

London Borough of Hackney  
Health in Hackney Scrutiny Commission  
Municipal Year 2025/26  
Date of Meeting: Thursday 12 February 2026

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

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| <b>Chair</b>                      | <b>Councillor Ben Hayhurst</b>   |
| <b>Councillors in Attendance</b>  | <b>Cllr Kam Adams, Cllr Grace Adebayo, Cllr Sharon Patrick, Cllr Claudia Turbet-Delof, Cllr Ian Rathbone, Cllr Anna Lynch and Cllr Ben Lucas (Vice-Chair)</b>  |
| <b>Apologies:</b>                 | <b>Cllr Frank Baffour</b>  |
| <b>Officers In Attendance</b>     | <b>Jacque Burke (Group Director Children &amp; Education), Dr Sandra Husbands (Director of Public Health) and Lola Akindoyin (Head of Programme – Sport England Place Partnership)</b>   |
| <b>Other People in Attendance</b> | <b>Dr Kirsten Brown (Clinical Director, City &amp; Hackney Place Based System), Dr Stephanie Coughlin (Chief Partnership and Place Officer, Homerton Healthcare), Jed Francique (Borough Director Hackney, ELFT), Nina Griffith (Director of Integration, C&amp;H PBP), Councillor Christopher Kennedy (Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture), Andreas Lambrianou (CE, City and Hackney GP Confederation), Charlotte Painter (Commissioning, NHS NEL), Charlotte Pomery (Strategic Director of Commissioning, NHS NEL), Basirat Sadiq (CEO Homerton Healthcare, and C&amp;H Place Based Leader) and Sally Beaven (Executive Director, Healthwatch Hackney)</b> |
| <b>Members of the Public</b>      |  |
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## Councillor Ben Hayhurst in the Chair

### 1 Apologies for Absence (19.00)

- 1.1 An apology for absence was received from Cllr Baffour.

## **2 Urgent Items / Order of Business (19.02)**

2.1 There were none and the order of business was as on the agenda.

## **3 Declarations of Interest (19.03)**

3.1 Cllr Turbet-Delof stated she was a member of the Council of Governors of Homerton Healthcare NHS Foundation Trust.

3.2 Cllr Lynch stated she was a bank staff nurse at Homerton Healthcare NHS Foundation Trust.

## **4 City & Hackney Place Based Partnership - annual update (19.05)**

4.1 The Chair stated that this item was to receive an annual update on the City and Hackney Place Based System. The item would focus on the future evolution of the partnership in the context of wider health system changes.

4.2 He welcomed for the item the following partners and stakeholders:

Bas Sadiq (BS), Chief Executive, Homerton Healthcare and Leader of C&H Place Based Partnership

Dr Stephanie Coughlin (SC), Chief Partnership and Place Officer for C&H PBP at Homerton Healthcare and a local GP

Nina Griffith (NG), Director of Integration, C&H Place Based Partnership

Jed Francique (JF), Borough Director for City and Hackney, ELFT

Charlotte Pomery (CP), Strategic Director of Commissioning, NHS NEL

Dr Kirsten Brown (KB), Clinical Director for City and Hackney Place Based Partnership, NHS NEL and a local GP

Charlotte Painter, NHS NEL

Andreas Lambrianou, CEO, City and Hackney Integrated Primary Care (previously the GP Confed)

Dr Sandra Husbands (SH), Director of Public Health City and Hackney

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

Sally Beaven (SB), Executive Director, Healthwatch Hackney

4.3 Members gave consideration to a briefing note 'Next Steps in Partnership Development in City and Hackney'.

4.4 BS, NG, KB and CP took members through the briefing which covered: Introduction; Contest - what we know about the wider system changes; partnership development plan; governance; principles and approach to governance; the ICB team; and next steps.

4.5 In her introduction BS stated that as Chief Executive of Homerton and City and Hackney Place-Based Leader since May 2024 she wanted to explain why they are considering a revised leadership model, which NG will go into in more detail.

She was proud to work with talented leaders across health, social care, and the voluntary sector who were present at the meeting including: JF, AL, KB, JB, SH and

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also VCS partners such as HCVS and Age UK as well as CP, the Strategic Commissioner from NHS NEL. Their clear, pre-existing ambition in City and Hackney is to improve population health and well-being while reducing health inequalities. This goes beyond healthcare, encompassing mental health, social connection, financial security, housing, and opportunity. The partnership's core purpose is integrating these elements. National trends reinforce their ambition, she added. The 'NHS 10 Year Plan' outlines three major shifts that align with the Partnership's goals: hospital to community, sickness to prevention, and analogue to digital. The shift to prevention and community care are interdependent and crucial for transformation, requiring deep community embedding and voice. They are refreshing the partnership to design a Neighbourhood care service structured around people's lives, not organisational boundaries. They see opportunities with new capital funding for neighbourhood infrastructure, and are actively advocating for City and Hackney to benefit. Central funding expectations require reallocating resources from acute services to community and primary care, supported by transformation funds which CP would be able to address later.

Their mature partnership is key to executing these difficult decisions. Neighbourhood working is central to City and Hackney's long-standing partnership philosophy— they had been adopting this direction before it became national policy to address inequality and improve outcomes. They must define 'neighbourhood care' as holistic care—not just health—placing the resident at the centre, with a 'cradle-to-grave' perspective that prioritises children. Their "superpower" as she described it is the ecosystem of partnership they have created and which they must safeguard. The national message is to support and enable robust local neighbourhood care models, not impose change. City and Hackney is already cited nationally for successfully making the 'left shift.' We must leverage this position. This is an opportunity to transition neighbourhood care from a concept they are building to the core mechanism for delivery, with an articulable impact. This requires collective leadership and learning from others and she detailed a recent fact finding trip to the Netherlands to benchmark systems there where collaboration is key.

