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Notice of Meeting

Healthier Select Committee

Thursday, 20th January, 2011 at 6.30 pm

in Committee Room 2 Council Offices
Market Street Newbury

Date of despatch of Agenda: Wednesday, 12 January 2011

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Jo Naylor on (01635) 503019
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Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

West Berkshire COUNCIL

To:	Councillors Geoff Findlay (Chairman), Paul Hewer, Tony Linden, Gwen Mason, Andrew Rowles and Julian Swift-Hook (Vice-Chairman)
Substitutes:	Councillors George Chandler, Billy Drummond, Adrian Edwards and Alan Macro
Officers and other Invitees:	Teresa Bell (Corporate Director, WBC Community Services), Beverley Searle (Director of Partnerships & Joint Commissioning, NHS Berkshire West), Jeremy Speed (Public Health Locality Lead, NHS Berkshire West), Jan Evans (Head of Older People's Services, WBC) and Jo Naylor (Principal Policy Officer).

Agenda

Part I

Page No.

1. **Apologies**
   To receive apologies for inability to attend the meeting (if any).

2. **Minutes** 1 - 6
   To approve as a correct record the Minutes of the meeting of this Committee held on 12th October 2010.

3. **Declarations of Interest**
   To receive any Declarations of Interest from Members.

4. **Changes to the NHS Policy Landscape** 7 - 20
   Purpose: To update Members of the scale of the policy change within the NHS arising from the White Paper: "Equity and excellence: liberating the NHS".

   Beverley Searle (Director of Partnerships and Joint Commissioning, NHS Berkshire West) will provide a brief overview of the key changes supported by Barbara Barrie (GP Partner and Joint Chair, Newbury and District GP Commissioning Group).

5. **Item 5a - Appendix A - Health Performance Indicators** 21 - 28
   Purpose: To review performance against the health performance indicators for West Berkshire and to be informed of the new revised targets for 2011. Jeremy Speed (Public Health Locality Lead, NHS Berkshire West) will present this item.

6. **Update from the Royal Berkshire Hospital on Maternity Services and 'Choose and Book'** 29 - 34

   Purpose: To receive a short briefing paper provided by the Royal Berkshire Hospital Foundation Trust setting out the most recent update in relation to maternity services and the 'Choose and Book' online booking of consultant appointments.

7. **Work Programme** 35 - 38

   Purpose: To monitor the completed and remaining work programme items for the Healthier Select Committee.

Part II

8. **Exclusion of Press and Public**

   RECOMMENDATION: That members of the press and public be excluded from the meeting during consideration of the following items as it is likely that there would be disclosure of exempt information of the description contained in the paragraphs of Schedule 12A of the Local Government Act 1972 specified in brackets in the heading of each item.

9. **Community Services Update** 39 - 48

   (Paragraph 3 – information relating to financial/business affairs of particular person)

   Purpose: To receive an update from Teresa Bell (Corporate Director, West Berkshire Community Services) on the current demand for care services.

Andy Day
Head of Policy and Communication

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HEALTHIER SELECT COMMITTEE

MINUTES OF THE MEETING HELD ON TUESDAY 12th OCTOBER 2010

Councillors: Geoff Findlay *(Chairman)* (AP), Paul Hewer (P), Gwen Mason (P), Tony Linden (P), Andrew Rowles (AP) and Julian Swift-Hook *(Vice-Chairman)* (P).

Substitutes: George Chandler (P), Billy Drummond, Adrian Edwards, Alan Macro

Also present: Julia Waldman (WBC Service Manager) and April Peberdy (Head of Partnerships – West Berkshire, NHS Berkshire West) and Jo Naylor (WBC Principal Policy Officer).

PART I

(Councillor Julian Swift-Hook in the Chair)

17. APOLOGIES.

Apologies for inability to attend the meeting were received on behalf of Councillors Geoff Findlay and Andrew Rowles. Councillor George Chandler substituted for Councillor Rowles. In Councillor Findlay's absence, Councillor Julian Swift-Hook chaired the meeting.

18. MINUTES.

The Minutes of the meeting held on 6th July and 9th September 2010 were approved as a true and correct record and signed by the Chairman.

19. DECLARATIONS OF INTEREST.

Councillor Julian Swift-Hook declared an interest in relation to all items on the Agenda that related to West Berkshire Mencap, as he was the Chairman of this organisation. He reported that the interest was personal and non prejudicial, he determined to remain to take part in the debate and vote on the matters.

20. URGENT ITEMS.

Councillor Julian Swift-Hook requested that Members consider a proposal to look at delayed discharges from the Royal Berkshire NHS Foundation Hospital and the West Berkshire Community Hospital as an urgent item at the next meeting.

Members of the Select Committee were supplied with the background on this issue including a copy of Councillor Swift-Hook's question to Council on 23rd September and the detailed response provided by Councillor Joe Mooney (Porfolio Holder for Adult Social Care) which clarified the numbers and extent of delayed discharges.

Members relayed concerns about fines that were being reported in other neighbouring local authority areas and considered this an important item.

RESOLVED that:

(1). The issue of delayed hospital discharges affecting residents within West Berkshire be considered as a priority for this Select Committee at the next meeting.

21. SCRUTINY OF DEPRIVATION AND FAMILY POVERTY IN WEST BERKSHIRE.

Mrs Julia Waldman (WBC, Service Manager) introduced Item 5 (Agenda Item 5) and gave an overview of the work underway to tackle deprivation and family poverty in West Berkshire. She described specifically the statutory duty placed on the local authority in relation the Child Poverty Act and how a Needs Assessment had to be completed by March 2011.

The focus for the current work on family poverty only addressed families with children under 19 years of age and not the entire population. Work was being undertaken by the Prevention and Early Intervention sub-group of the West Berkshire Children's Trust. Mrs Waldman described the Government's stance of allowing local authorities the flexibility to develop appropriate strategies according to their own local needs.

Mrs Waldman described the requirement for a robust Needs Assessment Tool that would highlight what poverty actually meant and welcomed the toolkit supplied by the Improvement and Development Agency (IDeA). She explained the complex process of using a wide range of data; e.g. Joint Strategic Needs Assessment (JSNA), Sustainable Community Strategy (SCS) and local data, etc. She explained that Lambourn and Greenham were both identified as 'place based' areas of deprivation within the District. She described how both 'place based' and 'people based' research methods would need to be used to identify families at risk.

Members asked about whether the Family Poverty Strategy should also consider the needs of the elderly living in poverty. Mrs Waldman explained the specific remit of the existing work was with families with children under 19 years of age. Mrs Peberdy described how data sampling methods could be revised to collect this type of information from local General Practitioners (GPs).

Members enquired as to the role of the Select Committee assisting in this agenda. Mrs Waldman replied that it would be helpful for the Select Committee to comment upon the Needs Assessment Tool once this had been developed.

A question was asked about the extent to which health issues caused family poverty or whether health related complaints were more a consequence of poverty? It was explained how substance misuse issues, mental health or physical disabilities were all often associated with a decline into poverty.

