drop-in sessions at the Group of Anaesthetists in Training (GAT) conference in June were not as well attended this year. Both trainee reps were considering ways of addressing this, including a repeat of the 'Rising Stars' exercise carried out a few years ago, where a wide range of stakeholders were asked to submit a report of their experiences as an academic trainee from which a booklet was produced, in order to encourage trainees who may be feeling discouraged.

In response, Dr Hartle confirmed that overall attendance at the GAT conference was less this year than previous years. Prof Lambert mentioned that at least 1/3 of recent grants have a trainee as an applicant, which will be useful to make contacts and gather content for a similar Rising Stars document. Dr Moonesinghe felt it was important to use the NIAA resources we have (website etc.) to promote the research opportunities on offer. Prof Lambert and Dr Klein agreed, suggesting the NIAA offer should shift slightly to focus on researchers who are already engaged with the NIAA and highlighting what we can do for them, e.g. offering to discuss research proposals, offering a lay rep to input into lay summaries etc. Dr Moonesinghe pointed out that the NIAA Researchers Database could potentially be refreshed as usage has dropped off in recent times. Prof Sneyd suggested working with the AAGBI Events team to identify potential research related speakers for next year's GAT.

Dr Moonesinghe mentioned a conversation she'd had with the Chair of the RCoA Training Committee re: simplifying the training curriculum; due to changes in GMC professional standards guidelines there is now opportunity to do so.

ACTION: NIAA Coordinator and Dr Moonesinghe to start the process of producing an updated Rising Stars document.

ACTION: NIAA Coordinator and Dr Moonesinghe to liaise with the 2017 GAT local organising committee to start discussing next year's event, and how the NIAA can be involved.

6.2 RAFT update

No written update received.

NIAAB/07.2016/7 HEALTH SERVICES RESEARCH CENTRE

7.1 Executive Management Board minutes for meetings on 18 May and 21 June

The minutes of the meetings were noted for information. There were no further comments.

7.2 HSRC activities update

Dr Moonesinghe highlighted the main points of the HSRC update paper: both Dr Moonesinghe as the new HSRC Director and Dr Iain Moppett as the new Deputy Director are now in post and have commenced work. The HSRC Away Day was held in June and the team have developed a new strategy which has been approved by the HSRC Board, and is being presented to the RCoA Council and NIAA Board.

The systematic reviews on the COMPAC initiative are now complete. The Delphi consensus process will begin in summer 2016 and will identify the core outcome measures for use in clinical effectiveness trials in anaesthesia and perioperative care. The systematic reviews on the Standardised Endpoints initiative are ongoing, and will identify standard definitions for perioperative outcomes for clinical trials.

NAP6 is ongoing; the baseline survey received over a 90% response rate and the activity survey is planned to launch in autumn 2016. The SNAP-1 manuscript has been submitted to a number of medical journals, but has so far been rejected without review. It is currently in the process of being submitted to the *BJA*.

SNAP-2, which will look at the epidemiology of critical care after surgery, will take place in March 2017. A parallel study will be taking place in Australasia and will be led by Prof Paul Myles.

NELA published its 2nd patient report in July. PQIP will be starting in October/November 2016. The grant application on improving outputs of national audits submitted to NIHR HS&DR was unsuccessful, but was given useful feedback. A new statistician will be appointed in autumn 2016. Plans are in place to strengthen the HSRC's communication and engagement policy. Dr Moonesinghe pointed out the list of peer-reviewed publications and presentations linked to the HSRC over the past six months, included in the meeting papers.

7.3 HSRC Strategy

Dr Moonesinghe delivered a presentation outlining the HSRC's strategy for the next 5 years, to accompany the strategy document included in the meeting papers. The presentation highlighted the 3 themes of the HSRC's work: 1) Audits and Quality Improvement including NAPs, NELA, and collaborating in the AAGBI-led ASAP project. 2) Methodological innovation in clinical measurement to develop better ways of measuring anaesthesia practice. 3) Facilitating research for patient benefit, including SNAPs and the EPOCH study.

Dr Moonesinghe mentioned the outputs achieved by the HSRC so far, including peer-reviewed publications in several high impact journals such as the *BJA*, involvement in national meetings, and a number of large grant awards the most notable being HQIP funding for NELA. The QuARC network is also a success with representation in 95% of UK hospitals. The HSRC has developed a graphic to illustrate the 5 themes of its 5-year strategy: Defining Quality, Evaluating Quality, Improving Quality, Developing People, Communicating and Engaging Widely.

