One-to-One Support Protocol

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"When I could stop my one to one support, I felt more normal, like everybody else. It makes me happy that I am like everyone else, because I don't need as much support now."

1. Introduction

This protocol outlines a joint approach by North Yorkshire Council and the Humber and North Yorkshire Integrated Care Board (ICB) to the arrangement, monitoring, and review of one-to-one care that goes beyond the usual core services and support someone receives.

It is designed to help health and social care staff and providers work together consistently and fairly when deciding if extra support is needed.

The main goals of the protocol are to:

- Make sure additional support is assessed and arranged consistently, proportionately, impartially and promptly through collaborative working.
- Always deliver the least restrictive and most independence-promoting support options.

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- Support people to take positive risks and live as independently as possible.
- Protect people's rights and dignity.
- Be open and consistent when working with care providers.
- Use public money responsibly.
- Make sure people get the right level of support for their needs and that reviews are undertaken in line with a person's needs.

Key principles underpinning the protocol:

- A culture of positive risk-taking to promote independence.
- A person-centred, strengths-based approach that prioritises the least restrictive options.
- Shared commitment across organisations to collaborative risk management.
- Strong inter-agency relationships to improve outcomes.
- A skilled, confident, and well-supported workforce.

A least restrictive approach benefits all stakeholders:

- People: Promotes dignity, independence, and choice by avoiding unnecessary restrictions.
- Providers: Enables person-centred care planning and efficient staff deployment based on assessed needs.
- Commissioners: Ensures one-to-one support is justified, safe, proportionate and defensible in supporting people's eligible needs.

2. Who This Applies To

This 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—residential and nursing homes, supported living, day services, and Local Authority provider services—for people who are:

- **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**

3. What is One-to-One Support?

Definition

One-to-one support is the direct, time-specific intervention of trained health or social care staff to provide enhanced supervision or assistance beyond the core commissioned service.

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It involves allocating a knowledgeable and trained staff member or members to support a person directly for a specified period of time.

It is designed to meet specific, assessed needs and promote meaningful engagement and therapeutic outcomes.

The purpose of one-to-one is to deliver personalised, purposeful support that enhances safety, dignity, and independence through structured interaction and observation.

Due to the highly restrictive nature of one-to-one support, it should be reviewed at agreed regular intervals and should not, in most cases, be regarded as routine practice.

Key Features of One-to-One Support

- **Assessed Needs & Goals**
  - Must be based on current, formally assessed needs.
  - Should support meaningful activity and clearly defined outcomes.
- **Dedicated Staffing**
  - One staff member per individual with no other responsibilities during the support period.
  - Staff rotation every 2 hours is recommended to prevent fatigue and maintain quality.
- **Continuous Observation**
  - Staff must maintain visual contact and be close enough to intervene if needed.
  - Privacy and dignity must be respected at all times.
- **Care Planning**
  - Staff must follow a detailed care plan, including Positive Behaviour Support (PBS) plans where applicable.
  - Plans should outline communication styles, known triggers, and effective de-escalation strategies. A Distressed Behaviours Aid Memoir tool can be found at ***Appendix C***.
- **Record Keeping**
  - Accurate, timely documentation is essential.
  - Records should include: time, location, people present, activity (including antecedent), crisis duration, interventions used, and responses.
  - An Example Observation Record can be found at ***Appendix B***.
- **Regular Review**
  - Care plans must be updated when changes in behaviour or response are observed.
  - Positive responses and outcomes to one-to-one support should be shared with the care team and reflected in the care plan.
- **Legal Considerations**

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- Refer to ***Appendix D*** for detailed guidance on Deprivation of Liberty Safeguards (DoLS).

This protocol makes clear the difference between the provision of care and support as part of the core offer of service and where assessment has identified the requirement for additional support on a 'one-to-one' basis for a specified period of time to meet clearly identified goals and outcomes.

Regular or continuous observation of one or more people may be required and undertaken by one or more carers, with or without the support of assistive technology and other environmental adaptations, however, this should not by default be delivered through provision of 'one-to-one' care. Background staffing, observation and line of sight are all considered factors of routine support that must be offered as part of any core accommodation or building based service(s).

4. Using One-to-One Support for Safeguarding

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 that one-to-one support:

- Restricts a person's freedom and therefore can feel intrusive and may upset the person.
- Can have a negative impact on a person's wellbeing.
- Can itself lead to escalation and therefore increase risk.
- Does not remove all risk.
- Must be used carefully and only when really needed.
- Must only be used once all less restrictive alternatives have been considered, with evidence documented.

When using one-to-one support for safeguarding, this protocol must still be followed. A One-to-One Support Checklist ***(Appendix A)*** must be completed and agreed. The person (or their family/representative) should be involved in all decisions. The goal and expected outcomes must be clear and reviewed regularly.

