Hackney

MINUTES OF A MEETING OF THE INNER NORTH EAST LONDON JOINT OVERVIEW AND SCRUTINY COMMITTEE FOR HEALTH

FRIDAY, 15TH JULY, 2011

Councillors Present: **Councillor Luke Akehurst in the Chair**

Councillor Denise Jones, Wendy Mead, Councillor Ann Munn, Councillor Benzion Papier, Councillor Lesley Pavitt, Councillor Rachael Saunders and Councillor Winston Vaughan

Apologies: **Councillor Ted Sparrowhawk**

Officers in Attendance:

Also in Attendance: **Sarah Barr (Senior Strategy, Policy and Performance Officer), Jeremy Gardner (Head of Communications), Caroline Gilmartin (Deputy Director of Primary Care and Adult Community Nursing), Neal Hounsell (Strategy and Performance Director), Michael McGhee (Director of Older People Services), Dr Lucy Moore (Integration Director), Gerald O'Mahony (Clinical Director and Lead Consultant Older People Services), Don Neame (Communications Director), Thomas Pharaoh (Senior Project Officer), Dr Steve Ryan (Medical Director), John Wilkins (Deputy Chief Executive and Director of Performance and Business Development) and 3 members of the public**

1 APPOINTMENT OF CHAIR AND VICE CHAIR

1.1 The appointment of the Chair and Vice Chair will be postponed for two reasons:

a) Some Members present were interim appointments and permanent Members will not be confirmed until the following month

b) Some members were confirmed just before this meeting so the Committee was requested to allow Members more time to consider and prepare their nomination for positions of Chair and Vice Chair.

1.2 In the absence of an appointed Chair it was agreed the hosting Borough (London Borough of Hackney) Chair of Health Scrutiny (Cllr Luke Akehurst) would chair the meeting.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBER

2.1 Apologies for absence from Councillors: Ted Sparrowhawk from London Borough of Newham and Denise Jones from London Borough of Tower Hamlets

3 DECLARATIONS OF INTEREST

3.1 Cllr Luke Akehurst from London Borough of Hackney declared he was a member of the Homerton Hospital NHS Foundation Trust.

4 LONDON CANCER SERVICES - IMPLEMENTATION

4.1 Presentation by Thomas Pharaoh from London Health Programmes about the London Cancer Implementation Programme.

4.1.1 The proposals for changing services were proposed by commissioning support services for London. In 2010 a review of cancer services was conducted which engaged 45 clinicians.

4.1.2 The case for change was published in December 2009, the model of care proposals were developed in August 2010 followed by a 3-month engagement process. It was reported over 85 per cent of survey respondents were supportive.

4.1.3 The three work areas were early diagnosis; common cancers and general care; rarer cancers and specialist care.

4.1.4 The compelling case for change was influenced by factors such as:

- Late diagnosis resulting in poor survival rates
- Variations in quality of care. (It was reported there are areas of excellence in London but inequalities in access and outcomes exist).

4.1.5 The vision is for treatment and care to be standardised, whereby Specialist surgery is centralised and common treatments localised where possible.

4.1.6 Seeing comprehensive pathways commissioned and organisational boundaries not a barrier. It was explained a patient can get lost in the system through organisation transition during their care.

4.1.7 The national patient experience survey revealed the patient's perception of the quality of cancer service care was worse than actual performance.

4.1.8 The key themes for the model of care are:

- Improve early diagnosis
- Providers to work together in a small number of integrated systems delivering standardised pathways

- Extended local provision of common cancer services to improve cancer rates across London.

4.1.9 In relation to early diagnosis this is an area where the UK performs poorly in comparison to Europe and the USA. It is suggested if the number of people through the door was improved survival rates would increase.

4.1.10 Working groups consisted of GPs, Public Health Consultants, Diagnostic Experts and patient representatives to identify the most effective evidence based interventions to improve early diagnosis.

