

**Meeting of the Breast Care Services
Review Project Board**

Held on Friday 11th September 2009 at 1pm
In the Elim Church



**Bristol Health Services Plan
Breast Care Service Review**

Minutes

Present:	Deborah Evans (in the Chair) Helen England	Chief Executive, NHS Bristol Co Director of Commissioning and Project Director, NHS Bristol
	Elizabeth Williams Maureen Livesey	Project Manager, NHS Bristol 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
	Habib Naqvi (on behalf of Angela Raffle) Robert Woolley	Senior Public Health Analyst, NHS Bristol Director of Corporate Development, University Hospitals Bristol NHS Foundation Trust
	Daphne Havercroft Ruth Randall Elisabeth (Lis) Kutt	Patient representative, BUST Patient representative Head of Division Diagnostics and Therapies Consultant Radiologist
	Jeremy Braybrooke	Medical Oncologist, Avon Somerset and Wiltshire Cancer Network
	Simon Sethi (on behalf of David Jarrett) Zenon Rayter	Assistant General Manager, North Bristol NHS Trust Breast Surgeon, University Hospitals Bristol NHS Foundation Trust
	Nick Gallegos	Medical Director and Consultant Breast Surgeon, Weston Area Health NHS Trust
	Heather Davies Nigel Warmington Alison Wint	Academic Nurse External Project Assurance, Basis Associate Medical Director, Avon, Somerset and Wiltshire Cancer Network
In attendance:	Emma Phillips (notes)	Project Support Officer, NHS Bristol
Apologies:	Richard Darling	PEC Chair, NHS North Somerset

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David Tappin	Director of Strategic Development, NHS Bristol
Kate Oliver	Voluntary Sector Organisation representative, The Care Forum
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.

Deborah Evans welcomed the group together and commented that she had briefed NHS South Gloucestershire's and NHS North Somerset's Chief Executives on the project's progress.

3 Minutes of the last meeting

The minutes were agreed as being an accurate record.

4 Matters arising

Deborah confirmed there was nothing to add to the matters arising included on the agenda.

4.1 Project milestones

Helen England reminded the Board of its request to review the project's timeline as members felt it seemed a little ambitious. Elizabeth Williams circulated an up-to-date action plan which superseded the one sent out with the minutes. She noted that a decision on the location for the hub has not been reached and this has created a delay of a couple of weeks, but the project is still on track. Helen highlighted the macro level timeline which indicates the project will conclude by the end of the year and proposals will be presented to Trust boards at the beginning of the calendar year 2010.

Deborah queried the location of screening within the proposed model, expressing concerns about losing screening from Central Health Clinic. Helen informed the Board that there is a strong clinical view that screening should be part of the integrated hub. Lis Kutt noted that much of the screening carried out at Central Health Clinic would move to the hub and some women would be

diverted to spokes located closer to their homes. The Board noted that Central Health Clinic is considered a good, accessible location and could remain as a spoke within the new model. Helen observed that a meeting had taken place prior to the Board where the optimal mix for screening was agreed as being a combination of static machines in the hub and spokes as well as mobile vans.

Deborah commented that she felt an access study was needed as part of the work to establish the location of screening points.

Action: Work stream 3 to produce an access study as part of the work to assess the location of the spokes.

Work stream 3 (Helen England)

4.2 Project resilience

Helen informed the Board that to provide some project resilience in light of the Swine Flu pandemic, Elizabeth Williams is now Project Manager whilst Eva Nabeta focuses her attentions on leading work stream 2.

4.3 Revised work stream 3 brief assessing feasibility of option of stand alone hub

Helen reminded the Board that it had requested this document be updated to reflect the Board's discussion at the last meeting. She noted that the revised document had been emailed to Board members with a deadline for comments. The work stream has since been working to this brief.

4.4 Explaining the role of Weston as an extension of the hub

Simon drew the Board's attention to the paragraph that had been added to this document about Weston. He thanked Nick Gallegos for his commitment and support in articulating the role of Weston as a satellite hub. Nick G noted that the document refers to the hub throughout and requested that this be altered to read the hub and satellite hub. Elizabeth mentioned that the next newsletter will contain a feature on the role of the satellite hub.

Action: Clinical outline model document to be updated to refer to the hub and satellite hub.

Simon Cawthorn

Action: Feature on the role of the satellite hub to be included in the next newsletter.

Elizabeth Williams

Maureen Livesey sought clarification on the current levels of activity and referral at Weston. Nick G informed the Board that they see between 120 – 140 breast care patients per year which is made up of a combination of symptomatic and patients detected through screening.