Further information on one-to-one support for safeguarding can be found at ***Appendix E.***

5. What Options Must be Considered Before Arranging One-to-One Support

The Strength's Pyramid (iESE 2024) illustrates the importance of a strength-based approach when assessing care needs. Before arranging one-to-one support, practitioners and providers must collaboratively identify the root cause of concerning behaviours and exhaust all less restrictive strategies.

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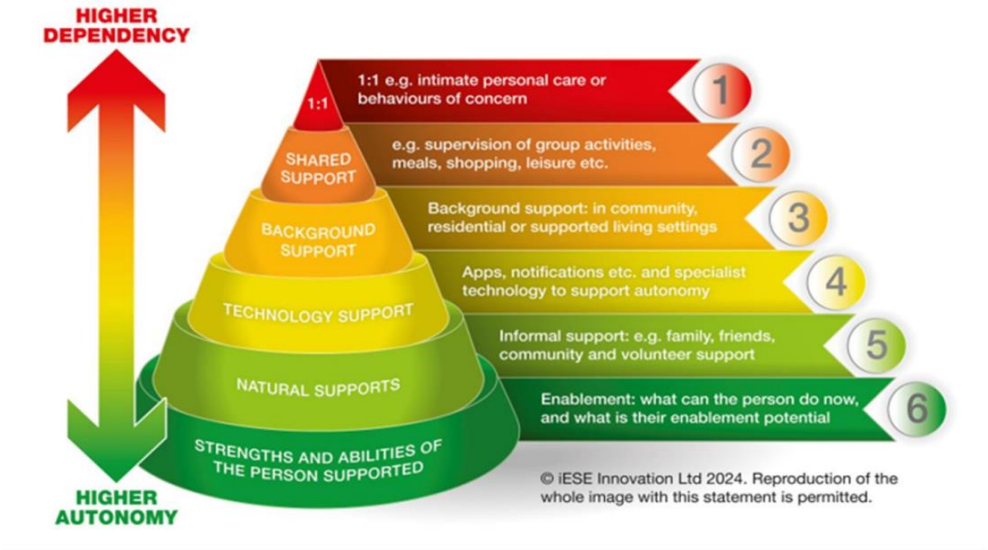

Examples of these strategies include:

Staff Training & Competency	• Do staff have the necessary skills and competencies? • Is additional training required? • Can training be accessed via the Local Authority, ICB, or other involved organisations? • Can the care provider commission the required training?
Behaviour Monitoring & Analysis	• Are ABC charts or dementia mapping being used to identify patterns or triggers? • Have findings informed care planning or external referrals?
Positive Behavioural Support (PBS) & Trauma-Informed Care	• Is behaviour understood as communication of unmet needs? (See ***Appendix C*** for Distressed Behaviours Aid Memoir tool which can be used to support this) • Are PBS or trauma-informed approaches in place and being followed? • Are sensory or perceptual differences (e.g. hallucinations) being considered?

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Specialist Team Involvement	• Have appropriate referrals been made (e.g. Occupational Therapy, Falls Team, Community Learning Disability Team, Older People's Mental Health)? • Has a multidisciplinary team (MDT) meeting been held?
Medication Use & Review	• Are medication interactions or side effects (e.g. sedation, falls) being monitored? • Is PRN medication used appropriately? • Are staff confident managing complex medication regimes?
Assistive Technology & Equipment	• Have sensors, monitors, or other assistive technologies been considered? • Has all relevant equipment been explored?
Environment & Setting	• Is the current setting appropriate for the person's needs? • Has the root cause of behavioural needs been identified before considering a move?
Falls Risk Management	• Has a person-centred multi-factorial falls risk assessment and interventions been completed? • Are NICE guidelines being followed? • Are interventions in place (e.g. assistive tech, OT, physio, GP input)?

6. How to Arrange One-to-One Support

The One-to-One Support Checklist (see ***Appendix A***) must be completed and agreed upon before any one-to-one support is commissioned. This Checklist should be supported by appropriate evidence and carried out collaboratively by health and social care practitioners and care providers, with meaningful involvement from the individual, their family, carers, and advocates wherever possible.

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One-to-one support may amount to a deprivation of liberty and therefore must follow Mental Capacity Act (MCA) principles. Any new or changed one-to-one arrangements must lead to a review of the authorised restrictions/deprivation of liberty, and where appropriate action taken to ensure that any increase in restrictions is appropriately reviewed and a request for authorisation made. Providers must inform the CQC of any updates. Further information can be found at ***Appendix D.***

"It makes me feel like I am less of a person, and I am not trusted to be on my own, it makes me feel different to everyone else and like I stand out, it makes me feel less of a person".

