Research into social care workers undertaking healthcare interventions

FEBRUARY 2022

Skills for Care

Author:
Liz Murphy
Senior Consultant

CONTENTS

Page

EXECUTIVE SUMMARY I

1 RESEARCH BACKGROUND AND METHODOLOGY 1

2 THE CURRENT LANDSCAPE 3

3 DELIVERY OF DELEGATED HEALTHCARE INTERVENTIONS 6

4 CREATING THE RIGHT CONDITIONS FOR DELEGATION 15

5 APPENDIX A: EXAMPLES OF EXISTING DELEGATION LEGISLATION, STANDARDS AND POLICIES 22

6 APPENDIX B: PILOT PROGRAMMES AND CASE STUDIES 29

7 APPENDIX C: DELEGATION OF INSULIN ADMINISTRATION PROGRAMME – SUMMARY OF TRAINING AND MONITORING STANDARDS 30

EXECUTIVE SUMMARY

Introduction

1. In 2021, Skills for Care worked with the Department of Health and Social Care to publish guidance on delegated healthcare tasks. The guides are aimed primarily at adult social care employers, managers and care workers in care homes and are intended to support decision-making and provide guidance on delivering delegated healthcare interventions safely and competently.
2. To further add to the knowledge and evidence base, Skills for Care commissioned York Consulting LLP to undertake an exploratory research project into current delegation practice. Twenty-five qualitative consultations were undertaken with representatives from providers, local authorities (LAs), Clinical Commissioning Groups (CCGs) and strategic organisations. These consultations explored knowledge of, and views towards, delegation, captured examples of where it is working well and highlighted key issues and challenges.

Definition and prevalence

3. The phrase "delegated healthcare intervention" was well recognised by consultees. There was also a general agreement on its definition, i.e., transferring a healthcare intervention from a registered practitioner to a non-registered individual, with assurances that the individual is supported, confident and competent in delivering the intervention.
4. The majority of consultees agreed that there is a strong argument for delegation, assuming that conditions are met such that it can be done appropriately and safely. Where that is the case, it was said to benefit social care workers, registered clinicians and those accessing care and support services. In particular, it can mean timely, flexible delivery of interventions and procedures, better continuity of care and more person-centred care.
5. Delegation for certain interventions is reportedly becoming more prevalent. These include blood pressure monitoring, oxygen saturation readings, insulin administration, basic stoma care, basic catheter care and PEG feeding.
6. However, consultees agreed that interpretations of delegation across the sector are varied and that the structures and processes for delegation are fragmented. They stated that it often takes place through informal agreements and on a case-by-case basis.

Delivery of delegated healthcare

7. **Governance and accountability:** currently considered to be variable and patchy. Whilst examples exist of effective practice, they are considered the exception rather than the norm. Inconsistencies and uncertainties in relation to the governance of delegation are causing challenges for providers and complications for CQC

inspectors. Encouragingly, there is work underway to put in place greater standardisation in some areas.

8. **Frameworks, standards and policies:** published guidelines on delegation do exist (Appendix A includes a summary), but tend not to be holistic or applicable to all settings. Providers are therefore designing their own delegation standards and protocols, which risks further fragmentation of practice and oversight.

9. **Training and monitoring:** there is a shared agreement on the importance of training and monitoring in the context of effective delegation, but real-world experiences are mixed. Consultees cite pressures within the adult social care sector, including capacity issues relating to workforce development, as constraining factors on the quality and timeliness of training. Similar concerns were raised over ongoing monitoring supervision.

10. Other issues and challenges impacting on effective delegation were said to include funding, insurance and communication between health and social care partners.

Creating the right conditions for delegation

11. Consultees cited the following key factors as being central to effective delegation:
    - Buy-in from staff to whom the tasks are being delegated.
    - Buy-in from individuals receiving care and their families.
    - Clear and standardised governance, policies and frameworks.
    - Collaborative, integrated working.
    - Clear and open communication.
    - Comprehensive and validated training, monitoring and competency assessment standards.
    - Formalised contracts.

12. It was felt the practice of delegation should not be examined in isolation but looked at within the context of wider systemic challenges faced by the sector concerning the need for, standardisation of care, greater integration and professionalisation of the care workforce.