4.1.11 LHP view the new proposed Health and Wellbeing boards as a vehicle to support this process locally, recognising local population issues whilst engaging with key players and promoting positive messages.

4.1.12 LHP advised they were working closely with the cancer community to develop a specification against which proposed systems could develop their plans. Hospitals were being asked to demonstrate how they could work together to improve patient experience and provide seamless cancer care. Proposals were submitted on 30th June 2011 demonstrating how they would address clinical outcomes and improve patient experience.

4.1.13 Organisations have been requested to develop service plans with a view for implementation around April 2012.

4.1.14 The proposed systems for London were:
- London Cancer (NE and NC London)
- 'The Crescent' (SE, SW, NW London).

4.1.15 It is anticipated LHP will be in a position to announce local implications autumn 2011.

4.1.16 The Committee was informed providers and commissioners will be required to work differently together and commission services in a more effective way. There will be a closer alignment between pathway descriptions, quality standards, outcome measures and the way that services are paid for and monitored.

(If you would like a copy of the presentation please contact the overview and scrutiny officer)

4.2 **Questions and Answers**

(i) **Wendy Mead referred to the aim of reducing late diagnosis and enquired how the new system proposed to achieve this objective?**

The Senior Project Officer from LHP advised the work would be around increasing public awareness and improving GPs diagnosis of cancer. In London they wanted providers to work together to improve access to diagnosis and to do outreach work to GPs to improve their knowledge and review the trends.

(ii) **Wendy Mead enquired if LHP had been out to Europe to see how their system for cancer diagnosis operated?**

The Senior Project Officer from LHP informed this research would be conducted by the national programme because the problem of late diagnosis was not unique to London and there are pockets of good practice in London that they needed to learn from.

(iii) **Cllr Munn enquired if information was available to identify what groups were not being diagnosed early.**

The Senior Project Officer from LHP explained the case for change document highlighted the evidence on this. However this varied according to things like the type of Cancer tumour, social demographic and many more so plans needed to be developed for each specific area to take into account local challenges.

(iv) **Cllr Pavitt referred to the issue not presenting early and commented this was a big challenge advising often patient had to keep going back to their GPs several times before they could get the correct diagnosis.**

The Senior Project Officer from LHP agreed there was a real need to raise the awareness of GPs and the public before the rate of late diagnosis could improve.

(v) **Cllr Vaughan asked for more details about the integrated cancer system and if was known what locations the systems would be in London**

The Senior Project Officer from LHP advised the specification document provided details of the system. In relation to the locations it was explained they were currently in receipt of the bids and had an assurance panel assessing the bid over the summer period. This assurance panel would approve the integrated cancer system bids. It was noted the system would involve the hospitals that currently operate services now but they would be commissioned to operate in a different way specifically for cancer services.

(vi) **Cllr Vaughan enquired if there would be standard policy related to drugs operated across the board.**

The Senior Project Officer from LHP advised taking into account outcome measures to be achieved the policy for drugs would be down to the individual trusts. It was explained a drug unit in London was set up and made recommendations to the trusts and would continue to do this work under the new system.

(vii) **Cllr Akehurst referred to the proposal to make changes to the chemotherapy services but not radiotherapy and queried if this was the correct changes to make.**

The Senior Project Officer from LHP informed delivery of chemotherapy services was covered by policy and governance to ensure it was conducted safely. Radiotherapy services were different and required not only specialist equipment but a specially adapted building too. The changes being proposed

for chemotherapy services were not only about location and how the service would be delivered. The proposal was to change to larger doses to reduce the number of trips required for treatment.

(viii) **Mr Vidal referred to the use of a patient panels when developing the current proposals and enquired if the same action would be taken when developing patient pathways to obtain an understanding of how it worked.**

The Senior Project Officer from LHP advised the providers were asked to inform how service user input would be incorporated.

