Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2025/26
Date of Meeting: Thursday 15 January 2026

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 Kam Adams, Cllr Frank Baffour, Cllr Ian Rathbone, Cllr Anna Lynch and Cllr Ben Lucas (Vice-Chair)**
Apologies:	**Cllr Grace Adebayo, Cllr Sharon Patrick and Cllr Claudia Turbet-Delof**
Officers In Attendance	**Jacquie Burke (Group Director Children & Education), Georgina Diba (Director of Adult Social Care and Operations), Chris Lovitt (Deputy Director of Public Health), Andrew Trathen (Consultant in Public Health), Angela Burns (Principal Public Health Specialist), Aysegul Dirrik (Project Manager Mental Health) and Collette Manny (Senior Trading Standards Officer)**
Other People in Attendance	**Sally Beaven (Healthwatch Hackney), Dr Stephanie Coughlin (C&H Place Based Partnership), Councillor Christopher Kennedy (Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture), Andreas Lambrianou (City and Hackney Integrated Primary Care, Breeda McManus (Homerton Healthcare), Councillor Joe Walker (Deputy Cabinet Member for Strengthening Neighbourhoods), Dr Olivier Andlauer (ELFT), Jed Francique (ELFT), Andrew Horobin (ELFT), Laura Marmion (Homerton Healthcare) and Vanessa Morris (Mind City Hackney and Waltham Forest)**
Members of the Public	
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Councillor Ben Hayhurst in the Chair

1 Apologies for Absence (19.00)

1.1 Apologies for absence were received from Cllrs Patrick, Adebayo and Turbet-Delof.

2 Urgent Items / Order of Business (19.02)

2.1 There were none.

3 Declarations of Interest (19.04)

3.1 There were none.

4 Community Mental Health 2/2 - ELFT's new offer (19.05)

4.1 The Chair stated that this was the second of two sessions to consider ELFT's Community Mental Health Transformation Programme and its aim to create a more integrated and accessible system, bringing together GP practices, social care, and voluntary services to offer new models of care with community-based support and early intervention. At the 11 November meeting they had received briefings from ELFT, Public Health, NHS NEL and Mind. The focus of this session would be to go through the details of the new offer.

4.2 He welcomed for the item:

Jed Francique (JF), Borough Director for City and Hackney, ELFT
Dr Olivier Andlaeur (OA), Clinical Director City and Hackney, ELFT
Andrew Horobin (AH), Deputy Borough Director - City & Hackney, ELFT
Georgina Diba (GD), Director Adult Social Care Operations, LBH
Aysegul Dirik (AD), Project Manager - Mental Health, LBH
Andrew Trathen, Consultant in Public Health, City and Hackney Public Health
Dr Stephanie Coughlin, Chief Partnership and Place Officer, Homerton Healthcare
Laura Marmion, Head of Neighbourhood Teams, Homerton Healthcare
Vanessa Morris (VM), Chief Executive, Mind CHWF (City, Hackney, Waltham Forest)

Also present were:
Cllr Chris Kennedy, Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture
Cllr Joe Walker, Deputy Cabinet Member for Strengthening Neighbourhoods
Jacquie Burke (JB), Group Director Children and Education and Acting Director Adults, Health and Integration
Sally Beaven, Executive Director, Healthwatch Hackney
Andreas Lambrianou, Chief Executive, City & Hackney Integrated Primary Care
Angela Burns, Principal Public Health Specialist, City and Hackney Public health
Collette Manny, Senior Trading Standards Officer, LBH

4.3 Members gave consideration to a joint presentation from ELFT and Adult Services Updated ELFT & LBH Adult Community Mental Health Offer (Phase 1)

4.4 JF, AH and AD took members through the presentation slides in detail which covered: Context - Adult Mental Health Treatment System; Integrated Community Mental Health Service via Section 75 agreement; Adult Social Care in mental health services including the transformation programme objectives; Drivers for Change; C&H ELFT service eligibility; Overall schematic of the new ELFT community MH model (Phase 1); Initial management of referrals (urgent & non urgent); Integrated Mental Health Service - social care at ELFT; Categorisation of needs of service users;

Strengthened, integrated neighbourhood care - features; Overall schematic of the new community MH model - phase 1; Other services; Understanding the level of success of the new model; Implementation; and Next steps.

4.5 The officers explained that the service operated under a long-standing Section 75 partnership agreement between the London Borough of Hackney (LBH) and the East London Foundation Trust (ELFT), where LBH delegates its statutory adult mental health social care duties to ELFT. This delegated arrangement aims to foster a more integrated and seamless service for residents who require specialist secondary mental health care. The transformation is specifically targeted at refining how social care functions are delivered within ELFT's community mental health services.

On the rationale for change, the current model, while providing a degree of integration, has, they argued, highlighted several areas requiring strategic revision and enhancement. The primary drivers for this proposed transformation are focused on service quality, compliance, and sustainability, rather than purely financial savings. The existing Section 75 agreement had not undergone a recent comprehensive review, necessitating an update to reflect current best practices and statutory duties. Feedback from service users and their carers consistently indicated a strong desire for improved joint working between health and social care staff, along with a simpler, less bureaucratic, and less cumbersome system of access and support. The new model also seeks to significantly strengthen collaboration, ensure full compliance with evolving national policy direction for community mental health, and deliver a fully integrated service offer. This integration is rooted in the contemporary understanding of the biopsychosocial model and the critical role of social determinants of health in mental wellbeing. The goal is to improve timely access to social care and ensure financial sustainability. This is achieved not through targeted financial savings but by eliminating duplication of effort and maximising the appropriate utilisation of highly skilled staff resources.