13. Consultees would welcome more consultation on delegation policy and practice, and stressed that views should be obtained from across the sector.

1 RESEARCH BACKGROUND AND METHODOLOGY

Background

1.1 Longstanding challenges faced by the adult social care sector have been brought into sharp focus over the last two years under circumstances created by Covid-19. The pandemic has had a profound effect on health and social care working practices and has magnified issues around variations in the quality of care, workforce pay and conditions, disjointed delivery and unmet need, amongst others.

1.2 This has meant that some of those working in the sector have needed to take on additional responsibilities beyond their standard roles. This has included the delegation of healthcare interventions[1] from registered professionals to care workers.

1.3 In 2021, Skills for Care worked with the Department for Health and Social Care to publish guidance on delegated healthcare tasks[2]. The guides are aimed primarily at adult social care employers, managers and staff in care homes and are intended to support decision-making and provide guidance on delivering delegated interventions safely and competently.

1.4 At present, there are information gaps around what is being delegated, on what scale, with what risk and how it is perceived by those involved. Skills for Care therefore commissioned York Consulting to conduct an exploratory research project to help provide more information on these topics.

Methodology

1.5 A qualitative approach was used comprising video conferencing and telephone interviews with providers, representatives of Local Authorities (LAs) and Clinical Commissioning Groups (CCGs) and members of strategic organisations operating in health and social care environments. Consultees were recruited through a list provided by Skills for Care, with some supplementary snowballing[3]. The consultations typically lasted between 45 and 60 minutes.

---

[1] From the Skills for Care website: *Social care workers may be asked to carry out healthcare interventions that are delegated by a registered healthcare professional such as a nurse, nursing associate or occupational therapist. These are usually called 'delegated healthcare interventions' and are often specific clinical interventions that support people's care and independence.*

[2] https://www.skillsforcare.org.uk/Learning-development/ongoing-learning-and-development/Delegated-healthcare-interventions/Delegated-healthcare-Interventions.aspx

[3] Procedure by which respondents are recruited for interviews or group discussions by means of informal contact between them (e.g. recommendation to contact another individual during an interview).

1.6 In total 25 interviews were completed:

- 11 with care providers.
- 9 with LAs and CCGs.
- 2 with the Care Quality Commission (CQC).
- 1 with NHS Wales.
- 1 with a member organisation.
- 1 with a nurse consultant.

1.7 A discussion guide was designed in conjunction with Skills for Care, covering the following topic areas:

- Understanding and purpose of delegated healthcare interventions.
- Current and future delegation activity.
- Support, implementation and delivery of delegated healthcare interventions.
- Outcomes and impacts.

Interpreting the findings

1.8 Although a rich level of insight was obtained from participants, the sample was relatively small[4]. As such, the findings should be seen as indicative rather than necessarily representative of any larger population.

1.9 In addition, the research concentrated on specific groups within the health and social care sector, namely (in the main) managers within care providers and those working at a strategic level in LAs, CCGs and partner organisations. Consultations with frontline care workers, registered nurses and other registered healthcare professionals were out of scope.

[4] In part owing to the ongoing pressures and challenges faced by the sector at the time of research.

2 THE CURRENT LANDSCAPE

Defining delegation

2.1 The phrase "delegated healthcare intervention" was widely recognised amongst those that contributed to this study, with a general agreement of its definition as follows:

> *"Transferring a healthcare intervention from a registered, clinical practitioner to a non-registered individual with assurances that the individual is supported, confident and competent in delivering that intervention." (LA)*

2.2 However, consultees also agreed that interpretations of delegation across the sector are varied and that the structures and processes around delegation are fragmented. In particular, they cited inconsistencies in governance, a lack of standardised categories for delegated tasks and uncertainties over role definitions; together leading to a confused system, "grey areas" and ambiguous protocols.

2.3 Several consultees said that, based on their observations, delegation was based largely on informal arrangements and practices, often on a case-by-case basis, rather than through formal service contracts. That said, examples do exist of more systematic approaches, with strategic organisations, LAs, providers and other stakeholders working together to formalise processes and procedures (further details on this topic are provided in Chapter 4). In some – albeit rare – circumstances, such as the Delegation of Insulin Administration Programme, this has been happening for over a decade.

