Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

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NHS Continuing Healthcare Enhanced Observation within Care Homes Policy

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Draft v1.0	14-02-2025	Development Practitioner	First Draft
Final v1.0	04-08-2025	Operational Group	The BLMK ICB Operational Group adopted the policy as approved.

Implementation Plan

Development and Consultation:	The following individuals were consulted and involved in the development of this document: ▪ Associate Director All Age Continuing Care ▪ Head of All Age Continuing Care ▪ All Age Continuing Care Quality & Assurance Manager ▪ CHC Operational Leads ▪ Chief Nurse
Dissemination:	Staff can access this document via the website and will be notified of new / revised versions via the staff briefing. This document will be included in the organisation's Publication Scheme in compliance with the Freedom of Information Act 2000.
Training:	The following training will be provided to make sure compliance with this document is understood: ▪ Dissemination training on all associated processes to relevant ICB, Care Home and Community Services staff
Monitoring:	Monitoring and compliance of this document will be carried out via: ▪ See Section 6.3
Review:	The Document Owner will ensure this document is reviewed in accordance with the review date on page 2.
Equality, Diversity and Privacy:	Appendix 1 - Equality Impact Assessment Appendix 2 - Data Protection Impact Assessment
Associated Documents:	The following documents must be read in conjunction with this document: ▪ BLMKICB Continuing Healthcare Operational Policy 2025 ▪ BLMKICB Continuing Healthcare Commissioning Policy 2025
References:	The following articles were accessed and used to inform the development of this document: ▪ National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care July 2022 (Revised) ▪ Mental Capacity Act 2005 ▪ Care Act 2014 ▪ NHS Act 2006

	▪ BLMKICB Continuing Healthcare Operational Policy 2025 ▪ Deprivation of Liberty Safeguards (DOLS)

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1.0 Introduction

1.1 NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (ICB) aims to ensure robust governance through its formal written procedural documents, such as this document, which communicate standard organisational ways of working. These documents help clarify operational requirements and consistency within day-to-day practice. They can improve the quality of work, increase the successful achievement of objectives and support patient safety, quality and experience. The ICB aims to ensure its procedural documents are user friendly, up-to-date and easily accessible.

1.2 The ICB must design and implement procedural documents that meet the diverse needs of our service and workforce, ensuring that none is placed at a disadvantage over others, in accordance with the Equality Act 2010. The Equality Impact Assessment initial screening, which was used to determine the potential impact this policy might have with respect to the individual protected characteristics is incorporated at Appendix 1.

1.3 A Data Protection Impact Assessment is a process which helps assess privacy risks to individuals in the collection, use and disclosure of personal information. The Data Protection Impact Assessment initial screening, which was used to determine the potential impact this policy might have with respect to an individual's privacy is incorporated at Appendix 2.

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

1.5 This Policy sets out the process in Bedfordshire, Luton and Milton Keynes (BLMK) on the assessment, implementation and use of additional and enhanced monitoring for individuals whose care is commissioned by the ICB within care home settings. It should be read in conjunction with the CHC Operational Policy and CHC Commissioning Policy for BLMK ICB.

1.6 For the purpose of this policy, 'Enhanced' or '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.

2.0 Scope

2.1 This policy applies to all ICB staff members, including Ordinary Members of the Board of the ICB, involved in policy-making processes, whether permanent, temporary or contracted-in under a contract for service (either as an individual or through a third-party supplier).

2.2 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 which 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."

2.3 This policy takes into account legislative changes brought about by the Care Act 2014, which preserves the existing boundary and limits of local authorities (LAs) responsibility in relation to the provision of nursing and/or healthcare.

2.4 This policy applies to BLMK ICB residents aged 18 and over who have been established as eligible for NHS Continuing Healthcare (NHS CHC) and require placement in a care home setting.

2.5 This policy is in place to support staff within care home settings to request additional support appropriately in order 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.

2.6 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.

3.0 Definitions

3.1 This section provides an explanation of terms used within this policy.

3.2 *NHS Continuing Healthcare* - means a package of ongoing care that is arranged and funded solely by the National Health Service (NHS) where the individual has been assessed and found to have a 'primary health need'. Such care is provided to an individual aged 18 or over, to meet health and associated social care needs that have arisen as a result of disability, accident or illness. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group. Eligibility for NHS CHC is not determined by the setting in which the package of support can be offered or by the type of service delivery.

NHS Funded Nursing Care - is the funding provided by the NHS to care homes with nursing to support the provision of nursing care by a registered nurse. In all cases individuals should be considered for eligibility for NHS CHC before a decision is reached about the need for FNC.

