NOTICE OF MEETING

ADULTS & HEALTH SCRUTINY PANEL

Thursday, 14th November 2024, 6.30 pm - George Meehan House, 294 High Road, N22 8JZ

(To watch the live meeting click here or watch the recording here)

Members: Councillors Pippa Connor (Chair), Cathy Brennan, Thayahlan Iyngkaran, Mary Mason, Sean O'Donovan, Felicia Opoku and Sheila Peacock

Co-optees/Non Voting Members: Helena Kania (Co-Optee)

Quorum: 3

1. FILMING AT MEETINGS

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The chair of the meeting has the discretion to terminate or suspend filming or recording, if in his or her opinion continuation of the filming, recording or reporting would disrupt or prejudice the proceedings, infringe the rights of any individual or may lead to the breach of a legal obligation by the Council.

2. APOLOGIES FOR ABSENCE

3. ITEMS OF URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business (late items will be considered under the agenda item where they appear. New items will be dealt with as noted below).

4. DECLARATIONS OF INTEREST

A Member with a disclosable pecuniary interest or a prejudicial interest in a matter who attends a meeting of the authority at which the matter is considered:

(i) must disclose the interest at the start of the meeting or when the interest becomes apparent, and

(ii) may not participate in any discussion or vote on the matter and must withdraw from the meeting room.

A member who discloses at a meeting a disclosable pecuniary interest which is not registered in the Members' Register of Interests or the subject of a pending notification must notify the Monitoring Officer of the interest within 28 days of the disclosure.

Disclosable pecuniary interests, personal interests and prejudicial interest are defined at Paragraphs 5-7 and Appendix A of the Members' Code of Conduct.

5. DEPUTATIONS/PETITIONS/ PRESENTATIONS/ QUESTIONS

To consider any requests received in accordance with Part 4, Section B, Paragraph 29 of the Council's Constitution.

6. MINUTES (PAGES 1 - 16)

To approve the minutes of the previous meeting.

7. ACTION TRACKER (PAGES 17 - 132)

To review progress against action points from previous meetings in 2024/25.

8. APPOINTMENT OF NON-VOTING CO-OPTED MEMBER

Report to follow.

9. SCRUTINY OF THE 2025/26 DRAFT BUDGET / 5-YEAR MEDIUM TERM FINANCIAL STRATEGY (2025/26 - 2029/30) (PAGES 133 - 198)

To scrutinise the revenue and capital proposals relating to the 2025/26 Draft Budget and the Medium Term Financial Strategy for 2025/26 to 2029/30.

The documents are:

- Main report to scrutiny
- APPENDIX 0 – Draft Budget report to Cabinet
- APPENDIX 1 – Forecast Budget Pressures 2025-26
- APPENDIX 2 – Proposed Savings 2025-26
- APPENDIX 3 – Proposed Changes to Capital Programme 2025-26 to 2029-30
- DOCUMENT A – Scrutiny Role

- DOCUMENT B (PART 1) – Savings Tracker 2024-25
- DOCUMENT B (PART 2) - Savings Tracker 2025-26 to 2028-29

10. WORK PROGRAMME UPDATE (PAGES 199 - 202)

To provide an overview of the 2024-26 work programme for the Panel and for any amendment to be proposed and considered.

11. NEW ITEMS OF URGENT BUSINESS

To consider any items admitted at item 3 above.

12. DATES OF FUTURE MEETINGS

- 17th Dec 2024 (6.30pm)
- 10th Feb 2025 (6.30pm)

Dominic O'Brien, Principal Scrutiny Officer
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Fiona Alderman
Head of Legal & Governance (Monitoring Officer)
George Meehan House, 294 High Road, Wood Green, N22 8JZ

Wednesday, 6 November 2024

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Agenda Item 6

MINUTES OF THE MEETING OF THE ADULTS & HEALTH SCRUTINY PANEL HELD ON THURSDAY 19th SEPTEMBER 2024, 6.30 - 9.30pm

PRESENT:

Councillors: Pippa Connor (Chair), Cathy Brennan, Thayahlan Iyngkaran, Mary Mason, Sean O'Donovan and Felicia Opoku

Co-optees: Helena Kania

12. FILMING AT MEETINGS

The Chair referred Members present to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'.

13. APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllr Mary Mason.

Cllr Sheila Peacock had given apologies for not being present in the meeting room, though she attended the full meeting online.

Apologies for absence were also received from Cllr Lucia das Neves, Cabinet Member for Health, Social Care & Wellbeing.

14. ITEMS OF URGENT BUSINESS

None.

15. DECLARATIONS OF INTEREST

Cllr Pippa Connor declared an interest by virtue of her membership of the Royal College of Nursing.

Cllr Pippa Connor declared an interest by virtue of her sister working as a GP in Tottenham.

Cllr Thayahlan Iyngkaran declared an interest as a consultant radiologist and a deputy medical director.

Helena Kania declared an interest as a co-Chair of the Joint Partnership Board.

16. DEPUTATIONS/PETITIONS/ PRESENTATIONS/ QUESTIONS

None.

17. MINUTES

Referring to the action points from the previous minutes, Cllr Connor requested an update on the Council's liaison with the Osborne Grove co-production group. Beverley Tarka, Director of Adults, Health & Communities, confirmed that Cllr das Neves had written to the group and had shared financial details following the meeting at which they had made a deputation. She added that various options were being worked through in relation to the site and that they would share further information more widely when this had been progressed. Vicky Murphy, Service Director for Adults Social Services, added that a further meeting with the group would be suggested to be scheduled for February 2025 at which they would provide as much updated information as possible.

Cllr Connor recommended that the action tracker for the Panel be included in the agenda papers under the minutes in future. **(ACTION)**

It was noted that the updates on Continuing Healthcare were not yet available as a meeting between the Director of Operations for Adult Community Services at the Whittington (who had presented the report) and the NCL CHC team (which would provide much of this information) had been postponed. An update would be provided to the Panel after this meeting had taken place.

The minutes of the previous meeting were approved as an accurate record.

RESOLVED – That the minutes of the meeting held on 30th July 2024 be approved as an accurate record.

18. APPOINTMENT OF NON-VOTING CO-OPTED MEMBER

Dominic O'Brien, Scrutiny Officer, reported that the recommendation to the Panel, following advice from Legal Services, was to defer the report due to the need for further due diligence of the process to be carried out, including references. Apologies were given for this delay. It was noted that the recruitment process was currently being reviewed and that a further update would be provided at the next meeting. **(ACTION)**

RESOLVED – That the report on the Appointment of a non-voting Co-opted Member be deferred.

19. DEMENTIA SERVICES UPDATE

The report for this item was presented in two parts, with the first part on community aspects introduced by Laura Crouch, Senior Services Manager at the Council, and the second part on NHS and partnerships introduced by Tim Miller, Assistant Director of Place, Integration, Transformation & Delivery (Haringey) at the NCL ICB. Also in attendance was Sade Olutola, Service Lead for Haringey Mental Health Services.

Slides presented by Laura Crouch covered the following points:

- An increasingly ageing population was expected to lead to increased demand for dementia services in the future with more people and more complex diagnoses. There were around 2,300 residents in Haringey thought to be living with dementia in Haringey in 2023/24, around two-thirds of which had been diagnosed with the condition.
- To prepare for the increased demand, it was necessary to look beyond traditional care models and to maximise community strengths, partners and resources. A dementia co-ordinator post had been created to enable partners to engage, network and create a more accessible and robust Borough.
- A set of Dementia Friendly Haringey Priorities had been developed through a number of sessions and activities across the Borough, involving carers, professionals and people with a diagnosis of dementia. These priorities included that Dementia Friendly Haringey will be a place where people with dementia and their carers:
    - Will be respected and experience a greater level of dementia awareness in the community.
    - Will have greater access to health and social care support services.
    - Will have access to a range of local social activities.
- 30 local services and organisations had signed up to a minimum of two actions to make their services more dementia friendly. These included GP practices and care providers.
- A list of key achievements on the ‘Greater Level of Dementia Awareness’ programme of work was provided (also available in the supplementary agenda papers) which included:
    - Funding for carers in a creative group.
    - A new ‘Singing for the Brain’ session twice per month at Tottenham Hotspur Stadium.
    - Nine dementia-friendly events with 40-50 attendees at each.
    - An uptake in referrals, walk-ins and signposting.
    - New dementia-friendly webpages had recently gone live.
    - Delivery of training for GPs, including double appointments for those with a diagnosis of dementia and phone calls in the morning to remind patients of their booked appointments.
    - Improvement of long-term cognition from new community activities in partnership with Jacksons Lane.
- New events were taking place at the Haynes Dementia Hub. Independent networks were being developed and activities such as carers’ lunch clubs and

an evening-based carers group, led by carers, was due to be launched soon. SEN students were gaining qualifications and work experience in the kitchens and other activities. The next wave of social care workers were being actively trained to be dementia-friendly in their practices.

- The assessment and referral pathways were now working well and the localities model had enabled people to be seen more quickly.
- A communications plan was being developed with the Grace Organisation and it was hoped that they could be supported further and built into what was being delivered Borough-wide.
- The Dementia Reference Group was continuing to grow and was attended by carers and people with dementia.
- The Learning Disability Partnership team was working across localities to identify, track and support those with a dementia diagnosis and those at higher risk. People with learning disabilities and especially people with Downs Syndrome were more likely to be affected by dementia and at an earlier age. A social component of that offer was being developed including a nostalgic music and dance group, chair-based exercises and a new memory café to be hosted at Winkfield Resource Centre.
- There were a range of core goals for 2024/25 to deliver on what the groups were saying that they wanted to see in the community. The aim was to create a Borough that was capable and adaptable in a demanding social and financial climate.
- A Dementia Friendly Parks Audit had been conducted and actions were being considered to make the signage more dementia friendly in Finsbury Park and Downhills Park, make seating more accessible and review the paving and walkways. A similar process would also be conducted with the leisure centres.
- Partnerships were being developed across the North Central London (NCL) area, especially with young onset dementia, and by looking at programmes of activities across NCL where referrals could be made.
- Members of the Panel were invited to sign up for the new Dementia-Friendly pledges and training which was now being delivered.

Laura Crouch then responded to questions from the Panel:

- Asked by Cllr Peacock about swimming facilities for people with dementia in Haringey, Laura Crouch reiterated the commitment to carry out an audit of facilities at leisure centres and said that this process would include dementia-friendly swimming.
- Cllr Peacock expressed concerns about the condition of the toilets at the Tom's Club at Chestnuts Community Centre. Laura Crouch agreed to provide this feedback to the organisers. **(ACTION)**
- Cllr Peacock commented that attendance at Singing for the Brain at Tottenham Hotspur Stadium was poor and that it should be advertised more prominently. She added that it could also be confusing to find the correct room. Laura Crouch noted that it had taken some time to negotiate the space for this and so the room location had been changed a few times. However, a new designated

area near the café had been requested so that attendees would not have to walk so far. The team was also looking for other venues in the area that could also host these sessions. Laura Crouch agreed to pass on the feedback on low numbers and promoting the sessions. **(ACTION)** She added that there would be further opportunities for digital advertising through the new dementia-friendly web pages. New printed leaflets about services were also being circulated in the community including to libraries and GP practices.

- Cllr Peacock informed the meeting that there was a new proposal to start a dementia café at the Tottenham Sports Centre.
- Asked by Helena Kania how service provision would be able to keep up with the expected rising demand in future, Laura Crouch said that there was a focus on building up community resources and that the whole dementia-friendly programme aimed to make more places accessible across the Borough. The team had been working closely with the Cypriot Centre on hosting events and there had also been discussion on working with Grace Organisation as previously mentioned. She added that a drop-in service was offered so that people could drop in and attend activities when they wanted to rather than requiring a full-time space. There was also no current waiting list for people referred into the service.
- Helena Kania expressed concern about the transport options available for people who wanted to attend the dementia centres. Laura Crouch responded that each service had its own transport method, mainly using minibuses with some use of taxis and cars. The Haynes Centre was currently able to pick people up from across the Borough and this was done on a needs basis with independent travel encouraged where possible.
- Asked by Cllr Iyngkaran about the organisations that had signed up to the dementia-friendly actions, Laura Crouch said that this included around 12 GP practices so far, noting that this was quite a detailed process to set up with good achievable targets. The initial areas had been targeted with the aim of building up clusters of GP practices over time and to spread this across the Borough. She added that GP-specific dementia-friendly training was having the biggest impact and so they were working with local health providers to release more GPs and other health professionals to attend training sessions. Cllr Iyngkaran suggested that other parts of the Council, including perhaps the Public Health team could use their links to help promote this initiative with GP practices. Will Maimaris, Director of Public Health indicated that he would be happy to look at how his team could help with this. **(ACTION)**
- Cllr Opoku suggested that dementia-friendly policies could be built into the premises for all new or expanded GP practices. Laura Crouch noted that she always promoted dementia-friendly, accessible and autism-friendly practices when meeting with the Haringey GP Federation or with the ICB. Tim Miller confirmed that the work on dementia-friendly practices was supported by the ICB and the Haringey GP Federation. He added that there was a clinical lead GP for the west of Haringey who had done a lot of work in this area. Cllr Connor suggested that an update to the Panel in 8-9 months' time on how this work with GP practices was progressing would be welcomed. **(ACTION)**

- Helena Kania requested figures on dementia service users. Laura Crouch said that there were currently 40 regular attendees at the Haynes while the Tom's Club tended to have around 60-70 people at each session. There was also a small group of regulars attending the drop-in activities. In the past 12 months there had been 27 referrals received, of which 16 had been offered places straight away. Cllr Connor suggested that an update on the figures to the Panel in 8-9 months' time would also be useful. **(ACTION)**
- Cllr O'Donovan commented that, in his experience of attending the dementia events and activities, it brought together people who were living with dementia and their carers with professionals to discuss issues and problems and also facilitated valuable activities. He also highlighted the barriers for some people in obtaining a diagnosis and reaching support services because of issues with isolation and stigma or with dementia not being quickly identified. He also highlighted the waiting times for the Haringey Memory Service as another barrier. It was noted that Tim Miller would address these points in his presentation.

Slides presented by Tim Miller covered the following points:

- The Haringey Memory Service was the key service for dementia diagnosis and post-diagnostic support in the Borough and was well connected and integrated with the Haynes Centre and with the dementia navigators and other dementia roles.
- The quality standard for referral to the service (typically from a GP) to completion of a diagnostic assessment was 6 weeks. Performance on this had recently been relatively stable and well-performing, comparing well to neighbouring boroughs. Those with longer waits would typically be up to 3 weeks longer due to logistics or capacity issues but there were not any hidden long waits.
- There was a measure used across the country on the number of people thought to have dementia compared to the number of confirmed diagnoses in order to see how well dementia was being detected and assessed for. Haringey performed slightly better than the London average on this measure with 66.3% of the expected number of people with dementia assessed and diagnosed. This was still a significant gap but was in line with what was seen nationally.
- The merger of the two Mental Health Trusts in NCL (Barnet, Enfield & Haringey Mental Health Trust and Camden & Islington NHS Foundation Trust) had been planned for some time and was expected to be completed in November 2024. As a result of this, the older people services would be generally moving towards a needs-led approach that was age-cohort based and this would further support people with the right care from the right teams. He also noted that there had been a lack of responsive crisis support for older people with dementia compared to working-age adults with mental health conditions and that a benefit of the merger would be a more consistent model of care that would see dementia crisis teams being introduced in Haringey.

Tim Miller and Laura Crouch then responded to questions from the Panel:

- Cllr O'Donovan highlighted the rise in dementia rates, particularly in minority communities, and noted that issues of stigma may be preventing people from presenting to services. Laura Crouch highlighted the networks being developed with the Cypriot Centre and other local groups and added that there had also been some success at the Black Health Fair this year. The team had been invited to present to the diversity leads who link in with local community/religious leaders and the aim was to find community-based facilitators to help communicate key information, including about services. Cllr Connor noted that, in terms of outreach, the Panel had previously spoken about the centre of excellence approach provided by the Haynes Centre but that the concern had been whether this was being duplicated across the Borough. It would therefore be useful for the Panel to receive further updates on the progress on this, including in relation to the Cypriot Centre, the Grace Organisation and any other organisations that would be involved in this kind of outreach. **(ACTION)**
- Referring to the figures on the 6-week wait quality standard, Cllr Iyngkaran welcomed the improvement from April 2023 to October 2023 but noted that there had been some slippage since then. He also requested details on the longest wait times. Sade Olutola responded that there had been some logistical challenges including some periods of staff sickness, cancellation of appointments due to clashes with other medical appointments for service users and requests for postponement of appointments from carers due to other commitments. She added that resources had been put in place to get this process back on track. She also noted that the longest current wait time was 12 weeks but that this resulted from the individual being hospitalised due to an unrelated issue.
- Cllr Connor highlighted a previous recommendation of the Panel which was to establish a secure online portal to enable service users, carers and social workers to be able to quickly access documents relating to assessments and care plans. Laura Crouch responded that the recent focus had been on rolling out the localities model and making sure that there were good customer-facing spaces across the Borough. The next phase would be to consider the digital approach on dementia. Tim Miller added that a digital portal would be challenging to implement with information across different sectors that would need to be pulled together. One area that had been discussed was having a named professional that would be the main contact for an individual (and their carer/family), based on their needs and their relationship with services, as a point of contact and advice. While he acknowledged that this was a different solution to the digital portal, it did have the potential to address some of the same issues such as on personalised and up to date information. He added that the NHS was ambitious about what could be achieved through the NHS App in terms of medical records and how this could be enhanced in future. However, this was still at the stage of testing and learning how these technologies could work for patients. He added that there was a technology provider called Patient Knows Best that worked in this area which may be of interest to the Panel. Cllr Connor requested further information to be provided

in a future update to the Panel on how the named person approach would be introduced and how individuals and their families would be able to access details on care plans and other relevant information. **(ACTION)**

- Cllr Opoku added that there were plans to expand the Universal Care Plan (a shared care planning system) in areas such as sickle cell disease and that it would be helpful to input into this process to enable dementia to also be included in future. **(ACTION)**
- Cllr Brennan highlighted the importance of directly involving the individual experiencing dementia in the process of shared records and any digital offer. Laura Crouch noted that the ongoing wider digital work was being designed to be accessible for people with neurodiverse needs. This would be an easier pathway for people to follow in the way that events were advertised and there would also be a reminder text service for events where people had expressed an interest.
- Asked by Cllr O'Donovan asked about outcome measures, Laura Crouch said that feedback was gathered after all events and compiled into a monthly dementia-friendly report. Data was also collected on the number of attendees at activities, referrals being made and the type of phone calls/contacts made.

20. SMOKE FREE GENERATION BY 2030 INITIATIVE

Will Maimaris, Director for Public Health, introduced this item noting that smoking remained the biggest contributor to the life expectancy gap between the richest and poorest parts of the country. He also noted that the new Government appeared to be continuing the previous Government's proposals to tighten the law on smoking and vaping.

Bezuayehu Gubay, Public Health Strategist and Commissioner, then presented details of Haringey's new plan to create a smokefree generation by 2030:

- Smoking is the single most entirely preventable cause of ill health, disability and death in the UK, leading to around 80,000 deaths a year and one in four of all cancer deaths.
- In Haringey, 17% of the GP registered population were smokers as of November 2023, which equated to 59,620 people.
- Various groups in Haringey had higher rates of smoking including people in routine and manual occupations (33% prevalence), people with long-term mental health conditions (28%), people from certain ethnic communities including the Turkish (28%), Polish (31%) and Romanian (31%) speaking communities and people living in the most deprived areas (20%). In addition, 5.4% of pregnant women were identified to be smokers at the time of delivery.
- Haringey had the second highest mortality rate in NCL for smoking attributable mortality in persons aged 35 years or more and had higher hospital admission rates than London as a whole.
- The economic impact of smoking on Haringey was estimated to be around £100m. The cost on an individual's finances was also significant with someone

smoking 20 cigarettes per day spending an average of £4,182 per year. An average smoker spends £1,945 per year.

- There were opportunities created through the Government's Smoke Free Generation by 2030 initiative including increasing the age of sale, strengthening enforcement on illicit tobacco and vaping sales as well as initiatives to support and incentivise people to stop smoking. Additional funding for anti-smoking in Haringey this year was £332,932.
- A process of assessment and self-evaluation was being carried out while strategic actions included writing a tobacco control strategy, embedding the tobacco control agenda in the Health and Wellbeing Strategy and the signing of a Tobacco Control Declaration by elected members.
- Other policy actions included school initiatives, promoting smoke-free environments, public education and enforcement actions. The overall goal was to achieve 5% of smoking prevalence by 2030 which was the national target.
- The equality focus included a targeted approach on the higher-risk groups referred to previously, using the swap to stop scheme to encourage smokers to switch to vaping, efforts to reach those most in need through health ambassadors from key community groups, a multilingual website and improved referral pathways. There was also increased workforce capacity to support these initiatives including more smoking advisers and speciality training on mental health.
- The Council had committed to supporting the Tobacco and Vapes Bill and there were options for elected members to provide support, including by signing up to the London Smoke Free Councillor Network.

Will Maimaris and Bezuayehu Gubay then responded to questions from the Panel:

- Cllr Connor requested further details on how high-risk groups would be targeted. Will Maimaris said that regulation was likely to have the most success but there was also additional resources going into smoking cessation services along with the community ambassador approach. Bezuayehu Gubay added that the direct engagement with local community organisations was combined with identifying current smokers through health records to encourage them to engage with interventions.
- Asked by Cllr Connor how children in schools would be prevented from vaping, Will Maimaris acknowledged that there was not yet a clear formulated plan around Personal, Social, Health and Economic (PSHE) education because this was still an emerging picture. Regulation may be required as the number of young people vaping was rising. Cllr Connor suggested that it would be useful to be updated on how work in schools on vaping progresses at a future date. **(ACTION)**
- Cllr Peacock expressed concern that some Council staff could be seen smoking outside some Council buildings which should be discouraged. Will Maimaris said that there had been some firm messaging to Council staff about smoking outside the premises. Some investment for workplace NHS health checks had also recently been secured which included smoking advice for staff.

Bezuayehu Gubay added that staff were also supported by linking to initiatives such as 'Stoptober'.

- Cllr Peacock highlighted the high prevalence of smoking in the Turkish community and also the marketing of vaping to children and young people. Will Maimaris said that the proliferation of colourful vapes that appeal to young people was recognised as a national issue. While the Council's trading standards team could enforce existing regulations, a shift in national levers would be required for further action.
- Cllr O'Donovan highlighted the potential mixed messaging of discouraging youth vaping but also encouraging smokers to switch to vaping. Will Maimaris responded that, although the harm from vaping wasn't fully understood, it was clearly much less harmful than smoking which is why there were efforts to switch smokers over to vaping. He acknowledged that there was a challenge of reconciling this with the message around potential harm for children and this is why further regulation and support was required nationally.
- Cllr O'Donovan highlighted research which indicated that managing stress/anxiety was a factor in young people vaping and also that young people wanted more reliable educational information about whether vaping was harmful. Cllr Connor requested that Cllr O'Donovan circulate any relevant research on this issue to the Panel. **(ACTION)** Will Maimaris observed that there were some similarities between the trend on vaping and young people and the use of smoking and alcohol in previous generations of young people. However, the trend around anxiety and stress was also reflected by increasing rates of self-harm in young people. He added that the team were doing some local research on vaping with schools and that there was a forthcoming seminar on this that he could report back on at a later date. Cllr Connor agreed that it would be useful for the Panel to be updated on this along with any future plans to engage with pupils via PSHE education and linking up with mental health teams if this was felt to be a factor. **(ACTION)**
- Asked by Cllr Opoku whether people who chew tobacco were included in the strategy, Bezuayehu Gubay said that they would still be supported if presenting to services but that there wasn't a specific workstream on this. Cllr Connor recommended that the wording of the strategy be amended to include 'tobacco products' as a way of including practices such as this. **(ACTION)** Will Maimaris agreed that there could be some consideration given to understanding the cultural practices around chewing tobacco.
- Cllr Iyngkaran referred to the graph on smoking prevalence in Haringey and queried the sharp drop in 2021 which was followed by a subsequent rise. Will Maimaris said that short term trends in the data should be treated with some caution as they tended to fluctuate and were based on a questionnaire that only a certain number of people were asked to complete. He also noted that there was some national evidence around increasing smoking prevalence in young people which hadn't been seen for some time.

21. HARINGEY SAFEGUARDING ADULTS BOARD - ANNUAL REPORT 2023/24

Dr Adi Cooper, Independent Chair of the Haringey Safeguarding Adults Board (HSAB), presented the Board's annual report for 2023/24, explaining that this set out the statutory duties of the Board and the work of the Board and its partners over the past year. Further key points in the report that she highlighted were:

- Details of the two Safeguarding Adults Reviews that were published last year, one of which highlighted issues around self-neglect, housing provision and multi-agency working and the other which focused on commissioned care in a care home and multiple areas of physical and mental health needs. The reviews included recommendations which were responded to.
- Details of the recent work with colleagues in the Joint Partnership Board to update, revise and co-produce the five-year strategy based on the concerns and interests of residents in Haringey.
- The Board's subgroups had changed slightly with two new subgroups to help clarify and focus on two major areas of focus for the Board:
    - Under the Safeguarding Adult Review subgroup there was now a subgroup looking at the implementation of recommendations emerging from Safeguarding Adult Reviews. She noted that there was a particular challenge, not just in learning from the Reviews but also in maintaining ongoing improvement with the churn in staffing and organisational structures and the pressures on the public sector. It was therefore necessary for the sub-group to go back to look at earlier Reviews carried out some years previously.
    - There was now a Practice & Improvement subgroup. There had previously been a Prevention & Training subgroup but these had now been split into two with an Engagement & Prevention subgroup focusing more on working with the voluntary sector, planning events for safeguarding adults and enhancing understanding of safeguarding across communities in Haringey. The new Practice & Improvement subgroup was focused more on practitioners engaged in safeguarding practices.
- Case studies gave examples of some difficult situations that practitioners were engaged with and delivering the outcomes that people want.
- A range of initiatives from partners around improvements in training, process and practice to support ongoing improvements in safeguarding.

Dr Cooper also informed the Panel that the Board received reports on a Quarterly basis where issues were raised which could lead to deep dives to check whether there was something more significant ongoing that was indicated by the data. She noted that data on safeguarding was not there as performance data but to prompt questions about issues that may be happening beneath the surface.

Dr Cooper then responded to questions from the Panel:

- Cllr Connor referred to Recommendation 8 of the 'Paulette' Safeguarding Adult Review, which said that the Board should consider conducting an audit of commissioned placements and care packages to ensure that social, cultural and emotional needs were recognised. She also referred to the 'Steve'

Safeguarding Adult Review, noting the detailed aspects of multi-agency communication and co-ordination in Recommendation 1. She asked how the Board would be able to keep abreast of important but detailed recommendations such as this. In relation to the recommendation on the 'Steve' Review, Dr Cooper explained that the multi-agency panel would be reporting to the Board on an annual basis about progress so the way that this recommendation was being implemented was by doing so on a routine basis rather than having to follow it up periodically. Similarly, the audit of cases within adult safeguarding was coming to the Board in a routine way. However, she acknowledged that the volume of recommendations was quite challenging and so when looking at these it was important to ensure that there was no duplication in the actions taken as some of the recommendations tended to cluster within Reviews as well as across Reviews. The new subgroup was trying to manage that process as the previous subgroup had found the volume of recommendations very high. This was not an issue unique to Haringey as the number of Reviews gradually increased following the introduction of the Care Act. She also commended the support provided by Council officers in managing this work. She noted that that the subgroup looking at historic Reviews was medium to long-term work, with a deep dive into one Review at a time, and identifying key themes that required focus on an ongoing basis. Some issues may become more or less important over time or may rely on changes to national guidance or legislation to be fully implemented.

- Asked by Cllr Connor about the joined-up approach through the Multi-Agency Solutions Panel, Vicky Murphy, Service Director for Adults Social Services, responded that the Panel was well known across all partners and internally as well as being promoted within the Safeguarding Adults Board and its subgroups. To get a referral through to the Panel, someone would need to be known to a provider and there would need to be consent under the Mental Capacity Act, so it wasn't always straightforward, but the ability to draw on expertise across partners was there.
- Helena Kania noted the high level of Violence Against Women & Girls (VAWG) referred to in the report and queried what more could be done. Dr Cooper explained that it was routine for the partners to speak to the Board on an annual basis to explain what they were doing in this area and to examine the crossover with the safeguarding adults work. She acknowledged that this was a particularly challenging area and that this was not just an issue in intimate relationships but also in wider family relationships so there needed to be the right training available so that this could be properly identified. Asked by Helena Kania about the unreported aspects of VAWG, Dr Cooper observed that pain and shame were issues connected to safeguarding which people were reluctant to talk about and this also applied to VAWG and domestic abuse making it difficult to disclose. She agreed that there was a lot of hidden abuse, coercion and control and that what was seen in safeguarding adults data was only the tip of the iceberg. This was why the work of the Engagement and Prevention subgroup was so important as this involved a focus on raising awareness in the community, including on how to report VAWG. Cllr Connor

noted that VAWG was referred to on page 57 of the agenda pack but that it wasn't clear where this was being addressed in terms of the Board and subgroups so recommended that this be clarified in future reports. **(ACTION)**

- Cllr Brennan queried why VAWG and domestic abuse did not appear to be sufficiently prioritised and why statistics were not properly publicised, for example through police ward meetings. Dr Cooper clarified that Adult Safeguarding was primarily about people with care and support needs and so VAWG was an area that overlapped with the Board's responsibilities but was a broader agenda. In relation to prosecutions, Dr Cooper said that an ongoing challenge was that victims with care and support needs were not always seen as credible witnesses or there was not enough evidence to prosecute. That wasn't to say that the Police weren't trying hard to build these cases, but it was a very challenging area.
- A member of the public asked a question about members of the community raising safeguarding issues with the Council but finding it difficult to receive a response. Beverley Tarka said that there were channels to report directly to safeguarding teams if there was a safeguarding concern relating to someone who was in receipt of care and support through the adult social care team and this would be prioritised. However, if this related to someone in the general population then this would not be something to be sent to the adult social care team. Asked by Cllr Connor about communications on these issues more generally, Will Maimaris said that there was an issue to consider on coordination and channels of communication when issues were raised around service provision or how a resident was being supported. Vicky Murphy said that she was happy to have a conversation after the meeting to understand the issues relating to the specific case referred to and taking this to the right team. **(ACTION)** In relation to the wider point about communications, she said that the methodology about locality working was strengthening the way that safeguarding worked to ensure that the team was in a position to respond quickly and in person.
- Cllr O'Donovan asked if there were specific safeguarding contacts at Alexandra Palace and Tottenham Hotspur Football Club as they hosted events with large numbers of people. Dr Cooper said that she wasn't aware of any specific contact with Alexandra Palace, but that Tottenham Hotspur had given a good presentation to the Board some years ago about raising awareness around safeguarding which had led to some follow up work.
- Noting the references to gambling harms and adult safeguarding in the report, Cllr O'Donovan queried whether the sponsorship of Tottenham Hotspur by gambling organisations sat well with their wider safeguarding policies. Dr Cooper responded that the Council's Public Health team, which worked specifically on gambling harms, was likely to be better placed to engage with Tottenham Hotspur on this type of issue as this did not fit with the Board's duties and responsibilities.
- Cllr Iyngkaran observed that Haringey had one of the highest proportions of gambling premises in London and, while acknowledging that national policy/legislation was relevant to this, asked what more could be done locally.