They explained that the previous operational model presented structural and professional challenges that the transformation seeks to address, for example, LBH-funded social workers were historically spread out across various community teams within ELFT. These social workers often operated within mixed health and social care roles, diluting their specific social care remit and professional focus and critically, the current structure lacked clear, dedicated professional social care leadership within ELFT, hindering the development of a distinct professional identity and governance for the social care aspect.

They explained that the core objective of the transformation is to establish a clearer, more defined, and professionally governed social care structure within ELFT. This separation of function from generic mixed roles will occur while vigilantly maintaining and strengthening integration with the broader health services.

They explained that the new model proposes establishing a borough-wide social care service dedicated to ELFT-eligible residents. This service will be operationally co-located or working in close partnership with health colleagues, aligning services geographically across paired neighbourhood quadrants, based on Primary Care Network (PCN) boundaries.

The explained that the services will be structured around three distinct but interconnected pathways, ensuring clear service user journeys: Initial Response and Safeguarding Pathway: Longer-Term Support Pathway, and Highly Specialist

Pathway. They also explained that the overall structure will be underpinned by two essential components: a small business support unit to ensure administrative efficiency and operational flow and the continued, critical operation of the Approved Mental Health Professional (AMHP) service, which retains its statutory function in line with the Mental Health Act. The services delivered through this transformed model are primarily aimed at individuals who present with a suspected or diagnosed mental illness that results in: Significant functional impairment, high complexity and/or risk or a need for specialist secondary care services provided by ELFT.

On the issue of service overlap they explained that it is crucial to clarify the scope of the Section 75 agreement and the new model. While the overall ELFT community model serves all ELFT-eligible clients (including those with purely a health need), the new social care model and the Section 75 agreement specifically address the estimated 425 individuals who have an overlap of both adult social care needs (e.g., funded care packages, needs assessments) and ELFT secondary mental health service needs. The overarching goal of this integrated approach is to establish a single, clear social worker channelled through the ELFT route for all individuals whose primary support need is rooted in their mental health condition. This avoids the service user having to navigate separate, often conflicting, health and local authority social care systems.

4.6 Members Questions:

a) Members asked for clarification on the quadrants and where staff will be located and how people get to the ‘front door’.

AH replied that each quadrant is its unique team and it has a unique team base. He also explained the single point of access which will be at the Raybould Centre. Currently there are several ways to access mental health services, urgent or non-urgent, and they’re bringing all of that together in one single point of access and this was at the request of service users and professionals that found it difficult to access their services. It will be a multidisciplinary team, psychologists, consultants, psychiatrists, nurses, social workers. They will triage every referral and if they need more information, they will have conversations with the referrers, be it a GP or member of the public.

This will allow for significantly more robust information gathering than previously achieved. Once the necessary information has been collated, the multidisciplinary team will then arrange the assessment. For urgent referrals, patients can be seen on the same day or within 24 hours, depending on the severity of need. This constitutes the initial point of access within the model.

b) Members asked about what would happen to referrals who do not meet the current criteria.

AH responded that if an individual does not meet the established criteria, the service will not simply disengage. A plan will be ensured. For instance, if a referral is received from a GP and is deemed unsuitable for ELFT, recommendations will be provided to the GP regarding the optimal course of action for that service user. Alternatively, if an onward referral is required to another ELFT service, the team may initiate this themselves. Therefore, the response will not simply be a refusal, but a decline accompanied by alternative options.

c) The Chair asked how the service aligned with IAPT as GPs may also refer in?
AH responded that the aspiration of this model is to integrate services more fully, which is an area they intend to focus on during the next stage of their transformation. He added that while it's correct that there are other services and points of initial contact, and they do have established interactions with these services they must ensure these are not overlooked.

AH went on to elaborate on the current community mental health service model, which is characterized by separate teams (e.g. recovery, assessment, rehabilitation). It was considered as somewhat inefficient and detrimental to service users due to frequent, disruptive transitions between teams, requiring new assessments and key workers. To resolve this, a new system based on three distinct pathways is being introduced, categorized by the service user's assessed level of need: Pathway One (lower need/short intervention), Pathway Two (enhanced need/care coordination), and Pathway Three (highest need/intensive engagement). Under this new "quadrant model," service users will remain with the same team even as their needs change, moving up or down the assigned pathway to adjust the intensity of care. This shift aims to ensure continuity of care, reduce duplicated effort, and eliminate potential service "cliff edges" while maintaining access to all existing mental health interventions.

d) The Chair commented that previously he was aware of a criticism that there was not as much support for higher level of community offer and asked if that was a valid concern of the previous model and does the new one go some way to addressing that?

AH replied that it did. He added that the Colocane case had necessitated the establishment of an assertive intensive service user group. To meet this requirement, a higher level of engagement and support will be provided to these individuals, who will be designated as Pathway 3 service users, thereby aiming to address their heightened needs.

The proposed service delivery model incorporates four quadrants, with each quadrant comprising two paired neighbourhoods. These quadrants will house fully integrated mental health teams, each possessing dedicated provision for psychology, administration, and occupational therapy. This fully integrated structure is expected to improve the service user experience by eliminating the need for external referrals for psychological interventions, as each team will be self-contained with its own range of professionals, including a consultant psychiatrist, psychological lead, and an operational lead/team manager.