Members enquired about the differences between family poverty in rural areas and more urban areas. It was explained that typically in rural areas, the major risk factors for poverty included lack of transport, lack of employment opportunities, lack of training for jobs, affordable housing availability and accessibility of West Berkshire Council services. In the urban areas, it was more likely that the factors were those associated with disadvantaged communities such as crime, being a victim of crime, antisocial behaviour, etc.

Members discussed the large divide between those living in poverty and the general affluence of the rest of the District. It was also mentioned how even in some urban housing estates there could be a large degree of isolation and detachment from basic shops and services.

Members also discussed poverty in rural Lambourn and the low wages that were often associated with jobs in the racing community. Equally an attainment gap

existed within West Berkshire, with deprivation linked to poorer outcomes in academic achievement.

It was suggested that the Family Poverty Strategy must include intelligence from Ward Councillors to receive their perspective on the issues in their communities.

Equally some Members enquired whether Greenham Common Trust grants might be available for the most deprived families to ensure children that attend school had the necessary Physical Education (PE) kit to undertake sports activities at school.

Members felt that the approach and Family Poverty Strategy should come back to the Select Committee for further consideration.

RESOLVED that a progress report be received in the new year on the Needs Assessment Tool and work underway to develop a Family Poverty Strategy for the District.

22. CARE FOR THE FUTURE: A DEVELOPING VISION OF HEALTHCARE FOR BERKSHIRE AND BUCKINGHAMSHIRE.

April Peberdy (Head of Partnerships for West Berkshire, NHS Berkshire West) attended as a substitute for Beverley Searle (Director of Partnerships and Joint Commissioning) she described that "Care for the Future" was a transformational programme to reform service and enable the NHS to keep up with the increased demand on health services, whilst still improving quality and driving down costs.

The changes included transferring hospital care to the community setting wherever possible and she explained that comments were being sought by 31st October 2010. Mrs Peberdy explained how generally patients preferred receiving care closer to home as this prevented the need to journey to acute hospitals.

Mrs Peberdy described that Specialist Services would be delivered in particular hospitals as centres of excellence. She described that patient choice was a significant consideration as well as educational measures to allow patients the ability to manage their own conditions better. This was particularly important for those with Chronic Obstructive Pulmonary Disease (COPD) in order to prevent frequent hospital admissions.

Members asked about the "Choose and Book" policy of the NHS and how this might influence services in relation to "Care for the Future".

Members welcomed the introduction of the Community Matron role but enquired about the timescales, the need for training of staff and the risk to patients unless all agencies involved in health and social care were working efficiently together and provided a seamless service. It was noted that the system sometimes fails the patient and that the changes presented a particular challenge to achieve joint working by 2012.

Mrs Peberdy described the work underway mapping patient pathways in order to improve the patient experience and clarify all the constituent parts of the healthcare system that had to identified and work properly together.

Members asked whether there would be greater investment within community services, including small General Practitioner (GP) surgeries in the rural areas. It was described how preventing acute hospital admissions should save a significant sum of money as costs of acute hospital beds were in the region of £2-3k per patient per week. It was further explained that GPs in the future would have a far

greater service commissioning role and would receive money to support this service delivery.

Treatment at local GP surgeries was also seen as advantageous in terms of preventing the need to travel and causing less stress for the patient.

Members described certain hospital centres which were already acknowledged for their specialist services; including Royal Berkshire Foundation Trust for cardiology services and the John Radcliffe in Oxford for burns, neurology and cancer care.

Members discussed the need for large enough GP surgeries to be available to undertake additional treatment procedures. A concern was raised that delays might occur as a consequence of the planning process.

Mrs Peberdy explained that although the overall funding to the NHS was increasing this was not keeping up with the increase in demand for services.

Members raised a point about how the new GP commissioning arrangements might work and if former NHS Berkshire West employees would be employed to undertake the commissioning functions. Mrs Peberdy explained it was not clear how the new structures would work, as yet, but that within a set allocation of money it was still possible to drive up performance.

Members were concerned about the natural linkages with Buckinghamshire area as they argued there were quite different urban and rural areas within this geographical boundary.

A point was also made in relation to previous mergers with Buckinghamshire for example when South Central Ambulance Trust formed. This resulted in an overall drop in performance than when Berkshire was a separate Ambulance Trust. Concerns were raised as to the potential risk of the same negative impact on performance occurring.

The fact that NHS patients occasionally received treatment at non-NHS Trusts within the area was also made.

It was requested that in the New Year a progress report to keep abreast of the key milestones be brought to the Committee.

RESOLVED that:

(1). The "Care for the Future" debate at this meeting becomes the basis of the Healthier Select Committee's submission to the NHS Berkshire West.

(2). An update be provided in the new year on the progress of the "Care for the Future" proposals.

23. WORK PROGRAMME.

The Vice-Chairman introduced the Work Programme (Agenda Item 7) which outlined the existing work items agreed for the Municipal Year.

It was recommended that the item on Local Area Agreement targets be renamed but some progress against existing health related performance indicators was still required.

Members felt further scrutiny of maternity services was needed to determine if the number of births was putting pressure on the maternity unit at the Royal Berkshire NHS Foundation Hospital. A written report was requested for the next meeting.

Members felt that the issue of adult social care was still important. Some felt this was broader than just exploring criteria for eligibility but understanding the preventative nature of services and the impact of the Putting People First Transformation Programme. It was agreed that Mrs Jan Evans (Head of Adult Social Care) be invited to attend the next meeting to update on the current position.

Members were aware that some patients were experiencing technical problems with booking system of consultant appointments at the Royal Berkshire NHS Foundation Hospital Trust. It was requested than an investigation occurred to determine if the problem still existed and depending on the outcome, this might become an item for the next agenda.

RESOLVED that:

(1). Delayed hospital discharges of patients from West Berkshire be explored as an urgent item at the next meeting.

(2). West Berkshire health performance indicator information be received at the next meeting.

(3). An update be provided at the next meeting as to the current position in relation to Adult Social Care in West Berkshire, including access to care, prevention and the impact of the National Care Review findings.

(4). The Royal Berkshire NHS Foundation Hospital (RBH) be asked to confirm data on the current number of deliveries at the maternity unit and describe if the maternity unit is suitable for meeting the current and future demands.

(5). Investigations be made to determine whether reported problems with the electronic booking system for consultant appointments at the Royal Berkshire NHS Foundation Hospital (RBH) had now been resolved.

(The meeting commenced at 6.35pm and closed at 8.06pm)

CHAIRMAN ……

Date of Signature: ……

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Title of Report:	**The changing NHS policy landscape**	**Item 4**
Report to be considered by:	Healthier Select Committee	
Date of Meeting:	20 January 2011	

Purpose of Report: **To brief Members on the significant policy changes that will shape future health and social care delivery.**

Recommended Action: **To note the briefing and consider what future action might be required.**

Healthier Select Committee Chairman	
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Supporting Information

1. Introduction

1.1 Significant change is taking place within the NHS and social care services following the white paper "Equity and excellence: liberating the NHS" which was published during 2010.

