Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year 2025/26
Date of Meeting: Monday 2 March 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 Sharon Patrick, Cllr Ian Rathbone and Cllr Ben Lucas (Vice-Chair)**
Apologies:	**Cllr Kam Adams and Cllr Anna Lynch**
Officers In Attendance	**Kat Buckley (Deputy Head of Transformation, AHI), Leanne Crook (Head of Transformation, AHI), Georgina Diba (Director of Adult Social Care and Operation, AHIs), Chris Lovitt (Deputy Director of Public Health, AHI), Anita Marsden (Head of Complex Care and Safeguarding, AHI) and Jacquie Burke (Group Director Children & Education and interim GD for Adults, Health and Integration)**
Other People in Attendance	**Dr Kirsten Brown (Clinical Director, City & Hackney Place Based System), Dr Stephanie Coughlin (Chief Partnership & Place officer, Homerton Healthcare, and local GP), Natasha Lewis (Lead Nurse for Sickle Cell, Homerton Heatlhcare), Breeda McManus (Chief Nurse and Director of Governance, Homerton Healthcare), Callum Hanlon (Consultant, Newton Impact), Sara Morosinotto (Enter & View and Volunteer Manager, Healthwatch Hackney), Sally Beaven (Healthwatch Hackney) and Councillor Christopher Kennedy (Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture)**
Members of the Public	
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Councillor Ben Hayhurst in the Chair

1 Apologies for Absence

1.1 Apologies for absence were received from Cllrs Adams and Lynch.

1.2 An apology for lateness was received from Cllr Patrick.

1.3 It was noted that Cllr Turbet-Delof joined the meeting remotely.

2 Urgent Items / Order of Business

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

3 Declarations of Interest

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

4 'Patient Voice: Sickle Cell Care in Hackney - what has changed 10 years on?' (19.05)

4.1 The Chair stated that this item was to consider Healthwatch Hackney's recent follow up report on Sickle Cell care in Hackney as well as Homerton Healthcare's response to its recommendations.

4.2 He welcomed for the item:

Sara Morosinotto (SM), Enter and View & Volunteer Manager, Healthwatch Hackney
Sally Beaven (SB), Executive Director, Healthwatch Hackney
Breeda McManus (BM), Chief Nurse and Director of Governance, Homerton Healthcare
Dr Stephanie Coughlin (SC), Chief Partnership & Place Officer at Homerton Healthcare and a local GP
Natasha Lewis (NL), Lead Nurse for Sickle Cell and Thalassaemia

4.3 Members gave consideration to the following documents:

a) Healthwatch Hackney's recent report 'Sickle Cell Care in Hackney - what has changed 10 years on?'
b) Presentation from Healthwatch Hackney
c) A response briefing from Homerton Healthcare published in Supplementary Agenda on 25th.

4.4 Sara Morosinotto took members through the presentation and the highlights of the report. She stated that the report follows up on the 2015 study, evaluating patient experience in Hackney's sickle cell care over the past decade. While acknowledging improvements, the quality of care, she stated, that care remains a "postcode lottery," determined by the patient's initial point of access (e.g., A&E or GP), not clinical need. Healthwatch's qualitative approach centered on the patient's voice. As regards the key findings regarding the systemic challenges, the "postcode lottery" stems from failures at entry points like A&E and GP services, where positive experiences rely on exceptional individual staff, not robust system design.

She described how the Medical Day Unit (MDU), however, which operates from 8:00 a.m. to 3:00 p.m. is a blueprint for excellent care, and described its five core elements:

Specialist Knowledge and Consistency.
Rapid Access to Pain Control.

Holistic, Patient-Centred Communication.
Dedicated, Predictable Environment.
Proactive Crisis Prevention.

The report strongly recommends these MDU elements be urgently adopted across all patient access points, especially GPs and A&E.

She went on to describe the other focus of treatment - Lloyd Ward. While it has demonstrated commendable progress since 2015, timely and effective pain relief remains inconsistent, depending on the staff member on duty, highlighting a lack of strictly enforced, system-wide protocols.

Their report concluded, she added, that two crucial systemic issues require urgent attention.
Firstly, racism and stigma, as 50% of their focus group participants reported being stereotyped, often as "drug-seekers." This prejudicial treatment delays care and erodes trust. Mandatory anti-racism training and zero-tolerance policies will be required to tackle this, she added. The second key issue was the poor transition from Children to Adult Services. The abrupt, fragmented transition causes a profound loss of trust and reluctance to engage with adult services. A structured, phased transition program is vital, she added.

She stated that they appreciated the prompt response from Homerton Healthcare. To dismantle the "postcode lottery," however, they require a multi-agency commitment, including a detailed official response from the North East London ICB concerning recommendations for primary care and A&E services.

4.5 Breeda McManus (Chief Nurse, Homerton Healthcare) took Members through Homerton Healthcare's formal response to the report. She began by expressing gratitude to Healthwatch Hackney for conducting the visit and providing the opportunity to formally respond to the subsequent recommendations. It was acknowledged that the Medical Day Unit (MDU) serves as the primary area for sickle cell and thalassemia patients. Consequently, the staff within this unit possess a high level of training and awareness regarding these conditions, which constitutes their day-to-day work. The positive findings from the visit regarding the MDU team's current practice were welcomed, with the intention being to extend this standard of care across other organisational services, including the Emergency Department (ED), Acute Assessment Unit (ACU), and general inpatient areas where sickle cell patients are treated.