Non-urgent assessments, particularly those requiring medical reviews, will be conducted within the service user's respective quadrant to ensure continuity of links with primary care. A key principle of the neighbourhood model is the provision of necessary services at the local level. Currently, City and Hackney ELFT lacks premises across the borough that align precisely with the new quadrant structure. However, the objective is to secure at least one suitable venue per neighbourhood for conducting groups, clinics, or services, enabling access close to service users' homes. This necessitates an innovative approach to location sourcing, including exploring options such as libraries, GP surgeries, and church halls, consistent with the original neighbourhood model's ethos. An Estates Workstream is actively identifying less formal, non-NHS venues to enhance engagement, thus maintaining a strong commitment to offering services locally wherever feasible.

e) Members asked if caseloads change how does that impact the new system, particularly if people are moving through the system pathways?

AH replied that the allocation of resources, particularly staffing, is weighted according to the varying levels of health needs across different quadrants and neighbourhoods, where higher incidences of illness have been observed. A formal review of this weighting has been conducted. The fundamental challenge being discussed, however, relates to patient flow, which presents a significant hurdle. They are maximising the effectiveness of our current resources, which includes an increase in provision and a redeployment of personnel. Their aim is to establish a system that is resilient for the future. Crucially, this necessitates robust collaboration with their partners to leverage community assets and support systems. This cooperation is vital to ensure residents and service users can be smoothly transitioned or discharged from services.

f) The Chair commended the proactive stance and innovative approach on Estates, moving beyond sole reliance on NHS sites to explore more imaginative and pragmatic solutions for implementation. However, as this new pathway programme commences operations, he asked would suitable locations in each of the quadrants be immediately available, or will the identification and securing of these sites be a phased undertaking? Presenting this model is certainly very appealing, he added, but he questioned whether the timeframe for site availability represents an aspirational goal rather than the current reality.

AH replied it’s a bit of both adding that they have premises for the quadrants, but they aren't physically located in all of them; for instance, they lack premises in the north. Team bases will use their existing buildings. It's currently an aspiration with an Estates Workstream addressing it and they can utilize some GP practices and other locations for specific clinics, but it remains a work in progress.

g) The Chair asked how the Estate Pathway work aligns with the ICB estates pathway, where it's trying to move services down to Neighbourhoods?

JF responded that the integration was effective, stating that their estates colleagues, within the Integrated Health and Care team, actively engage in discussions regarding their estate with ICB partners. They have held conversations about their estate, what is available, and they are assessing the spaces under the responsibility of the ICB and NHS Property Services.

The Chair commented that the lack of premises in the north of the borough warrants attention, particularly given the withdrawal of the Wellbeing Network and the more culturally sensitive services, such as Bikur Cholim. Exploring options for locating culturally sensitive services where they are currently being provided would appear to be a clear area for consideration.

OA added that the strategy involves a two-tiered approach to service delivery. The first tier is the establishment of a "team base," serving as the main administrative and operational headquarters where staff are permanently located, with dedicated office space, computers, and other necessary resources before conducting community-based activities such as home visits. The second tier involves creating "outposts," which will function as satellite locations primarily for conducting clinics. Theyhave already secured commitments from three GP surgeries to host clinics. While the full implementation of four to eight dedicated team-based headquarters may not be

achieved within the next few months, interim measures ensure that accessible locations are available for residents who face difficulties accessing services due to geographical distance or complexity.

AH went on to state that the service model for mental health in the borough encompasses both neighbourhood-specific and borough-wide provisions. Borough-wide services will be consolidated into a 'health hub' to centralise expertise and improve patient care. Examples of these services include the physical health monitoring for service users receiving Depot injections, and regular blood monitoring and physical health checks for individuals prescribed Clozapine, which is essential given the high risk of long-term conditions for people with serious mental illness.

While the core mental health services are being aligned with the neighbourhood-based quadrant model, some specialist teams are also adapting. The Early Intervention Service and Home Treatment Team are aligning their operations across the east and west of the borough to ensure care continuity across geographical areas. The integration of Older Adult Services into this new model is planned for a subsequent phase of work.

A significant focus remains, he added, on improving social inclusion to ensure service accessibility for younger adults, racialised communities, and people with various disabilities, age profiles, and sexual orientations.

The organisation is also actively pursuing capital funding to establish 24/7 neighbourhood mental health centres, similar to the established model in Tower Hamlets (Barnsley Street), which is influenced by the Trieste approach. These centres would function as integrated, single-point-of-access facilities staffed by mental health professionals, the voluntary sector, and social care, catering to any individual in the neighbourhood requiring secondary mental health services, including crisis support via 'guest beds'. This ambition aligns well with the overarching integrated community model.

h) The Chair asked how does this fit in? This sounds like a short-term crisis intervention, after which the person would presumably be referred to a neighbourhood quadrant?

AH replied that the plan is to establish 24/7 neighbourhood centres, one per neighbourhood (half a Quadrant), which would serve as the central hub for all secondary mental health care provision for residents. This includes long-term, short-term, and crisis care. The model involves transposing an existing neighbourhood into a centre and adding further provisions.

The Chair asked if the emergency provision for people in crisis was still present at the Homerton entry point. AH clarified that yes, they do have their Crisis Assessment Team at the Raybould Centre, which is currently being merged with their Single Point of Access. This will create a unified urgent and non-urgent service, which is still operational. Furthermore, the neighbourhood centres themselves will offer this provision, including emergency care. This means people living within that neighbourhood can present themselves and receive emergency assistance, similar to the model used in Tower Hamlets.

i) Members asked when there would be an outcome on the latest funding bid, referred to?

