Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2017/18
Date of Meeting: Wednesday, 29th January 2020

Minutes of the proceedings of the Health in Hackney Scrutiny Commission held at Hackney Town Hall, Mare Street, London E8 1EA

Chair	**Councillor Ben Hayhurst**
Councillors in Attendance	**Cllr Peter Snell, Cllr Yvonne Maxwell (Vice-Chair), Cllr Deniz Oguzkanli, Cllr Emma Plouviez and Cllr Patrick Spence**
Apologies:	**Cllr Tom Rahilly**
Officers In Attendance	**Dr Sandra Husbands (Director of Public Health)**
Other People in Attendance	**Tracey Fletcher (Chief Executive, Homerton University Hospital NHS Foundation Trust), Nina Griffith (Unplanned Care Workstream Director), Dean Henderson (Borough Director for Hackney, ELFT), Dr Priscilla Kent (Consultant Psychiatrist, ELFT), David Maher (MD City & Hackney CCG), Jon Williams (Executive Director, Healthwatch Hackney), Nichola Gardner (Neighbourhoods Director C&H, ELFT), John Makepeace (Local Pharmaceutical Committee), Nickil Patel (Local Pharmaceutical Committee), Lorna Solomon (HUHFT Unison), Jordan Rivera (HUHFT UNISON), Dan Burningham (Programme Director Mental Health, CCG), Dr Waleed Fawzi (Older Adult Consultant Psychiatrist, ELFT) and Eugene Jones (Director of Strategic Transformation, ELFT)**
Members of the Public	**7**
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Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 An apology for absence was received from Cllr Rahilly and for lateness from Cllr Plouviez.

1.2 Apologies for absence were also received from Anne Canning, Laura Sharpe and Kirit Shah.

2 Urgent Items / Order of Business

2.1 There were no urgent items and the order of business was as on the agenda.

3 Declarations of Interest

3.1 Cllr Maxwell stated that she was a member of the Council of Governors of HUHFT. She also added in relation to item 5 that she and the Mayor had been present for the GMB-initiated "Christmas card" protest in December at HUHFT.

3.2 Cllr Snell stated that he was Chair of the Board of Trustees of the disability charity DABD UK.

4 Minutes of the Previous Meeting

4.1 Members gave consideration to the draft minutes of the meeting held on 4 December and noted the matters arising. The Chair added that the PIN notice referred to in action 5.3(a) had now been circulated to the Commission members.

4.2 Cllr Snell thanked the Chair, the O&S officer and the CE of the GP Confederation for their contributions to the lobbying letter sent to NHSE in relation to 0-5 childhood immunisations as set out on pages 15-17. He also thanked Connect Hackney for providing the list of providers as requested and added that this group now needed to be monitored so that the great range of activity they provide can be built on as part of the Legacy Plan.

RESOLVED:	**That the minutes of the meeting held on 4 December be agreed as a correct record and that the matters arising be noted.**

5 Update from Homerton University Hospital NHS FT Chief Executive

5.1 The Chair stated that he has asked Tracey Fletcher (**TF**), Chief Executive of the Homerton University Hospital NHS Foundation Trust (HUHFT) to attend the meeting to answer questions on two recent developments: the new Pathology Partnership and a pay dispute relating to the soft facilities contractor at the hospital.

5.2 Members gave consideration to a copy of the presentation *Pathology Partnership Outline Business Case* which had been agreed at the 18 December meeting of the HUHFT Board. The plan was to create a new Pathology Partnership with Barts Health NHS Trust and Lewisham and Greenwich NHS Trust.

5.3 TF summarised the key points in the agreed Outline Business Case. HUHFT Board had decided it would not be viable for them to update the service on their own and under the national challenge from NHSE to create pathology networks they looked to securing appropriate partners so as not to be at the whim of

commercial providers in going it alone. The next step was to develop the Full Business Case. No contracts had yet been signed and they would continue to be a working lab on site but the Board was satisfied with this proposal. Central to the partnership agreement was that it would be a legal agreement between three Trusts and there would a jointly appointed MD. The three would jointly share the benefits and risks and each partner would have equal votes and a veto. Upgrading the Homerton's Pathology facility would require significant investments in IT. The agreement with the other two Trusts wold give an added level of resilience to all three organisations and at Greenwich Hospital their lab was already quite new.