Dr Cooper explained that the outcome of the Board's conversation on gambling was to raise awareness with partner agencies in the context of adult safeguarding, including in relation to financial abuse. Will Maimaris acknowledged that gambling was a significant public health issue and that the Council had a gambling harms programme that was supported by the Cabinet Member for Health, Social Care and Wellbeing. The Council was limited on what it could do on the activities of gambling organisations, but he was happy to share information about the Council's work in this area at a future meeting. **(ACTION)**

- Cllr Iyngkaran referred to a case study in the report of physical abuse from a carer and queried why there were still difficulties in bringing this to prosecution despite the incident being captured by CCTV. While Dr Cooper was not able to elaborate further on the details of the specific case, she explained that there were a number of parallel processes alongside the safeguarding inquiry relating to cases such as this and that this related to the difficulties that the Police experienced in bringing prosecutions, as discussed earlier in the meeting. She emphasised that these case studies provided some insight into the sort of issues that practitioners deal with in relation to safeguarding adult issues.
- Referring to page 75 of the agenda pack, Cllr Connor noted that the number of safeguarding concerns had decreased by 38% in 2023/24 compared to the previous year, while the number of Section 42 enquiries had increased by 29% and the proportion of concerns leading to Section 42 enquiries had also increased. Dr Cooper commented that the data suggested that people were getting better at referring concerns through more appropriate pathways so this should not be seen as performance data but rather as an illustration about how something was changing. Vicky Murphy concurred with this and said that teams were getting better at managing concerns and partners had an improved understanding of what safeguarding was and the most appropriate way to manage concerns. Additionally, the safeguarding team had been brought back in-person 18 months previously following the pandemic and were better able to review initial concerns and ensure that a Section 42 process was followed.
- Referring to page 84 of the agenda pack, Cllr Connor noted that the NCL ICB was developing a Safeguarding Case Review Tracker and asked whether the Board had something similar. Dr Cooper explained that the ICB's tracker was to record roles and responsibilities across the local NHS organisations in relation to Safeguarding Adults Reviews which was welcome. The Board tracked the implementation of recommendations from Safeguarding Adults Reviews as previously described in relation to the work of the Implementation subgroup.
- In relation to the Board's priorities and objectives, under Section 8 of the report, Cllr Connor commented that, while she had understood the work of the subgroups and of ensuring that processes were in place, she hadn't understood as clearly from the report about the impact made for residents. Dr Cooper acknowledged that this was tricky because of the complexities relating to safeguarding and also because the role of the Board was to seek assurance that certain things were happening and that practice was being maintained at the right level. However, it was possible to assess impact and improvements in

practice through case file audits. Referral analysis was also relevant as, when referrals of concerns from members of the public increased for example, this could be an indication of greater awareness of safeguarding in the community. While the Board looked at various indicators of impact, it could be quite difficult to demonstrate directly. In addition, wider societal factors that impacted on safeguarding were beyond the control of the Board, for example the cost-of-living increases driving increases in financial abuse.

Cllr Connor then summarised the discussion and described the creation of the two new subgroups as a particularly significant development. She noted that the Panel would welcome further detail on progress with their work in the following year's report, including on the implementation of Safeguarding Adults Review recommendations and on how changes in practice were impacting on the lives of residents. With regards to the Practice & Improvement subgroup, it would be useful to understand the mechanisms to support practice improvement and safeguarding across the partnership. **(ACTION)**

22. WORK PROGRAMME UPDATE

Cllr Connor highlighted the scrutiny community consultation event, known as the 'Scrutiny Café' which was due to take place the following day. This would help to inform the issues for inclusion in the Panel's work programme for both Panel meetings and Scrutiny Review topics.

Scrutiny Officer, Dominic O'Brien, noted that the feedback from the Scrutiny Café would be provided in a report to the Overview & Scrutiny Committee on 14th October. He also informed the Panel that future Panel dates would need to be changed due to the Budget Scrutiny process being brought forward to November rather than December. This would mean that the next Panel meeting scheduled for 5th November would be cancelled and that a new Panel meeting on the budget would take place on 14th November. The next meeting date on 17th December would remain in place but would be used for regular agenda items rather than the budget.

Dominic O'Brien reported that the Panel had previously requested an agenda item on preparedness for a future pandemic and that, following liaison with the Director for Public Health, it seemed likely that February 2025 would be a suitable date for this item.

23. DATES OF FUTURE MEETINGS

- Thurs 14th November (6.30pm)
- Tues 17th December (6.30pm)
- Mon 10th February (6.30pm)

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……

Adults & Health Scrutiny Panel – Action Tracker 2024-25

MEETING 2 – 19th Sep 2024

No.	ITEM	STATUS	ACTION	RESPONSE
27	Safeguarding Adults Board annual report	**Added to work programme**	Consideration to be given to receiving a future report on gambling harms.	Added to Work Programme.
26	Safeguarding Adults Board annual report	**Completed**	Individual case to be referred to appropriate officer.	Case has been referred to relevant teams with Vicky Murphy's business manager copied in.
25	Safeguarding Adults Board annual report	**Update due in Sep/Nov 2025**	Recommendation from the Panel on future reports: - progress on subgroup for implementation of SAR recommendations. - details of mechanisms to support practice improvement and safeguarding across the partnership and how changes in practice were impacting on the lives of residents. (Practice & Improvement subgroup) - that clarification be provided on where Violence Against Women & Girls (VAWG) is addressed through the Board and its subgroups.	Recommendations have been provided to Dr Adi Cooper ahead of next year's report.
24	Smoke-free strategy	**Completed**	Recommendation from the Panel – that the practice of chewing tobacco to be included in the strategy and wording to include "tobacco products".	The Public Health team have confirmed that this recommendation will be taken forward and added to the tobacco control strategy and action plan.
23	Smoke-free strategy	**In progress**	Cllr O'Donovan to circulate any relevant research on young people and vaping.	
22	Smoke-free strategy	**Update to be requested in 2025/26**	Update to be provided to Panel on work in schools on vaping including the local	Added to Work Programme.

			research/seminar, PSHE education and links with mental health teams.	
21	Dementia services	**Update to be requested in summer 2025**	Update to be provided to Panel in approximately 9 months on: - progress with dementia-friendly GP practices - number of dementia service users - progress on outreach work and 'centre of excellence' approach (replicating that of the Haynes Centre in the west of the Borough) in the centre and east of the Borough - progress on the named-person approach where service users/carers have a single point of contact for all details on care plans and other information	Added to Work Programme.
20	Dementia services	**Completed**	Recommendation from the Panel – that input be provided to Universal Care Plan for expansion to include dementia patients.	Response from Tim Miller: There is work occurring across London to promote and expand the use of UCP targeting those likely to be using urgent and crisis hospital care. Residents with dementia may have Universal Care Plan's (UCPs), as would other suitable residents seen by care teams who use the UCP – e.g. care home teams and end of life teams. The Memory Service itself has viewing access to UCP, so are aware of people's UCPs. Once the service transforms to a diagnosis-to-end of life service, it does aspire to completing the UCP for every patient – which is expected by 2027.
19	Dementia services	**Completed**	Recommendation from the Panel - for the Public Health team to provide support to promote dementia-friendly actions at GP practices.	Response from Director for Public Health – "*The Haringey Public Health Team is part of the Age Well Board in Haringey. Through this board we are contributing to the efforts to make Haringey dementia friendly including supporting participation of GP practices."*

18	Dementia services	**In progress**	Feedback from Panel to be provided on condition of toilets at Toms Club at Chestnuts Community Centre.	a) Details have been provided to Chestnuts Community Centre. Response awaited.
17	Dementia services	**Completed**	Feedback from Panel to be provided on suggestion to advertise the Singing for the Brain sessions at Tottenham Hotspur Stadium more prominently.	Response b) - Details on the Singing for the Brain Group at Tottenham Hotspurs have been widely shared with the Dementia Friendly Haringey network. The group is also listed in our updated leaflets which have been recently shared and are available to view on our Dementia Friendly Haringey webpage https://new.haringey.gov.uk/health-wellbeing/health-services-support/mental-health-wellbeing/dementia-friendly-haringey Officers will also follow up with Spurs and Alzheimer's Society to look at how we can further advertise the group.
16	Co-opted members	**Completed**	Update to be provided on recruitment process.	Report to be brought to November 2024 meeting.
15	Minutes	**To be included in future papers**	Action tracker to be included in agenda papers for all future meetings.	Action tracker included from November 2024 meeting onwards.

MEETING 1 – 30th Jul 2024

No.	ITEM	STATUS	ACTION	RESPONSE
14	Cabinet Member Questions	**COMPLETE**	Response to be provided to the Joint Partnership Review of the Haringey Opportunities Project.	**Background for Haringey Opportunities Project (HOP)** The Haringey Opportunities Project (HOP) is a day opportunities and community service based in Tottenham, N17. It is designed to support adults aged 18+ with severe learning disabilities and autism. Officially launched on 12th August 2021, the project

				provides a structured environment where individuals can engage in both centre-based activities and opportunities for community involvement. The service accommodates individuals with varying levels of need, ranging from those requiring intensive support to those needing less. Centre404 is the commissioned Positive Behaviour Support (PBS) provider for the service, with the current contract running until 30th June 2025. Due to delays in the initial launch, which was postponed from April 2020 to August 2021, the contract was extended to allow for further improvements and a comprehensive service review. **Service Review and Improvement Plan** The primary objective of the review was to evaluate Centre404's performance against its contractual commitments and assess the overall quality of service delivery, both at the centre and within the broader community. The review was designed to identify gaps and areas requiring improvement to ensure the service meets the agreed outcomes for individuals with severe learning disabilities and autism. Following the review, key findings and identified areas for improvement were communicated to Centre404. In response, a detailed improvement plan was developed, targeting the specific concerns raised during the review. To ensure continuous improvement and compliance, progress is being closely monitored on a monthly basis. This monitoring includes both scheduled and unscheduled commissioning visits, allowing for a thorough evaluation of service delivery and timely identification of any issues. The results of the HOP review were first presented to the Commissioning Co-production Group, where a summary of the improvement plan was also shared. It was agreed that the full

				review report would next be submitted to the Severe and Complex Autism and Learning Disability (SCALD) Reference Group for further discussion and input. As part of the preparations for a potential re-commissioning of the service, which is scheduled to end in June 2025, the Commissioning Co-production Board has endorsed the formation of a dedicated working group to oversee the redesign process. This working group will likely include members of SCALD, ensuring a collaborative approach that integrates the perspectives and experiences of family members of current service users. Their involvement is critical to shaping a service that reflects the needs and expectations of the individuals and families it supports. By incorporating the insights of key stakeholders and maintaining rigorous oversight, the improvement plan and working group will guide the ongoing transformation of HOP, ensuring it continues to deliver high-quality, person-centred services in the future.
13	Health & Wellbeing Strategy	**Feedback to be considered and also addressed in next update report**	Recommendations for consideration and clarifications requested for the next update were: • It was noted that social isolation was included under the Improving Mental Wellbeing theme, but it was recommended that this could also be included under Preventative Health theme given the link to dementia and other conditions. • There were some challenges acknowledged in how some outcomes could be	Added to Work Programme.

			realistically monitored, such as people accessing green spaces. • Further clarification was requested on how the outcomes, monitoring and reporting would fit within the governance structure. • Further detail would be required on how health policy would be able to link to and influence the Local Plan in relation to housing policy and what realistic outcomes could be achieved given the complexities in this area. • Further detail would be required on how on the future partnership working and community engagement would work in practice.	
12	Health & Wellbeing Strategy	**To be added to 2025-26 Work Programme**	Panel to be provided with a further update in 12-18 months.	Added to Work Programme.
11	Health & Wellbeing Strategy	**COMPLETE**	Further detail was requested on why life expectancy was lower than other parts of the Borough in the Stroud Green ward.	Response from Will Maimaris: "I checked the raw data for this and this revealed an error in what we presented in the map. Life expectancy in Stroud Green Ward for 2016-20 was 79.8 for males (compared to Haringey average of 80.0) and 84.1 for females (compared to Haringey average of 84.6). So, life expectancy is not significantly different from the borough average, and the shading on the map should have been one

				shade lighter than it was for both females and males for this ward. Please accept my apologies for this error."
10	Health & Wellbeing Strategy	**COMPLETE**	Information to be circulated about the ABC Parenting programme which provides peer support for new mothers.	ABC parents has been started by clinicians at North Middlesex Hospital aimed at new mums in Haringey and Enfield to support with parenting from a health and wellbeing point of view but also for mothers to build informal networks that can support them. Further details: https://www.northmid.nhs.uk/abcparents/
9	Health & Wellbeing Strategy	**COMPLETE**	An update was requested on the current status of the ageing and frailty project.	• The GP Federation are now implementing an Ageing Well (AW) programme across Haringey and Enfield on creating age-friendly environments through the collaboration of local individuals, businesses, and organisations within the borough. They are training AW Friends, Champions and Experts to seed expertise across the boroughs. • Age Well festival run by Public Voice in collaborative with partners will be held 21st September in Bruce Castle Park from 12pm to 5pm. The festival will be a day of creative, active and wellness activities for residents to take part in along with music and dance performances to enjoy on the main stage. Link below for more information: https://new.haringey.gov.uk/events/haringey-age-well-festival-2024 • The West Frailty project is continuing to gather self-assessments from older residents using an adjusted clinical frailty assessment tool – the findings will be analysed and learning identified in due course.
8	Continuing Healthcare	**COMPLETE**	Data was requested on CHC assessments for people in care homes.	The responses to action points 2 to 8 are all addressed in **ATTACHMENT A1**.

7	Continuing Healthcare	**COMPLETE**	Information was requested on the work being carried out by the ICB on upscaling awareness of CHC across NCL.	Additional information has also been provided in relation to action points 2 and 3 – please see **ATTACHMENTS A2 to A6**.
6	Continuing Healthcare	**COMPLETE**	Information was requested on why CHC figures in Haringey/NCL was significantly lower than the national average.	
5	Continuing Healthcare	**COMPLETE**	Data on health inequalities and ethnicity relating to the recipients of CHC in Haringey was requested.	
4	Continuing Healthcare	**COMPLETE**	Clarification was requested on the funding for advocacy services for residents undertaking the assessment process.	
3	Continuing Healthcare	**COMPLETE**	The information provided to residents should: - Make clear that the recording of assessments can be requested. - Make clear how decisions could be challenged and explain the process for this. - Provide details on financial assessment/eligibility and ensure that residents are clear about any financial contribution that may be required from them.	
2	Continuing Healthcare	**COMPLETE**	The Panel emphasised that clear written information should be provided to residents/families/carers/advocates	

			prior to any assessment or checklist taking place so that they were clear about the process and the questions that would be asked.	
1	Minutes	**COMPLETE**	Update to be provided on liaison with the Osborne Grove co-production group.	Verbal update provided at Panel meeting on 19th September 2024. A further meeting with the co-production group was expected in February 2025.

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Whittington Health
NHS Trust

Anthony Rafferty
Director of Operations ACS,
Whittington Hospital,
Magdala Avenue,
N19 5NF
www.whittington.nhs.uk

Dear Haringey scrutiny panel

RE: Questions following Haringey scrutiny panel regarding CHC 30/7/24

1. ***The Panel emphasised that clear written information should be provided to residents/families/carers/advocates prior to any assessment or checklist taking place so that they were clear about the process and the questions that would be asked. The information provided to residents should also:***

- ***Make clear that the recording of assessments can be requested.***
- ***Make clear how decisions could be challenged and explain the process for this.***
- ***Provide details on financial assessment/eligibility and ensure that residents are clear about any financial contribution that may be required from them.***

Patients are provided with the Patient Information Leaflet and Decision Support Tool (DST). The patient Information Leaflet and Checklist is provided at Checklist stage. – See attached.

Whittington Health do not have a policy on making a recording, but our team follow the NCL CHC policy for this. When there has been a need to record assessment, patients can be provided with the NCL Recording of Assessments if requested. – See attached

The appeal process is explained at the CHC assessment together with the funding changes if a patient is made CHC eligible this would be NHS funding. If a patient is no longer CHC eligible the handover period is 14 days to the local authority. The patient is also informed that all care via social services is means tested and there will be a financial assessment, and they may need to pay a contribution. This is clearly documented in the DST on the relevant page. See attached copy of letter

Outcome letters are sent following ratification to patients with the outcome together with the DST. – See attached

2. ***Clarification was requested on the funding for advocacy services for residents undertaking the assessment process.***
   Referrals are made for an advocate if a patient does not have a representative this is VoiceAbility for Haringey- included in the CHC10 see attached.
   NHS England have also recommended patients can also be directed to Beacon Advocacy Organisation which is commissioned by NHS England to provide free advice on NHS Continuing Healthcare for up to 90 minutes to members of the public- Whittington Health are in the process of updating their information via a patient information leaflet and including it on to a pre assessment letter in the coming months.

3. ***Data on health inequalities and ethnicity relating to the recipients of CHC in Haringey was requested***.
   See data table below. Date ranges from 2023 to present. There is clearly work to be done in this area and the figures for the collection of data is improving

4. ***Information was requested from the ICB explaining was CHC figures in Haringey/NCL was significantly lower than the national average***.
   Whittington have asked if NCL CHC can provide CHC data on NCL boroughs versus the whole of London/ National. The figures may be lower due to health care professionals making fewer referrals (GPs, social workers and district nursing).

5. ***Information was requested on the work being carried out by the ICB on upscaling awareness of CHC across NCL.***
   Whittington and the ICB would love to get more engagement from the deprived side of Haringey (East Haringey, Northumberland Park) by engaging GPs and doing workshops on CHC or posters to be put in areas where or communities which do not have access to CHC can get information. Outreach work with community elders and voluntary care sector. Whittington health have a good record at working to address health inequality and inequalities to access. This is an area where CHC could focus.

6. ***Data was requested on CHC assessments for people in care homes.***
See data table on funding type for Haringey residents who may also be placed outside of Haringey

(There are only 2 nursing homes in Haringey Stamford and Priscilla Wakefield House)

Row Labels	Sum of Ethnicity Total
African	27
Any Other Black background	2
Any Other Asian background	13
Any Other Black Background	16
Any Other Ethnic Group	26
Any Other Mixed Background	6
Any Other White background	81
Bangladeshi	3
British	177
Caribbean	48
Chinese	6
Greek / Cypriot	4
Indian	11
Irish	11
Not Known	83
Not Stated	196
Pakistani	4
White and Asian	2
White and Black African	3
White and Black Caribbean	4
White British	57
White English	4
White Irish	4
(blank)	
Grand Total	**788**

Funding Type	2021	2022	2023	2024
Joint Funded POC	9	11	11	10
Nursing Home	254	225	225	242
POC	318	300	258	255
Specialist Centre	10	6	10	7
Total	**591**	**542**	**504**	**514**

Yours sincerely

Anthony Rafferty

Director of Operations for Adult Community Services
Whittington Health

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- Department of Health & Social Care

Guidance

Public information leaflet: NHS continuing healthcare and NHS-funded nursing care

Updated 30 May 2022

Introduction

This is a guide for people who may be in need of ongoing care and support from health and social care professionals as a result of disability, accident or illness. It explains the process used to determine whether someone is eligible for NHS continuing healthcare (often referred to as NHS CHC, or just CHC).

We recognise that the funding arrangements for ongoing care can be complex and highly sensitive, and often affect people at a very uncertain stage of their lives. National guidance exists to ensure that everyone has fair and consistent access to NHS continuing healthcare, regardless of where they live in England.

This guidance, which is called the National framework for NHS continuing healthcare and NHS-funded nursing care (the national framework), sets out how eligibility for NHS continuing healthcare is determined and how needs should be assessed and addressed.

The national framework was first introduced in 2007 and most recently updated in 2022. None of the 2022 amendments and clarifications to the national framework are intended to change the eligibility criteria for, or access to, NHS continuing healthcare. This leaflet takes into consideration the changes made in the 2022 update of the national framework.

NHS continuing healthcare

What is NHS continuing healthcare?

NHS continuing healthcare means a package of ongoing care that is arranged and funded solely by the National Health Service (NHS) specifically for the relatively small number of individuals (with high levels of need) who are found to have a ‘primary health need’ (see more in the ‘Primary health need’ section below).

Such care is provided to an individual aged 18 or over to meet health and associated social care needs that have arisen as a result of disability, accident or illness.

NHS continuing healthcare is free, unlike support provided by local authorities, which may involve the individual making a financial contribution depending on income and savings. It is the responsibility of the integrated care board (ICB) to decide the appropriate package of support for someone who is eligible for NHS continuing healthcare.

Who is eligible for NHS continuing healthcare?

People over 18 years of age who have been assessed as having a ’primary health need’ are entitled to NHS continuing healthcare.

Eligibility for NHS continuing healthcare is not dependent on a particular disease, diagnosis or condition, nor on who provides the care or where that care is provided.

How do you become eligible for NHS continuing healthcare?

Eligibility for NHS continuing healthcare is assessed in 2 stages, in most cases:

- a screening process using the ‘checklist’ is used
- where the checklist is positive, the next stage of assessment involves a multidisciplinary team (MDT) undertaking a comprehensive assessment and evaluation of an individual’s health and social care needs and reviewing evidence such as medical records, examinations, assessments and so on to make an assessment of eligibility for CHC using a standardised tool called a ‘decision support tool’ (DST) to help inform the decision

More information on these processes can be found later on in this leaflet.

Where can you receive NHS continuing healthcare?

You can receive NHS continuing healthcare in any setting (apart from acute hospitals) – including in your own home or in a care home. If you are found to be eligible for NHS continuing healthcare in your own home, the NHS will pay for your package of care and support to meet your assessed health and associated social care needs. If you are found to be eligible for NHS continuing healthcare in a care home, the NHS will pay for your care home fees, including board and accommodation. Individuals who are eligible for NHS continuing healthcare have had a right to have a personal health budget since October 2014, and ICBs should offer individuals who are eligible for

NHS continuing healthcare the option of taking up a personal health budget, and support to do so.

Will I have to pay for NHS continuing healthcare?

No. The NHS care and support package or personal health budget provided should meet your health and associated social care needs as identified in your care plan. The care plan should set out the services to be funded and/or provided by the NHS. In some circumstances you might wish to purchase additional private care services, but this decision must be voluntary. Any additional services that you choose to purchase should not be meeting the assessed needs for which an ICB is responsible.

Does NHS continuing healthcare last forever?

Not necessarily. Once eligible for NHS continuing healthcare, your care will be funded by the NHS.

You should normally have a review of your care package after 3 months, and then every 12 months. The focus of these reviews should be on whether your care plan or arrangements remain appropriate to meet your needs.

If your needs have changed to such an extent that they might impact on your eligibility for NHS continuing healthcare, then the ICB may arrange a full reassessment of eligibility. This may mean your funding arrangements change, as eligibility for NHS continuing healthcare is based on needs rather than on the condition and/or diagnosis (See more in the ‘Reviews’ section below.)

Primary health need

The concept of a ‘primary health need’ helps determine which health services it is appropriate for the NHS to provide to meet your needs, and which services local authorities may provide. We recognise that this concept is not straightforward. However, in order to decide whether or not you have a primary health need, there will be an assessment of eligibility which looks at the totality of your relevant needs in relation to 4 key characteristics:

- nature: this describes the characteristics and type of your needs and the overall effect these needs have on you, including the type of interventions required to manage them
- intensity: this is the extent and severity of your needs and the support required to meet them, including the need for sustained or ongoing care
- complexity: this is about how your needs present and interact and the level of skill required to monitor the symptoms, treat the conditions and/or manage the care
- unpredictability: this describes the degree to which your needs fluctuate and thereby create challenges in managing them, including the risks to your health if adequate and timely care is not provided

If it is decided that you have a primary health need, you will be eligible for NHS continuing healthcare.

You can read more about the concept of the ‘primary health need’ in the national framework (paragraphs 55 to 67).

Assessments

Making decisions about who is eligible for NHS continuing healthcare

The process of assessment of eligibility and decision-making should be person-centred. This means placing you at the centre of the assessment and care-planning process and involving you throughout.

It also means making sure that you have the opportunity to play a full role in the assessment process and receive the support to do this where needed. You could do this by asking a friend or relative to act as your representative and help explain your views.

The full assessment process for NHS continuing healthcare usually involves 2 steps:

1. screening using the checklist tool
2. a full assessment of eligibility using the decision support tool (see section below on the ‘fast track process’)

Screening using the checklist tool

The first step in the assessment process for most individuals is screening using the checklist tool. The checklist can be used in a variety of settings to help practitioners identify people who may need a full assessment of eligibility for NHS continuing healthcare.

The checklist does not indicate whether you are eligible for NHS continuing healthcare, only whether you require a full assessment of eligibility. It is important to be aware that the majority of people who ‘screen in’ (have a ‘positive checklist’) are found not to be eligible once the full assessment has been done.

The checklist threshold has deliberately been set low in order to ensure those who may need an assessment of eligibility for NHS continuing healthcare have this opportunity.

When should a checklist be completed?

Screening for NHS continuing healthcare should be at the right time and location for you and when your ongoing needs are known clearer. In the vast majority of cases, a checklist should be completed when

you are in a community setting. There may be rare circumstances where assessments may take place in an acute hospital environment.

You should normally be given the opportunity to be present at the completion of the checklist, together with any representative you may have.

Not everyone will need to have a checklist completed. There are many situations where it is not necessary to complete a checklist, particularly when there is no suggestion that you might need NHS continuing healthcare or where you are recovering from a short-term illness and your longer-term needs are not yet clear.

Checklist outcomes

There are 2 potential outcomes following completion of the checklist:

- a negative checklist, meaning you do not require a full assessment of eligibility, and you are not eligible for NHS continuing healthcare
- a positive checklist meaning you now require a full assessment of eligibility for NHS continuing healthcare. It does not necessarily mean you are eligible for NHS continuing healthcare

Next steps following a negative checklist

A negative checklist means you do not require a full assessment of eligibility and therefore you are not eligible for NHS continuing healthcare.

If you believe this checklist outcome is inaccurate, then you can ask the ICB to reconsider the outcome.

Next steps following a positive checklist

A positive checklist means that you require a full assessment of eligibility for NHS continuing healthcare.

Your ICB will arrange for this full assessment to take place. Having a positive checklist does not necessarily mean you will be found eligible for NHS continuing healthcare.

The full assessment of eligibility for NHS continuing healthcare

For the full assessment of eligibility, a multidisciplinary team of professionals (usually referred to as the MDT) will assess whether or not you have a primary health need using the decision support tool (often referred to as the DST).

An MDT is made up of 2 or more professionals, and will usually include both health and social care professionals who are knowledgeable about your health and social care needs, and, where possible, have recently been involved in your assessment, treatment or care

The ICB is responsible for identifying someone to co-ordinate the assessment process and this person should be your main point of contact.

Professionals should put you at the centre of the NHS continuing healthcare assessment process, and seek and consider your views, or those of your representative, as appropriate, throughout the process. The assessment will involve contributions from a range of professionals involved in your care to build an overall picture of your needs. This is known as an ‘assessment of needs’. Your own views should be given appropriate weight alongside professional views to help achieve an accurate picture of your needs.

The multidisciplinary team will then use the information from your assessment of needs to complete a ‘decision support tool’. While the multidisciplinary team will normally meet face to face, it may sometimes involve contributions from people using technology if they cannot be there in person. It is best practice for assessors to meet with the individual being assessed, ideally before the MDT meeting, and any arrangements should include a consideration of the best options for you.

Assessment of eligibility for NHS continuing healthcare using the decision support tool

Eligibility for NHS CHC is based on your needs, not on your diagnosis or condition. The decision support tool collates and presents the

information from your assessment of needs in a way that assists consistent decision-making regarding NHS continuing healthcare eligibility. The decision support tool brings together and records your various needs in 12 ‘care domains’, which are broken down into a number of levels.

The purpose of the tool is to help the multidisciplinary team assess the nature, complexity, intensity and unpredictability of your needs – and so recommend whether or not you have a ‘primary health need’.

The multidisciplinary team will then make a recommendation to the ICB as to whether or not you have a primary health need, which will determine your eligibility for NHS continuing healthcare. The ICB should usually accept this recommendation, except in exceptional circumstances and with clearly articulated reasons for their decision.

Notification of the eligibility decision for NHS continuing healthcare

The eligibility decision regarding NHS continuing healthcare should normally be made within 28 calendar days from the date the ICB received notification that you needed a full assessment of eligibility (normally through a positive checklist), though in some situations it will take longer than 28 days for a decision to be made.

The ICB should then inform you in writing as soon as they can, giving clear reasons for their decision on whether or not you are eligible. They should also explain your right to request a review of the decision.

Fast track pathway tool

If you have a rapidly deteriorating condition and the condition may be entering a terminal phase, then you may be eligible to receive urgent access to NHS continuing healthcare via fast track.

In the fast track pathway there is no requirement to complete a checklist or the decision support tool. Instead, an appropriate clinician

will complete the fast track pathway tool to establish your eligibility for NHS continuing healthcare.

This clinician will send the completed fast track pathway tool directly to your ICB, which should arrange for a care package to be provided for you, normally within 48 hours from receipt of the completed fast track pathway tool.

Your ICB should review your care needs and the effectiveness of your care package. There may be some instances where it becomes appropriate to reassess your eligibility for NHS continuing healthcare using the decision support tool. If this is necessary, your ICB will carefully explain the process, as detailed in the ‘Assessments’ section above.

Next steps

What if you are not eligible for NHS continuing healthcare?

If you are not eligible for NHS continuing healthcare, the ICB can (with your permission) refer you to your local authority who can discuss with you whether you may be eligible for support from them. If you are not eligible for NHS continuing healthcare but still have some health needs, then the NHS may still pay for part of your package of support.

This is known as a ‘joint package of care’. One way in which this is provided is through NHS-funded nursing care (see ‘NHS-funded nursing care’ section below). The NHS might also provide other funding or services to help meet your needs.

If the local authority is involved in funding some of your care package then, depending upon your income and savings, you may have to pay them a contribution towards the costs of that part of your care

package. There is no charge for the NHS elements of a joint package of care.

Whether or not you are eligible for NHS continuing healthcare, you are still entitled to make use of all of the other services from the NHS in your area in the same way as any other NHS patient.

Please see the ‘Individual requests for a review of an eligibility decision’ section below for more information on your rights if you are dissatisfied with the outcome of your eligibility decision.

Services provided if you are entitled to NHS continuing healthcare

If you are eligible for NHS continuing healthcare, your ICB will be responsible for your care planning, commissioning services and your case management. The ICB will discuss options with you as to how your care and support needs will be best provided for and managed.

When deciding on how your needs will be met, your wishes and preferred outcomes should be taken into account. This should include discussions about your preferred setting in which to receive care (for example, at home or in a care home) as well as how your needs will be met and by who.

The NHS care package or personal health budget provided should meet your assessed health and associated social care needs, as identified in your care plan.

Reviews

You should normally have a review of your care package within 3 months of a positive eligibility decision being made. After this you should have further reviews as required and at least on an annual basis.

The focus of these reviews should be on whether your care plan or arrangements remain appropriate to meet your needs. Any adjustment to your care plan will be made accordingly.

The most recently completed decision support tool will normally be available at the review and is used as a point of reference to identify any potential change in needs.

If your needs have changed to such an extent that they may impact on your eligibility for NHS continuing healthcare, then the ICB may arrange a full reassessment of eligibility, in line with the process outlined in the ‘Assessments’ section above.

Neither the NHS nor the local authority should withdraw from an existing care or funding arrangement without a joint reassessment of your needs, and without first consulting with one another, and with you, about any proposed change in arrangement, as well as ensuring that alternative funding or services are put into effect.

Individual requests for a review of an eligibility decision

If you disagree with a decision not to proceed to full assessment of eligibility for NHS continuing healthcare following screening using the checklist, you can ask the ICB to reconsider the decision.

If you disagree with the eligibility decision made by the ICB (after a full assessment of eligibility including the completion of the decision support tool), or if you have concerns about the procedure followed by the ICB to reach its eligibility decision, you can ask the ICB to review your case through its local resolution process.

Where it has not been possible to resolve the matter through the local resolution process, you can apply to NHS England for an independent review of the decision.

NHS England can consider asking the ICB to attempt further local resolution prior to the independent review.

Following an independent review, if the original decision is upheld but you remain dissatisfied, you have the right to make a complaint to the Parliamentary and Health Service Ombudsman.

Any individual has a right to complain about any aspect of the service they receive from the NHS, the local authority or any provider of care. The details of the complaints procedure are available from the relevant organisation.

NHS-funded nursing care

For individuals in care homes with nursing, registered nurses are usually employed by the care home itself. In order to fund the provision of such nursing care by a registered nurse, the NHS makes a payment direct to the care home.

This is called ‘NHS-funded nursing care’ and is a standard rate contribution towards the cost of providing registered nursing care for those individuals who are eligible.

Local authorities are not permitted to provide or fund registered nursing care (except in very limited circumstances).

Registered nursing care can involve many different aspects of care. It can include direct nursing tasks as well as the planning, supervision and monitoring of nursing and healthcare tasks to meet your needs.

