NHS England

NHS Continuing Healthcare Independent Review Panel Report

NHS Continuing Healthcare Independent Review Panel

Report on Mrs **** *********

NHS England Case Reference	
Date of Independent Review Panel Meeting	
Venue	

INDEPENDENT REVIEW PANEL MEMBERS	
Name	**Designation**
	Independent Chair
	NHS Representative
	Local Authority Representative

CLINICAL ADVISER	
Name	**Qualifications**

INDIVIDUAL'S DETAILS	
Name	
DOB	
Representatives	

Integrated Care Board (ICB)	
Name	
Representative including team location (place)	

NHS ENGLAND REPRESENTATIVE	
Name	**Designation**
	Independent Review Panel Case Manager

OBSERVER (if applicable)	
Name	**Designation**
N/A	N/A

APPLICATION DETAILS	
Is it a current or retrospective case	Current
Review period if a retrospective case	N/A
Date of Decision Support Tool if a current case	30 March 2021
Date of ICB decision	31 March 2021

(Where this document refers to ICB this also includes any predecessor organisation who may have made a decision prior to 1 July 2022.)

1 The Independent Review Panel's recommendations

The Independent Review Panel (IRP) has considered Mr ***** request for a review of the decision ***** ICB (formerly **** CCG) made on 31 March 2021 that Mrs ******* was not eligible for NHS Continuing Healthcare.

It has considered the documentary evidence and the evidence given during the IRP meeting on 3 May 2023, a note of which is included in this report.

For the reasons set out in this report it makes the following recommendation:

- The IRP concluded that Mrs ******** did have a primary health need. It therefore recommends that she was eligible for NHS Continuing Healthcare.

Having regard to the issues raised concerning the ICB's procedure the IRP recommends:

- That ********** ICB review the DST written by the Multi- Disciplinary Team for Mrs ****** on 30 March 2021 and consider if there are any training issues for staff with regard to:

- Ensuring the agreement of all members of the MDT is demonstrated.
- Ensuring that the discussion of the 4 Key Characteristics is robust.
- Ensuring the location of the care received is not included as part of the discussion of eligibility.

2 The Independent Review Panel's terms of reference

The way in which the IRP works is governed by The NHS Commissioning Board and Clinical Groups (Responsibilities and Standing Rules) Regulations 2012.
and by the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care revised in July 2022.

The IRP has the responsibility of reviewing (1) the decision reached by an Integrated Care Board on an individual's eligibility for NHS Continuing Healthcare or (2) the procedure followed by an Integrated Care Board in reaching its decision on an individual's eligibility for NHS Continuing Healthcare.

3 Some matters to be taken into account when reviewing the eligibility decision.

An individual is eligible for NHS Continuing Healthcare if they have a "primary health need." This is when it can be said that the main aspects of the care, they require are focussed on addressing and/or preventing health needs. It is not about the reason why

an individual requires care or support, and it is not based on their diagnosis. It is about the level and type of their overall actual day-to-day care needs taken in their totality.

The fact that an individual needs to move into safe accommodation which provides 24-hour care, such as a residential or nursing care home, because of their physical and/or mental condition does not, of itself, mean that the individual has a primary health need and is eligible for NHS Continuing Healthcare.

In considering whether an individual has a primary health need the IRP first considers the evidence of individual's needs and reach a conclusion on their levels of need in the care domains in the Decision Support Tool associated with the National Framework.

The Decision Support Tool does not, however, directly determine eligibility. The IRP has to consider the totality of the individual's needs. The evidence in the Decision Support Tool helps to inform the IRP's consideration of whether an individual has a primary health need using the four key characteristics of nature, intensity, complexity, and unpredictability.

The guidance on how the Decision Support Tool should be used to identify a primary health need explains:

> *"A clear recommendation (and decision) of eligibility to 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.*
>
> *Where there is either:*
>
> - *A severe level of need combined with needs in a number of other domains, or*
> - *a number of domains with high and/or moderate needs*
>
> *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.*
>
> *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 deciding 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 equal one high.' The judgement whether someone 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.*

The IRP must also consider whether or not, taken as a whole, the nursing or other health services required by the individual were.

- more than incidental or ancillary to the provision of accommodation which local authority social services are under a duty to provide and
- of a nature beyond which a local authority whose primary responsibility is to provide social services could be expected to provide.

If they were, then this indicates that the individual had a primary health need.

Local authorities can and do commission care in care homes (with or without nursing) where the person's needs to be met include elements of 'general nursing' which can be provided by healthcare assistants or care assistants. A local authority can fund this 'nursing care' provided it meets the "incidental and ancillary" test outlined above.

4 The background to Mrs ******* case

Mrs ******* was born on 30 September 1939. She has been living in ******** Nursing Home EMI unit since January 2020 and remains living there. Following an incident where she was found five miles from her home, having walked there thinking she had an appointment with the doctor, she was admitted to ********** Residential Home on 5 November 2019. However, the staff there found that they could not meet her needs and she moved to ******* Nursing Home in the EMI (Elderly Mentally Infirm) unit after just two months. She remains there to this day and is visited two to three times a week by her son, ********

Mrs ******** had three children, a daughter and two sons. Sadly, her daughter has predeceased her. Of her two sons, ******* has been her carer for a number of years. ****** ******* moved to live with his mother in order to take care of her, prior to her admission to **********

Mrs ********* has a medical history of:

Alzheimer's Dementia
Atrial Fibrillation
Diverticulitis
Osteoarthritis
History of Urinary Tract Infections
History of Chest infections
Partially sighted due to bilateral cataracts
Knee replacement
Lumbar disc degeneration
COPD
Spinal curvature
Bilateral leg oedema

An NHS Continuing Healthcare Checklist was competed on 17 February 2020 the outcome of which was "Referral for full assessment for NHS Continuing Healthcare is necessary". A full assessment was arranged for 13 March 2020, but this was postponed due to an outbreak of diarrhoea and vomiting in the care home, and then COVID 19 restrictions came into place.

The case file notes that Mrs ********** was considered to be approaching the end of her life on 1 June 2020 and NHS Continuing Healthcare funding was agreed. Following a review of Mrs **********'s health needs on 18 March 2021 a Decision Support Tool (DST) was completed at a Multi-Disciplinary Meeting (MDT) on 30 March 2021. ********* **********, Mrs **********'s son, was invited to a telephone conversation to discuss his mother's care but was unavailable, according to the DST. He did send in a completed Self-Assessment Form which was considered by the assessing nurse and social worker at the MDT.