Crucially, they must broaden leadership to include new channels of communication with communities in Hackney. They must engage residents to ensure they understand the 'left shift' and that community-based care is not substandard, addressing concerns that the hospital currently feels safest. She handed over to NG who will detail the refreshed partnership program designed to achieve this 'gear shift'—enabling us to demonstrate meaningful impact on inequalities within one to two years, so people can tangibly observe the positive shifts in their lives.

4.6 NG reported on the future of the City and Hackney health partnership, building on its strong history of collaboration across health services, local government, and the voluntary sector. Following significant progress in integrated care since the 2021 shared vision, a refresh is now needed to align with national NHS reforms and improve local outcomes.

This work is driven by three systemic changes:

- 1) The NHS Northeast London ICB is moving to a smaller, strategic commissioning role, shifting focus to neighbourhood development.
- 2) Localities like City and Hackney will take more responsibility for delivery, including creating neighbourhood health plans, potentially overseen by Health and Wellbeing

Boards. 3) The 'NHS 10-Year Plan' promotes outcome-based, multi-provider contracts with capitated budgets to incentivise prevention and collaboration.

In response, City and Hackney partners have a 12-month development plan focusing on six areas: establishing a shared vision/outcomes; reinforcing trust; creating a delivery-focused governance structure with delegated power; defining core functions; embedding resident voice/accountability; and testing new financial approaches. A shared clinical leadership model is also underway.

The governance goal is to reduce duplication and establish a powerful Partnership Board with formal delegation from statutory bodies. A Memorandum of Understanding will underpin joint accountability, guided by strong partnership values and community voice.

NG emphasised that resident voice and public accountability are paramount, especially given national changes (e.g., potential Healthwatch abolition). Changes within the ICB will also significantly impact the partnership's formation. She concluded that success depends on trust, shared ownership, and collaboration, building on the partnership's strong foundation to deliver better outcomes.

4.7 KB emphasized the partners' shared belief in the need for robust, inclusive clinical and care professional leadership, rooted in frontline experience and resident insights. Due to NHS NEL's changing role, City and Hackney's clinical leadership model will evolve, increasingly drawing from partnership organizations.

Clinical leaders have developed a prospective model and agreed-upon principles, endorsed by the Executive Partnership, which mandate integrated, multi-level clinical leadership (neighborhood, place, and interfacing with NHS NEL/partners). Leadership must be diverse, agile, and flexible to meet changing population needs.

A future model envisions partnership leaders collaborating on strategic objectives. Clinical leadership will be formally embedded in all future governance to ensure clinical decision-making includes clinician participation—an established practice. The funding and sustainability of this leadership are agreed upon. This endorsed approach is now being implemented, she added, to maintain strong, equitable clinical and care professional leadership.

4.8 CP provided the perspective from the NHS NEL (the ICB). She stated that on February 12th, the ICB had finalized and shared its organizational structure with staff, following a consultation period. Simultaneously, the ICB submitted planning documents to NHS England, detailing its approach to swiftly implement 'left shifts' to improve local health and well-being.

The new structure, designed to deliver strategic commissioning and integrated neighbourhoods, is to be divided into four main departments:

Finance and Corporate Support (focusing on strategic resource allocation and health equity),

Strategy and Population Health (defining priorities, integrating analytics, and driving the digital agenda),

Clinical and Quality Commissioning (implementing a new clinical leadership model to achieve a 50% running cost reduction), and

Strategic Commissioning (encompassing commissioning frameworks, pathways, contracting, and procurement, with a focus on primary, proactive, and planned care).

Crucially, the ICB retains capacity at the place level with two Neighbourhood Development Directorates. Each place will have a Place Deputy Director leading a small team focused on neighbourhood development, primary care support, medicines optimisation, and engagement, ensuring strategic commissioning is grounded in local experience and VCS collaboration. The ICB also prioritizes workforce commissioning, linking with wider determinants of health like employment.

Acknowledging the challenging 50% workforce reduction which is required of them, she commended the staff for their dedication during this difficult time.

To facilitate 'shifts left' towards community, prevention, and digital enablement, she added, the ICB had announced significant recurring investments: an additional £10 million annually into primary care from April 2026, largely for enhanced long-term conditions management, and £20 million annually for mental health across North East London. The transformation fund would also invest in neighbourhood health (including clinical leadership and VCS engagement), 'care closer to home' (for unplanned/urgent care), and long-term conditions prevention. Her update covered both the final ICB structure and the submission of key planning and investment documents.

## Members' Questions

4.9 Members asked questions and the following was noted:

a) Given the welcome retention of a deputy director and a small team for City and Hackney within NHS NEL and despite budget constraints, could an update be provided on the status of key roles and personnel within the organisation, specifically clarifying: does a place-based lead, such as Basirat Sadiq, remain in post; will the Clinical Director role, previously held by Dr Brown continue, along with the primary care lead role; and have the funding streams for the integrated primary care organisation (formerly the GP Confederation) been committed, in light of the impending dissolution of the borough level Health and Care Boards?

CP replied that the Place Based Leader will remain as that is not a function they're seeking to shift. The Clinical Director role will also remain at Place as will the number of their sessions but the sessions will have more of a locality focus and then feed into the Strategic Commissioning from from the Place perspective as now. A number of Place Clinical Directors will also take on a role across NEL e.g around Planned Care or Urgent Emergency Care for example. It is really important that they've kept that as other clinical models are more centrally based. The funding they're putting in through Neighborhood Health development will detail how they want clinical leadership to work locally. They have in effect made funding available for a full-time clinician to work in the Place and for that to be distributed as the Place sees most appropriate.

