NHS
Norfolk and Waveney
Integrated Care Board

Norfolk and Waveney ICB

NWICB Framework for the Commissioning of One-to-One Care within Care Home Settings Policy & Procedure

Document Control Sheet

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Version	**1**
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Produced by	Associate Director of NHS Continuing Healthcare and Complex Care.
What is it for?	To advise and provide guidance on the assessment, implementation, and use of additional and one-to-one monitoring for individuals whose care is commissioned by the ICB within care home settings
Evidence base	
Who is it aimed at and which settings?	
Consultation	N/A
Impact Assessment:	
Other relevant approved documents	• ICB Commissioning Policy for NHS Continuing Healthcare and Complex Care • LPS National Framework for NHS Continuing Healthcare (2022)
References:	• Mental Capacity Act (2005) • Equality Act 2010
Monitoring and Evaluation	
Training and competences	
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Version Control

Date	Detail of Change	Author	Version
August 24	Newly developed policy	Director of Quality Assurance in Complex Care ICB	1

Contents

1 STATEMENT OF OVERARCHING PRINCIPLES

All Policies, Procedures, Guidelines and Protocols of the Norfolk and Waveney Integrated Care Board (hereafter referred to as the "ICB") are formulated to comply with the overarching requirements of legislation, policies or other standards relating to equality and diversity.

2 INTRODUCTION

A number of individuals in receipt of NHS Continuing Healthcare (CHC) residing in care home settings require support across a 24-hour period for the purpose of meeting their identified health and care needs. A proportion of these individuals have high levels of risk, associated with the nature of their needs, which can require closer monitoring and supervision to manage.

Individuals may require closer supervision due to, for example, a high risk of harm to themselves or others, a very high risk of falls or a high risk of choking (though these reasons are not exhaustive). For these people, they, their care team, or representative may suggest or identify a need to increase their level of support, which may require additional funding to facilitate, following a risk assessment.

This policy provides a framework to aid decision making relating to the requirement for enhanced observational support, or one-to-one observations, as part of an individual's care package/plan. This policy aims to comply with the laws set out under The Mental Capacity Act (2005) and compliments the Commissioning policy for NHS Continuing Healthcare and Complex Care which can be found on the ICB website.

For the purpose of this policy, 'one-to-one observations' refers to: "One designated healthcare staff member who is knowledgeable and trained about the resident's care plans and risk assessments, assigned to one resident for attentive, continuous observations during a set period of time". This staff member must have immediate access to the individual at all times as per the observation agreement signed by the ICB and the care home.

The individual becomes the assigned member of staff's responsibility for the duration of the one-to-one hours and no other resident is assigned to them during that period, unless stated within the agreement with the ICB / care plan. Rest breaks of the staff member should be covered at all times, which is the responsibility of the care home.

The purpose of the one-to-one observation should be to minimise the risk that an individual poses to themselves or others, outlined in their care plan or needs assessment. The implementation of one-to-one observations should only be considered when all other less restrictive options have been tried and failed. It should be in place only where clinically justified according to a thorough needs-based risk assessment.

3 PURPOSE

The purpose of this document is to advise and provide guidance on the assessment, implementation, and use of additional and one-to-one monitoring for individuals whose care is commissioned by the ICB within care home settings. This policy aims for all additional monitoring arrangements to be ethical, equitable, necessary, and proportionate, person centered, safe and reasonable.

This policy is in place to support staff within care home settings to request additional support appropriately to receive a timely response. It informs of the expectations of the ICB upon considering, agreeing, reviewing, reducing, and withdrawing any additional funds for one-to-one monitoring.

This policy provides a clear pathway and process for requesting and implementing one-to-one observations in a fashion which adheres to local and national policies as noted in section 10.

This policy implements standardised forms to use when requesting one-to-one observations.

This policy aims to reduce the risk of restrictive interventions being used unnecessarily or disproportionately and to ensure that where this level of care and support is required, it can be agreed in an efficient way.

This policy is in place to ensure that all requests for one-to-one monitoring adheres to the NHS Continuing Healthcare (2022) framework which states "the need for a clear clinical rationale and evidence to support any subjective judgement in relation to resident needs to enable the commissioning of an appropriate care package".

This policy is intended for use by the Norfolk and Waveney ICB Continuing Healthcare team. It will apply to all care homes caring for individuals in receipt of CHC funding, except where it has been identified that the individual requires bespoke or highly specialised placement that includes enhanced observations as standard.

This policy is also intended for sharing with individuals in receipt of CHC funding, their families or representatives, and local health and social care services, including the acute hospital teams for planning and discharge purposes.