2.4 It is difficult in a study like this to form robust conclusions on the scale of delegation across a geographic area or part of the sector. However, consultees broadly agreed that, to some degree, all providers are engaged in delegation, *"though the extent to which they do so is dependent on the care provider, as some are more flexible than others and may have more specialist training or experience within their workforce" (LA)*. Risk is evidently a key influencing factor as well, with providers often referring to the stipulations enshrined in the Care Act 2014 as guidance.

Examples of delegated tasks

2.5 Delegated tasks highlighted most commonly by consultees included:

- Catheter and stoma care beyond standard practice (e.g., catheter flushing and changing stoma bags).
- Diabetes management and insulin administration.
- Nutrition and hydration practices beyond standard care (with some taking on additional PEG feeding responsibilities).
- Oxygen monitoring.
- Pressure area care, tissue viability, skin integrity and wound healing (with some undertaking training in replacement dressings).

- Prevention e.g., theory and practice around fall and pressure wound prevention.

2.6 Consultees consistently reported that delegation was becoming more prevalent, driven in part by the pandemic and the need for providers to take on additional responsibilities. Interviews with CQC, LAs and CCGs supported this, with all of them reporting an increase in delegation-related enquiries and requests for information.

> *"We receive enquiries on a daily basis from providers about delegation, much more so than in the past". (CQC)*
>
> *"Providers are increasingly needing to provide care for individuals with more and more complex healthcare needs. We are often asked if training is available for certain interventions. Recently, we've been asked a lot about insulin administration, buccal midazolam[5], PEG feeding and administering oxygen." (LA, Training Manager, Adult Social Care Training Team)*

2.7 To provide guidance and a framework for employees to work within, several of the providers consulted had adopted a traffic light system for delegation, whereby tasks are placed into three categories:

- **Low risk intervention:** standard care that can be undertaken by care workers that have completed mandatory training.
- **Delegated intervention:** requires additional training and competency sign-off from a registered practitioner.
- **High risk intervention:** exceeds the level of care the provider is safely able to offer.

2.8 However, providers also noted that the distinctions between the above categories were becoming increasingly blurred. They spoke of a "needs must" situation under Covid-19, whereby they were routinely delivering elements of care that would normally fall outside of their remit. As discussed further in Chapters 3 and 4, some providers evidently feel that there are questions over the adequacy of the support, training and monitoring that they have received from registered professionals.

Support for delegation

2.9 The majority of consultees agree that there is a strong argument for delegation, assuming that conditions are met such that it can be done appropriately and safely. Where that is the case, it was said to benefit social care workers, registered clinicians and those accessing care and support services. In particular, it can mean timely, flexible delivery of interventions and procedures, better continuity of care and more person-centred care. In the case of diabetes management, for example, having trained care workers in residential homes administer insulin avoids the need to wait for district nurses and the potential disruption of mealtimes. This in turn can reduce anxiety and stress for care workers and those they are supporting.

[5] Emergency medication given into the buccal cavity (the side of the mouth between the cheek and the gum) when an individual is having a seizure.

> *"A great benefit of our employees taking on additional care responsibilities is a greater flexibility and independence and a higher quality of life for residents. Our residential cohort are very active, and so it makes sense for us to take on more interventions in-house, rather than to wait for district nurses to come to the care home to change a dressing, for example." (Care Provider)*

2.10 Appropriate delegation can also help to alleviate pressures in other parts of the system, by freeing up a proportion of registered professionals' time. This in turn may result in fiscal savings.

2.11 Other points put forward in support of delegation were professional development, empowerment of care workers and increased job satisfaction (in each case on the proviso that employees were taking on additional responsibilities willingly). In the main, providers said their staff were keen to develop their skills and that they (the provider) wanted to support them in this and wanted to cultivate a confident and motivated workforce.

2.12 On a strategic level, delegation aligns with long-standing arguments for greater integration of health and social care. It can contribute towards the sector's response to growing demand and has the potential to deliver positive benefits in terms of recruitment and retention.