KB added that the new role, "Clinical Director for Neighborhood Development," will differ from her current position, and her own appointment has not yet been confirmed. The remit will change. She added that currently, she manages about 20 NEL-funded clinical leads, including Zara (the Primary Care lead for C&H). NEL funding for these roles will end however. She added however that transformation funding exists for place-based clinical leadership. She was working with partner clinical leaders to decide how to best use and invest this funding. They agree that a strong clinical leadership across all partners is vital for system success, fostering relationships, and achieving true integration and efficacy.

b) The Chair commented that NGs points regarding the three major changes—specifically the ICB's shift towards a more strategic, less commissioning-focused role, with greater emphasis on providers, and the responsibility for delivery resting at a 'place' level—presents a logical inconsistency. He stated that to assign responsibility for delivery to an area, that lacks the necessary financial levers to deliver them, constitutes an inherent contradiction, or an oxymoron, and risks being perceived by the public as a typical political manoeuvre.

NS replied that despite initial optimism, the role of the ICB had shifted, meaning the local place-based partnership will no longer retain a strategic health commissioning function. This change is viewed as an opportunity to maintain a strong collaborative relationship with the ICB for service delivery and to develop a more genuinely integrated place-based partnership. The plan is to create a structure with delegated authority from the local Health and Well-being Board and provider boards, allowing the local partnership to remain influential as the ICB's role evolves. Future changes in NHS commissioning, such as aligned incentives, are anticipated, offering further opportunities for collaboration with the ICB to benefit City and Hackney.

c) A Member raised concerns about potential conflicts of interest, noting that some partners on the boards are also delivery partners, effectively "marking their own homework." She asked if this had been analyzed and considered, and if patient voices are represented on the boards. The Chair sought clarification on whether "the board" referred specifically to the Health and Wellbeing Board.

BS began by addressing the issue of conflict of interest, acknowledging the experience of others present, and asserting the necessity of committed leadership focused on patient-centred care and improved outcomes. She observed that successful systems involve leaders making crucial decisions, and a healthy degree of disagreement exists among the current group regarding the optimal approach. However, a framework for progression is in place, built on mature relationships. She emphasizes that maintaining focus on the overarching ambition and vision will ensure appropriate leadership and sound decisions, a belief supported by the historical context of City and Hackney. The delivery of the necessary care outcomes will ultimately justify this approach, she added.

NG added the strength of the partnership is consistently rooted in its ability to unite both service providers and commissioners. Therefore, the inclusion of delivery agents at the decision-making table is considered vital and a fundamental strength of this collaboration.

However, acknowledging the inherent difficulty in self-evaluation—the issue of "marking one's own homework"—it is recognised that the governance structure must incorporate a mechanism for accountability regarding delivery. This accountability will likely be established through two primary channels. Firstly, a highly robust system for public accountability is being developed to clearly demonstrate that the partnership is acting in the best interests of our residents. Secondly, the Health and Wellbeing Board will be utilised to provide a further layer of oversight. She stated that they anticipate that the Partnership Board will have a formal reporting line to the Health and Wellbeing Board, operating under delegated authority from it for the implementation of the Neighbourhood Health plan. Consequently, the Health and Wellbeing Board will exercise oversight to ensure the Partnership Board fulfils its stated obligations and objectives. The precise mechanisms for this relationship are currently undergoing final development.

d) The Chair asked for further clarity on reporting lines and accountability to residents.

NG replied that they are still at the early stages on the nuts and bolts of how the governance system will operate. She added that they are also still awaiting national guidance regarding the contents of the neighbourhood health plan and the responsibilities of the Health and Wellbeing Boards in relation to these plans. Ultimately, they believe they are accountable to the local population of City and Hackney. They will also be accountable to the Integrated Care Board (ICB) as their commissioner of health services. Furthermore, there will be an accountability to the Health and Wellbeing Board, as this is likely the body that holds the statutory responsibility for the neighbourhood health plan. However, at this early stage, we cannot describe in detail what that accountability will entail.

e) The Chair asked how the BS will balance the urgent need for increased community service spending with the significant financial pressure on her own Trust, which like others now faces no future bailouts. Given board pressure and accountability, how will she manage these competing demands for investment in the community versus adherence to central DoH imposed budgetary demands on the system which the large Trusts themselves must deliver?

BS replied that in her capacity as Place Based Leader she chairs the Executive Partnership Board, consciously separating this role from her responsibilities as CEO of Homerton Healthcare. She emphasize the paramount importance of partnership resilience and shared commitment, citing a past example where Cost Improvement Programmes were collectively reviewed to prevent detrimental decisions by single organisations.

She strongly supports the strategic shift of resources from acute to community care, viewing it as achievable through transformative work and she stated she believes additional support, as outlined by Nina, is vital to build the necessary trust and confidence so that the partnership will always act in the system's best interest. This collective relationship ensures that the system supports an individual organisation even when a beneficial partnership decision adversely affects it.

The principle is currently demonstrated in discussions, including those about primary care. She acknowledged the constructive tension that is being actively managed but stresses the need to prioritise actions benefiting the population. She concluded by stating this is what stakeholders should expect and that the leadership should be held accountable if they fail to deliver on this commitment.

f) A Member commended the ICB staff for their challenging work stating that she knew many in the system who are awaiting decisions. She asked how these proposals align with concurrent local government changes, specifically the 2024 English Devolution White Paper. This paper suggests potentially abolishing local council health scrutiny panels, favouring reporting directly to the Health and Well-being Board. She asked if they'd considered this potential shift, or any changes regarding elected mayoral roles in London boroughs in health scrutiny. She added that while the final direction is uncertain, this background of reduced localism is a concern. Specifically, she worried about the loss of Health Scrutiny committees, which are a crucial forum for councillors and residents both for raising concerns and celebrating successful partnerships.

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CP replied that public services generally are undergoing extensive reforms, including devolution, changes in children's services, safeguarding, SEND, and adult social care. This substantial volume of change presents significant challenges. Areas impacted by devolution are also navigating complex changes across the Integrated Care Board (ICB) structure, NHS England, the Department of Health and Social Care, and local government.