She explained that the integrated Sickle Cell and Thalassemia service provides both acute and community care to registered patients residing in City and Hackney. However, the Emergency Department also treats sickle cell patients from outside this geographical area, particularly for pain management outside of normal working hours. This complexity was noted as having implications for the administration of pain relief, as not all presenting patients are registered with Homerton Healthcare. Homerton is recognised as a specialist centre for sickle cell and thalassemia, currently managing approximately 450 adult and 170 paediatric patients, with shared care arrangements in place with the Royal London, for children. The service was currently unable to transition young adults to the adult service due to staffing issues.

The MDU's care was consistently described as excellent, with 100% of interviewed patients reporting it as a safe, welcoming, and trustworthy environment. The team continues to provide a comprehensive, patient-centred model of care, encompassing screening and genetic counselling. A specialist clinic is also run by Consultant Nurse and Advanced Nurse Practitioners, focusing on disease-modifying therapies and improving patient outcomes.

The importance of continuing to work closely with GPs was emphasised to ensure a collaborative approach, while acknowledging the need for further work to strengthen relationships with local GPs, particularly concerning care plans and analgesia monitoring. Established pathways exist, but a review of these was deemed necessary, she added. She explained that Lloyd Ward prioritizes high-quality patient care, fostering a culture of reflection and learning, specifically focusing on: 1) Reflective work on racism and stigma, and 2) Pain relief administration audits. The organization has undertaken deep work to mitigate institutional racism and stigma for equitable care, alongside regular audits to ensure timely and effective pain management protocols. The Homerton was also actively improving cross-boundary communication with Primary Care by liaising directly with Dr. Kirsten Brown to refine pathways and protocols with GPs, aiming for safer and more integrated care transfers.

Active patient engagement, particularly with the sickle cell community, was central to the Homerton's approach. They will also co-design services and maintain a strong partnership with Solace (the dedicated sickle cell patient group) through regular dialogue. This ensures the patient voice shapes and evaluates care. There is a deep commitment to continuously optimizing the sickle cell patient experience, involving specialized care, adapting protocols based on evidence and feedback, and improving all aspects of service delivery to enhance quality of life and clinical outcomes.

Members' Questions

4.6 Members asked questions and the following was noted:

a) A Member welcomed the reports, asking BM to elaborate on co-design and the involvement of "expert patients." She specifically asked how often these "expert patients" participated, noting that global majority communities often report their pain as "almost invisible" due to racial bias. This bias impacts pain management, appointment length, and issues with not being believed or mistakes in accessing care. Clarification was sought on how the voices of these expert patients were truly incorporated and how frequently they informed improvements.

BM replied that the Sickle Cell Group had been established for some time, meeting every other month. A number of existing patients were part of this group and had committed to developing educational materials. This would include real, lived patient stories, such as what it felt like to attend the Emergency Department or be admitted as a sickle cell patient. These powerful voices and lived experiences would be captured in videos and training materials to be shared with staff, ensuring their care was developed and improved based on this feedback.

b) A Member commended the findings on the MDU (pp. 70-71) but expressed concern about General Practice, noting a significant training need had been identified. He was astonished that 94% of patients surveyed had raised concerns about GP knowledge of sickle cell, including outdated views (e.g., questions about being born with it or marrying a cousin). Given Hackney's large affected population, he questioned if GP

knowledge had improved over the past decade. He also highlighted disturbing statistics: up to six-hour waits for pain relief and 88% of respondents feeling disbelieved about their pain. While stating his own GP surgery was excellent and questioning the figures' accuracy, he asked BM for her thoughts on the service's progress over the last ten years.

BM acknowledged that there was more to be done to strengthen relationships and training with GPs. She stated that there was now an Urgent Care Portal, accessible by acute and community providers, as well as the London Ambulance Service, which provided patient care plans. This gave GPs direct access to information on the patient's care plan and prescribed pain relief, which was expected to improve the management of patients in the community. She added that the sickle cell team at the Homerton had, and would continue to, develop training programmes with GPs to address gaps in knowledge. She stressed that continued education and training was essential due to the wide range of conditions seen in general practice.

KB added that she worked with BM on the response to the Healthwatch report and was happy to follow up with a response from the ICB regarding primary care. She noted that the paper was informed with a GP lens and agreed that the statistics were shocking and a cause for concern. She echoed the Councillor's worries and outlined three areas for consideration:

i) Ensuring accurate communication between GPs and the hospital, so GPs were clear on the patient's care plan;
ii) Addressing the clear knowledge gap through GP education, noting that an excellent GP education programme in the City of Hackney, supported by consultants from the Homerton, was currently in place and would continue and;
iii) Clinical leadership, pointing out that historically there had been a clinical lead for sickle cell in primary care, which was no longer the case.