2.13 However, there was also a strong consensus that for delegation to work well, effective leadership, governance, accountability and resourcing are required, underpinned by adequate funding. Most consultees questioned whether this currently exists on a systematic level and voiced significant concerns about the absence of national or government-led directives or frameworks on delegation. This is fuelling uncertainties about the governance of delegation at a national level and accountability at a local level. The result is a considerable degree of variation in delegation practice which has the potential to increase risk and result in inconsistent levels of care.

3 DELIVERY OF DELEGATED HEALTHCARE INTERVENTIONS

Introduction

3.1 Consultees often described delegation practice (at provider, LA and CCG level) as "patchy" and "inconsistent". Providers are reportedly feeling increased pressure to take on additional care tasks (via requests from district nurses and CCGs, for example). However, it is not always clear who is, or should be, responsible for the delegation agenda and who is therefore providing the system leadership to ensure that providers and their workforces are appropriately trained and supported.

Governance and accountability

3.2 The consultation feedback suggests that some regions are progressing well in building governance and accountability frameworks relating to delegation. Certain LAs and CCGs were said to be more responsive to enquiries and more proactive in driving forward the agenda. These LAs and CCGs are also more willing to explore training and funding solutions to help ensure that delegation is adequately resourced and is governed by official service level agreements[6]. However, these LAs/CCGs were generally considered the exception rather than the norm. The picture reported more commonly was one of a "*postcode lottery"*.

3.3 Consultees typically agreed on how the governance of delegation should be structured, i.e. that:

- It is the responsibility of providers to ensure that their employees are adequately trained and competent in the care they provide.
- That registered professionals are ultimately accountable for the clinical care of individuals.
- That it is the CQC's duty to inspect and regulate practice.

3.4 However, consultees were far less clear about where the responsibility lies for deciding what can be delegated, when, and the mechanisms through which competencies are assessed.

> *"There are a lot of 'it depends'. It depends on the type of provision and who is funding that provision. It depends on how the health and care systems are structured and the degree of joint-working or integration. It depends on how health care, social care and personal care are being defined. It depends on individual providers and the relationship they have with registered professionals."*
> *(Strategic organisation)*

3.5 The current situation has resulted in a number of complications. Some providers report feeling unprotected and without recourse if they are asked by a registered professional to take on additional duties. Some said they feel "cast adrift" and that it

[6] See Chapter 4 for examples.

has been difficult to establish and maintain contact with their clinical leads and/or LAs and CCGs to discuss issues, concerns or risks.

3.6 This is also creating confusion for CQC inspectors, particularly in terms of what constitutes proof that a registered professional has undertaken the necessary steps to measure competency when delegating care. The CQC representatives contributing to this study reported a large increase in enquiries from inspectors unsure whether certain documentation constitutes acceptable evidence that appropriate training and monitoring is in place. Providers are uneasy about this, citing a risk to their quality-of-care assessments and CQC rating.

3.7 One provider noted that as guidelines are prepared and written by clinical professionals, it should be the case that they are up to date and fit for purpose. However, they feel this is not always the case, making them less confident that they are delegating care effectively.

> *"We are feeling increased pressure to take on additional tasks but often there is no follow-up to check that the delegated care has been delivered appropriately. The governance currently isn't there to pick up on competency issues or skills gaps. There's no rechecking of competency and no standards to monitor against. We are being pulled up by the CQC because things aren't tallying with the delegation guidelines, but we haven't been provided with all the training and information. There is a lot of inconsistency. It shouldn't be up to the provider to review and pick up on when the protocol falls short of the most recent guidelines." (Care provider)*

3.8 Providers also spoke of "blurred lines" in terms of the kinds of care that they are legitimately able to deliver and how, as a result, some practice may be going unregulated. One stakeholder discussed the treatment of disease, disorder and injury (TDDI), explaining that some non-TDDI registered providers are having to deliver that kind of care, despite not being officially recognised as doing so. They put this down to resourcing issues and increasing complexity of care needs.

> *"People are living longer and are developing more complex needs. Registered managers are not sure what to do. Do they transfer their resident's care to TDDI or have them stay there?" (Strategic Organisation)*

3.9 Nonetheless, work is being undertaken to standardise areas of delegation, such as the Delegation of Insulin Administration project and the All Wales Medicine Strategy Group (see example below). However, concerns remain that without a centralised body responsible for ensuring consistency and common standards in delegation, the fragmented landscape that currently exists will remain.