(ix) **Cllr Vaughan expressed the importance of consultation with the voluntary sector and enquired if this during the consultation process LHP had consulted organisations such as the Local Involvement Networks (LINks) across the capital.**

The Senior Project Officer from LHP confirmed LINk organisations across the capital were visited and Health Overview and Scrutiny Committees. Once they have more detailed information they would return and update.

(x) **Mrs Rocke-Caton expressed concern about clinicians sometimes leaving the patient in a state of fear whilst testing was being conducted leaving a person to think they had cancer. Remarking this caused undue stress and anxiety for the patient believing they have it and then later finding out they did not.**

The Senior Project Officer from LHP acknowledged there were some instances were information was not conveyed in the correct manner. However an organisation has an obligation to give potential life threatening news in a sensitive way. This it was hoped would be addressed through raising awareness.

5 BARTS AND EAST LONDON HEALTHCARE MERGER PROJECT

5.1 Presentation by Dr Lucy Moore, Integration Director of the Barts and East London Healthcare Merger Project and Dr Steve Ryan, Medical Director of the Barts and the London Trust about the proposed merger of three acute trust in North East London. The main points of the presentation were:

5.1.1 The hospitals being proposed in this merger are:

- Newham and Whipps Cross general hospital:
  local hospitals providing A&E, urgent and community care, outpatients, maternity, women's and children's services and planned surgery
- Barts and The London NHS Trust (BLT) which currently operates three hospitals:
  The Royal London: providing all the services available at Newham and Whipps Cross plus a major trauma centre, an acute stroke centre providing immediate care for people who have suffered a stroke, and more specialist care/complex surgery for adults and children
  Barts: near St Paul's provides specialist cancer, urology and cardiac (heart) care as well as sexual health services and a minor injuries unit

In 2016 the heart attack unit at **The London Chest** in Bethnal Green will move to Barts.

5.1.2 It was noted there was a huge amount of expertise and knowledge to be shared among the trusts and segments of exemplar services. For example

- Newham trust have a nationally adopted End of Life care model
- Whipps Cross trust have low rates for MRSA amongst the lowest in the country and;
- Barts and the London trust have the country's most advanced major trauma centre.

5.1.3 One of the major contributing factors to the decision for the merger is to improve the life expectancy and tackle the challenging health needs of the population. North East London has some of the most deprived, unhealthiest communities and big health inequalities (17 years difference in life expectancy).

5.1.4 Another key factor is the challenging financial climate currently facing the NHS. Members were informed health care was getting more expensive and it was important for the NHS to find ways to make services more sustainable in the long term, whilst creating the ability to invest in services such as maternity due to increasing birth rates in East London.

5.1.5 It was highlighted all three trusts individually cannot achieve foundation trust status as required in the pending Health and Social Care Bill. All three trusts face would have significant difficulty in being able to meet the financial requirements of foundation trust status. This would leave them subject to the following options:

- To merge with another trust,
- Be taken over,
- Have their future decided by the Secretary of State for Health.

5.1.6 It was recognised that there are areas that need to be improved such as:

- Patient experience could be much better
- Some services are excellent but far too many needed to improve.

5.1.7 The nature of healthcare is changing. New understanding of best practice means we need to take a fresh look at our services e.g. ensuring senior doctors are on site for more hours of the day.

5.1.8 A solution to the challenges outlined was being sought and it was proposed to develop an organisation that will be:

- Based on preventing ill-health
- Provide locally accessible, excellent quality, sustainable and comprehensive health services that are focused on each individual's need
- Ensures better access to high-quality care when it is needed
- Working with partners
- Grow its own talent and create jobs to bring greater prosperity to East London.

5.1.9 At the heart of this vision is a number of key benefits but it is expected to provide:

- Continued access to high quality and sustainable local hospital services

- Equitable access to high quality specialist services.