5.4 Members asked detailed questions and the following as noted:

(a) Members asked what consultation there had been with local GPs. TF replied that there had been discussions and there was a local GP also on the Council of Governors. Putting together the Full Business Case would now require getting down into the detail of the clinical model and this would involve further talks with GPs and these would begin the following week.

(b) A Member questioned the quality of the service up to now with examples of tests getting lost and asked about the interim plan. TF stated that lab services would continue on site. She added that tests already go to Royal London as well. Four years previously the service from Barts had not been very responsive but this had since been turned round and response rates were high. HUHFT closely monitors turnaround times from Royal London, Newham and Whipps Cross already. HUHFT will jointly manage the new model and so will have an opportunity to influence the other two partners and again the new partnership model will provide added resilience between the three Trusts.

(c) A Member asked whether there would be a full public consultation before the FBC gets agreed in March. TF clarified that the FBC would more likely happen in April, not March. They are now working through the detail of which tests will happen where and the IT changes necessary and they would be seeking detailed feedback from the key stakeholders including the GPs, while this is not a full public consultation it was vital they sought the opinions of the GPs for example because they wanted to set up a service that would work and the Board would take all this feedback into account before formally agreeing the FBC.

(d) A Member stated that it was unfortunate that this document referred to the other options considered but did not detail them and asked if this could be provided. TM replied that this paper was an overview presentation and behind it lay a very weighty document which went into the finances of each option. The challenge with this document was to put in as much information as possible while still respecting the commercial confidentiality aspects. The Chair asked if Members could see even a summary of the other options. TF undertook to investigate but commented that that level of detail would only be in the private board papers.

ACTION:	**Chief Executive of HUHFT to provide Members with a summary providing more financial detail on the other options considered in the Outline Business Case.**

(e) A Member of the public questioned whether the Trust had abided by its statutory duty to engage. TF replied that it would be difficult to establish how you could do this effectively and constructively here. Enabling some public input to the discussion had been done and they had also done more than the other two partners.

5.5 The Chair moved the discussion on to the second item the pay dispute against the contractor ISS. He stated that some of the 300 staff had been paid £10.49 per hr not £10.55 i.e not the London Living Wage (LLW) and 32p per hour below the NHS Agenda for Change recommendation. There was no occupational sick pay and no sick pay for the first three days of illness. This begged the question, he added, about when HUHFT had initiated the contract what requirements they had raised with the contractor ISS and to what extent were they seeking to address these in the new contract.

5.6 TF replied that they had followed up on a number of issues with ISS who had assured them that that they would pay at the uplifted LLW rate and would backdate payments to October for all staff. They had also taken a number of questions back to ISIS re the future contract and were awaiting a reply.

5.7 Members asked detailed questions and the following was noted:

(a) A Member stated that a hospital a like a council had a social responsibility to its local community and was there leeway in the contract renegotiation to insist on comparable pay and conditions and whether this provided an opportunity to perhaps insource these functions and avoid a two tiered workforce. She added that not paying sick pay for 3 days had serious implications in a hospital as staff would be forced to come into work while ill. TF replied that they were trying to ascertain what the processes would be. They would not be able to in-source this service in the time available to them but while it could not be practically achieved in this instance, prior to the end of the current contract, this didn't rule out, in the longer term, looking at insourcing as a possibility for the future. She was asked if other Trusts were looking at insourcing soft services and she replied that they were and Trusts were moving in both directions on this issue.

(b) The Chair stated that as the contract was 5 years with a 3 year extension could HUHFT break this if they were unsatisfied with the answers they received on the sick pay issue for example. TF replied that the timeframe now made this impossible. A tender process for a contract this complex would need perhaps 18 months.

(c) The Chair invited Lorna Solomon (LS) the HUHFT UNISON rep to comment. LS stated that nobody working for ISS currently gets the London Living Wage and staff transferred since 2015 are paid below the rate by ISS. She stated she was pleased that ISS had now stated that they would pay LLW from 4 Nov. In terms of in-sourcing she stated that UNISON had raised this issue with HUHFT management for over a year now and had not received a response. She clarified that the contract was 5+2 but asked whether it could be 5+1 which would be a more realistic timetable. She added that UNISON had asked HUHFT to make a formal commitment to being a London Living Wage Employer, a commitment to which all contractors would need to comply, and

they had not done so and this had therefore made it much harder for the union to challenge the low pay rates being offered by ISS.