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

Referral and Assessment Process

If a care provider identifies the need for additional one-to-one support, they must refer the case to the Customer Service Centre for reassessment. The case will be allocated to an assessor, who will complete a Conversation Record outlining the outcomes, risks, and evidence supporting the need for one-to-one care.

The assessment must explore previous interventions and consider all less restrictive alternatives. A CHC screening checklist must also be considered as part of this process if long-term needs are known.

Assessment Requirements

Assessors must ensure that all other care options have been considered and exhausted before recommending one-to-one support. The assessment and support plan must clearly state:

- **The specific needs to be met**
- **The outcomes to be achieved**
- **Evidence supporting the need for one-to-one care**

The One-to-One Support Checklist (***Appendix A***) must be completed and agreed upon, with input from health and social care practitioners, care providers, and—where possible—the individual, their family, or advocates.

Where the person receives NHS Continuing Healthcare or section 117 funding and North Yorkshire Council is the Lead Commissioner, the assessment and One-to-One Support Checklist will be undertaken in collaboration with the relevant NHS assessor in line with existing standard processes.

Commissioning and Review

One-to-one support must be:

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- **Time-limited, with a clear review date (no later than six weeks from start)**
- **Costed and detailed in the support plan, including hours covered**
- **Monitored, with a plan to reduce or withdraw support where appropriate**

Care providers must evidence delivery and progress toward reducing one-to-one support in care records.

All providers must:

- ✓ **Ensure enough suitably qualified, competent, skilled, and experienced staff to meet the needs of people using the service at all times and fulfil all other regulatory requirements**
- **Use dependency tools to ensure their APL rate aligns with their service model**
- **Cover core services set out in the APL Service Specification, including a base level of one-to-one care, within the agreed base rate.**

Where the assessor requires support to discuss the terms of the APL contract with a provider; for example, what should be included in a base rate, they may escalate to HAS Contracting for support.

If a provider's model changes (e.g. supporting more complex needs), they may request a revised rate through the Council's Sustainability Policy—though approval is not guaranteed. Initial contact should be made with HAS Contracting.

Residential/Nursing Care Context

The direct care hours set out in the Approved Provider List (APL) contract are based on the 2019 Actual Cost of Care (ACOC) exercise, and include an average of shared and direct care hours per resident. Providers that have accepted ACOC should staff their services accordingly. They should also consider the direct care hours required for new admissions to ensure a balance of needs across the home.

b) Process for 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

If a care provider identifies the need for additional one-to-one support, they must refer the case to the relevant CHC/S117 Team.

The ICB will only authorise one-to-one support where there is a clearly documented clinical rationale which evidences the need for additional restrictions to be considered and supported by appropriate risk assessments (See ***Appendix B*** - example observation record). Crucially this **must** be done prior to any one-to-one being put in place.

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Were a provider to implement one-to-one prior to the provision of evidence and the receipt of a positive decision from the ICB, the provider does this at their own risk; although, the ICB recognises the need for providers to keep individuals safe which may include a level of restriction.

ICB CHC/S117 teams **must** review this evidence and ensure that all other care options have been considered and exhausted before recommending one-to-one support utilising the One-to-One Support Checklist ***(Appendix A).***

Any request for additional direct support must clearly specify the measurable goals and impact the proposed additional support is intending to achieve, noting that additional support will be commissioned on a time-specific basis. The request must state the hours of the one-to-one request and intended length of time the one-to-one is needed for. Care providers should also state what clinical or therapeutic interventions have been undertaken prior to requesting one-to-one and/or actions taken, referrals already made to universal services and all outcomes.

Additional direct staffing support **must** be reviewed and documented three times daily as a minimum (AM, PM, EVE and when needs change) by the care provider. Daily diary records **must** be sent to the CHC/S117 Team when seeking a decision in support of additional staffing including when further extension beyond the initial approval date is sought.

In all instances a review of the individuals presenting needs must be undertaken, to ensure that the appropriate evidence is made available to decision makers. The ICB is committed to making safe, proportionate and defensible decisions in supporting the needs of eligible people.

Out of Hours Requests

The onus remains on the care provider to present to the ICB the complete rationale and clinical evidence which justifies the need for additional direct staffing support, including a proposed plan of activity that will be attempted and the proposed goals that will be worked towards. The ICB will only consider decisions in support of the additional staffing including those that may be retrospective (up to 3 days) if the information has been collated and presented to the ICB as required.

The ICB will not approve any additional direct staffing support for which there is no ***evidenced rationale*** and where this one-to-one protocol has not been followed.