OA replied that it would be for next financial year as it's capital funding. It would be to transform some of their premises to accommodate guest beds and make sites safe. Staffing was a separate bid but the key was to reduce waiting in A&E and to get people out of A&E as quickly as possible, or avoid them having to present there in the first place, and instead to go to a much nicer environment which is not hospital based and that contributes also to reducing stigma for patients.

JF stated that the proposed neighbourhood centres aim to provide a comprehensive, multi-agency, and holistic service that addresses the wider determinants of health, extending beyond the secondary care offer. The objective is to establish a "one-stop shop" delivering health and care treatment alongside broader support such as employment and financial advice.

Officers explained that to assess the efficacy of this model, a rigorous evaluation framework was being developed, incorporating several key measures. These include evidencing a strong, seamless, and joined-up working relationship between the service providers, ensuring care is delivered closer to residents' homes within local communities, and strengthening interfaces with primary care, GPs, IOPS, and the voluntary and community sector. Furthermore, the assessment will focus on the seamlessness and helpfulness of the onward journey for individuals who do not meet eligibility criteria for ELFT. A critical metric will be the timely access to support, with a focus on significantly reducing current waiting times for secondary care mental health support (e.g., from referral to assessment, and assessment to treatment commencement). He added that the framework will measure social inclusion by ensuring equitable access, experience, and outcomes for different cohorts of the population engaging with the services.

He went on to add that engagement with key partners and stakeholders is central to the implementation. This involves re-establishing the partner agency reference group for quarterly meetings to facilitate co-design of pathways and interfaces. Similarly, reference groups with 'experts by experience' (service users and carers) will continue to be a vital component for co-design, testing ideas, and gathering continuous feedback. Finally, staff views on the direction of travel, model effectiveness, and new ways of working will be actively sought, acknowledging the significant nature of this organisational change.

j) Members asked how the partners agency reference group works?

The reference group was established and operational during the design phase, involving a range of partners. These included representatives from the voluntary sector, public health, the local authority, and the Homerton. This ensured the involvement of various key stakeholders. Their engagement with the group involved presenting their plans and discussing proposed ideas, while actively soliciting and considering their feedback. This collaborative approach defined the function of the stakeholder and partner agency reference group. They are now in the process of reactivating this group for the implementation phase. This would allow them to maintain the same level of crucial input, test their service developments with the partners, and gain insights into their early experiences with the new service.

OA stated that the implementation phase is commencing immediately and will proceed over the coming months, culminating in the full deployment of the new system by the

summer. This transition encompasses the alignment of leadership, staffing, estates, and all structural elements, including the 'front door' service.

Collaboration from system partners is essential, as articulated through ongoing feedback and support for the implementation process via the established reference group and other mechanisms. Key areas for partner engagement include providing input on the rollout's progress, participating in core development initiatives for pathways, and strengthening interfaces with all services.

Particular emphasis is placed on maintaining strong working relationships with the local authority, ELFT, primary care, Homerton, and the voluntary sector. Partners are also requested to assist in identifying suitable neighbourhood estate locations to ensure accessible service delivery across the area, including opportunities for co-location. Furthermore, co-developing cohesive, multi-agency neighbourhood health service offers is a priority. This unified approach, focusing on optimising flow and managing caseloads, is fundamental to addressing the observed 30% increase in demand since the COVID-19 pandemic, by maximising the efficient use of existing system resources through close and coherent collaboration.

k) Members asked about the timeline for implementation.

JF replied that implementation is a phased approach. The initial six month focus on putting the 'building blocks' in place: starting with leadership, then working into the quadrants, and finally implementing the 'front door' system around June/July for full structural implementation. However, the required cultural change, embedding new processes and ways of working, is an ongoing effort expected to take 18 months to two years.

l) The Chair asked if a similar framework is being rolled out amongst the other boroughs in the ICB or are we leading the way in how it works?

AH replied that in ELFT London they are the first, Newham is going to take a similar approach and outside London, Luton and Bedfordshire are also planning to do a model like this.

OA added that the situation is also dependent on the specific context, as the integration with the local authority, for instance, varies considerably across London and the country. Hackney was the first in the country to co-locate social workers and mental health nurses. This joint working acknowledged the vital importance of both professions, which are constantly interacting, making the arrangement logical. This initiative was established some time ago and has since undergone continuous development and expansion. A similar pattern is observed in the relationship with primary care and that extends significantly beyond having a step-down protocol for patients receiving their monthly injection in GP surgeries. While some directorates and areas within NEL question the feasibility of this, ELFT has been implementing this for years and are continuously developing greater integration.

m) The Chair asked if it was that case that the money that had previously been allocated to the Wellbeing Network was being rolled into this, so in essence there is no overall reduction? Or is it the case that it's the same envelope that Hackney and ELFT were putting in, notwithstanding the Wellbeing Network?

JF replied that there's a couple of different but related budgetary points here. When AH was talking about no reduction in resources for community mentor services, he was specifically talking about the budget that ELFT gets to deliver secondary care mentor services but in terms of the money they get to deliver those services, there's no reduction. ELFT is reutilising that money to deliver this new model separate to that. He added that the broader spend on mental health, which includes public health, but also includes voluntary community sector and other aspects of the system, that's a different question and commissioning colleagues would be best placed to answer that. OA added that this is in the context of having to save about 5% and they are making their efficiency savings in other parts of the system, but not in the budget allocated for community services.

n) Members asked how the Council might assist in identifying co location opportunities and also what engagement ELFT did with elements of the community such as faith groups?