The outcome of the DST was that Mrs ********** was not eligible for NHS Continuing Healthcare (CHC). She was deemed eligible for NHS-funded Nursing Care.

********* (*********) appealed this decision on behalf of Mr ********** on 20 April 2021. An NHS Needs Portrayal Document was completed on 3 November 2021 (updated on 12 November 2021). This was sent to Mr ********** and ********* for comments. ********* submitted its comments in a document dated 20 September 2022, a copy of which was in the case file.

A Local Review Panel/Multi-Disciplinary Team Meeting (LRM) was held on 16 November 2022, the outcome of which was that Mrs ********** was not found to have a primary need for healthcare and was therefore not found to be eligible for NHS Continuing Healthcare at the time.

An Outcome letter was sent to ********* on 2 January 2023. On 23 January 2023 ********* wrote to NHS England requesting an Independent Review.

An Independent Review Panel (IRP) was convened on 3 May 2023 to review the decision made at the MDT on 30 March 2021, using the DST of the same date. The IRP's remit is to review the assessment made on 30 March 2021 and to take into account evidence from the three months preceding that date.

Mr ********* ********** attended the hearing on behalf of his mother, along with a representative from *********. The meeting was held virtually using Microsoft Teams.

5 Reasons for the Request for Independent Review

When completing the Request for an Independent Review Questionnaire, Mr ********* answered the question, "Why are you unhappy with the CCG's [now ICB's] assessment of your [his mother's] care needs which led to the decision regarding your (his mother's] ineligibility for NHS Continuing Healthcare? by stating:

"Please see ********* representations dated 20/09/2022 and supplementary representations enclosed."

This was also the response to the question, "Why are you unhappy about the procedures followed by the CCG [now ICB] in reaching its decision?"

The Independent Review Panel had sight of both of these documents, (one dated 20 September 2022 comprising of 134 pages, and the one dated 7 March 2023 of 15 pages), and took the contents into account when making its decisions.

6 Evidence considered by the IRP.

In reaching its recommendations the IRP considered:

6.1 Documentary evidence as listed below:

- Documentary evidence in the case file prepared by NHS ********* Integrated Care Board (ICB)
- IRP Pro Forma/Summary of case
- Authority to Act/Consents
- Decision Support Tool (DST) dated 30 March 2021
- Outcome Letter for DST dated 12 April 2021
- Retrospective Social Services Adult Needs Assessment dated 15 June 2021
- Needs Portrayal Document, dated 3 November 2021 and 12 November 2021
- Submissions from ********* dated 20 September 2022
- Notes of Local Resolution Panel Meeting (LRM), held on 16 November 2022
- Outcome Letter from LRM, dated 2 January 2023
- Application from ********* to NHS England for an Independent Review, dated 23 January 2023.
- NHS-E Questionnaire signed by Mr **********, dated 27 January 2023
- Submissions from ********* dated 7 March 2023
- Care Home Records
- GP Records
- Social Services Record (see above)
- Mental Health Records

For a comprehensive list of all records considered please see case file.

6.2 Evidence given during IRP meeting on 3 May 2023.

7 The IRP's view of Mrs's levels of need under the Care Domains in the Decision Support Tool

7.1 Breathing

Assessed level of need		
ICB: Low	**Applicant:** Low	**IRP:** Low

Discussion at IRP: The ICB submitted that Low was the appropriate level of care need; Mrs ********* had a diagnosis of chest infections and episodes of breathlessness. **********, the family's representative agreed with the Low level of need: Mrs ********* had a diagnosis of COPD [Chronic Obstructive Pulmonary Disease], she had episodes of breathlessness which did not affect every day simple tasks and there were no identifying triggers, so a Low level of need is appropriate. Mr ********* agreed with the Low level and added that his mother's breathlessness was unpredictable. **IRP Deliberations:** The IRP considered the evidence. It noted that despite Mrs ********* having a diagnosis of COPD she was active frequently, walking around**********, however she did have some needs, based on her diagnosis and history. Accordingly, the IRP concluded that Low was the appropriate level of care needs for this domain, based on her having a condition (COPD) and that this did not have an impact on her daily living activities.

7.2 Nutrition – Food and Drink

Assessed level of need		
ICB: Moderate	**Applicant:** High	**IRP:** High
Discussion at IRP: The ICB submitted a Moderate need in the LRM meeting because of further evidence of the element of supervision: the MUST score went back to 0 from 2, there was weight loss, but it was stabilised which is why the level of care need was increased from Low to Moderate, there was a timely need at meal times, and Mrs****** was also seen by a dietitian and snacks and supplements were recommended. The representative continued that the leg oedema could have impacted the weight, and that there were discrepancies in weight recordings, but it was stable for the considered review period. Care records indicate at page 852 that Mrs ****** weight was at 60Kg. There was no difficulty in swallowing and no referral was made to SALT team. She was on thickened fluids but there was no regularity with this, so a Moderate level was awarded. The Chair noted that the date on page 852 was April 2021. Accordingly, she clarified at this point that the role of the IRP is to consider the DST held on 30 March 2021, and not a "consideration period", meaning that only evidence on that date (30 March 2021) and three months prior would be considered by the IRP. The ICB representative apologised and added that it considers either side which can reflect to three months before or after of the date of the DST. The family's representative submitted that they were contending the level, stating that a High level of need was required. The representative continued by saying that on 25 March 2021 some weight loss was recorded, nutritional supplements were		

implemented as there was a risk of malnutrition under the wider impact of leg oedema. The family considers that the MUST score is incorrect as further weight loss could have occurred but was not recorded because of the oedema. We agree that there were no choking concerns. Our main concern was malnutrition so we would feel a High level of need is appropriate.

Mr added that he was surprised that the MUST moved off from 2, as his mother was not eating at all, and the leg oedema could have added to the recorded weight due to the fluid retention in the legs.

When asked by the Clinical Adviser if her upper arm was measured, whether her clothes fitted, and commenting that Mrs ******** was having a lot of sugary food and had a protein-based diet like milkshakes and desserts which would have further affected the oedema in her limbs, Mr ********** said that we were in Lockdown [COVID restrictions] and could not comment on any assessments being done, that his mother went from a size 16 to a size 10, and possibly 8, and that regarding her diet, his mother's appetite changed with the progressing dementia, and her liking for sweet things became more and more prominent.

The family's representative from ********* added that generally Mrs ********* was reluctant with interventions.