(d) The Chair asked whether there was an obligation to offer back pay and whether the new contract could be 5+1. TF replied that their new Director of Workforce was picking up all these issue with ISS and she would need to get back on the contract term issue. On the in-sourcing issue their Estates Department had been through a period of instability which they had been working to remedy and in this time it would not have been appropriate to consider in-sourcing. She added that she sees the ISS workforce every day and has regular informal contacts with them. She fully understood and appreciated their commitment to the site and their pride in the Homerton as their local hospital.

(e) LS asked TF is she could clarify on the London Living Wage Commitment issue. TF replied that she would take this issue back.

(f) A Member expressed a concern that TF could not commit on future contracts. TF replied that this decision needed a collective Board view and she would not be able to decide unilaterally but that ISS had been challenged by them on the issue.

5.8 The thanked TF for her attendance and asked if she could report back in 3 months on progress. He also congratulated the Trust again on its recent excellent A&E performance.

ACTION:	**Chief Executive of HUHFT to report back to the Commission in c. 3 months on the response from ISS on the pay and conditions issues raised by them and on the possibility of the Trust making a formal commitment to becoming a London Living Wage employer.**

RESOLVED:	**That the report and discussion be noted.**

6 Integrated Commissioning UNPLANNED CARE workstream

6.1 The Chair stated that the Commission received a regular rolling programme of updates, in turn, from each of the 4 workstreams in Integrated Commissioning and Members' gave consideration to an update report from the Unplanned Care Workstream.

6.2 The Chair welcomed Nina Griffith **(NG),** Workstream Director Unplanned Care to the meeting and Members gave consideration to the update report.

6.3 NG took Members through the key points of the report.

6.4 Members asked detailed questions and the following points were noted:

(a) A Member expressed concern about the ongoing challenges with the GP Out of Hours and NHS 111 service in the new configuration. NG replied that call answering rates were increasing. The local GPs contacted by the CCG had also stated that the new system and that the numbers using it and the overall performance was looking much better.

(b) A Member asked what was being done to get more people on to the Co-ordinate My Care platform. NG replied that this was a big area of focus as it was not just for end of life care planning but was also being used to support patients who are frail or patients with dementia. A lot of work had to be done on rationalising the IT issues in such a shared system. There's a current focus on ensuring that staff at the Homerton and at St Joseph's are using it appropriately. Dr Victoria Holt (previous head of CHUHSE) was brought in to review the plans and now 80% of the relevant practitioners were reviewing, editing and updating CMC plans.

(c) A Member asked about use of co-production and in particular participation in decision making within the Neighbourhoods Programme. NG stated that Shirley Murgraff was the public rep and held officers to account. SM added that their job was to communicate with local communities and stated that Neighbourhoods needed to be referred to always with a capital 'N'.

(d) Jon Williams (JW) added that he chaired the Communications and Engagement Group under the Integrated Commissioning Board. It was important that public reps understood both the system and how to get involved with it. It was quite challenging and exacting but this element has to work well if the whole integrated commissioning process is to succeed. It's also key to driving forward the 'prevention' agenda.

(e) The Chair asked John Makepeace (JM) member of the Local Pharmaceutical Committee about a reference in the report on p.48 to the creation of 8 Neighbourhood Community Pharmacy Leads and asked how did this squared with the recent decision by NHSE London to cut funding for the 'Pharmacy First' programme in City and Hackney. JM replied that the 8 leads would be meeting the following day to address this and they were working for example on the flu plan for next year. The LPC was very disappointed that the funding for Pharmacy First had finally been withdrawn but was pleased that the CCG had been so supportive in their campaign against this and they were in discussions with the CCG about possible alternative approaches. Nickil Patel (NP) stated that he was one of the Community Pharmacy Leads and was the Vice Chair of the LPC. He stated that under that previous Minor Ailments Scheme (called Pharmacy First locally) that pharmacies got £5.90 per consultation, per patient. The scheme allowed patients to bypass GPs and therefore reduce the pressure on the latter for appointments. Pharmacists would still refer people to GPs if issues were more serious. The scheme also helped divert people from A&E and assisted with Hospice care arrangements.

(f) Michael Vidal, a member of the public and a Workstream Public Rep, added that the current guidance on Over the Counter Medicines had no clear definition of "socially vulnerable" on which that system depended. Public Health had assisted the CCG Medicines Team in coming up with a local definition. The CCG was devising a communications plan regarding what replaces 'Pharmacy First'. NP added that patients were as disappointed as the LPC with the withdrawal of this scheme.