She stressed the importance of re-establishing this clinical leadership role within general practice to raise issues, inform colleagues through education and pathways, and work with the hospital to ensure the best possible outcomes. They were therefore considering the appointment of a GP, with ‘sickle cell’ as part of their portfolio, for clinical leadership going forward.

BM then addressed the issue of the KPI compliance for time to pain relief and analgesia in the Emergency Department. She confirmed that compliance was audited monthly and they would review and respond to their position on this. She noted that while there were improvements, there was more to do, and the service reported on this target to the Solace patient group every other month to maintain focus and drive improvements. She recognised there was room for improvement on the 30-minute target but noted that compliance was much improved for patients achieving analgesia within a 45-minute window. She assured Members that surveillance would continue, and they would report back to the Solace group.

c) The Chair acknowledged the point about monitoring KPIs and reporting to the Solace group but, in light of the potential reforms that could affect Healthwatch's future, he asked about the review process for the wide range of issues in the report. He asked what kind of "safety check" would be in place in a year's time to ensure meaningful improvements had been made, suggesting the possibility of an independent external body, if proportionate, to provide reassurance to the Commission if Healthwatch was unable to provide this in a year’s time.

BM provided reassurance by stating that the sickle cell service had an external peer review process, separate from the Healthwatch report, which was led by other sickle cell haematology consultants across London (a Pan-London peer review). This external review would continue, and the recommendations from the Healthwatch report would be shared with them for oversight. Furthermore, she reiterated the importance of the Solace group, which had received the report, and confirmed that she attended those meetings. This group would be able to "sense-check" the progress on the recommendations. She added that they would also encourage the Solace group, with the support of the external peer review team, to re-examine the service in 12 to 18 months to assess delivery on the recommendations and commitments.

d) Members highlighted concerns about the quality of transition from childhood and adult care, noting that patients were "falling through the cracks." They observed that the Homerton's transition plan was "on hold" and requested an update on when it would resume and the current impact on patients in transition.

BM offered reassurance that patients were still being cared for by the Royal London team. The reason the transition plan was on hold was due to workforce issues, specifically the number of haematologists currently employed, and the ongoing difficulty in recruitment. She explained that the loss of a pioneer haematologist approximately 18 months to two years ago had impacted the service and its capacity to take on more patients. She stated that recruitment was ongoing and they were seeing some trainees return to the service, hoping to be in a position to review the transition plan in the next six months. She stressed that safety was paramount, and they would continue working closely with the Royal London until they had the right workforce to safely transition the patients.

e) The Chair stated that he agreed with colleagues about some of the findings here being alarming. While A&E and GPs manage diverse diagnoses, he felt the specialised Lloyd Ward should possess more specific knowledge, despite differing from the MDU. He found the Lloyd Ward figures most surprising, questioning if high staff turnover or reliance on agency/bank staff was a factor. He suggested staff education on this Ward could offer a relatively quick improvement.

BM reported significant progress on Lloyd Ward but stressed continuous improvement was needed. She noted positive management and awareness, but cautioned the report was based on a "point in time" sample. A new ward manager is focusing on team development and communication. Overall, Lloyd Ward is perceived as improved compared to a decade ago, and this progress must continue.

f) The Chair commented that officers have outlined an 18-month to two-year plan and suggested that 18 months would be suitable for the Commission to revisit this, perhaps with representation from Solace group, to provide a patient perspective and hear their feedback. This would allow Members to hear directly from them regarding the perceived progress, or lack thereof. Furthermore, if Healthwatch was still operating—and he hoped they would - their continued participation would be most welcome.

SB stated that if Healthwatch was still there in 18 months they would be happy to come back. She emphasised however the importance of ensuring that patient involvement groups, such as the Solace group, are aware of the existing avenues for their voices to be heard, such as the option to submit questions to the Health and

Wellbeing Board. This point was raised as a general consideration for all patient groups, particularly should Healthwatch cease to exist. It was suggested that the potential disbandment of Healthwatch could usher in a new era where the Commission draws more heavily upon the perspectives of patient voices and groups than had historically been the case.

4.7 In closing the Chair stated that he appreciated that it was a difficult report in many respects but he was impressed by the way Healthwatch had tackled the issue and was also by Homerton Healthcare not being defensive, but genuinely trying to deal with the criticisms which had been raised. He thanked everyone for their reports and their attendance.

ACTION: Item to be revisited in 18 months on the work programme with possible input from Solace.

5 CQC Assessment of Hackney Adult Social Care (19.40)

5.1 The Chair stated that this item was to receive a briefing on the Council's response to the recent CQC assessment of Hackney Adult Social Care - the first council wide inspection under a new national inspection regime. The overall score achieved by the Council was 62 and a rating of 'Requires Improvement', unluckily just 1 point below the rating needed for 'Good'.

5.2 He welcomed for the item:

Jacquie Burke (JB), Group Director Children and Education and acting Group Director Adults, Health and Integration
Georgina Diba (GD), Director ASC and Operations
Cllr Chris Kennedy (CK), Cabinet Member for Health, ASC, Voluntary Sector and Culture.