4 EQUALITY STATEMENT

The ICB will ensure that all staff, volunteers, service users and visitors are treated with dignity and respect, and no individual is treated differently on the grounds of their marital status, maternity, race, gender, gender reassignment, disability, age, religious belief, or their sexual orientation in accordance with the Equality Act 2010.

The ICB assures staff, volunteers and people entitled to our services are treated fairly, equally and with respect and dignity. The ICB will challenge discriminatory attitudes and provide rules and standards of behaviour.

The ICB will monitor the use of this Policy, and will ensure that the policy is implemented fairly, and will take action if it appears that it is has a disproportionate effect.

5 SCOPE

This policy applies to all employees of the ICB, including fixed term or agency employees when working within the ICB and whilst on ICB business.

6 OTHER POLICIES

- The Mental Capacity Act (2005)
- Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards (LPS National Framework for NHS Continuing Healthcare (2022)
- ICB Commissioning Policy for NHS Continuing Healthcare and Complex Care

7 POLICY DETAILS

7.1 Roles and Responsibilities

ICB staff	Staff within the CHC team have a duty to familiarise themselves with this document. CHC staff should support care homes to access this document and ensure that all requests for one-to-one from the care home comply with the guidance outlined within this document. CHC clinical staff have a duty to carefully review and consider all requests for one-to- one care. They are also responsible for identifying the need for one-to-one / additional observations upon new and review assessments. All CHC staff have a responsibility to approach a senior colleague for advice and support in cases that are complex or unclear, to ensure the needs of the individual are considered and at the forefront of all decision making. In addition, CHC staff should approach specialist services (dementia services, falls teams etc.) for advice and guidance where necessary, to ensure all less restrictive options are considered before the implementation of one-to-one.
Care Home and Domiciliary care staff	Care managers have a responsibility to become familiar with this document and should ensure that staff within the home are aware of the documentation expectations of the ICB for those being considered for or receiving one-to-one monitoring. Care managers must follow the one-to-one pathway (Figure 1. Section 11.3), when requesting funds for increased monitoring of a resident in receipt of NHS CHC. Care staff have a responsibility to liaise with the CHC team if there is any part of this policy which is unclear, or they need support to implement. Care staff must ensure that they have understood the expectations set out within this policy before signing the memorandum of understanding (found in appendix B). Care staff have a responsibly to access support from local services to ensure the needs of their residents are met. A request for one-to-one care should not be in place of care and support interventions which are in the remit of the care provider.

	Care staff have an obligation to inform the CHC team upon any changes to a person's needs which may affect their need for one-to-one observations. This should be done regardless of whether a formal review of the one-to-one is due. By withholding information regarding a change of need, care providers may be at risk of breaking the commissioning agreement and recharges applied.
Collaboratively	CHC and care staff should, at all times, uphold effective and respectful communication and cooperation with one another and ensure that all discussions and decisions are made with the individual or resident.