Determining eligibility for NHS-funded nursing care

Your eligibility for NHS continuing healthcare should always be considered before a decision is reached about your need for NHS-funded nursing care.

You are eligible for NHS-funded nursing care if:

- you do not qualify for NHS continuing healthcare but have been assessed as requiring the services of a registered nurse and it is determined that your overall needs would be most appropriately met in a care home with nursing, and
- you are resident within a care home that is registered to provide nursing care

Assessment for NHS-funded nursing care

You may not need to have a separate assessment for NHS-funded nursing care if you have already had a full multidisciplinary assessment of eligibility for NHS continuing healthcare, as in most cases this process will give sufficient information for the ICB to decide on the need for NHS-funded nursing care.

If necessary, your ICB can arrange for an assessment to help determine whether you are eligible for NHS-funded nursing care. This decision could be based on a nursing needs assessment which specifies your day-to-day care and support needs.

People who do not require a full assessment of eligibility for NHS continuing healthcare can still be eligible for NHS-funded nursing care.

The NHS-funded nursing care rate

Since 2007, NHS-funded nursing care has been based on a single-band rate. This rate is the contribution provided by the NHS to support the provision of nursing care by a registered nurse, as set out above.

If you are eligible for NHS-funded nursing care your ICB will arrange for a payment at the nationally agreed rate to be made directly to your care home. The balance of the care home fee will then be paid by yourself, your representative or your local authority (or a combination of these) unless other contracting arrangements have been made.

NHS-funded nursing care reviews

Reviews of your need for NHS-funded nursing care will usually be undertaken after 3 months, then at least annually.

At these reviews consideration will also be given as to whether your needs have changed such that you are either no longer eligible for NHS-funded nursing care or that you might now be eligible for NHS continuing healthcare.

In order to decide whether you might now be eligible for NHS continuing healthcare, a checklist will normally be completed at the NHS-funded nursing care review. However, where a checklist and/or decision support tool have previously been completed and it is clear that there has been no material change in your needs then it should not be necessary to repeat the checklist or the decision support tool.

Dissatisfaction with the NHS-funded nursing care decision

If you are not happy with the decision regarding NHS-funded nursing care, you can ask the ICB for the decision to be reviewed and/or use the ICB complaints process.

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Department of Health & Social Care

NHS Continuing Healthcare Decision Support Tool

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What is the Decision Support Tool (DST)?

1. The DST is a national tool which has been developed to support practitioners in the application of the National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care 2022 (the National Framework). The tool is a way of bringing together information from the assessment of needs and applying evidence in a single practical format to facilitate consistent evidence-based recommendations and decision-making regarding eligibility for NHS Continuing Healthcare. All staff who use the DST should be familiar with the principles of the National Framework and have received appropriate training.

When should the DST be used?

2. The DST should be completed by a multidisciplinary team, following a comprehensive assessment and evaluation of an individual's health and social care needs. Where an assessment of needs has been recently completed, this may be used, but care should be taken to ensure that this remains an accurate reflection of current need.

3. The comprehensive assessment of needs should be in a format such that it can also be used to assist Integrated Care Boards (ICBs) and local authorities to meet care needs regardless of whether the individual is found eligible for NHS Continuing Healthcare.

4. The assessment of needs should be carried out in accordance with other relevant existing guidance, making use of specialist and any other existing assessments as appropriate. The DST is not an assessment of needs in itself.

5. The assessment of needs that informs completion of the DST should be carried out with the informed and active participation of the individual wherever possible. The individual should be given the opportunity to be supported or represented by a carer, family member, friend or advocate if they so wish. The eligibility assessment process should draw on those who have direct knowledge of the individual and their needs.

6. An individual will be eligible for NHS Continuing Healthcare where it is identified that they have a 'primary health need'. The decision as to whether an individual has a primary health need takes into account the legal limits of local authority provision. Using the DST correctly should ensure that all needs and circumstances that might affect an individual's eligibility are taken into account in making this decision. The concept of the 'primary health need' is explained in paragraphs 55-67 the National Framework.

7. Completion of the tool should be carried out in a manner that is compatible with wider legislation and national policies where appropriate.

Note:

Whilst this document is intended to be as clear and accessible as possible, the nature of the NHS Continuing Healthcare process is such that some words used may not be immediately understandable to someone who is not professionally trained. As far as is possible, professionals completing the DST should make sure that individuals, and carers or representatives (where consent is given), understand and agree to what has been written. In some situations advocacy support may be needed.

How should consent be approached with the DST?

8. There are a number of principles which underpin the NHS Continuing Healthcare process: most importantly that assessments and reviews should always focus on the individual's needs and follow a person-centred approach. The individual should be fully informed and empowered to participate actively in the assessment process and any subsequent reviews, and their views should be considered. In addition, there are a number of legal requirements when it comes to an individual's consent for parts of the NHS Continuing Healthcare process.

9. In the spirit of the person-centred approach, practitioners should make all reasonable efforts to seek the participation of the individual (or their representative) for the assessment and review process for NHS Continuing Healthcare, during each stage of the process. For a comprehensive assessment, the best evidence available at the relevant time should be considered. This should involve consideration of the individual's (or their representative's) view, and they should be empowered and assisted to participate. Throughout the process, this person-centred approach should be embedded in all decisions which relate to the individual's needs assessment, and their care planning.

10. Consent is a legal requirement for any physical intervention on, or examination of, a person with capacity to give consent. To the extent that an assessment for NHS Continuing Healthcare involves such an intervention or examination, informed consent must be sought from an individual with capacity to give consent. Please refer to paragraph 85 of the National Framework which gives detailed guidance on what is required for consent to be valid.

11. It is necessary to obtain an individual's explicit consent before sharing any personal data with a third party such as a family member, friend, advocate, and/or other representative.

12. However, it is not necessary to seek consent from an individual in order to share their personal data as part of their NHS Continuing Healthcare assessment (and subsequent reviews) between health and social care professionals.

13. If there is a concern that the individual may not have capacity to give consent to a physical intervention/examination that is part of the assessment process, or to the sharing of personal data with third parties such as a family member, friend, advocate, and/or other representative, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice. It may be necessary for a 'best interests' decision to be made, bearing in mind the expectation that everyone who is potentially eligible for NHS Continuing Healthcare should have the opportunity to be considered for eligibility. Guidance

on the application of the Mental Capacity Act 2005 in such situations is provided in paragraphs 86-96 of the National Framework.

14. The fact that an individual may have significant difficulties in expressing their views does not of itself mean that they lack capacity to make a decision. Appropriate support and adjustments should be made available in compliance with the Mental Capacity Act 2005 and with equalities legislation.

15. Robust data-sharing protocols, both within an organisation and between organisations, will help to ensure that confidentiality is respected but that all necessary information is available to complete the DST. The duty to share information (for the purposes of providing an individual with health or adult social care) as set out in Section 251B of the Health and Social Care Act 2012 applies equally to assessments for NHS Continuing Healthcare as it does to other health and/or care and support assessments.

Who can complete the DST? The Multidisciplinary Team (MDT)

16. In accordance with regulations, an MDT in this context means a team consisting of at least:

    - two professionals who are from different healthcare professions, or
    - one professional who is from a healthcare profession and one person who is responsible for assessing persons who may have needs for care and support under part 1 of the Care Act 2014.

17. Whilst as a minimum requirement an MDT can comprise two professionals from different healthcare professions, the MDT should usually include both health and social care professionals, who are knowledgeable about the individual’s health and social care needs and, where possible, have recently been involved in the assessment, treatment or care of the individual. ICBs may use a number of approaches (e.g. face-to-face, video/tele conferencing etc.) to arranging these MDT assessments in order to ensure active participation of all MDT members, the individual and their representative, and any others with knowledge about the individual's health and social care needs as far as is possible. It is best practice for assessors to meet with the individual being assessed, ideally before the MDT meeting, and any arrangements should include consideration of the best options for the individual, following a person-centred approach. For example, it may be that a hybrid meeting (including a combination of people in the room and people "dialling in") should be considered.

What is the role of the individual/representative in the assessment of eligibility process?

18. It is important that the individual and/or their advocate are empowered to participate actively in the NHS Continuing Healthcare process. The individual should be invited to be present or represented wherever practicable. The individual and their representative(s) should be given reasonable notice of completion of the DST to enable them to arrange for a family member or other person to be present, taking into account their personal circumstances. If it is not practicable for the individual (or their representative) to be present, their views should be obtained and actively considered in the completion of the DST. Those completing the DST should record how the individual (or their representative) contributed to the assessment of their needs, and if they were not involved why this was.

19. Even where an individual has not chosen someone else to support or represent them, where consent has been given for the sharing of personal data with family, friends, advocates and/or other representatives, the views and knowledge of family members, friends, advocates, and/or other representatives should be taken into account.

20. Completion of the DST should be organised so that the individual understands the process and receives advice and information to enable them to participate in informed decisions about their future care and support. The reasons for any decisions should be transparent and clearly documented.

How should the DST be used?

21. All sections of the DST must be completed.

22. The DST is intended to support the process of determining eligibility and ensure consistent and comprehensive consideration of an individual's needs. The evidence set out in the tool should be used by the MDT to help make a recommendation based on the four key characteristics of nature, intensity, complexity and unpredictability of needs, as explained in paragraphs 167-172 of the National Framework and Practice Guidance note 3.

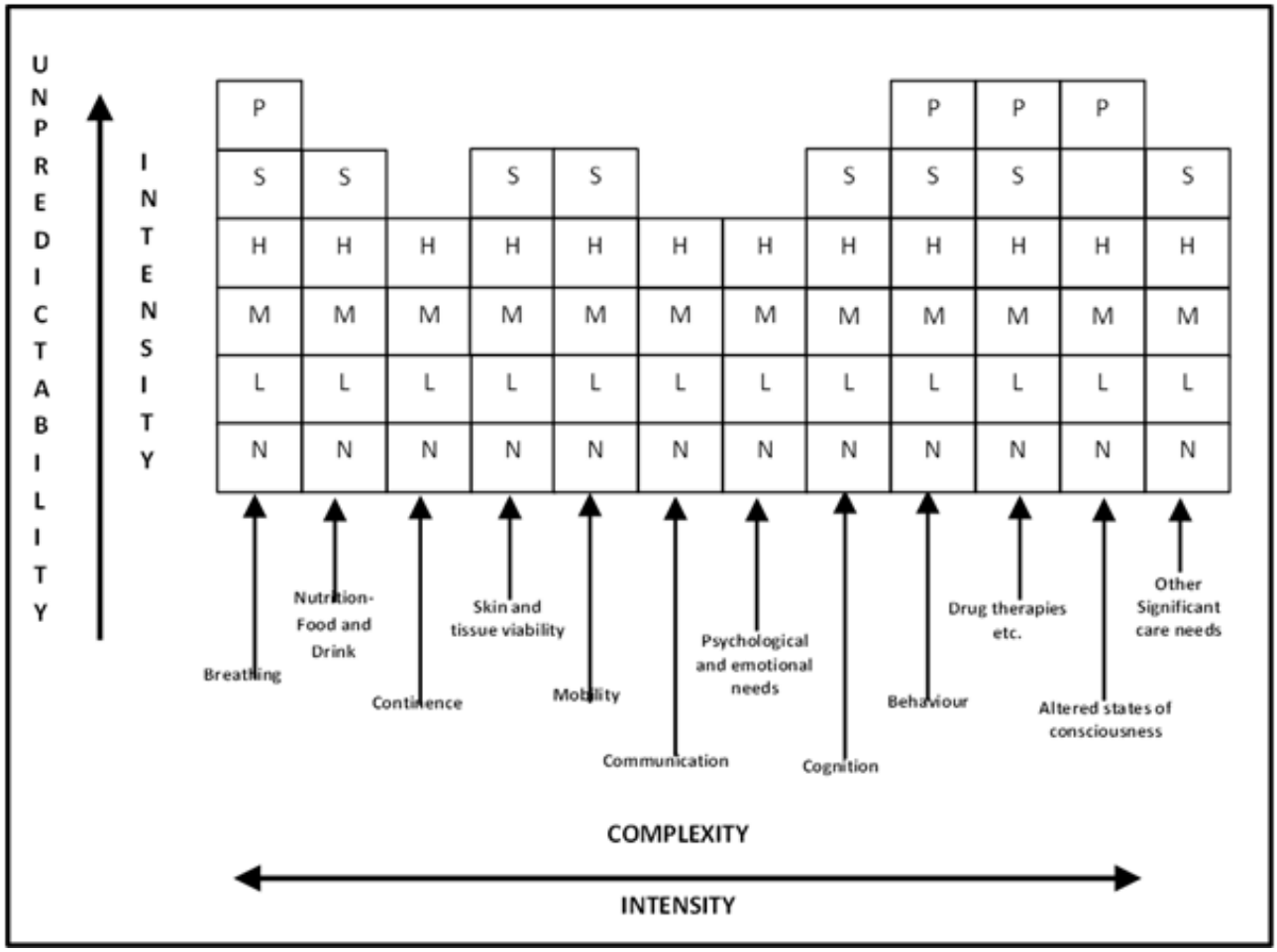
23. The DST requires the MDT to set out the individual's needs in relation to 12 care domains. Each domain is broken down into a number of levels, each of which is carefully described. The levels represent a hierarchy from the lowest to the highest possible level of need (and support required) such that, whatever the extent of the need within a given domain, it should be possible to locate this within the descriptors provided. This involves matching, as far as possible, the extent and type of the individual's specific needs with the descriptor in the DST that most closely relate to them. This approach should build up a detailed picture of needs and provide the evidence to inform the decision regarding eligibility. However, an exact match will not always be possible and, apart from more obvious cases, the domain descriptor levels will not determine eligibility but merely help inform consideration of the

"primary health need" test using the four key characteristics of nature, intensity, complexity and unpredictability. These four key characteristics should be applied to the totality of needs.

How are the care domains divided into levels of need?

24. Each domain is subdivided into statements of need representing no needs (‘N’ in the table below) low (L), moderate (M), high (H), severe (S) or priority (P) levels of need, depending on the domain (see Figure 1). The table below sets out the full range of the domains. The detailed descriptors of them are set out in the 12 domain tables for completion later in this document.

Figure 1: Diagram which shows how the different care domains are divided into levels of need.



Text alternative to Figure 1

Diagram which shows an arrow on the left-hand side going upwards to indicate increasing Unpredictability and intensity, and an arrow at the bottom of the diagram which points to two sides to indicate complexity and intensity.

In the middle of the diagram, the 12 domains are included below a table which showcases the different levels of need.

The 12 domains are Breathing, Nutrition – Food and Drink, Continence, Skin and tissue viability, Mobility, Psychological and emotional needs, Cognition, Behaviour, Drug therapies etc., Altered states of consciousness, and Other Significant care needs.

Each domain is subdivided into statements of need representing no needs (N), low (L), moderate (M), high (H), severe (S) or priority (P) levels of need, depending on the domain. These increase in intensity and unpredictability.

For Breathing, the levels are: (N), low (L), moderate (M), high (H), severe (S) or priority (P)
For Nutrition – Food and Drink, the levels are: (N), low (L), moderate (M), high (H), severe (S)
For Continence, the levels are: (N), low (L), moderate (M), high (H)
For Skin and tissue viability, the levels are: (N), low (L), moderate (M), high (H), severe (S)
For Mobility, the levels are: (N), low (L), moderate (M), high (H), severe (S)
For Communication, the levels are: (N), low (L), moderate (M), high (H)
For Psychological and emotional needs, the levels are: (N), low (L), moderate (M), high (H)
For Cognition, the levels are: (N), low (L), moderate (M), high (H), severe (S)
For Behaviour, the levels are: (N), low (L), moderate (M), high (H), severe (S) or priority (P)
For Drug therapies etc, the levels are: (N), low (L), moderate (M), high (H), severe (S) or priority (P)
For Altered States of Consciousness, the levels are: (N), low (L), moderate (M), high (H), or priority (P)
For Other Significant care needs, the levels are: (N), low (L), moderate (M), high (H), severe (S)

25. The descriptors in the DST are examples of the types of need that may be present. They should be carefully considered but may not always accurately describe every individual's circumstances. The MDT should first determine and record the extent and type of need in the space provided. If there is difficulty in placing the individual's needs in one or other of the levels, the MDT should use professional judgement based on consideration of all the evidence to decide the most appropriate level. If, after considering all the relevant evidence, it proves difficult to decide or agree on the level, the MDT should choose the higher of the levels under consideration and record the evidence in relation to both the decision and any significant differences of opinion. The MDT should not record an individual as having needs between levels. It is important that differences of opinion on the appropriate level are based on the evidence available and not on generalised assumptions about the effects of a particular condition or assumptions about the individual's needs.

26. Care should be taken regarding terminology. The fact that an individual has a condition that is described as 'severe' does not necessarily mean that they should be placed on the 'severe' level of a particular domain. It is the domain level descriptor that most closely fits their needs and the support they require that should be selected (for example, the fact that an individual is described as having 'severe' learning disabilities does not automatically mean that they should be placed on the 'severe' level of the Cognition domain, similarly an

individual considered as having a high risk of falling might or might not fit the high level in the mobility domain).

27. The Fast Track Pathway Tool (rather than DST) should always be used for any individual with a primary health need arising from a rapidly deteriorating condition and the condition may be entering a terminal phase. For other individuals who have a more slowly deteriorating condition and for whom it can reasonably be anticipated that their needs are therefore likely to increase in the near future, the domain levels selected should be based on current needs but the likely change in needs should be recorded in the evidence box for that domain and taken into account in the recommendation made. This could mean that a decision is made that they should be eligible for NHS Continuing Healthcare immediately (i.e. before the deterioration has actually taken place) or, if not, that a date is given for an early review.

28. It should be remembered that the DST is a record of needs and a single condition might give rise to separate needs in a number of domains. For example, an individual with cognitive impairment will have a weighting in the cognition domain and as a result may have associated needs in other domains, all of which should be recorded and weighted in their own right (refer to Practice Guidance note 30).

29. Some domains include levels of need that are so great that they could reach the ‘priority’ level (which would indicate a primary health need), but others do not. This is because the needs in some care domains are considered never to reach a level at which they on their own should trigger eligibility; rather they would form part of a range of needs which together could constitute a primary health need.

30. Within each domain there is space to justify why a particular level is appropriate, based on the available evidence about the assessed needs. It is important that needs are described in measurable terms, using clinical expertise, and supported with the results from appropriate and validated assessment tools where relevant.

31. Needs should not be marginalised just because they are successfully managed. Well-managed needs are still needs. Only where the successful management of a healthcare need has permanently reduced or removed an on-going need, such that the active management of this need is reduced or no longer required will this have a bearing on NHS Continuing Healthcare eligibility. This principle is incorporated into the domain descriptors of the DST. For example, in the behaviour domain the level of support and skill required to manage risks associated with challenging behaviour helps determine the domain weighting. In such cases the care plan (including psychological or similar interventions) should provide the evidence of the level of need, recognising that this care plan may be successfully avoiding or reducing incidents of challenging behaviour (refer to paragraphs 162-166 of the National Framework and Practice Guidance note 23). For example, where psychological or similar interventions are successfully addressing behavioural issues, consideration should

be given as to the present-day need if that support were withdrawn or no longer available and this should be reflected in the Behaviour domain.

32. It is not intended that this principle should be applied in such a way that well-controlled health conditions should be recorded as if medication or other routine care or support was not present. For example, where needs are being managed via medication (whether for behaviour or for physical health needs), it may be more appropriate to reflect this in the Drug Therapies and Medication domain. Similarly, where an individual's skin condition is not aggravated by their incontinence because they are receiving good continence care, it would not be appropriate to weight the skin domain as if the continence care was not being provided (refer to paragraphs 162-166 of the National Framework).

33. There may be circumstances where an individual may have particular needs that are not covered by the first 11 defined care domains within the DST. In this situation, it is the responsibility of the assessors to determine and record the extent and type of the needs in the “additional” 12th domain provided entitled ‘Other Significant Care Needs’ and take this into account when determining whether an individual has a primary health need. The severity of the need should be weighted in a similar way (i.e. from 'Low' to 'Severe') to the other domains using professional judgement and then taken into account when determining whether an individual has a primary health need. It is important that the agreed level is consistent with the levels set out in the other domains. The availability of this domain should not be used to inappropriately affect the overall decision on eligibility.

How should the DST be used to help to identify a Primary Health Need?

34. MDTs are required to make a recommendation as to whether the individual has a primary health need and is therefore eligible for NHS Continuing Healthcare. This should take into account the range and levels of need recorded in the DST and include consideration of the nature, intensity, complexity and/or unpredictability of the individual’s needs. Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual’s needs.

35. At the end of the DST, there is a summary sheet to provide an overview of the levels chosen and a summary of the individual’s needs, along with the MDT’s recommendation about eligibility or ineligibility. A clear recommendation (and decision) of eligibility for NHS Continuing Healthcare would be expected in each of the following cases:

    - A level of priority needs in any one of the four domains that carry this level.
    - A total of two or more incidences of identified severe needs across all care domains.

36. Where there is either

- A severe level need combined with needs in a number of other domains or
- A number of domains with high and/or moderate needs

37. This may also, depending on the combination of needs, indicate a primary health need and therefore careful consideration needs to be given to the eligibility decision and clear reasons recorded if the decision is that the person does not have a primary health need.

38. In all cases, the overall need, the interactions between needs in different care domains, and the evidence from risk assessments should be taken into account in determining whether a recommendation of eligibility for NHS Continuing Healthcare should be made. It is not possible to equate a number of incidences of one level with a number of incidences of another level, as in, for example 'two moderates equals one high'. The judgement whether an individual has a primary health need must be based on what the evidence indicates about the nature and/or complexity and/or intensity and/or unpredictability of the individual's needs.

39. MDTs are reminded of the need to consider the limits of local authority responsibility when making a primary health need recommendation (refer to paragraphs 55-67 of the National Framework).

40. The recommendation should:

    - provide a summary of the individual's needs in the light of the identified domain levels and the information underlying these. This should include the individual's own view of their needs.
    - provide statements about the nature, intensity, complexity and unpredictability of the individual's needs, bearing in mind the explanation of these characteristics provided in paragraphs 55-67 of the National Framework.
    - give an explanation of how the needs in any one domain may interrelate with another to create additional complexity, intensity or unpredictability.
    - in the light of the above, give a recommendation as to whether or not the individual has a primary health need (refer to paragraphs 55-67 of the National Framework). It should be remembered that, whilst the recommendation should make reference to all four characteristics of nature, intensity, complexity and unpredictability, any one of these could on their own or in combination with others be sufficient to indicate a primary health need.

What happens after the DST has been completed?

41. The coordinator should ensure that all parts of the DST have been completed, including the MDT's recommendation on eligibility (agreed/signed by MDT members), and forward it to the ICB for decision making. The coordinator should also advise the individual of the timescales for decision making (i.e. normally within 28 calendar days of receiving a positive Checklist or where a Checklist is not used, other notice of potential eligibility). In doing this, they should also check whether there is a need for urgent and/or interim support and liaise with the ICB and local authority to ensure that this is put in place where appropriate.

42. The equality monitoring data form should be completed by the individual who is the subject of the DST, but not if one has already been completed when screening with a Checklist and only if the individual agrees to this. Where the individual needs support to complete the form, this should be arranged by the ICB co-ordinator. The equality monitoring form should be forwarded to the appropriate location, in accordance with the relevant ICB's processes for processing equality data.

43. A copy of the completed DST (including the recommendation) should be forwarded to the individual (or, where appropriate, their representative) together with the final decision made by the ICB, along with the reasons for this decision. If someone is acting as the individual's representative, they are entitled to receive a copy of the DST provided that the correct basis for sharing such information has been established. This basis could be any one of the following:

    a) consent from the individual concerned (where they have capacity to give this).

    b) a 'best interests' decision made by a court appointed deputy (health and welfare) or someone who holds Lasting Power of Attorney (health and welfare) for that individual.

    c) a "best interests" decision to share information made under the Mental Capacity Act (where the individual lacks capacity to consent to the sharing of information).

44. Where an individual lacks capacity but has an appointed Lasting Power of Attorney (Health and Welfare), information (including a copy of the completed DST) should be shared in order for them to carry out their LPA duties, unless there are compelling and lawful reasons why this should not happen. If there is doubt in such cases advice should be sought.

Decision Support Tool for NHS Continuing Healthcare

Section 1 – Personal Details

Was this DST completed whilst the individual was in an acute hospital? Yes □ No □
Date of completion of Decision Support Tool _____

Name

NHS number and GP/Practice:

Permanent address and telephone number	**Current location (if different from permanent address)**

Gender _____

Please ensure that the equality monitoring form at the end of the DST is completed
Was the individual involved in the completion of the DST? Yes/No (please delete as appropriate)

Was the individual offered the opportunity to have a representative such as a family member or other advocate present when the DST was completed? Yes/No (please delete as appropriate)

If yes, did the representative attend the completion of the DST? (please delete as appropriate) Yes/No

Please give the contact details of the representative (name, address and telephone number)

Decision Support Tool for NHS Continuing Healthcare
Section 1 – Personal Details

Summary

a) Summary pen portrait of the individual's situation, relevant history (particularly clinical history) and current needs, including clinical summary and identified significant risks, drawn from the multidisciplinary assessment:

Individual's view of their care needs and whether they consider that the multidisciplinary assessment accurately reflects these:

Decision Support Tool for NHS Continuing Healthcare
Section 1 – Personal Details

b) Please note below whether and how the individual (or their representative) contributed to the assessment of their needs. If they were not involved, please record whether they were not invited or whether they declined to participate.

Please list the assessments and other key evidence that were taken into account in completing the DST, including the dates of the assessments:

Decision Support Tool for NHS Continuing Healthcare
Section 1 – Personal Details

c) Assessors' (including MDT members) name/address/contact details noting lead coordinator:

Contact details of GP and other key professionals involved in the care of the individual:

Please indicate which of these have contributed to the assessment of needs for the MDT to consider when completing this Decision Support Tool.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

1. Breathing: As with all other domains, the breathing domain should be used to record needs rather than the underlying condition that may give rise to the needs. For example, an individual may have Chronic Obstructive Pulmonary Disease (COPD), emphysema or recurrent chest infections or another condition giving rise to breathing difficulties, and it is the needs arising from such conditions which should be recorded.

1. Describe below the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.

2. Circle the assessed level overleaf.

	Score	Comments
CHC Assessor:		
Social Worker:		
Client / NOK and family:		

Decision Support Tool for NHS Continuing Healthcare Section 2 – Care Domains

Please refer to the user notes

1. Breathing

Description	Level of need
Normal breathing, no issues with shortness of breath.	No needs
Shortness of breath or a condition which may require the use of inhalers or a nebuliser and has no impact on daily living activities. OR Episodes of breathlessness that readily respond to management and have no impact on daily living activities.	Low
Shortness of breath or a condition which may require the use of inhalers or a nebuliser and limit some daily living activities. OR Episodes of breathlessness that do not consistently respond to management and limit some daily living activities. OR Requires any of the following: low level oxygen therapy (24%). room air ventilators via a facial or nasal mask. other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.	Moderate
Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers. OR Breathlessness due to a condition which is not responding to treatment and limits all daily living activities	High
Difficulty in breathing, even through a tracheotomy, which requires suction to maintain airway. OR Demonstrates severe breathing difficulties at rest, in spite of maximum medical therapy OR A condition that requires management by a non-invasive device to both stimulate and maintain breathing (bi-level positive airway pressure, or non-invasive ventilation)	Severe
Unable to breathe independently, requires invasive mechanical ventilation.	Priority

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

2. Nutrition – Food and Drink: Individuals at risk of malnutrition, dehydration and/or aspiration should either have an existing assessment of these needs or have had one carried out as part of the assessment process with any management and risk factors supported by a management plan. Where an individual has significant weight loss or gain, professional judgement should be used to consider what the trajectory of weight loss or gain is telling us about the individual's nutritional status.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.

2. Circle the assessed level overleaf.

	Score	Comments
CHC Assessor:		
Social Worker:		
Client / NOK and family:		

Decision Support Tool for NHS Continuing Healthcare Section 2 – Care Domains

Please refer to the user notes

2. Nutrition – Food and Drink

Description	Level of need
Able to take adequate food and drink by mouth to meet all nutritional requirements.	No needs
Needs supervision, prompting with meals, or may need feeding and/or a special diet (for example to manage food intolerances/allergies). OR Able to take food and drink by mouth but requires additional/supplementary feeding.	Low
Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed. OR Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non-problematic PEG.	Moderate
Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway. OR Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers. OR Nutritional status “at risk” and may be associated with unintended, significant weight loss. OR Significant weight loss or gain due to identified eating disorder. OR Problems relating to a feeding device (for example PEG) that require skilled assessment and review.	High
Unable to take food and drink by mouth. All nutritional requirements taken by artificial means requiring on-going skilled professional intervention or monitoring over a 24 hour period to ensure nutrition/hydration, for example I.V. fluids/total parenteral nutrition (TPN). OR Unable to take food and drink by mouth, intervention inappropriate or impossible.	Severe

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

3. Continence: Where continence problems are identified, a full continence assessment exists or has been undertaken as part of the assessment process, any underlying conditions identified, and the impact and likelihood of any risk factors evaluated.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.

2. Take into account any aspect of continence care associated with behaviour in the Behaviour domain.

3. Circle the assessed level overleaf.

	Score	Comments
CHC Assessor:		
Social Worker:		
Client / NOK and family:		

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

3. Continence

Description	Level of need
Continent of urine and faeces.	No needs
Continence care is routine on a day-to-day basis; Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc. AND is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence/constipation.	Low
Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation or other bowel problems.	Moderate
Continence care is problematic and requires timely and skilled intervention, beyond routine care (for example frequent bladder wash outs/irrigation, manual evacuations, frequent re-catheterisation).	High

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

4. Skin (including tissue viability): Evidence of wounds should derive from a wound assessment chart or tissue viability assessment completed by an appropriate professional. Here, a skin condition is taken to mean any condition which affects or has the potential to affect the integrity of the skin.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.

2. Circle the assessed level overleaf.

	Score	Comments
CHC Assessor:		
Social Worker:		
Client / NOK and family:		

Decision Support Tool for NHS Continuing Healthcare Section 2 – Care Domains

Please refer to the user notes

4. Skin (including tissue viability)

Description	Level of need
No risk of pressure damage or skin condition.	No needs
Risk of skin breakdown which requires preventative intervention once a day or less than daily without which skin integrity would break down. OR Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound(s). OR A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.	Low
Risk of skin breakdown which requires preventative intervention several times each day without which skin integrity would break down. OR Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is responding to treatment. OR An identified skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment.	Moderate
Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is not responding to treatment OR Pressure damage or open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule', which is/are responding to treatment. OR Specialist dressing regime in place; responding to treatment.	High
Open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule' which are not responding to treatment and require regular monitoring/reassessment. OR Open wound(s), pressure ulcer(s) with 'full thickness skin loss with extensive destruction and tissue necrosis extending to underlying bone, tendon or joint capsule' or above OR Multiple wounds which are not responding to treatment.	Severe

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

5. Mobility: This section considers individuals with impaired mobility. Please take other mobility issues such as wandering into account in the behaviour domain where relevant. Where mobility problems are indicated, an up-to-date Moving and Handling and Falls Risk Assessment should exist or have been undertaken and the impact and likelihood of any risk factors considered. It is important to note that the use of the word 'high' in any particular falls risk assessment tool does not necessarily equate to a high level need in this domain.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, with reference to movement and handling and fall risk assessments where relevant. Describe the frequency and intensity of need, unpredictability, deterioration and any instability.

2. Circle the assessed level overleaf.

	Score	Comments
CHC Assessor:		
Social Worker:		
Client / NOK and family:		

Decision Support Tool for NHS Continuing Healthcare Section 2 – Care Domains

Please refer to the user notes

5. Mobility

Description	Level of need
Independently mobile	No needs
Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.	Low
Not able to consistently weight bear. OR Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning. OR In one position (bed or chair) for the majority of time but is able to cooperate and assist carers or care workers. OR At moderate risk of falls (as evidenced in a falls history or risk assessment)	Moderate
Completely unable to weight bear and is unable to assist or cooperate with transfers and/or repositioning. OR Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate OR At a high risk of falls (as evidenced in a falls history and risk assessment). OR Involuntary spasms or contractures placing the individual or others at risk.	High
Completely immobile and/or clinical condition such that, in either case, on movement or transfer there is a high risk of serious physical harm and where the positioning is critical.	Severe

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

6. Communication: This section relates to difficulties with expression and understanding, in particular with regard to communicating needs. An individual's ability or otherwise to communicate their needs may well have an impact both on the overall assessment and on the provision of care. Consideration should always be given to whether the individual requires assistance with communication, for example through an interpreter, use of pictures, sign language, use of Braille, hearing aids, or other communication technology.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.