5.3 Members gave consideration to the following reports:

a) Presentation on Hackney's feedback to the CQC report.
b) CQC report in full - Hackney Council: Local authority assessment.

5.4 The Chair invited CK (the Cabinet Member) to make introductory comments. CK stated that of course it was a disappointment that service had so narrowly missed the 'good' rating by one point, nevertheless, data from the new ASCOF (Adult Social Care Outcomes Framework) measures and the national audit of adult social care over the past two years indicated that the service was trending in a positive direction. This sentiment of moving forward is widely held, with staff reportedly welcoming the report's recommendations as a basis for improvement. He viewed the report as a positive stage in the ongoing journey of improving adult social care in Hackney, which the council intends to fully embrace and address.

5.5 JB took Members through the presentation. She stated that having recently assumed the Group Director Adults Health and Integration portfolio in an Interim capacity she expressed considerable appreciation for the commitment and enthusiasm of the staff within adult social care in embracing the CQC inspection's findings and recommendations.
The presentation was structured around the four core themes explored during the assessment: working with people; providing support; ensuring safety; and leadership.

It was noted that the assessment process for the CQC inspection had been protracted. The local authority received notice in February 2025, the inspection commenced in July, and the final report was subsequently published in February 2026.

The local authority had been rated "Needs Improvement" missing an "Good" rating by one point. The quality statement scores utilised a traffic light system (red, amber and green for outstanding), with no "reds" recorded, and an equal distribution between "ambers" and "greens," which is considered representative of the current stage of their improvement journey.

Key strengths identified included a robust commitment to strength-based and person-centred practice, effective support for people's independence, acknowledged anti-racism work, culturally appropriate social work, strong leadership, transparency, accountability, and a focus on continuous improvement. Furthermore, the provision of quality advice and guidance for individuals with non-eligible needs was noted to mitigate assessment delays, alongside positive relationships with providers and partners, establishing a sound foundation for continuous improvement.

5.6 Members Questions

a) The Chair stated that the Commission had previously noticed delays in social care assessments. He had raised this privately and publicly and while he didn't want to speak for Cllr Kennedy he felt it was a shared concern. They had received feedback that this was a national issue, lacking significant benchmarking data. Although a national benchmarking formula has now been mentioned, he felt there had been a lack of candour in the past when they had initially enquired if this was an issue and they had to wait for the CQC to come along and confirm this. This affects how the Commission functions, he added, as it always seeks a constructive relationship in dealing with these challenging issues.

CK made reference to Clinton Ferguson, a national 'expert by experience adviser' on adult social care, who strongly objects to the term "waiting well." He suggested that when reviewing the February published LOFs for adult social care, which the government requires all local authorities to report on using the same measures, the Commission should consider regular reporting on assessment and assessment times. This was proposed because the Commission was rightly dissatisfied, he added, with the information previously provided.

b) A Member noted the value of the frank, open discussion and welcomed the report. He thanked staff for their hard work, highlighting the positive aspects of the report. He then focused on the RAG status slides, observing that areas scored down were fundamental, specifically: safeguarding, safety, assessing needs, care provision, and continuity. He asked what was being done to ensure safety was given top priority and how this interacted with workforce pressures and growing acuity demand, stating that resident safety was the number one priority.

GD responded to the perception of a lack of transparency regarding waiting lists, reminding the Commission that performance data and actions to address waiting lists were presented at the previous Health in Hackney meeting. She attributed waiting list issues partly to a substantial increase in demand without corresponding resources, as noted by JB. Actions, as set out in the January report, focused on prioritising those

with the greatest need, such as through character assessments at the first point of access, which had reduced waiting times for some individuals to as low as 19 days. She acknowledged the issues and stated the team was exploring different mechanisms and learning from partners to reduce the time span. She also confirmed the commitment to return to the Commission with new DHSC performance metrics, noting the ongoing work to process and present this data.
She agreed with the importance of safeguarding, stating that failure to safeguard the most vulnerable meant the service was not meeting residents' needs. She noted the report showed positive feedback on safeguarding knowledge and skills among practitioners and on the statutory duty. The main safeguarding feedback from the CQC was twofold:
1. Safe pathways and transitions: A new pathway for young people transitioning from children's to adult services was being established when the CQC visited, and she was pleased to report it went live in February; and
2. Contingency planning: This was about supporting people who go into crisis, such as a hospital admission or absence of a carer. Work was underway on contingency and crisis planning to ensure care and support plans were flexible to meet future needs.

*c) A Member thanked the officers and asked: What was being done about the website inhibiting the ability to self-serve and access information (referenced on slide 84) and what were the reasons for the low uptake of direc*t payments? He further asked for clarity on the definition of ‘reablement’?

Re the Website, GD replied that a corporate website redesign was underway, and the adult social care team would work with corporate colleagues to improve accessibility, building on recommendations from a previous Healthwatch report. The goal over the next year was to update the website, making it more accessible and considering different contact methods while also aiming to reduce the overall pathways into social care.