OA replied that for example local GPs including the Clinical Lead, Dr Brown, was offering space for clinics in her surgery.

o) The Chair asked the CE of Mind if she had concerns in terms of the withdrawal of the services from the Wellbeing Network and as good as the aspirations of this model may be, would there be a gap?

VM replied that a good, well-functioning mental health system is based on preventing poor mental health, but also preventing reversion of poor mental health. And so a system that focuses on the wider determinants, the role of community and belonging in neighbourhoods in its broadest sense is something that's extremely important and she added there will be risks if we don’t continue to focus on that. She added that she’d been involved in supporting the transformation work and endorsed the approach being taken.

p) The Chair asked if the Deputy Director of Public Health (CL) could comment on the commissioning intentions here?

CL replied that the Council’s commissioning intentions regarding the current Mental Health and Public Health Grant, which includes services from Mind and Partners, are not yet fully developed. A reduction in funding has occurred and has been subject to scrutiny, with an unavoidable impact on service provision. The contract is still ongoing, and the Council is actively considering future commissioned services to improve mental health and address wider determinants. The end date for the Wellbeing Network contract is June 27 and the contract value had been reduced from £1.4m to £900k.

q) The Chair asked for an update on plans for the replacement?

AT (Public Health) added that they haven't fully developed their commissioning intentions but they want to ensure that funding goes towards supporting treatments as opposed to teams and that prevention and a focus on wider determinants were the key components.

The Chair commented that a service is nearing its conclusion without a concrete plan for its replacement. This is arguably contrary to the approach just outlined by ELFT which presented a clear, well-considered plan for service evolution. Consequently, we

would require early clarification regarding the intended future provision. He recalled some feedback from approximately eight to ten years previously during a comparable withdrawal of culturally sensitive services, indicating that GPs found the transition extremely challenging.

r) The Chair asked Dr Coughlin to what extent she recognised the importance of those services as somewhere for GPs to refer to?

SC replied that GPs are acutely aware of local community needs and seek community-specific groups to help support patients and residents. They would be keen to participate in discussions to shape future services, leveraging their expertise in supporting and managing patients within primary care.

4.7 In closing, the Chair expressed approval for the new proposals but articulated the ongoing concern regarding the impending cessation of the Wellbeing Network. This concern centres on the detailed planning for its replacement, particularly in light of historical precedent. A similar withdrawal eight to ten years prior led to substantial opposition, notably from the GP community, which resulted in Public Health subsequently assuming responsibility after initial NHS funding ceased. While acknowledging budgetary complexities and the debate around departmental funding responsibility, he stressed the paramount importance of focusing on patient needs and the principle of integrated care. He added that the proposed new culturally sensitive services, while commendable, will face increased difficulty if a major resource, such as the Wellbeing Network, is simultaneously withdrawn. Consequently, he advocated for rigorous attention to the replacement plan. He proposed that the future agenda item should include an item to monitor subsequent progress of what will replace the Network.

RESOLVED: That the report and discussion be noted.

5 Update on Adult Social Care (20.10)

5.1 The Chair stated that the purpose of this item was to receive a verbal briefing from the Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture and the Acting Group Director of Adults Health and Integration on next steps for adult social care services.

5.2 The Chair opened by expressing the Commission’s thanks to Helen Woodland, who, it was announced over the Christmas period, would be standing down as the Group Director of Adults, Health and Integration. She had been with the Council since before the pandemic and was the most experienced director at that level. She also had led the Council through the Transformation programme and the CQC inspection of the Adult Social Services. She was robust in her approach, but fairly candid, which we always appreciated. He added that one of the testaments to her leadership was the high quality of the team she built under her Sandra, Amy and Georgina, and the stability of that leadership that she had created over a long period of time that he thought should not be underestimated.

5.3 He welcomed the following presenters for the item:

Jacquie Burke, Group Director Children and Education and Acting Group Director Adults, Health and Integration

Cllr Chris Kennedy, Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture

5.4 The Chair asked about the projected timeline for Helen's replacement and if there was any intention of reverting to a previous model of an overall director for Adults and Children's services.

Cllr Kennedy replied that there wasn't. He added that they were in a situation though, where they've got the pre-election period coming up and it would be difficult and unwieldy to try and have a recruitment process for a permanent Group Director during that, so realistically they were looking at starting the process after the local elections and therefore possibly end of August at the earliest before appointing a replacement.

The all-staff Adult Social Care meeting that afternoon, attended by over 120 members of staff, served as an opportunity to acknowledge Helen's contribution to both Adult Social Care and the wider Hackney team. He had expressed his satisfaction with how our staff have engaged with the Transforming Outcomes Programme and the CQC inspection. With Jacquie Burke stepping in as interim, this is an opportune moment to focus on the ICB's restructure, new ways of working with health partners, and potential outcomes from the Casey review and he was delighted that Jacquie had agreed to the interim role.

Contrary to the suggestion of a pause due to the leadership transition and eased immediate financial pressure, the reablement work—the final stage of the TOP programme—will continue at full thrust. There will be no hiatus. The Adult Social Care Finance Improvement Board will also carry on, with Jacquie attending in place of Helen. Furthermore, they intend to establish an Adult Social Care Board to address any recommendations or issues raised by the forthcoming CQC report, alongside its existing focus on finance.

