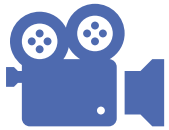
2025

One-to-One Support Protocol - Launch

NORTH YORKSHIRE COUNCIL

NHS
Humber and North Yorkshire
Integrated Care Board (ICB)

Housekeeping



Session will be recorded

Distractions to a minimum

Microphones on mute

Agenda

Welcome & Opening Remarks
Protocol Overview Presentation
Alternative Strategies
Real Stories
Process
Next Steps
Q&A Session
Closing Remarks
Finish

Welcome

Hannah Brown (NYC)
Carl Donbavand (ICB)

Protocol Presentation

Hannah Brown

Carl Donbavand

One-to-One Support Protocol

The Protocol

What

This protocol is here to help health and social care staff, as well as care providers, make sure that 1:1 commissioned support is arranged, monitored, and reviewed in a consistent way.

It's all about making sure the support provided is the least restrictive and least intrusive possible, while still meeting the person's needs.

The guidance applies to care funded by North Yorkshire Council (NYC), Humber & North Yorkshire ICB, or both – including packages that are jointly funded or fully funded through CHC.

Why

When we looked at care packages with 1:1 support, a few things stood out:

- There were some **inconsistencies** in how support was being arranged and delivered.
- In many cases, **other preventative options hadn't been tried** before 1:1 support was requested – either by practitioners or providers.
- A lot of packages included **12 or even 24 hours of 1:1 support**, which suggests the care might be more restrictive than necessary and not always tailored to the individual.

How

To get this right, we set up a working group with input from lots of different teams – including frontline staff, practice leads, in-house Complex Care, Safeguarding/DoLS, and Contracting.

North Yorkshire Council (NYC) and Humber & North Yorkshire ICB have worked together to develop the protocol, making sure it reflects both health and social care perspectives.

We've also spoken directly with independent care providers to hear their views and make sure the guidance works in practice – not just on paper.

Who this applies to?

The protocol applies to care commissioned by North Yorkshire Council and/or any care commissioned by the Humber & North Yorkshire ICB, including fully and jointly funded packages. It covers all commissioned care settings:

- Funded by Adult Social Care (ASC)
- Eligible for Continuing Healthcare (CHC)
- Jointly funded by North Yorkshire Council and the ICB
- Supported under Discharge to Assess (D2A) pathways
- Entitled to Section 117 Aftercare

Definition

What is One-to-One Support?

One-to-one support is a time-limited, targeted intervention by trained health or social care staff, providing enhanced supervision or assistance beyond core services. It addresses assessed needs and fosters meaningful engagement and therapeutic outcomes.

Its purpose is to deliver personalised support that promotes safety, dignity, and independence through structured interaction and observation.

Key Features:

Assessed Needs & Goals

Dedicated Staffing

Care Planning

Continuous Observation

Record Keeping

Regular Review

One-to-one support is **extra help** provided after reassessment, beyond the standard care included in core services.

Routine support–like staffing, observation, and line of sight–is always part of core accommodation services.

Strength- Based Approach

Safeguarding, MCA & DoLS

Sometimes one-to-one support is needed to keep someone safe. But it should not be the first or only option. It must be a short-term solution to reduce immediate risk.

It is important to remember:

- It can feel intrusive and may upset the person.
- It must be used carefully and only when really needed.
- The person (or their family/representative) should be involved in decisions.
- The goal and expected outcomes must be clear and reviewed regularly.

The protocol outlines the need to keep MCA and DoLS restrictions in mind when considering utilising 1:1 support.

The protocol sets out the requirements around:

- Circumstances requiring DoLS / Community DoL consideration
- Protection of individual's right to liberty
- Best interest decisions
- Assessment and review of support needs

The One-to-one Support Checklist (Appendix A)

Before any one-to-one support is arranged, practitioners and care providers must complete and agree on a checklist before any additional one-to-one support is commissioned.

This checklist should be backed by relevant evidence and completed together by health and/or social care professionals and care providers. Wherever possible, the individual receiving support – along with their family, carers, and advocates – should be meaningfully involved in the process.

The Checklist covers:

- Alternative less restrictive options explored
- Multi-agency involvement
- Staff training needs
- Risks and responsibilities
- Clear objectives / goals
- Communication & transparency
- Documentation
- Review date

Alternative Strategies

Debbie Lee – CHC Practice Development -Humber and North Yorkshire ICB, Quality and Nursing Team

One-to-One Support Protocol

Alternative Strategies & Support

The protocol sets out various strategies that must be considered before considering and arranging 1:1 support, ensuring the underlying causes of the behaviour are fully understood.