2. Circle the assessed level overleaf.

	Score	Comments
CHC Assessor:		
Social Worker:		
Client / NOK and family:		

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

6. Communication

Description	Level of need
Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language.	No needs
Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.	Low
Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual.	Moderate
Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to assist them have been taken. The individual has to have most of their needs anticipated because of their inability to communicate them.	High

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

7. Psychological and Emotional Needs: There should be evidence of considering psychological needs and their impact on the individual's health and well-being, irrespective of their underlying condition. Use this domain to record the individual's psychological and emotional needs and how they contribute to the overall care needs, noting the underlying causes. Where the individual is unable to express their psychological/emotional needs (even with appropriate support) due to the nature of their overall needs (which may include cognitive impairment), this should be recorded and a professional judgement made based on the overall evidence and knowledge of the individual. It could be argued that everyone has psychological and emotional needs, but this domain is focused on whether and how such needs are having an impact on the individual's health and well-being, and the degree of support required. If an individual has a severe level of need in the cognition domain they may not be able to consciously withdraw from any attempts to engage them in care planning, but careful consideration will need to be given to any evidence of psychological or emotional needs that are having an impact on their health and well-being.

1. Describe the actual needs of the individual, providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.

2. Circle the assessed level overleaf.

	Score	Comments
CHC Assessor:		
Social Worker:		
Client / NOK and family:		

Decision Support Tool for NHS Continuing Healthcare Section 2 – Care Domains

Please refer to the user notes

7. Psychological and Emotional Needs

Description	Level of need
Psychological and emotional needs are not having an impact on their health and well-being.	No needs
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which are having an impact on their health and/or well-being but respond to prompts, distraction and/or reassurance. OR Requires prompts to motivate self towards activity and to engage them in care planning, support, and/or daily activities.	Low
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, which do not readily respond to prompts, distraction and/or reassurance and have an increasing impact on the individual's health and/or well-being. OR Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in care planning, support and/or daily activities.	Moderate
Mood disturbance, hallucinations or anxiety symptoms, or periods of distress, that have a severe impact on the individual's health and/or well-being. OR Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and/or daily activities.	High

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

8. Cognition: This may apply to, but is not limited to, individuals with learning disability and/or acquired and degenerative disorders. Where cognitive impairment is identified in the assessment of need, active consideration should be given to referral to an appropriate specialist if one is not already involved. A key consideration in determining the level of need under this domain is making a professional judgement about the degree of risk to the individual.

Please refer to the National Framework guidance about the need to apply the principles of the Mental Capacity Act in every case where there is a question about an individual's capacity. The principles of the Act should also be applied to all considerations of the individual's ability to make decisions and choices.

1. Describe the actual needs of the individual (including episodic and fluctuating needs), providing the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.

2. Where cognitive impairment has an impact on behaviour, take this into account in the behaviour domain, so that the interaction between the two domains is clear.

3. Circle the assessed level overleaf.

	Score	Comments
CHC Assessor:		
Social Worker:		
Client / NOK and family:		

Decision Support Tool for NHS Continuing Healthcare Section 2 – Care Domains

Please refer to the user notes

8. Cognition

Description	Level of need
No evidence of impairment, confusion or disorientation.	No needs
Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident. OR Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.	Low
Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration.	Moderate
Cognitive impairment that could, for example, include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues they are unable to consistently do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult even with supervision, prompting or assistance to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration.	High
Cognitive impairment that may, for example, include, marked short or long-term memory issues, or severe disorientation to time, place or person. The individual is unable to assess basic risks even with supervision, prompting or assistance, and is dependent on others to anticipate their basic needs and to protect them from harm, neglect or health deterioration.	Severe

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

9. Behaviour: Human behaviour is complex, hard to categorise, and may be difficult to manage. Challenging behaviour may be caused by a wide range of factors including extreme frustration associated with communication difficulties or fluctuations in mental state. Challenging behaviour in this domain includes but is not limited to:
- aggression, violence or passive non-aggressive behaviour
- severe disinhibition
- intractable noisiness or restlessness
- resistance to necessary care and treatment (but not including situations where an individual makes a capacitated choice not to accept a particular form of care or treatment offered)
- severe fluctuations in mental state
- inappropriate interference with others
- identified high risk of suicide

1. Describe the actual needs of the individual, including any episodic needs. Provide the evidence that informs the decision overleaf on which level is appropriate, such as the times and situations when the behaviour to likely to be performed across a range of typical daily routines and the frequency, duration and impact of the behaviour.

2. Note any overlap with other domains.

3. Circle the assessed level overleaf.

	Score	Comments
CHC Assessor:		
Social Worker:		
Client / NOK and family:		

The assessment of needs of an individual with serious behavioural issues should include specific consideration of the risk(s) to themselves, others or property with particular attention to aggression, self-harm and self-neglect and any other behaviour(s), irrespective of their living environment.

Decision Support Tool for NHS Continuing Healthcare Section 2 – Care Domains

Please refer to the user notes

9. Behaviour

Description	Level of need
No evidence of ‘challenging’ behaviour.	No needs
Some incidents of ‘challenging’ behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or create a barrier to intervention. The individual is compliant with all aspects of their care.	Low
‘Challenging’ behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The individual is nearly always compliant with care.	Moderate
’Challenging’ behaviour of type and/or frequency that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.	High
‘Challenging’ behaviour of severity and/or frequency that poses a significant risk to self, others or property. The risk assessment identifies that the behaviour(s) require(s) a prompt and skilled response that might be outside the range of planned interventions.	Severe
‘Challenging’ behaviour of a severity and/or frequency and/or unpredictability that presents an immediate and serious risk to self, others or property. The risks are so serious that they require access to an immediate and skilled response at all times for safe care.	Priority

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

10. Drug Therapies and Medication: Symptom Control: The individual's experience of how their symptoms are managed and the intensity of those symptoms is an important factor in determining the level of need in this area. Where this affects other aspects of their life, please refer to the other domains, especially the psychological and emotional domain. The location of care will influence who gives the medication. In determining the level of need, it is the knowledge and skill required to manage the clinical need and the interaction of the medication in relation to the need that is the determining factor. In some situations, an individual or their carer will be managing their own medication and this can require a high level of skill.

References below to medication being required to be administered by a registered nurse do not include where such administration is purely a registration or practice requirement of the care setting (such as a care home requiring all medication to be administered by a registered nurse).

1. Describe below the actual needs of the individual and provide the evidence that informs the decision overleaf on which level is appropriate, including the frequency and intensity of need, unpredictability, deterioration and any instability.

2. Circle the assessed level overleaf.

	Score	Comments
CHC Assessor:		
Social Worker:		
Client / NOK and family:		

Decision Support Tool for NHS Continuing Healthcare Section 2 – Care Domains

Please refer to the user notes

10. Drug Therapies and Medication: Symptom Control

Description	Level of need
Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects.	No needs
Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime. OR Mild pain that is predictable and/or is associated with certain activities of daily living. Pain and other symptoms do not have an impact on the provision of care.	Low
Requires the administration of medication (by a registered nurse, carer or care worker) due to: non-compliance, or type of medication (for example insulin), or route of medication (for example PEG). OR Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care.	Moderate
Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for the task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. However, with such monitoring the condition is usually non-problematic to manage. OR Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.	High
Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. Even with such monitoring the condition is usually problematic to manage. OR Severe recurrent or constant pain which is not responding to treatment. OR Non-compliance with medication, placing them at severe risk of relapse.	Severe
Has a drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and/or deteriorating condition. OR Unremitting and overwhelming pain despite all efforts to control pain effectively.	Priority

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

11. Altered States of Consciousness (ASC): ASCs can be caused by a range of clinical conditions, including Transient Ischemic Attacks (TIAs), Epilepsy and Vasovagal Syncope. General drowsiness would not normally constitute an ASC for the purposes of this domain.

1. Describe below the actual needs of the individual providing the evidence that informs the decision overleaf on which level is appropriate (referring to appropriate risk assessments), including the frequency and intensity of need, unpredictability, deterioration and any instability.

2. Circle the assessed level overleaf.

	Score	Comments
CHC Assessor:		
Social Worker:		
Client / NOK and family:		

Decision Support Tool for NHS Continuing Healthcare Section 2 – Care Domains

Please refer to the user notes

11. Altered States of Consciousness (ASC)

Description	Level of need
No evidence of altered states of consciousness (ASC).	No needs
History of ASC but it is effectively managed and there is a low risk of harm.	Low
Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.	Moderate
Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm. OR Occasional ASCs that require skilled intervention to reduce the risk of harm.	High
Coma. OR ASC that occur on most days, do not respond to preventative treatment, and result in a severe risk of harm.	Priority

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

12. Other significant care needs to be taken into consideration: There may be circumstances, on a case-by-case basis, where an individual may have particular needs which do not fall into the care domains described above or cannot be adequately reflected in these domains. If the boxes within each domain that give space for explanatory notes are not sufficient to document all needs, it is the responsibility of the assessors to determine and record the extent and type of these needs here. The severity of this need and its impact on the individual need to be weighted, using the professional judgement of the assessors, in a similar way to the other domains. This weighting also needs to be used in the final decision. It is important that the agreed level is consistent with the levels set out in the other domains. The availability of this domain should not be used to inappropriately affect the overall decision on eligibility.

1. Enter below a brief description of the actual needs of the individual, including providing the evidence why the level in the table overleaf has been chosen (referring to appropriate risk assessments), and referring to the frequency and intensity of need, unpredictability, deterioration and any instability. 2. Circle the assessed level overleaf.

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

12: Other significant care needs to be taken into consideration

Description	Level of need
	Low
	Moderate
	High
	Severe

Decision Support Tool for NHS Continuing Healthcare Section 2 – Care Domains

Please refer to the user notes

Assessed Levels of Need

Care Domain	P	S	H	M	L	N
Breathing						
Nutrition- Food and Drink						
Continence						
Skin (including tissue viability)						
Mobility						
Communication						
Psychological and Emotional Needs						
Cognition						
Behaviour						
Drug Therapies and Medication						
Altered States of Consciousness						
Other significant care needs						
Totals						

Decision Support Tool for NHS Continuing Healthcare
Section 2 – Care Domains

Please refer to the user notes

Please note below any views of the individual on the completion of the DST that have not been recorded above, including whether they agree with the domain levels selected. Where they disagree, this should be recorded below, including the reasons for their disagreement. Where the individual is represented or supported by a carer or advocate, their understanding of the individual's views should be recorded.

Decision Support Tool for NHS Continuing Healthcare
Section 3 – Recommendation

Please refer to the user notes

Recommendation of the multidisciplinary team filling in the DST

Please give a recommendation on the next page as to whether or not the individual is eligible for NHS Continuing Healthcare. This should take into account the range and levels of need recorded in the Decision Support Tool and what this tells you about whether the individual has a primary health need. Any disagreement on levels used or areas where needs have been counted against more than one domain should be highlighted here. Reaching a recommendation on whether the individual's primary needs are health needs should include consideration of:

- Nature: This describes the particular characteristics of an individual's needs (which can include physical, mental health, or psychological needs), and the type of those needs. This also describes the overall effect of those needs on the individual, including the type ('quality') of interventions required to manage them.

- Intensity: This relates to both the extent ('quantity') and severity (degree) of the needs and the support required to meet them, including the need for sustained/on-going care ('continuity').

- Complexity: This is concerned with how the needs present and interact to increase the skill required to monitor the symptoms, treat the condition(s) and/or manage the care. This may arise with a single condition, or it could include the presence of multiple conditions or the interactions between two or more conditions. It may also include situations where an individual's response to their own condition has an impact on their overall needs, such as when a physical health need results in the individual developing a mental health need.

- Unpredictability: This describes the degree to which needs fluctuate and thereby create challenges in managing them. It also relates to the level of risk to the individual's health if adequate and timely care is not provided. An individual with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

Each of these characteristics may, alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care that is required to meet the individual's needs.

The totality of the overall needs and the effects of the interaction of needs should be carefully considered when completing the DST.

Also please indicate whether needs are expected to change (in terms of deterioration or improvement) before the case is next reviewed. If so, please state why and what needs you think will be different and therefore whether you are recommending that eligibility should be agreed now or that an early review date should be set.

Where there is no eligibility for NHS Continuing Healthcare and the assessment and care plan, as agreed with the individual, indicates the need for support in a care home setting, the team should indicate whether there is the need for registered nursing care in the care home, giving a clear rationale based on the evidence above.

Decision Support Tool for NHS Continuing Healthcare
Section 3 – Recommendation

Please refer to the user notes

Recommendation on eligibility for NHS Continuing Healthcare detailing the conclusions on the issues outlined on the previous page. This should include the following headings: Overview; Nature; Intensity; Complexity; Unpredictability; and Recommendation.

Date of agreed MDT recommendation:

for ICB use only**: Date of Eligibility Decision/Verification:**

Signatures of MDT making above recommendation:
Health professionals

Printed Name	Designation	Professional Qualification	Signature	Date

Social care/other professionals

Printed Name	Designation	Signature	Date

About you — equality monitoring

We collect equalities information to meet our duties under the Equality Act 2010 and develop our insights into CHC patients and ensure we provide appropriate care. The categories included in the questions may not be exhaustive or reflect how you feel or identify. We will be reviewing these to align with approaches across Government. Filling these in is optional, and you do not have to provide an answer if you do not wish to do so.

Please provide us with some information about yourself. We collect information to help us understand whether people are receiving fair and equal access to NHS Continuing Healthcare (CHC) via the NHS CHC Patient Level Data Set (PLDS) which is used to help achieve better patient outcomes, better experiences and better use of resources in CHC. The lawful basis for collecting this information is Article 6 (1) (c) of the GDPR enacted by the Data Protection Act 2018. Please note that NHS CHC PLDS data is pseudonymised for analysis purposes. This means that identifiers such as names, NHS numbers and dates of birth are removed. Detailed information about the use of individual's identifiable data is publicly available at https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe/gdpr/gdpr-register

1 What is your gender?

Tick one box only

☐ Male
☐ Female
☐ Indeterminate (unable to be classified as either male or female)
☐ I prefer not to answer

2 Which age group applies to you?

Tick one box only

☐ 18-24
☐ 25-34
☐ 35-44
☐ 45-54
☐ 55-64
☐ 65-74
☐ 75-84
☐ 85+
☐ I prefer not to answer

3 Do you have a disability as defined by the Equalities Act 2010?

Tick one box only.

The Equality Act 2010 defines a person with a disability as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.

☐ No
☐ Yes
☐ I prefer not to answer

4 What is your ethnic group?

Tick one box only.

A White
☐ British
☐ Irish
☐ Any other White background, write below
Click here to enter text.

B Mixed
☐ White and Black Caribbean

☐ White and Black African
☐ White and Asian
☐ Any other Mixed background, write below

Click here to enter text.

C Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi

☐ Any other Asian background, write below

Click here to enter text.

D Black, or Black British
☐ African
☐ Caribbean
☐ Any other Black background, write below

Click here to enter text.

E Other ethnic group
☐ Chinese
☐ Any other ethnic group, write below
Click here to enter text.

Prefer not to say
☐ I prefer not to answer

5 What is your religious or other belief system affiliation?

Tick one box only.
☐ Baha'i
☐ Buddhist
☐ Christian
☐ Hindu
☐ Jewish
☐ Muslim
☐ Pagan
☐ Sikh
☐ Zoroastrian
☐ Other
☐ None
☐ Prefer not to answer
☐ Unknown

6 Which of the following best describes your sexual orientation?

Tick one box only.

☐ Heterosexual or Straight
☐ Gay or Lesbian
☐ Bisexual
☐ Other sexual orientation
☐ Prefer not to answer

Other, write below

Click here to enter text.

www.gov.uk/dhsc

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Department of Health & Social Care

NHS Continuing Healthcare Checklist

July 2022

Published May 2022

What is the Checklist and why is it used?

1. The Checklist is a screening tool which can be used in a variety of settings to help practitioners identify individuals who may need a referral for a full assessment of eligibility for NHS Continuing Healthcare.

2. All staff who complete the Checklist should be familiar with the principles of the National Framework for Continuing Healthcare and NHS-funded Nursing Care and also be familiar with the Decision Support Tool for NHS Continuing Healthcare.

3. The Checklist threshold at this stage of the process has intentionally been set low, in order to ensure that all those who require a full assessment of eligibility for NHS Continuing Healthcare have this opportunity. Practitioners should advise those for whom the Checklist is completed that a positive checklist does not automatically lead to eligibility for CHC, and only indicates that the individual requires a full assessment for NHS Continuing Healthcare.

4. There are two potential outcomes following completion of the Checklist:

    - a **negative** Checklist, meaning the individual does not require a full assessment of eligibility and they are not eligible for NHS Continuing Healthcare; or

    - a **positive** Checklist meaning an individual now requires a full assessment of eligibility for NHS Continuing Healthcare. It does not necessarily mean the individual is eligible for NHS Continuing Healthcare.

Note:

All these tools are available electronically (as Word documents) and pages or boxes can be expanded as necessary.

It is important to note that these are national tools and the content should not be changed, added to or abbreviated in any way. However, ICBs may attach their logo and additional patient identification details if necessary (e.g. adding NHS number, etc.).

When should the Checklist be completed?

5. Where there may be need for NHS Continuing Healthcare, the Checklist should normally be completed.

6. There will be many situations where it is not necessary to complete the Checklist. See paragraph 121 of the National Framework and page 9 below.

7. Screening and assessment of eligibility for NHS Continuing Healthcare should be at the right time and location for the individual and when the individual's ongoing needs are clearer. This may be in a variety of settings, although the full assessment of eligibility should normally take place when the individual is in a community setting, preferably their own home. The core underlying principle is that individuals should be supported to access and follow the process that is most suitable for their current and ongoing needs. This will help practitioners to correctly identify individuals who require a full assessment of eligibility for NHS Continuing Healthcare.

8. To understand how NHS Continuing Healthcare interacts with hospital discharge, please refer to paragraphs 101-108 of the National Framework.

Who can complete the Checklist?

9. The Checklist can be completed by a variety of health and social care practitioners, so as long as they have been trained in its use.

What is the role of the individual in the screening process?

10. The individual should be given reasonable notice of the intention to undertake the Checklist and have the process explained to them. They should normally be given the opportunity to participate actively in the completion of the Checklist, together with any representative they may have, so that they can contribute their views about their needs.

11. There are a number of principles which underpin the NHS Continuing Healthcare process: most importantly that assessments and reviews should always focus on the individual's needs and follow a person-centred approach. The individual should be fully informed and empowered to participate actively in the assessment process and any subsequent reviews, and their views should be considered. In addition, there are a number of legal requirements when it comes to an individual's consent for parts of the NHS Continuing Healthcare process.

12. In the spirit of the person-centred approach, practitioners should make all reasonable efforts to seek the participation of the individual (or their representative) for the assessment and review process for NHS Continuing Healthcare, during each stage of the process. For a

comprehensive assessment, the best evidence available at the relevant time should be considered. This should involve consideration of the individual's (or their representative's) view, and they should be empowered and assisted to participate. Throughout the process, this person-centred approach should be embedded in all decisions which relate to the individual's needs assessment, and their care planning.

13. Consent is a legal requirement for any physical intervention on, or examination of, a person with capacity to give consent. To the extent that screening for NHS Continuing Healthcare involves such an intervention or examination, informed consent must be sought from an individual with capacity to give consent. Please refer to paragraph 85 of the National Framework which gives detailed guidance on what is required for consent to be valid.

14. It is necessary to obtain an individual's explicit consent before sharing any personal data with a third party such as a family member, friend, advocate, and/or other representative.

15. However, it is not necessary to seek consent from an individual in order to share their personal data as part of their NHS Continuing Healthcare assessment (and subsequent reviews) between health and social care professionals.

16. If there is a concern that the individual may not have capacity to give consent to a physical intervention/examination that is part of the assessment process, or to the sharing of personal data with third parties such as a family member, friend, advocate, and/or other representative, this should be determined in accordance with the Mental Capacity Act 2005 and the associated code of practice. It may be necessary for a 'best interests' decision to be made, bearing in mind the expectation that everyone who is potentially eligible for NHS Continuing Healthcare should have the opportunity to be considered for eligibility. Guidance on the application of the Mental Capacity Act 2005 in such situations is provided in paragraphs 86-96 of the National Framework.

How should the Checklist be completed?

17. Completion of the Checklist is intended to be relatively quick and straightforward. It is not necessary to provide additional detailed evidence along with the completed Checklist.

18. Practitioners should compare the domain descriptors to the needs of the individual and select level A, B or C, as appropriate, choosing whichever most closely matches the individual. If the needs of the individual are the same or greater than anything in the A column, then ‘A’ should be selected. Practitioners should briefly summarise the individual’s needs which support the level chosen, recording references to evidence as appropriate.

19. A full assessment for NHS Continuing Healthcare is required if there are:

    - two or more domains selected in column A;
    - five or more domains selected in column B, or one selected in A and four in B; or

- one domain selected in column A in one of the boxes marked with an asterisk (i.e. those domains that carry a priority level in the Decision Support Tool), with any number of selections in the other two columns.

20. There may very occasionally be circumstances where a full assessment of eligibility for NHS Continuing Healthcare is appropriate even though the individual does not apparently meet the indicated threshold as set out above. A clear rationale must be given in such circumstances and local protocols followed.

21. The principles in relation to 'well-managed need' (outlined in the Assessment of Eligibility section of the National Framework, paragraphs 162-166) apply equally to the completion of the Checklist as they do to the Decision Support Tool.

What happens after the Checklist?

22. Whatever the outcome of the Checklist – whether or not a referral for a full assessment of eligibility for NHS Continuing Healthcare is considered necessary – the outcome must be communicated clearly and in writing to the individual or their representative, as soon as is reasonably practicable. This should include the reasons why the Checklist outcome was reached. Normally this will be achieved by providing a copy of the Checklist.

What happens following a negative Checklist?

23. A negative Checklist means the individual does not require a full assessment of eligibility and they are not eligible for NHS Continuing Healthcare.

24. Where it can reasonably be anticipated that the individual's needs are likely to increase in the next three months (e.g. because of an expected deterioration in their condition), this should be recorded and a decision made as to whether the checklist should be reviewed within a specified period of time.

25. If an individual has been screened out following completion of the Checklist, they may ask the ICB to reconsider the Checklist outcome. The ICB should give this request due consideration, taking account all of the information available, and/or including additional information from the individual or carer, though there is no obligation for the ICB to undertake a further Checklist.

What happens following a positive Checklist?

26. A positive Checklist means that the individual requires a full assessment of eligibility for NHS Continuing Healthcare. It does not necessarily mean that the individual will be found eligible for NHS Continuing Healthcare (refer to paragraphs 134-137 of the National Framework).

27. An individual should not be left without appropriate support while they await the outcome of the assessment and decision-making process.

NHS Continuing Healthcare Needs Checklist

Date of completion of Checklist _____

Name		**DOB**	

NHS number and GP/Practice:	

Permanent address and telephone number	**Current location (if different from permanent address)**

Gender _____

Please ensure that the equality monitoring form at the end of the Checklist is completed

Was the individual involved in the completion of the Checklist? Yes/No (please delete as appropriate)

Was the individual offered the opportunity to have a representative such as a family member or other advocate present when the Checklist was completed? Yes/No (please delete as appropriate)

If yes, did the representative attend the completion of the Checklist? Yes/No (please delete as appropriate)

Please give the contact details of the representative (name, address and telephone number).

Did you explain to the individual how their personal data will be shared with the different organisations involved in their care? Yes/No (please delete as appropriate)

Continued overleaf

Did you explain to the individual how their personal data will be shared with other third parties, such as a family member, friend, advocate and/or other representative? This consent should be recorded in writing, and ideally identify the individuals with whom the data can be shared (e.g. on the Consent form). Yes/No (please delete as appropriate)

When not to screen

There will be many situations where it is not necessary to complete the Checklist.
Practitioners should review the statements below on when it may not be appropriate to screen for NHS Continuing Healthcare before they start the process of completing the Checklist.

The situations where it is not necessary to complete the Checklist include:

(a) It is clear to practitioners working in the health and care system that there is no need for NHS Continuing Healthcare at this point in time. Where appropriate/relevant this decision and its reasons should be recorded. If there is doubt between practitioners, the Checklist should be undertaken.

(b) The individual has short-term health care needs or is recovering from a temporary condition and has not yet reached their optimum potential (although if there is doubt between practitioners about the short-term nature of the needs it may be necessary to complete the Checklist). See paragraphs 101-108 of the National Framework for how NHS Continuing Healthcare may interact with hospital discharge.

(c) It has been agreed by the ICB that the individual should be referred directly for full assessment of eligibility for NHS Continuing Healthcare.

(d) The individual has a rapidly deteriorating condition and may be entering a terminal phase – in these situations the Fast Track Pathway Tool should be used instead of the Checklist.

(e) An individual is receiving services under Section 117 of the Mental Health Act that are meeting all of their assessed needs.

(f) It has previously been decided that the individual is not eligible for NHS Continuing Healthcare and it is clear that there has been no change in needs.

If upon review of these statements, it is deemed that it is not necessary to screen for NHS Continuing Healthcare at this time, the decision not to complete the Checklist and its reasons should be clearly recorded in the patient's notes.

Name of individual		**Date of completion**	
	C	B	A
Breathing*	Normal breathing, no issues with shortness of breath. **OR** Shortness of breath or a condition, which may require the use of inhalers or a nebuliser and has no impact on daily living activities. **OR** Episodes of breathlessness that readily respond to management and have no impact on daily living activities.	Shortness of breath or a condition, which may require the use of inhalers or a nebuliser and limit some daily living activities. **OR** Episodes of breathlessness that do not consistently respond to management and limit some daily activities. **OR** Requires any of the following: - low level oxygen therapy (24%); - room air ventilators via a facial or nasal mask; - other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.	Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers. **OR** Breathlessness due to a condition which is not responding to therapeutic treatment and limits all daily living activities. **OR** A condition that requires management by a non-invasive device to both stimulate and maintain breathing (non-invasive positive airway pressure, or non-invasive ventilation)
Brief description of need and source of evidence to support the chosen level			Write A, B or C below: ☐

Name of individual		**Date of completion**	
	C	B	A
Nutrition	Able to take adequate food and drink by mouth to meet all nutritional requirements. **OR** Needs supervision, prompting with meals, or may need feeding and/or a special diet (for example to manage food intolerances/allergies). **OR** Able to take food and drink by mouth but requires additional/supplementary feeding.	Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed. **OR** Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means, for example via a non-problematic PEG.	Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway. **OR** Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers. **OR** Nutritional status 'at risk' and may be associated with unintended, significant weight loss. **OR** Significant weight loss or gain due to an identified eating disorder. **OR** Problems relating to a feeding device (e.g. PEG) that require skilled assessment and review.
Brief description of need and source of evidence to support the chosen level			Write A, B or C below: ☐

Name of individual		**Date of completion**	
	C	B	A
Continence	Continent of urine and faeces. **OR** Continence care is routine on a day-to-day basis. **OR** Incontinence of urine managed through, for example, medication, regular toileting, use of penile sheaths, etc. **AND** Is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence/constipation.	Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation or other bowel problems.	Continence care is problematic and requires timely and skilled intervention, beyond routine care. (for example frequent bladder wash outs/irrigation, manual evacuations, frequent re-catheterisation).
Brief description of need and source of evidence to support the chosen level			Write A, B or C below: ☐

Name of individual		**Date of completion**	
	C	B	A
Skin integrity	No risk of pressure damage or skin condition. **OR** Risk of skin breakdown which requires preventative intervention once a day or less than daily, without which skin integrity would break down. **OR** Evidence of pressure damage and/or pressure ulcer(s) either with 'discolouration of intact skin' or a minor wound. **OR** A skin condition that requires monitoring or reassessment less than daily and that is responding to treatment or does not currently require treatment.	Risk of skin breakdown which requires preventative intervention several times each day, without which skin integrity would break down. **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is responding to treatment. **OR** An identified skin condition that requires a minimum of daily treatment, or daily monitoring/reassessment to ensure that it is responding to treatment	Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is not responding to treatment. **OR** Pressure damage or open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule', which is responding to treatment. **OR** Specialist dressing regime in place which is responding to treatment.
Brief description of need and source of evidence to support the chosen level			Write A, B or C below: ☐

Name of individual		**Date of completion**	
	C	B	A
Mobility	Independently mobile. **OR** Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.	Not able to consistently weight bear. **OR** Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning. **OR** In one position (bed or chair) for majority of the time but is able to cooperate and assist carers or care workers. **OR** At moderate risk of falls (as evidenced in a falls history or risk assessment)	Completely unable to weight bear and is unable to assist or cooperate with transfers and/or repositioning. **OR** Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate. **OR** At a high risk of falls (as evidenced in a falls history and risk assessment). **OR** Involuntary spasms or contractures placing the individual or others at risk.
Brief description of need and source of evidence to support the chosen level			Write A, B or C below: ☐

Name of individual		**Date of completion**	
	C	B	A
Communication	Able to communicate clearly, verbally or non-verbally. Has a good understanding of their primary language. May require translation if English is not their first language. **OR** Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.	Communication about needs is difficult to understand or interpret or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual.	Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to assist them have been taken. The individual has to have most of their needs anticipated because of their inability to communicate them.
Brief description of need and source of evidence to support the chosen level			Write A, B or C below: ☐

Name of individual		**Date of completion**	
	C	B	A
Psychological/ Emotional	Psychological and emotional needs are not having an impact on their health and well-being. **OR** Mood disturbance or anxiety symptoms or periods of distress, which are having an impact on their health and/or well-being but respond to prompts, distraction and/or reassurance. **OR** Requires prompts to motivate self towards activity and to engage them in care planning, support and/or daily activities.	Mood disturbance, hallucinations or anxiety symptoms or periods of distress which do not readily respond to prompts, distraction and/or reassurance and have an increasing impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in support, care planning and/or daily activities.	Mood disturbance, hallucinations or anxiety symptoms or periods of distress that have a severe impact on the individual's health and/or well-being. **OR** Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and/or daily activities.
Brief description of need and source of evidence to support the chosen level			Write A, B or C below: ☐

Name of individual		**Date of completion**	
	C	B	A
Cognition	No evidence of impairment, confusion or disorientation. **OR** Cognitive impairment which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident. **OR** Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.	Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration.	Cognitive impairment that could for example include frequent short-term memory issues and maybe disorientation to time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make some choices appropriate to need on a limited range of issues, they are unable to do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult, even with supervision, prompting or assistance, to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration.
Brief description of need and source of evidence to support the chosen level			Write A, B or C below: ☐

Name of individual		**Date of completion**	
	C	B	A
Behaviour*	No evidence of ‘challenging’ behaviour. **OR** Some incidents of ‘challenging’ behaviour. A risk assessment indicates that the behaviour does not pose a risk to self, others or property or create a barrier to intervention. The individual is compliant with all aspects of their care.	‘Challenging’ behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self, others or property. The individual is nearly always compliant with care.	‘Challenging’ behaviour of type and/or frequency that poses a predictable risk to self, others or property. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions.
Brief description of need and source of evidence to support the chosen level			Write A, B or C below: ☐

Name of individual		**Date of completion**	
	C	B	A
Drug therapies and medication: symptom control*	Symptoms are managed effectively and without any problems, and medication is not resulting in any unmanageable side-effects. **OR** Requires supervision/administration of and/or prompting with medication but shows compliance with medication regime. **OR** Mild pain that is predictable and/or is associated with certain activities of daily living; pain and other symptoms do not have an impact on the provision of care.	Requires the administration of medication (by a registered nurse, carer or care worker) due to: – non-compliance, or – type of medication (for example insulin); or – route of medication (for example PEG). **OR** Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care.	Requires administration and monitoring of medication regime by a registered nurse, carer or care worker specifically trained for this task because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. However, with such monitoring the condition is usually non-problematic to manage. **OR** Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.
Brief description of need and source of evidence to support the chosen level			Write A, B or C below: ☐

Name of individual		**Date of completion**	
	C	B	A
Altered states of consciousness*	No evidence of altered states of consciousness (ASC). **OR** History of ASC but effectively managed and there is a low risk of harm.	Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.	Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm. **OR** Occasional ASCs that require skilled intervention to reduce the risk of harm.
Brief description of need and source of evidence to support the chosen level			Write A, B or C below: ☐
Total from all pages			

Please highlight the outcome indicated by the Checklist:

1. Referral for full assessment for NHS Continuing Healthcare is necessary (known as a positive Checklist).

Or

2. No referral for full assessment for NHS Continuing Healthcare is necessary (known as a negative Checklist).

Rationale for decision

Please send this completed Checklist to the ICB without delay.