Re Direct Payments, GD replied that the low uptake was due to multiple reasons, including some residents preferring the Council to manage the process, finding it safer and easier given their complex needs and appointments. However, the service recognised the need to make direct payments easier and "less scary" for individuals who might find arranging their own care overwhelming. Frontline social workers would be supported to explain the process in a more accessible manner.

Re Reablement, GD briefly explained reablement as supporting people to regain their independence, particularly following a hospital stay, a fall, or a change in function, with the aim of maintaining independence and providing short-term care to achieve this. She advised that a full presentation on reablement, led by Leanne, would follow in the next session.

d) A Member thanked GD and offered empathy for the team's efforts, noting her experience with residents confirmed the team's commitment. She pressed for more detail on resource needs, stating that the long waiting times were negatively impacting residents. She asked what further resources the Council could offer the team, noting that the efforts and intentions were clear, but the data showed they were not delivering, despite being close to achieving a "good" rating.

GD thanked the Cllr for her appreciative comments, which she would pass on to the team, and affirmed the hard work of the staff. She confirmed the service was experiencing increased demand without a corresponding increase in staffing

resources. Any budget changes had rightly been focused on care support commissioning—the actual care delivered in residents' homes—which had increased substantially, and which was successfully keeping the majority of people at home. She stated that the lack of funding for increased staffing was a national issue. She reframed the question of what the Council could do to what the system could do, noting that adult social care was facing increasing demand against a backdrop of health inequalities in Hackney and higher rates of younger working-age adults with complex health and serious mental illness needs. The service would continue to manage and prioritise risk and explore different ways to reduce the waiting list. Ultimately, she stressed the need for a system-wide change in how demand is understood and prevented. She highlighted a two-year project led by Leanne to manage demand and support people to remain independent outside of statutory services while remaining safe.

e) The Chair noted the comparison with Camden, which had achieved an 'Outstanding' rating, acknowledging the new CQC process and potential variation in inspector experience. He asked officers what Camden was doing differently, particularly regarding waiting lists and assessment times.

GD stated her understanding that Camden also had a waiting list and waiting times, suggesting the difference might be in how the data, described as 'flow and demand' in Camden, was articulated. She added that she had not seen Camden's specific numbers but believed they had a significant waiting list. She concluded that there was learning for Hackney in how to articulate the work being done to manage demand and keep people safe.

JB concurred, emphasising the willingness of health partners like Homerton Healthcare, who were engaging on 'early help'. She stated that a more developed and coherent offer before statutory intervention levels was needed, referencing the business case Leanne was developing. Workshops were planned with Homerton on neighbourhood working and on expanding reablement. JB identified the website as a critical demand management tool, explaining that a better, more interactive website would enable more people and professionals to self-serve, reducing the number of people coming through the "front door" for Information, Advice, and Guidance, thereby freeing up resources for assessments for those who genuinely need it. She confirmed that corporate colleagues in ICT were looking at how other authorities operate. She agreed it was a system issue with a willingness for change. The digital part was one of the six corporate transformation projects. Regarding resources and funding, she confirmed they were working with external sources like the LGA to benchmark funding and spending, seeking outside advice and support to ensure money was spent effectively and all system partners were engaged to provide Hackney residents with a better experience.

f) A Member proposed that the Commission would benefit from hearing from neighbouring boroughs, such as Camden, on how they manage their adult social care portfolio and what best practices could be learned.

The Chair asked the O&S Officer to note this and suggested the new Commission should return to it in a year's time. CK concurred stating the development areas identified in the slides be a starting point for the Commission's agenda planning over the next two years.

ACTION: An item on ASC involving benchmarking with Camden to be added to future work programme list.

5.7 The Chair concluded the item, thanking all attendees and echoing Members appreciation for Georgina and the team. He acknowledged the increased demand on the team, their excellent work, and the maturity demonstrated in addressing the recommendations, reporting on progress, and continuously striving to improve the service.

RESOLVED: That the discussion be noted.

6 Transforming Outcomes Programme in Adult Social Care - Spotlight on Reablement (20.00)

6.1 The Chair stated that the purpose of this item is to receive an update on the progress of the Transforming Outcomes Programme with a specific focus on Reablement as requested at the Commission's meeting on 10 Sept. This would be the 6th regular update on TOP.

6.2 He welcomed for the item:

Leanne Crook (LC), Assistant Director of Transformation, Adult Social Care
Callum Hanlon (CH), Consultant, Newton Impact
Georgina Diba (GD), Director - Adults Social Care and Operations
Cllr Chris Kennedy (CK), Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture

6.3 Members gave consideration to the report 'Spotlight on reablement'

6.4 LC took Members through the presentation in detail providing an update on the Transforming Outcomes Programme with a detailed focus on the reablement workstream.

She began by outlining the financial performance of the overall Transforming Outcomes Programme. The programme has a MTFP target of £5.8 million in cost avoidance between 2024 and 2027. As of two weeks prior to the presentation, the programme was projected to slightly exceed its target for the current financial year. The projected cost avoidance for the end of 2026/27 was close to the £5.8 million target, though it was noted that updated figures were expected to bring it fully on track. This financial target includes the benefits of the reablement programme. The cost avoidance figures are non-cumulative, representing the amount by which the budget is reduced each year.