Examples of these strategies include:

- Staff Training & Competency
- Behaviour Monitoring & Analysis
- PBS & Trauma-Informed Care
- Specialist Team Involvement
- Medication Use & Review
- Assistive Technology & Equipment
- Environmental Assessment
- Falls Risk Management

Alternative Strategies

- 1:1 is resource-intensive and does not always manage the risks it is intended for such falls or challenging behaviour effectively.
- 1:1 will limit autonomy, can reduce social interaction, create dependency and reduce skills and abilities.
- Evidence supports person-centred, multifactorial approaches.
- Person-centred care should be the priority.
- The aim is to support safe, dignified, sustainable care.

Alternatives:

- ✓ Enhance independence and dignity.
- ✓ Improve quality of life and engagement.
- ✓ Reduce staff burnout and improves efficiency.
- ✓ Minimizes restrictive practices while maintaining safety.

A Person-Centred, Evidence-Based Approach

Understand the Root Cause – Not Just the Risk.

1:1 is often used in response to behaviours, falls, or confusion.

Explore underlying causes: pain, boredom, anxiety, delirium, unmet needs, communication difficulties.

Person-Centred Care Planning.

Tailor care to the person's life history, preferences, routines, and strengths. Involve families and carers in co-producing care plans. Supports both behavioural and physical safety.

Early Intervention & Individualised Strategies.

Use proactive approaches like: Falls prevention plans. Mobility support. Hydration and nutrition prompts. Sensory stimulation. Prevent escalation before 1:1 becomes necessary.

Meaningful Engagement & Environmental Adjustments

Provide purposeful activities to reduce distress and wandering. Adjust the environment: Clear signage Safe flooring. Good lighting. Accessible call bells

Multidisciplinary Team (MDT) Collaboration

Regular reviews with: Nurses, Therapists, Psychologists, Families-Ensures consistent, coordinated care and appropriate use of 1:1.

Evidence-Based Alternatives to 1:1

Therapeutic engagement (e.g., activity coordinators)Technology (e.g., falls sensors, door alarms) Zoning or cohorting for safe observation without 1:1 staffing

Falls Prevention

- NICE guidance does not list enhanced observation or 1:1 care among its recommended interventions
- Consider instead proactive strategies: risk assessment, medication review, physiotherapy, mobility aids, referrals to OT/PT/falls teams.
- Overall, Health Review (e.g. Blood Pressure, Vision, Infections)
- Environmental changes to reduce falls (footwear, lighting, clear pathways, low beds, crash mats)
- Technology such as bed/chair sensors or motion alarms allows monitoring without constant staff presence.
- Exercise and strength conditioning
- Scheduled checks or intentional cohort observation

https://www.valeofyorkccg.nhs.uk/rss/referral-support-service/supporting-our-partners-in-care-our-quality-team/quality-improvement-programmes/react-to-falls-prevention/

Behaviour That Challenges & Frameworks

Framework/Model	Focus	Key Features
Dementia Care Mapping (Alzheimer's Society, 2025)	Preparation and briefing Observation Analysis Feedback (written and verbal) Action planning.	Focus on the experience of the person with dementia to action plan and provide person-centred care for them
The WHELD programme (Ballard et al., 2020)	Well-being and Health for People Living with Dementia). Person-centred care. Meaningful activities. Positive social contact. Psychosocial over medication. Staff coaching & support	Evidence-based approach to improve quality of life, reduce agitation, and manage other behavioural and psychological symptoms of dementia (BPSD) in care home residents
VIPS (Brooker & Latham, 2015)	Valuing Individuals Perspective Social environment	Respect and dignity in care that is tailored to the unique needs, preferences, and life history of each person. :Understand and responding to the world from the viewpoint of the person in a social and physical environment that supports psychological well-being and reduces distress.
PBS	Identify triggers and support needs to maintain positive emotions and provide help during escalation. Used when there's distress or risk of harm."	Considers whole person and needs; creates supportive environments; proactive and preventative.

