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## Minutes

<b>Present:</b>	Deborah Evans (in the Chair)	Chief Executive, NHS Bristol
	Helen England	Co Director of Commissioning and Project Director, NHS Bristol
	Eva Nabeta	Project Manager, NHS Bristol
	Maureen Livesey	Lay representative, Local Involvement Network (LINKs)
	Nick Rooney	Consultant Histopathologist, North Bristol NHS Trust
	Simon Cawthorn	Consultant Breast Surgeon, North Bristol NHS Trust
	Tony Jones	Patient and Public Involvement Manager, NHS Bristol
	Jo Williams (on behalf of Angela Raffle)	Specialist Trainee in Public Health, NHS Bristol
	David Tappin	Director of Strategic Development, NHS Bristol
	Daphne Havercroft	Patient representative, BUST
	Ruth Randall	Patient representative
	Richard Darling	PEC Chair, NHS North Somerset
	Angela Jones (on behalf of Monica Lamont)	Consultant Radiologist, Avon Breast Screening Unit
	Kate Oliver	Voluntary Sector Organisation representative, The Care Forum
	Claire Garnell	Breast Care Nurse, Weston Area Health NHS Trust
	Simon Sethi (on behalf of David Jarrett)	Assistant General Manager, North Bristol NHS Trust
	Zenon Rayter	Breast Surgeon, University Hospitals Bristol NHS Foundation Trust
	Nick Gallegos	Medical Director and Consultant Breast Surgeon, Weston Area Health NHS Trust
	Heather Davies	Academic Nurse
<b>In attendance:</b>	Emma Phillips (notes)	Project Support Officer, NHS Bristol
<b>Apologies:</b>	Robert Woolley	Director of Corporate Development, University Hospitals Bristol NHS Foundation Trust

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Hester McLaine	Commissioning Lead for Cancer, NHS Bath and North East Somerset
Jeremy Braybrooke	Medical Oncologist, Avon Somerset and Wiltshire Cancer Network
Monica Lamont	Director, Avon Breast Screening Unit
David Jarrett	General Manager, North Bristol NHS Trust
Angela Raffle	Consultant in Public Health, NHS Bristol

## Action

### 1 Arrival and coffee

### 2 Welcome, introductions and apologies

Those present introduced themselves and apologies were noted as above.

DE welcomed the group together and noted that this meeting signals the conversion of the Steering Group into the Project Board.

### 3 Minutes of the last meeting

The incorrect spelling of Robert Mansel's name on the first page was noted and the Board agreed the minutes to be an accurate record.

It was agreed to discuss matters arising under the relevant agenda headings of this meeting.

### 4 Exception Report

HE introduced the report explaining that the reason for producing it was to identify the issues that had impeded the progress of the project and consider the best way to take the project forward now. The report notes that there had not been clear articulation of the project's rationale and there had not been sufficient project management support. The structure of the project allowed people to work very separately, keeping clinicians and patient representatives fragmented. HE alluded to the well-attended stakeholder event on 6<sup>th</sup> April which achieved a clear consensus to take the project forward. This was followed up by a workshop that allowed a smaller group of stakeholders to shape the Project Initiation Document which articulates the objectives of the project.

HE highlighted that the report suggests a change to the scope of the project which is the removal of health education. It was recognised that the proposed model will have education and training implications which would be picked up. HE also referred to the involvement of BANES. Out of 162 breast cancer patients

from BANES, 142 of these were seen at the Royal United Hospital Bath with very small numbers being seen in Bristol or Weston. Therefore, the report proposes that BANES scrutiny committee will be kept briefed and NHS Bath and North East Somerset will remain a key stakeholder but will not have Board membership, however, will be corresponded with and given the opportunity to comment throughout the process so that the impact of any proposals on patients in the BANES area can be fully understood before decisions are made.

Copies of the proposed Project Organisation Chart were circulated. HE explained the key role of the Project Board will be one of governance; the Project Team will be the main engine of the project, over-seeing, tasking and co-ordinating the individual workstream groups. EN will provide full time project management support. HE noted the importance of having clear governance to reach the project's recommendations for approval by the Bristol, North Somerset and South Gloucestershire (BNSSG) Chief Executives. In order to achieve this, external assurance has been sourced to provide an independent health check, recommend actions and manage issues and risks.

The Board considered each of the report's recommendations one-by-one:

- 3.1 (geographical scope and role of BANES) – the Board signed off this recommendation.
- 3.2 (project organisation) – following a concern raised by KO, members discussed the capacity of lay people including patient representatives and voluntary sector organisation (VSO) representatives to contribute to each of the workstreams as well as the Project Team and Project Board. The Board agreed there should be a minimum of two lay representatives on each workstream and that additional places should be offered to relevant organisations to provide representation, however, if organisations do not want to be included this should not hinder the progress of the project. HE emphasised that patient and public involvement will be embedded throughout the project. HE also noted that Professor Mansel has agreed to chair a group of external clinicians who will be involved in testing the final proposals. The Board signed off this recommendation.
- 3.3– the Board noted the new project management arrangements.
- 3.4 – the Board agreed the specification of external project assurance.
- 3.5 – the Board noted the useful work that has previously been undertaken in relation to this project and agreed this

should be used in the next stage.

- 3.6 – the Board noted the need for formal reporting and the execution of formal project controls.