She explained that the programme's focus has evolved, with a continuing emphasis on demand management—promoting independence and ensuring appropriate care package sizing. A greater proportion of the current work, however, is centred on prevention, reduction, and delay of care needs. Key workstreams now include: granular demand analysis and maximisation of prevention; the implementation of digital solutions for efficiency and prevention; the reablement deep dive; reintroducing carers' support into the transformation programme to accelerate the delivery of the carer strategy action plan; increasing the uptake and ease of access to direct payments; and brokerage to link care workers with residents needing support.

Furthermore, work on home adaptations has been delivered and is now a live service, the Preparing for Adulthood team is operational, and the new care charging approach has been handed over to the service following Cabinet approval.

The core of the presentation focused on reablement, defined as an approach of "doing things with people, not doing things for people." Reablement aims to help individuals, often following a hospital stay, regain skills and confidence over a short-term period before long-term care needs are assessed. The council is implementing a social model of reablement to support a wider range of social care needs, with the goals of reducing or preventing the need for ongoing care and supporting the council's financial sustainability.

The council's strategy is to scale the model with the eventual goal of offering reablement to nearly everyone. This requires a scalable model with the right workforce and provider relationships. Critically, the inclusion criteria are broadening to include individuals likely to still require some ongoing care, as they will still significantly benefit from the service in terms of independence and financial impact.

She reported that the reablement programme had completed its diagnostic phase and established a service with two pathways: the traditional ‘Reablement at Home’ (the largest part, planned for expansion to the community) and ‘Reablement Assessment Flats’ located in ‘extra care provision’. The assessment flats are for individuals who cannot return home immediately after hospital discharge or those being considered for residential care, with the aim of working towards goals to avoid deterioration or a long-term residential placement. This model necessitated a reorganisation of staff, with community care workers moved to the assessment flats and a pilot provider delivering community care.

The service has maintained the volume of activity during the pilot and is now preparing for Phase Two, which will significantly expand activity volume from four people per week to 20, which is equivalent to everyone relevant leaving hospital with a package of care. This expansion will involve working with five providers on a larger pilot, leading up to a broader recommissioning of the home care service to include reablement. The long-term objective is to achieve a "reablement first" culture across Adult Social Care, eventually exploring enablement for individuals with a learning disability or mental health needs.

Regarding the financial projections for reablement, the average reduction in care package size achieved through the pilot is 8.2 hours per week. Based on this data and the projected service volume, the financial benefit is projected to be around £920,000 in cost avoidance in the next financial year (2026/27), escalating to £4 million and then £7 million in the subsequent two years, as the benefits accumulate. These figures are factored into the council's future Medium-Term Financial Plan modelling.

6.5 Members’ Questions

*a) A Member sought further information regarding the Reablement Assessment Flats (RAFs), particularly in relation to the ambitious cumulative savings outlined up to 2028/2029. He inquired whether the number of RAFs would change as the number of service users scales up, how the Council planned to expand the provision, and what proportion of the projected savings were related to service users utilizing the RAF*s.

LC confirmed that the RAFs account for a very small proportion of the savings and are not expected to scale up in the same way as 'reablement at home'. She explained that the stay in a RAF is slightly longer and the process is slower, which is appropriate for the specific and less widespread type of demand they address compared to reablement at home. She also highlighted that the projections do not yet include the further potential benefit of avoiding residential placements through this approach, as the modeling for that demand has not been completed. She concluded that there are no current plans to significantly scale up the RAFs unless demand changes significantly, as the current number is believed to be about right for the population, with scaling-up focused on community provision.

b) Members asked how many flats there currently were and if they were owned in-house?

LC replied that there were 12 to 15 and that the RAFs are part of the existing in-house extra care provision. The buildings are owned by a registered social landlord, but the Council provides the care in-house.

c) A Member asked for details about the type of care and support provided in the RAFs and whether people who cannot return to their own homes after a hospital stay due to disability could be accommodated.

LC explained that the initial care provided is goal-based reablement care, focusing on achieving goals over a short period. People may use the RAFs because they are unable to return home after a hospital visit due to issues like hoarding that need resolving, or because small adaptations need to be made to their home. The RAFs provide a safe interim place for reablement while home issues are addressed. She also noted they are used for people who might otherwise be considered for a residential placement, offering a chance to regain independence first, citing a case study of a gentleman who was able to return home safely with support after a stay in a RAF. She stressed that the preferred option is always for someone to return home if it is safe to do so.

d) A Member expressed surprise that the Council had secured these flats given the housing crisis and hoped the provision could be built upon. His main question related to balancing the quality of care against the cost-saving demands and what lessons had been learned so far in that process?

LC clarified that she could not take credit for securing the properties, as they were existing extra care flats that had been repurposed. She acknowledged that balancing quality of care with demand is the biggest challenge, and the reablement work is central to addressing this. The aim is to keep people safe at home, promote independence, reduce care packages, and prevent/delay the need for greater support, thereby increasing capacity for others. The reablement approach encourages staff, particularly the Occupational Therapy (OT) led service, to think creatively about meeting people's needs safely and promoting their long-term independence.

e) The Chair inquired whether the Council used the Newton model or their guidance for implementation and if there were benchmark authorities that had achieved similar savings. He further asked how many hospital re-admissions would be required for the system not to be cost-effective, seeking an understanding of the potential knock-on issues.