Name(s) and signature(s) of assessor(s)	**Date**

Contact details of assessors (name, role, organisation, telephone number, email address)

About you — equality monitoring

We collect equalities information to meet our duties under the Equality Act 2010 and develop our insights into CHC patients and ensure we provide appropriate care. The categories included in the questions may not be exhaustive or reflect how you feel or identify. We will be reviewing these to align with approaches across Government. Filling these in is optional, and you do not have to provide an answer if you do not wish to do so.

Please provide us with some information about yourself. We collect information to help us understand whether people are receiving fair and equal access to NHS Continuing Healthcare (CHC) via the NHS CHC Patient Level Data Set (PLDS) which is used to help achieve better patient outcomes, better experiences and better use of resources in CHC. The lawful basis for collecting this information is Article 6 (1) (c) of the GDPR enacted by the Data Protection Act 2018. Please note that NHS CHC PLDS data is pseudonymised for analysis purposes. This means that identifiers such as names, NHS numbers and dates of birth are removed. Detailed information about the use of individual's identifiable data is publicly available at https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe/gdpr/gdpr-register

1 What is your gender?

Tick one box only

☐ Male
☐ Female
☐ Indeterminate (unable to be classified as either male or female)
☐ I prefer not to answer

2 Which age group applies to you?

Tick one box only

☐ 18-24
☐ 25-34
☐ 35-44
☐ 45-54
☐ 55-64
☐ 65-74
☐ 75-84
☐ 85+
☐ I prefer not to answer

3 Do you have a disability as defined by the Equalities Act 2010?

Tick one box only.

The Equality Act 2010 defines a person with a disability as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.

☐ No
☐ Yes
☐ I prefer not to answer

4 What is your ethnic group?

Tick one box only.

A White
☐ British
☐ Irish
☐ Any other White background, write below
Click here to enter text.

B Mixed
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any other Mixed background, write below

Click here to enter text.

C Asian or Asian British
☐ Indian
☐ Pakistani

☐ Bangladeshi

☐ Any other Asian background, write below

Click here to enter text.

D Black, or Black British

☐ African
☐ Caribbean
☐ Any other Black background, write below

Click here to enter text.

E Other ethnic group

☐ Chinese
☐ Any other ethnic group, write below
Click here to enter text.

Prefer not to say

☐ I prefer not to answer

5 What is your religious or other belief system affiliation?

Tick one box only

☐ Baha'i
☐ Buddhist
☐ Christian
☐ Hindu
☐ Jewish
☐ Muslim
☐ Pagan
☐ Sikh
☐ Zoroastrian
☐ Other
☐ None
☐ Prefer not to answer
☐ Unknown

6 Which of the following best describes your sexual orientation?

Tick one box only

☐ Heterosexual or Straight
☐ Gay or Lesbian
☐ Bisexual
☐ Other sexual orientation
☐ Prefer not to answer

Other, write below

Click here to enter text.

www.gov.uk/dhsc

North Central London
Integrated Care Board

Guidance for use of audio and video recording of assessments and / or meetings

Kim Hine

December 2022

Contents

1. Background

Many NHS organisations have been increasingly aware of the use of recording by clients (the term client will be used for all those individuals' requiring assessments who interact with ICS services), whether this is for a GP consultation, acute hospital treatment or clinical assessments of any kind. It has been recognised by NCL ICB, as well as national NHS organisations, that staff need guidance and advice about individuals and / or their representatives recording.

Unlike clinicians, who are required to obtain consent or document a best interest decision to make audio or visual recording of individuals they are treating or assessing, clients and /or their representatives do not require clinicians' permission to record consultations, assessment or meetings or any kind.

Recordings by clients and / or their representatives, covertly or overtly, in order to keep a record of what was said, are considered personal "note taking".

2. Purpose

This guidance sits as an adjunct to NCL ICB Continuing Care (CC) and Continuing Healthcare (CHC) Policies and Standard Operating Procedures as well as any other provider policies, to provide clarification to clinical and non-clinical staff dealing with situations where an individual and / or their representative have requested to record the meeting or concerns regarding recording of meetings covertly.

This guidance will also be used in the development of a client / representative leaflet to inform them of the structure and expectations of meetings / assessments.

3. Scope

The guidance for use of audio and video recording of assessments and / or meetings is for the use of CC, CHC and Complex Individualised Commissioning staff in relation to the covert and / or overt recording of meetings and assessments by individuals and their representatives.

4. Key documents and legislation

NHS Protect - Patients recording NHS staff in health and social care settings - https://www.proceduresonline.com/barnet/fs/files/patient_record_nhs.pdf

Malicious Communications Act 1988 - https://www.legislation.gov.uk/ukpga/1988/27/pdfs/ukpga_19880027_en.pdf

Communications Act 2003 - https://www.legislation.gov.uk/ukpga/2003/21/contents

Data Protection Act 2018 - https://www.gov.uk/data-protection

Regulation of Investigatory Powers Act 2000 - https://www.legislation.gov.uk/ukpga/2000/23/contents

Records Management Code of Practice 2021 - https://transform.england.nhs.uk/information-governance/guidance/records-management-code/records-management-code-of-practice-2021/

Encryption Guide for NHSmail July 2022 Version 9 https://s3-eu-west-1.amazonaws.com/comms-mat/Training-Materials/Guidance/encryptionguide.pdf

Attachments guide for NHSmail May 2022 Version 7 https://s3-eu-west-1.amazonaws.com/comms-mat/Training-Materials/Guidance/attachmentsguide.pdf

Freedom of Information (FOI) Act 2000 - https://www.legislation.gov.uk/ukpga/2000/36/contents

Environmental Information Regulations (EIR) 2004 - https://www.legislation.gov.uk/uksi/2004/3391/contents/made

UK General Data Protection Regulations 2021 (UK GDPR) - https://uk-gdpr.org/#:~:text=The%20EU%20General%20Data%20Protection,by%20organisation%20around%20the%20world.

NCL related policies – on NCL ICB intranet

- Confidentiality Policy
- Information Governance Policy
- Information Security Policy
- Information Management Policy

5. Responsibilities

The NCL ICB Assistant Directors of CHC are responsible for publishing, monitoring the implementation of and updating the Guidance for use of audio and video recording of assessments and / or meetings.

All staff working for or on behalf of NCL ICB including those on permanent or fixed term contracts, interims, self-employed contractors / consultants, Governing Body members and volunteers are responsible for complying with the NCL ICB Guidance for use of audio and video recording of assessments and / or meetings.

All NCL ICB line managers are responsible for ensuring their teams comply with the NCL ICB Guidance for use of audio and video recording of assessments and / or meetings.

6. Principles

There are no specific legal requirements that govern an individual making a personal recording, either covertly or overtly.

Recordings made for personal records are deemed to constitute “note taking” and are therefore permitted and do not fall under the Data Protection Act 2018.

Although clients and / or representatives do not require permission to record the assessment or meeting, common courtesy would suggest that permission is sought.

The content of any recording made by an individual and / or their representative is confidential to them only, although they can waive their confidentiality to share third parties and share unadulterated on any social media sites of their choosing.

However, this right changes if the recording is no longer being used as a record of a meeting, especially if it is modified in anyway. This is particularly pertinent if the recording is used in a way that it is designed to cause detriment or harassment of another individual captured in the recording. Use of a recording on these terms may lead to civil action for damages or may in fact be a criminal offence and could be considered a breach of the Data Protection Act 2018.

Covert recordings may be rated as inadmissible in court.

The Human Rights Act will need to be considered in regard to recording of meetings as the use of a recording maybe considered illegal under UK General Data Protection Regulations (UK GPDR.)

Recordings cannot be published without agreement of all attendees as this is considered an infringement of individual rights

Sharing of the recording without due consent could be considered a criminal offence depending on how the publication was made. The most likely offences may be considered:

- contrary to section 1 of the Protection from Harassment Act 1997
- contrary to section 4, 4A or 5 of the Public Order Act
- contrary to section 1 of the Malicious Communications Act 1988
- contrary to section 127 of the Communications Act 2003

However specific legal advice should be sought by the ICB when relevant.

7. Audio and Video recordings by clinical teams

In accordance with the NHSE Records and Management Code of Practice 2021 the following must be considered when client interactions are captured via audio and / or visual recording.

- The clinical appropriateness to use audio or visual recording methods
- Signed consent is required to record an assessment
- Recorded on Microsoft Teams whether the assessment is completed via Microsoft Teams or face to face
- Transparency to the client and / or representative regarding the purpose and use of the recording, providing understanding how the contents will be utilised, stored and destroyed
- The medium by which the recording is made and ensure it is able to be viewed throughout the retention period

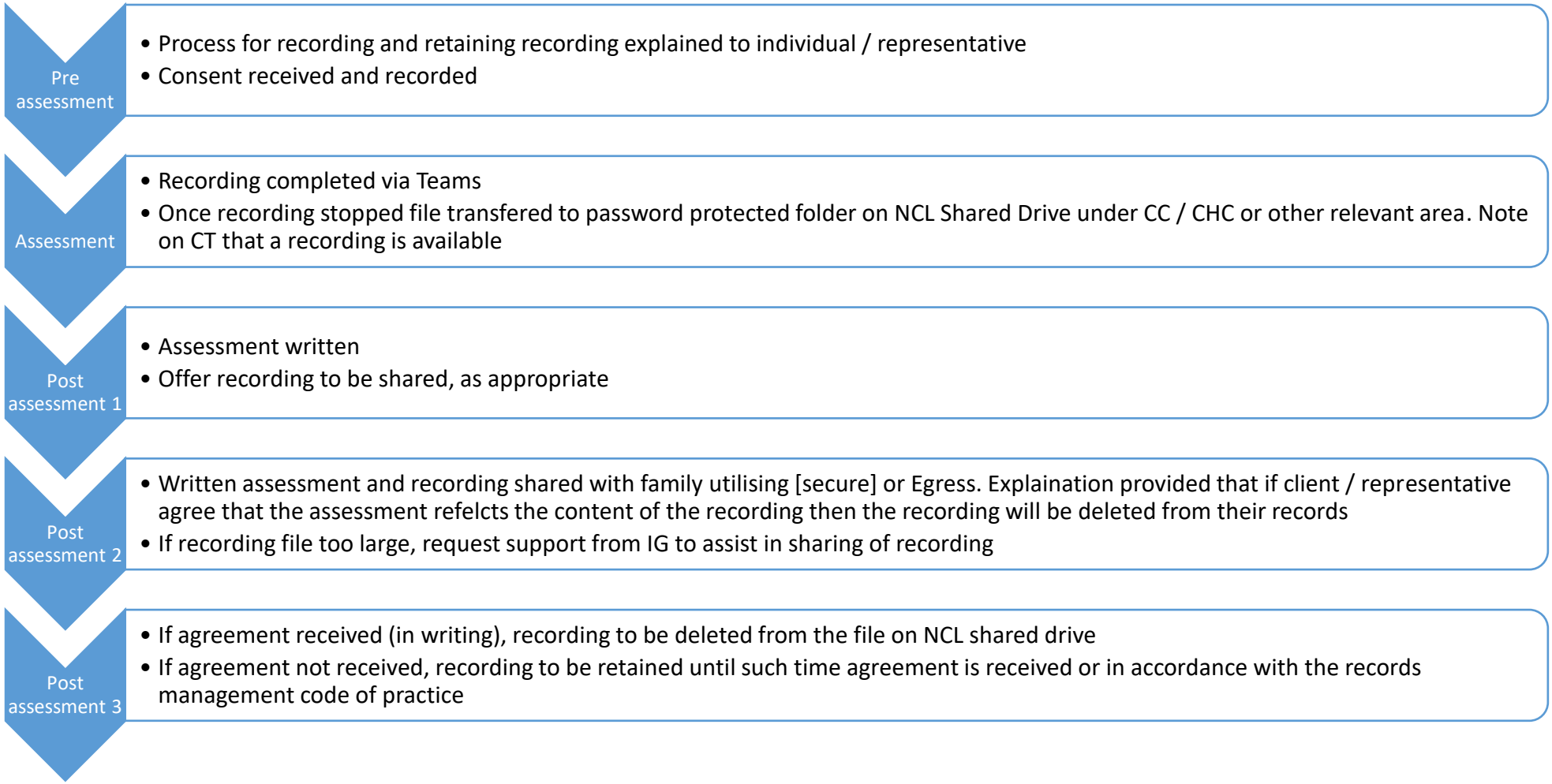
- The retention of the recording. The Records Management Code of Practice 2021 states “if the recording is going to be kept elsewhere then there is no reason to keep the original recording, providing the version in the main record is the same as the original or there is a summary into words which is accurate and adequate for its purpose”. In practice this means, for example, that once the assessment has been written and the content agreed by the client and / or representative then the recording can be deleted, providing they have been informed of the process.
- Audio and visual recordings are not able to be stored on Care Track however should be transferred from Teams to a password protected folder on the NCL shared drive under CC / CHC or other relevant area. Where clinical teams, working on behalf of the ICB, sit in provider organisations, the ICB will work with the provider to ensure recordings are stored appropriate and securely on their IT systems.
- Any files retained on the NCL drive will be subject to the usual spot check access audit processes

If a meeting is recorded for the purpose of minute taking then, once the minutes have been written, shared, and agreed as a true reflection of the meeting then the recording will be disposed of.

In Accordance with the NCL ICB Confidentiality Policy July 2022 “Transferring patient information by email to anyone outside the ICB’s network may only be undertaken by using encryption as per the current NHS Encryption Guidance or through an exchange within the NHS Mail system (i.e. from one NHS.net account to another NHS.net account or to a secure government domain e.g. gsi.gov.uk), since this ensures that mandatory government standards on encryption are met. Sending information via email to clients is permissible, provided the risks of using unencrypted email have been explained to them, they have given their consent and the information is not person-identifiable or confidential information.”

In practice this means any recordings can be shared via NHS.net. Recordings sent to an unsecure email address must be done using {secure} or via Egress. The file size for transfer is 100MB therefore it may be necessary to decrease the quality of the recording to allow to be sent via email. Alternatively, for files over 100MB, discuss potential solutions with the IG team.

Figure 1. Process for recording and sharing files when clinical teams are making the recording



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nclhealthandcare.org.uk

NHS
North Central London
Integrated Care Board

07 October 2024
Laycock PDC
Laycock Street
London
N1 1TH
0203 198 9743
northcentrallondon.icb.nhs.uk

Dear

Re: Continuing Healthcare Eligibility Decision for

Decision: Not Eligible for Continuing Healthcare

Following your assessment and completion of a Decision Support Tool by a multidisciplinary team on ENTER DATE, North Central London Integrated Care Board (NCL ICB) has considered your eligibility for fully funded NHS Continuing Healthcare. We are now in a position to advise you that based on the available evidence and your present level of need, the ICB have made the decision that you are not currently eligible to receive NHS Continuing Healthcare.

NCL ICB's role in accordance with the National Framework for NHS Continuing Healthcare and Funded Nursing Care July 2022 (Revised) is to consider the recommendation by the multidisciplinary team to decide whether or not you are eligible to receive Continuing Healthcare, which is fully funded by the NHS.

NCL ICB considered the National Framework's key characteristics for eligibility, those of nature, intensity, complexity and unpredictability. It must be recognised that the application of these characteristics relies on the clinical judgement of the multidisciplinary team. Taking account of your care requirements as a whole the ICB considered that either the nature, intensity, complexity or unpredictability of your needs are not of a level which indicates that you have a primary health need and therefore you are not eligible for NHS Continuing Healthcare funding.

We can confirm that Funded Nursing Care (FNC) was considered although as you currently do not reside in a care home with nursing, it was determined that a decision on eligibility for this contribution was not required at this time.

Further information on NHS Continuing Healthcare and Funded Nursing Care can be found online at:

https://www.england.nhs.uk/healthcare

What you need to do next

You continue to be entitled to access the full range of primary, community, secondary and other health services. In accordance with the Care Act 2014, the local authority may make arrangements

to assess your care needs and undertake a financial assessment to determine if and how much you may be required to pay towards the cost of your care.

What to do if you are unhappy with this decision

If you wish to appeal against this decision, there is a statutory time limit of six months from the date of this letter to notify the Continuing Healthcare team. Once we have received your request, we will be in contact within 10 working days to confirm next steps and any further detail required of you. (Please see addendum to this letter for the appeals process.)

I understand that this outcome may not meet your expectations and if there is any further explanation required, please contact the Continuing Healthcare Service local to your area on 020 3198 9743 or by email using the details below.

Borough CHC service	Email address
Barnet, Camden or Enfield CHC Team	Nclicb.chc@nhs.net
Haringey CHC Team	whh-tr.continuingcare1@nhs.net
Islington CHC Team	continuingcare3@nhs.net
NCL CHC Appeals Team	nclicb.chcappeals@nhs.net

Yours sincerely,

Assistant Director of Complex Care (Professional Lead: CHC)
NHS North Central London ICB

cc

If you are copied into this letter and wish to receive a copy of the Decision Support Tool / assessment form (providing you are entitled to a copy under the Data Protection Act) please send a written request to the Continuing Healthcare Service.

Advocacy arrangements

If you feel you would like an advocate to be part of any interaction with the Continuing Healthcare Services, including assessments and reviews, please contact your local borough Continuing Healthcare Team on the contact details provided or you can contact the following borough-based

Advocacy services directly.

Borough	Service	Contact details
Barnet	POhWER	Tel: 0300 456 2370 Email: pohwer@pohwer.net Website: www.pohwer.net/
Camden	Rethink	Tel: 0300 7900 559 / 07483 431771 Email: camden.advocacy@rethink.org Referral Email: advocacyreferralhub@rethink.org Website: www.rethink.org
Enfield	POhWER	Tel: 0300 456 2370 Email: pohwer@pohwer.net Website: www.pohwer.net/
Haringey	VoiceAbility	Tel: 0300 303 1660 Email: helpline@voiceability.org Website: www.voiceability.org
Islington	Rethink	Tel: 0300 7900 559 Referral Email: advocacyreferralhub@rethink.org Website: www.rethink.org

NHS Continuing Healthcare Assessment for Eligibility Process: Experience Survey

NCL ICB wished to ask questions about your experience of the NHS Continuing Healthcare assessment processes. By giving us this feedback, we can identify opportunities to improve and find out where individuals are having good experiences.

Taking part in this survey is optional and what you tell us is confidential. Your answers will remain anonymous and only be used for the purposes of improving services. Please DO NOT include any personal data that identifies you or someone else, such as names, address, and contact emails or phone numbers. Any personal details will be deleted from the survey responses.

This survey does not form part of any NCL ICB complaints or appeals process. If you disagree with the eligibility decision that has been made or have any concerns, please contact the service or complaints team on the contact details included on the letter.

The survey can be completed by clicking on the link below.

https://nhs.quiqcloud.com/url/L7P0K1

Alternatively, if you wish to receive a paper copy of this survey, please send the request to the CHC service and this can be sent to you.

North Central London Integrated Care Board (NCL ICB)
Appeal Process

If you wish to appeal the outcome of a full Continuing Healthcare assessment / Decision Support Tool, the following process will need to be followed.

- Your appeal must be lodged, in writing, with the relevant borough CHC service (see letter for contact details) within six months from the date on the decision letter.
  Only in exceptional circumstances would an appeal be considered outside of this timeframe.

- NCL ICB will respond with a written acknowledgement and the details of the allocated case manager, who will be the main point of contact throughout the appeal process.
  Also included will be an appeal pack which includes a consent form and a reason for appeal form, both will need completing and returning to the CHC service.

- The consent form will need to be completed and returned by you or your representative with appropriate authority, to give consent for the appeals team to access the patient's records and share details with other members of the Multi-Disciplinary Team.

- The person(s) appealing must submit the reasons for the appeal including any supporting information.

- Once received an informal meeting will take place between yourself and the case manager to discuss the appeal and attempt to resolve any matters raised before the need to move to formal resolution.

- If your appeal remains unresolved after the informal discussion, then a formal local resolution panel will be convened. The purpose of a local resolution panel is to discuss the appeal, the level of needs and the content of the assessment. After the panel, eligibility for Continuing Healthcare will be considered.

- There are 3 possible outcomes of a local resolution panel.
  - The original recommendation is upheld.
  - The original recommendation is overturned.
  - New and relevant information was presented and a request for a review or new assessment is made.

If, following the Local Resolution Panel, you remain unhappy with the outcome then you are able to request an Independent Review Panel with NHS London. Further details will be provided in the appeal outcome letter. In all but exceptional circumstances a Local Resolution panel and outcome must be completed prior to an Independent Review being considered.

Report for: Adults and Health Scrutiny Panel, 14 November 2024

Item number:

Title: Scrutiny of the 2025/26 Draft Budget and Medium Term Financial Strategy 2025/2030

Report authorised by: Taryn Eves, Director of Finance and Section 151 Officer

Lead Officer: Frances Palopoli, Head of Corporate Financial Strategy & Monitoring

Ward(s) affected: N/A

Report for Key/ Non Key Decision: N/A

1. Describe the issue under consideration

1.1 To consider and comment on the Council's Draft 2025-26 Budget and 2025-2030 Medium Term Financial Strategy Report proposals relating to the Scrutiny Panels' and Scrutiny Committee remit.

2. Recommendations

2.1 That the Panels and Committee scrutinise the proposals presented in the report attached in Appendix 1 and provide recommendations on the Budget proposals to the Overview and Scrutiny Committee (OSC) Committee on 20 January 2025.

3. Background information

3.1 The Council's Overview and Scrutiny Procedure Rules (Constitution, Part 4, Section G) state: "The Overview and Scrutiny Committee shall undertake scrutiny of the Council's budget through a Budget Scrutiny process. The procedure by which this operates is detailed in the Protocol covering the Overview and Scrutiny Committee".

3.2 Also laid out in this section is that "the Chair of the Budget Scrutiny Review process will be drawn from among the opposition party Councillors sitting on the Overview and Scrutiny Committee. The Overview and Scrutiny Committee shall not be able to change the appointed Chair unless there is a vote of no confidence as outlined in Article 6.5 of the Constitution".

4. Overview and Scrutiny Protocol

4.1 The Overview and Scrutiny Protocol lays out the process of Budget Scrutiny and includes the following points:

a. The budget shall be scrutinised by each Scrutiny Review Panel, in their respective areas. Their recommendations shall go to the OSC for approval. The areas of the budget which are not covered by the Scrutiny Review Panels shall be considered by the main OSC.

b. A lead OSC member from the largest opposition group shall be responsible for the co-ordination of the Budget Scrutiny process and recommendations made by respective Scrutiny Review Panels relating to the budget.

c. Overseen by the lead member referred to in paragraph 4.1.b, each Scrutiny Review Panel shall hold a meeting following the release of the Draft Budget/MTFS Cabinet paper. Each Panel shall consider the proposals in this report, for their respective areas. The Scrutiny Review Panels may request that the Cabinet Member for Finance and/or Senior Officers attend these meetings to answer questions.

d. Each Scrutiny Review Panel shall submit their final budget scrutiny report to the OSC meeting on 20 January 2025 containing their recommendations/proposals in respect of the budget for ratification by the OSC.

e. The recommendations from the Budget Scrutiny process, ratified by the OSC, shall be fed back to Cabinet. As part of the budget setting process, the Cabinet will clearly set out its response to the recommendations/ proposals made by the OSC in relation to the budget.

5. 2025/26 Draft Budget and MTFS 2025/30 – Key Messages from report presented to Cabinet on 12/11/2024 (Appendix 1 to this report)

Introduction / Background

5.1 The main purpose of this report is to specifically update on the budget preparations for 2025/26 and with a focus on the General Fund. Further updates on the Housing Revenue Account and Dedicated Schools Budget will be presented to Cabinet in December 2024.

5.2 It sets out the latest information and based on the most up to date assumptions that underpin the budget and sets out the details of the draft revenue and capital proposals for balancing the budget and Capital Programme for 2025/26. Proposed budget reductions are being launched for consultation and scrutiny. The feedback from the consultation will be considered in developing the final draft budget that will be presented to Cabinet in February 2025.

5.3 The last update was published in March 2024 and showed an estimated £14m budget gap for 2025/26. This report describes how the current forecasts have moved and what the key drivers for the revised position are. The most significant movement has been the increase in both demand and costs of providing social care services and addressing homelessness. Acknowledging and providing for this, is vital to enable the Council to continue to provide services to the most vulnerable requiring extra support and help to both manage risk and prevent escalation of need. This has led to an additional £39.6m

needed for next years' service budgets with consequential impact on increasing the budget gap. Extensive modelling has been undertaken to arrive at this figure which represents the current best assumption. This is an extremely volatile landscape that the Council is operating within. These figures will be kept under review right up to the presentation of the final Budget to Cabinet in February 2025.

5.4 Whilst there have been improvements to the macroeconomic position such as underlying inflation now close to the target of 2%, this isn't translating into similar reductions in costs in particular social care placement costs for adults and children. The Bank of England base rate fell by 0.25% in August and, while estimates are that this will continue to fall, it is unlikely to be at pace and therefore there is likely to be little improvement in borrowing costs in the short to medium term.

5.5 The Autumn Budget took place on 30 October; the Office for Budget Responsibility (OBR) also published its updated economic and fiscal outlook for the next 5 years. The Budget announced £1.3bn new grant funding for local government in 2025/26, £600m of which will be earmarked for social care. While new funding is positive, the distribution methodology is as yet unknown and any additional funding will not meet the significant increase in financial pressures set out in this report.

5.6 As highlighted in previous reports, the reserve balances of the authority are unsustainably low and do not provide the capacity to bridge the forecast budget gap.

5.7 In summary, despite the work undertaken over the last 6 months, the 2025/26 budget update presented in this report is still not balanced with a remaining budget gap of £32m, even if all the proposals in this report are agreed. Therefore, there is considerable further work to be undertaken between now and 3 March when next year's budget is agreed. This will include lobbying central government for additional funding; looking at additional cost reductions and ensuring value for money is achieved for each pound spent; income generation strategies and wider transformation. Despite these significant challenges, in 2025/26, the Council is expected to still be setting a balanced net budget in March that will result in spending of almost £310m on day-to-day services to our 264,000 residents and which is an increase on the current year.

Key Assumptions

5.8 The following summarise the funding assumptions included in the draft 2025/26 Budget report considered by Cabinet on 12 November:

- Government funding for 2025/26 will be in line with that of 2024/25. Due to timing this has not yet been adjusted to reflect the impact of announcements made in the Autumn Budget Statement
- Main Council Tax will increase by 1.99% and Adult Social Care precept by 3% (total 4.99%) for 2025/26
- Bank of England base rate remains at or around 5%

- Inflation – assumptions vary according to the contract type and the market in which we are operating (see paragraphs 12.13 – 12.16)
- £39.6m budget built in for additional evidenced budgetary pressures
- No allowance for non-evidenced budgetary growth
- Previously agreed savings for 2025-2029 will be delivered in full, albeit there may be some delay in full delivery (see paragraph 12.24)

Next Steps

5.9 The report is clear that that the Council still has at least £32m of budget reductions to identify before a balanced budget for 2025/26 can be approved in March 2025 and this assumes that all the proposed budget reductions set out in this report are agreed following the consultation period. Any reductions not taken forward following consultation will need to be replaced with alternative savings on a £ for £ basis.

5.10 All services must continue to identify additional budget reduction proposals. The focus will be on efficiencies and management actions and mitigations to reduce the £39.6m of demand pressures that do not impact on outcomes for residents but with a gap remaining of this size, reductions in service provision cannot be ruled out at this stage.

5.11 The next update will be presented to Cabinet on 12 December 2024, which will also include any detailed financial implications for Haringey from the Budget Statement on 30 October if more becomes known when the Policy Statement is published by Government in November.

Financial Position for 2026/27 Onwards

5.12 The report is clear that the focus of this report has been on preparations for the 2025/26 budget but a review of the assumptions across the next five years has also been undertaken.

5.13 Financial planning across the medium term is more difficult for the reasons set out in the report but the latest position shows that assuming a balanced budget is set for 2025/26, there will remain an estimated cumulative budget gap of £132.8m by 2029/30.

5.14 Budget planning for these future years will need to commence shortly. This will continue to identify efficiencies across all services, and this will be an integral part of the annual financial planning process because the Council will need to continue to demonstrate that every £ spent is offering the best value for money. The transformational changes that are also needed take longer to identify and implement and will focus around the areas set out in paragraphs 14.8 – 14.10 of the report.

Capital Programme Update (Section 15)

5.15 Given the Council's challenging financial position, over the summer the existing capital programme has been reviewed to ensure that the schemes within it continue to contribute to the Corporate Delivery Plan and are essential. As a

result of this exercise, there are a number of schemes that are proposed for removing from the existing programme and these are summarised in Table 7 and set out in detail in Appendix 3.

5.16 Each year, there will also be a need for new capital investment and for 2025/26 this has been limited to only essential spending required for health and safety, maintenance and maintaining essential services and largely relates to the maintenance of the Council's highways infrastructure, operation and commercial estate. Capital investment can provide opportunities to delivery revenue savings or additional income and for 2025/26, it is proposed to invest in the Council's digital technology which will improve the efficiency across a range of services as well as improve the customer experience. Full details are set out in Appendix 3.

Risk Management (Section 18)

5.17 The report outlines the known risks and uncertainties in paragraphs 18.6 – 18.17 and provides details of current estimates and assumptions on corporate contingency and reserves.

5.18 Paragraphs 18.19 and 18.20 emphasise that Council reserve balances remain unsustainably low.

Report Appendices (1, 2, 3)

5.19 Appendix 1 summarises the additional budget proposed to be added to 2025/26 to address evidenced forecast pressures. These sums are over and above the £10.4m already assumed from last year's financial planning process for service pressures.

5.20 Appendix 2 – summarises new proposed savings and management actions for 2025/26 and beyond.

5.21 Appendix 3 – summarises the proposed changes to the Capital Programme 2025/26-2029/30

6 Further Useful Background Material

6.1 **Document A** is an aide memoire to assist with the scrutiny of budget proposals including possible key lines of enquiry. This report is specifically concerned with Stage 1 (planning and setting the budget) as a key part of the overall annual financial scrutiny activity.

6.2 **Document B** 3 lists the previously agreed MTFS savings relevant to each Panel/Committee and details progress of delivery as at Q1 23/24.

6.3 The Finance Update report presented to Cabinet in September can be accessed Here. It provides the forecast outturn position as at Quarter One.

6.4 The Council's 2024/25 Budget Book provides details of service budgets for the current year. It can be accessed Here.

7 Contribution to strategic outcomes

7.1 The Budget Scrutiny process for 2024/25 will contribute to strategic outcomes relating to all Council priorities.

8.0 Statutory Officers comments

Finance

8.1 There are no financial implications arising directly from this report. Should any of the work undertaken by Overview and Scrutiny generate recommendations with financial implications then these will be highlighted at that time.

Legal

9.2 There are no immediate legal implications arising from this report.

9.3 In accordance with the Council's Constitution (Part 4, Section G), the Overview and Scrutiny Committee should undertake scrutiny of the Council's budget through a Budget Scrutiny process. The procedure by which this operates is detailed in the Protocol, which is outside the Council's constitution, covering the Overview and Scrutiny Committee.

Equality

9.4 The draft Borough Plan sets out the Council's overarching commitment to tackling poverty and inequality and to working towards a fairer Borough.

9.5 The Council is also bound by the Public Sector Equality Duty under the Equality Act (2010) to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act
- Advance equality of opportunity between people who share those protected characteristics and people who do not
- Foster good relations between people who share those characteristics and people who do not.

9.6 The three parts of the duty applies to the following protected characteristics: age, disability, gender reassignment, pregnancy/maternity, race, religion/faith, sex and sexual orientation. Marriage and civil partnership status applies to the first part of the duty.