5.1.10 The benefits of the merger as expected to achieve and bring:

- Raise all standards of work to the best across the three trusts
- Work together to resolve areas where none of the trusts are doing well, e.g. involving patients in decisions about their care and improving the patient experience
- Take advantage of new developments in healthcare and technology to:
  - Provide locally led services supported by better use of IT and link to specialists
  - Consolidating specialist services
  - Separating urgent and planned care
  - Ensuring senior doctors are on site for longer.
    (In England an individual's rate of survival reduces if admitted to hospital at the weekend. By sharing rotas a 24/7 service could be developed.
  - Pooling resources to make more impact on public health campaigns like the small c campaign
- Remove organisational barriers:
- Reduce costs
- Be more competitive when bidding for research funding.

5.1.11 Merging the trusts would mean better prospects and being a world leader to attract quality staff giving access to better staff training and development for:

- Doctors and Nurses to gain experience in different hospitals along the whole patient pathway
- Opening up opportunities for career progression
- Becoming world class would enable the trust to recruit some of the best Doctors and researchers in the world.
- Joining forces with other partners in an Academic Health Science Centre would mean that senior Doctors should be more likely to secure funds and work with colleagues that could pool their talents to develop new technology, techniques and treatments.

5.1.12 The merged trust would be in a better position to develop partnerships that benefit patients:

- Local community and education providers to increase the community wealth as it has been evidenced that people in employment live healthier, longer, more productive lives
- Health partners such as GPs, community nurses, health visitors, other local hospitals and mental health trusts so as to gain a better understanding of local health needs to plan and deliver an integrated service. The transfer of Tower Hamlets Community Health Services to Barts and The London will bring significant benefits to the community, which could be developed in other areas
- Local Councils to provide tailored services that reduce inequalities and better integrate with social care and healthcare in the community.

5.1.13 The key milestones dates advised were:

- Outline Business Case signed off NHS London - August 2011
- Full Business Case approval - Sept/Oct 2011
- Submission to NHS transaction board/Secretary of State: Nov/Dec 2011
- Merger April 2012

- Foundation trust application 2013
- Foundation trust authorisation March 2014.

5.1.14 The Members were informed that to create a new and different organisation structure did not require a formal consultation with the public because it was not a service change. The trust was required to formally consult staff and was in the process of doing this.

5.1.15 Members were informed the project team proposed to distribute copies of the manifesto to the patients and public (around 15,000 copies) would be sent to libraries, membership lists and community groups. Engagement about these proposals would involve posters in hospitals. Attendance at meetings. Presentation to LINks and to LINk Forum to collate comments and views.

(If you would like a copy of the presentation please contact the overview and scrutiny officer)

5.2 **Questions and Answers**

(i) Cllr Pavitt made the following comments and queries:

a) **Referenced the use of IT systems and asked if assurance could be given that this new system the NHS was investing in would work**
b) **Referred to the trust's population of 1 million and queried why only 15,000 consultation booklets were being produced if the intent was to consult the full population**
c) **Enquired if the Gateway Surgical Centre was in house?**

The Medical Director from BLT informed as the lead for IT in BLT he acknowledged IT systems did not work well at present and they recognise systems need to be improved. It was noted there is an IT work stream and the proposal is to have the same IT system in all three trusts.

In relation the comments about the number of documents produced for the consultation the comments were noted and taken back for review by the project team.

It was confirmed the Gateway Surgical Centre referred to in the presentation was operated by Newham trust.

(ii) Cllr Saunders made the following comments and queries:

a) **Is the merger driven by money or could more information be provided about the clinical drivers behind the proposals?**
b) **Raising clinical standards what does it mean?**
c) **Will the new trust find it easier to attract staff having the reputation of being a world leader?**

The Medical Director from BLT acknowledged this was a big challenge but by having the ability to partner with big brand organisation like Alder Hey Trust could help to resolve the workforce issues like the difficulties in filling junior Doctor posts.

It was confirmed the proposal to merge was not just about finance but would assist with improving healthcare pathways for the local population; especially since BLT had recently acquired the community health services business. With

improved IT system it could work better and working more closely with pharmacists and dentists etc in the community setting could improve efficiency.