The All Wales Medicines Strategy Group (AWMSG) advises the Welsh Government on the use, management and prescribing of medicines in Wales.

Currently, the AWMSG is working to address the lack of consistency in medicine policy and medicine support across Wales. Specifically, it is seeking to define key terminology as an initial step toward greater standardisation across health board authorities, the aim being to improve clinical governance and accountability.

Under the Wales Social Wellbeing Act, medicine management is commissioned and funded as a healthcare intervention. However, there is growing support for redefining it as personal healthcare and part of daily living, placing it within the remit of personal and social care.

Until the legislation offers clear guidance, the situation remains ambiguous and discussions about the clinical accountability and governance of medication management are likely to continue. The AWMSG is working alongside the National Commissioning Body to drive forward the delegation agenda.

> *"Looking at enhancing social care skills and what is routinely delegated needs to be part of training and competency signed of a registered district nurse. There needs to be clearer national policy around what is an enhanced skill and what is considered as a Level 2. There is a push towards standardisation on agreeing to national set of principles for local authorities to review their existing policies and commission activity for the delegation of medicine management." (Strategic organisation)*

Existing frameworks, standards and policies

3.10 Whereas standardised, national regulations for delegation do not currently exist, various frameworks and guidance documents are available. These tend to provide a steer on when to delegate, what the delegation process should involve, and which competencies should be met by the health and social care workers undertaking the tasks. Existing government legislation and regulations, whilst not necessarily specific to the topic in question here, help to provide the context and offer a foundation for the development of more specific guidelines.

3.11 The providers and LAs consulted for this study said they have used publicly available guidance/documentation on delegation to develop their own protocols, policies and standards. This publicly available guidance/documentation includes the following (a summary of each can be found at Appendix A[7]):

- Health and Social Care Act (2008).
- Care Act (2014).
- Health and Social Care Protocol (2014).
- Welsh Government: Third Party Delegation Framework (2016).
- NHS England: Delegation of healthcare tasks to personal assistants (2017).
- Royal College of Nursing: Accountability and Delegation – A guide for the nursing team (2017).
- Jersey Care Commission: Personal Care and Clinical Tasks Guidance for Adult Social Care (2020).
- Nursing and Midwifery Council: NMC Code and Delegation and Accountability: Supplementary information to the NMC Code (last updated 2020).
- Trend Diabetes and NHS England: Delegation of Insulin Administration project resources (2020).
- All Wales Guidelines for Delegation (2021).

Training and monitoring

> *"Care provision is like building a wall. While the wall may stand up, it may not pass a building assessment." (Care provider)*

3.12 There is a strong consensus that for delegation to function effectively and safely, it requires a structured programme of training, observation and ongoing monitoring delivered by registered professionals. This resonates with existing guidelines on delegation, which often state that there should be initial training delivered by a registered clinician, in-situ observation of the intervention on several occasions in order to sign off competency, followed by ongoing monitoring and reassessment.

3.13 However, the experience of consultees is often rather different. They cited unclear lines of communication between health and social employees, uncertainties over who is responsible for driving forward delegation policy, variable training and sub-standard ongoing monitoring. They spoke of feeling pressured to take on additional care interventions while also experiencing challenges accessing appropriate training and ongoing support.

3.14 One provider voluntarily took part in a delegated insulin administration pilot. Initially, they found the training to be well-structured, well-delivered and comprehensive, with an assurance that reviews would take place at three-month intervals. However, the

[7] Examples were either referenced by research participants or located during YCL desk research.

review process had not begun a year later and, due to staff turnover and the lack of ongoing training and support, the provider was finding it increasingly difficult to keep delivering the practice, often having to resort to asking trained employees to come in on their days off to administer insulin.

3.15 The same provider has recently felt pressured to take on additional dressing responsibilities and has the same concerns over the adequacy of the training (rather than receiving in-person, practitioner-delivered insulin training, they were directed to a number of YouTube videos). Speaking to senior members of the local clinical team has reportedly been difficult and they have been met with resistance when attempting to initiate a conversation about handing back the care to registered professionals.