1.2 The paper attached at Appendix A outlines the most significant changes and how these will shape the future of health and social care services. This paper will be presented by Beverley Searle (Director for Partnerships and Joint Commissioning, NHS Berkshire West).

1.3 The proposals for change include changing powers and responsibilities for GPs and therefore the GP Commissioning Lead for this area – Barbara Barrie (GP Partner, Thatcham Medical Practice) has also been invited to this meeting to help explain the changes.

1.3 Two fact sheets (Appendix B and C) are also attached to assist Members in their understanding of the new developments.

2. Recommendation

2.1 To note the briefing and consider what future action may be required.

Appendices

Appendix A – NHS Policy Landscape briefing
Appendix B – Factsheet: Local Democratic Legitimacy
Appendix C – Factsheet: Commissioning for Patients

Policy Landscape briefing info for Healthier Select Committee
January 2011

Introduction

This paper provides a brief overview of the policy changes impacting on the NHS currently. The first section is taken from the Department of Health website, followed by a brief description of local implications and sources of further detail. Two factsheets are attached to provide further detail about Health and Wellbeing Boards and GP Commissioning in particular.

1.0. Quick guide to health and care reform. (From Department of Health Website)

Why is it happening?

Much of the health and social care system is excellent but England falls behind many of its European neighbours on a number of key health measures, such as cancer survival rates. Out health and care system needs to deliver an improved service with better results for patients:

- there needs to be more focus on improving quality, as poor quality care costs more money – if hospital acquired infections are not tackled, or if there are no steps to prevent falls among older people, it can cost the NHS billions of pounds every year
- services need to be joined up more effectively – patients who need support from both health and care professionals too often find their needs aren't met, because health and social care professionals don't work together locally
- about half of all deaths in this country are preventable, so more needs to be done to encourage people to look after their own health by eating well and exercising more
- health costs are rising because of an ageing population and advances in medical technology so steps need to be taken now to cut waste and improve performance.

What does it mean for the patient?

'No decision about me without me' will be the principle behind the way in which patients are treated – patients will be able to make decisions with their GP about the type of treatment that is best for them. Patients will also have more control and choice over where they are treated and who they are treated by. They will be able to choose their:

GP
consultant
treatment
hospital or other local health service.

Patients will be able to get the information they need, such as how well a hospital carries out a particular treatment, to help them decide on the best type of care. If patients are unhappy with their local hospital, or other local services, they will be able to choose another one to treat them. Patients will be able to rate hospitals and clinics according to the quality of care they receive, and hospitals will be required to be open about mistakes and always tell patients if something has gone wrong. Patients will

have a strong collective voice through a national body, HealthWatch, and in their communities through arrangements led by local authorities.

What does it mean for the public?

The public will be able to have more influence over what kind of health services should be available locally. They will also have greater opportunities for holding to account local services that are not performing well. They will be able to get more information about how their local health services are performing, such as how well their local hospital carries out a particular operation or treatment. There will be more focus on preventing people from getting ill – the Public Health Service will pull together services locally to encourage people to keep fit and eat more healthily.

What does it mean for GPs and other primary care clinicians?

GPs will be responsible for designing local services for patients – they will decide, for example, what services are needed for patients with asthma or diabetes or how pre- and post-operative care can be best organised. Working with other local clinicians, GPs will take over from managers in Primary Care Trusts as the people who buy health services for patients. GPs will also be more directly accountable to patients, who will be able to choose any GP practice they like, regardless of where they live.

What does it mean for hospitals and other health service providers?

Providers of hospitals and other services will have greater freedom and fewer centrally set targets. They will be paid according to their performance and payment will reflect results – this will provide an incentive for greater quality. If they provide a good service that is popular with patients, they'll be able to grow and expand. Providers will also be able to make more money from different sources of revenue and reinvest it into NHS services.

What does it mean for local authorities?

Councils will have a much greater leadership role in local health services – they will be responsible for local health care priorities, joining up health and care services and ensuring they meet the needs of their local communities. They will work with GPs and others to define what local health priorities should be – whether that's reducing smoking rates, improving stroke care or maternity services. They will also have a much more clearly defined role in leading the development of public health services in their area.

How will the new health and care system be run?

Local authorities will be responsible for local health care priorities, while central government will have much less control over health services.

The NHS will be measured by how successfully it treats patients – for example, whether it improves cancer survival rates, enables more people to live independently after having a stroke or reduces hospital acquired infection rates. An independent and accountable NHS Commissioning Board will be established to:

lead on the achievement of health results

allocate and account for NHS resources
lead on improvements in quality
promote patient involvement and choice.

The Board will also have a duty to promote equality and tackle inequalities in access to healthcare. Monitor will become an economic regulator to promote effective and efficient providers of health and care, encourage competition, regulate prices and safeguard the continuity of services. The role of the Care Quality Commission will be strengthened as an effective quality inspectorate covering both health and social care. HealthWatch will represent the views of patients, carers and local communities.

2.0. Health and Social Care Bill

The Bill is anticipated in January 2011, and will provide further detail regarding the current statutory functions of PCTs – some of these will be stopped altogether, with others being transferred to either the NHS Commissioning Board, GP Commissioning Consortia or Local Authorities.

3.0. Policy Changes - Local Implications

3.1. GP Commissioning

There are currently 4 GP Commissioning Consortia in the area served by Berkshire West Primary Care Trust: 2 in the Reading Borough Council area (with some overlap into the West Berkshire Council area) 1 in West Berks and 1 in Wokingham. GP Commissioning leads already work in a collaborative way, with work streams and projects in place across the whole area, while maintaining a strong focus on their own locality.
Discussions are currently underway about the nature of the commissioning support arrangements required by the consortia.

3.2. Public Health

Responsibility for Public Health will be transferring from PCTs to Local Authorities, with Directors of Public Health being joint appointments between Local Authorities and “Public Health England” a new body to be established in shadow form in 2011. A ring fenced budget will transfer in 2013, following shadow arrangements in the previous year.
Discussions are in progress between Berkshire Unitary Authorities, the Regional Director of Public Health and the 2 Directors of Public Health for Berkshire West and East PCTs about locally appropriate arrangements.

3.3. Health and Wellbeing Boards

These will be established by 2013 to achieve effective strategic commissioning across NHS, Social Care, and related children’s and public health services. Discussions are underway about the most appropriate approach locally – in order to achieve an effective balance between locally focussed activities within a single Council area, with local accountability and governance, as well as a strategic approach across the Berkshire West area. In order to achieve an effective functioning system, there is a requirement to establish shadow arrangements at the earliest opportunity.
Health and Wellbeing Boards will be required to develop a joint health and wellbeing strategy that spans the NHS, social care, public health and potentially other wider health determinants such as housing.