A genuine concern exists regarding local accountability. The Health and Well-being Board is a current focus, but planning guidance for neighbourhood health plans and the Board's role remains unpublished, despite being anticipated since November. This indicates ongoing discussion about neighbourhood planning and the Boards' function.

Regarding ICB Board structure, the prevailing view, she added, is for streamlined local government representation, often linked to the elected mayor. For example, in London, the Mayor is expected to delegate this ICB representation to another elected member.

The scale of change is considerable and difficult to track. The status of previous scrutiny reform proposals is unclear. Healthwatch also anticipates changes, although some resistance has been noted in the House of Lords. In summary, a massive volume of interconnected change is underway, making a holistic overview challenging.

g) Sally Beaven commented that Healthwatch Hackney currently has a standing agenda item on the Hackney Health and Wellbeing Board, which they use to present resident feedback. She was considering whether, perhaps from April onwards, HWB could support the neighbourhood forums to each introduce an item representing their individual neighbourhoods. The focus is on how they can begin working to ensure that the neighbourhood resident voice is effectively channeled to the appropriate decision-making bodies, and that residents feel their concerns are being heard.

SH replied that in response to the Member's challenge regarding local accountability, it will be maintained through the Health and Well-being Board. While they await formal guidance and potential new legislation regarding the remit and composition of the Health and Well-being Board, they can assure Members that it remains a member forum, thus providing democratic accountability. As SB just described, the element of community voice is already embedded within the Board, and they are committed to developing this further. Therefore, even in the absence of guidance and new legislation, they are actively considering how to maintain local accountability alongside ensuring the partnership operates effectively.

h) A Member asked for clarification on how the partnership will measure the direct impact of current health inequality initiatives on local residents. Also what were the primary challenges integrating the local authority and the NHS over the last year?

SH replied that the Population Health Hub, despite Integrated Care Board (ICB) changes, has been crucial. It not only focuses on reducing health inequalities through specific projects but also offers vital support, like robust evaluation frameworks, to the entire health and care partnership. While overall population health improvements take time to measure, the hub is successfully measuring immediate indicators such as reductions in inequities in access, care outcomes, and patient experience. She reassured Members that mechanisms and tools to measure health inequalities are in place, monitored at various levels.

KB replied that effective integration is best achieved at the neighbourhood level, where frontline clinicians and care professionals can address population needs. Consequently, their future integration efforts are heavily focused here. While some integration is needed at the 'place' and ICB levels, the neighbourhood program is delivering the true potential for convergence, with all partners fully engaged and observing increasing success. The next phase, involving integrated neighbourhood teams, will focus on practical frontline service delivery and optimisation. She added that she was highly optimistic about this collaborative engagement, as they have secured very strong commitment from all partner organisations.

i) Members asked how population health and health inequality will be explicitly prioritised in the new vision and how City and Hackney will ensure a strong voice within the wider North East London system?

KB replied that their focus for delivery is centered on neighborhoods, underpinned by a commitment to population health and the reduction of health inequalities. They are currently undertaking a pilot project utilizing a population health data system named Optum, which is specifically examining a cohort concerning frailty and proactive care. This initiative will form the foundation for all their neighborhood-based work. This pilot represents the initial stage of their operational approach, with population health management positioned as the core of the activities.

Building on KB's points CP noted that the ICB's allocation of funds to Optum for service delivery across places and neighbourhoods demonstrates a strong commitment to local, place-based working and commissioning. They are dedicating ICB capacity and are firmly committed to this robust approach. This emphasis on neighbourhood health is now embedded in all layers of health and social care policy, including Better Care Fund reforms and adult social care. While operating within a flexible London ecosystem, the importance of prioritising neighbourhood and place, alongside the broader North East London and London regional strategy, is fully acknowledged.

4.10 In closing the Chair stated that there was a degree of reassurance here that, at a management level, we appear to be maintaining a cohesive structure at Place, whether through the small team at the Integrated Care Board (ICB) or the executive partnership and it's a welcome development. He added however that questions persist regarding the governance function and potential conflicts of interest. He added that he still lacked a full understanding of the mechanism for leveraging additional funding should a need be identified, amongst other related issues, which he hoped will become clearer over time. Therefore, this may be an item to revisit once this new system is more firmly established, to gain a greater comprehension.

Furthermore, he added, there were other points they did not have time to explore, such as the feasibility of meaningfully shifting funding from acute care to prevention or to Place, and the matter of capital funding, which BS alluded to, and which the Commission would be keen to examine in the future. He thanked the senior executives attending and stated the Members appreciated their commitment to the locality and ensuring that this new system functions optimally for the benefit of Hackney.

He added that a future agenda should also look at the implications of the capitated budgets particularly concerning the current budgetary landscape. Historically, based

on demographic weighting over the past decade, Hackney has fared relatively well. However, the critical question is what our position will be moving forward, especially if the Department of Health ceases to backfill provider overspends, which he understood to be the emerging consensus. These and other related impacts on our residents will warrant future discussion by next year's Commission.

RESOLVED: That the report and discussion be noted.

## **5 Sport England Grant Award for the Hackney Place Partnership (19.50)**

5.1 The Chair stated that this item was to receive a briefing on the Sport England grant award for the Hackney Place Partnership building on the previous King's Park Moving Together Project.

5.2 He welcomed for the item Lola Akindoyin (LA), Head of Programme - Sport England Place Partnership (Hackney)

5.3 Members gave consideration to the following reports:

- a) Presentation 'Conditions for tackling inequalities in physical activity - next steps for Hackney's Place Partnership work with Sport England'
- b) The Cabinet report on the decision from 24 Nov '25.