IRP Deliberations: The panel considered the evidence. It considered that Mrs ********** was at risk nutritionally. It noted that Mrs ********** was able to be weighed despite challenge and that an upper arm measurement would have been useful. The Care Home records note that Mrs ********** was eating a large amount of food, although in some entries it was unclear if she ate all she was offered or only part of it. The panel noted Mr **********'s comment made in the Self-Assessment Form submitted to the DST meeting which stated, "She is essentially cachectic due to significant unintended weight loss." The panel was aware that Mr ********** is medically qualified.

The DST meeting checked with the Care Home staff and ascertained that Mrs ********** was receiving fortified food, adding that this "is not a prescribed dietary supplement following assessment from Dietician." However, the IRP took note of the evidence in the GP records that a letter from the Dietician dated 26 March 2021 recommended Fortisip and fortified foods.

The IRP was concerned about the diet being offered to Mrs ********** interacting with her oedema, and that her actual weight was being skewed by the weight of the fluid retention in her legs, leading to a BMI score which appeared to be acceptable (it was 23 at the time of the DST). The GP records note this same concern on 25 March 2021, recording that their "rough estimation of oedema – 1.5kg". The IRP accepted Mr **********'s evidence regarding the physical appearance of his mother, finding him a credible witness throughout. Mr ********** commented that his mother's clothing no longer fitted, and that he had been unable to visit for a period due to COVID restrictions. The IRP noted that this meant that the changes in Mrs **********'s physical appearance would have been obvious to him. The IRP noted that all the ICB assessments were virtual, meaning that, so far as the IRP was aware,

there were no direct observations of Mrs ******** from the professionals involved in the DST or subsequently.

Taking all this into account the IRP concluded that the appropriate level of care need for this domain was High. The descriptor for a High level of care need has a list of options, including "Nutritional status "at risk" and may be associated with unintended, significant weight loss." The IRP based its decision on Mrs ********** having lost a lot of weight, (such that her son considered her to be "essentially cachectic"), her dress size moved from 16 to 10 or even 8, and she was identified as being nutritionally at risk by a Dietician who saw her on 26 March, four days before the DST being considered by the IRP, by making the recommendation that Mrs **********'s diet should be fortified and supplemented.

The IRP did not conclude that the care level of High was appropriate based on the other options within the descriptor for a High level of care need.

7.3 Continence

Assessed level of need		
ICB: Moderate	**Applicant:** Moderate	**IRP:** Moderate

Discussion at IRP: The ICB submitted that Moderate was the appropriate level of care need, as Mrs ********** was double incontinent, there was a history of UTI [Urinary Tract Infections] and risks of constipation.

The family's representative agreed with the level of Moderate. Mrs ********** was at risk of constipation and was given Movicol and other medication. Her needs were unpredictable and intense as there was an enhanced risk of skin moist infection, and her needs required ongoing reviews. Mr ********** did not add anything to this.

IRP Deliberations: The IRP considered the evidence. Mrs ********** was doubly incontinent at the time of the DST and staff were required to support her with the use of pads, supervision, and reassurance. The IRP concluded that Moderate was the appropriate level of care need for this domain.

7.4 Skin (including tissue viability)

Assessed level of need		
ICB: Moderate	**Applicant:** Moderate	**IRP:** Moderate

Discussion at IRP: The ICB submitted that Moderate was the appropriate level of care for this domain. The representative said that Mrs ********** had bi-lateral leg oedema and was non-compliant with compression bandages. Her skin was intact, there was for no need of complex dressings, moisturising creams were used. There was intervention from a tissue viability nurse. Mrs ********** had a history of sores. On 16 March 2021 there was seeping of fluids, which improved and responded to treatment. On 25 March 2021, there was area of sore and redness in the lower leg, on 26 March 2021 care records indicate improvement in the leg wound. "Sore on leg went dry." The wound was measured at 3.0 cm long and 0.5 cm wide, and staff were told that a dressing should be applied if leakage occurred. The representative concluded by saying that we scored Moderate, as staff were managing wounds well.

When asked by the Chair if dressing the wound was recommended by the tissue viability nurse, the ICB representative replied that he could not comment on this as records do not indicate that. He added that leakage with a leg oedema is not uncommon, or sores, and that there is evidence of Mrs ********** being in compliance.

The family's representative agreed with the level of Moderate. He stated that Mrs ********** had a trauma wound which responded to treatment, and that wound dressing with oedema did present challenges. He continued that the tissue viability nurse was involved but Mrs ********** was resistant to receive care. There was ongoing care required for hygiene care needs with the family noting that three carers were required to give her a shower. Creams were prescribed on 21 March 2021, and generally two to three staff were quite frequently required when dressing the wound. The representative concluded that Mrs ********** was at a risk of skin breakdown with the complexity and the nature.

Mr ********** added that he was not sure how they helped with her legs. She was given compression socks but was reluctant to wear them and as there was difficulty with her behaviour, socks were hard to put on.

The Clinical Adviser asked if, as records show she had gross oedema and her skin being very fragile, she was referred to the GP or a tissue viability nurse for care and management and was informed that she was.

IRP Deliberations: The IRP considered the evidence. It noted that a few days before the DST there had been a deterioration whereby Mrs ********** had a trauma leading to broken skin. The fragility of her legs put her at risk of skin breakdown, and at the time of the DST she had an open wound.

Mrs ********** had cellulitis and lymphoedema, and dry skin. She was wandering most of the time she is awake and would not allow bandages to be applied, or treatment socks. No specialist dressings were applied, and the entry regarding the tissue viability nurse on 30 March 2021 states "would benefit from bandaging to reduce oedema but does not tolerate anything". Staff were asked to take measurements for stockings when Mrs ********** was resting. The Care Home Record of the same date states "advice to continue with cream."

Mrs ********* has heart failure which indicates that the leg oedema will not improve, and there is no evidence in the case file that her heart has been monitored during the COVID restrictions, nor that heart specialist nursing staff have visited.
The IRP noted that the GP records state a Waterlow Score of 11, indicating a level of risk, and that she was noted to have had episodes of cellulitis.

The IRP concluded that Mrs ********* has an identified skin condition that required daily monitoring, assessment, and preventative intervention without which her skin integrity would break down, and that the appropriate level of care need was Moderate on the date of the DST.

7.5 Mobility

Assessed level of need		
ICB: High	**Applicant:** High	**IRP:** High

Discussion at IRP: The ICB submitted that High was the appropriate level of care due to high risk of falls, the condition of her spine, that she had arthritis and it required two to three members of staff to manage her mobility. Mrs ********** had a history of falling, for example on 21 December 2020 she fell whilst walking, on 14 December 2020 she gradually slid down with assistance until she sat on the floor. She was found on her back near a radiator prior to this on 4 December 2020. She had another fall four days after the DST assessment. She had prior falls on 4 February 2020, 19 April 2020, and 17 September 2020. On 3 January 2021 Mrs ********** had a fall which required an admission to hospital where a hematoma was diagnosed. The representative concluded by saying that based on this rationale we awarded a High level of need.