5.5 The Chair expressed a concern bout who would provide a sufficiently robust voice to challenge inappropriate transformation or savings plans on safety grounds with an interim in post.

Cllr Kennedy replied that JB would absolutely fulfil that role as she is qualified social worker with long time appropriate experience.

5.6 JB stated the brought extensive leadership experience from Children's Services and, despite having a background in social work, successfully transitioned to overseeing education, a common trajectory for Directors of Children's Services. To quickly integrate with the adult social care sector she had engaged with key external bodies, including the Association of Directors of Adult Social Services (ADASS), holding a one-to-one meeting with the Chair. Furthermore, she had established links with the Local Government Association (LGA) and secured the assistance of a highly experienced Director of Adult Social Services (DASS) who will act as a critical friend. She emphasised a commitment to seeking external support and benchmarking, viewing this as essential for validating the council's proposed actions, the planned transformation, and her own strategic vision. This external 'sense-checking' will be a continuous process, she added.

5.7 The Chair asked about a previous criticism of the service that Hackney was spending more on adult social care than other boroughs. He noted that the previous GDs pushback on that had been that it was based on incorrect data and that as

Hackney insources more that brings extra costs with it so you need to very carefully disentangle that before making benchmark assessments.

JB replied that the process of benchmarking is currently underway and will continue during the interim period until a permanent replacement for Helen is appointed. This initiative aims to provide the incoming post-holder with a clear financial overview and established benchmarking data. To this end, contact has been made with the LGA and ADASS. Furthermore, discussions have taken place with the Section 151 Officer and the new Directors of Adult Social Care Finance and Children's Finance to examine current expenditure, allocation, and the prudence of spending. The potential involvement of the LGA for an independent assessment is also being considered. A key priority remains the achievement of excellent financial stewardship, with a continuous focus on identifying efficiencies to ensure that council and public funds are directed towards residents with the greatest need, thereby achieving optimal value for money.

5.8 The Chair stated that while he entirely agreed about the importance of financial stewardship his concern was that the Council properly looks at benchmarkws comparisons and then decisions are made for the right professional reasons. He added that for a future work programme there should have items on the progress of the reablement programme and he asked Members to keep a focus on benchmarking data and to request it.
He welcomed JB to her interim post and thanked her and the Cabinet Member for attending for this item.

RESOLVED: That the update be noted.

6 Adult Social Care Business Critical Performance Dashboards (20.20)

6.1 The Chair stated that the purpose of the item was to receive a briefing on the new Adult Social Care performance dashboards.

6.2 He welcomed for the item: Georgina Diba (GD), Director Adult Social Care Operations, LBH.

6.3 Members gave consideration to two documents:

a) Briefing note on ASC Business Critical Performance Dashboards
b) Business Critical Performance Dashboard as at Dec 2025.

6.4 GD in her presentation focused on the four critical performance metrics relevant to Adult Social Care that are part of the new corporate ‘Business Critical Dashboards’. She acknowledged from the outset that these do not constitute a comprehensive overview of the full breadth of Adult Social Care services. She further suggested that the Commission consult the new government guidance which has just been published for a more complete understanding of performance and outcome improvement.

The first performance area discussed was the type of care provided, with home care being the most prevalent. This trend is viewed positively as it signifies the maximisation of individuals' independence within their own homes. Direct payments, which empower recipients to select their own blend of care, follow in frequency. While residential care remains relatively stable, increases have been observed in both

supported living and nursing provision. The report also highlighted support for 161 individuals in extra care (formerly housing with care), noting that these specific services were rated 'Good' by the Care Quality Commission (CQC) following a recent inspection.

Secondly, performance related to Care Act 2014 activity was shared, focusing on formal assessments and reviews, including social work, occupational therapy, and carer assessments. It was noted that these figures do not encompass the extensive supplementary work undertaken by staff, such as safeguarding, multidisciplinary team meetings, and high-risk panel involvement. As an example of volume, the preceding month saw 214 Care Act assessments and 255 Care Act reviews completed by approximately 88 staff.

The third metric concerned the number of individuals awaiting assessment. The increase in demand, approximately 23% over the last three to four years, has resulted in waiting lists for both occupational therapy and social work assessments, though the latter is currently decreasing. A waiting list prioritisation policy based on risk is in place, and the service implements front-door measures to ensure urgent care is provided immediately when required. Initiatives to reduce waiting times have included conducting Care Act assessments at the initial contact, which has reduced the average time to be seen to 11.6 days.

6.5 The Chair interjected to ask how long people had been waiting which was not clear. GD replied that she could provide averages, that doesn't obviously give the whole picture, but for Occupational Therapists the average wait is 112 days, and for social work it's 300 days.

6.6 GD drew Members attention to the *Adult Social Care priorities for local authorities for 2026-2027*, recently published by the Department of Health and Social Care, which includes metrics on the waiting time for care assessments. The proposal is to utilise these new metrics and incorporate wider data, particularly focusing on service satisfaction, to gauge the outcomes for individuals. An initiative was mentioned where individuals with the longest waiting times were contacted and offered alternative assessment locations; however, the majority opted to wait for a home visit. This suggests that while waiting times are long, these individuals feel safe and are content to wait, prompting a need to reflect on current information, advice, and prevention strategies to reduce the reliance on statutory care.

6.7 Concerns were expressed regarding the presentation of waiting time data, with a suggestion by the Chair to differentiate the data by the level of urgency and risk.