5.4 LA took Members through her presentation in detail and reminded them that this was her third visit and they had tracked the journey of the Sport England partnership from its beginning. She was pleased to report positive news: the financial commitment is £1.6 million, plus an additional £293,000 for Multi-Use Games Areas (MUGAs), totaling almost £2 million. They started this initiative almost eight years ago. Sport England aimed to understand the main barriers to physical activity and pilot interventions, focusing on King's Park ward—one of twelve national pilots. A core goal was to use community insight to inform future investment strategies. The learning from these twelve locations has shaped Sport England's current strategy, underscoring the importance of place-based, collaborative partnerships guided by community insight, evidence, and a clear understanding of local opportunities and barriers. The work in King's Park identified critical elements encouraging less active residents. A key principle has been adopting a strength- and asset-based approach, not creating new initiatives but strengthening existing community assets and dismantling barriers.

Specific initiatives included enhancing Daubney Fields with new pathways, an outdoor gymnasium, and active play equipment. We've learned the importance of hyper-local spaces, which explains the increased focus on MUGA work, an excellent example of applying community insight championed by partners external to the formal structure. Findings confirm that MUGAs, located close to homes, are pivotal for increasing physical activity.

The community partners were essential. They collaborated with organisations whose core mission isn't exclusively physical activity but who use their expertise in addressing wider inequalities to connect with groups needing support. The goal is multi-faceted: building confidence, establishing social connections, and introducing people to safe, comfortable local spaces, exemplified by physical activity sessions hosted in Homerton and Dalston Libraries.

Moving forward, they will expand and deepen this work to other borough areas, continuing to build on the established foundation. Sport England advocates for intensifying similar efforts while maintaining a system-wide approach, seeking new partners, activating key spaces, and collaborating intentionally with community partners.

A new priority, she reported, is integrating physical activity into talking therapies, alongside improving data and insight capture to inform policy and contribute to regional/national understanding.

In summary, effectively addressing physical activity inequalities requires a multi-domain approach considering all resources (policy, practice, and assets). Building individual and community capacity remains central. Therefore, continuity is vital, and their work must connect with efforts addressing wider inequalities, as physical activity inequalities are not isolated.

## 5.5 Members Questions

a) The Chair enquired about the integration model with IAPT (talking therapies). Will participants transition directly from IAPT to a related activity commissioned or provided by the service? He then raised access issues, citing Mabley Green's MUGAs. He frequently sees children scaling the fence to use the facility after the caretaker locks it post-final football match. This irony—children keen to play but blocked by inaccessibility, perhaps due to excessive health and safety concerns—needs addressing. How is the problem of access being managed?

LA firstly apologised for being the sole presenter, she had hoped to have a Sport England and IAPT rep with her but the scheduling changes prevented that. She stated that she was very enthusiastic about the Talking Therapies partnership. This aligns with a Sport England/healthcare transformation initiative, selecting Hackney, Pennine Lancashire, and Doncaster as mental health trailblazers. The deeply integrated model, evaluated by UCL, incorporates physical activity as a core treatment component. Post-treatment, community referrals will sustain activity. Crucially, the model builds clinicians' capacity to support patient physical activity. While she personally lacked the full subject matter expertise on this, clinicians had made clear that the potential for strong clinical outcomes here was very significant.

Regarding MUGAs the focus is multifaceted: fostering greater inclusion (e.g., for women and girls) and activating spaces; improving physical condition and utility; and addressing systemic issues concerning maintenance, management, and access which they hoped would bear fruit in the long term..

b) A Member stated he was impressed by the final report from the initial project phase, particularly the strong statistics on inclusivity, outreach, and participation. His main query concerns the expansion: what methodology and robust data supported the selection of locations for the next phase? He briefly reviewed the material and noted data caveats on the cover page and sought clarification on the selection mechanism and the confidence level in reaching residents with the greatest need. Finally, he asked, with the King's Park phase complete, could the officer detail the measures for integrating capacity building to ensure the capability and positive progress achieved are sustained beyond the funding period.

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LA replied that the identified areas, aligned with existing borough data, were determined by Sport England using their Place Needs Classification (PNC), which utilizes various datasets to locate areas with the least active residents. As Sport England is funding this, the deepening phase must focus on these PNC-identified areas, not local decisions. Learning from the Kings Park Moving Together initiative, they identified strong community-based physical activity leadership. Their strengthening efforts will increase the visibility of this excellent work and foster greater partner collaboration.

To support effective organizations, they are developing mechanisms for peer assistance. In collaboration with Public Health, they are establishing two forums: a quarterly Physical Activity Network for community delivery organizations, and a forthcoming Community of Practice, launching soon after last year's event, to bring together stakeholders focused on increasing physical activity in Hackney.

c) A Member stated that this initiative was very encouraging and resonates positively. Hackney recognises mental health as a fundamental human right and has previously called for more diverse therapeutic approaches, which this initiative seems to embody. The incorporation of sports as a somatic experience for mental health support is particularly welcome. Her observation is about talking therapy's high dropout rate. Given UCL's data analysis role, it would be beneficial to understand how this integrated approach might improve retention. In addition, regarding the MUGAs, she presumed "hyper-local" means Kings Park. A concern in her ward is the vulnerability of MUGAs to redevelopment, specifically for housing. She asked if they were considering the risk of MUGAs in the borough being susceptible to redevelopment?

LA replied regarding the mental health trailblazer, that there's a significant opportunity to analyze data on the efficacy of interventions, including system-embedded, often group-based services, and the sustained contribution of physical activity to well-being. She could share this information with the commission as the delivery phase progresses, following the planned April 1st launch, supported by an advisory group.

The MUGAs initiative is a partnership effort with Hackney Quest, a community insight partner. They will investigate various areas, including the protection of MUGAs' the impact of development and changes, and the dual nature of MUGAs as potential locations for activation and support, but also associated with occasional harm. They will be examining the full spectrum of issues to ensure they meet all community needs.

d) The Chair suggested that a progress update would be beneficial when this initiative returns during the delivery cycle. He presumed they will be required to produce data sets for Sport England detailing the engagement with their services. Therefore, it would be useful to receive a summary of the infographics presenting this data, including the number of participants, the rate of attrition, and the number of supported areas. This overview of the project's scale would be helpful for a subsequent meeting

e) A Member commented that it was very important that Hackney sustains this grant and she asked how success would be measured in the long term and about the sustainability after the initial funding period.