3.4. HealthWatch

The NHS White Paper proposed that HealthWatch becomes the national champion for health and social care consumers. At a national level, it is expected that HealthWatch England would aim to be a strong, independent body that can represent the views of patients and communities as the independent consumer arm of the Care Quality Commission (CQC).
To strengthen the voice of communities, it is proposed that Local Involvement Networks (LINks) would evolve to become local HealthWatch organisations.Local organisations would be able to feed information into HealthWatch England, as well as local Health Scrutiny and the Health and Wellbeing Board
Local arrangements are yet to be confirmed, but it is expected that the Local Authorities will take a lead in this, in partnership with existing groups.

3.5. PCT Clusters

In order to maintain the capacity required to enact the continuing statutory duties of PCTs prior to their closure in 2013, while at the same time, supporting the development of effective GP Commissioning consortia, PCTs will form into clusters by June 2011.
Locally, Berkshire East and Berkshire West will form a cluster, with Milton Keynes, Oxfordshire and Buckinghamshire forming another, and Southampton, Hampshire, Isle of Wight and Portsmouth the final cluster in the South Central Strategic Health Authority area.

4.0. Papers for Further Details of Policy Changes

The following documents are all available from the Department of Health website.

Liberating the NHS:
Legislative Framework and Next Steps.
Published 14.12.10

Healthy Lives, Healthy People: Our strategy for public health in England.
Published 30.11.10

Healthy Lives, Healthy People:
Consultation on the funding and commissioning routes for public health.
Published 21.12.10 (responses required by 31st March 2011)

The Operating Framework for the NHS in England 2011/12.
Published 15.12.10

Achieving equity and excellence for children:
How liberating the NHS will help us meet the needs of children and young people.
Published 16.09.10

The NHS Outcomes Framework 2011/12.
Published 20.12.10

Bev Searle, Director of Partnerships and Joint Commissioning. NHS Berkshire West.

LOCAL DEMOCRATIC LEGITIMACY: FACTSHEET
Gateway reference: 15320

1. Introduction

The NHS and Public Health white papers together provide local authorities with an enhanced role in supporting the delivery of health and social care services.

Local authorities will take on the major responsibility of improving the health and life-chances of the local populations they serve, and will lead others to work together to improve health and wellbeing.

Local authorities will lead on public health, using a new ring-fenced budget and health premium, which will reward areas who make the most progress. Directors of Public Health will move from the NHS to local authorities.

2. Mutually respecting partners

Better health and wellbeing will only come from the NHS and local authorities working together, with high quality local leadership and relationships being an essential foundation for achieving better health and wellbeing outcomes.

3. Statutory health and wellbeing boards

There is a need to improve the strategic coordination of commissioning services across NHS, social care, related childrens and public health services. To support this, the Health and Social Care Bill will require the establishment of a health and wellbeing board in every upper tier local authority by April 2013.

Health and wellbeing boards will bring together elected representative and the key NHS, public health, social leaders and patient representatives to work in partnership. This will ensure services are joined up around the needs of people using them, and that resources are invested in the best way to improve outcomes for local communities.

4. Flexible geographical scope

The Health and Social Care Bill will give flexibility for health and wellbeing boards to choose to do their work at whatever level “makes sense locally”. This means they might choose to work together to set up a board covering more than one local authority area, or to carry out some of their work more locally, focussing on the needs of a specific district or neighbourhood.

5. Core membership

To achieve the most effective integration and joint action, core members of the board must include GP consortia, the director of adult social services, the director of children’s services, the director of public health and a representative from local HealthWatch. To increase local democratic legitimacy and to represent the interests of the public the Bill prescribes there must be a minimum of at least one local elected representative.

Local authorities can decide to invite and include other members, for example other groups or stakeholders who can bring in particular skills or perspectives, such as the voluntary sector, clinicians or providers.

By making the boards statutory and specifying a core membership health and wellbeing boards provide the forum for public accountability.

The role of the boards will be to improve joint working and commissioning and increase local democratic engagement with the commissioning of services, alongside patient engagement through local HealthWatch.

6. Enhanced joint strategic needs assessment

The core purpose of health and wellbeing boards is to join-up commissioning across NHS, social care, public health, children's services and other services that the board agrees have an impact on the wider determinants of health – for example leisure or housing.

The aim is to achieve better health and wellbeing outcomes for their whole population and a better quality of care for patients and other people using services.

Through new health and wellbeing boards, local government will lead in bringing together the NHS, social care, public health and children's services to understand local needs through a joint strategic needs assessment (JSNA) and to create a joint health and wellbeing strategy (JHWS) to address them. Local authorities and GP consortia will have an equal responsibility to develop the strategy.

The Bill will place a legal obligation on NHS and local authority commissioners to refer to the JSNA in exercising their commissioning functions.

7. The new joint health and wellbeing strategy

The ambition is for health and wellbeing boards to go further than analysis of common problems to deep and productive partnerships that develop solutions to challenges (rather than just commentating on them).

To support this ambition the Bill specifies boards should develop a joint health and wellbeing strategy that spans the NHS, social care, public health and potentially other wider health determinants such as housing. Through the strategy, the council, NHS and other partners will agree, at a high level, how they will address the health and wellbeing needs of their community, giving the overarching framework for developing plans for the NHS, social care, public health and other relevant services.

The Bill will place a legal obligation on NHS and local authority commissioners to have regard to the JHWS in exercising their commissioning functions.

This new way of working is not about one partner on the health and wellbeing board having the power to overrule others' decisions – it's about fundamentally changing the dynamic to one of collaborative leadership. The work of the health and wellbeing boards is about influencing, shaping and driving services.

8. Increased joint commissioning and pooled budgets

Health and wellbeing boards will be able to look at the totality of resources available to support local people's health and wellbeing, across the budgets the NHS, council and other partners hold. The Health and Social Care Bill and health and wellbeing boards are intended to encourage local authorities and their NHS partners to make more use of the flexibilities already available to them – such as pooling budgets or having lead commissioning arrangements – when drawing up the joint health and wellbeing strategy.

Health and wellbeing boards will be expected to consider how the mechanisms for integration already included in the NHS Act, such as pooled budgets or lead commissioning arrangements, could be used to provide more integrated commissioning across health and social care.

9. Health and wellbeing boards as an open-ended vehicle
Local authorities will have freedom to delegate additional functions to the health and wellbeing board. For example, housing or other wider determinants of health could be considered by the board, with the aim of providing better (and more integrated) services to communities

GP consortia will be able to develop voluntary arrangements with a local authority to deliver services on their behalf. For example, local authorities, with their commissioning expertise may be well placed to support GPs in developing new arrangements.

10. Referral and enhanced security
The Department of Health listened to feedback about the importance of having independent scrutiny functions and reconsidered its proposals. We are therefore persuaded that health and wellbeing boards will not have a health scrutiny function.

Rather than placing a duty on the health and wellbeing board, the Bill will place the powers for health overview and scrutiny with the local authority itself. Local authorities can then choose how to exercise these functions, whether through current Health Overview and Scrutiny Committees or alternative arrangements.