Social Care Needs – There is not a legal definition of the term 'social care need' in the context of NHS CHC. However, the Care Act 2014 introduced National Eligibility Criteria for care and support to determine when an individual or their carer has eligible needs which the local authority must address, subject to means where appropriate. These criteria set out that an individual has eligible needs under the Care Act 2014 where these needs arise from (or relate to) a physical or mental impairment or illness which results in them being unable to achieve two or more of the following outcomes which is:

- managing and maintaining nutrition
- maintaining personal hygiene
- managing toilet needs
- being appropriately clothed
- being able to make use of the home safely
- maintaining a habitable home environment
- developing and maintaining family or other personal relationships
- accessing and engaging in work, training, education or volunteering
- making use of necessary facilities or services in the local community, including public transport and recreational facilities or services
- carrying out any caring responsibilities the adult has for a child

Healthcare Needs – are related to the treatment, control, or prevention of a disease, illness, injury or disability and the care or aftercare, by a professional, of a person with these needs.

Care Packages – suite of services (nursing, therapies, home care etc.) that are designed to match the assessed needs of an individual.

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.

4.0 Policy Statement

4.1 This policy aims for all additional monitoring arrangements to be ethical, equitable, necessary and proportionate, person-centred, safe and reasonable.

4.2 This policy is in place to support staff within care home settings to request additional support appropriately to ensure 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.

4.3 The purpose of the one-to-one observation should be to minimise 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 and continually reviewed for effectiveness.

4.4 The individual becomes the assigned member of staff's responsibility for the duration of the one-to-one hours and no other resident assigned to them during that period.

Rest breaks of the staff member should be covered at all times, which is the responsibility of the care home.

4.5 It will be the responsibility of the care home 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.

4.6 Care homes 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 does not count as part of the core healthcare staff on floor duty for the other residents.

4.7 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.

4.8 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 has not been clinically identified, this will not be authorised by the ICB. However, an individual/their family are able to 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.

5.0 Roles and Responsibilities

5.1 The following have specific responsibilities in relation to this policy.

5.2 The Board

The ICB's Board has a responsibility to scrutinise, review and approve this policy in conjunction with the overall aims of the ICB and its statutory obligations under the NHS Act (2006).

5.3 Chief Executive

The ICB has legal responsibilities under the NHS Act and Standing Rules Regulations (2012) to have regard to the Framework and exercise its functions in regard to NHS CHC and FNC. The Chief Executive for BLMK ICB has overall responsibility to ensure suitable governance arrangements are in place.

5.4 Chief Nurse

The Chief Nurse holds the Executive position for oversight of NHS CHC performance and strategic planning using NHS CHC intelligence for wider commissioning, contracting & procurement and financial authority.

5.5 Associate Director Continuing Healthcare

Responsible for the direct oversight of this policy's implementation and operation, including governance. Provides financial scrutiny and authority.

5.6 **CHC Staff & Care Home Staff**

CHC clinical staff have a duty to carefully review and consider all requests for one-to-one enhanced observation care and ensure the process for decisions will be transparent, fair and equitable for the residents of BLMK. They are also responsible for ensuring the regulations of the Mental Capacity Act 2005 are adhered to when stipulating one-to-one enhanced observation as part of the individuals care plan.

It is the responsibility of CHC staff to review the need for one-to-one enhanced observation care regularly.

Care home managers have a responsibility to ensure that staff within the home are aware of the expectations of documented evidence of one-to-one needs, which the ICB require for those being considered for the required level of monitoring.

Care home staff have a responsibility 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 the remit of the care home should provide as standard.

Care home 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 homes may be at risk of breaking the commissioning agreement.

CHC and care home 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 at the centre.

6.0 Processes and Procedures

6.1 Guide to level of Observation

6.1.1 It is recommended that care providers use this guidance to help assess the level of observation required for an individual and actions required.

Level 1 – General Observation

The individual has **safe and predictable behaviour** and would be considered routine to manage. This would be considered a minimum level of observation for people being either supported in their own homes or a care setting and should fall within the assessed needs of the service.

Level 2 – Intermittent Observation

The individual displays **mainly predictable behaviour** but considered to have occasional unsafe behaviour such as an Individual in their room monitored under hourly observations. This might include:

- A potential risk of falls
- A cognitive impairment which results in increased risk or a behaviour where there is some occasional challenge.
- A previous history of risk however the person has shown signs of improvement.