Care Setting Context:

The ICB expects each resident to have dedicated time with staff during the day for personal care, mealtimes or other interventions. For residents receiving CHC funding, the ICB expects these rates are inclusive of **a minimum of 4 hours** of one to one per day by virtue of the

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complexity that underpins people with CHC and the frequency and intensity of their interventions we believe must equate to 4 hrs per day as a minimum. Therefore, the ICB will fund up to a maximum of 20 hours of the 24 hours one-to-one per day (as per paragraph above). This applies unless the ICB commissions services through existing local authority-led framework agreements, where a specified minimum number of direct care and support core hours is established. Providers will be expected to address their rotas accordingly.

Provision of one-to-one support hours in supported living or residential settings (such as for people with learning disabilities and/or autism) who may have ongoing care needs requiring one-to-one as core component of their package can be considered. This will require an analysis of the total support package and background support which may be funded through the core model based on already agreed support and background support funded within the placement and associated frameworks.

Residents with a falls history or assessed as high risk of falls will not automatically be approved for one-to-one funding by the ICB. Care providers are expected to utilise assistive technology, multifactorial assessments and interventions with universal services to abate any associated falls risk in line with NICE Clinical Guidelines 2013 [CG161 2013].

For people who already reside in their care setting

In the first instance, the ICB should only authorise additional funding for one-to-one support on top of the core service, when it is safe proportionate and defensible to do so, adhering the key principles set out within this document. Each instance will only be considered for a **maximum of 14 days** and will be subject to monitoring through the continued provision of documentation and evidence with the ICB during that period.

Where review of the situation identifies that a further 14 days of additional one-to-one is required the ICB will approve additional direct support through one-to-one for a **maximum of up to 6 weeks** (reviewed every 14 days). Where a pattern is emerging that the individual may require additional support for longer, as part of their daily/weekly routines a full assessment is to take place and consider the longer-term care and support plan including whether their current environment is appropriate to meeting their needs, to enable transparent decision making.

For people new to a care setting

If an individual has received one-to-one in another care setting (e.g. hospital) and the there is a clinical rationale for ongoing support, in the first instance, the ICB will only authorise funding in support of the additional direct staffing for a **maximum of 7 days** subject to the conditions of monitoring and review as set out above.

If the care provider identifies there is an ongoing need for one-to-one, the care provider is expected within the first 7 days to clearly document the clinical rationale which is evidenced

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and supported by appropriate risk assessments (See ***Appendix B*** - Example observation record).

7. Monitoring and Review

Assessor / Commissioner Responsibilities

- Consider and try all less restrictive options first and make sure this is clearly documented.
- Make sure any commissioned one-to-one support is time-specific with specific person-centred goals, outcomes, and clearly documented review dates.
- Review all one-to-one support after two weeks (or one week for people new to a care setting).
- Set ongoing review dates for all one-to-one support based on each person's individual needs (e.g. weekly reviews may be appropriate for people when settling into a new service).
- Regularly monitor that this protocol is being implemented correctly across care provision.
- Proactively work with care providers where regular monitoring identifies ongoing disputes over assessed one-to-one support.
- Where support is found to be absent without justification, refer the case to contract management (for LA funded packages) and/or follow individual contract arrangements (for ICB funded packages).
- Uphold the hourly rate for one-to-one support in line with the lead commissioner's agreed contractual rates.

Provider Responsibilities

- Ensure one-to-one support is requested and delivered in line with this protocol.
- Ensure staff delivering one-to-one support have no other responsibilities during the specified time period and are not being counted in general staffing during this time.
- Agree contingency plans for breaks, handovers, and emergencies in advance.
- Keep records of one-to-one support—such as one-to-one observation records, care plans, staff timesheets, and rotas—and share with assessors and commissioners if requested. An example observation record is available in ***Appendix B***.
- Update care plans and notify the relevant assessment team or case manager of any changes as soon as possible—ideally by the next working day, and no later than seven working days. This includes any improvements in a person's presentation, proposed reduction or withdrawal of one-to-one support.
- Care providers remain responsible for the appropriate registration, quality and practice of agency staff, and such arrangements should be time limited.

Family requests for one-to-one care without evidence will not be funded. Families may

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make private arrangements with independent care providers for additional services not covered by the assessed care plan. If families choose to pay for extra services that aren't included in the assessed care plan, and later cannot continue paying, the Commissioner will **not** take over the responsibility for funding or arranging those services.

"I wouldn't want a staff member with me if I am trying to chill out or I am having private time. I wouldn't want a staff member with me if I am spending time with my friends or my family. I want to be able to do my own thing without feeling like I am being watched all the time".

8. Useful Resources

- National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care July 2022 (Revised)
- Nothing Ventured, Nothing Gained: risk guidance for people with dementia, Department of Health 2010
- iESE Innovation Ltd 2024. The Care Cubed Journey – Strengths Pyramid
- NICE Clinical Guidelines 2013 [CG161 2013] - Falls in older people: assessing risk and prevention.

9. 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**

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