## 5 Progress to date – Project Status Report

EN presented the Project Status Report and explained the overall project status has been identified as amber suggesting the project is not at a critical stage but does require attention. EN explained that this is primarily a reflection of being at the initiation stage for phase two where controls have not been properly established. Once the Project Initiation Document has been signed off this is expected positively impact rating of project status. In the breakdown of the report, workstreams that have continued to progress (service model and clinical pathways and location) have been awarded green status. The next steps include the first meeting of the Project Team to develop detailed plans to ensure the forward progress of all the workstreams and update reports to the local scrutiny bodies.

The Board signed off the Project Status Report.

## 6 Introduction to the Project Initiation Document (PID)

The aim of the PID was identified as ensuring clear agreement on the purpose, objectives and controls for the project. The Terms of Reference are touched on in the PID but the full document will be circulated with the minutes to answer questions raised about quoracy.

EN delivered a presentation guiding the Board through the PID. She articulated the vision and objectives of the project, introduced the four workstreams and explained the project management approach which will be in stages. The Board agreed the approach and the stages identified. EN also described the communication mechanisms and indicated the milestones for the project. TJ commented that the milestones appeared ambitious as they show that all the workstreams will be completed, their work will be signed off by the Project Board and by PCT Boards ready to be presented to the scrutiny committees in September. It was also remarked that PCT Boards do not meet in August and that scrutiny committees expect PCT Boards to have made their decisions first. The Board noted that one of the risks identified with this project is the retention of momentum. The Board requested that the milestones are broken down to show the tasks that need to be completed and by whom.

**Action: HE and EN to expand on the milestones for the project which will be reviewed at the next Project Board meeting.**

HE, EN

The Board signed-off the PID.

**7 Project Assurance Report**

HE informed the group that this is the report produced by the supplier of external assurance. The amber scores relate to the PID not being ratified yet.

The Board noted the report.

**8 Workstream brief for workstream 3 – process and criteria**

HE explained that workstream 3 is concerned with the location for the hub and subsequently the spokes. HE highlighted that the brief states that proposed changes need to demonstrate benefits for patients, be clinically driven, be locally led and have patient and public involvement embedded throughout. The brief identifies two options for the location of the hub- NBT's Southmead site and UHB's city centre site. A third, stand-alone option, is disregarded in the brief as not being feasible, primarily due to affordability and the ability to ensure important clinical adjacencies. The Board asked for further documentation that clearly demonstrates and rules out a third option to ensure this stands up to scrutiny.

**Action: HE to produce document assessing feasibility of a third option of a stand-alone hub.**

HE

Discussions started to develop that appeared to argue the advantages and disadvantages of the two sites and DE reminded the Board that their role is to agree the process and criteria for making the decision- the workstream group will make a recommendation following this.

HE outlined the process: formulating a specification for the hub, evidence collated and synthesised by an agreed panel (evidence will come from a wide-range of stakeholders and open to anyone to contribute to), panel feeds back to the Project Board. The Board considered the criteria for the hub and comments were made about including Darzi's quality strands and equity. HE emphasised that these would be embedded in the service model and the main criteria for the hub will be to enable the integrity of the model. DT noted that the criteria outlined in the brief is very specific and suggested aggregating the criteria to a higher level that would encompass the specific points made and pick up any others. The criteria could be then generalisable for other location decisions in the future.

The Board discussed the appropriateness of creating a competitive process between NBT and UHB. It was noted that there may not be a need for this as one or other of the locations may not meet the requirements for the hub from the outset. The Board agreed the workstream group should carry out a desk-top exercise in the first instance which may rule out one of the

contestants. If this is not the case, both Trusts should be approached to see if a consensus can be achieved. If the Trusts are not able to make an agreement, there will need to be a transparent contest. DT remarked that both Trusts had been written to some time ago and confirmed they would be able to accommodate a single breast care service, however, this was prior to the creation of the proposed service model and simply based on the two units merging. The Board agreed that teasing out the differentiating criteria would be important factors in the decision making process.

**Action: HE to develop the criteria for the location of the hub that the two sites will be assessed against.**

HE

HE will email the Board when she has completed the further work required for this and the Board agreed to signing off the process and criteria for workstream 3 by email. Board members with suggestions for any further criteria should email HE.

## 9 Outline of the Service Model

SC presented his paper and confirmed that the outline model has been supported by all local breast clinicians. The principles behind the model are improved patient care and improved patient outcomes. The model enables specialists to work together and share clinical experience and learning, creating a strong and efficient multi-disciplinary team. SC stated that having all clinicians working in a combined team will help to achieve and demonstrate best clinical standards. An IT system which will facilitate strong communication links between the hub and spokes is important, as will be good links with Universities to develop research.

SC emphasised that Weston will not be undermined by the model, but will be strengthened and supported and seen as an extension of the hub. The Board requested this was expanded on and that Weston is supported to ensure it meets criteria to be defined as a hub service.

**Action: SC to write section about Weston.**

SC

ML voiced concerns about the spokes. SC informed the Board that there is currently a pilot running which he will feed back on at the next meeting.

## 10 Next steps

The Board agreed that these had been covered during the meeting.

The Board will meet at the review gateways of the project. The next meeting will be in July and future meeting dates will be confirmed then.

**11 Close**

Thanks were given to the clinicians for working together and driving the project forward and to all the patient representatives for their valuable input.