- **Defining Quality**: current work under this theme includes the COMPAC and StEP initiatives involving international collaborations. Importantly, the HSRC is providing organisational leadership for these projects, and will develop new strategies to implement practice by collaborating with partners to develop, disseminate and adopt professional guidelines. Prof Sneyd queried whether the HSRC plans to develop its own named guidelines, or will guidelines be developed in partnership with others? Dr Moonesinghe clarified it would be the latter of these and should there be the capacity, the HSRC will act as a facilitator in this respect.

- **Evaluating Quality**: current work under this theme includes the NAP and SNAP projects, and supporting stakeholders with survey development and dissemination. NAP6 will reach the end of its data collection period in November 2016, and Dr Tim Cook will be handing over his role as NAP Director in March 2018. There is a plan to recruit a new NAP lead to have a handover period of 1 year with Dr Cook, as well as a plan to look at implementing Dr Moppett's recommendations following his external review of the NAP programme. The HSRC strategy includes evaluation of the sustainability of SNAPs to consider how they continue to be delivered and funded in the future, and also how surveys for fellows and members are distributed.

Dr Moonesinghe introduced the new proposed **HSRC Perioperative Improvement Research Lab (PIRL)**. The concept is similar to embedded research teams and Trusts will be invited to apply for evaluation support from PIRL who will provide in-house expertise to clinicians that are developing new or innovative services, by evaluating their clinical and cost effectiveness. The support provided by PIRL will include expertise in improvement science including statistics, health economics and social sciences. Prof Sneyd questioned whether the HSRC will be offering its services in relation to systematic reviews – he is aware of instances where this has generated large amounts of income for researchers. Dr Moonesinghe advised there would be no capacity within the HSRC to consider this, but it would be something to think about in future.

Dr Klein questioned how the PIRL initiative will work in practice and be monetised. Dr Moonesinghe advised there will be open competition for applications and they will start out in small numbers, perhaps inviting applications along a theme. They will charge a nominal fee in the beginning but over time may create a surplus which could subsidise other HSRC activities. The proposal is still in the early stages and the finer details are yet to be determined.

Dr Moonesinghe introduced the second new proposed HSRC initiative: **Big Data,** embarking on a new model of research using administrative and routine data as well as national audit datasets; exploring opportunities to collaborate using electronic health records which are

increasingly being used more frequently in Health Services Research overall. Dr Moppett will be leading on this piece of work.

This led on to the next new proposed project, which will involve supporting partner organisations to develop **registries and databases**. This often proves to be a more difficult piece of work to undertake than organisations first realise due to information governance, storage and other issues. The HSRC's plan is to utilise the experience gained through PQIP, NELA, SNAPs, NAPs etc. to support partner organisations to develop databases and registries according to their needs. Two pilots are currently being proposed:

(i) Front of Neck Airway (FONA) registry to be developed with the Difficult Airway Society and the RCoA Airway Leads, building on the NAP4 study to enable learning from front of neck airway access incidents.
(ii) Working with the national Perioperative Exercise Testing and Training Society (POETTS) to develop a database recording cardiopulmonary exercise testing and outcomes.

The HSRC plan to provide the expertise and infrastructure enabling these organisations to carry out this work and to charge a fee for the support; the costs involved will be borne by the partner organisation.

o **Improving Quality:** current work under this theme includes NELA which will be bidding for a new contract towards the end of 2016/early 2017. A key aspiration is to develop sufficient methodological expertise to bring NELA in-house. Currently part of the HQIP funding is allocated to the Royal College of Surgeons' Clinical Effectiveness Unit as they provide the statistical expertise around risk adjustment, and there is a desire to develop this expertise internally within the HSRC.

PQIP, the new national clinical audit of perioperative outcomes, will be starting later this year. The aim is to embed the programme in 70% of UK hospitals; establishing and promoting it as a national audit and quality improvement programme by building similar relationships as built through EPOCH and NELA.

o **Developing People:** Through the work being developed by the RCoA/HSRC Quality Working Group there are plans to develop a **Quality Faculty** which will link with the Q Initiative being led by NHS England and the Health Foundation and will build clinical quality and improvement, and strengthen the existing networks, e.g. QuARCs and trainee research and audit networks. There are also plans to develop future academic leaders and improve sustainable funding to support these; there are currently 8 HSRC research fellows who are mainly based in the London area and rely on their hospitals to support their salaries. There is a wish to move away from this and to recruit trainees more widely by developing regional fellowships in partnership with local training schemes and jointly funded fellowships with charitable partners, for example the Royal College of Surgeons. In addition the HSRC are keen to provide a physical centre for fellows, and as a result some desk space has been allocated on the 5th Floor of Churchill House for this purpose.