6.5 The Chair thanked NG for the update and all contributors for their attendance.

RESOLVED:	**That the report and discussion be noted.**

7 Community Mental Health Transformation in City & Hackney

7.1 The Chair stated that the East London Foundation Trust had been awarded funding from NHSE to undertake a radical redesign of community mental health services arising from the national *Community Mental Health Framework for Adults and Older Adults*. Members' gave consideration to a briefing report.

7.2 The Chair welcomed to the meeting

Dr Priscilla Kent (PK), Consultant Psychiatrist, ELFT
Dean Henderson (DH), Borough Director City and Hackney, ELFT
Nichola Gardner (NG), Neighbourhoods Director, City and Hackney, ELFT

7.3 DH took Members through the report. He added that for 20% of the patients whom ELFT supported the delivery happens in Primary Care with 80% in secondary care and the aim of this broad national transformation programme was to shift that around. It represented a huge change in focus to localise and target mental health support into Primary Care. PK added that the focus was to bring services outside of hospitals and Community Mental Health Teams and to better integrate with primary care. She described the pilots in Hackney Marches Neighbourhood effectively extending the 'crisis café' concept and focused around a community centre in the Kingsmead Estate and another project in Clissold Park Neighbourhood.

7.4 Members asked detailed questions and the following points were noted:

(a) The Chair asked if this work involved IAPT and DH replied that no, the focus here was SMI (severe mental illness). The Chair asked whether the 5 Mental Health Community Workers per Neighbourhood would be in GP surgeries. PK replied they wouldn't because many GP surgeries are small and there was a need for more space so there is a focus on sites such as community centres.

(b) Members commented that the move from 20:80 primary to secondary care split to 80:20 was massive and asked what the driver was and what medical evidence was there that it would be an improvement. DH replied that the drivers was better support and long term care. Currently they supported 1500-2000 in the community with outpatient follow up. In addition there would still be 800-1000 that will need some support in secondary care and the other 2000 could be seen in a primary care or community setting, every 1-3 months. The aim was to support them more actively and, for this cohort, the care goes out to them rather than them having to attend outpatient appointments.

(c) A Member asked that while this model is based around Neighbourhoods how would it cater for BME, LGBT, older people and young people. She added that Young Black Men for example get sectioned more because the services do not meet their needs and how this new model might use co-production approaches to address this. PK replied that their outreach is very much focused on those who don't engage easily. They go into communities such as Kingsmead Estate and run activities which will promote mental health wellbeing such as cycling, running, boxing etc.

(d) Members asked what evidence ELFT had that they would get clients in via this new approach. Which groups are so far amenable to working with ELFT. PK replied there were a number of examples such as the boxing at Hackney Marshes Neighbourhood, the football programme out of King's Hall as well as work with Turkish-Kurdish and with LGBT groups.

(e) The Chair stated that Living in Hackney Scrutiny Commission had asked this Commission to ascertain what work was being done in mental health on transition of Young People to adult services. Their review on serious violence raised the issue of knife crime and how young people are being so adversely affected. Was ELFT working with the Gangs Unit and the Met Police in any way to support those who are vulnerable and what outreach would they consider. PK replied that they were going into schools and working on mental health support there. She added that Council officers would be better placed to respond. NG added that she was having a meeting in February with the Met to address these issues.

(f) The Chair stated that the point of transition from CAMHS to adult mental health services remained a problem and asked what was being done on transition. DH replied that this was a very important area of focus for ELFT and that the worked closely with officers in the CAMHs service and suggested that Sarah Wilson from ELFT's CAMHS team could update the Commission on this. Another Member commented that it is not just about transition of the individual. Boys and girls were being groomed and intimidated and there must be ongoing liaison between all the partners to figure out how best to tackle these problems at root he added. David Maher (CCG MD) replied that the new NHS Long Term Plan clearly set out an expectation for mental health support to be seamless from the ages of 0-25 and this would drive the approach to the work. DH added that ELFT was involved in the Young Black Men programme for a few years now and one of the main challenges was the level of school exclusions. Dan Burningham (Programme Director, Mental Health, CCG) added that the current structures were a consequence of the funding history. This Community Mental Health funding being discussed here did not cover transition or IAPT. However, there was significant levels of investment in CAMHS initiatives taking place separately and there was also separately major investment going into IAPT. He added that each element received different strands of funding. The VCS was included in this community mental health transformation work because they have reach into communities that the Trusts do not and this is the reason for the references in the document to the need for a blended team.