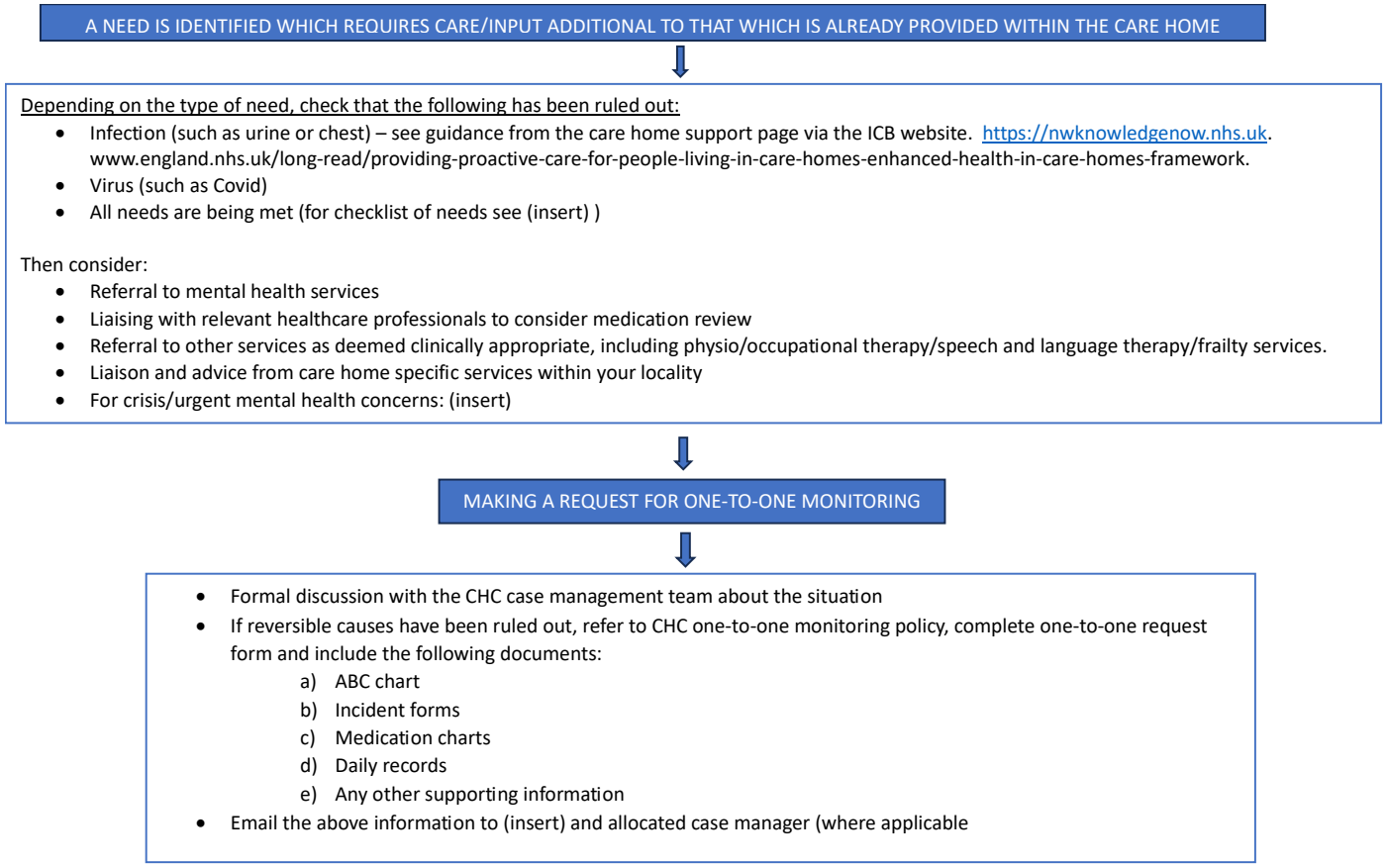
7.2 Procedure for Requesting One-to-One Funding

The Mental Capacity Act states "before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action." This principle must be considered when requesting one-to-one monitoring for an individual who lacks capacity to consent to these arrangements. It is crucial for different methods of support, de-escalation, and treatment to be tried before considering one-to-one monitoring, which is an invasive intervention.

Before considering submitting a request for one-to-one monitoring, care providers are expected to have addressed the needs of an individual in less restrictive ways, utilising local services. Consider the following:

i. What has been tried so far? Have all other less restrictive options been tried and failed?
ii. Has the use of virtual ward been explored.
iii. Risk assessments: assess and rate the level of risk and harm and the type of harm and likelihood of that harm occurring.
iv. Begin monitoring charts: ABC charts, falls logs, food diaries etc. For dementia specific documentation advice visit www.icaredementia.org
v. Has the person been referred to, assessed, or supported by a specialist service? For example, if there is a falls risk, have they been assessed by a physiotherapist or frailty team? Or if the risk is behavioural or related to a person's psychological state, have they been referred to or seen by the local mental health service?
vi. Involvement of the person, their family, representative or advocate should be considered in all instances. It may also be appropriate to involve the person's care team in the process of requesting increased monitoring, for example, their mental health team or care coordinator.
vii. The ICB requires evidence that the principles of The Mental Capacity Act have been followed prior to the request for one-to-one monitoring. This evidence should include a Mental Capacity assessment, Best Interest documentation and DoLS application. This ensures that not only has the individual's legal rights been considered, but placed at the heart of the decision-making process, which has been carefully considered, weighing up the type and level of need in relationship to proportionate responses and the likelihood and seriousness of harm.

Figure 1: Guidance flowchart for care staff requesting one-to-one monitoring via NHS CHC



The ICB will request evidence of the above actions being taken before considering a request for funding of one-to-one care, as detailed below.

When submitting a request for one-to-one monitoring, the care provider should include:

viii. A care plan / clear statement of needs and risks
ix. Be specific about timings of the one-to-one being requested: For how long? How often? What time of the day or night?
x. What would the purpose of the one-to-one be? (for example: the 4 hour one- to-one between 18.00 – 22.00 would be to support Mrs. Smith during the peak of her sundowning period when she becomes particularly distressed and disorientated which often causes other residents to shout at her).

The request should be emailed to the CHC team secure email address nwicb.chcclinicalteam@nhs.net The request should be accompanied by the required documents as outlined above.