Dr Moonesinghe highlighted the desire to build core expertise within the HSRC, pointing to the Royal College of Surgeons' Clinical Effectiveness Unit for comparison – a non-clinical academic led unit hosting a wide range of expertise including statisticians, epidemiologists and health services researchers. The HSRC wishes to build a similar level of core expertise in-house, which is also linked to the proposed PIRL initiative.

o **Communicating and Engaging Widely:** Dr Moonesinghe outlined a proposal to invite two PPI representatives to formally join the HSRC Board, to ensure consistent patient input at Board level. There will be a continued support to the PCPIE group led by Dr Mark Edwards, and some focus on the effectiveness of the JLA Priority Setting Partnership outcomes to determine whether the exercise should be repeated in the next 5-10 years. There will be continued engagement with patients being involved in the COMET and StEP initiatives which are both professional and patient partnerships, and a commitment to involve patients throughout all core HSRC projects e.g. NELA and PQIP.

Dr Moonesinghe highlighted a change to the HSRC Terms of Reference to now invite co-opted members to join the Board, including the AAGBI's Anaesthesia Sprint Audit of Practice

(ASAP) Coordinator, and a rep from the APAGBI, the British Pain Society/Faculty of Pain Medicine and the OAA. Other specialist societies will be invited to join the Board in future as and when required.

Prof Mythen highlighted the lack of representation from Intensive Care Medicine. Dr Moonesinghe stated there has always been caution around encroaching on ICNARC's work, and invited the Board to give a view on whether they felt this was the right decision, highlighting in particular there is FICM, ICS and two critical care associations represented on the SNAP-2 project. Prof Pearse stated that there is engagement with ICU on projects where relevant, but thinks it may be too soon to really approach this. Prof Mythen suggested that HSRC should have a conversation with FICM to foster inclusion with the Faculty. Dr Moonesinghe also outlined the HSRC's desire to move towards more international collaborations over the next few years, following COMET/StEP projects.

Prof Sneyd referred to the subject of electronic records and whether there were any plans for HSRC to enter into discussions with North American health research groups, many of whom often want to collaborate with European partners. Prof Sneyd can provide contact details for the Michigan group. Prof Lambert queried whether there would be scope for the HSRC to offer a co-badged PGCert qualification, in conjunction with UK Universities? It can also be used as a mechanism to raise income for the HSRC. Dr Moonesinghe was supportive of this suggestion, and encouraged further discussion on the mechanics of this.

Prof Mythen questioned whether the strategy has been funded or not. Dr Moonesinghe clarified that some has already been funded, but some is still to be determined. Prof Grocott raised the issue of funding for SNAPs, which remains a key element of work not yet funded and needs discussion between partners. This is to be discussed at the Executive Board meeting to discuss funding, which will follow the main meeting.

ACTION: Prof Sneyd to provide contact details for the Michigan health research group

7.4 NIAA-RCS Systematic Review programme

Dr Moonesinghe stated that it had been requested to add this item to the NIAA Board agenda as it is currently a standing item for the HSRC Board but was not felt to be the best place to discuss it. The Board agreed this item should be added to future NIAA Board meeting agendas. It was also clarified that the item will be part of the funding strategy discussions in the subsequent Executive Board meeting.

ACTION: NIAA Coordinator to add NIAA-RCS Systematic Review programme item to NIAA Board agenda for future meetings.

NIAAB/07.2016/8 CLINICAL TRIALS NETWORK

Prof Pearse updated the Board on CTN membership, which is continuing to progress with a steady stream of new applications. The first Network meeting is taking place in Birmingham in November, where the first adopted studies will be presented and will welcome discussion on new ideas and gather any feedback on early successes.

The CTN requested Board input on the draft Regulations document which were circulated as an enclosure for this meeting. Prof Pearse expressed thanks to Mr Goodwin and Ms Drake for their help in putting it together. Prof Pearse noted that the CTN strategy would form a separate document to the Regulations, which would be reviewed on an annual basis but with very few changes.

Mr Hepworth queried the lack of lay representation on the CTN Board if this work is related to patient recruitment. Prof Pearse responded to clarify that patient engagement had been discussed, but most patient involvement would be within the research projects and trials being considered by the CTN rather than in the infrastructure of the group, and this would be where their time would be best spent. The CTN would be considering the scientific and methodological structure of the trials; issues such as patient recruitment would fall within the remit of the PCPIE group.