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LA replied that their multi-faceted approach, detailed on slide six, outlines the conditions for increasing resident physical activity. They partner with Sport England's national evaluation team to review activity across Hackney and assess our system's maturity. This systematic review is crucial for gathering evidence, particularly as many initiatives happen outside their immediate scope. Integrating these elements provides a comprehensive picture of how they collectively work to reduce physical activity inequalities. Simultaneously, she added, they focus on understanding what is happening, for whom, and what types of activity are being undertaken, identifying who we are engaging and who they are missing. Therefore, a key part of the work is enhancing data collection with community partners, co-designing a mutually beneficial approach that meets their operational needs and the Sport England reporting requirements.

Cllr Kennedy (Cabinet Member) added that the deepening involvement funding was secured after a rigorous selection and a challenging interview process, solely due to the exceptional work of Lola and the team, for which the Council was sincerely grateful.

Regarding MUGAs, their partner, Hackney Quest, successfully ensured all relevant borough organisations signed a MUGA Charter. All organisations have now confirmed ownership and are the designated point of contact and formally responsible for any issues—a commitment that was previously lacking. This initiative, emerging from a temporary funding source, is expected to create a lasting legacy.

f) A Member asked if LA could elaborate on the lessons learned from the "Kings Park Moving Together" initiative and how those insights will be applied to the seven identified neighbourhood areas going forward?

LA replied that supporting individuals to increase physical activity is complex, facing many obstacles. A critical insight is that social contact often drives and sustains participation; thus, facilitating these opportunities is vital. Activity retention correlates strongly with enjoyment, as seen in the successful Homerton Library hula hooping project, which boosted mental well-being through intrinsic pleasure and peer connection. These initiatives are the result of collaboration with community partners, combining their established practices with designs tailored to the borough's diverse needs and demographics.

5.6 The Chair drew the item to a close, noting that the 'go live' date for the project is anticipated for April 1st. He asked if officers could present, in 9-12 months, an update, including a concise data summary, on all current initiatives. He also echoed Cllr Kennedy's praise to Lola for her diligent work in securing this very successful bid and appreciated her long and beneficial service to Hackney.

**ACTION 1:** LA to ensure that information about the clinical outcomes of the mental health trailblazer is shared with the commission once available.

**ACTION 2:** LA to return in 9-12 months with a progress report on the Sport England project continuing an overview and infographics presenting such data as the number of participants, the rate of attrition, and the number of supported areas etc.

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

## 6 Cabinet Member Question Time - Cllr Kennedy (20.15)

6.1 The Chair stated that It was customary for each Cabinet Member to attend one Cabinet Member Question Time Session each year with their relevant Scrutiny Commission. The purpose is to allow Members to ask questions on areas separate from a review or other key work programme items being considered during that year. To make these sessions more manageable Cabinet Members are confined to three agreed topic areas and gives a verbal report followed by a Q&A.

6.2 He welcomed Cllr Christopher Kennedy (CK), Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture

6.3 The three topic areas requested by Members were:

1) Central government has a major advertising campaign called 'Care' to recruit more care workers. How is Hackney improving recruitment and retention of care workers in the context of managing increasingly large and complex demand?

2) How can boroughs like Hackney retain the vital importance of 'Place' in dealing with the NHS, when ICBs are embarking on a number of initiatives such as reviewing the existence of Health and Care Boards (the local sub committee of our ICB), eliminating 'place' based commissioners, and potentially reducing the representation from local authorities on the ICB itself, all at the same time as local Healthwatch reps will disappear?

3) Are you confident that the local system response to measles outbreaks is sufficiently robust considering outbreaks continue intermittently, and what progress has been made on vaccinations?

6.4 On Q1 Recruitment and Retention Strategy for Hackney's Social Care Workforce Cllr Kennedy stated that the sustainability and quality of social care services in the Hackney are intrinsically linked to the health of its social care workforce. This workforce is distinct in its composition, with a significant majority—approximately 73%—employed within the independent home care sector. While this independent workforce is the backbone of care delivery, it presents unique challenges, particularly regarding staff stability.

The compensation structure within the independent sector in Hackney generally offers an hourly wage slightly above the London average. However, this marginal pay advantage has not translated into low staff turnover. Worryingly, the turnover rate in the independent sector is nearly double the regional average for London. This high churn necessitates continuous recruitment efforts. A mitigating factor, however, is that an estimated three-quarters of the employees who leave their roles within Hackney's independent sector remain within the broader social care sector, suggesting a retention issue within specific providers or roles rather than a wholesale flight from the profession.

Despite the turnover challenges, a positive indicator for the overall health of the local social care market is the low vacancy rate, which stands at 5.7%. This figure is significantly below both the regional and national averages, suggesting that while

retaining staff is difficult, the borough is relatively successful at attracting new entrants to fill required positions.

The Council plays a vital role in supporting and professionalizing the independent workforce. Key to this support is the collaboration with organizations like "Flourish," which provides essential training and development opportunities for staff across the commissioned providers. Furthermore, the Council has implemented a critical policy lever by mandating that all commissioned home care providers must adhere to and pay their staff at the London Living Wage. This measure is designed to improve the economic viability of a career in care and reduce the incentive for staff to seek employment outside the sector purely for better pay.

A significant strategic overhaul is underway in how the Council commissions care packages. The previous practice of 'spot purchasing'—where individual care packages were procured on an ad-hoc basis—is being phased out. The Council is transitioning to a more structured and efficient approach, utilizing frameworks and Dynamic Purchasing Systems (DPS). Concurrently, the implementation of a dedicated home brokerage function is proving crucial. This function is vital for the swift and efficient coordination of care packages, particularly those required to facilitate timely patient discharge from local hospitals, thereby easing pressure on the health system.