9.7 Further equalities comments are provided in Appendix 1.

10. Use of Appendices and Other Appended Documents

Appendix 1 – 2025/26 Draft Budget and MTFS 2025/30 Report (12 November 2024 Cabinet) + 3 Appendices

Document A – Key lines of enquiry for budget setting

Document B – Previously agreed savings 2024/25 – 2028/29 per O&S Panel/Cttee

11. Local Government (Access to Information) Act 1985

None.

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Report for: **Cabinet 12 November 2024**

Title: **Draft 2025-26 Budget and 2025-2030 Medium Term Financial Strategy Report**

Report authorised by : **Taryn Eves, Director of Finance**

Lead Officer: **Frances Palopoli, Head of Corporate Financial Strategy & Monitoring**

Ward(s) affected: **All**

Report for Key/ Non Key Decision: **Key**

1. Describe the issue under consideration

1.1. The main purpose of this report is to specifically update on the budget preparations for 2025/26 and with a focus on the General Fund. Further updates on the Housing Revenue Account and Dedicated Schools Budget will be presented to Cabinet in December 2024.

1.2. It sets out the latest information and based on the most up to date assumptions that underpin the budget and sets out the details of the draft revenue and capital proposals for balancing the budget and Capital Programme for 2025/26. Proposed budget reductions are being launched for consultation and scrutiny. The feedback from the consultation will be considered in developing the final draft budget that will be presented to Cabinet in February 2025.

1.3. The last update was published in March 2024 and showed an estimated £14m budget gap for 2025/26. This report describes how the current forecasts have moved and what the key drivers for the revised position are. The most significant movement has been the increase in both demand and costs of providing social care services and addressing homelessness. Acknowledging and providing for this, is vital to enable the Council to continue to provide services to the most vulnerable requiring extra support and help to both manage risk and prevent escalation of need. This has led to an additional £39.6m needed for next years' service budgets with consequential impact on increasing the budget gap. Extensive modelling has been undertaken to arrive at this figure which represents the current best assumption. This is an extremely volatile landscape that the Council is operating within. These figures will be kept under review right up to the presentation of the final Budget to Cabinet in February 2025.

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1.6. As highlighted over, the reserve balances of the authority are unsustainably low and do not provide the capacity to bridge the forecast budget gap.

1.7. In summary, despite the work undertaken over the last 6 months, the 2025/26 budget update presented in this report is still not balanced with a remaining budget gap of £32m, even if all the proposals in this report are agreed. Therefore, there is considerable further work to be undertaken between now and 3 March when next year's budget is agreed. This will include lobbying central government for additional funding; looking at additional cost reductions and ensuring value for money is achieved for each pound spent; income generation strategies and wider transformation. Despite these significant challenges, in 2025/26, the Council is expected to still be setting a balanced net budget in March that will result in spending of almost £310m on day-to-day services to our 264,000 residents and which is an increase on the current year.

2. Cabinet Member Introduction

2.1 Our driving ambition in Haringey is to create a fairer and greener borough where everyone can belong and thrive.

2.2 We will always set local priorities that are fair, put the interests of working people first and protect those most in need – and we will work in collaboration with our residents and communities to do so.

2.3 Our budget puts funding behind local priorities. We will build hundreds of new council homes, help hundreds of people into work, fix hundreds of roads and pavements, plant hundreds of street trees – among many other key actions to make this borough fairer and greener.

2.4 We all know that this year's council budget comes at a time of crisis. We've had more than a decade of government austerity. Public investment in this country has fallen well behind the rest of Europe. Many public services are

struggling. The cost of local services – especially social care and social housing – has gone through the roof.

2.5 Just this year, the cost of temporary accommodation is up 68% across London. The cost of adult's social care in Haringey is up 10%. At the same time, Haringey's core government funding is £143m a year less in real terms than it was in 2010.

2.6 Haringey provides temporary accommodation to just under 3,000 residents and social care to 3,780 adults – and the need is rising.

2.7 Like most London councils – and many more around the country – we are under real pressure. We've set out hard budget decisions here to balance the books this year. There will be more to come before the financial year is out. Whatever we do though, we will make sure our choices are fair – that they prioritise the people in Haringey who need support most.

2.8 We know that we need fair funding reform for the long-term. Budgets for local services need to be driven by local need. At the moment they are skewed by outdated funding rules. Those need to change – and we will work with our fellow boroughs to press for that change.

2.9 The national picture is beginning to improve. The new government's commitment to end fiscal austerity, rebuild public services and expand public investment are what we need to turn the economy and the country around.

2.10 We welcome the additional funding that the new government announced in the national budget on 30th October 2024 and look forward to a fair funding settlement in the future. We will continue to make a strong case to the new government for the resources that we need to fix the fourteen years of underfunding that local services have faced.

2.11 There are very real challenges at the moment, but there's also a real opportunity to reset the foundations – locally and nationally. This year and in future years our council budget will start with local priorities, focus on the needs of working people and build towards our shared ambition of a fairer and greener borough.

3. Recommendations

3.1 It is recommended that Cabinet:

a) Note the Council's current financial position as set out in this report which sets the foundations for the full draft budget for 2025/26 that will be presented to Cabinet in February 2025.

b) Note the budget pressures that have been identified for 2025/26 and across the medium term as set out in Section 12 and Appendix 1.

c) Note the draft revenue savings proposals summarised in Section 12 and Appendix 2.

d) Note the proposed changes to the General Fund Capital Programme for 2025/26 to 2029/30 as set out in Section 15 and Appendix 3.

e) Agree to commence consultation on the 2025/26 Budget and MTFS 2029/30 revenue and capital proposals. This includes with residents, partners and business and with Scrutiny Panels between November 2024 and January 2025 as set out in Section 19.

f) Note that the final draft General Fund Revenue Budget, Capital Programme, HRA 2025/26 Budget and Business Plan and Treasury Management Strategy Statement will be presented to Cabinet on 11 February 2025 to be recommended for approval to the Full Council meeting taking place on 3 March 2025.

g) Delegate the final decision on whether or not to participate in the 8 Authority borough business rates pool from 1 April 2025 to the Director of Finance following consultation with the Lead Member for Finance and Local Investment as set out in Section 10.7.

4. Reasons for decision

4.1 The Council has a statutory obligation to set a balanced budget for 2025/26 and this report forms a key part of the budget setting process by setting out the forecast funding and expenditure for 2025/26 at this point and options for setting a balanced budget. In order to ensure the Council's finances for the medium term are maintained on a sound basis, this report also sets out the funding and expenditure assumptions for the following four years in the form of a Medium-Term Financial Strategy. The final budget for 2025/26, Council Tax levels, Capital Programme, Treasury Management Strategy, Housing Revenue Account (HRA) budget and Business Plan will be presented to Cabinet in February 2025 for recommending to Full Council on 3 March 2025.

5. Alternative options considered

5.1 The Cabinet must consider how to deliver a balanced 2025/26 Budget and sustainable MTFS over the five-year period 2025/30, to be reviewed and adopted at the meeting of Full Council on 3 March 2025.

5.2 The Council has developed the proposals contained in this report in light of its current forecasts for future income levels and service demand. These take account of the Council's priorities; the extent of the estimated funding shortfall; the estimated impact of wider environmental factors such as inflation, interest rates, household incomes and, in some service areas, the legacy of the Covid-19 pandemic. It is this appraisal that has led to these options being presented in this report. These will be reviewed and, where necessary, updated in advance of the final Budget report being presented.

5.3 These proposals will be subject to consultation, both externally and through the Overview and Scrutiny process, and the outcomes of these will inform the final budget proposals.

6 Medium Term Financial Strategy (MTFS)

6.1 Although the statutory local authority budget setting process continues to be on an annual basis, a longer-term perspective is essential if local authorities are to demonstrate a clear understanding of their financial sustainability. Short-termism is counter to both sound financial management and governance.

6.2 The Medium-Term Financial Strategy (MTFS) provides the financial framework for the delivery of the Council's aims, ambitions, and strategic priorities as set out in the Corporate Delivery Plan (CDP). The aim of the MTFS is to:

- Plan the Council's finances over the next five years, taking account of both the local and national context.
- Provide the financial framework for the delivery of the Council's priorities and ensure that these priorities drive the financial strategy - allocating limited financial resources whilst also continuing to support residents.
- Manage and mitigate future budget risks by forward planning and retaining reserves at appropriate levels.

6.3 The greater the uncertainty over future central government policy and financial support, the more important it is to demonstrate a collective understanding of the best estimates of financial pressures, opportunities and funding over a longer timeframe, acknowledging financial pressures and risks.

6.4 In developing the medium to long term financial strategy, the authority must test the sensitivity of its forecasts, using scenario planning for the key drivers of costs, service demands and resources.

6.5 The MTFS must be developed in alignment with the stated objectives and vision and Corporate Delivery Plan and needs to be reviewed regularly to test that delivery of the agreed outputs and outcomes are still achievable. Where this is not the case, plans will need to be reassessed and re-set.

6.6 In future years, the expectation is the Council's Medium Term Financial Strategy will be published in July as the key document to set the foundations for the budget setting process for the forthcoming year.

7 Borough Vision and Corporate Delivery Plan

7.1 On 15 October 2024, Haringey's Borough Vision was published with 'Making Haringey a place where everyone can belong and thrive is at the heart of a new shared vision for the borough'. The aim of the vision is to galvanise the actions not just of the council but also of partners, residents and businesses behind a set of common objectives. Haringey 2035 identifies the six key areas for collaborative action over the next decade:

- Safe and affordable housing
- Thriving places
- Supporting children and young people's experiences and skills
- Feeling safe and being safe
- Tackling inequalities in health and wellbeing
- Supporting greener choices

7.2 This builds on the Haringey Deal which sets out the council's commitment to developing a different relationship with residents, alongside the Corporate Delivery Plan (CDP) which sets out the organisational priorities every two years.

7.3 The most recent CDP was approved by Cabinet in July 2024 and can be found here - The Corporate Delivery Plan 2024-2026 (haringey.gov.uk). it outlines the strategic objectives, priorities, and initiatives aimed at creating a fairer, greener borough. The plan is set out in eight separate themes:

- Resident experience and enabling success
- Responding to the climate emergency
- Children and young people
- Adults, health and welfare
- Homes for the future
- Safer Haringey
- Culturally rich borough
- Place and economy.

7.4 The Haringey Deal is 'how' we do things. The Council is changing the way it works. This starts with foundational principles of Knowing Our Communities and Getting the Basics Right. Across all services the Council is striving to build stronger relationships with residents and hear more from those often overlooked; build on the borough's incredible strengths, and work in partnership to solve challenges. Key Metrics for each theme have been set to determine if activities are having the intended effect and are reported to Cabinet and the Overview and Scrutiny Committee every six months.

7.5 The Budget and MTFS process is the way in which we seek to allocate financial resources in order to support the delivery of this plan alongside analysing and responding to changes in demand, costs and external factors.

8 National Financial Context

8.1 The new Government was elected on 4 July and on Monday 29 July the Chancellor delivered a statement to the House of Commons on immediate public spending pressures facing the government.

8.2 The key points from this statement which impact on Local Government were:

- The results of an audit of public spending undertaken by HM Treasury which revealed £22bn unfunded commitments from the previous Government; immediate action to find savings in response, and long-term reforms to restore public spending control and improve public services.
- The date of the next Budget was confirmed as Wednesday 30 October 2024 and formally commissioned an Office for Budget Responsibility (OBR) forecast for this date.
- The launch of the next Spending Review which will settle the multi-year Spending Review will not be published until spring 2025.
- Acceptance of the recommendations of the independent Pay Review Bodies for public sector workers' pay.
- The publication of next steps and draft legislation on priority tax commitments ahead of the full announcement and costing at the Budget on 30 October.

8.3 The in-year savings proposed by Government included the introduction of means testing for winter fuel payments. Future year savings include cancellation of the proposed adult social care charging reforms. Both decisions impact the Local Government sector although the actual financial impact for Haringey cannot be quantified at this point.

8.4 The Chancellor also accepted the independent Pay Review Body recommendations and confirmed pay uplifts averaging 5.5% for public sector workers. Although Local Government pay is managed through a different process, agreement at this level in the wider public sector could impact on the outcome of 2025/26 pay award in the local authority sector.

8.5 It was confirmed that moving forward, Spending Reviews will be set every two years to cover a three-year period, with a one-year overlap with the previous Spending Review. This is a positive announcement for the local government sector and if delivered as announced, 2025/26 will be the last one-year finance settlement and subsequently announcements will move back to multi-year funding settlements providing greater certainty and stability. There was also a commitment to a single major fiscal event once a year.

8.6 Representations to HM Treasury ahead of the Autumn Budget statement were requested. London Councils led on a London-Wide response to this which can be found https://www.londoncouncils.gov.uk/news-and-press-releases/2024/london-councils-budget-representation-2024#:~:text=Councils%20in%20the%20capital%20and%20across%20the%20UK%20have%20a

Autumn Statement – Key Messages

8.7 The Chancellor of the Exchequer delivered the 2024 Autumn Budget on 30 October. With this budget Government has announced the aim to prioritise growth and put public services back on track, with a boost for housing investment and additional funding for social care and homelessness. The Office for Budget Responsibility (OBR) also published its updated economic and fiscal outlook.

8.8 The key headlines for London Local government include:

- Core Spending Power will increase by an estimated 3.2% in real terms in 2025/26. This includes £1.3bn of new grant funding – with £600m earmarked for social care, and £700m for general services.

- Additional funding of £233m for homelessness prevention in 2025/26.

- The distribution of both will not be known until the provisional Local Government Finance Settlement in December 2024.

- An increase of £1bn for SEND and alternative provision in 2025/26 which will be added to the Dedicated Schools Grant High Needs Block allocation.

- The Small business rates multiplier will be frozen and retail, hospitality and leisure (RHL) businesses will receive a 40% business rates relief in 2025/26. Councils will be compensated for the loss of business rates income.

- Business rates will be reformed from 2026/27 to include lower multipliers for high-street RHL businesses, funded by increases for properties valued over £0.5m.

- The Affordable Homes Programme will increase by £500m in 2025/26.

- Right-to-buy discounts will be reduced by government, and local authorities will be able to retain 100% of the receipts from right-to-buy purchases.

- Government will consult on a new long-term social housing rent settlement of CPI+1% for 5 years as well as the option on further potential measures such as a 10-year settlement.

- Employer National Insurance Contributions will increase by 1.2% in 2025/26 – although for public sector, including local government the increase for direct employees is expected to be compensated.

- There was no explicit mention of Council Tax principles in the Budget however it has been indicated that for 2025/26 these would remain at 2.99% main rate and 2% Adult Social Care (ASC) precept. This is in line with current financial assumptions.

- The most relevant economic figures for the Council are inflation rates are forecast at 2.6% for 2025/26 and Interest rates are expected to fall from 5.0% to 3.5% in the final year of the forecast, 2029/30.

- Government has recognised the pressures local authorities face and have stated they will have a framework in place to support those in most difficulty. The Government has also committed to pursuing reforms to return the sector to a sustainable position, which includes allocating funding through the Local Government Finance Settlement. Further details will be set out through an upcoming local government finance policy statement to be published mid / late November.

9. Haringey Context

9.1 Haringey is an outer London borough – receiving outer London levels of funding but which exhibits many inner London characteristics including levels of deprivation, high housing costs and urban density. Unlike many other London boroughs, it also continues to have a growing population – with the number of over 65s 24% higher in 2024 than it was in 2010.

9.2 The core grant funding available from government for Haringey to deliver services and meet the needs of residents is around £143m less in real terms than it was in 2010/11.

9.3 Haringey's local population has been hit hard by the Covid pandemic and the cost of living crisis.

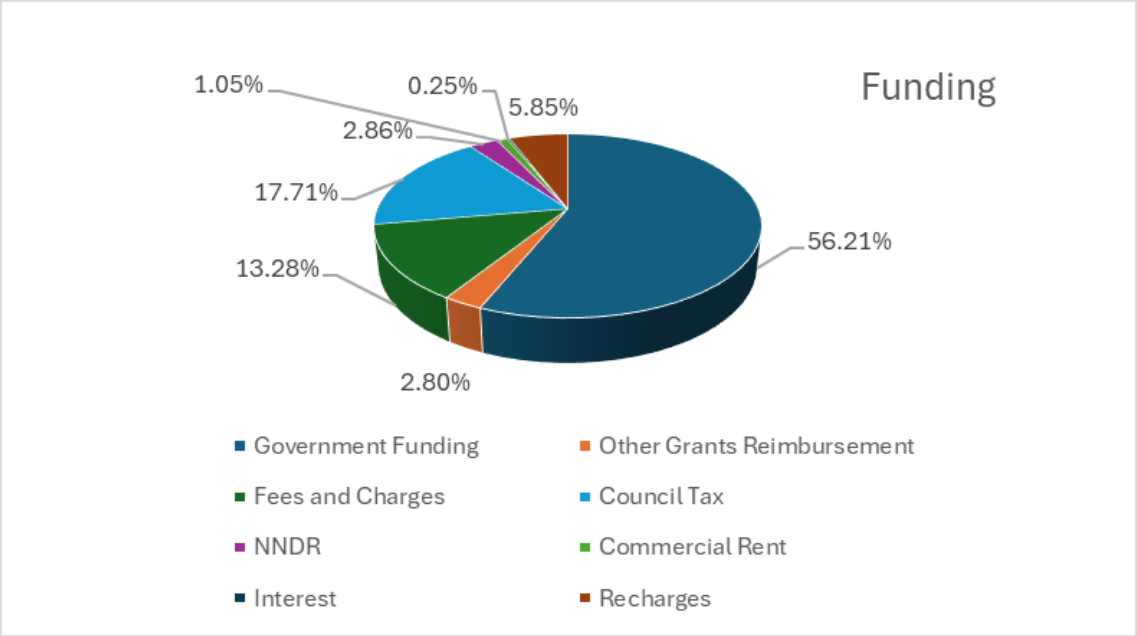
9.4 The most recently reported data shows that 22.5% of residents aged 16 to 65 were claiming Universal Credit in Haringey in Aug 2024 - over 42,000 people. 8.1% of residents aged 16+ were claiming unemployment-related benefits in Haringey in August 2024 - over 15,000 people, one of the highest figures of the last 3 years and is the third highest in the UK. One in five households have an active mortgage so may be impacted by the continuing high interest rates.

9.5 For schools, falling rolls in primary classes are adding additional pressures on stretched budgets particularly as grant income is linked to pupil numbers. Even where numbers have been relatively stable, cost inflation on key items such as utilities and building maintenance, continues to provide challenges and increasing numbers of local schools are now carrying budget deficits.

10 Revenue Budget – Income

10.1 With a statutory requirement to set a balanced budget each year, the Council's spending power is determined by its income levels. The Council's main funding sources are set out in Chart 1 and includes Government Grant, Council Tax and Business Rates, fees and charges and rental income and other partner contributions, such as from health.

Chart 1: 2024/25 Gross Income



Government Funding

10.2 Core Spending Power is used by the Government as a measure of resources available to local authorities to fund service delivery and is a combination of Government funding and Council Tax.

10.3 The provisional local government finance settlement which includes details of the level of Government funding is published in December of each year, followed by final settlements published in the February.

10.4 Financial Plans assume that Government funding for 2025/26 will be in line with that of 2024/25. However, the Autumn Budget announced £1.3bn new grant funding for local government in 2025/26, £600m of which will be earmarked for social care. While any new funding is positive, the distribution methodology is not yet known and any benefit may be offset by the impact of

increased employer NI on key service providers. A Policy document is expected to be published late November which should provide more clarity although detailed allocations will not be fully clear until the Provisional Local Government Finance settlement is published in mid/late December. Any additional funding will not meet the significant increase in financial pressures set out in this report.

10.5 Over and above the grants published in the Local Government Finance Settlement, there are a number of service specific grants which are included in individual service budgets. Financial Plans for 2025/26 also currently assume that these service specific grants continue at the same level as in 2024/25, but announcements are awaited of a number of grants where funding is at risk of stopping in 2025/26. In line with our budget principles, any reductions in Government Grant must result in an equivalent reduction in spend. Through the Autumn Statement, Government has announced £1bn to extend both the Household Support Fund and Discretionary Housing Payments (DHPs) and £69m to continue delivery of a network of Family Hubs.

Business Rates

10.6 Business rates are set nationally. The valuation of business premises is set by the Valuation Office and Government sets the multiplier which determines the pence per pound paid in tax. The Council is currently a 'top up' authority which means that it does not generate sufficient business rates income to meet the needs of residents in the borough and therefore receive a top up amount on baseline business rates funding. Each year, the business rates baseline funding is increased in line with inflation as of September which has now been published as 1.7%. With an OBR forecast inflation of 2.6% in 2025/26 just announced, any potential increase in business rates baseline funding is yet to be confirmed.

10.7 In 2024/25, Haringey is part of an eight borough Business Rates Pool with other London boroughs which is expected to generate a financial benefit of £2m. An expression of interest has been submitted by the Director of Finance to continue to participate in the 8-borough pool in 2025/26. Intentions of other participating authorities is not yet known and confirmation of the pool for 2025/26 will not be confirmed until the final Local Government Finance Settlement is published in February 2025.

10.8 The longer-term approach to business rates is under review by the Government and whether this can provide a long-term sustainable approach for funding Local Government.

Council Tax

10.9 Income collected through Council Tax is determined by the level of the tax and the council tax base.

10.10 Financial Plans currently assume that the council tax base will increase by an average of 1% in 2025/26 to reflect the Council's ambitious housebuilding programme and takes into account the number of households receiving Council Tax reduction and other discounts. The average Council Tax band is expected to remain as Band C – the average across London is a Band D.

10.11 The Council Tax referendum threshold is unlikely to be known until the Provisional Local Government Finance Settlement is published in December 2024. For planning purposes, it is assumed that the Council will be able to increase the tax by up to 2% for the Adult Social Care precept and up to 3% main Council Tax in 2025/26. Any final Council Tax increases are part of the budget setting process and agreed by Full Council each March. Through this report the financial position is presented as two scenarios – a 1.99% Council Tax increase and 4.99% increase. Each 1% increase in Council Tax generates approximately an additional £1.3m in income.

Fees and Charges

10.12 Income from fees and charges (including rents from commercial and operational properties) is around 13.3% of the Council's income. Many of these are set by Government but there are many which the Council has discretion over the level.

10.13 Each year, all fees and charges are subject to review. This review process is currently underway, and proposed changes will be approved by Cabinet in December. Every 1% increase in fees and charges equates to approximately £1.03m of additional income.

11 Revenue Expenditure

11.1 Spending patterns are volatile and each year there are new pressures. Medium term financial planning and the budget for 2025/26 aims to review both existing pressures and understand new pressures emerging to enable a budget to be set that is robust and achievable. The starting position is a review of the financial position in the previous and current financial years.

2023/24 Budget Outturn

11.2 The 2023/24 provisional General Fund outturn was an overspend of £19.2m and required a significant, unbudgeted drawdown from reserve balances. The report to Cabinet in July 2024 made clear that it was expected that a number of the service overspends would continue into 2024/25 notably in adult and children's social care and temporary accommodation. These unbudgeted spends were driven not just by demand and complexity of need but more notably due to the market conditions resulting in prices being significantly above underlying inflation. The lack of supply for temporary accommodation and placements for children with significant need exacerbated this position.

2024/25 Budget Position

11.3 Last year's 2024/25 budget preparation process had undertaken analysis to derive realistic estimates of service demands and cost of service provision across all services. However, by Quarter 1, similar to other authorities, demand and price pressures were beyond their estimates and an overspend of £20m is forecast for 2024/25, of which £14.5m (71%) is driven by adult social care and Housing demand and £4.2m relates to Children and Family services. A copy of the full report to Cabinet is here Q1 Finance Update Cabinet.

12 Approach to 2025/26 Financial Planning

12.1 Work began on a structured budget planning process for setting the 2025/26 budget early in the 2024/25 financial year. This process consists of the Council's leadership team working together to collectively understand the budget position and what is driving the spend, share information across directorates and develop a number of cross - directorate and directorate specific savings proposals to address the financial challenge.

Pressures

12.2 The existing MTFS published in March 2024 provided for £10.4m of service pressures but as set out in the paragraphs above, demand and costs are running well above this provision. Benchmarking has been used to provide the most up to date evidence and insight in the light of the pressures in the current financial year and any which will continue into future years. This has used population projections; inflation estimates and any other known factors. In order to set a balanced budget, all known financial pressures must be funded.

12.3 The estimated pressures are based on a series of assumptions with the best-known information at the current time. Many of these assumptions will carry risk and uncertainty and therefore for demand led services, such as social care and housing, scenario planning is undertaken to identify a best case and worst-case scenario before a judgement is made and forms the basis for estimating future service pressures.

12.4 This process has identified that in addition to the £10.4m known in March, an additional budget provision of £39.6m will be required for 2025/26 and £75.2m over the next five years as set out in Table 1 and Appendix 1. This significant increase since the last update in March 2024 is not new but the more robust financial modelling and forecasting that has been undertaken over the summer has identified pressures which are expected to continue into future years, as well as more realistic assumptions around inflationary impacts on the price of some services. One off funding through the use of reserves and other balances previously used to manage these pressures are now exhausted.

12.5 As expected, 80% of the new forecast budget pressures for next year relate to Adults and Children's social care and housing demand. A further 9% is associated with Housing Benefit.

12.6 Considered together with the £10.4m of pressures included in the March 2024 update, this means that in 2025/26, almost £25m will need to be built into the Adult Social Care budget, £11.5m into the housing demand budget and £6.5m into the Children and Families budget.

12.7 The estimated additional budget requirement for adult social care in 2025/26 is £25m - £9.3m identified at the last update in March 2024 and an additional £15.1m as set out in Table 1. This represents an increase in numbers supported and an average inflationary increase of 3.5%. This inflation assumption includes some risk given that in the current year, prices have increased by an average of 6.5%. The number of older people with a long-term care package is expected to increase from 1,782 in April 2024 to 2,000 on average during 2025/26. Almost 60% of the adult social care budget is spent on younger adults and numbers are assumed to increase from 1,664 with a long-term care package to 1,800, which includes 25 young people who will transition from children's services.

12.8 In 2025/26, it is assumed that £11.5m additional budget will be required for housing demand - £750,000 identified at the last update in March 2024 and the additional £10.8m as set out in Table 1. Compared to 2023/24, numbers have increased by an average of 8% in the current year and a further increase of 6% is forecast for 2025/26. However, it is largely the price of bed and breakfast and nightly paid accommodation that is driving this pressure and a 10% increase has been assumed for 2025/26 which is reflective of current market conditions.

12.9 Within Children and Family services, an additional £6.5m is expected to be needed - £660,000 identified at the last update in March 2024 and the additional £5.9m as set out in Table 1. The number of children in our care has reduced and over the last 6 months at around 64 per 10,000 (in line with statistical neighbours) - a reduction of around 100 children since 2018. However, the service continues to see an upward trend of children with more and more complex needs, needing more complex support packages and this is evidenced by the rise in the number of children with Deprivation of Liberty Orders (DOLs) where the cost of the care package can average over £10,000 per week. For these reasons we are forecasting a small rise of these very expensive placements over the next three years. An inflationary uplift of 3.5% has been assumed for 2025/26. This accounts for £3m of the additional budget requirement.

12.10 In line with the trend across the country, the number of children with Education, Health and Social Care Plans continues to increase and in 2025/26, the Council is expecting to have 3,200 active care plans in place. Although the cost of the support is funded through the Dedicated Schools Grant, there are a number of associated costs, such as home to school transport and educational psychologist support that falls to the General Fund. An additional £2.7m is expected to be needed in 2025/26.

12.11 The pressure highlighted in Environment and Resident Experience relates to challenges around management of housing benefits particularly supported exempt accommodation and the transition to Universal Credit. The pressure is forecast as one-off, with management actions expected to remove the pressure across the MTFS period.

12.12 All assumptions will remain under review over the next few months as new information emerges and the budget for 2025/26 can be set on the most up to date, realistic and reliable estimates of service pressures.

Table 1 – Additional Forecast Service Pressures 2025/26 (over and above £10.4m assumed in March 2024).

Pressures						
Directorate	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2029/30**	**Total**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Children's Services	5,858	2,816	2,172	1,772	1,680	14,298
Adult Social Services	15,160	930	7,210	7,200	6,920	37,420
Housing Demand	10,797	3,000	2,000	2,000	1,000	18,797
Environment and Resident Experience	3,500	(1,000)	0	(2,000)	0	500
Culture Strategy and Engagement	619	77	23	23	23	765
Finance Procurement and Audit	0	0	0	0	0	0
Placemaking and Housing	3,700	0	0	0	0	3,700
Cross Cutting Reductions	0	0	0	0	0	0
Total	**39,634**	**5,823**	**11,405**	**8,995**	**9,623**	**75,480**

12.13 Although the latest reported CPI inflation rate of 1.7% (September) appears to have stabilised close to the Government target of 2%, many of the Council's suppliers are charging above these rates. This is particularly notable in the care services and temporary accommodation where prices are also being driven upwards by lack of supply. Forecasting the impact on 2025/26 budget figures is challenging as it needs to also encompass the

forecasts for changes in client numbers, complexity of care needs and changes to how key partners operate of align their budgets.

12.14 The latest forecasts have been used as a basis for the estimates for next year included in this budget update. These estimates have been based on average 3.5% inflation for the care services and 10% for housing demand contracts. It is highly likely that these forecasts will need to be amended before the final 2025/26 Budget is presented in February 2025 and may lead to increases to budget requirement.

12.15 The 2024/25 pay award has now been settled – a flat rate of £1,491 for all those on NJC Terms and Conditions and 2.5% for all other grades from 1 April 2024. The Government's acceptance of the independent Pay Review Body recommendations which translated into pay uplifts averaging 5.5% for public sector workers means there is a risk that the Local Government sector will be pressing for similar levels of increase in future years. Financial Plans assume a 3% increase for 2025/26.

12.16 Assumptions around the inflationary impact for key council contracts including waste, highways maintenance and utilities have been refreshed and changes reflected in the draft figures presented in this report. Many of these contract increases are pegged to September inflation rates so little further movement is expected on these estimates. However, for utilities, the position is much more volatile and estimates for these budgets are expected to need to increase ahead of the final Budget presented in February. Financial Plans currently assume a 5% increase on utility contracts.

12.17 The Bank of England base interest rate was reduced by 0.5% in August. Forecasts vary over the speed of any further reductions and decisions could be influenced by the market response to the Budget statement on 30 October. A prudent assumption has been made at this point which assumes the rate will remain at or around 5% across the 2025/26 financial year. This makes it even more important to generate savings to the capital programme that require council borrowing.

12.18 All other key corporate budgets have been reviewed. Concessionary Fare forecasts for 2025/26 are largely in line with the current MTFS however there looks to be significant step up from 2026/27 as passenger numbers return from the Covid pandemic dip. The North London Waste Levy (NLWA) is the most significant levy, but it is currently too early to update current assumptions with any certainty. An update on all levies is expected before the end of December 2024.

12.19 The Council has a Treasury Management Strategy Statement (TMSS) that sets out in detail the Council's approach to managing its cash flows, borrowing and investment activity, and the associated risks. Treasury management is the management of the Council's investments, cash flows, its banking and capital market transaction and the effective control of the risks associated with those activities. Surplus cash is invested until required

in accordance with the guidelines set out in the approved TMSS, whilst short term liquidity requirements can be met by short term borrowing from other local authorities. The TMSS for 2025/26 will be considered by Audit Committee in January 2025 for recommendation for approval by Full Council in March 2025. The TMSS will also be considered by Overview and Scrutiny Committee in January as part of the budget scrutiny process and in accordance with the CIPFA Treasury Management Code of Practice.

Budget Reductions

12.20 Given the increase in pressures highlighted above, the budget gap for 2025/26 increases from £14m forecast in March 2024 to £51.4m before any mitigations. The Council must significantly reduce its expenditure in the current year, for next year and across the medium term if it is to meet the future financial challenge.

12.21 In the current year, all services are reviewing non essential spend to bring down the forecast overspend of £20m and updates will be included in the 2024/25 quarterly monitoring reports. At the same time, proposals for reducing spend and increasing income for 2025/26 have been considered.

12.22 Directorates were tasked initially with a number of key tasks across all revenue and capital budgets including:

- Benchmarking against other councils who are providing key services at lower costs;
- Consider as to how services could be delivered within a smaller envelope; what would need to change; how services would be impacted.