Framework/Model	Focus	Key Features
Active Support. (Jones et al., 2011)	Providing assistance which focuses on engaging and participating in all areas of life.	Proactively reduces behaviours of concern and improves quality of life.
SPELL (National Autistic Society n.d.)	Structure Positive Empathy Low arousal/level of regulation Links	Person-centred approach that enables individualised supportive plan to suit each person's unique profile of differences
Trauma Informed Care (McNally, 2022).	Recognising adults with a learning disability are more vulnerable to traumatic experiences and increasing awareness of the impact of trauma experiences on mental and physical health	Safety, trust, choice, collaboration, and empowerment for trauma-informed care. Recognise, respond, and prevent re-traumatisation.
HELP (Bradley & Korossy 2016)	Health Environment Lived experience, Psychiatric conditions	Comprehensive diagnostic evaluation using a multi-perspective, biopsychosocial and person-centred approach is recognised as good practice for understanding and supporting behaviours that challenge

Alzheimer's Society. (2025). Dementia Care Mapping. Retrieved from https://www.alzheimers.org.uk/dementia-professionals/dementia-experience-toolkit/research-methods/dementia-care-mapping
Ballard C, Orrell M, Moniz-Cook E, Woods R, Whitaker R, Corbett A, et al. Improving mental health and reducing antipsychotic use in people with dementia in care homes: the WHELD research programme including two RCTs. Programme Grants Appl Res 2020;8(6). https://doi.org/10.3310/pgfar08060
Bradley, E., & Korossy, M. (2016). HELP with behaviours that challenge. Journal on Developmental Disabilities, 22(2), 101
Brooker, D., & Latham, I. (2015). Person-centred dementia care: Making services better with the VIPS framework (2nd ed.).
Jessica Kingsley Publishers. Jones, E., Perry, J., Lowe, K., Allen, D., Toogood, S., & Felce, D. (2011). Active Support Handbook: A handbook for supporting people with learning disabilities to lead full lives.
ARC (Association for Real Change)
McNally, P. (2022). A Framework for the Implementation of Trauma-Informed Care in Residential and Supported Living Services for Adults with a Learning Disability. Ulster University
National Autistic Society (n.d.). The SPELL framework. Retrieved from https://www.autism.org.uk/what-we-do/autism-know-how/training/the-spell-framework

- George is 82 and diagnosed with advanced vascular dementia requiring full daily assistance.
- He maintains a strong emotional connection to his wife, often calling her name during moments of distress and confusion.
- George frequently wanders, which increases his falls risk, he picks up items as he does so. He also looks for ways to leave the building and shows agitation and aggression towards people and objects who he sees are obstructions to him moving freely.
- His unpredictable behaviours cause distress among residents and staff, challenging caregiving efforts and emotional wellbeing.

He is assigned 1:1 staff who supports by:

- Asking and guiding him to sit him in his chair during moments of distress and pacing.
- Offering food and drinks aiming to calm him when he is distressed.
- Telling him that his wife is not here and he cannot see her now.
- Taking George to his room to "calm down."
- Preventing him from picking up objects around the environment, asking him to stop touching them and telling them they don't belong to him.

Why these actions can make things worse

- Trying to get him to sit down may feel controlling when George is agitated and needs to move. This can escalate frustration if he feels misunderstood or restricted.
- Offering food and drinks during distress does not align with his emotional state – he may not be receptive to comfort through food. This could feel dismissive if used as a distraction rather than addressing his emotional needs.
- Telling him his Wife isn't there can seem to be a contradiction of his emotional reality, this increases confusion and emotional pain. This may feel invalidating leading to further agitation or grief.
- Taking him to his room to "Calm Down" may feel isolating or punitive, especially if the room lacks comforting or familiar elements. This doesn't address the cause of his distress or offer emotional support.
- Preventing him from picking up objects removes a potential coping mechanism – collecting objects may be soothing or purposeful for him. Misses the opportunity to provide safe, meaningful alternatives that support his need for activity.
- 1:1 support focused on control rather than connection can feel intrusive or like surveillance if not delivered with empathy and understanding. May create feelings of being a "problem" rather than a person with needs and preferences. Without meaningful engagement, 1:1 support can increase agitation and resistance.

Addressing the Root Cause: 1:1 may not be the right choice for George

Reviews

Has George been reviewed by all appropriate professionals- rule out infections, review medications, review pain relief. CMHT/Falls Team

Safe Freedom of Movement

Rather than restricting George, environments can be designed to allow safe exploration. REACT

Emotional Connection & Identity

George maintains a strong emotional bond with his wife. Supporting this connection can reduce distress and wandering

Meaningful Activity & Engagement

Wandering may reflect George's need for stimulation or purpose. Activities should be tailored to his interests

Sensory-Based Interventions

Sensory stimulation can help regulate mood and reduce agitation

Validation & Communication Techniques

Staff should validate George's emotions and redirect with empathy

Using The Checklist

Rationale

- Have less restrictive options been explored and ruled out?
- Are staff skills maximized, or training needs identified?
- What risks are being mitigated, and who is responsible?
- Is one-to-one support justified, safe, and proportionate?
- Are relevant professionals/services informed and involved?
- Has assistive technology been considered and documented?