11. Implementation framework
Subject to Parliamentary approval, health and wellbeing boards will become a statuary committee of local authorities at the same time GP consortia taken on responsibility for the NHS budget.

Although boards will only formally assume powers and duties in April 2013, the new partnership arrangements are critical to developing the new system for health and care, and need to be hardwired into it from the start. That means developing them alongside other parts of the system like GP consortia, starting now.

Legislating for change is not the same as making it happen. The benefits for local communities cannot be achieved without developing the right local relationships and leadership.

Leaders in local authorities, emerging GP consortia and PCTs need to work together now to consider and establish the right local arrangements.

In the first phase, a network of early implementers – areas who want to start work on new arrangements now – will be supported by DH to share experience and expertise. The outputs of this work will be shared with other councils and GP consortia. We will be writing to all local authorities in January, inviting them to engage in this network.

The second phase of implementation will be the establishment of “shadow” health and wellbeing boards in every upper-tier authority by the end of 2011, with shadow running during 2011/12.

The final phase will be in April 2013 onwards, when statutory duties and powers will take full effect – this will be supported by enhanced scrutiny powers for local authorities

To be successful, it is important that all key partners in a local area take this work forward together, recognising that not everybody is starting from the same point, and that some GP consortia or councils will already be further on with their plans than each other. Partners will need to build learning and share skills together as they go, investing time, effort and commitment in building relationships.

Date issued: 16 December 2010

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COMMISSIONING FOR PATIENTS: FACT SHEET

Gateway reference: 15318

1. Introduction

The Government's ambition is for an NHS that puts patients first and continually improves the quality and outcomes of care for everyone. This improvement will come from devolving power to professionals, patients and carers.

By April 2013, there will be a comprehensive system of GP commissioning consortia, supported by and accountable to a new independent NHS Commissioning Board.

2. The principle of GP commissioning

Key decisions affecting patient care should be made by healthcare professionals in partnership with patients and the wider public, rather than by managerial organisations.

GP commissioning builds on the key role that GP practices already play in coordinating patient care and acting as advocates for patients. It gives groups of GP practices financial accountability for the consequences of their decisions.

3. Granting GP consortia statutory powers and duties

The purpose of consortia being statutory bodies is to ensure that they have a separate identity from that of their member practices.

Being a statutory body means that consortia can have clear powers and duties. This will not affect the status of GPs and GP practices as providers of primary care.

The legislative framework will be designed to make sure that consortia are able to focus on improving quality of care within the resources available to them.

4. Composition of GP consortia

All holders of primary medical contracts will have a duty to be a member of a consortium for each contract they hold, i.e. for each GP practice.

Individual GPs or GP practices will not have to take commissioning and financial decisions on their own. The majority of GPs will continue focusing on providing primary care.

Membership of consortia will be flexible, with consortia able to expand, contract, dissolve or merge.

The precise size of a consortium is less important than the ability to scale up or scale down depending on the nature of the activity being undertaken.

The NHS Commissioning Board will need to be satisfied that prospective consortia, when applying to be established, have made appropriate arrangements to ensure that they can discharge their functions.

5. Robust governance arrangements

Commissioning decisions will need to reflect the healthcare needs of the practice's registered patients together with the needs of unregistered patients for whom the consortium is responsible.

All consortia should have an Accountable Officer who need not be a GP or clinician. However, strong clinical leadership is a critical component of successful commissioning, and clinical experience will be essential in understanding how best to improve quality and outcomes.

The consortium's Accountable Officer will be responsible for ensuring that a consortium promotes continuous improvements in the quality of services it commissions, complies with its financial duties, and provides good value for money.

All consortia will be required to have a published constitution.

Consortia will be required to make remuneration arrangements and commissioning plans public, to hold an open annual general meeting, and to publish an annual report showing the results of patient and public consultations.

6. Partnership working and public involvement

There will be increasing focus given to partnership working and the importance of multi-professional involvement in commissioning.

The NHS Commissioning Board will hold consortia to account for financial performance and outcomes, but there will also be a stronger role for local authorities in helping shape commissioning priorities, and in promoting a joint approach to improving the health and wellbeing of local communities.

There is a commitment to greater patient and public involvement within emerging GP consortia. The Health and Social Care Bill will place a duty on GP consortia and the NHS Commissioning Board to ensure that people who may receive a service are involved in its planning and development. Local Healthwatch will strengthen the patient's voice, and the enhanced role of local authorities will increase the democratic legitimacy of NHS commissioning decisions.

7. The NHS Commissioning Board

The NHS Commissioning Board will be established in shadow form as a Special Health Authority in April 2011, and as a full non-departmental public body from April 2012.

The Board will be responsible for establishing GP consortia, and in doing so will ensure that there is a comprehensive system of consortia across England. The Board will hold consortia to account, but will only have the power to intervene where there is evidence that consortia are failing or are likely to fail to fulfil their functions.

The NHS Commissioning Board will have a vital role in providing national leadership for driving up the quality of care, including safety, effectiveness and patients' experience, and promoting choice and patient and public involvement.

The Board will need to be able to demonstrate good clinical evidence in support of its decisions, maintain effective relationships with professional bodies, and have strong internal professional leadership.

The Board will publish a business plan setting out how it intends to achieve its statutory duties, and the objectives or requirements that have been set for it by the Secretary of State. It will also publish an annual report setting out progress against both its duties and objectives and requirements.

8. Clear accountability

GP consortia will have a stronger focus on improving the quality and outcomes of care for patients. They will be under a statutory obligation to seek to reduce inequalities in access to healthcare.

The NHS Commissioning Board will draw on the national outcome goals in the Outcomes Framework to develop a Commissioning Outcomes Framework, to help hold consortia to account for promoting improvements in quality.

GP consortia will also be required to ensure that their expenditure does not exceed the commissioning budget allocated to them. There will be a clear line of financial accountability from consortia to the NHS Commissioning Board and in turn to the Secretary of State. The Board will have the powers to intervene where there is a significant risk of financial failure.

There is a need to ensure a fair approach to handling current deficits and surpluses. The expectation is that any debt will be fully resolved by the end of 2012/13. Further detail is included in the NHS Operating Framework for 2011/12.

9. Commissioning primary care

The NHS Commissioning Board will commission primary medical care services, but we are planning an explicit duty for all GP consortia to support the Board to improve the quality of these services.

The NHS Commissioning Board will be able to ask GP consortia to carry out some commissioning functions in relation to primary medical care on its behalf. This will mean that consortia have a core role in improving patient care across the system.

The NHS Commissioning Board will retain formal responsibility for ensuring that a practice is meeting its core contractual duties. The Care Quality Commission will be responsible for ensuring that GP practices are meeting standards of safety and quality.

10. Commissioning specialised and complex services

The NHS Commissioning Board will commission national and regional specialised services, drawing on engagement with GP consortia. The specialised services portfolio will be kept under regular review. There will be a criteria-based approach to deciding which services are 'specialised'.