While the independent sector is the largest employer, the Council maintains a direct workforce, primarily comprising staff in its extra care units, who represent approximately 8% of the total social care workforce. For this internal team, the Council maintains a robust focus on staff development and long-term career planning. This includes fostering professional progression pathways and offering social work apprenticeships to cultivate local talent and ensure a pipeline of qualified professionals.

Internal surveys conducted among the Council's own social care staff consistently indicate high levels of job satisfaction, which reinforces the effectiveness of the internal development and management strategies.

A concerted effort is also being made to reduce the reliance on external agency staff, a common challenge across the public sector. The Council is proactively moving agency workers onto fixed-term contracts where appropriate to convert temporary capacity into stable, contracted employment. When external support is genuinely necessary, the Council utilizes the "Connect to Hackney" agency platform, a controlled and vetted system designed to ensure quality and compliance while minimizing reliance on expensive external agencies. This strategic approach aims to build a more stable, satisfied, and high-quality internal social care team.

## 6.5 Members Questions

a) The Chair asked for clarification on two points. First, on the CQC inspection: setting aside that it will be an item at the next meeting could he update specifically on feedback concerning the need to expedite the move away from spot purchasing for care workers. Secondly, how does the insourcing of 25 staff reconcile with the Council's long-standing affordability concerns regarding broader insourcing, or is cost not the primary barrier?

CK replied that the CQC correctly observed an excessive reliance on 'spot purchasing' instead of adopting framework approaches, particularly Dynamic Purchasing Systems.

This transition is essential for market fluidity. A robust provider onboarding process is key to securing better value and appropriate care. The service was essentially insourced six years ago, before he took on the portfolio. However, legacy agency contracts persisted due partly to the original insourced contracts offering 37-hour agreements with no overtime provision. Overtime, such as for staff illness, was offered to agency staff, incentivizing them to remain agency workers for more hours. We had to gradually and equitably modify in-house contracts to incorporate overtime flexibility, which aided the subsequent staff onboarding.

b) A Member commented that Hackney's staff retention is strong, with movement typically remaining within the sector. Despite the current national care advertising campaign, what single measure could the national government provide to Hackney Council to resolve all its retention and recruitment challenges?

CK replied that the central issue has been correctly identified. A consultation regarding fair remuneration for adult social care is currently underway and directed at national government. However, as local authorities, we have requested the opportunity to implement these changes locally. Analogous to the approach taken when reconciling differing rent levels between registered social landlords and council rates—allowing a period for convergence—local authority feedback to the consultation has been largely supportive of improved pay rates. Nevertheless, we acknowledge that local authorities will not receive upfront funding to immediately implement these enhanced rates. Therefore, the focus is on convergence. The government could provide a clear pathway to convergence, which would lead to uplifted entry-level pay rates, standardized across the sector. Ultimately, the long-term goal is to make social care as attractive as working within the NHS, though this constitutes at least a ten-year plan. This matter may also be addressed in the Casey report.

c) A Member stated he was impressed by the successful retention of care workers. He asked if CK could provide the age range of carers and the proportion who are local residents? He also asked if we prioritise local recruitment and what the most common caring role was in the borough?

CK replied that the care workforce is predominantly older (likely over 50) and approximately 85% are Black and Global Majority women, making pay a significant equity issue.

Regarding local employment, 95% of staff employed by commissioned care providers for Hackney residents live in the borough (or the borough where the facility is located for residential care), indicating a very localised workforce.

The primary activities residents require assistance with, in order, are: dressing, transferring in and out of bed, and toileting. Most care packages involve assisting with at least two of these three activities per home visit.

6.6 Before moving on to the second theme for Cllr Kennedy the Chair stated that the second question reply can be brief because they had spent a time on the subject in the first item, but he would like CK to elaborate more on the local authority representation on the ICB board going down from two to one councillor and the general issue of political governance in the new system.

6.7 On Q2 (retaining the vital importance of Place in dealing with the NHS) CK stated that his prepared remarks have largely been covered in item 4 so he would

offer brief supplementary points. The core governance change is a reduction to one Councillor representative on the ICB and Cllr Warby from Barking and Dagenham and he would have to compete for the single statutory representative role on the new Board, though the Chair Dame Marie Gabriel is seeking a way to retain both of them.

Regarding capital, Basirat Sadiq noted funding for neighbourhood centres is becoming available to support the transition to neighbourhood-level engagement. There is also an underused opportunity for public questions at the Health and Wellbeing Board, which has been utilised only twice in about five years. He added that Lord Hunt in a lengthy article stated that the House of Lords would never agree to the elimination of Healthwatches, a view shared by most informed opinion.

Finally, he commended BS's excellent articulation of the 'sickness to prevention' and 'hospital to community' shifts which had been discussed under item 4. Crucially, the 'analog to digital' shift is the third enabler for effective neighbourhoods and resource management. The locally funded Optum work (successor to EIS) provides vital system-level data analysis. For example, City and Hackney use the Rothwood frailty index, age data, and GP/A&E attendance to identify the most vulnerable. These individuals are offered a personalised health plan to reduce frequent visits, which facilitates the other two strategic shifts.

## 6.8 Members Questions

a) A Member commented that her experience at the Homerton showed a remarkable level of digital optimisation, making pens virtually unnecessary even at the ward level. The Trust deserves praise for its digital commitment. This commitment was recently recognised, particularly for its 'ambient technology.' This involves recording patient consultations (with consent), allowing clinicians to focus entirely on the dialogue instead of typing. The subsequent recording is processed using AI, which is always subject to appropriate oversight. She stated she had great confidence in the new system discussed. From a commissioning perspective, there should be no concern regarding its effective use. The organisation has a clear cultural drive for digital optimisation, always prioritising the patient and equity, especially for those requiring extra time due to language barriers or complex terminology.

b) A Member stated he was surprised by CK's statement that only one or two public questions have been submitted in the last five years to Health and Wellbeing Board. This raises a question about public awareness of meeting schedules and question submission opportunities, as he had no recollection of being notified about these public meetings. How are the public informed of these meetings and the chance to submit questions?