20% of patients are symptomatic patients referred from Somerset. The biggest group of patients referred to Bristol from the Weston area are those who have opted for reconstruction. These are single figure numbers. Nick G also noted that Weston has visiting oncologists and Jeremy Braybrooke explained that whilst chemotherapy is given at Weston, patients requiring radiotherapy are referred to Bristol Haematology and Oncology Centre or Musgrove Park.

Maureen asked if there would be any essential change as far as Weston's patients were concerned. Nick G and Simon both reassured her that the only change would be a strengthening of Weston as the team there would be able to benefit from linking in to the multi-disciplinary team at the hub to discuss complex cases. Lis noted the need for imaging to be strengthened at Weston and suggested that links to the hub will support this.

Deborah suggested a pictorial representation be included in the feature in the newsletter on the role of the satellite hub.

Action: Pictorial representation to be included in the newsletter feature on the role of the satellite hub.

Elizabeth Williams

Simon highlighted further revisions that had been made to the Outline Service Model document, which were discussed as part of agenda item 5.

4.5 Agree composition of external multi-disciplinary panel

Helen requested the Board consider the multi-disciplinary representation for the external panel which will be convened at the end of the review process. Panel members suggested were:

Dr Mary Wilson, Clinical Director at the Nightingale Centre, Manchester.

Chris Holcombe, Consultant Breast Surgeon, Royal Liverpool and Broadgreen University Hospitals NHS Trust.

Andrew Hanby, Professor of Breast Pathology and Consultant Histopathologist, St James's University Hospital, Leeds.

Robin Wilson, Clinical Radiologist, Kings College Hospital, London.

The Board suggested an oncologist should be on the panel. Helen asked Jeremy Braybrooke to suggest someone.

Nick G noted that all the representatives are from large

conurbations with large services so spend all their time in hubs. He suggested there should be a representative from a smaller service on the panel.

Heather Davies felt it was important to have clinical nurse specialist representation.

Action: Helen to review final external panel in light of comments received.

Helen
England

5 Draft clinical pathway consultation

Simon highlighted further revisions that had been made to the Outline Service Model document. This includes that all referrals to the symptomatic service will be seen at the hub or satellite hub. He noted that all clinicians have agreed the importance of integrating plastics and oncology and recognised the current debate as part of the location work stream about whether one of these clinical adjacencies is important enough to determine a preferred location for the hub. Simon commented that Monica Lamont had requested a sentence indicating this be included after mention of both disciplines in the document. Deborah sought clarification on the meaning of integration and Simon explained that this indicated two or more specialities working together to benefit patients and clinicians. He suggested this would involve sharing expertise and discussing cases.

Daphne Havercroft referred the Board to the sentence on page 2 of the document, "Integration of surgery in the hub with plastic surgery is yet to be decided clinical adjacency issues to be fully determined in the work stream on location of the hub". She suggested it be amended to read:

"Integration of breast surgery with plastic surgery as part of the outline clinical model was agreed to by all stakeholders at the 6th April 2009 workshop. The decision on co-location of plastic surgeons and breast surgeons at the hub to enable the desired integration to take place is to be fully determined in the work stream on location of the hub."

Nigel Warmington, who facilitated the 6th April workshop stated that he felt this to be an accurate statement. Simon commented that he would be happy with Daphne's suggested amended.

The Project Board agreed the revised document with the addition of the amendment suggested by Daphne.

Action: Document to be updated to reflect agreed amendment.

Simon
Cawthorn

Helen noted that at the 6th April event, screening had been considered to be an integral part of the model, but the detail of how the integrated hub, the spokes and the screening service would work together needed further work. She indicated that one

of the issues now faced is that the Avon Breast Screening Service covers Avon whilst this review is limited to Bristol, North Somerset and South Gloucestershire. These issues are currently being worked through.

Nick G identified that in agreeing the importance of supporting integration with both oncology and plastics, there is the potential for tension between the two disciplines and stakeholders involved in the review. Deborah recognised that this is indeed the current situation.

Simon commented that, prior to the panel meeting to determine whether there is a preferred location for the hub; oncologists had agreed that oncology did not need to be co-located with the hub, particularly as a model for providing more chemotherapy services at home is being developed. Therefore, oncologists did not present to the independent panel but views of others led panel members to question oncologists' views on how they will provide support to the hub if not co-located. Jeremy identified himself as being independent on account of being employed by University Hospitals Bristol NHS Foundation Trust (UHB) but working with North Bristol NHS Trust (NBT). Jeremy highlighted that oncology for breast cancer patients can be split into two separate roles – one dealing with early stage cancer and one dealing with advanced metastasis. He noted the extent to which oncology would need to be integrated into the hub would depend on whether the model separated out early stage cancers and advanced. Jeremy added that most models of care see these as two distinct and separate roles. Jeremy informed the group that the majority of oncology work is outpatient based and therefore outpatient facilities at the hub would be essential for oncologists. With the move to delivering more chemotherapy in the community, space for treatment would not be as essential. Jeremy mentioned that radiotherapy treatment is dependent on machines and bunkers which are based at UHB and therefore if the hub were to be at Southmead patients would have to travel for their radiotherapy although this would happen some time after their surgery and so Jeremy did not feel this implied a need to co-locate. Jeremy indicated that the development of intra-operative radiotherapy might be an influential factor for co-location, but added that it is difficult to predict what will happen in the future.