The family's representative agreed with a High level of need. Mrs ********** had a high risk of falls based on her history. She had been admitted to hospital following a fall, she was incredibly restless frequently walking, and had a diagnosis of osteoporosis which required recurrent supervision.

The Chair asked Mr ********** if his mother was always very mobile, and he responded she became very restless when she went into her care home. He added that he thought that there were severe and complex needs with her restlessness.

The Clinical Adviser asked if there was any consistency of staff at Green Park and was told by Mr ********** that unfortunately due to COVID there were a lot of agency staff involved, so there was no continuity of care which made things difficult.

IRP Deliberations: The IRP considered the evidence. It noted that the Care Records demonstrate that Mrs ********** was mobile for most of the time she was awake, walking round the nursing home, using sticks to support herself. Sometimes she would leave the sticks behind, but not always.

The IRP concluded that High was the appropriate level of care need for this domain based on her falls history and her constant mobility leaving Mrs ********* at a high risk of falling.

7.6 Communication

Assessed level of need		
ICB: High	**Applicant:** High	**IRP:** High
Discussion at IRP: The ICB submitted that High was the appropriate level of care need. The level was increased to High at the LRM which noted that there were some conflicts in the records, for example some records indicated that Mrs ********** would refuse meals, but others contradicted that. At this time there was also a decrease in cognitive functions. The family's representative agreed the level being High. On 3 March 2021 Mrs ********** was recorded as being offered coffee, she said yes but continued walking. The representative submitted that Mrs ********** had no reliability to her responses, there was no recognition of her care needs, so we agreed to a High. The representative added that there was unpredictability with her needs so the staff anticipated her needs, which as the agency staff lacked familiarity, they unfortunately could not anticipate her needs well. Mr ********** added that he agreed that it was difficult to anticipate his mother's needs and carers could not grasp this due to her lack of ability to communicate with them. She could not articulate her needs at all. The Clinical Advisor commented that Mrs ********** was visually impaired because of bilateral cataracts. Mr ********** added that this did not help with communication. **IRP Deliberations:** The IRP considered the evidence. Mrs ********** was unable to communicate reliably. It noted that Mrs **********'s answers to questions asked of her could not be relied upon to be relevant, or based on her understanding of what was being asked of her. The IRP concluded that Mrs ********** did not understand and appeared to answer randomly. Mrs ********** could speak and did so, but staff needed to anticipate her care needs in order to provide them. The care records note that Mrs ********** was "chatting" with staff and other residents on occasions, but the panel accepted Mr **********'s submission to the DST that his mother cannot hold a meaningful conversation or prompt attention to her care needs. The care records also note that Mrs ********** was constantly walking around the care home, particularly at night, which the IRP considered could be part of an expressive communication, signalling, for example, that she was anxious, or perhaps in pain.		

Taking all this into account, the IRP concluded that Mrs ********* had a High level of care needs for this domain based on her being unable to reliably communicate her needs at any time and in any way, even when all practicable steps to assist have been taken. Staff had to anticipate most of her needs because of her inability to communicate.

7.7 Psychological and Emotional Needs

Assessed level of need		
ICB: Low	**Applicant:** Moderate	**IRP:** Moderate
IRP Discussion: The ICB submitted that the level went from Low to Moderate at the LRM. The representative stated that there were periods of distress and agitation, which could manifest in aggressive behaviour. There were disturbed sleeping patterns with restlessness, for which Zopiclone and Lorazepam PRN (as and when needed) were prescribed. The triggers were when it came to personal care and hygiene. Although medication was prescribed it was not frequently used or administered. The ICB representative continued by saying that the GP records on page 1091, state that the tissue viability nurse could not finish the examination of Mrs ********** because she did not like the intervention and did not allow the review. He continued by saying that there were delays in her treatment due to cognition and lack of understanding. The Chair noted that the case file indicated that the LRM had not changed the level of care need from Low and asked the ICB representative to confirm which level he was submitting to the IRP. The representative said he was a bit confused because the notes he was given to support him state a level of Moderate, but that might have been a mistake. He added that if the LRM agreed it was Low, then he would submit Low to the IRP. The family's representative submitted a Moderate level of care need, based on any individual who requires pharmacological medication prescribed and administered, then psychological and emotional needs was an ongoing issue. The representative continued that on 23 March 2021 Mrs ********** was not settled after medication being given, she was still restless and required further reassurance and support as indicated in the records. He added that Mrs ********** was not sleeping well after the GP changed her medication from 1 April 2021. She required a lot of reassurance and support was needed to settle her down; continuing healthcare was required even after administration of changed medication.		

There was a level of unpredictability of when Mrs ********** would become restless, or what length of time of providing care needs were impacted as it was very complex.

The Chair asked Mr ********** about his mother's mood when he visited. He replied that it was low at times, and he had spoken to the night nurse who had mentioned that the medication was not having any effects on her, maybe that is why it was not consistently given.

IRP Deliberations: The IRP considered the evidence. It was not able to take into account the comment made by the family's representative regarding the change to medication from 1 April 2021, since that is outside the date subject to the IRP's review (namely the date of the DST which was 30 March 2021).

The IRP noted that Mrs ********** was wandersome and did not appear to respond to prompts or reassurance. It also noted the impact her restlessness would have on her oedematous legs. The care records show that Mrs ********** appeared to try to communicate, ("chatting" with staff and other residents is recorded) and it considered that she was anxious and wandering as an expression of that anxiety, based on the staff being usually unable to engage her in social activity and her ongoing resistance to care interventions. The IRP also noted reference in the care home records where Mrs ********** was said to become involved in social activities.

The IRP also discussed that Mrs ********** could be in pain from her legs, having a diagnosis of osteoarthritis, however she was prescribed an analgesic patch which should have managed this.

The IRP concluded that there was sufficient evidence to indicate that Mrs ********** had care needs of a Moderate level for this domain. The descriptor for the Moderate level of care need states," 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." The IRP took the view that Mrs ********** had some considerable mood disturbance, anxiety (as evidenced by her wandering) and periods of distress, (as evidenced by the staff's having to offer reassurance which was not always successful in alleviating Mrs **********'s anxiety). The IRP also took into account that Mrs ********** had mostly withdrawn from social engagement with others, whilst acknowledging that she did appear to participate at times. The descriptor for the care level of Moderate continues, "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." The panel noted that Mrs ********** was consistently resistive to receiving care, and that the provision of medication did not appear to resolve these issues sufficiently for them not to impact on her overall psychological and emotional state.