Care providers should expect a response to a one-to-one request during normal working hours of 09.00 – 17.00 weekdays (excluding bank holidays). Requests after 16.00 may not be responded to until the next working day. For out of hours requests and implementation of one-to-one, care homes should ensure that there is clear clinical rationale and evidence why this intervention needed to begin before receiving confirmation from CHC due to the level of risk or urgency of the situation.

The CHC team will authorise one-to-one monitoring for an agreed period, depending on the nature and acuity of the individual's needs. The review period will be clarified and agreed upon the funding decision. Funding within the ICB is subject to approval via a financial authorisation panel request and in some circumstances, is discussed within a high cost and complex case meeting, held daily

involving a panel of stakeholders.

At the point of authorisation, the agreement form found in appendix B of this document, is to be completed by both the care provider and CHC team. The CHC case manager and line manager will monitor the number of one-to-one provisions being funded and ensure all reviews are facilitated.

7.3 Conditions of Agreeing One-to-One Funding

Once all stages of section 11.3 have been addressed, a memorandum of understanding (see declaration within appendix B) will be shared with the care provider and patient/relative/representative for signing. This is to ensure the following agreements are carried out:

- Thorough documentation kept and provided by the care provider, which may include, but not exhaustive: monitoring charts; intervention charts; incident reports; ABC charts; or any other documentation relating to the care and intervention provided to the person.

- The care provider and the ICB will maintain open lines of communication which allows the exchange of information and documentation as required, in a timely fashion, to ensure funding is seamless and care plans are followed with the person at the heart of all interaction.

- As above, the care provider and ICB will work together to ensure that visits and meetings can be facilitated where appropriate, to review and monitor one-to-one arrangements being funded via CHC.

In any instance where an individual or their family/representative wishes to implement one-to-one or additional care or monitoring where a clinical need is not present, this will not be authorised by the ICB. However, an individual/their family can make private contractual arrangements with the care home for care outside of the assessed need, but this must not include any core services/costs funded under contract by the ICB. In such circumstances the ICB should be notified of the private arrangement by the provider so that it is able to make clear to both provider and individual that the ICB has no liability for the care that is being commissioned privately as it is not based upon the ICB's assessed need of the individual.

Requests for one-to-one funding to manage falls risks will be carefully considered. Best practice and NICE Guidelines (2013) advise on the use of assistive technology to manage this risk. Multifactorial assessment and interventions and involvement from local frailty and falls services should also be considered, prior to requesting 1:1 for falls management.

All persons in receipt of funding for one-to-one / additional observations will be reviewed regularly. The frequency and length of the one-to-one will be reviewed, and the review dates will be agreed upon approval of the request and following subsequent reviews. The care homes have a duty to facilitate reviews as agreed and should be aware that payment of the one-to-one provision depends on the evidence provided for its purpose by the care home staff.

Care staff should be prepared to provide documentation upon request to ensure payment of one-to-one monitoring by the ICB. This could include staff timesheets and rotas to provide evidence of hours worked to cover the one-to-one hours.

The following points should be noted by the care provider in relation to staffing of the one-to-one care:

- In all instances, the first option for staffing the one-to-one would be via the workforce of the care home/ establishment where a person's care is being delivered already.
- If staffing numbers cannot accommodate this provision, in most circumstances it will be the responsibility of the care provider to source agency or temporary staff to provide this input. The ICB will pay the care fee, in addition to the fee for the additional monitoring, directly to the care provider, for the agency arrangements to be managed by care staff directly with the external source.
- The external staff member would be required to work under the jurisdiction, insurances and standards of the care home and should receive appropriate induction and access to the person's care plan at the commencement of each shift.
- It will be the responsibility of the care provider and their agreement with the external agency to ensure that the one-to-one carer is working within the agreements of the individual's care plan. The one-to-one carer should not be used to bolster general staffing numbers within the care home and should be designated to the person's care only, or as agreed between the care provider and the ICB.
- Specifically for care homes, they must ensure, in all cases, that the staff member providing the one- to-one is rostered in as additional support specifically for this provision and is not counted as part of the core healthcare staff on floor duty for the other residents.
- It is the expectation of the ICB that in cases where external agencies are used to staff the one-to-one that these agencies are Care Quality Commission (CQC) registered and compliant.

7.4 Training Requirements

The care provider should seek training opportunities, where required, to ensure implementation of one-to-one monitoring is therapeutic and meaningful for the individual in accordance with their care plan.