CK replied that public awareness of the Health and Well-being Board is low, largely because information dissemination, such as via X (formerly Twitter), has failed to reach the general public, primarily attracting existing organizations like "Keep Our NHS Public." A major challenge, especially with the Board's anticipated role in neighbourhood health plans, is effectively publicizing the public question time and genuinely holding the system to account. We need to find better ways to advertise this opportunity, he added. He suggested perhaps that this Commission could play a more significant role in both scrutiny and boosting public awareness of how to participate. In response to recent concerns about potential abolition or erosion of health scrutiny structures (at the time the NHS Ten Year Plan was published,) he stated that the Commission is a statutory function and cannot be prevented from meeting or

performing its duties. Furthermore, key system partners in Hackney have always been keen attendees at the Commission and at HWB.

6.9 In response to Q3 on measles CK stated that his immediate assessment was affirmative regarding the robustness of our current system response. However, his confidence did not extend to the future. This apprehension was due to the fact that we currently have the lowest, MMR vaccination rates in the nation. In 2024, Hackney had been surpassed by Birmingham, Lambeth, and Wandsworth in the number of confirmed cases, but in 2025, Hackney recorded the highest number of confirmed cases nationwide. The effectiveness of our system response is attributable to the presence of an Enhanced Immunization Service, which operates out of the Springfield Park Primary Care Network (PCN). Regrettably, this service is currently funded by the Integrated Care Board (ICB), and as yet, they have not secured future ongoing funding for it. This is why his confidence is high for the present but diminishes when considering the future.

#### 6.10 Members Questions

a) A Member stated she was deeply concerned about the high incidence of measles in Hackney, which consistently has one of the lowest MMR coverage rates in the country. Previous strategies have obviously failed to significantly improve uptake. She proposed utilising schools as proactive vaccination delivery points to reach children in situ, rather than relying on parents to attend surgeries. She added that the NHS must actively engage with parents where they are—in schools and playgrounds—to increase coverage and ensure parents understand the severity of measles, which can be fatal or cause lasting damage. Furthermore, she stated that health partners must counter the significant social media misinformation regarding the MMR vaccine, much of which is rooted in the discredited autism link, as anti-vaccination campaigns are hindering public health efforts.

b) A Member stated that his experience during the pandemic, including the Barts Health vaccine effort, showed that community engagement was crucial for progress, leading to vaccination sites in pharmacies, places of worship, and a mobile bus. Given the serious, potentially fatal, nature of measles and its persistent incidence, he proposed we re-implement such strategies. Although uptake remained challenging even with focused efforts and permanent clinics like Bocking Street, he believed every practical measure was taken. I question if the NHS should renew focus on these community methods, particularly as the measles situation is not receding, despite some official reassurances.

KB replied that her experience was primarily in the north of the borough, particularly the Springfield Park PCN, where initiatives mirror the methods outlined. They collaborate intensely with the local community, led by their Clinical Director, Dr Khan and Inequalities Lead, Gemma, a senior nurse, to ensure direct access. This includes home visits for childhood vaccinations. They have also successfully implemented and continue to offer numerous, conveniently scheduled vaccination clinics across the north of the borough, such as continuous Sunday clinics in Springfield Park. Though ongoing effort is needed, a significant recent success was the reduction of measles cases following last year's outbreak.

SH replied that she agreed fully with KB's point. Though precise figures are unavailable, vaccine uptake, despite being the country's lowest (especially for MMR), has significantly improved post-pandemic due to extensive efforts by primary care, the ICB, and Public Health. Vaccine hesitancy is complex, she added. The WHO

framework cites complacency, often linked to needing better information to counter misinformation. However, our community's complacency stems more from a perceived lack of immediate urgency. This explains the high COVID-19 vaccination rates when the threat was acute, versus lower MMR uptake until a disease outbreak (measles or pertussis) prompts action. A prolonged period without widespread mortality from infectious diseases means vaccination is often not prioritized amid competing personal demands.

Their current focus in Public Health, she added, is communicating this urgency without undue alarm, while also addressing convenience and accessibility. They are actively bringing vaccines to the public, ensuring accessibility, providing accurate information, and helping the community understand non-vaccination consequences to foster the necessary urgency.

c) The Chair asked KB about a reference to extra top-up funding that's going into the north east of the borough and if that was sustainable.

KB replied she had heard that day about potentially an enhanced service for immunizations across NEL but hadn't yet received the details. They have been pushing to make sure that that money comes to Place and they can use their knowledge of local populations to optimise its use. She undertook to keep Members updated on it.

CK added that Dr. Tehseen Khan had shared a notable best practice at the recent anchor institution meeting: a parent, initially a patient seeking children's vaccinations, was so interested in the process that she trained to become a nurse. She now works in his practice, using her community trust to effectively communicate the benefits of vaccination, an approach vital for improving uptake rates.

6.11 The Chair thanked Cllr Kennedy for his always thoughtful and considered responses to the questions and he thanked Drs Husbands and Brown also for assisting on this item.

RESOLVED: That the report and discussion be noted.

## **7 Minutes of the Previous Meeting (20.55)**

7.1 Members gave consideration to the draft minutes of the meeting held on 15 January and the Action Tracker.

RESOLVED: That the minutes of the meeting held on 15 January 2026 be agreed as a correct record and that the updated Action Tracker be noted.

## **8 Health in Hackney Scrutiny Commission Work Programme (20.56)**

8.1 Members gave consideration to the updated Work Programme for the Commission.

RESOLVED: That the updated Work Programme be noted.

## **9 Any Other Business (20.57)**

9.1 There was none.

**Thursday 12 February 2026**

**Duration of the meeting: 7.00 - 9.10 pm**