The NHS Commissioning Board will have responsibility for health services for those in prison or custody, high security psychiatric services and the current PCT duties in relation to healthcare for the armed forces and their families.

GP consortia are likely to work collaboratively with each other on particular aspects of commissioning, such as commissioning low volume services. The NHS Commissioning Board will also be able to commission some services on behalf of consortia, where this is agreed by both parties.

Responsibility for commissioning maternity services will lie with GP consortia, but with a strong role for the Board in promoting quality improvement.

11. Autonomy for the NHS with national leadership

The functions of the NHS Commissioning Board will be defined in primary legislation, rather than being at the discretion of the Secretary of State through legal delegation.

Instead, the Secretary of State will set a mandate for the Board, which will include the totality of the Government's requirements and expectations for the NHS over a three year period, updated annually.

Each year the Secretary of State will be obliged to undertake a formal public consultation on the priorities within the mandate for the NHS Commissioning Board.

In the event of emergencies, it is vital for the Government to be able to act decisively. The Board will be under a duty to ensure NHS preparedness and resilience by assuring that clear arrangements are in place.

12. GP pathfinders and managing the transition to consortia

Consortia pathfinders will test out design concepts for GP commissioning and explore how emerging consortia will best be able to undertake their future functions.

Pathfinders and other emerging consortia will work closely with PCTs to deliver the QIPP agenda.

The NHS Commissioning Board will start to establish consortia from April 2012. Once established as statutory bodies, consortia will be able to take on staff from PCTs.

In the autumn of 2012, consortia will receive notification of the budgets for which they will be statutorily accountable in their own right from April 2013 onwards.

15. Conclusion

Our proposals for GP commissioning and the NHS Commissioning Board are intended to transform the quality of care and health outcomes for patients. Day-to-day decision making will be more sensitive and responsive to their needs and wishes.

A clear framework established and developed by the NHS Commissioning Board will promote quality, choice, patient and public involvement, and effective stewardship of public resources.

The plans are intended to unlock the benefits of GP-led commissioning, focussing on achieving a step-change in the quality of patient care, delivering better value for the taxpayer and improving the health of local communities.

Date issued: 16 December 2010

Title of Report:	**Health Performance Indicators**	**Item 5**
Report to be considered by:	Healthier Select Committee	
Date of Meeting:	20 January 2011	

Purpose of Report: **Monitoring of the current performance against health indicators for West Berkshire.**

Recommended Action: **To note the briefing and consider what remedial action, if any, is required.**

Healthier Select Committee Chairman	
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Supporting Information

1. Introduction

1.1 The Committee has previously monitored health performance indicators for the District. The latest performance data for West Berkshire is shown at Appendix A.

1.2 Jeremy Speed (Public Health Locality Lead, NHS Berkshire West) will attend the meeting to present this data and answer questions.

1.3 Many of the National indicators remain the same as the targets set under Local Area Agreement. This includes targets for addressing cardio-vascular disease, alcohol-related hospital admissions and childhood obesity.

2. Recommendation

2.1 To note the briefing and consider what remedial action, if any, is required.

Appendices

Appendix A – Presentation on health performance indicators for West Berkshire, January 2011.

West Berkshire Health Scrutiny Committee January 2011

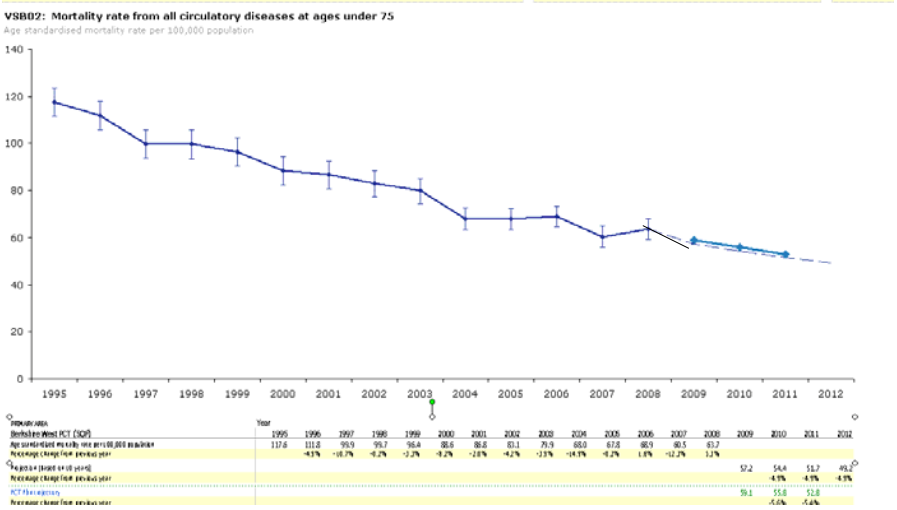
Jeremy Speed

Public Health Locality Lead –
West Berkshire

NHS
Berkshire West

National Indicator Monitoring

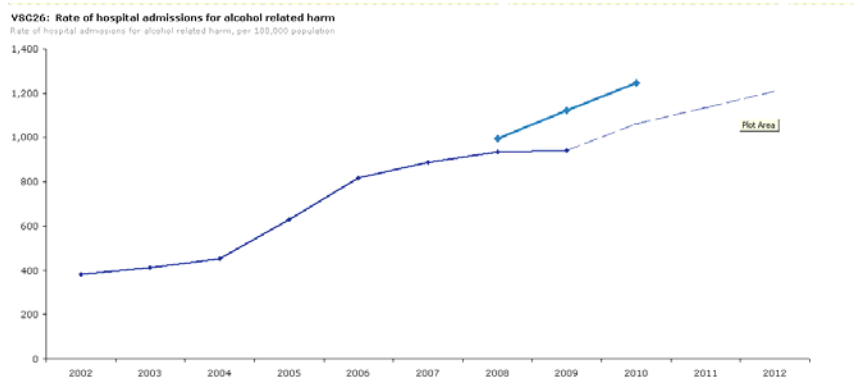
- NI 121 - Reduction in Mortality Rate from all Circulatory Diseases at ages under 75
- NI 39 - Reduction in the Rate of Alcohol Related Hospital Admissions
- NI 56 Reduction in Obesity Among Primary School Children in Year 6



54.8

Action Plan Milestone Measures

- Cardiac Rehabilitation
  - 2009/10 — 11,272 Attendances
- Activity For Health
  - 2009/10 Number of Referrals – 311
  - Q1 and Q2 2010/11 - 137
- Smoking Quitters
  - 2009/10 – 612 Four Week Quits
  - Q1 and Q2 2010/11 - 195 Four Week Quits
- RMW Quitters
- Test Purchasing
  - 2009/10 — 41 Tests