LC confirmed that the work was part of the original engagement with Newton, and their expertise had been drawn upon for implementation, scale, and modeling feasible financial projections similar to those seen elsewhere. Regarding hospital readmissions, she added that this is closely monitored, with data collected as part of the ASCOF (Adult Social Care Outcomes Framework). She reported no indication that the reablement approach is leading to hospital readmissions and that the care and support plans appear to be meeting individuals' needs safely. The monitoring continues as the service grows.

f) The Chair pressed for more detail on the robustness of the readmission monitoring system.

LC explained that the monitoring is part of the NHS statutory returns. The Council's system can track if someone previously worked with is admitted to the hospital and provides their history, including previous reablement packages. This data is built into the system to flag potential issues, and the performance team monitors this as a standard indicator.

g) The Chair then asked why this transformation project had taken longer compared to others.

LC explained that an honest appraisal after the initial diagnosis had revealed that the desired outcomes could not be achieved with the existing structures. This necessitated an unanticipated, relatively large-scale staffing restructure between the Council and the community provider to implement a scalable model. Completing this restructure added at least an extra year to the program.

6.6 The Chair concluded the item, thanking the officers. He suggested reviewing the item in a year or 18 months to assess progress, particularly concerning the cost savings and the overall functioning of the service, expressing that it was very good to hear that progress was being made.

RESOLVED: That the report and discussion be noted.

7 TOP in Adult Social Care - Update on Disabled Facilities Grant Adaptations (20.40)

7.1 The Chair stated that the purpose of this item was to receive a follow up on Disabled Facilities Grant adaptations. The Commission had last considered this on 13 Feb last year and Members were quite concerned about the performance so the Commission had asked officers to come back with an update on waiting times, a performance dashboard and updates on adopting innovative solutions in technology enabled care.

7.2 He welcomed for the item:

Leanne Crook (LC), Assistant Director of Transformation, Adult Social Care
Callum Hanlon (CH), Consultant, Newton Impact
Georgina Diba (GD), Director - Adults Social Care and Operations
Cllr Chris Kennedy (CK), Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture

7.3 Members gave consideration to the report ‘Spotlight on reablement’

7.4 KB took Members through the presentation. It detailed the conclusion of a project focused on reviewing and streamlining the pathway for adaptations funded by the Disabled Facilities Grant (DFG). This initiative, which commenced over a year prior, has now transitioned into 'business as usual' within the Council's services.

She added that a significant restructuring took place in October 2025 with the launch of the new DFG Home Adaptation Service. This involved integrating functions previously handled by private sector housing and insourcing the Home Improvement Agency from an external contractor. The new team is now situated within adult social care, allowing for close collaboration with the occupational therapy service, which serves as the primary referral source.

Key improvements implemented include:

Technology: Building a new pathway within the adult social care case management system to enhance visibility between occupational therapists and grant managers, ensuring better communication with residents.
Application Process: Streamlining the required resident information at the outset to minimise back-and-forth communication, particularly concerning paperwork and landlord consent.
Means Test: Increasing the means test threshold from £10,000 to £20,000, thereby fast-tracking the application pathway for a greater number of residents with lower-cost adaptations.
Contracting: Approving the use of a dynamic purchasing system to procure experienced and trust-marked contractors, ensuring relevant guarantees and warranties.
Policy: Developing a new comprehensive policy covering all adaptations (DFG-funded and Council Home Adaptations and Repairs), which has been recognised as an example of best practice nationally.
Performance: Agreeing upon key performance indicators (KPIs) and developing dashboards to enable caseload visibility. This will assist in identifying bottlenecks in the adaptation process and allow for monthly retrospective performance tracking.

7.5 AM then provided an update on the Disabled Facilities Grant (DFG) adaptation service, which launched in September 2025. The service utilises the Mosaic case management system, phased in as cases transitioned from external Home Improvement Agents (HIAs). All referrals from the Occupational Therapy (OT) assessment service are now processed through Mosaic.

Performance tracking through Mosaic is currently focused on the administration stage, specifically consent, funding, and procurement, with breakdown stages including approval and the timeliness of works completion. The system also supports a post-completion dashboard to monitor resident satisfaction, cost-monitoring/value for money, and long-term impact on resident well-being and care packages. This centralised system manages performance, tracks progress, and identifies/unblocks potential issues.

Due to data collection commencing only in October, a full, complete data set was not yet available, she added. The service has aligned its monitoring with best practice and national guidance by categorising referrals based on urgency and complexity (e.g., urgent/simple, urgent/complex, non-urgent).

Initial data, though based on small numbers however, shows promising average times for cases completing the full cycle, specifically noting 45 days for the administration stage and 7 days for approval. While data on completed works is forthcoming, these early averages indicate positive changes to the length of time taken. The performance dashboard will be monitored monthly through the Lead Member Dashboard, with the aim of having a comprehensive data set by September of the following year to demonstrate the success and timely delivery of the service.