(iii) **Cllr Munn made the following comments and queries:**

a) **Asked for clarity if the proposed merger involved service reconfiguration or not?**
b) **If it was not possible for the individual trusts to obtain foundation trust status on their own?**
c) **had the trust taken into consideration the cost implications for implementing a new IT system as this usually involved a big initial expense before savings would materialise.**

The Integration Director from the Merger Project Team confirmed the project was aware there would be initial cost implications of changing an IT system and would be reviewing it in more detail.

In relation to the trusts achieving foundation trust status independently it was noted following a review all three trusts as individual organisations could not achieve foundation trusts status. This was due to a combination of factors such as accumulated debt, cost of improvements, cost of PFI schemes etc. The benefit from this proposal is by coming together as one they are more confident they can achieve foundation trust status.

In relation to service changes she advised for example maternity service would remain on three sites but specialist services may be consolidated.

(iv) **Cllr Cameron queried about moving specialist services and the impact this would have on the community.**

The Medical Director from BLT advised for example specialist services such as chemotherapy would in the vision be moved out to other sites and the project informed as one trust they could move this service out to the other acute trust locations quicker. It was envisaged by 2012/13 once established the trust could look into providing chemotherapy treatment at home for patients.

(v) **Cllr Cameron enquired if there would be plans to move radiotherapy treatment out to locations nearer to the community too because currently patients had a long travel route in addition to treatment.**

The Medical Director from BLT explained due to the expensive specialist equipment and building needed for this service there were no plans to move the location for this type of treatment. Although the trust had listened to the view of patients and were considering how best to support their needs and this involved looking at increasing the dosage to reduce the number of treatments.

(vi) **Cllr Vaughan commented on a big challenge facing the Newham acute trust was the increasing birth rate. Highlighting the problem was recruitment and retention of midwives and enquired if the proposed trust had considered how this problem would be addressed.**

The Medical Director from BLT informed there was a maternity working group reviewing projected birth rate and model of care to consider what the system would be able to cope with. It was reported the trust had plans and hoped to

work with City University to access the education programme for specialisms like midwifery to improve recruitment.

(vii) **Cllr Vaughan commented this had been an issue for Newham since the Darzi review and suggested if the trust talked to their healthcare workers they could give them the resolution. Highlighting even though staff were recruited the key issue was retention.**

The Medical Director from BLT explained staff would be a focal point in the new organisation and their vision was to achieve the aim outlined in the presentation related to staff to resolve the workforce issues.

(viii) **Wendy Mead made the following comments and queries:**

a) Raise concern about the heart attack centre as the City of London was previously advised it would open 2014 but the presentation stated 2016

b) Raised concern about City residents having to travel to sites further away.

The Medical Director from BLT confirmed the date for opening the Heart Attack Centre in 2014 was correct. He assured the Committee outpatients' appointments would remain local and gave an example of a planned hip operation being carried out on another site and this would mean it would not be subject to postponement as is currently the case if an emergency operation needed to be preformed. It may be decided to keep emergency operation at the Royal London and planned at another site. This was viewed as a really good proposal which should lead to shorter length of stays and planned cases not being cancelled, but confirmed any proposed changes would need to be consulted on.

(ix) **Cllr Munn referred to slide 12 and asked for confirmation the merger related to management or services.**

(x) **Mr Vidal requested for the final version of the business case once completed to be sent to Joint North London LINks group.**

The Integration Director from the Merger Project Team informed the final version of the outline business case should be ready shortly and she would make sure a copy was sent to LINks. The project was due to produce their manifesto at the end of July and this would be the start of their engagement. In response to concern raised about finances it was acknowledge this concern was shared by all. It was expressed the trust did recognise the size of the challenge and the need to give assurance. The project team advised it had heard a lot about what works and what does not work with mergers. A lot of work was being done through clinical groups to learn from past mergers and involve the staff.