7.5 The Chair thanked the officers for their report and for their attendance.

RESOLVED:	**That the report be noted.**

8 Consolidating dementia and challenging behaviours in-patient wards

8.1 The Chair stated that at its meeting on 4 November the Commission considered a proposal from ELFT and the CCG to consolidate all older adult in-patient beds for patients with challenging behaviour and complex psychiatric symptoms of dementia across east London into one site at Sally Sherman Ward at the East Ham Care Centre. This would involve consolidating beds from Thames House Ward at Mile End Hospital into Sally Sherman ward. The

Commission reserved its endorsement of the proposals subject to a site visit and the Chair and the Vice Chair attended a site visit to both sites on 24 January.

8.2 The Commission gave consideration to a revised report from ELFT and the Chair welcomed to the meeting:

Eugene Jones **(EJ),** Director of Strategic Service Transformation, ELFT
Dan Burningham **(DB)**, Programme Director Mental Health, CCG
Dr Waleed Fawzi **(WF)**, Consultant Psychiatrist, ELFT

8.3 The Chair stated that following the site visits attended by himself and the Vice Chair his concerns about capacity had been addressed and the Sally Sherman Ward provided far better surroundings than Thames House ward. He was still of the view that it was not correct to say that Thames House had been an improvement from the previous location at Cedar Lodge in Hackney.

8.4 The Vice Chair stated that as the Council's Dementia Champion she had been pleased to see the environment in Sally Sherman which was more calming and which had been decorated appropriately and had a gym and Namaste care etc on site. The site at Mile End where 6 patients shared a bathroom was not ideal. She took issue with the framing of this cohort as "displaying challenging behaviour" because that behaviour was often a consequence of their surrounding environment. She had had concerns about the distance of the move but the quality of new venue somewhat made up for this. She stated that staff had mentioned that once patients are discharged to nursing homes they do not return but she had a concern that nursing homes simply do not have the resources or skills to support this small but challenging cohort. There was a danger that in nursing homes the medication levels would be increased to calm patients whereas they had seen the more personalised attention that distressed patients can receive in the ELFT wards.

8.5 Members asked detailed questions and the following responses were noted:

(a) Dr Fawzi (WF) stated that 99% of this patient cohort come from the dementia ward pathway. Some people with dementia become aggressive and are difficult to manage and so cannot be catered for either in care homes or at home. He added that as the care pathways improve the Trust will require fewer continuing care beds for example there used to be 60 in Hackney. By the time most of these patients have completed their care journey at East Ham Care Centre they will just require physical care, they won't be able to walk and there will be the physical deterioration associated with late stage dementia. He acknowledged that moves can be very distressing for dementia patients but the priority was to have patients in the setting where they can get the best care at each stage of their pathway. He added that local Care Homes can be proud of the care they provide for non-challenging patients with dementia and they do their best to provide reasonable levels of stimulation.

(b) A Member asked what support went into Care Homes to help them up-skill. EJ replied that they were in the process of looking at investment in community pathways and upskilling and engaging care home staff was part of this. They would engage with nursing homes and also work on a rapid response service to

support the homes. They would also work on up-skilling on prevention so as to avoid admissions to secondary care.

(c) A Member asked how they decided on which patients can be in-patient and which could be supported in care homes. WF replied that the focus was always on ensuring the patient was in the correct environment with the appropriately trained staff. He explained that there were a number of reasons as to why this cohort would display challenging behaviours. Some display challenging behaviours because of psychiatric conditions e.g. delusons and this can be treated with medication. Some of this cohort are disorientated and they are oriented by use of special signage in the wards, by speaking slowly, by holding hands and by helping them to eat etc. Some in this cohort might have a history of aggression or violence and when this is high level they might require sedation.

(d) Michael Vidal, a resident and public rep on the Planned Care Workstream, took issue with the references on p.83 of the report which stated that the proposal had been "endorsed" by the CCG Governing Body and Planned Care Core Leadership Group. He stated that this was not correct. He also asked why the table at 6.7 only focused on those over 65 and asked what the projections were for those under 65. WF replied to the latter by stating that the projections were based on all presenting need but that there were very few presentations with early onset. EJ added that Members would have met a client with early onset on the visit. WF added that the NHS nationally had very few places for early onset dementia and so many end up with older patients or in settings which can be a long way from home. EJ stated that in relation to the two committees they had endorsed it subject to a clarification on travel. David Maher (MD of C&HCCG) commented that this was a technicality. He had been present at the Governing Body meeting and the proposals were supported however it was not a formal decision.