Objective

- Are expected outcomes and goals clearly defined?
- Is there a shared understanding with commissioners?
- What strengths exist, and how can support promote change?
- What specific support is being offered (activity vs. observation)?
- Is there a review or end date with a management plan?

Risk

- Could support increase distress or physical intervention?
- Are staff trained and clear on when/how to intervene?
- Is restraint training provided, and boundaries understood?

Communication

- Has rationale, objectives, and risks been clearly shared with providers?

Delivery of Care

- Do staff understand the purpose and risks of support?
- Is engagement meaningful and tailored to the individual?
- Are flexible activities available to adapt to needs?
- How does support enhance the person's life?
- Is documentation accurate and reflective of care?
- Are staff supported to reflect and adapt interventions?
- Is joint working in place across care and health teams?
- Are breaks and handovers scheduled to avoid gaps?
- Are risk and escalation plans in place for staff safety?

How are working together towards this?

- Looking at ways through which assessors can be upskilled in key areas such as understanding challenging behaviours, Learning Disabilities and Neurodiversity.

- Seeking out existing NHS/local authority teams to work collaboratively, offer training to each other and encourage multidisciplinary team working.

- Seeking out opportunities for joint assessments with MDT teams
- E-learning: NHS e-LfH and peer mentoring.

- Collaborative learning, workshops, real case studies.

- Working collaboratively to ensure reviews are person-centred, evidence-based and completed promptly.

Real Stories

Vicky Wareham

One-to-One Support Protocol

Kezzie's Story

Sylvia’s Journey in Palliative Residential Care

Background and Initial Assessment

Background

Sylvia is an elderly woman with depression admitted for palliative care after severe health decline.

Physical Condition

She was malnourished, immobile, and required full assistance for personal care and transfers.

Emotional and Care Needs

Sylvia needed emotional support, encouragement to eat, and help with medication adherence.

Interventions and Outcomes

Person-Centred Care Approach

The care team focused on Sylvia's preferences and life history to provide personalised support and emotional connection.

Joyful Intervention

A special ice cream van visit created a nostalgic experience that improved Sylvia’s mood and engagement.

Significant Health Improvements

Sylvia regained appetite, gained weight, improved mood, and transitioned from immobility to walking with aid.

Long-Term Independence

Two years later, Sylvia became largely independent, requiring minimal care due to compassionate support.

Ronald's Experience with Dementia Care

2025

Background and Challenges

Background

Ronald had a fulfilling life as an engineer, widower, father of four, and ballroom dancing enthusiast.

Daily Routine and Behaviour

Ronald maintained an early morning routine but showed distress and agitation by 8a.m, requiring close supervision.

Care Challenges

Staff focused on reactive risk management to ensure safety, which disrupted the environment and overlooked emotional needs.

Need for Empathy

Ronald's behaviour highlighted the importance of a personalised, empathetic approach in dementia care.

Interventions and Impact

Empathetic Engagement

The trainer's empathetic approach enabled a calming connection that revealed Ronald's emotional concerns.

Therapeutic Routine Innovation

Introducing ballroom music and quieter breakfasts transformed Ronald's routine, eliminating morning distress.

Enhanced Social Atmosphere

Other residents joined the activities, creating a more social and supportive home environment.

Tailored Care Benefits

Personalised care approaches built staff confidence and met emotional needs, improving quality of life.

Process

One-to-One Support Protocol

Process (Section 6a)

for One-to-One Support Requests where Local Authority is Lead Commissioner

Referral and assessment Process

- The care provider identifies need for 1:1 support → refer to Customer Service Centre.
- The case is allocated to an assessor to complete a **Conversation Record:** Outlines outcomes, risks, and evidence for 1:1 care.
- **Assessment must:** Review previous interventions. Consider all less restrictive alternatives. Include CHC screening checklist if long-term needs are known.

Assessment Requirements

- Assessors must exhaust all other care options before recommending 1:1 support.
- Assessment and support plan must clearly state: Specific needs to be met, Outcomes to be achieved, Evidence supporting the need for 1:1 care
- One-to-One Support Checklist (Appendix A) must be completed with input from: Health and social care practitioners Care providers Individual, family, or advocates (where possible)
- For individuals with NHS CHC or Section 117 funding (with NYC as Lead Commissioner): Assessment and checklist completed jointly with NHS assessor per standard process.