Deborah summarised Jeremy's main points as being the need to plan outpatient facilities well and that he felt, at this stage, there is not an overwhelming case for the hub to be co-located with oncology. However, future proofing is difficult to determine. Deborah emphasised the need for the due diligence process to test the sustainability of the model in 5 – 10 years time.

Daphne asked Jeremy if he felt that not co-locating oncology with the hub would be detrimental to research. Jeremy replied that research is very important but as long as there is a focus on

research and the resources are available, this could be carried out wherever the hub is sited. He commented that research needs to be based at the hub as it tends to straddle surgery and oncology.

Jeremy sought clarification on whether the model would separate early breast cancer from advanced. Daphne noted that from a patient perspective this would be preferred.

Heather Davies expressed concern that plastics and oncology were being separated out. Deborah clarified that both plastic surgeons and oncologists are considered core members of the team and will see patients at the hub. The discussion is concerned with how this will be managed if plastic surgeons and oncologists are not based on the hub site, for example, with oncology outpatient appointments and community chemotherapy services.

Robert Woolley referred to the support Weston will receive from plastic surgeons via video link. Simon clarified that this will provide a link to the multi-disciplinary team meetings and will not be a link to the theatres.

Jeremy summarised that all clinicians involved want to integrate. The issue lies with determining which functions it is essential to physically co-locate. He reiterated that oncology, with the exception of radiotherapy is very flexible. He also noted that the number of patients opting for reconstruction surgery is very small and therefore the question needs to be around patient benefits. Simon referred to recently published papers that discuss the benefits of putting microsurgery in breast care units. He noted that more patients are requesting microsurgery and the papers demonstrate it improves patient experience, cost effectiveness and aesthetic results. Daphne commented that when preparing the patient groups' presentation for the panel, patients felt it was extremely important that decisions for reconstruction without information were 'pot luck' and patients did not have any idea as to what the result would look like.

Simon recognised the hard work and good collaboration of all the clinicians involved. He emphasised the importance of resolving the issues around integration in order to continue to progress the project.

Tony Jones noted that at the beginning of the review it was felt that the spokes might be able to carry out some of the diagnostic functions of the model and receive referrals from low-risk patients. He recognised that this had been written out to reflect clinicians' anxieties and the lack of evidence to support this idea. He expressed concern that if this aspiration were removed completely it may be difficult for the model to move towards it in the future. Simon commented that there is currently a pilot running in Yate which will provide data on whether this model

work in the future. The Board agreed these aspirations should be reflected in the document.

Action: Document to be updated to reflect aspiration that some diagnostic functions could be carried out at the spokes and low risk patients could be referred to spokes in the future if evidence becomes available to support this.

Simon
Cawthorn

6 Progress report for work stream 3

Helen circulated a summary report from work stream 3. She referred to the panel meeting held on the 4th September to hear the views of clinicians and other key stakeholders to understand the differential criteria that might lead to identifying a preferred location for the hub. Helen praised the high degree of participation on the day. She informed the Board that clinicians presented by discipline, across Trusts, symbolising their commitment to working together. Helen talked the Board through her paper. She highlighted the panel's recommendation to reconvene and to invite the clinical group as a whole in order to answer questions and concerns raised by the panel on the 4th September which could not be answered at the time.

Deborah observed that this had been discussed extensively as part of item 5. The Project Board supported and endorsed the report and recommendations.

7 Preparation for Outline Business Case – financial and activity review

Deborah praised the Project Team for producing good work on finances early on in the project.

Helen noted the purpose of the paper was to test the affordability of activity under the new model. She identified it as being an initial paper focusing on current resource utilisation and the potential for future savings and investment.

Lis Kutt expressed wariness that the paper did not address additional costs that will be incurred by moving follow ups to the spokes. She also noted that the paper assumes the bed base will be matched on seven day occupancy, but that if more surgery is done as day case there will not be 85% occupancy at weekends, unless all complex cases are undertaken on a Friday.

Tony Jones suggested there may be costs incurred in making the service more accessible and patient centred, although these are unknown at present.

Deborah reminded the Board that the current situation is not one where PCTs have additional resource to invest.