Taking all this into account, the IRP concluded that Moderate was the appropriate level of care need, rather than Low because of the lack of response from Mrs **********, and the increasing impact on her daily activities.

7.8 Cognition

Assessed level of need		
ICB: Severe	**Applicant:** Severe	**IRP:** Severe
Discussion at IRP: The ICB said that the level of care need was increased from High to Severe at the LRM. Mrs ********** is in the advanced stages of dementia. She has a lack of self-awareness, and Aricept was discontinued. The family's representative agreed with the level being Severe. Mrs ********** has a diagnosis of Alzheimer's Disease and could not recognise her basic needs such as hygiene, there was evidence of disorientation, and could not recognise her surroundings or her son at times. He continued by saying that Mrs ********** had no recognition of risk and was reliant on carers for her basic needs, the staff were required to anticipate her needs, and she required support and monitoring 24-hours a day. There were concerns about Safeguarding and self-harm or neglect. The Chair asked if Mrs ********** had ever had a Mini Mental State Examination which would have given an indication of progression of the Dementia and was told by Mr ********** that she had not been assessed in that way. **IRP Deliberations:** The IRP considered the evidence. It noted evidence in the case file indicated that Aricept had not been discontinued, but the prescribing of it had been moved from secondary care to the GP on 27 April 2021 (a date outside the date of the DST in any case). Nevertheless, there was evidence in the case file that Mrs ********** had marked short and long-term memory issues, and disorientation to time, place, or person. Staff were noted to prompt and supervise her in all activities of daily living. The IRP concluded that Mrs ********** was unable to assess basic risks on the date of the DST and needed protection from harm and neglect. The IRP noted the link between Mrs **********'s cognitive impairment and her mood, which would impact on the domain of Psychological and Emotional. Taking all this into account the IRP concluded that Severe was the appropriate level of care need for the domain of Cognition.		

7.9 Behaviour

Assessed level of need		
ICB: High	**Applicant:** High	**IRP:** High
Discussion at IRP: The ICB submitted that High was the appropriate level of care need, Mrs ********** refuse interventions and staff had to retreat and retry. The representative continued that Mrs ********** was not aggressive, but refusal was consistent. Staff did manage her behaviour but there was variability for members of		

staff which did not help the situation. Care plans indicate two to three members of staff are required for daily tasks. There was also noncompliance in medication.

The family's representative agreed to High for this domain, adding that there was aggression and physical behaviour. He added that Mrs ********** was resistant to care of her skin, her nutritional and hygiene needs, and she was restless despite medication. He stated that carers could not manage well despite Mrs ********** receiving medication. She had a history of inappropriate behaviour, for example, going to other people's room and acting out when asked to leave. Having care given by three carers spoke to intensity of care, and also to unpredictability with the associated behaviour of Mrs **********. Also, there was complexity of care with risk association, and Mrs **********'s behaviour was impacted by other domains.

Mrs ********** add. that although it was not documented, his mother was very resistant to care, and it could take up to two to three carers for her hygiene needs.

IRP Deliberations: The IRP considered the evidence. It noted that the care staff managed to deliver care to Mrs ********** even though she was consistently resistant. Mrs ********** had challenging behaviour as evidenced by the need of staff to retreat and return, her potential to harm others or to be harmed by going into other residents' rooms, and that the planned interventions were potentially not going to be successful due to her behaviour. The IRP did note that there were no records to Mrs ********** not eventually receiving care. The IRP also took into account the recorded history of Mrs ********** hitting staff with her sticks which increased the level of care need as staff had to be cautious when approaching her at all times.

Taking all this into account the IRP concluded that High was the appropriate level of care need for Mrs ********** for the domain of Behaviour at the time of the DST, based on Mrs ********** posing a predictable risk with her challenging behaviour for which planned interventions were effective in minimising but not always eliminating risks.

7.10 Drug Therapies and Medication: Symptom Control

Assessed level of need		
ICB: Moderate	**Applicant:** High	**IRP:** High
Discussion at IRP: The ICB submitted that Moderate was the appropriate level of care need. Mrs **********'s medication regime was changed to reflect the pain from oedema and her spine, for which a patch was being used. The degree of analgesia was high. Staff would be more vigilant around medication which was of a regular pattern with no changes during the considered period. It was administered by a registered nurse who was qualified to increase or decrease treatment with guidance and review from the GP.		

The family's representative submitted that they were looking for a High level of need for this domain, monitoring of controlled substances and supervised administration falls into the High level of descriptor which requires a 24-hour monitoring. The representative continued by stating that there were interactions of needs with her medication with ongoing monitoring of Mrs **********'s emotional or medical pain needs.

The representative also commented that it was not noted in the notes but there was an incident of a heart failure which was later conveyed by the family.

Mr ********** said that the heart failure was out of the period of review. He added that he spoke to the GP around that time frame who suggested his mother will not be suitable for hospital care and needed a supportive environment.

IRP Deliberations: The IRP considered the evidence. The MARS charts in the case file list the following medication for 30 March 2021:

Sevodyne Pain relief patch 15mcgs weekly
Diprobase Cream (3 x daily)
Donepezil (Aricept) 5 mgs
Furosemide 40 mgs am.
Furosemide 20 mgs lunchtime

PRN
Conotrane cream (3 x daily)
Lorazepam 1mg
Macrogol
Zopiclone 3.75mg

Note: Lorazepam was not administered.

The IRP was concerned that there was not much indication in the case file about monitoring of Mrs **********'s pain levels, or symptoms which might have been having a significant effect. It noted that Mrs ********** was prescribed Lorazepam and Zopiclone on an "as and when required" basis, which meant that an assessment had be carried out by a registered nurse or specially trained care staff, on a number of times during the day, about whether she needed medication, which increased her level of care need.

At the time of the DST there were no records of Lorazepam being administered. However, the Care Home Records note that Zopiclone was administered, during the evening, when typically, staff would locate Mrs ********** walking around the home. The Records note that the Zopiclone was frequently not effective, and that in any case the common outcome was that Mrs ********** slept for a few hours in the early morning. She would then often nap in the corridors during the day.

The prescription of Zopiclone and Lorazepam PRN required a registered nurse or a member of specially trained staff to assess Mrs **********'s medication needs, and the panel concluded that this met the High level of care needs, bearing in mind the risks associated with both of these medications.