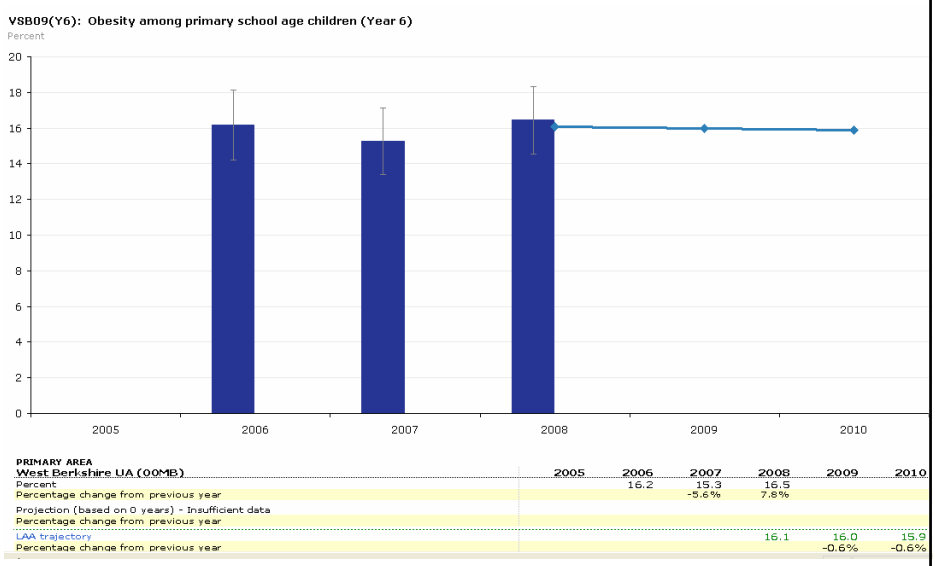


PRIMARY AREA West Berkshire UA (00HB)	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Rate of hospital admissions for alcohol related harm, per 100,000 population	383.0	411.1	452.4	630.8	816.6	889.0	933.7	940.7			
Percentage change from previous year		7.3%	10.0%	39.4%	29.5%	8.9%	5.0%	0.8%			
Projection (based on 5 years)									1,063.3	1,137.0	1,210.7
Percentage change from previous year										6.9%	6.5%
LAA trajectory							995.0	1,122.0	1,246.0		
Percentage change from previous year								12.8%	11.1%		

Action Plan Milestone Measures

- Alcohol Screens – 2009/10 2235
- 2010/11 Q's 1 and 2 3663

- Tier 2 Attendances – 2009/10 120
- 2010/11 Q's 1 and 2 98



PRIMARY AREA West Berkshire UA (00MB)	2005	2006	2007	2008	2009	2010
Percent		16.2	15.3	16.5		
Percentage change from previous year			-5.6%	7.8%		
Projection (based on 0 years) - Insufficient data						
Percentage change from previous year						
LAA trajectory				16.1	16.0	15.9
Percentage change from previous year					-0.6%	-0.6%

Action Plan Milestone Measures

- Activ8 Attendances
  - 2009/10 6160
- Family to Dinner Primary School Sessions
  - 2009/10 20
- Low Income Healthy Eating Sessions
  - 2009/10 9

Any Questions?

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Title of Report:	**Update from the Royal Berkshire Hospital on Maternity Services and 'Choose and Book'**	**Item 6**
Report to be considered by:	Healthier Select Committee	
Date of Meeting:	20 January 2011	

Purpose of Report: **To consider the update provided by the Royal Berkshire Hospital and consider what action, if any, is required.**

Recommended Action: **To note the update report and take a decision on future action.**

Healthier Select Committee Chairman	
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Supporting Information

1. Introduction

1.1 At the last meeting of the Select Committee Members asked for an update on two Work Programme items relating to the Royal Berkshire Hospital NHS Foundation Trust (RBH). These were the topics of maternity services and the 'Choose and Book' system of accessing consultant appointments.

2. Background

Maternity Services

2.1 The issue of maternity services was previously looked at by the Health Scrutiny Panel on 6th October 2008. Members received a detailed presentation from the Chief Medical Officer at that time.

2.2 Professor Rory Shaw described the year on year increase in babies being delivered comparing figures from 2002 to 2008. An extract of the minutes of this Health Scrutiny Panel (6th October 2008) can be found at Appendix A.

2.3 Members were told that once the threshold of 6,000 births per annum was reached this would mean enhancements to the existing unit were required to comply with the regulations (i.e. increased size of the unit, staffing levels, etc.)

2.4 Members are asked to consider the most recent update on the maternity services as provided by the RBH from Keith Eales, the Trust's Director of Corporate Affairs (see Appendix B).

'Choose and Book'

2.5 Members of the Committee had reported some concerns about the 'Choose and Book' system which is designed to allow patients to book appointments with consultants using online technology.

2.6 The RBH were asked to comment on whether these issues, and problems with booking, had now been resolved. Their response can also be found at Appendix B.

3. Recommendation

3.1 Members are asked, in light of this briefing (Appendix B), which items can be considered completed and should be removed from the Healthier Select Committee's work programme.

Appendices

Appendix A – Extract of the minutes of the Health Scrutiny Panel held on 6th October 2008.

Appendix B – Update on services at the Royal Berkshire Hospital – January 2010

Extract of the HEALTH SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON

6 OCTOBER 2008

14. STRATEGIC REVIEW OF MATERNITY AND NEONATAL SERVICES.

Professor Rory Shaw (Chief Medical Officer at the Royal Berkshire Hospital) described the growing Maternity Service required to serve a population of approximately half a million people (Agenda Item 4).

In 2007/08, 5,986 babies were born at the Unit. The number of deliveries per day has risen from 12 deliveries in 2001 to an average of 18 per day in 2008/09. He described the unpredictability of births on any given day and the difficult nature of preparing to meet the demand.

It was explained how the local authority may be able to help with population predictions as this would assist with the accurate modelling of the future service. It was reported that once 6,000 births per annum has been reached, regulatory requirements insist on a certain unit size with appropriate staffing levels, etc. It is therefore helpful to know population predictions before committing to large-scale expenditure on developing the Unit.

Neonatal intensive care activity is also increasing, up from 376 admissions in 2003 to 615 admissions in 2007/08 and the hospital is charting these trends.

Professor Rory Shaw explained how women in labour occasionally are diverted to another hospital in a local network if the RBH has reached capacity. This may be Swindon, North Hants, Wexham Park, Oxford, High Wycombe, etc. A reciprocal arrangement is in place with these hospitals should they be at capacity. It was explained that diversions of this sort occur relatively infrequently. The term “closure” is often used within the media adding to the negative connotations of the practice.

Jill Valentine (Head of Midwifery) explained how women are not always happy about the prospect of being diverted to another hospital but are accepting when they realise the benefit of a unit which is not at full-capacity and can offer better one-to-one care.

Those West Berkshire residents using the Royal Berkshire Hospital maternity services equates to approximately 2,000 births. Equally, many West Berkshire residents chose North Hants Hospital in Basingstoke to deliver.