12.23 In total £18.8m of proposed reductions have been identified. These are a combination of proposed savings and management actions. Savings are defined as those which could have an impact on service delivery and management actions are more focussed around internal inefficiencies which do not impact on outcomes for residents and will be delivered by generating increased income, introducing efficiencies to existing processes to release resource or redesign of how services are currently delivered.

12.24 Proposed reductions are summarised in Table 2,3 and 4 below and set out in full in Appendix 2 including any expected impact on current service delivery, equality impact or consultation requirements.

Table 2 – Proposed Savings 2025/26 to 2029/30

Savings						
Directorate	**2025/26 £000s**	**2026/27 £000s**	**2027/28 £000s**	**2028/29 £000s**	**2029/30 £000s**	**Total**
Children's Services	(25)	0	0	0	0	(25)
Adult Social Services	(651)	(979)	(335)	(450)	0	(2415)
Housing Demand	(412)	0	0	0	0	(412)
Environment and Resident Experience	(1,200)	(200)	0	0	0	(1,400)
Culture Strategy and Engagement	(460)	(2,000)	(2,100)	(125)	0	(4,685)
Finance Procurement and Audit	0	0	0	0	0	0
Placemaking and Housing	0	0	0	0	0	0
Cross Cutting Wide Reductions	0	0	0	0	0	0
Total	**(2,748)**	**(3,179)**	**(2,435)**	**(575)**	**0**	**(8,937)**

Table 3 – Proposed Management Actions 2025/26 to 2029/30

Management Action						
Directorate	**2025/26 £000s**	**2026/27 £000s**	**2027/28 £000s**	**2028/29 £000s**	**2029/30 £000s**	**Total**
Children's Services	0	0	0	0	0	0
Adult Social Services	0	0	0	0	0	0
Housing Demand	0	0	0	0	0	0
Environment and Resident Experience	(2,614)	0	0	0	0	(2,614)
Culture Strategy and Engagement	(26)	0	0	0	0	(26)
Finance Procurement and Audit	0	(32)	0	0	0	(32)
Placemaking and Housing	0	0	0	0	0	0
Cross Cutting Wide Reductions	(13,410)	(4,450)	(3,800)	0	0	(21,660)
Total	**(16,050)**	**(4,482)**	**(3,800)**	**0**	**0**	**(24,332)**

Table 4 – Total proposed savings and management actions 2025/26 to 2029/30

Total (Savings and Management Actions)						
Directorate	**2025/26 £000s**	**2026/27 £000s**	**2027/28 £000s**	**2028/29 £000s**	**2029/30 £000s**	**Total**
Children's Services	(25)	0	0	0	0	(25)
Adult Social Services	(651)	(979)	(335)	(450)	0	(2,415)
Housing Demand	(412)	0	0	0	0	(1,112)
Environment and Resident Experience	(3,814)	(200)	0	0	0	(4,014)
Culture Strategy and Engagement	(486)	(2,000)	(2,100)	(125)	0	(4,711)
Finance Procurement and Audit	0	(32)	0	0	0	(32)
Placemaking and Housing	0	0	0	0	0	0
Cross Cutting Wide Reductions	(13,410)	(4,450)	(3,800)	0	0	(21,660)
Total	**(18,798)**	**(7,661)**	**(6,235)**	**(575)**	**0**	**(33,269)**

12.24 The above proposed reductions are on top of previously agreed proposals and the current assumption is that the £8.6m of savings approved in March 2024 for the year 2025/26 and £19.1m across 2025/26 to 2028/29 will be delivered in full, albeit there may be some delay in full delivery. This assumption will be tested ahead of the February report and alternative savings will need to be identified for any which are now non-deliverable.

13 Updated 2025/26 Financial Position

13.1 Table 5 shows the budget gap still remaining after corporate budget adjustments, updates to funding assumptions, recognition of forecast service pressures and application of all new savings and management actions.

13.2 The review of the corporate budgets has identified £1.3m of additional budget will be required in 2025/26. This is a combination of a change in the funding arrangements of spend previously funded by the Dedicated Schools Grant but which will now be funded by the General Fund, historic unfunded pension costs and an increased provision for the funding of redundancy costs that are likely to result from the 5% reduction in staffing that is proposed.

13.3 At this point work is still being undertaken to understand the impact of the September CPI figure and also analysis of potential to continue to participate in the 8 Authority Pool next year. An update will be provided in the next report to Cabinet in December 2024.

Table 5 – Forecast Budget Gap 2025/26

	2025/26 £'000
Budget Gap (as at March 2024)	13,999
Review of Corporate Budget assumptions	1,342
Additional income from 4.99% Council Tax increase	(4,059)
Additional forecast service pressures	39,634
New savings and Management Actions	(18,798)
Revised Gap (as at November 2024)	**32,100**

13.4 This means that the Council still has at least £32m of budget reductions to identify before a balanced budget for 2025/26 can be approved in March 2025 and this assumes that all the proposed budget reductions set out in this report are agreed following the consultation period. Any reductions not taken forward following consultation will need to be replaced with alternative savings on a £ for £ basis.

13.5 All services must continue to identify additional budget reduction proposals. The focus will be on efficiencies and management actions and mitigations to reduce the £39.6m of demand pressures that do not impact on outcomes for residents but with a gap remaining of this size, reductions in service provision cannot be ruled out at this stage.

13.6 The next update will be presented to Cabinet on 12 December 2024, which will also include any detailed financial implications for Haringey from the Budget Statement on 30 October if more becomes known when the Policy Statement is published by Government in November.

14 Financial Position for 2026/27 Onwards

14.1 The focus of this report has been on preparations for the 2025/26 budget but a review of the assumptions across the next five years has also been undertaken.

14.2 Financial planning across the medium term is more difficult for the reasons set out in the report but the latest position shows that assuming a balanced budget is set for 2025/26, there will remain an estimated cumulative budget gap of £132.8m by 2029/30.

14.3 The key drivers of this cumulative budget gap are the estimated year on year increasing costs of providing demand led services; estimated inflationary provisions; corporate pressures such as capital financing costs and North London Waste Authority levy increases. Finally, an increase in the corporate contingency to provide against known risks in respect of both expenditure and income.

14.4 This forecast gap is based on the best estimates at this stage and includes:

- Government funding remains in line with 2024/25 allocations.
- Service demand pressures of £38.4m (2026/27-2029/30).
- Pay and price inflation of 2%.
- Interest rate of borrowing costs of 5%.
- Council Tax base increase of 1% and Council Tax level increase of 1.99%.
- Delivery of £10.5m of savings for 2026/27 to 2028/29 that have been previously approved.
- Corporate Contingency remains at £10m.

14.5 Over the course of the MTFS, these estimated pressures are reduced by previously agreed / proposed savings. These estimated pressures and savings are summarised in Table 6.

Table 6 - Budget Gap 2026/27 to 2029/30

Type	2026/27	2027/28	2028/29	2029/30
	£'000	£'000	£'000	£'000
Pressures	46,865	40,832	32,600	36,907
Agreed Saving's	(2,848)	(3,292)	(3,022)	0
Proposed Saving's	(8,677)	(6,440)	(125)	0
Cumulative Total	**35,340**	**66,440**	**95,893**	**132,800**

14.6 Like 2025/26, the number of people requiring Council support is expected to continue to increase over the next five years. Addressing a budget gap of this scale will require a more fundamental review of Council services to determine which and how services are provided rather than the more traditional salami slicing across all budgets. In the future, not everything may be affordable, and the Council's limited financial resources will need to continue to be prioritised to the most vulnerable and ensure all spend is aligned to the priorities as set out in the Borough Vision and Corporate Delivery Plan. This may mean spending more in some areas of greater need and priority and more significant reductions in other areas.

14.7 Budget planning for these future years will need to commence shortly. This will continue to identify efficiencies across all services, and this will be an integral part of the annual financial planning process because the Council will need to continue to demonstrate that every £ spent is offering the best value for money. The transformational changes that are also needed take longer to identify and implement and will focus around the following areas.

Prevention and Early Intervention.

14.8 Reducing the high expected demand for social care and housing services expected over the medium term, it is critical that the Council has a greater focus on prevention and early intervention. There is evidence that supporting people at an earlier stage leads to better outcomes for the individuals as well as reducing costs to the Council.

Commercialisation and Income Generation.

14.9 Increasing income provides an opportunity to protect the Council's spending on priority services and contributes to closing the budget gap. An annual review of fees and charges to reflect full cost recovery will be undertaken and will include an improvement in internal processes to ensure income due can be collected as well as making it easier for residents, businesses and visitors to make payment through increased use of technology and digital channels. However, commercialisation is more than just fees and charges. This will focus on how the Council can generate additional revenue through greater utilisation of its assets and services, through partnership and shared working across the public and the private sector, maximising opportunities for external funding and considering alternative arrangements for protecting service delivery such as shared services.

Commissioning and Procurement

14.10 The budget proposals put forward in this report are expected to deliver £6m of reductions across services over the next three years as a result of improved commissioning and procurement arrangements. On average 55% of the Council's day to day spend is with external organisations, including the

voluntary and community sector. Improvements continue to ensure there is a comprehensive contracts register is in place. Over the next few months, work will be undertaken to analyse this register, identify contracts that are due for re-tender over the next three years and opportunities to be more ambitious in the spending reductions that can be achieved. This will include joint commissioning across services where opportunities arise.

15 Capital Programme Update

15.1 The current capital programme was agreed in March 2024, and both spend and delivery continues to be monitored quarterly and reported to Cabinet. The latest update is the Quarter 1 report and forecasts the Council is expected to spend £120m in 2024/25 and £584m over the next five years, investing in schools, highways and transport, the environment and housing as well as maintenance of the commercial and operational estate.

15.2 Like most authorities, this capital investment requires a level of borrowing for which borrowing costs need to be funded through the Council's revenue budget, allowing for the interest on the borrowing and the repaying the debt (known as the minimum revenue provision). The current programme in 2024/25 assumes that 55% is funded through borrowing and the revenue budget includes £17.4m of borrowing costs.

15.3 With interest rates remaining high in the short term at least, it is essential that levels of borrowing are kept to a minimum. It is estimated that for every £1m of capital expenditure that is through borrowing the Council has to budget £72,000 per annum to pay the interest and repay the debt.

15.4 The Council will continue to identify external funding that can be utilised to fund the capital programme to reduce the need for borrowing, including grants and other contributions such as Section 106, CIL and the contributions parking income can make to eligible spend within the programme on essential maintenance to roads and other transport schemes across the borough.

15.5 The Council is currently reviewing its Capital Strategy, and this will be published as part of the 2025/26 suite of budget reports in February 2025. This strategy will set out the approach for determining the Council's capital investment ambitions and will be informed by the Council's Asset Management Strategy which details service asset needs to deliver the priorities set out in the Corporate Delivery Plan. The strategy will also include the outcome of the review of governance which is currently underway to ensure the capital programme agreed each year is deliverable and affordable and there is a clear framework in place for tracking progress and adopting a forward planning approach with an aspiration to focus on a ten-year planning period.

15.6 Given the Council's challenging financial position, over the summer the existing capital programme has been reviewed to ensure that the schemes within it continue to contribute to the Corporate Delivery Plan and are essential. As a result of this exercise, there are a number of schemes that are proposed for removing from the existing programme and these are summarised in Table 7 and set out in detail in Appendix 3.

15.7 Each year, there will also be a need for new capital investment and for 2025/26 this has been limited to only essential spending required for health and safety, maintenance and maintaining essential services and largely relates to the maintenance of the Council's highways infrastructure, operation and commercial estate. Capital investment can provide opportunities to delivery revenue savings or additional income and for 2025/26, it is proposed to invest in the Council's digital technology which will improve the efficiency across a range of services as well as improve the customer experience. Full details are set out in Appendix 3.

Table 7 – Proposed changes to the Capital Programme 2025/26 to 2028/29

Directorate	Existing Budget	Reductions	Increases	Revised Budget	Movement	
	(£'000)	(£'000)	(£'000)	(£'000)	(£'000)	%
Adults, Health & Communities	62,184	(47,188)	5,000	19,997	(42,188)	(68%)
Children's Services	59,728	0	0	59,728	0	0%
Culture, Strategy & Engagement	105,490	(1,540)	2,965	116,915	11,425	11%
Environment & Resident Experience	154,825	(69,047)	34,651	120,429	(34,396)	(22%)
Placemaking & Housing	344,713	(19,742)	13,247	338,218	(6,495)	(2%)
Corporate Contingency			10,000			
	726,941	**(137,517)**	**65,863**	**655,287**	**(71,654)**	**(10%)**

15.8 The proposed schemes to be removed from programme includes the Tottenham Hale and Wood Green Decentralised Energy Networks (DEN). These schemes are currently funded through a combination of Government grant (£12.3m), Government Loans (£13.3m), Strategic CIL (£3.2m) and Council borrowing (£44.6m). Given the Council's current financial position, the current Council led delivery model is no longer viable. Discussions are underway with Department of Energy Security and Net Zero (DESNZ) on the future scope of these schemes to eliminate the financial dependency on the Council whilst still supporting the Government's emerging policy on Heat Zoning. This scheme will therefore be removed from the programme at this stage. Any future council funded capital requirement will be considered as part of future annual reviews of the Capital Programme and affordability will need to be considered alongside all other Council priorities for future capital investment.

15.9 Given the more unpredictable nature of capital spending plans, the delivery plans and the profile of spend over the capital programme period will all be subject to review over the next few months and will determine the level of borrowing required both in 2025/26 and over the five year MTFS period.

15.10 Only schemes which are sufficiently developed, have approved outline business cases and have been subject to internal governance and decision making processes will be included in the capital programme going forward and will be presented as either 'in delivery' or 'planned delivery' over the five year capital programme period. All other schemes will be held in the 'pipeline' and reviewed as part of the review of the capital programme each year.

15.11 There are significant levels of salary capitalisation within the capital programme to deliver the schemes. As the capital programme reduces there is a risk that the level of capitalised salaries will be unachievable, creating a pressure on revenue.

15.12 To manage a level of uncertainty with schemes, including inflation and other essential repairs, maintenance or health and safety requirements, it is proposed to increase the capital programme contingency by £5m in 2025/26 and 2026/27.

15.13 The proposed schemes for removing and adding to the capital programme set out in Appendix 3 will be subject to the same consultation process as the revenue proposals. The full updated draft capital programme will be published in February 2025 as part of the suite of budget reports for recommendation for approval at full Council on 3 March 2025 and will take into account any feedback received.

16 HRA Update

16.1 This update on Financial Plans is primarily focussed on the Council's General Fund. A separate process is underway for reviewing the Housing Revenue Account (HRA) 30 year Business Plan and developing the draft revenue budget and capital programme for 2025/26. This will be presented to the Housing, Planning and Development Scrutiny Panel before being presented to Cabinet in February and for recommending to Council for approval on 3 March 2025.

16.2 The financial position of the HRA remains very challenging, particularly in the short term whilst the Council's new build programme and investment into existing stock is underway which longer term will increase the supply of permanent housing across the borough. Therefore, the work continues to identify efficiencies and opportunities to delay borrowing for the HRA capital programme to improve the position over the next two to three years.

17 DSG Update

17.1 For schools, the indicative 2025/26 Dedicated Schools Budget (DSB) funding, which is ring fenced for the delivery of education services, is not yet known. Funding for 2024/25 totals £230m. In July 2024 the Education and Skills Funding Agency (ESFA) reported that due to the timing of the general election they were not in a position to publish indicative schools and high needs national funding formula (NFF) allocations for 2025/26.

17.2 The actual grant level for schools is dependent on updated pupil census numbers and the final schools finance settlement for 2025/26 is expected in December 2024 and to include allocations of the additional £1bn that was announced by Government for SEND and alternative provision as part of the budget on 30 October.

17.3 In March 2023, Haringey was successful in joining the Department for Education (DfE) Safety Valve Programme, which targets local authorities with the highest DSG deficits to identify transformation plans to bring spend more in line with agreed budgets over the short to medium term, in return for support to deal with historic deficits. Pressures are predominately in the high needs block with progress against agreed plans being monitored through quarterly finance update reports.

17.4 The draft DSG budget will be included in the report to Cabinet in February 2025 and will be in line with the expectations of the Safety Valve programme where the successful delivery of the programme will result in funding being released by DfE to support the reduction of the deficit and bringing the High Needs Block into balance by 2027/28.

18 Risk Management

18.1 The Council has a risk management strategy in place and operates a risk management framework that aids decision making in pursuit of the organisation's strategic objectives, protects the Council's reputation and other assets and is compliant with statutory and regulatory obligations.

18.2 The Council recognises that there will be risks and uncertainties involved in delivering its objectives and priorities, but by managing them and making the most of opportunities it can maximise the potential that the desired outcomes can be delivered within its limited resources more effectively.

18.3 There is a need to plan for uncertainty as the future is unknown when formulating the budget. This is achieved by focussing on scenario planning which allows the Council to think in advance and identify drivers, review scenarios and define the issues using the most recent data and insight.

18.4 The Council's Section 151 Officer has a statutory responsibility to assess the robustness of the Council's budget and to ensure that the Council has sufficient contingency/reserves to provide against known risks in respect of both expenditure and income. This formal assessment will be made as part of the final report on the Council's budget in February 2025 and will draw on independent assessments of the Council's financial resilience where available. It is critical that this report outlines the number and breadth of potential risks and uncertainties the council faces when arriving at the budget proposals.

18.5 Risks and uncertainties currently known are set out in the following paragraphs.

Government Funding and Legislation

18.6 There will be a one-year funding settlement for 2025/26 and a multiyear review to begin and conclude by Spring 2025. Thereafter, Spending Reviews are expected to be published every 2 years, with a 3-year outlook. The level of Government funding available for Local Authorities and for Haringey is therefore still not known. The current working assumption is that any new Government funding for 2025/26 will be insufficient which is significant challenge given the current volatile economic situation and with demand increasing across many services, most notably social care and temporary accommodation.

18.7 It remains unclear if planned reforms and changes in legislation of the previous Government will by pursued by the new Government or if there will be new legislation that increases the responsibilities of Local Authorities. This includes the long-awaited fair funding review and business rates reform and reforms in social care and housing. Financial Plans currently assume that any changes in legislation and additional requirements will be fully funded but this is a risk to the current financial position.

Inspection and Regulation

18.8 Local Authorities are subject to increasing inspection and regulation, including by Ofsted, CQC and the Regulator of Social Housing as well as additional requirements that have emerged from the Grenfell Inquiry report. All of these could have financial implications for the Council which are not yet known.

Economic Conditions

18.9 The Office for Budget Responsibility published the latest forecast for inflation and interest rates on 30 October 2024. Inflation has reduced compared to the last couple of years, but the OBR forecast is still 2.6% for 2025/26 and will not return to 2% until 2029. It should also be noted that national inflation figures are not always reflected in cost of services, such as social care so there remain a risk that the forecast additional budget assumed in this report for pay and price is not sufficient. Volatility is likely to continue for some time

from the on-going impact of wars and unrest internationally which will impact on the Council's cost of services and supply chains.

18.10 The high cost of living continues to impact on many of our residents which results in more requiring support from the Council, particularly with housing support. A project is underway to review the early intervention and prevention support across the Council for those residents most at risk of facing financial hardship.

Estimate of Pressures for 2025/26

18.11 The update in this report uses the best known information for demand and other service pressures in 2025/26 and has been based on the outturn position in 2023/24 and the latest in year monitoring position. There is a risk that the in year monitoring position could worsen when the quarter 2 report is published with further overspends continuing into 2025/26. In addition, the 2023/24 accounts are currently subject to External Audit and therefore the outturn position for last year remains provisional until the process is complete.

18.12 The £39.6m identified in Table 1 is based on a series of assumptions that will continue to be reviewed over next few months and therefore the position for 2025/26 is subject to change. All services are considering actions and mitigations that continue to support the needs of our most vulnerable but in a more cost effective way to reduce these future pressures. However, small scale changes in these areas are not going to be sufficient and will require more fundamental changes in how we deliver these services and with a focus on prevention and early intervention which will take time to have an impact. Sufficient pace is needed to make these changes. Short term solutions are still needed for the 2025/26 budget to be sustainable.

18.13 There are also some budget increases that will not be known until later in the year, such as the increase of levy payments. Financial Plans currently assume minimal increase.

Identifying and Delivery of Budget Reductions

18.14 As set out in this report, a significant budget gap for 2025/26 remains and work is continuing to identify additional savings and actions to mitigate the significant additional budget required to meet demand pressures. The focus will be on identifying efficiencies that improve processes and no impact on outcomes for residents but there is a risk that these will not be sufficient and some service reductions may be required for a balanced budget to be set.

18.15 The financial position and budget gaps set out in this report assume that all savings in 2024/25, previously approved savings and any new savings for 2025/26 when the budget is approved in March 2025 are delivered in full. In

advance of the full draft budget being presented to Cabinet in February 2025, all assumed savings will need to have full delivery plans in place that provide assurance on delivery.

Changes in Accounting Practice

18.16 The Dedicated Schools Grant (DSG) currently has a statutory override which allows the Council to separate DSG deficits from local authority reserves which is in place until March 2026. Funding arrangements are not known after 2026 and there is a risk that this deficit will fall to the Council to fund from its own reserves. The Safety Valve programme is delivering well to reduce the spend on the high needs block and is in line with the agreed timetable but at the same time the Council continues to see increases in the number of children with Education Health and Social Care Plans over and above what had been assumed when agreeing the programme with the DfE. The Council's low level of reserves will make it particularly challenging if the funding of the DSG deficit falls to the Council after 2026 and work will continue with the DfE to find a longer-term solution to funding for schools and high needs.

18.17 To recognise the financial impact of risks facing the Council and manage this uncertainty it is vital that adequate reserve levels are maintained and the budget each year includes a level of contingency. The current level of reserves is lower than the Council would want, and the aim is to increase levels over the course of the MTFS and where there is an unplanned drawdown of reserves they will need to be replenished.

Reserves and Contingency

18.18 The Councils corporate contingency budget for 2025/26 will be set at £10m, an increase of £3m from the previous year. The General Fund reserve will be maintained at £15m, with other reserves totalling £52.3m in March 2024.

18.19 Based on known commitments this year, the forecast balance for March 2025 on reserves is £43.5m as shown in Table 8 below. This assumes no further drawdown in 2024/25 to fund the current overspend which is a significant risk. A number of the reserves are committed or not available and therefore the General Fund balance of £15.1m and the £3.3m of reserves is a more realistic assumption of what is available to use to manage risks and uncertainties. This represents only 5.4% of the net budget which is an unsustainable level and given the current in year overspend forecast for 2024/25.

18.20 Therefore, any use of reserves to balance the budget next year is not a viable option and across the medium term there will need to be a planned replenishment of reserves to a more sustainable level. Replenishment means making an annual contribution to reserves included in the budget agreed in March each year. Given the significant budget gap that remains for 2025/26, any replenishment will commence from the 2026/27 budget.

18.21 A full five-year review on reserve balances and a five-year forecast will be included in the Budget report to Cabinet in February 2025.

Table 8: Reserves for 2024/25 and 2025/26

	Actual March 2024 £'000	March 2025 Forecast £'000
General Fund Reserve	15,140	15,140
Risks and Uncertainties		
Transformation Reserve	5,037	3,073
Labour market resilience reserve	230	230
Budget Planning reserve	5,096	0
Collection Fund	1,231	0
Total Risk and Uncertainties	**11,594**	**3,303**
Contracts and Commitments		
Services Reserve	11,747	11,707
Unspent grants reserve	12,706	12,302
PFI lifecycle reserve	5,533	5,533
Debt Repayment Reserve	1,072	1,072
Insurance Reserve	7,234	7,234
Schools Reserve	2,400	2,400
Total Contracts and Commitments	**40,692**	**40,248**
Grand Total	**52,286**	**43,551**

19 Consultation and Scrutiny

19.1 The Council, as part of the process by which it sets its budget, seeks the views and opinions of residents and businesses on the draft budget and the proposals within it.

19.2 This consultation and engagement exercise will begin following the Call In period and will conclude on 2nd January 2025. The results will be shared with Cabinet so they can be taken into consideration in the setting of the final budget and the implementation of budget decisions.

19.3 There needs to be considerable further work undertaken between now and the issue of the Budget report in February 2025 to present a balanced Budget to be agreed.

19.4 Therefore, while this year's Budget consultation and engagement process will include budget proposals described in this report, it must be recognised that there will be significant additional proposals required to balance the budget, after the Budget consultation document has been issued but before the consultation closes. The consultation will focus on proposals which most directly impact residents and will allow responders to share how they believe they will be impacted and also any ideas they have for ways the council might bridge the budget gap.

19.5 Statutory consultation with businesses and engagement with partners will also take place during this period and any feedback will be considered and, where agreed, incorporated into the final February 2025 report.

19.6 Additionally, the Council's budget proposals will be subject to a rigorous scrutiny review process which will be undertaken by the Scrutiny Panels and Overview and Scrutiny Committee from November to January. The Overview and Scrutiny Committee will then meet in January 2025 to finalise its recommendations on the budget package. These will be reported to Cabinet for their consideration. Both the recommendations and Cabinet's response will be included in the final Budget report recommended to Full Council in March 2025.

19.7 Finally, the consultation when published will be clear in the report which proposals it is anticipated would be subject to further, specific consultation as they move towards implementation.

20 Contribution to the Corporate Delivery Plan 2024-2026 High level Strategic outcomes

20.1 The Council's draft Budget aligns to and provides the financial means to support the delivery of the Corporate Delivery Plan outcomes.

21 Carbon and Climate Change

21.1 There are no direct carbon and climate change implications arising from the report.

22 Statutory Officers comments (Director of Finance, Head of Procurement, Assistant Director of Legal and Governance, Equalities)

Finance

22.1 The financial planning process ensures that the Council's finances align to the delivery of the Council's priorities as set out in the Borough Vision and Corporate Delivery Plan. In addition, it is consistent with proper

arrangements for the management of the Council's financial affairs and its obligation under section 151 of the Local Government Act 1972.

22.2 Ensuring the robustness of the Council's 2025/26 budget and its MTFS 2024/25 – 2028/29 is a key function for the Council's Section 151 Officer (CFO). This includes ensuring that the budget proposals are realistic and deliverable. As the MTFS report is primarily financial in its nature, comments of the Chief Financial Officer are contained throughout the report.

22.3 The formal Section 151 Officer assessment of the robustness of the council's budget, including sufficiency of contingency and reserves to provide against future risks will be made as part of the final budget report to Council in March 2025.

22.4 The removal of the DEN projects from the capital programme and the pivot to an alternative solution may trigger a clawback of grant spent to date. Officers are discussing the change of strategy with the relevant government department to minimise the risk of clawback.

Procurement

22.5 Strategic Procurement have been consulted in the preparation of this report and will continue to work with services to enable cost reductions. Strategic Procurement note the recommendations in section 3 of this report do not require a procurement related decision.

Assistant Director of Legal & Governance

22.6 The Local Authorities (Standing Orders) (England) (Regulations) 2001 and the Budget and Policy Framework Procedure Rules at Part 4 Section E of the Constitution, set out the process that must be followed when the Council sets its budget. It is for the Cabinet to approve the proposals and submit the same to the Full Council for adoption in order to set the budget. However, the setting of rents and service charges for Council properties is an Executive function to be determined by the Cabinet.

22.7 The Council must ensure that it has due regard to its public sector equality duty under section 149 of the Equality Act 2010 in considering whether to adopt the recommendations set out in this report.

22.8 The report proposes new savings proposals for the financial year 2025/26, which the council will be required to consult upon and ensure that it complies with the public sector equality duty.

Equality

22.9 The Council has a public sector equality duty under the Equality Act (2010) to have due regard to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;

- Advance equality of opportunity between people who share those protected characteristics and people who do not;
- Foster good relations between people who share those characteristics and people who do not.

22.10 The three parts of the duty apply to the following protected characteristics: age, disability, gender reassignment, pregnancy/maternity, race, religion/faith, sex and sexual orientation. Marriage and civil partnership status apply to the first part of the duty.

22.11 Although it is not enforced in legislation as a protected characteristic, Haringey Council treats socioeconomic status as a local protected characteristic.

22.12 This report details the draft budget proposals for 2025/26 and MTFS to 2029/30, including budget adjustments and capital proposals.

22.13 The proposed decision is for Cabinet to note the budget proposals and agree to commence consultation with residents, businesses, partners, staff and other groups on the 2025/26 Budget and MTFS. The decision is recommended to comply with the statutory requirement to set a balanced budget for 2025/26 and to ensure the Council's finances on a medium-term basis are secured through the four-year Medium-Term Financial Strategy.

22.14 Existing inequalities have widened in the borough in recent years because of the COVID-19 pandemic, national economic challenges, and persistently high inflation, with adverse impacts experienced by protected groups across many health and socioeconomic outcomes. Due to high inflation in the last two years, many residents are finding themselves less well off financially and more are experiencing, or on the periphery of, financial hardship and absolute poverty. Greater socioeconomic challenge in the borough drives demand for the Council’s services, which is reflected in the impacts on spend for adult social care, children’s services and temporary accommodation detailed elsewhere in this report.

22.15 A focus on tackling inequality underpins the Council's priorities and is reflected in the current Corporate Delivery Plan. Despite the significant financial challenge outlined in this report, the Council is committed to ensuring resources are prioritised to meet equality aims.

22.16 During the proposed consultation on Budget and MTFS proposals, there will be a focus on considering the implications of the proposals on individuals with protected characteristics, including any potential cumulative impact of these decisions. Responses to the consultation will inform the final package of savings proposals presented in February 2025.

22.17 Savings proposals identified between the publication of this report and the final package of proposals identified in February 2025 will undergo an equalities screening process to identify where negative impacts on protected

groups may arise. Where such potential impacts are identified, a full Equalities Impact Assessment will take place to understand the impacts in full and describe the actions to mitigate those impacts. At this stage, the assessment of the potential equalities impacts of decisions is high level and, in the case of many individual proposals, has yet to be subjected to detailed analysis. This is a live process, and as plans are developed further, each service area will assess their proposal's equality impacts and potential mitigating actions in more detail.

22.18 Initial Equality Impact Assessments for relevant savings proposals will be published in February 2025 and reflect feedback regarding potential equality impacts gathered during the consultation, where proposals are included. If a risk of disproportionate adverse impact for any protected group is identified, consideration will be given to measures that would prevent or mitigate that impact. Final EQIAs will be published alongside decisions on specific proposals. Where there are existing proposals on which decisions have already been taken, existing Equalities Impacts Assessments will be signposted.