GD explained how an initial triage process has indicated that a significant proportion of those waiting have expressed a desire to do so. She added that a more nuanced presentation of the data could provide a more comprehensive picture of the situation. It was acknowledged that waiting lists have become a national issue, primarily driven by a substantial increase in demand (from 2,600 individuals at the start of 2020 to 3,914 by the end of December) with no corresponding increase in staffing levels. The service's current focus is on preventing the need for the waiting list, ensuring the safety of those on the list, prioritising urgent care, and finding ways to support those with the longest waits from an equity perspective.

6.8 A Member asked about safeguarding inquiries noting that there was a plateau on the graph, which is welcome, and the report mentions the 32 inquiries are set

against over 200 concerns. While the graph does not map concerns against inquiries, this was a contentious point during the previous discussion at the Commission therefore he asked if there was merit in future in adding in figures for concerns within the graph to facilitate a comparison.

GD replied that they bring the full data set in September when the Safeguarding Adults Board Annual Report is presented and she would be happy to do this. They also as a matter of course do deep dives on the data and whether they are making the appropriate decision in terms of whether they meet their statutory duty, so again she would be happy to provide a more detailed feedback on the conversion rate from concerns to statutory inquiries.

6.9 A Member asked what 'strength based working' entailed.
GD replied that it was one of the eight Practice Principles they use. Instead of looking at a person from a deficit based model and what they can't do, they start with what they can do and build on that. So it's much more about looking at their abilities, their networks and the communities around them and actually using that as a platform to keep people as independent as they can be. So it's a specific approach that they often use in social work, but actually strength based is used across a number of different disciplines as well.

6.10 Cabinet Member Cllr Kennedy clarified that the set of slides and these figures presented by GD were drawn up before the Government guidance came out in December listing metrics that they particularly wanted to see adult social care departments reporting back on. He agreed with GD that it really makes sense for Scrutiny to look at how we compare on a regular basis with others based on the data sets that the Government will be collecting and for and this should form the basis of future regular updates to Scrutiny. The Chair asked who had come up with these metrics and CK replied it was the Business Performance and Internal Data team that came up with it, based on historic bits of reporting that we'd always done as an organisation. There was a logic behind it, but it hasn't kept up with developments in reporting especially in the health and social care area.

GD stated that a potential agenda item for a future meeting would be to review these new national guidelines. If this constitutes the established guidance this will enable effective scrutiny. She added that it is essential to gain greater clarity and benchmark data on waiting times, irrespective of these specific guidelines. Currently, it is challenging to ascertain whether we may be overlooking any best practice until this data is available.

6.11 The Chair thanked GD and CK for their attendance and report.

ACTION: GD to provide a future report in 6 months on Hackney's adherence to the new national benchmarks on adult social care with a focus on benchmarking our statistical neighbours.

RESOLVED: That the reports and discussion be noted.

7 Dignity for the Deceased: implementing recommendations from the Fuller Inquiry (20.40)

7.1 The Chair stated that the purpose of this item was to receive a briefing on how Hackney based organisations have responded to the recommendations of the

national Fuller Inquiry. The Fuller Inquiry was set up to look at how David Fuller was able to carry out abuse of the deceased at Maidstone and Tunbridge Wells NHS Trust Mortuary and issued an initial phase 1 report in November 2023. A phase 2 report was subsequently published in July 2025 containing recommendations as to how policy, procedures and practices in mortuaries, hospitals, hospices, ambulances, care homes and the funeral sector needed to be improved to safeguard the security and dignity of the deceased.

7.2 He welcomed the following presenters for the item:

Chris Lovitt (CL), Deputy Director of Public Health - City and Hackney
Emmanuel Ross (ER), Public Health Programmes and Projects Officer, LBH
Breeda McManus (BM), Chief Nurse and Director of Governance, Homerton Healthcare

7.3 Members gave consideration to a report from Public Health on the implementation of the recommendations.

7.4 ER stated he was a project officer for the Public Health Team in City in Hackney and the previous year was seconded for six months to Hackney Mortuary which had provided a first-hand insight into the vital work conducted there. The report addresses the local response to the Fuller Recommendations. The original Inquiry had been conducted in two phases: the first investigated the specific circumstances of the offence, while the second, published in July of the previous year, examined the systemic care of the deceased across various settings. The inquiry generated 75 recommendations, categorised by sector. City and Hackney Public Health has subsequently collaborated with relevant partners to review and facilitate the implementation of these recommendations. Key points of this report were that Hackney operates two public mortuaries: one managed by the Council and the other by the Homerton. Both facilities have confirmed that they have adopted measures to ensure compliance with the recommendations. Furthermore, the Council, through its Public Health function, has engaged with other components of the system to disseminate the recommendations and solicit their respective responses on implementation. It was also noted that central government had published its response, accepting a significant number of the recommendations, with others remaining under consideration.

He concluded that a lot of progress has been made locally and they were working to communicate with the sector outside of the hospital and the Council. Public Health also wanted to thank partners in Adult Social Care, Hackney Trading Standards as well as the Homerton and St Joseph's and local funeral directors for engaging with the work.

7.5 Members' Questions

a) With reference to point 3.17 of the report a Member expressed surprise that only two responses had been received from private funeral directors and that the Council is unable to compel a response as there is currently no licensing or compulsory registration scheme.