Members scrutinised a range of issues including:

- The likely impact of 10,500 new homes in West Berkshire on the birth rate for the area.
- The self-contained nature of the Unit and the fact that anaesthetists and other health professionals are fully operational within the Unit and rarely have the capacity to be deployed elsewhere in the hospital.
- The need to guarantee the same type of service at another hospital when a woman in labour is diverted from the Royal Berkshire Hospital.
- Whether the increasing population would allow for a midwife-led Unit operating out of the West Berkshire Community Hospital.

- How out-of-area admissions are included within the increasing numbers seen at the neonatal service.
- The high temperature in the Rushey Ward delivery suite and opportunities for installing air-conditioning.

It was reported that the proposal to refurbish the Rushey Ward delivery suite included installing air-conditioning as part of the business case.

Bev Searle (Area Director NHS Berkshire West) described how the Public Health Information Manager may be able to assist the RBH in predicting demand, including new registrations for National Insurance numbers, etc.

RESOLVED that

(1) The Chief Medical Officer and members of the Royal Berkshire Hospital Maternity Service be thanked for their attendance at the Health Scrutiny Panel.

(2) The item on the Review of Maternity and Neonatal Services be noted.

Update from the Royal Berkshire Hospital NHS Foundation Trust on Maternity Services and 'Choose and Book' procedures.

Maternity:

The expected birth rate at the Trust for this year (2010/11) remains below 6,000 births. The rate has remained steady over the past two years.

The fluctuations in demand have been greater this year. During the period of September – November 2010 we experienced an unprecedented increase in demand which stretched capacity in the Trust. To ensure that they were offered the best possible care for their delivery, some mothers were diverted to nearby units during this period. The number of births during December has remained well within the expected range and we anticipate the same for the remainder of the financial year. There were no diversions during December.

The forecast for the birth rate in our area remains static. However, we have in place plans which will enable us to improve our existing service further.

During the coming financial year we will open a midwife led unit which will be located and staffed separately from the delivery unit. The four birthing rooms will double our midwife led capacity and offer an increased focus on natural births as well as creating additional capacity in our delivery suite. Following this development, we will create a high dependency unit which will co-locate mothers with the highest level of need with appropriate staffing.

These developments will offer a better experience for mothers using our services and will continue the pattern the Trust has established of only diverting patients to other services during exceptional circumstances.

We are therefore confident that the maternity service offered remains adequate for the expected birth rate both now and in the future, based on current predictions.

Choose and Book:

The Trust has seen a reduction in instances where a patient cannot book an appointment first time on Choose and Book due to capacity issues. This has reached a point where we now match the national best practice target.

An external team reviewing cancer pathways in the Trust praised the use of Choose and Book in the Breast Cancer pathway (which allows GPs to refer patients with suspected Breast Cancer issues via Choose and Book and reduce the turn around times in contacting patients and booking them for their appointment). This will be rolled out to all other cancer areas during 2011.

We have also broadened the range of appointments that are available through Choose and Book.

To ensure the best possible performance is delivered consistently we hold monthly meetings with our PCT and local GPs where any Choose and Book related issues are raised and addressed, along with performance monitoring.

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Title of Report:	**Healthier Select Committee Work Programme**	**Item 7**
Report to be considered by:	Healthier Select Committee	
Date of Meeting:	20 January 2011	

Purpose of Report: **To consider the completed work and the outstanding items on the work programme.**

Recommended Action: **To identify if any work remains to be carried forward.**

Healthier Select Committee Chairman	
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Supporting Information

1. Introduction

1.1 The current version of the work programme is attached at Appendix A for the Select Committee's information.

1.2 Members are asked to consider which items can now be considered concluded and removed. Future work requests will be received and considered by the Overview & Scrutiny Management Commission for inclusion as part of their ongoing work programme.

Appendices

Appendix A – Healthier Select Committee Work Programme

HEALTHIER SELECT COMMITTEE WORK PROGRAMME

Reference (a)	Subject/purpose (b)	Methodology (c)	Expected outcome (d)	Review Body (e)	Dates (f)	Lead Officer(s)/ Service Area (g)	Portfolio Holder(s) (h)	Comments (h)
OSMC/09/16	Local Area Agreement Targets (LAA) Monitoring of progress of Health and Wellbeing LAA targets.	In meeting review with information supplied by, and questioning of, lead officers.	Monitoring item	HSC	Start: 20/01/11 End:	Bev Searle - Director of Partnerships & Joint Commissioning - 0118 982 2760 NHS Berkshire West	Councillor Pamela Bale	Monitoring of LAA activity.
OSMC/09/17	Capacity of maternity services at the Royal Berkshire Foundation Hospital. Fact finding report to establish the current capacity to meet demand for services.	In meeting review with information supplied by, and questioning of, lead officers.	Monitoring item	HSC	Start: 20/01/11 End:	Chief Executive and Chairman of the Royal Berkshire Hospital. Royal Berkshire Hospital Foundation Trust	Councillor Joe Mooney	Investigation of the reported pressures on the maternity unit.
OSMC/	Delayed discharges from hospital To determine the causes of delayed discharges from hospitals affecting West Berkshire residents.	In meeting review with information supplied by, and questioning of, lead officers.	Investigate ways to improve the current system, and improve patient experience.	HSC	Start: Spring 2011 End:	Chief Executive of the Royal Berkshire NHS Trust and Bev Searle - NHS Berkshire West. Royal Berkshire NHS Trust & NHS Berkshire West	Councilor Joe Mooney	

HEALTHIER SELECT COMMITTEE WORK PROGRAMME

Reference (a)	Subject/purpose (b)	Methodology (c)	Expected outcome (d)	Review Body (e)	Dates (f)	Lead Officer(s)/ Service Area (g)	Portfolio Holder(s) (h)	Comments (h)
OSMC/09/12	Review of the Council's eligibility criteria for social care. To review the existing criteria for accessing social care in light of the findings of the National Care Enquiry.	In meeting review with information supplied by, and questioning of, lead officers.	Investigate how the national changes will influence access to local social care, and make recommendations.	HSC	Start: TBC End:	Jan Evans - 2736 Community Services	Councillor Joe Mooney	Review of how national changes may need to influence local criteria for accessing social care.
OSMC/10/85	Investigation of deprivation and child poverty in the ten most deprived wards in the District. To investigate what work is being done to tackle deprivation and how this can be applied to improve the quality of life across the District's most deprived wards.	In meeting review with information supplied by, and questioning of, lead officers.	Investigate ways to improve outcomes, and make recommendations to partner agencies.	HSC	Start: 12/10/10 End:	Julia Waldman Children & Young People	Councillor Gordon Lundie	
OSMC/10/86	Electronic booking system for consultant appointments at the Royal Berkshire Foundation Hospital To determine ways to rectify problems being experienced by patients using the electronic booking system.	In meeting review with information supplied by, and questioning of, lead officers.	Investigate ways to improve the current system, and improve patient experience.	HSC	Start: TBC End:	Chief Executive and Chairman of the Royal Berkshire Hospital. Royal Berkshire Hospital Foundation Trust	Councillor Joe Mooney	

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