The descriptor for a High level of care need in the domain of Drug Therapies and Medication: Symptom Control states, “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 (Mrs ********** was given Zopiclone when she was walking about the unit, not sleeping), or risks regarding the effectiveness of the medication (Mrs ********** was noted to continue walking after being given Zopiclone meaning that staff had to observe her after she had taken the medication until it took effect), or the potential nature or severity of side-effects” (Mrs ********** may have fallen asleep in an unsafe place, such as on the floor). However, with such monitoring the condition is usually non-problematic to manage” (the IRP considered that the risk to Mrs ********** was reduced by the care provided by staff who remained with her after administering Zopiclone until she fell asleep safely.

In addition, the IRP noted that Mrs ********** received treatment for pain, and that staff would be required to monitor her pain levels, which was not straightforward given Mrs **********’s level of cognition and her difficulties with communicating. The descriptor for this domain continues by stating “Moderate pain or other symptoms which are having a significant effect on other domains or on the provision of care” (the IRP considered that the wandering behaviour exhibited by Mrs ********** may have been stimulated by her being in pain (as well as her psychological state), and that staff had to physically locate Mrs ********** as she walked around the home in order to provide her with care, thus having a significant effect on the provision of care).

The panel considered symptom control for Mrs **********, noting that her oedematous legs required constant monitoring and treatment in order to avoid damage to her skin. Her constant walking around the home, albeit with the aid of sticks, presented a risk of falls, and staff needed to be aware of where she was at all times, an issue which is reflected in the care home records. Mrs ********** was prescribed Furosemide which affected her urinary output and that required monitoring, and she was prescribed an opioid patch for the control of pain, identifying a need to monitor her level of pain. The panel noted that it is possible that Mrs ********** was restless due to a level of pain that affected her wellbeing.

Another factor impacting on her care is that Mrs ********** refuses to sit still and rest her legs, meaning staff have to monitor her more closely. At the time of the DST, she was constantly on the move, and would remove any bandages applied. Her oedematous legs would “leak” and she was prone to superficial wounds, making her overall management more difficult.

The IRP also noted that Mrs ********** has a diagnosis of COPD (Chronic Obstructive Pulmonary Disease) requiring staff to monitor her breathing at all times.

Taking all this into account the IRP concluded that High was the appropriate level of care need for this domain, based on her being prescribed medication on an “as and when required” basis, and her having symptoms that were having a significant effect on other domains and the provision of care, as well as the links to the descriptor as discussed in the paragraphs above.

7.11 Altered States of Consciousness (ASC)

Assessed level of need		
ICB: Low	**Applicant:** Low	**IRP:** Low
Discussion at IRP: The ICB submitted that Low was the appropriate level of care need based on one noted collapse, and therefore a reflection of historical needs. The family's representative agreed with this level of need, stating that nothing was highlighted from care home records just what was heard from the family. Mr ********** stated that his mother had a collapse at home and was taken to hospital, but no exact date can be given for this. **IRP Deliberation:** The IRP considered the evidence. It noted that Mrs ********** was diagnosed with Atrial Fibrillation which can lead to collapse, and the verbal evidence from her son that she had a collapse at home. Accordingly, the IRP agreed that the appropriate level of care need for this domain was Low, based on Mrs **********'s medical history.		

7.12 Other significant care needs to be taken into consideration.

Assessed level of need		
ICB: No Needs	**Applicant:** No Needs	**IRP:** No Needs
All present agreed that there were no other significant care needs which had not been taken into account by the other domains. This domain is available should such additional care needs make a significant difference. However, on this occasion, none were identified, and it was agreed by the IRP that there were No Needs for this domain.		

8 IRP's assessed levels of need for Mrs **********

Care Domain	P	S	H	M	L	N
Breathing					X	
Nutrition – Food and Drink	[redacted]		X			
Continence	[redacted]	[redacted]		X		
Skin (including tissue viability)	[redacted]			X		
Mobility	[redacted]		X			

Communication	[redacted]		X			
Psychological and Emotional Needs				X		
Cognition		X				
Behaviour			X			
Drug Therapies and Medication: Symptom Control			X			
Altered States of Consciousness					X	
Other significant care needs	[redacted]					X
Totals		1	5	3	2	1

9 The IRP's consideration of the four key characteristics

9.1 Nature

Nature 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.

Having considered the totality of the evidence, including the evidence in the DST dated 30 March 2021, the LRM Minutes following the MDT meeting held on 23 January 2023, contemporaneous records and the written submissions, as well as the oral evidence given at the IRP, the IRP summarised Mrs **********'s needs as follows (for full discussion of needs please refer to paragraph 7 above and the DST of 30 March 2021):–

Severe Care Needs: Cognition

- Mrs **********'s cognition had been deteriorating for a number of years, (as would be expected in a person with an Alzheimer's diagnosis), and at the time of the DST she was disorientated to time, place and person. She continued to be prescribed and given Donepezil, a cognitive enhancer, although she had been discharged from the Mental Health Services and prescribing this drug then came under the overview of the GP.

High Care Needs: Nutrition, Mobility, Communication, Behaviour, Drug Therapies & Medication

- Mrs **********, on the face of it, had a BMI of 23, a score which is within the normal range. However, she had oedema in both of her legs, and the GP calculated that the additional weight from this fluid was 1.5Kg. Evidence from Mrs **********'s son, who had not seen her for a period time due to COVID restrictions, was that she had lost a lot of weight and appeared "cachectic." Mrs ********** was physically active for most of the day and night, increasing her nutritional needs. She was prescribed fortified food, including Fortisip, by a Dietician in a letter dated 26 March 2021, just prior to the date of the DST. Mrs ********** was able to feed herself, however, staff had to prompt and persuade her to eat.

- Mrs ********** was independently mobile and wanders around the home, using her sticks as a support, and as such was at a high risk of falls at the time of the DST. Staff were required to constantly monitor where she was, and she had a number of falls just prior and after 30 March 2021. Carers would transfer her in and out of bed as she could be unsteady, and a sensor mat was in place to alert staff when she attempted to mobilise unaided.

- In line with Mrs **********'s ongoing cognitive deterioration, her ability to communicate deteriorated, and the totality of the evidence suggests she could no longer reliably communicate her needs. Whilst there is some limited evidence that Mrs ********** could still, at times, express a preference for food, she had to have most of her needs anticipated because of her inability to communicate.

- Mrs **********'s behaviour was challenging, both verbally and physically. She was consistently resistance to receiving care and required two to three carers to meet her care needs. Staff had to adopt a "leave and return" strategy which prolonged the provision of care. Staff needed to monitor where she was in order to prevent her going into other residents' rooms. Staff had to be cautious when providing care as Mrs ********** had hit staff with her sticks.