Prof Pearse invited any further comments from Board members on the CTN Regulations once they had had time to digest the content. The CTN Strategy would be presented to the Board in the

autumn, with finalised CTN Regulations approved at the next Board meeting. It was agreed that any further comments and discussion would be conducted by email in the meantime.

Prof Pearse sought the Board's input on CTN Board Members' terms of office. Currently this is being proposed as three years and renewable for a further two terms to a maximum of nine years. Prof Sneyd suggested that in order not to lose expertise and experience, Board members appointed as Director or Deputy part-way through their term as a Board member shouldn't have their term cut short as Director/Deputy, but it should be extendable annually by invitation.

Dr Walker queried whether there is proposed to be any paediatric representation on the Board. Prof Pearse responded that the main focus of the CTN will be on trials involving adults; however there is no explicit exclusion on trials involving children.

ACTION: Board members to review CTN Regulations and submit any comments by email to Prof Pearse and Mr Goodwin by 31 August.

NIAAB/07.2016/9 NIAA COMMUNICATIONS

Ms Hines noted the list of specialist societies who have not included the NIAA logo or a web link on their own website, included in the Communications paper. These will be encouraged to do so as soon as possible. As already discussed earlier in the meeting the Research Database appears to have become inactive of late, and any ideas from the Board for NIAA representation at the 2017 GAT conference were welcomed. Ms Hines also presented an example of the final version of the *NIAA Comprehensive Review 2014-15* which had just recently been sent for printing, and thanked all who had contributed content. This version will include a copy of the NIAA Strategy as an insert in the booklet. Ms Hines confirmed that the Strategy will be uploaded to the NIAA website in due course.

Prof Mythen suggested sending written communication to the specialist societies who don't currently have any NIAA link or logo on their website, requesting that they consider doing so or attempting to understand why this hadn't yet been done.

ACTION: NIAA Coordinator to draft a letter to specialist societies who don't have any reference/links to NIAA on their websites.

NIAAB/07.2016/10 ANY OTHER BUSINESS

10.1 NIAA Research Council Chair

Prof Sneyd noted that his term of office as NIAA Research Council Chair was due to end shortly and that plans for the recruitment of his successor would need to be put in place. Ms Hines mentioned that she was drafting a list of terms of office for NIAA members and would factor this in.

10.2 Military Anaesthesia

Ms Drake raised the issue of Col Tom Woolley's written update on military anaesthesia, which had been included as an additional item in the papers. She also raised the question of whether these updates should be presented in Research Council meetings going forward. Prof Mythen confirmed that this should be the case.

ACTION: NIAA Coordinator to draft a list of terms of office for NIAA members
ACTION: NIAA Coordinator to draft a timetable for recruiting Prof Sneyd's replacement
ACTION: NIAA Coordinator to include Military Anaesthesia to the Research Council agenda as a standing item

NIAAB/07.2016/11 DATES OF FUTURE BOARD MEETINGS

Thursday 10 November 2016, 1.30 pm, RCoA
TBC February 2017, RCoA
Further 2017 dates TBC

ACTION POINTS

Item		Responsible	Action	Due
2	Minutes of the previous meeting	Ms Hines	Amend and upload the non-confidential minutes of meeting held on 4 February 2016	Next meeting
2	*For information*	Prof Pearse	*Draft a news item to publicise Dr Abbott's NIHR CRN Trainee award*	*ASAP*
4.2	NIAA Terms of Reference	Ms Hines	Amend the Terms of Reference to reflect the Chair's casting vote in any tied voting	ASAP
6.1	Academic Trainees	Dr Moonesinghe	Start the process of producing an updated Rising Stars document	Next meeting
6.1	Academic Trainees	Dr Moonesinghe	Liaise with 2017 GAT local organising committee, to start discussing NIAA involvement	Next meeting
7.3	HSRC Strategy	Prof Sneyd	To provide contact details for Michigan group	ASAP
7.4	NIAA-RCS Systematic Review programme	Ms Hines	Add to NIAA Board agenda as standing item	Next meeting
8	Clinical Trials Network	All Members	Review CTN Regulations and submit any comments to Prof Pearse and Mr Goodwin	31 August 2016
9	NIAA Communications	Ms Hines	Draft a letter re: NIAA logo and/or link on specialist society websites	ASAP
10	AOB	Ms Hines	Draft a list of terms of office for NIAA members	ASAP
10	AOB	Ms Hines	Draft a timetable for recruiting Prof Sneyd's replacement	Next meeting
10	Military Anaesthesia	Ms Hines	Add to NIAA Research Council agenda as standing item	ASAP