Staff working within care that support residents with behavioural challenges should be able to access support from their management team. Care placements may also wish to consider additional training for staff, such as the Positive Behavioural Support training module provided by the Association for Psychological Therapies, for example. Other suggested training could be in relation to delirium, depression, and de-escalation. Training and regular support can increase confidence in staff and management teams and organisations and enhance quality of care and experience for residents. Training care will not be funded by the ICB unless in specific areas.

8 HELPFUL LINKS

Enhanced Health in Care Homes Framework (EHCH) Version 3

Knowledge NoW

NICE Guideline 10

NICE Guideline 161

www.icaredementia.org

APPENDIX A: ABBREVIATIONS AND DEFINITIONS

Abbreviation / Item	Definition
CE	Chief Executive
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
NHS	National Health Service
SC	Social Care
We	The ICB
NICE Guidelines (NG)	National Institute for Clinical Excellence Guidelines which provides national guidance and advice to improve health and social care. NICE Guideline 10 (2015) in particular section 1.4.11, has details on the varying types of observations within psychiatric settings, though the needs of care home residents are likely to differ, as will the level of observation. These different types or 'stages' of supervision of a person to maintain their safety and wellbeing will depend on their needs and up to date risk assessments.
The Mental Capacity Act (MCA)	An act in place to safeguard people who may lack the mental capacity to make decisions about their care and treatment and applies to those aged 16 and over.
Deprivation of Liberty Safeguards (DoLS)	Comes under the remit of the MCA and applies when a person (18 years or older) is under continuous supervision and control due to their health or social care needs and is not free to leave and lacks the capacity to consent to these arrangements.
Liberty Protection Safeguards (LPS)	LPS will replace the DoLS system to deliver improved outcomes for those who are, or need, to be deprived of their liberty. It will provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements.
Risk Assessment	The process of identifying what hazards exist in the workplace and how likely it is that they will cause harm to employees and others. It is the first step in deciding what prevention or control measures need to be taken to protect staff from harm.

APPENDIX B: ONE-TO-ONE COMMISSIONING AGREEMENT

ONE-TO-ONE COMMISSIONING AGREEMENT

This form is for use and completion by the care home and CHC case manager for the provision of one-to-one monitoring.

This form is only to be completed once the following steps have been followed:

1. A member of the CHC team have confirmed that the one-to-one request has been approved;

2. The care home representative has read the 'Commissioning of One-to-One within Care Homes' policy.

Once completed, please return via secure email to nwicb.chcclinicalteam@nhs.net and copy in CHC case manager where allocated.

Please note that funds for the one-to-one provision will not be released until this form is returned to the CHC team.

Name			
NHS Number		**Date of birth**	
Date of CHC eligibility			

2 PLACEMENT DETAILS	
Name & address of care home	
Name & designation of person requesting funding	
Date funding requested	

3 DETAILS OF ONE-TO-ONE REQUEST	
Number of hours:	
Time frame:	
Purpose (summary)	
Provider: (if different to care home)	
Latest CQC inspection date & rating:	
Hourly rate:	£
Total weekly rate:	£
Date 1:1 agreed by ICB:	
Name of CHC staff member completing the agreement	

4 DOCUMENTATION	
This section MUST be completed in order to secure funding (please provide copies)	
One-to-one care plan in place?	
Monitoring charts in place?	
Family / representative aware of arrangements?	
Capacity Assessment completed? **Date:**	
Best Interest Decision completed? **Date:**	
DoLS submitted/updated? **Date sent:**	
Activity plan in place for 1:1 input?	
Date of next planned one-to-one review:	

5 COMMENTS / OTHER RELEVENT INFORMATION
i.e. joint funding, additional mo *nitoring charts etc.*

Declaration:
I have read and understood all sections of the policy 'NHS Commissioning of Additional Monitoring and One-To-One Supervision within Care Home Settings'.

1) I understand that in order for payment to be processed, documentation and monitoring forms need to be completed by the care home and accessible for sharing with the CHC team.
2) I am aware of my duty to inform the CHC team of any changes to a resident's needs which may impact on their requirement for one-to-one monitoring.
3) (For homes using outside agencies only) I understand that the duty of the care home is to ensure any outside agencies are CQC registered and thoroughly inducted to the home environment and familiar with the most up-to-date patient care plan.
4) I understand that the one-to-one carer is an additional staff member, not counted in the general staffing numbers and is not to be shared with other residents in the home.
5) I pledge to support staff within the home to keep accurate, up-to-date and comprehensive documentation relating to the one-to-one care of the resident.

Date of next one-to-one review			
Signature of care home representative			
Print name & designation		**Date**	
Signature of CHC representative			
Print name & designation		**Date**	