7.6 Members Questions

a) A Member asked, notwithstanding that officers may not YET be able to list the specific completion of works, what progress was being made and what the projections were. He added that given that the previous 368-day figure was alarming, he anticipated hearing a significantly lower figure.

AM and KB replied that the initial target of 368 days for adaptations had represented the end-to-end process then prior to current levels of insight. This figure represented the cycle from inception to completion. With the ongoing service transition from the in-house Home Improvement Agency, and the implementation of the new Dynamic Purchasing System (DPS) framework for procurement, a shift is occurring. A pilot of the DPS framework, which informed the business case, demonstrated significantly reduced processing times.

The DPS framework had facilitated greater access to a diverse range of contractors, enabling the simultaneous undertaking of a higher volume of adaptations. Although comprehensive data was not yet available, anecdotal evidence indicated substantial improvements; a new staff member starting in June was able to approve, complete, and post-inspect works within six months, for example. Live case examples exist where referrals, approvals, and completion of works have been achieved within this timeframe. Furthermore, the service was now able to commit to completing urgent adaptations—particularly for individuals whose health was deteriorating—within four to four and a half months. This allows residents to return home or live safely and independently for as long as possible. The service anticipates presenting case studies and more extensive data in the future, they added.

b) A Member asked about the Council's ability to identify all disabled residents who may be eligible for this support but are unaware of its availability. He stated that he understood that registration of a disability was not mandatory. Given this, what was the Council's strategy for outreach to these potentially eligible but currently unreached residents, and what capacity exists to execute this? He concluded that he was aware of instances where residents were unaware of support to which they were entitled.

AM replied that the service had updated its existing website with the new policy and relevant information leaflets. She stated that the service would also ensure that these leaflets were more widely accessible. Access to the service operates on a needs-led basis, requiring an occupational therapy (OT) assessment to identify needs and subsequently generate a referral for adaptations. This OT assessment does not need to be provided by the local authority; assessments from reablement services or children's services are also accepted. She stated that the intention was to collaborate with the DFG foundations, acknowledging the quality of the recent work, to disseminate information and promote the effectiveness of disabled facilities adaptations, particularly through the OT service. The commitment to broadening the message's reach through both the foundations and appropriate forums was reiterated.

c) The Chair commented that he understood that you have to have an OT referral as a prerequisite for support.
AM replied that you did and that assessment then established the need for the adaptations.

d) A Member sought clarification on the established procedure for residents to request an Occupational Therapist assessment, specifically inquiring whether a direct self-referral mechanism is available, or if the request must originate from a formal organisation. The concern was raised that the lack of clarity on self-referral may inadvertently deter residents from pursuing necessary assessments.

AM replied that residents seeking an Occupational Therapy assessment may self-refer via the website or customer services. Should a major adaptation be identified as necessary, the occupational therapist will then initiate the subsequent referral to the adaptation service.

e) A Member asked if officers could elaborate on the relationship between the successful implementation of the reablement programme and the achievement of the ambitious savings targets discussed under the previous agenda item, as these two areas appear to be interconnected? Furthermore, what was the potential financial exposure or risk should the reablement programme not meet its objectives?

AM replied that the Occupational Therapy (OT) led reablement service is able to seamlessly refer individuals for adaptations through the disabled facilities adaptation service, which is facilitated by the service being situated within Adult Social Care. This structure eliminates the need for separate waiting lists or additional OT assessments for service users. Regarding the potential risk to savings, LC added that saving projections are not dependent on the adaptation program. While clients may experience delays for smaller-scale home safety adaptations, the majority of savings are derived from the reablement-at-home aspect of the service. It was further noted that adaptations and reablement can occur concurrently, and the savings model is based solely on the reablement component.

7.7 The Chairs stated that despite this programme being in its early stages the efforts undertaken appeared to be comprehensive and appropriate for the programme's objectives, suggesting a highly promising development. He asked that when the items come back if officers can bring case studies and more data. It would be helpful too to present the data disaggregated according to the four established categories to ensure full transparency. He thanked officers for their detailed report and their attendance.

RESOLVED: That the report and discussion be noted.

8 Minutes of the Previous Meeting (20.57)

8.1 Members gave consideration to the minutes of the meeting held on 12 February 2026.

RESOLVED: That the minutes of the meeting held on 12 Feb 2026 be agreed as a correct record and that the Action Tracker be noted.

9 Health in Hackney Scrutiny Commission Work Programme (20.58)

9.1 Members gave consideration to the updated work programme.

RESOLVED: That the updated work programme for 2025/26 be noted.

10 Any Other Business (20.59)

10.1 Cllr Lucas (Vice Chair) stated that Cllr Hayhurst had Chaired this Commission with distinction for many years and was stepping down as a councillor and this would be his last meeting. He stated that Members were exceptionally grateful to him for his service over the years and wished him well. The Chair thanked the Members and the Overview and Scrutiny officer for his support to him over many years.

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Duration of the meeting: 19.00-21.00