- Due to her advanced dementia and lack of understanding, Mrs ********** required all of her medication to be administered to her. She was prescribed Lorazepam and Zopiclone PRN (as and when required), although there is no evidence of Lorazepam having been given in the three months prior to the DST. Staff would administer Zopiclone to help her sleep, (it is recorded as having little effect, and that staff would sit with her to ensure her safety after administration) meaning that they would have to monitor and assess her needs for medication, increasing her care needs level. Mrs ********** had a number of physical symptoms, (pain, leaking legs, restlessness, resistance to care, sleeplessness, anxiety) that required staff to monitor her closely. In addition, Mrs ********** had a diagnosis of COPD which required constant monitoring of her breathing.

The IRP found that on the date of the DST Mrs **********'s total needs were not consistent with the type and quality of care that a Local Authority social services department would have been expected to legally provide, even alongside visiting NHS services and an NHS FNC contribution. In reaching this conclusion, the IRP noted that the 'level' of Mrs **********'s needs in a number of the DST domains were High which had an impact on the totality of her needs and on the intensity and complexity of needs, as did the impact of interactions between needs as discussed in paragraph 9.3 below.

In coming to this conclusion, the IRP noted that the DST of 30 March 2021 and the subsequent LRM on 16 November 2022 did not appear to fully analyse and evaluate the nature of Mrs **********'s on the date of the DST, and in particular did not appear to recognise the full nature and risks of Mrs **********'s nutritional needs, and the needs for monitoring captured in the domain of drug therapies & medication: symptom control and the effects on her challenging behaviour on the number of staff offering her care.

The IRP considered the principle of "well-managed needs," as set out in paragraph 162 of the National Framework (National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care revised in July 2022) which clarifies that "well-managed needs are still needs." The IRP concluded that in the domains of Behaviour, Psychological & Emotional, Nutrition, and Skin Integrity, Mrs **********'s care needs were well managed, and that staff knew when to provide care, and when to leave her for a while and return later to provide care.

For example, Mrs ********** rarely settled during the day (walking around the home more or less continuously) and slept only for short intervals at night, and sometimes during the day in the corridors. Staff were required to constantly monitor her whereabouts and to assess her physical and mental state. Staff were required to be particularly careful when providing personal care due to the fragility of her skin generally, and specifically for her legs which were swollen. Staff had to be cautious approaching Mrs ********** as she could become both physically and verbally abusive. A registered nurse or a specially trained member of the care staff were required to provide her with her medication. Mrs ********** was consistently resistive to care, although there are no records of her care needs not being met eventually.

The IRP considered that Mrs ********** had ongoing needs for which she was receiving excellent care, but the level of care needs required were such that she was eligible for NHS Continuing Healthcare based on the nature of her care needs, which were such that they had an effect on her overall health and wellbeing, and the type and level of care delivery and monitoring.

Taking all this into account the IRP concluded that Mrs ********** had a primary health need on the date of the DST, namely 30 March 2021, based on the nature of her care needs and as such was eligible for NHS Continuing Healthcare.

9.2 Intensity

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

After considering the totality of the evidence the IRP concluded that Mrs *********'s needs had a degree of intensity around the care she needed on a daily basis to keep her safe and to meet her needs. For example, it was difficult for staff to meet her nutritional needs as she was constantly walking around the unit, even though it was unsafe to do so, and although offered food, she would often not eat all she was offered.

Staff were required to constantly monitor where Mrs ********* was and what she was doing, and when providing care needed to be vigilant in order to protect the integrity of her skin. The quantity and degree of those needs inevitably increased

both the time and the level of support required from staff to meet Mrs **********'s care needs.

Mrs ********** was consistently restless, and sleep deprived, meaning that staff had to be vigilant about her whereabouts in the home, and, as evidenced in the care home records, would have to sit with her until she settled, if she was given Zopiclone, to prevent her getting out of bed putting herself at risk of falling.

The IRP took into account the reports of the length of time required to deliver care to Mrs **********, including the frequency of the need to adopt the strategy of "leave and return", the constant monitoring of Mrs **********'s whereabouts in the home both to protect her from harm, and from her going into other residents' rooms, that two to three carers were required to provide her with personal care, including personal hygiene, as evidenced orally in the IRP hearing by the applicant and the ICB, and that she had care needs over several domains.

Mrs ********** had a number of physical symptoms which required monitoring by staff in order to manage her pain, her skin, her nutrition, and her psychological & emotional wellbeing, involving a level of care from staff over and above the usual level of social care which is the legal requirement of a Local Authority to provide.

Having considered the evidence, the IRP concluded that Mrs ********** had a primary health need based on intensity on 30 March 2021, and as such was eligible for NHS Continuing Healthcare based on intensity.

9.3 Complexity

Complexity 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 interaction 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 where a physical health need results in the individual developing a mental health need.

The IRP concluded that a high level of skill was required from care staff to manage Mrs *********'s mental and physical conditions and to monitor and manage her care.

The IRP found that this was largely due to the interaction of needs, and the impact that Mrs *********'s significant cognitive impairment had on her physical needs.

Although Mrs ********* had an acceptable BMI score, the evidence that she appeared cachectic was accepted by the panel and it concluded this indicated that, despite being offered a good diet, she was nutritionally at risk. The complexity was the link to her heart failure and oedematous legs, and the interaction between domains, specifically the domains of Cognition, Nutrition, Skin, Mobility, Communication, Behaviour and Drug Therapies and Symptom Control. It appeared that, probably due to her cognitive impairment, Mrs ********* did not understand

the need to eat and despite carers offering her food, she would refuse it, or just leave it and continue her walking around the home. Walking around the home increased the risk to her skin, and at the time of the DST she had a small wound, for which she resisted treatment. Her continuous mobilisation meant that she was constantly at risk of falling and staff were required to monitor and supervise her, adding to the complexity of providing her with care. In addition, staff would be cautious given that Mrs ********** had a history of verbal and physical aggressive behaviour.

Mrs ********** was unable to communicate her needs at any time and staff were required to anticipate her needs, and when she was offered assistance, she was frequently resistant, meaning that staff would have to approach her several times in order to meet her needs. At all times, staff were required to monitor Mrs **********'s medication needs, and a registered nurse or specially trained member of staff was required to make decisions regarding the "as and when required" medication that she was prescribed.