A Personalised Support Plan is required:

- Obtain consent or complete a mental capacity assessment to ascertain whether the person lacks mental capacity to consent. If the person lacks mental capacity to consent, a best interest's decision with involvement of all other interested parties who are appropriate to consult is required. If there is no one appropriate to consult, for decisions about major medical treatment or where the person should live, an Independent Mental Capacity Advocate (IMCA) must be consulted.
- Personalised care plan/risk assessments which identify anxieties, factors which may increase risks.
- Increase level of contact to monitor on an hourly basis or appropriate dependent on needs.
- Refer to services such as GP, Falls Service, Occupational health, DISS(Dementia Intensive Support Service)/Community Mental Health Team for medication review/symptom management.
- Define reasons for increased need, such as lack of access to next of kin, activities relevant to the persons likes and dislikes or previous work and patterns i.e if they were night workers do they wonder because of this?
- Consider low rise bed, alarm mats, assisted technology.
- Consider staffing levels and ability to manage the individual's needs.
- Consider the environment, is there increased anxiety due to noise levels, television/radio, other residents, pain management, bowel/continence management, infection.

Level 3 – Observation within Line of Sight

The individual displays **infrequent unpredictable unsafe behaviours** towards themselves/others which may result in serious harm such as an individual in the lounge with a group of residents monitored by a present member of staff. This might include:

- Falling, have a history of repeat falling which cannot be managed by techniques described in Level 2 observation.
- Heightened level of risk linked to increased confusion/disorientation/agitation and may also have a deterioration in normal level of mobility.
- Harming themselves or others which is unpredictable in nature.
- Absconding risk due to reduced level of cognition.

A Personalised Support Plan is required which would include:

- All interventions recommended for Level 2 plan.
- Consider increased level of observation with possible 1:1 management. Identify peak times of risk and potential causes where this level of observation is required, taking into consideration MCA/Deprivation of Liberty.
- Liaise with DISS/Community Mental Health Team or other relevant service.
- If the individual has been assessed as lacking mental capacity to consent to their **Personalised Support Plan** which stipulates them being under

continuous supervision and control and not free to leave the care setting where the support is being delivered, an application for authorisation of this deprivation of liberty must be made to the local authority.

Level 4 – Observation within arm's length

The individual displays **frequent unpredictable unsafe behaviours** towards themselves/others which may result in serious harm. This is the highest level of observation and should only be implemented in exceptional circumstances where there is imminent and significant risk of harm to themselves or others that may result in death. This might include:

- There is a risk of suicide.
- There is a serious risk of harm to the individual or others due to increased behaviour.
- Techniques such as restraint have been required due to the increased risks.

A Personalised Support Plan should include discussion with the MDT regarding the need for this level of support and external intervention required. This might also include:

- All interventions recommended for Level 2 and 3 plan.
- Consideration of level of observation support and identify appropriately trained staff to manage observation.
- Review of care by the MDT involved.
- Escalation to other appropriate services where there is increasing concern for the person and welfare of others, where it might be appropriate to consider in-patient services.
- All staff involved with enhanced observation must have a period of handover prior to managing care. It must be noted that this level of observation is emotionally demanding, so consideration by the care provider in changing staff/backfill by another member of staff for a short period of time on a regular basis.
- Level 4 observation is obtrusive and restrictive. Consideration should be given by the care provider to all other less restrictive options that may be available, and a rationale given for why they are not available in this case.
- If the individual has been assessed as lacking mental capacity to consent to level 3/4 observation as part of their **Personalised Support Plan**, any decision to implement such a plan must be made in the person's best interests. Evidence to support the best interest's decision-making process must be available within the shortest possible timescale and will be required to support any application to deprive the person of their liberty.

6.2 Application for Enhanced Observation

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

- What has been tried so far? Have all other less restrictive options been tried and failed?
- Risk assessments: assess and rate the level of risk and harm and the type of harm and likelihood of that harm occurring.
- Monitoring charts; ABC charts, falls logs, food diaries etc. For dementia specific documentation advice visit www.icaredementia.org

- 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? Have activities increased or different approaches been tried?
- 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. Documentation within the care records of discussions and a record of the views of all parties.

6.2.2 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.

6.2.3 Requests should be emailed to the CHC team blmkicb.chc@nhs.net accompanied by the required information:

- Clear statement of need, risks and intention
- Specific timings of the one-to-one being requested: For how long? How often? What time of the day or night?
- ABC Charts
- Incident forms
- Medication charts
- Daily records
- Staffing ratios
- Any other supporting information, including as previously mentioned evidence of attempts to try less restrictive options and adherence to The Mental Capacity Act.

6.2.4 Alternatively requests can be made directly to CHC case manager at time of assessment or review, ensuring above information is available.

6.2.5 Once the CHC team ensure that there is clear clinical rationale and evidence why this intervention is needed, The ICB 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.