CL replied that initial observations suggest this is a notable omission. This was a recommendation put forth by the Fuller Inquiry and, as such, requires implementation by the national government. However, in the interim, they did instruct and request

Trading Standards to conduct visits following the events in Hull concerning the funeral directors there. Trading Standards department has acted upon this and consequently, they have been able to provide funeral directors with clear guidance on the proper care of the deceased. Nevertheless, regarding the actual regulation, the national government has not yet provided a response. He added that he understood they are committed to providing further responses to these recommendations, particularly those focused on enhancing the regulation of services like funeral directors, by the summer of 2026.

b) A Member commended the government's recent actions and the council's substantial progress in addressing previous regulatory deficiencies in this area. The reopening of the mortuary following repair works was also to be welcomed. He had a question however about the extent of cooperation achievable with partners under the current regulatory framework, though the existing relationship appears positive, referencing the successful partnership with Co-op Funeralcare for dignity funerals and the upcoming tender process. He also made a specific query about the status of the council's intended communication with care providers to obtain further information. Finally, he added that a significant number of government recommendations remain under consideration (21) or accepted in principle (43), with only 11 having been accepted and implemented.

ER replied that care homes in the borough have been written to and information is being collected for local monitoring and to offer support to care homes where gaps are identified. And then responses from care homes that are received by Hackney will be used in inform, follow up and improvement activity.

JB added a note from GD, who had left the meeting, stating that “As of 31 December last year, there were 13 residential and nursing care hubs operating within the borough, supporting 146 Hackney funded residents. And in respect of the Fuller recommendations, routine contract management is already in place, supported by individual placement agreements and scheduled quality assurance activity. But while our current contractual framework does not contain specific clauses relating to the Fuller recommendations on the care of the deceased, we will incorporate these requirements into the updated placement framework and associated quality checks for new placements from 26/27. We will also embed this area into routine site visits and provider forums across quarter one to quarter four, ensuring that expectations around dignity, secure processes and timely handover after death are consistently communicated, monitored and supported across the sector. All care homes in the borough have been written to and we are collecting this information for local monitoring to offer targeted support where gaps have been identified and use that for any quality assurance and improvement activity going forward”.

c) A Member asked about the implications locally because the government is still considering a significant number of Fuller recommendations and what action will be taken if care homes do not demonstrate improvements?

CL replied that the Inquiry was very detailed and made numerous recommendations. Substantial local effort has been undertaken to implement these recommendations, notwithstanding the current state of the regulatory framework, which may not fully align with the inquiry's desired standards. He added that specific details regarding certain recommendations have been omitted, primarily for security purposes, to safeguard against unauthorized access to premises and confidential data.

Significant progress in implementation has been achieved locally, he said, even while changes to the national regulatory framework—such as adjustments to the Care Quality Commission's inspection regime for care homes—are still pending. Communication with the CQC has already occurred, providing clear direction that council contracts will be modified and providers closely monitored.

While welcoming national regulatory change for the additional authority it confers, confidence remains high, he added, that key providers have been informed of and have implemented the recommendations, with a commitment to continually prioritise and address any remaining areas for improvement. The Fuller inquiry notably criticised the lack of systemic governance, and bringing this matter to Scrutiny positions this local authority as one of the first to do so since the recommendations were issued in June. By having this item the Commission is demonstrating the importance of this locally, ensuring high-quality oversight and effective questioning. A future scrutiny item, if desired, could provide further assurances. Regarding the governance requirements for Homerton Mortuary, the Chief Nursing Officer had overseen the implementation of recommendations via their Quality Committee. Within the council, the Director of Public Health holds the licence, and an internal audit process is in place to review policies and procedures, enabling rapid escalation of any required improvements to lead members and Cabinet.

d) The Chair asked BM to make any final comments from the Homerton’s perspective.

BM replied that they have implemented all relevant recommendations, as CL mentioned, and assured their Quality Committee and Board. They continuously monitor mortuary security and will update their Board annually for ongoing assurance, she added.

e) A Member asked if the proposed recommendations include a provision for incorporating the feedback of the deceased's families regarding their engagement with the service and could you elaborate on how this feedback is integrated into the current implementation of these recommendations?

CL replied that Hackney Mortuary facilitates the viewing of the deceased by family members, a service that is frequently commended. As part of broader recommendations, enhanced security protocols are being implemented to ensure rigorous verification of visitors and appropriate access to the deceased. The initial phase of the full inquiry focused significantly on gathering and amplifying the authentic testimonies of families affected by the criminal interference with the deceased. While families of the deceased were not directly involved in the current report's preparation, a feedback mechanism is in place to ensure that any measures adopted in response to the full inquiry do not unduly impede the ability of family members to view the deceased with dignity and appropriateness. He suggested that once the further recommendations, presuming government agreement, are established, this matter should be revisited for an updated presentation.

7.6 The Chair thanked the officers for their diligence in this area and for bringing the report.

RESOLVED: That the report and discussion be noted.

8 Minutes of the Previous Meeting (20.55)

8.1 Members gave consideration to the draft minutes of the meeting held on 11 November and the Matters Arising.

8.2 Members noted the updated Action Tracker.

RESOLVED: That the minutes of the meeting held on 11 November 2025 be AGREED as a correct record and that the matters arising and Action Tracker be noted.

9 Health in Hackney Scrutiny Commission Work Programme (20.56)

9.1 Members gave consideration to the revised draft of the Commission's Work Programme for 25/26.

RESOLVED: That the updated work programme be noted.

10 Any Other Business (20.57)

10.1 There was none.

Duration of the meeting: 7.00-9.00 pm