23 Use of Appendices

Appendix 1 Forecast Budget Pressures 2025/26
Appendix 2 Summary of new proposed savings and management actions
Appendix 3 Summary of proposed changes to the Capital Programme 2025/26 to 2029/30

24 Background papers

None

2025/26 Forecast Budget Pressures **Appendix 1**

Directorate	Service	Description	2025/26 Forecast Pressure (£'000)
Culture, Strategy and Engagement	Digital Services	Additional essential IT and digital costs to protect against cyber security and licensing costs,	545
Culture, Strategy and Engagement	Human Resources	Additional cost of Disclosure and Barring Service checks and reduction in the income budget to reflect lower levels of income from schools than expected.	74
Placemaking and Housing	Assets – operational estate	The increase budget will address the current overspend in running costs of the Council's operational estate, including repairs and maintenance, utility costs and business rates.	2,200
Placemaking and Housing	Strategic Asset Management	The Strategic Asset Management Team are currently funded through one off funding that is due to end in March 2025 and therefore ongoing funding of the team means alternative funding is required in the base budget. A further review of resource requirements of the team will be undertaken in 2025/26.	1,500
Children and Family Services	Education Psychology Service (EPS)	Loss in funding through the reclassification of the High Needs Block funding (HNB). The HNB can no longer be used to support EPS statutory Service and there is a need for an increase in staff numbers to meet increase in demand.	860
Children and Family Services	Education, Health and Social Care Plans	Loss in High Need Block Funding as HNB can no longer contribute towards a Statutory Assessment Team and there is a need for an increase in staff numbers to meet increase in assessments.	475
Children and Family Services	Home to School Transport	Increase in the number of children requiring home to school transport and increase in the price of transport.	1,439
Children and Family Services	Children's Social Care	Increase in the number and cost of high-cost placements to support looked after children and those requiring Council's support.	3,085
Environment and Resident Experience	Housing Benefit	Increase in the budget for bad debts provision for housing benefit claims and review of those in receipt of housing benefit in supported accommodation.	3,500

Directorate	Service	Description	2025/26 Forecast Pressure (£'000)
Adults, Health and Communities	Housing Demand	Due to market challenges and increased demand, the cost of temporary accommodation is increasing. Overall cost projections take into account; the predicted number of households accessing temporary accommodation, the landlord charges and amounts recoverable, any predicted rise in charges, the expected movement out of temporary accommodation based of historic performance trends and any specific schemes and initiatives that provide additionality either in movement or reduced unit cost (our mitigations). These are predominantly new social housing supply and new council temporary accommodation. We are under a statutory obligation to provide temporary accommodation until alternative settle accommodation is secured.	10,797
Adults, Health and Communities	Adult Social Care	Adult Social Care faces a number of challenges which affect total numbers in the population who may have eligible needs. Demography, multiple health conditions, including lifelong conditions, age of individuals and other socio-economic factors, where the increase in numbers with a long-term care package accounts for approximately 50% of the pressure. Whilst the increase in cost can be explained in part by price increases in an increasingly challenged provider market, there is significant evidence to account for the increase in cost that is as a result of increasingly poor health conditions among older adults and the impact of those transitioning from children's services, where the impact of the rise in EHCP is having an impact on adults, this results in more complex care packages where eligibility for funded health care will not offset the overall increase.	15,160
	Total		**39,635**

Appendix 2

2025/26 PROPOSED SAVINGS

Cross Council - Savings

Description	Cabinet Member	Budget impacted (£'000)	2025/26 Savings proposed (£'000)	2026/27 Savings proposed (£'000)	2027/28 Savings proposed (£'000)	2028/29 Savings proposed (£'000)
Enabling Services Review *This proposal will review staff who provide enabling services support to the organisation to develop new delivery models that will reduce duplication across services and ensure efficient support to all frontline services across the organisation.*	All	160,000	(1,000)	(1,000)	(500)	-
Procurement and Contract Management *This project will be delivered as two workstreams. Workstream 1 will review all existing contracts to ensure value for money. Workstream 2 will put in place increased governance to ensure that for all new contracts all commissioning options have been considered, outcomes for residents offer value for money and are affordable and improve contract management arrangements of suppliers.*	All	600,000	(3,000)	(3,000)	(3,000)	-
Staffing Efficiencies *Staffing budgets in the Council chargeable to the General Fund amount to c.£160m. All Directorates are required to deliver a 5% reduction in their staffing budget from 2025/26. Recognising all services are different, there is no single approach and instead Directorates will use a range of tools, including:* • *Implementing a vacancy rate and/or reducing vacant posts.* • *Reducing use of agency workers.* • *Review of spans and layers of control to reduce management overheads.* • *Service efficiencies resulting in fewer employees being required.*	All	160,000	(8,560)	-	-	-

Description	Cabinet Member	Budget impacted (£'000)	2025/26 Savings proposed (£'000)	2026/27 Savings proposed (£'000)	2027/28 Savings proposed (£'000)	2028/29 Savings proposed (£'000)
Asset Management *Continuation of current projects to review all rent and lease agreements within the commercial portfolio and a further reduction in operational sites for the delivery of Council services. Savings will be generated through increased rental income and capital receipts from the routine disposal of sites which will reduce the need for borrowing to deliver the capital programme.*	Cllr Gordon	11,000	(350)	(450)	(300)	
Income Generation *Review across all services to identify commercial opportunities to expand existing income sources and new opportunities, with a focus on attracting external funding, charges reflecting the true cost of services and improving collection of income whilst also protecting those at risk of financial hardship.*	All	N/A	(500)	-	-	-
TOTAL			**(13,410)**	**(4,450)**	**(3,800)**	**0**

Culture, Strategy and Engagement- Service Specific Savings

Description	Cabinet Member	Budget impacted (£'000)	2025/26 Savings proposed (£'000)	2026/27 Savings proposed (£'000)	2027/28 Savings proposed (£'000)	2028/29 Savings proposed (£'000)
Digital Transformation *Through the Digital Service staffing restructure and a new approach, we now have a team of developers who are developing a roadmap of digital opportunities across different directorates, already adding up to almost half of the current target of £2.8m. We can now propose going further with digital transformation savings for the Council, with a target of £2m per year for each of 2026/27 and 2027/28 from across the Council. We are also already reducing the cost of our digital estate through contract and licence reductions and can propose a further £200k for 2025/26, to come from Digital Service budgets.*	Cllr Carlin	6,000	(200)	(2,000)	(2,000)	-
Culture *Review discretionary culture budgets, which support cultural organisations in the borough through grant funding and commissioning to deliver the Council's civic and cultural programmes. Any potential impacts will be carefully managed and phased towards the end of the MTFS period to allow time to plan for mitigations and development of alternative funding streams.*	Cllr Arkell	2,443	(25)	-	(100)	(125)
New Local Membership *The proposal is not to renew our membership of the New Local think tank. Membership provides access to policy advice, a network of other Councils with shared aspirations and values and a number of events each year which officers have attended. However, membership is not essential.*	Leader	20	(20)	-	-	-

Description	Cabinet Member	Budget impacted (£'000)	2025/26 Savings proposed (£'000)	2026/27 Savings proposed (£'000)	2027/28 Savings proposed (£'000)	2028/29 Savings proposed (£'000)
Residents Survey *We currently undertake a formal, independent residents survey every three years. This is the only resident research we do and which is undertaken by a specialist polling company from a representative sample of residents. The cost of the survey is approximately £75,000. The relatively high cost comes from the survey being conducted in person by researchers knocking on doors. This is the 'gold standard' used for research as it captures residents who would not answer the phone or respond to online questionnaires. The proposal is to remove the annual budget provision (£25k pa) and in future a business case would need to be made during the budget round for the resources to undertake a residents survey*.	Leader	25	(25)	-	-	-
Digital - Service Desk *Efficiencies have already been made in the way the internal Digital Service desk is run as part of a major restructure of the Digital Service to deliver savings this year, however a review has identified additional measures to reduce staff demand on the service desk further. Most queries are to do with forgotten passwords or problems with the remote VPN security system so changing our approach to password management and using the Microsoft integral VPN rather than our current separate system should reduce demand significantly and enable a saving to be made.*	Cllr Carlin	600	(100)	-	-	-
Registrars *Statutory fees that we can charge for Registrar Services have increased. The full impact of the increased fees will be seen in 2024/25 and if the current level of demand remains, an additional £90,000 of income will be achieved annually.*	Cllr Carlin	(532)	(90)	-	-	-
TOTAL			**(460)**	**(2,000)**	**(2,100)**	**(125)**

Adults Health & Communities – Service Specific Savings

Description	Cabinet Member	Budget impacted (£'000)	2025/26 Savings proposed (£'000)	2026/27 Savings proposed (£'000)	2027/28 Savings proposed (£'000)	2028/29 Savings proposed (£'000)
Connected Care Review *To review the delivery model for the Connected Care Service to identify alternate options for enhanced service offer and sustainability, selecting and implementing the most appropriate model to ensure this vital service best meets the needs of residents and is sustainable.*	Cllr das Neves	200	49	(879)	(35)	-
Day Opportunities – Commissioning Review *To undertake a commissioning review of the current range and type of day opportunities available to eligible Haringey residents and their carers.*	Cllr das Neves	7,500	0	(100)	(300)	(450)
Integrating Connected Communities *Further development of the Adult Social Care locality model and prevention approach: there is an opportunity to integrate the Connected Communities model and rationalise resources across the directorate.*	Cllr das Neves	750	(700)	-	-	-
Housing Related Support Contract Savings *A review of contract provision across Housing Related Support has enabled a proposal of multiple lower value savings opportunities. These will be achieved by natural wastage (pausing recruitment or not recruiting to vacant posts), streamlining service delivery, exploring options for consolidating office space usage by commissioned services and ceasing delivery of small value contracts where we have clear data to show low utilisation rates.*	Cllr Williams	10,600	(412)	-	-	
TOTAL			**(1,063)**	**(879)**	**(35)**	**-**

Environment and Resident Services – Service Specific Savings

Description	Cabinet Member	Budget impacted	2025/26 Savings proposed (£'000)	2026/27 Savings proposed (£'000)	2027/28 Savings proposed (£'000)	2028/29 Savings proposed (£'000)
Parking Fees & Charges *Parking and Highways Fees and Charges review to ensure Controlled Parking Zone costs are fully recovered.*	Cllr Chandwani	22,425	(500)	-	-	-
Parking services optimised efficiency *A review of parking operations to optimise efficiency levels through increase use of technology and changes to deployment plans*	Cllr Chandwani	22,425	(300)	-	-	-
Reduction in Housing Benefit accommodation costs *Creation of a focused team dedicated to providing a joined-up assessment of Housing Benefit Supported Accommodation and the criteria for successful claims, so that it is consistent with neighbouring authorities.*	Cllr Chandwani		(200)	(200)	-	-
Leisure service means tested discounting *Introduce means tested discounting for Leisure Centre memberships and services to ensure access to fitness and leisure is open to all. This replaces the current blanket discount for all customers aged 65 and over but opens up discounts to disabled young people and those on low incomes.*	Cllr Arkell	1,837	(200)	-	-	-
A range of Management actions: • *Directorate service review (£167,000)* • *Review of Council Tax Reduction Scheme (£2m)* • *Street Lighting - reduced energy costs (£67,000)* • *Reduction in cost of Out of Hours contract savings (£80,000)* • *Parking visitor voucher storage savings (£300,000)*	Cllr Chandwani	1,895 34,900 1,263 110 6,795	(2,614)	-	-	-
TOTAL			**(3,814)**	**(200)**	-	-

Children's Services and Education – Service Specific Savings

Description	Cabinet Member	Budget impacted (£'000)	2025/26 Savings proposed (£'000)	2026/27 Savings proposed (£'000)	2027/28 Savings proposed (£'000)	2028/29 Savings proposed (£'000)
Pendarren House *This proposal is for Pendarren Activity Centre to become fully self funded and therefore reduce the Council's contribution.*	Cllr Brabazon	25	(25)	-	-	
TOTAL			**(25)**	**-**	**-**	

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Proposed Changes to Capital Programme 2025/26 to 2029/30 Appendix 3

Adults, Communities and Health

Adults, Health & Communities (AHC)	2024/25 (£'000)	2025/26 (£'000)	2026/27 (£'000)	2027/28 (£'000)	2028/29 (£'000)	2029/30 (£'000)	Total (£'000)
Budget	**9,038**	**5,051**	**7,377**	**12,377**	**28,341**	**0**	**62,184**
Proposed Reductions							
Osborne Grove Nursing Home	(700)	(1,000)	(5,000)	(10,000)	(28,341)	0	**(45,041)**
Wood Green Integrated Care Hub	0	(1,000)	0	0	0	0	**(1,000)**
Locality Hub	(810)	(337)	0	0	0	0	**(1,147)**
Total	**(1,510)**	**(2,337)**	**(5,000)**	**(10,000)**	**(28,341)**	**0**	**(47,188)**
Proposed Increases							
Initiatives under Housing Demand Programme		5,000					**5,000**
Total	**0**	**5,000**	**0**	**0**	**0**	**0**	**5,000**
Proposed Net Increase/(Reduction)	(1,510)	2,663	(5,000)	(10,000)	(28,341)	0	**(42,188)**
Revised Budget	**7,529**	**7,714**	**2,377**	**2,377**	**0**	**0**	**19,997**

Proposed Reductions

- The Osbourne Grove Nursing Home scheme was in the capital programme on a self-financing basis and that it would generate enough savings by having in borough care to pay for the cost of creating and running the facility. The project has not been able to generate sufficient savings so is being withdrawn from the programme.
- The Wood Green Integrated Care Hub was an NHS led project. The NHS has decided not to proceed with the scheme so the Council contribution will no longer be required.
- The Locality Hub scheme cost has been lower than expected, so the budget can be reduced. Should further hubs be required they will be considered for inclusion in the next budget cycle alongside other competing priorities for capital investment.

Proposed Increases

- Initiatives to reduce use of temporary accommodation. This budget is a contribution from the General Fund to the HRA for the purchase of additional houses to support more people rather than being placed in temporary accommodation. Each purchase will be subject to a business case that proves

that the purchase will save more than the cost of temporary accommodation and the cost of servicing the debt.

Culture, Strategy and Engagement

Culture, Strategy & Engagement	2024/25 (£'000)	2025/26 (£'000)	2026/27 (£'000)	2027/28 (£'000)	2028/29 (£'000)	2029/30 (£'000)	Total (£'000)
Current Budget	**54,025**	**36,941**	**12,954**	**1,570**	**0**	**0**	**105,490**
Proposed Reductions							
Alexandra Palace	0	0	(1,540)	0	0	0	**(1,540)**
Total	**0**	**0**	**(1,540)**	**0**	**0**	**0**	**(1,540)**
Proposed Increases							
Capital support for delivering digital solutions	0	1,965	1,000	0	0	0	**2,965**
Total	**0**	**1,965**	**1,000**	**0**	**0**	**0**	**2,965**
Proposed Net Increase/ (Reduction)	0	1,965	(540)	0	0	0	**1,425**
Revised Budget	**54,025**	**38,906**	**12,414**	**1,570**	**0**	**0**	**106,915**

Proposed Reductions

- Following a review of capital expenditure needed for Alexandra Palace, it is proposed that £1.5m can be removed for 2026/27 but this will be subject to review as part of the 2026/27 budget setting process.

Proposed Additions

- Increasingly, organisations like the Council, are more and more reliant on IT for the delivery and transformation of services. This investment is required to allow the Council to continue to improve service delivery and efficiency and the resident experience by investment into replacement and new digital tools.

Environment and Resident Experience

Environment & Resident Experience	2024/25 (£'000)	2025/26 (£'000)	2026/27 (£'000)	2027/28 (£'000)	2028/29 (£'000)	2029/30 (£'000)	Total (£'000)
Budget	**35,060**	**26,043**	**32,167**	**33,197**	**28,360**	**0**	**154,825**
Proposed Reductions							
Move Broadwater Farm Leisure Refurb to HRA	0	(236)	0	0	0	0	**(236)**
Decentralised Energy Networks	(6,597)	(10,326)	(16,750)	(16,000)	(17,813)	0	**(67,486)**
Reduce Festive Lighting Lights	0	(75)	0	0	0	0	**(75)**
Borough Roads	0	(1,250)	0	0	0	0	**(1,250)**
Total	**(6,597)**	**(11,887)**	**(16,750)**	**(16,000)**	**(17,813)**	**0**	**(69,047)**
Proposed Increases							
Structures (Cornwall Road, Ferry Lane, & Wareham Road Bridge)	0	2,100	0	0	0	0	**2,100**
Flood Water Management	0	1,200	900	900	900	900	**4,800**
Replacement Parks and Housing Machinery	0	300	250	100	50	50	**750**
Borough Parking Plan	0	250	250	250	250	250	**1,250**
Increase in Disabled Bays	0	150	80	80	80	80	**470**
New Communal Refuse Round Vehicles		180					**180**
Waste Vehicles and Bins	0	0	25,101	0	0	0	**25,101**
Total	**0**	**4,180**	**26,581**	**1,330**	**1,280**	**1,280**	**34,651**
Net Increase/(Reduction)	(6,597)	(7,707)	9,831	(14,670)	(16,533)	1,280	**(34,396)**
Revised Budget	**28,463**	**18,336**	**41,998**	**18,527**	**11,827**	**1,280**	**120,429**

Proposed Reductions

- Given the current financial constraints of the Council, it is proposed to reduce spend on the borough's roads in 2025/26 only and review again as part of the 2026/27 budget setting process. This will result in an average reduction of 33 to 23 road resurfacing schemes and a reduction of footway renewal schemes from 24 to 15.

Proposed Additions

- The addition to the structures budget is necessary to fund urgent works to the bridges listed in the table above.
- Ongoing management of the infrastructure across the borough to manage flooding and surface water is essential and this proposed addition to the capital programme will allow for an annual rolling programme of maintenance to upgrade the existing infrastructure to combat the effects of climate change.
- Maintenance of the borough's parks and open spaces requires the routine replacement of parks and housing machinery, and this additional scheme will allow for an annual rolling programme of replacement.
- The Parking Investment Plan 2024/25 was approved by Cabinet on 12th March 2024 and the Council has a commitment to review all its controlled parking zones (CPZ) on a 5-year cycle and to implement new ones where there is a need.
- The extension of disabled parking facilities remains a priority. This service is essential for those with disabilities, who need to rely on car use for their independence. This includes access to education, employment, and leisure. In 2025/26 it is aimed to significantly increase disabled parking provision near to places of interest. This will include (but is not limited to) high streets, medical centres, places of worship, community centres, and parks, completing the work undertaken in 2024/25. The disabled bays budget will allow the Council to meet this priority.
- The introduction of a new communal refuse round will require additional vehicles and machinery.
- The Council is retendering its waste collection service with a view to having a new service in place for April 2027. Currently the Council pays Veolia to provide vehicles in their contract price. It is estimated that the Council can fund the vehicles in a more financially advantageous manner.
- Tottenham Hale and Wood Green Decentralised Energy Networks (DEN). Given the Council's current financial position, the current Council led delivery model is no longer viable. Discussions are underway with Department of Energy Security and Net Zero (DESNZ) on the future scope of these schemes to eliminate the financial dependency on the Council whist still supporting the Government's emerging policy on Heat Zoning. This scheme will be removed from the programme until future plans have been determined. Any future council funded capital requirement will be considered as part of future annual review of the Capital Programme and affordability will need to be considered alongside all other Council priorities for future capital investment.

Placemaking and Housing

Placemaking & Housing	2024/25 (£'000)	2025/26 (£'000)	2026/27 (£'000)	2027/28 (£'000)	2028/29 (£'000)	2029/30 (£'000)	Total (£'000)
Budget	**160,940**	**47,927**	**131,646**	**4,200**	**0**	**0**	**344,713**
Proposed Reductions							
Wards Corner	(6,085)	(2,937)	(1,400)	(1,200)	0	0	**(11,622)**
Wood Green Regen	0	(1,449)	(552)	0	0	0	**(2,000)**
Tottenham Streets & Spaces	(4,820)	(1,300)	0	0	0	0	**(6,120)**
Total	**(10,905)**	**(5,686)**	**(1,952)**	**(1,200)**	**0**	**0**	**(19,742)**
Proposed Increases							
Asset Management of Council Buildings	0	2,245	5,100	5,005	897	0	**13,247**
Total	**0**	**2,245**	**5,100**	**5,005**	**897**	**0**	**13,247**
Net Increase/(Reduction	(10,905)	(3,441)	3,149	3,805	897	0	**(6,495)**
Revised Budget	**150,035**	**44,486**	**134,795**	**8,005**	**897**	**0**	**338,218**

Proposed Reductions

- The Wards Corner scheme under its current design is not financially viable and is proposed to remove from the capital programme until more detailed plans come forward. The Council has a compulsory purchase order in place to acquire properties on Wards Corner and this commitment will remain. The cost of any acquisitions will be funded through the Capital Programme's unallocated contingency line.
- The current capital programme includes a number of different schemes for place shaping in Wood Green and Tottenham Hale funded by borrowing of £7.6m and £16.4m respectively. Any schemes that are not yet committed are currently under review to ensure that the Councils takes a holistic view on capital investment across these two geographical areas and focus spend where it will have the biggest impact.

Proposed Additions

- The recent survey of the Council's operational and commercial estate has identified that just over £13m will be required over the next five years to maintain the Council's estate. The Council is currently reviewing all of its operational estate to determine service delivery requirements for the future and therefore decisions on maintenance spend will be determined by the long-term use of each building. This budget will be subject to annual review.

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Appendix 1

Financial Scrutiny: Understanding your Role in the Budget Process

This document summarises issues and questions you should consider as part of your review of financial information. You might like to take it with you to your meetings and use it as an aide-memoir.

Overall, is the MTFS and annual budget:

- A financial representation of the council's policy framework/ priorities?
- Legal (your Section 151 Officer will specifically advise on this)?
- Affordable and prudent?

Stage 1 – planning and setting the budget

Always seek to scrutinise financial information at a strategic level and try to avoid too much detail at this stage. For example, it is better to ask whether the proposed budget is sufficient to fund the level of service planned for the year rather than asking why £x has been cut from a service budget.

Possible questions which Scrutiny members might consider –

- Are the MTFS, capital programme and revenue budget financial representations of what the council is trying to achieve?
- Does the MTFS and annual budget reflect the revenue effects of the proposed capital programme?
- How does the annual budget relate to the MTFS?
- What level of Council Tax is proposed? Is this acceptable in terms of national capping rules and local political acceptability?
- Is there sufficient money in "balances" kept aside for unforeseen needs?
- Are services providing value for money (VFM)? How is VFM measured and how does it relate to service quality and customer satisfaction?
- Have fees and charges been reviewed, both in terms of fee levels and potential demand?
- Does any proposed budget growth reflect the council's priorities?
- Does the budget contain anything that the council no longer needs to do?
- Do service budgets reflect and adequately resource individual service plans?
- Could the Council achieve similar outcomes more efficiently by doing things differently?

Stage 2 – Monitoring the budget

It is the role of "budget holders" to undertake detailed budget monitoring, and the Executive and individual Portfolio Holders will overview such detailed budget monitoring. Budget monitoring should never be carried out in isolation from service performance information. Scrutiny should assure itself that budget monitoring is being carried out but should avoid duplicating discussions and try to add value to the process. Possible questions which Scrutiny members might consider –

- What does the under/over spend mean in terms of service performance? What are the overall implications of not achieving performance targets?
- What is the forecast under/over spend at the year end?
- What plans have budget managers and/or the Portfolio Holder made to bring spending back on budget? Are these reasonable?
- Does the under/over spend signal a need for a more detailed study into the service area?

Stage 3 – Reviewing the budget

At the end of the financial year you will receive an "outturn report". Use this to look back and think about what lessons can be learned. Then try to apply these lessons to discussions about future budgets. Possible questions which Scrutiny members might consider –

- Did services achieve what they set out to achieve in terms of both performance and financial targets?
- What were public satisfaction levels and how do these compare with budgets and spending?
- Did the income and expenditure profile match the plan, and, if not, what conclusions can be drawn?
- What are the implications of over or under achievement for the MTFS?
- Have all planned savings been achieved, and is the impact on service performance as expected?
- Have all growth bids achieved the planned increases in service performance?
- If not, did anything unusual occur which would mitigate any conclusions drawn?

How well did the first two scrutiny stages work, were they useful and how could they be improved?

Savings Tracker 2024-25

Red	Saving fully/partially unachievable
Amber	Saving achievable but full/partial slippage required
Green	Saving met in full and on time

Saving proposal	2024/25 £'000s	2024/25 Projected Full Year Savings £'000s	2024/25 Savings (surplus)/ shortfall £'000s	RAG Status (Delivery of 2024/25 Saving)	Comment on Delivery RAG Status	Actions plans to mitigate shortfall
Amendments to Existing Savings	486	486	0	Green	On Track	
Improved processes and practises to ensure that residents receive the right level of care	850	425	425	Amber	Delays in onboarding means the work has not yet commenced.	Service reviews to establish the right level of care is provided, resulting in opportunities to reduce where levels of need have changed. Significant improvements in staffing budget have enabled ASC to increase resources to improve levels of reviews, currently at 7%
Contract reviews	500	250	250	Amber	Commissioning team is subject to a restructure and therefore contract reviews will not be completed until new structure is in place. Savings expected to be delivered in 2025/26.	
Use of public health growth	292	292	0	Green		
Transport Cost Reviews	100	0	0	Amber		
Supported Living Review	300	150	150	Amber	Team not in place to commence programme of work.	This mainly focuses on LD cohort, ensuring value for money and that joint household commissioned services are streamlined.
Stength Based Working	350	175	175	Amber	Team not in place to commence programme of work.	Encouraging the use of community resources, reducing the need for formal care services. This approach fosters greater independence and the potential to improve the well being of service users, leading to a reducation in support costs.
sexual health MTFS	300	300	0	Green		
Review of 1 to 1 support	100	50	0	Amber	Additional resource needed to carry out reviews and programme management capacity.	A review of all 1 to 1 support, sitting mainly within the LD service.
Mental Health Service Review	200	100	100	Amber	Working with housing to step people down into social lets. Reviewing all clients in temporary placements. In discussions with providers for new scheme's which will enable us to move on 15 people. Review and aim to bring people back into Haringey. Ensure provision in Haringey is our primary option.	We would need to consider and negotiate commissioned contracts.
Grant Review (BCF/S75)	200	0	200	Amber	BCF is NHSE grant with no opportunties to make savings.	

Savings Tracker 2024-25

Red	Saving fully/partially unachievable
Amber	Saving achievable but full/partial slippage required
Green	Saving met in full and on time

Saving proposal	2024/25 £'000s	2024/25 Projected Full Year Savings £'000s	2024/25 Savings (surplus)/ shortfall £'000s	RAG Status (Delivery of 2024/25 Saving)	Comment on Delivery RAG Status	Actions plans to mitigate shortfall
Direct Payments	800	0	800	Amber	This relies on both current recipients of care agreeing to the change and a market that can respond to that demand. Last financial year saving £200K in total.	
Continuing Health Care	1,200	5,809	(4,609)	Green	The relationship and process in regards to CHC decision solely rests with ICB. This is a temporary resource till September and workforce has been unstable. Failure to address the process and resourcing issue will lead to an unsustainable model.	
Care Package Review (Quality Review	150	75	0	Amber	Lack of resource/staffing in order to carry out these reviews along with unmet needs and resulting complications.	Streamline the review process, with regular, standardised reviews to identify and eliminate unnecessary services and avoiding over-provision.
0-19 years Public Health Nursing Services efficiencies	150	150	0	Green		
PH Reserves Drawdown	480	480	0	Green		
PH - MH Contracts efficiencies	50	50	0	Green		
Mental Health insourcing	500	0	0	Amber	Savings are reliant on the time scales to implement the exit plan from the current MoU. Staff alignment into localities. Handover of work between organisations. There is a PID and action plan in place with task and finish groups to complete the work by August 2024. This will give was the second half of the year to focus and our statutory functions and any realisable savings. We need to continue with an integrated approach to ensure safe delivery of support for Haringey Mental Health Clients and ensure effective use of resources across organisations.	three of the mental health core teams have already aligned to the localities model. Therefore a shift in council oversight has already started. We will focus on reviews in these areas as a priority to deliver our target.

Savings Tracker 2024-25

Red	Saving fully/partially unachievable
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Saving proposal	2024/25 £'000s	2024/25 Projected Full Year Savings £'000s	2024/25 Savings (surplus)/ shortfall £'000s	RAG Status (Delivery of 2024/25 Saving)	Comment on Delivery RAG Status	Actions plans to mitigate shortfall
Review entitlement for Council to fund Social Care for adults (proactive fraud excercise)	250	125	125	Amber	A tool Audit use to manage any fraud within the financial assessment team. Audit wanted to cease the contract, as such improvements were made that it was no longer needed.	
Digital Transformation Savings	155	0	155			
Resettlement	150	150	0	Green		
Localities Hub	550	0	550	Amber	Cross directorate saving.	Connected Communities has delievered its agreed £250k through restructure
Transitions	673	673	0	Green	Project board in place, team being recruited and cohort of young people identified that will support the realisation of year 1 savings.	
Total	**8,786**	**9,740**	**(1,679)**			

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Savings Tracker 2024-25

	2025/26-2028/29				
Saving proposal	**2025/26 £'000s**	**2026/27 £'000s**	**2027/28 £'000s**	**2028/29 £'000s**	**Panel**
Transport Cost Reviews	150	0	0	0	Adults and Health Scrutiny Panel
0-19 years Public Health Nursing Services efficiencies	150	0	0	0	Adults and Health Scrutiny Panel
PH Reserves Drawdown	-480	0	0	0	Adults and Health Scrutiny Panel
Mental Health insourcing	500	0	0	0	Adults and Health Scrutiny Panel
Digital Transformation Savings	360				Adults and Health Scrutiny Panel
Resettlement	150	-300	0	0	Adults and Health Scrutiny Panel
Localities Hub	250	200	0	0	Adults and Health Scrutiny Panel
Transitions	1152	777	724	1220	Adults and Health Scrutiny Panel
Total	**2232**	**677**	**724**	**1220**	

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Adults and Health Scrutiny Panel

Work Plan 2024 - 26

1. **Scrutiny review projects;** These are dealt with through a combination of specific evidence gathering meetings that will be arranged as and when required and other activities, such as visits. Should there not be sufficient capacity to cover all of these issues through in-depth pieces of work, they could instead be addressed through a "one-off" item at a scheduled meeting of the Panel. These issues will be subject to further development and scoping. It is proposed that the Committee consider issues that are "cross cutting" in nature for review by itself i.e. ones that cover the terms of reference of more than one of the panels.

Project	Comments	Status
Hospital discharge	To review delays to hospital discharge in Haringey. Evidence sessions for this Review have now been completed.	Report to be published shortly.
Digitalisation and communications with residents	To review the current arrangements for communication processes and systems for residents presenting with complex needs involving a multidisciplinary team including: • How the team communicates between one another regarding the actions needed to facilitate care for the resident. • How the team communicates with the resident and family members, how it provides a single point of contact, plan of actions and timeframe for these actions. • How the team communicates with Council Members who request details about the actions and the timeframes for these actions to be carried out. • What systems are in place to facilitate the above to take place.	ToR approved

2. **"One-off" Items;** These will be dealt with at scheduled meetings of the Panel. The following are suggestions for when particular items may be scheduled.

Date	**Agenda Items**
2024-25	
30 July 2024	• Cabinet Member Questions – Adults & Health • Haringey Health & Wellbeing Strategy 2024-29 • Continuing Healthcare
19 September 2024	• Haringey Safeguarding Adults Board (HSAB) Annual Report • Dementia services • Smoke-free Strategy
14 November 2024 (Budget Meeting)	• Scrutiny of 2024/25 Budget and MTFS
17 December 2024	• Quality Assurance/CQC Overview • CQC Inspection
10 February 2025	• Preparedness for a future pandemic • Cabinet Member Questions – Adults & Health

2025-26	
June/July 2025	• Cabinet Member Questions – Adults & Health • Dementia update • VACANT
September 2025	• Haringey Safeguarding Adults Board (HSAB) Annual Report • Quality Assurance/CQC Overview • VACANT
November 2025	• Scrutiny of 2024/25 Budget and MTFS
December 2025	• Health and Wellbeing Strategy update • VACANT • VACANT
February 2026	• Cabinet Member Questions – Adults & Health • VACANT • VACANT

<u>To be allocated</u>

Issues arising from scrutiny consultation exercise:

- Communications with residents
- Impact of Housing Conditions on Health and Wellbeing

- Autism Strategy 2021-2031
- Support for Carers

Issues arising from previous work programme or follow up from current work programme:

- **Osborne Grove Nursing Home**
- **Health & Wellbeing Strategy** – Last update provided in July 2024. Next update suggested for late 2025/early 2026. A number of recommendations for issues to be included in the next update was specified in July 2024.
- **Gambling harms**
- **Dementia services** – Last update provided in September 2024. Next update suggested for summer 2025. A number of recommendations for issues to be included in the next update was specified in September 2024.
- **Smoke-free Strategy -** Last update provided in September 2024. Further update suggested for 2025/26 on work in schools on vaping, PSHE education and links with mental health teams.
- **Continuing Healthcare** – Last update provided in July 2024.
- **Modern Slavery** (including training for Police)
- **Adult Social Care Commissioning and Co-production Board –** Previous update in November 2023, next update anticipated 6-9 months later.
- **LGA Peer Review** – Further update to be scheduled. Previous update was in June 2023. Strategic plan is expected to be in place by Jan 2024.
- **Workforce reform agenda** – Further update to be scheduled. Previous update was in June 2023. At the previous update it was noted that the 30% vacancy rate in Adult Social Care represented a risk and so it would be useful to monitor staff turnover and the vacancy rate at the next update on this issue.
- **Integrated Care System** (ICS) – At a meeting in July 2022 it was suggested that a further report be brought to a future meeting including details on: a) the development of the co-design/co-production process; and b) the communications/engagement process for the next suitable new project.