6.2.6 Funding within the ICB is subject to approval via a financial authorisation pathway, which will include the signing of an Individual Placement Agreement (IPA) between the ICB and care provider. This will act as an agreement to ensure:

- Thorough documentation kept and provided by the care home relating to the care and interventions provided to the individual.
- The care home 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 individual at the heart of all interaction.
- As above, the care home 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.

6.2.2 The individual's needs will be reviewed regularly by the ICB, involving the individual/representative and the care provider to assess the quality and effectiveness of the one-to-one Enhanced Observations with an aim to safely reduce the requirement.

6.3 Monitoring

6.3.1 Regular audit of Enhanced Observation decisions will be undertaken by the ICB. Data will be provided to the Governing Body and appropriate learning developed.

Bedfordshire, Luton and Milton Keynes Health and Care Partnership

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

Appendix 1 - Equality Impact Assessment Initial Screening

Name of Policy:	Continuing Healthcare Enhanced Observation in Care Homes Policy
Date of assessment:	16/07/2025
Screening undertaken by:	AACC Quality & Assurance Manager

Protected characteristic and inclusion health groups. Find out more about the Equality Act 2010, which provides the legal framework to tackle disadvantage and discrimination: https://www.equalityhumanrights.com/en/equality-act/protected-characteristics	Could the policy create a disadvantage for some groups in application or access? (Give brief summary)	If Yes - are there any mechanisms already in place to mitigate the potential adverse impacts identified? If not, please detail additional actions that could help. If this is not possible, please explain why
Age A person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).	No	
Disability A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	No	
Gender reassignment The process of transitioning from one gender to another.	No	
Marriage and civil partnership Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'.	No	
Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26	No	

weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.		
Race Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins.	No	
Religion or belief Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	No	
Sex A man or a woman.	No	
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex, to both sexes or none.	No	
Carers Individuals within the ICB which may have carer responsibilities.	No	
Please summarise the improvements which this policy offers compared to the previous version or position.		
This is a new policy and it describes the way in which Bedfordshire, Luton and Milton Keynes (BLMK) ICB will commission the provision of Enhanced observation carers for individuals in care homes who have been assessed as eligible for NHS Continuing Healthcare (CHC) in accordance with The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (2022)		
Has potential disadvantage for some groups been identified which require mitigation?		
~~Yes~~ / No – (If there are significant impacts and issues identified a full Equality / Quality Impact Assessment (EQIA) must be undertaken.)		

Appendix 2 - Data Protection Impact Assessment Initial Screening

Name of Policy:	Continuing Healthcare Enhanced Observation in Care Homes Policy
Date of assessment:	05/06/2025
Screening undertaken by:	AACC Quality & Assurance Manager

Stage 1 – DPIA form **please answer 'Yes' or 'No'**

1.	**Will the policy result in the processing of personal identifiable information / data?** This includes information about living or deceased individuals, including their name, address postcode, email address, telephone number, payroll number etc.	~~Yes~~ / No
2.	**Will the policy result in the processing of sensitive information / data?** This includes for living or deceased individuals, including their physical health, mental health, sexuality, sexual orientation, religious belief, National Insurance No., political interest etc.	~~Yes~~ / No
3.	**Will the policy involve the sharing of identifiers which are unique to an individual or household?** e.g., Hospital Number, NHS Number, National Insurance Number, Payroll Number etc.	~~Yes~~ / No
4.	**Will the policy result in the processing of pseudonymised information by organisations who have the key / ability to reidentify the information?** **Pseudonymised data -** where all identifiers have been removed and replaced with alternative identifiers that do not identify any individual. Re-identification can only be achieved with knowledge of the re-identification key. **Anonymised data -** data where all identifiers have been removed and data left does not identify any patients. Re-identification is remotely possible, but very unlikely.	~~Yes~~ / No
5.	**Will the policy result in organisations or people having access to information they do not currently have access to?**	~~Yes~~ / No
6.	**Will the policy result in an organisation using information it already holds or has access to, but for a different purpose?**	~~Yes~~ / No
7.	**Does the policy result in the use of technology which might be perceived as being privacy intruding?** e.g., biometrics, facial recognition, CCTV, audio recording etc.	~~Yes~~ / No
8.	**Will the policy result in decisions being made or action being taken against individuals in ways which could have a significant impact on them?** Including profiling and automated decision making. (This is automated processing of personal data to evaluate certain things about an individual i.e., diagnosis and then making a decision solely by automated means - without any human involvement)	~~Yes~~ / No
9.	**Will the policy result in the collection of additional information about individuals in addition to what is already collected / held?**	~~Yes~~ / No
10.	**Will the policy require individuals to be contacted in ways which they may not be aware of and may find intrusive?** e.g., personal email, text message etc.	~~Yes~~ / No