Lis questioned the lack of information about capital cost. Robert Woolley noted that to demonstrate the model is affordable revenue costs should not exceed the amount currently available to spend for providers. If money is spent on new facilities, capital charges will be incurred. There are various streams of capital. Foundation Trusts have to borrow capital and NHS Trusts access restricted funds through the Department of Health. Nick G commented that the model has to be revenue neutral.

Deborah suggested that the project should work to the maxim that the future service cannot cost more than the existing service, including the cost of servicing capital needed and make some savings (10 – 15%). She noted the challenge for the Project Team is to keep remodelling the service until it can achieve this.

Helen noted that the paper's focus was on the cost of activity not estates and capital. She recognised that the two need to join together but suggested they could be run as two separate pieces of work at this stage.

Daphne commented that the scrutiny committees had expressed a wish to see funding for the breast care services review ring fenced and noted the need for complete transparency.

Deborah noted that much of the cost of breast care service is governed by the NHS pricing regime and is therefore nationally set. She suggested a bottom-up costing was needed in order to demonstrate how the service will be delivered.

Maureen Livesey questioned whether, by providing follow up care in the spokes, i.e., in primary care, costs would be incurred by PCTs rather than acute trusts. Deborah clarified that there is just one pot of money and that everything is funded by PCTs.

Simon mentioned consultation on a local tariff for nurses doing follow ups rather than consultants. He also suggested that ultimately costs would be reduce as there would be less follow-ups and less operations would need to be corrected.

Nick Rooney asked as the paper suggests day case rates can be increased as part of the new model, why is this not being implemented now. He cautioned that the Board needs to ensure savings are actually achievable. Simon reassured him that this is achievable – NBT currently manage 84% of their breast surgery patients as day cases. Zenon Rayter added that new technologies will also contribute to increasing day case rates.

8 Report from work stream 4

Habib Navqi introduced the reports.

8.1 Health Equity Audit of the Breast Care Service

Habib noted the aim of a health equity audit is to determine

the data available to complete an equality impact assessment. This paper sets out the system for reviewing inequalities in health in line with demographic markers. Habib noted that the data had come from the Cancer Intelligence Service and covered all diagnosed breast cancer patients from 1998 – 2007. He noted that most of the findings were comparable to national findings. He highlighted that mortality increases with age, there are higher levels of mortality amongst people of higher social economic status, diagnosis tends to be at a younger age for black and minority ethnic patients. Complaints and Patient Advice and Liaison Service (PALS) data were considered and did not show any inequalities, but did highlight examples of good practice, such as the South Asian women's group demonstrating the walking route from Charlotte Keel Health Centre to Central Health Clinic. The primary recommendation from this report was the need to improve patient profiling as much of the data sought was of poor quality.

8.2 Design and Delivery of an Equitable Service

Habib noted that this report gives examples of what needs to be in place in order to provide an equitable service. He highlighted embedding equality in policies and procedures, staff inductions and training as key. He also identified the need to consider facilities, such as transport, disabled access, mens' requirements, catering, double appointments for people with learning difficulties etc.

8.3 Embedding Equity Profiling into Monitoring of Service Performance and Outcomes

Habib noted that this report covers how equity monitoring should be built into the new service model. He highlighted that the report recommends wider consultation with representation from all the equality strands. He indicated that the equality strands and codes identified in the report are aligned to the census.

Deborah thanked the Public Health team for producing very thorough and helpful papers.

Alison Wint commented that the suggested patient profiling form is very comprehensive and would take staff some time to complete. The Board noted this to be an implementation issue which would require consideration. Elizabeth Williams confirmed that this will be picked up in the next piece of work for this work stream which is the completion of an equality impact assessment.

The Project Board received the reports with thanks.

9 Feedback from scrutiny committees and plan for impact

assessment

Elizabeth Williams noted there had been no cause for concern as a result of presenting to the local scrutiny committees. All had received the report very positively. All scrutiny committees will be visited again when the impact assessment is complete, which is dependent on a decision being made on the location of the hub.

10 Progress report

The Board received the progress report with thanks.

11 Any other business

Board members requested electronic copies of the papers tabled at the meeting.

Action: Electronic copies of tabled papers to be circulated with the minutes.

Helen sought absolute clarification that the Board was happy for work stream 3 to carry out the actions outlined in the progress report presented under item 6 of the agenda. The Board confirmed this.

Elizabeth Williams noted the December date for the Project Board has now been set for the 14th December, 2 – 4pm.

12 Future meetings

Wednesday 7th October, 2 – 4pm, the Elim Church

Tuesday 10th November, 12 – 2pm, the Elim Church

Monday 14th December, 2 – 4pm, the Vassall Centre