The Medical Director from BLT advised slide 12, information about specialist services, would require the trust to carry out its statutory duty to consult.

The Communications Director from the Merger Project Team explained the merger being discussed related to bringing all the trusts together as one organisation. However whilst doing this process they were flagging up areas

where they may return to consult for service change. For the initial change they do not have a legal duty to consult but wish to engage in dialogue with the Health Overview and Scrutiny Committees but acknowledged for service changes they would need to consult.

6 INNER NORTH EAST LONDON MENTAL HEALTH INPATIENT SERVICES

6.1 Presentation by Gerald O'Mahony, Clinical Director and Lead Consultant Older Peoples Services, from East London NHS Foundation Trust, Caroline Gilmartin, Associate Director (Performance, contracting and Procurement) and Jeremy Gardner, Head of Communications from NHS East London and the City. The main points of the presentation were:

6.1.1 Dementia is deemed as a terminal illness that will end your life. 2/3rd of inpatient cases related to dementia. The Commission noted individuals were presenting late thus requiring hospital stay.

6.1.2 In keeping with national guidance and principles the vision is to develop a range of early identification, assessment and support services. At present 70% of people with dementia live at home and the trust wants to bring services to the community.

- Invest in a broader range of community services and offer intensive home-based support as an alternative to hospital/institutional care admission
- Offer choice in treatment and care options to users and carers
- Embed a re-enablement approach to treatment and care throughout the service.

6.1.3 A review of the bed base spend revealed a disproportionate amount of spend across the three locations.

6.1.4 This led to two options under consideration:

- The first was to stay as it is.
- The second was to re-configure dementia assessment wards to enable more investment and flexible services that would be person centred and in the community. Under the reconfiguration proposals the trust would change from operating three small units in three different boroughs to one large unit in a central location accessible by all the local authorities.

6.1.5 Out of scope of these proposals will be other adult in-patient and residential services, including continuing care wards and respite care these will continue to be borough based for each local authority.

6.1.6 It's proposed the reconfiguration of the centralised unit will enable pooling of skills which will develop the service.

6.1.7 Previously older people mental health services were not a priority and service performance became poor. A national strategy and refocus over the last two years resulted in investment in dementia services in East London.

6.1.8 It was explained how demand for the service had changed in Hackney from approximately 40 case referrals per year to 10 a week. The new Memory clinic in Newham alone was seeing approximately 500 referrals a year.

6.1.9 There has been investment over the past two years in dementia services for City and Hackney, Newham and Tower Hamlets.

6.1.10 Among the clinical benefits noted in the presentation from implementing the proposals the key highlights were:

- A sliming down of in-patient ward services
- Increased community services. There would be a nurse led service operating in the community. Greater emphasis would be placed on the building of partnership working following the centralisation of the unit.

6.1.11 It was highlighted the cost of running a ward was the same irrespective of the number of occupants i.e. the operating costs for a ward with 7 occupants was similar to one with 20 occupants. The financial savings would come from reducing the number of units from 3 to 1. This was expected to deliver approximately £2million in savings.

6.1.12 The reconfiguration will change staff teams to allow strong community services. Enabling a lot of close working with partners and good services.

6.1.13 The proposed location for the central unit was Mile End Hospital.

6.1.14 The consultation process was being led by NHS ELC and dialogue would be via the Joint Overview and Scrutiny Committee for Inner North East London.

6.1.15 Formal consultation was scheduled to commence 1st September 2011 and the PCT was in the process of preparing the consultation document.

6.1.16 A host of public engagement events were planned for each borough with the key aim being to engage with key stakeholder groups for older people and carers to acquire a range of views from the communities.

6.1.17 The main concerns raised so far related to access for patients and carers to Mile End Hospital.

6.1.18 A transport impact analysis was commissioned by East London NHS Foundation Trust and this identified an aggregate impact on journey time and journey complexity for service users and carers. Although there was likely to be some impact for some service users and carers in south Newham. Members were advised it was proposed to support service users and carers who faced travel problems to ensure access would be simple and equitable, by the use of minibus or taxi travel.