(e) Jon Williams (JW) (Executive Director Healthwatch Hackney) stated that he had received feedback on the proposals from the Alzheimer's Society survey of staff. They had expressed concerns about the move. They felt that the move would discourage family and friends from visiting the new ward in East Ham. There were some concerns about the operation of the taxis or travel passes by family and friends and they would prefer a ward in Hackney. He added that 'Dementia Voice' had also been asked about the move and had expressed similar views including the comment that "I feel people with dementia are being forgotten about".

(f) Carol Ackroyd (Hackney Keep Our NHS Public) echoed the comments from Healthwatch. This group were difficult to support in family homes and asking family and friends to travel long distances out of borough was a problem. She added that plans were being worked up to re-develop the St Leonard's site and they were not taking any of this mental health bed capacity issue into account. She asked couldn't such services be better provided in Hackney at the remodelled St Leonard's.

(g) Shirley Murgraff (SM) (Hackney Keep Our NHS Public) commented that she agreed with Michael Vidal on the Governing Body decision. She took issue with the reference in the report that the voice of services users/families had been taken into account stating this was small number whilst the City &

Hackney Older People's Reference Group had not been consulted. She added that nursing homes were also moving further away. As the population aged the carers for older people would themselves be old and there was a failure to look at longer term needs and the possibility of using St Leonard's for these services needs to be addressed. EJ replied that the patients' families visited Sally Sherman and were pleased with it. SM dismissed this.

(h) EJ replied that the reduction in bed capacity has been well evidenced over many years. In the past more were needed and now only 4 or 5 beds were needed in Thames House ward for this cohort making it no longer feasible, hence the consolidation plan. If, for example, a ward such as this could be created at a future St Leonard's site it would of course have to take patients from outside the borough to make it viable. There is no sufficient scope or capacity in the re-designed St Leonard's for a ward such as this, he added. DH added that once capacity goes below certain levels and there is for example no back up it becomes unsuitable for use. A City and Hackney ward on its own had become unviable and was so merged into Thames House and this is now being consolidated in Sally Sherman ward as the situation evolves. The consolidation creates a centre of excellence and centralises expertise it also locates it with other physical health support nearby. ELFTs offer of transport for the few families and friends from Hackney and Tower Hamlets who will be affected will be sufficient to help mitigate the impact of the move.

(i) The Chair asked if there could be an audit mechanism put in place at East Ham Care Centre to record the transport usage and that a clear auditable process is set up to ensure that information about the transport officer is clearly imparted to the family and friends of each affected patient. EJ replied that there could as travel was already a KPI. WF also pointed out that currently there are some patients in Thames House ward in Mile End from Hackney that get discharged to Mary Seacole Home (at St Leonard's) so there are examples of patients returning to Hackney already.

ACTION:	**ELFT is asked to set up an auditable process to ensure that the transport offer to families of friends from Hackney and Tower Hamlets has been clearly imparted and that there is a record of how much the transport offer has been taken up.**

(j) The Vice Chair asked if Healthwatch could be brought in to review how the move had worked. EJ replied that they could and this would be helpful.

ACTION:	**ELFT to invite Healthwatch Hackney after a suitable time to review how the move from Thames House Ward in Mile End to Sally Sherman Ward at East Ham Care Centre for this cohort is operating and for Healthwatch to report back to the Commission.**

8.6 The Chair thanked officers for the site visits and for the reports and stated that he was now minded to endorse. Cllr Maxwell stated that she would also endorse but would ideally like to see such a ward in Hackney. Cllr Oguzkanli stated that he could not endorse it. In his view any service could be provided elsewhere. Cllr Pouviez stated that she was not minded to endorse and was agnostic on it. She stated that she continued to have reservations about the

whole care pathway here and wondered if it was a good provision that only a few lucky people can get into. Cllr Snell and Cllr Spence stated that they were minded to endorse.

RESOLVED:	**That the proposal be ENDORSED with 4 votes in favour and 2 against.**

9 Health in Hackney Scrutiny Commission- 2019/20 Work Programme

9.1 Members noted the updated work programme.

RESOLVED:	**That the updated work programme be noted.**

10 Any Other Business

10.1 There was none.

Duration of the meeting: 7.00 - 9.15 pm