Process (Section 6a)

for One-to-One Support Requests where Local Authority is Lead Commissioner

Commissioning and Review

One-to-one support must be:

- Time-limited with a review date (within 6 weeks)
- Costed and detailed in the support plan (including hours)
- Monitored with a plan to reduce or withdraw support

Care providers must: Record delivery and progress toward reducing 1:1 support in the daily care record

All Providers must

Ensure sufficient qualified, skilled, and experienced staff at all times
Use dependency tools to align APL rate with service model
Deliver core services in APL specification, including base 1:1 care within base rate
Assessors can escalate APL contract queries (e.g. base rate content) to HAS Contracting

Process (Section 6b)

When NHS CHC/s117 One-to-One Support Requests Funded (or Proposed to be) by the NHS Humber and North Yorkshire ICB

Referral and assessment Process

- The care provider identifies need for 1:1 support → refer the relevant CHC/S117 Team before implementation
- Include documented rationale, daily record relevant risks assessments, intended outcomes, hours and duration
- The ICB will only authorise one-to-one support with a documented clinical rationale which justifies need
- ICB CHC/S117 teams will review all evidence and confirm all other options have been considered before recommending one-to-one support, using the **checklist**.
- Daily records must be sent to the CHC/S117 Team for decision-making, including extensions *Appendix B* - **example observation record**

Out of Hours

- Out-of-hours requests require complete rationale and clinical evidence which justifies need
- The ICB recognises the necessity to keep individuals safe and will consider retrospective decisions (up to 3 days)

Process (Section 6b)

When NHS CHC/s117 One-to-One Support Requests Funded (or Proposed to be) by the NHS Humber and North Yorkshire ICB

For existing residents

- Additional 1:1 support above core service is only authorised if safe and proportionate, for **up to 14 days** at a time, with ongoing documentation required.
- If further support is needed, this may be extended **up to 6 weeks** (reviewed every 14 days) with regular reviews.
- Where a pattern is emerging, additional support is required for longer, consideration of a full assessment is to take place and review of care environment.

For new residents

- who have received one-to-one care in another care setting (e.g. hospital), the ICB may authorise **up to 7 days** of additional staffing, subject to monitoring and evidence requirements.

Monitoring & Review

The protocol sets out clear guidance for assessors, commissioners and providers to improve accountability and transparency.

Requirements include:

- Ensuring support is delivered in line with the protocol (e.g. least restrictive options are considered first)
- Mandatory two-week review for all new 1:1 support arrangements (or one week for people new to a care setting).
- More robust controls and monitoring of 1:1 support, including requirement for person-specific timeframes for ongoing review of any 1:1 support
- Clearer recording & evidence of how 1:1 support is delivered & outcomes achieved; example observation record included, staff timesheets and rotas
- Notify relevant case managers of any changes, including improvements and proposed reductions

Useful Resources and Appendices

Appendix A – One-to-One Support Checklist

Appendix B – Example Observation Record

Appendix C – Distressed Behaviours Aid Memoir

Appendix D - MCA, DoLS – Further Information

Appendix E - Safeguarding

Appendix F – Real Stories

Next Steps

Implementation Plan

One-to-One Support Protocol

Implementation Plan

NYC Roll Out

- Soft launch with case managers in July 2025 - already supporting partners to implement the protocol
- Finalised Protocol with Appendix to be made available to Care Market Partners
- Internal rollout to assessors and practitioners planned for later in the year via a series of practice development sessions.
- Embedding the Checklist within internal BAU approval processes

ICB Roll Out

- Soft launch with case managers in July 2025 - already supporting partners to implement the protocol
- Finalised Protocol with Appendix to be made available to Care Market Partners
- Formalised in ICB panel decision making processes
- Further Practice development with case managers
- Further ICB generic market engagement events planned later in the year
- Further work to do with stakeholders around this

Contacts

Humber and North Yorkshire Integrated Care Board (ICB)

Continuing Healthcare and Section 117 Aftercare Teams

Care Market Partners Webpage:

https://humberandnorthyorkshire.icb.nhs.uk/continuing-healthcare-and-section-117-aftercare

Public Webpage

https://humberandnorthyorkshire.org.uk/nhs-continuing-healthcare/

North Yorkshire Council

Service Development

HASservicedevelopment@northyorks.gov.uk

HAS Contracting

HASContracting@northyorks.gov.uk

NY Partnership

Welcome to North Yorkshire Partnerships | North Yorkshire Partnerships

Q & A Session

Closing Remarks

Carl Donbavand

One-to-One Support Protocol