The proposed consultation timetable was listed in the presentation. *(If you would like a copy of the presentation please contact the overview and scrutiny officer)*

6.2 **Questions and Answers**

(i) **Cllr Vaughan enquired about the travel analysis conducted and asked if it was conducted by Transport for London (TfL)**.

The Associate Director (Performance, contracting and Procurement) from NHS East London and the City (NHS ELC) advised the initial analysis was conducted by a private organisation and they worked with a range of sources to inform them. It was anticipated further analysis would be conducted to follow up on the gaps identified.

(ii) Cllr Munn raised concern about the current long average length of stay time and queried if it would be best to reduce the length of stay and establish a good discharge planning process first before implementing the changes.

The Clinical Director and Lead Consultant, Older Peoples Services from ELFT explained the assessment process was mapped out and identified to take 6 weeks. The trust has identified the delay related to finding long term placements i.e. residential care. As usually when an individual is admitted their illness is advanced. It was acknowledged it would be sensible to start with improving the discharge planning first. However this would require dedicated staff and as a small unit they do not have the staff available to carry out this work in tandem or prior to implementing the new model of care.

(iii) Cllr Munn enquired if the trust was sure that the new service model with fewer beds would work if currently they encountered challenges due to waiting for beds from partners.

The Clinical Director and Lead Consultant, Older Peoples Services from ELFT informed for Hackney the requirement is 7 beds and this same number will be allocated to Hackney in the new model of care.

It was noted the proposals were developed based on evidence of good practice. The comments from the consultation will form part of the decision making process. If there was clear evidence during the process that showed the proposals would not work they would need to be changed.

(iv) Cllr Vaughan enquired if the burden of care under the proposed model would fall to carers?

The Clinical Director and Lead Consultant, Older Peoples Services from ELFT informed the trust wanted to put a service together that gave meaningful support for a longer period of time. After diagnosis a service user would have follow up support, advice etc from services like Alzheimer's Society. It was noted on average a person could live with the illness for about 10 years and often came to inpatient services when the illness was at a critical stage i.e. 7-9 years into the illness. It was noted often families were happy to be left to their own devices and would seek help or support when the illness become too much to manage.

(v) Mr Vidal enquired if service users were involved and consulted when the travel analysis was being conducted.

The Older Adults Mental Health Commissioning lead from ELFT confirmed a selection of service users were consulted for a period of a week to review their old journey compared to the new journey. No one had a longer journey except those service users and carers in South Newham.

7 INNER NORTH EAST LONDON DRAFT TERMS OF REFERENCE AND PROCEDURE RULES

7.1 Cllr Vaughan from London Borough of Newham requested for Members agreement of the draft Terms of Reference (TOR) and Procedure Rules for the INEL JOSC could be postponed until the next meeting. He advised the Legal Officer in Newham Council had raised some concerns regarding the TOR and procedure rules and this was not present to their Full Council meeting for agreement. He suggested the Overview and Scrutiny Officer supporting the INEL JOSC liaised with the Overview and Scrutiny Team in Newham for the full details and amendments to present for sign off.

7.2 The Members agreed to postpone.

ACTION	Overview and Scrutiny Officer to contact Newham Overview and Scrutiny Team to get requested amendments for TOR and Procedure rules to present for the next meeting of the INEL JOSC.

8 URGENT ITEM / ORDER OF BUSINESS

8.1 Cllr Vaughan suggested the venues to host the INEL JOSC meetings were rotated and he offered Newham to start for the next meeting.

8.2 Member agreed.

ACTION	Overview and Scrutiny Officer to rotate INEL JOSC meeting around the Boroughs.

Duration of the meeting: 4.00 - 6.15 pm

Signed

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Chair of Committee

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