Taking the above into consideration and the totality of Mrs **********'s needs as discussed in paragraphs 7 and 9.1 above, the IRP found that at the time of the DST the level of input and skill needed to meet Mrs **********'s needs, and to anticipate and plan for changes in her condition, were more than the type of care, planning and monitoring that a Local Authority would be expected to provide, even where the NHS is paying for an element of registered nursing care by way of an NHS FNC contribution.

Accordingly, the IRP found that Mrs ********** was eligible for NHS Continuing Healthcare on the date of the DST, based on the key characteristic of complexity.

9.4 Unpredictability

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

The IRP found that whilst Mrs ********* undoubtedly had many needs, with some interaction of needs during the review period, as discussed in the paragraphs above, that these were not 'unpredictable' so as to evidence a primary health need.

In coming to this conclusion, the IRP disagreed with the written submissions that Mrs *********'s care needs were unpredictable based on her diagnosis of Alzheimer's Dementia, her Mobility, or her history of Altered States of Consciousness.

Unpredictability is not about anything untoward or unexpected ever happening to a person or about predicting every health episode that may occur, for example when someone wanders or has a fall as happened in Mrs *********'s case.

The IRP agreed that, upon review of all contemporaneous records, there was no evidence to suggest Mrs *********'s care changed at short notice, or that care plans

would have needed to be frequently amended. Due to familiarity with Mrs *********, care home staff were aware of any changes in her presentation and were able to anticipate her care needs and the level of support required to meet those needs, and although there was an expected deterioration in both Mrs *********'s mental and physical health presentation she could not be described as having a fluctuating or rapidly deteriorating condition associated with a primary health need.

9.5 Overview of the 4 Key Characteristics

The IRP looked at the totality of Mrs **********'s care needs and how the four key characteristics impacted on her. It took into account the nature of her care needs and noted that she had significant needs across several domains which increased the amount and skill level required of the staff caring for her. In summary, the IRP concluded that Mrs ********** had 1 Severe care need for the domain of Cognition, and 5 High care needs for the domains of Nutrition, Mobility, Communication, Behaviour and Drug Therapies and Medication: Symptom Control, as well as a number of Moderate and Low care needs.

There were interactions across the domains, such as between Cognition, Nutrition and Continence, where it is probably that her reduced cognition caused her to lose an understanding of the need to eat, and her incontinence raising the risk to the integrity of her skin. In addition, Mrs ********** was resistive to care, and this caused some complexity for staff who, although there are no reports of her not receiving care, had to approach her carefully and leave and return in order to ensure that she was looked after appropriately such that there was no threat to her general health. The IRP noted Mrs **********'s consistent restlessness and considered that there were interactions with other domains, such as Cognition, Drug Therapies & Medication and Behaviour which needed to be taken into account by staff when meeting her care needs.

Regarding Intensity, the IRP noted that Mrs **********'s care plan indicated that two to three staff could be required to provide her with care, especially that of a personal nature. This level of care is intense by definition and appeared to be a regular occurrence for Mrs **********, such that it was written into her care plans.

However, the IRP did not consider Mrs **********'s care needs to be unpredictable, noting that she appeared to have her routines and to have predictable behaviour when offered care. The IRP noted that her care plans showed no evidence of rapid changes having to be made to accommodate changes in her care needs.

Having carefully considered the frequency and length of care interventions coupled with the levels of skill, knowledge and experience required to deliver them successfully, and the totality of her care needs, the IRP concluded that the nature, intensity, and complexity of Mrs **********'s care needs demonstrated a primary health and need.

10 The IRP's application of the "incidental and ancillary" test in Mrs **********'s case

The IRP considered that, taken as a whole, the nursing or other health services required by Mrs ********* were more than incidental or ancillary to the provision of accommodation which local authority social services are under a duty to provide and were of a nature, intensity and complexity beyond which a local authority whose primary responsibility is to provide social services could be expected to provide.

11 The IRP's view on the primary health need test

Taking into consideration all of the evidence of Mrs *********'s needs and the nature, intensity and complexity of those needs, the IRP concluded that she did have a primary health need.

12 Further comments

None.

13 The IRP's recommendation on eligibility

The IRP concluded that Mrs ********* did have a primary health need. It therefore recommends that she was eligible for NHS Continuing Healthcare.

The IRP's consideration of procedural issues

14 The IRP's view on procedural issues raised by applicant.

********** raised three process issues at the IRP.

1. Lack of signature from social worker on the DST

The IRP also noted this, and the ICB representative was given the opportunity to respond. He stated that during COVID 19 restrictions it had not been possible to obtain signatures from all present when conducting assessments virtually. He said they now asked the social worker to send in an email verifying their agreement with the assessment.

The IRP accept that COVID 19 restrictions had been an issue at the time of the DST (30 March 2021) but considered it would demonstrate a multi-disciplinary approach to the DST assessment if a copy of the email from the social worker verifying the agreement with the decision was included in the case file, for the avoidance of doubt.

The IRP decided to make a recommendation.

2. ********* complained that the Key Characteristics of Complexity and Unpredictability were not discussed in sufficient details in the DST, dated 30 March 2021 (page 145 of the case file).

The IRP noted that the Key Characteristics of Complexity and Unpredictability were limited to some four or five lines and agreed with this observation from *********. It decided to include this issue when it made its recommendation.

3. ********* commented that under "Complexity" it was written that Mrs **********'s needs "can be managed with the level of care interventions she receives in the EMI Nursing Care home." The family's representative pointed out that NHS Continuing Healthcare can be applicable irrespective of where someone presides.

The representative from the ICB was unable to comment as he had no access to the case file at the hearing.

The IRP agreed with this observation from ********* and decided to also include this matter in its recommendation.

15 The IRP's view on procedural issues it has identified (if any)

None.

16 The IRP's recommendations on procedural issues

Having regard to the issues raised above concerning the ICB's procedure the IRP recommends:

That ******** ********** ICB review the DST written by the Multi- Disciplinary Team for Mrs ********* on 30 March 2021 and consider if there are any training issues for staff with regard to:

1. Ensuring the agreement of all members of the MDT is demonstrated.
2. Ensuring that the discussion of the 4 Key Characteristics is robust.
3. Ensuring the location of the care received is not included as part of the discussion of eligibility.

Signed:

Annex: Meeting held to consider Mrs **********'s case on 3 May 2023

1. At the beginning of the hearing the Chair confirmed to all present that none of the Independent Review Panel (IRP) members had any prior knowledge of or contact with Mrs *********, and that none of them had any conflicts of interest.

2. The Chair informed those present that the report of the hearing is usually sent out by NHS England within six weeks.

3. The Independent Review Panel would like to thank Mr ********* for attending, as it is always helpful to hear directly from a family member