> *"The insulin training was absolutely by choice initially, but it has been so poorly executed, it's left a bitter taste in my mouth. I've tried to have a conversation about handing it back and was told 'that's not going to happen'…We've been given no choice about the dressings, and it's really hit and miss. I've emailed a range of people as it's very concerning. The Primary Care Network is supposed to have a clinical lead but it's just not happening…The latest has been bladder washouts. We've said no, we can't take it on." (Care provider)*

3.16 In another case, a provider had agreed to take on a specific intervention as part of a resident's care plan, under the agreement that they would receive appropriate support and supervision. However, the provider experienced ongoing issues reaching the clinical team, resulting in repeated delays to the training and concerns over the person's care and welfare. The provider was unable to find the appropriate training in time through their CCG, often being faced with outdated contact details and/or receiving no replies to calls and emails. Eventually, they paid for external training to avoid, what in their opinion, could have been a crisis situation.

> *"We appreciate everyone is stretched but we're just not seeing the right levels of co-operation and duty of care. The roles and responsibilities still need ironing out. We find it very difficult to get in touch with people." (Care provider)*

3.17 Providers are keen to see greater structure and a clearer set of policies around training and monitoring as a significant element of risk is introduced without them, including avoidable harm. Several providers argued that these should be included or reflected within formal contracts and service level agreements.

Challenges and barriers to implementation

Safety and interpretation

3.18 Safety, clinical oversight and clear governance were said to be paramount for delegation to operate effectively. However, consultees also noted that managing delegation and taking on the responsibility for signing-off and monitoring responsibilities can introduce additional risk for registered clinicians and that some may be averse to this. Similarly, care providers themselves need to be risk-averse, which can result in a reluctance to take out delegated tasks without appropriate clinical supervision.

> *"There is an accountability issue. Understandably, District Nurses can be very protective and therefore risk-averse, not willing to risk taking staff through training and signing them off as competent. In some cases, even with things like eye and eardrops, they want to sign off tasks." (Strategic organisation)*

3.19 Several stakeholders also highlighted challenges associated with interpretation. Staff can be trained to undertake specific tasks, execute and monitor interventions and record information related to that activity. However, how that information is then used is also essential in ensuring quality of care and safety. In other words, staff may know how to record data but there is a greater level of risk if they lack a sound understanding of when that data requires them to take (urgent) action or escalate. In other words, performing a delegated task is only one part of the responsibility; accurate interpretation is equally important.

Communication and process of effective delegation

> *"There is a rub between care provision policy and NHS policy and rubs between local and regional contexts and the national position. It's very blurry within the community. It's understandable that you often see a professional tug of war going on." (CCG)*

3.20 Lack of information sharing across different organisations and resistance to adapting practice were believed to be included among the consequences of inconsistent systems, blurred lines of responsibility and conflicting policies and approaches. There is a perceptible degree of frustration around delegation, often resulting from a perceived lack of understanding of each other's positions across and within the health and social care systems and between clinical, residential home, nursing home and home care settings. This can subsequently lead to limited coordination and planning and with individuals needing to negotiate and communicate with multiple organisations.

3.21 One stakeholder suggested that the process of delegation in general needs examining. Particularly when transitioning from a clinical to community environment and working with individuals with different skills sets, definitions and levels of understanding, it was felt registered clinicians could benefit from support and training in effective delegation and recognising when they are delegating.

> *"I think there is something to be said for looking at the delegation mindset. Not everyone realises or recognises when they are passing on responsibility, particularly when it becomes ingrained in your day to day. Even some very experienced managers don't speak in those terms, and it needs to be recognised as a skill that needs nurturing." (Care provider)*

3.22 It was argued by several stakeholders that the system is not always structured in ways that support effective joint-working between registered professionals and care workers. To promote delegation and to motivate those involved in its delivery, it was felt a greater understanding and appreciation of the variation each other's roles, skill levels, day-to-day practice and working environments, how they all fundamentally guide the deliverance of care in different settings and the unique pressures faced across different parts of the system.

Recruitment and retention

3.23 Consultees that have been involved in delegation programmes, or have seen delegation working well, stressed that it should be treated not as a series of ad-hoc interventions, but as a programme of sustainable quality improvement. They argue that care workers need to approach it willingly, with a desire to take on additional responsibilities and that they should feel encouraged to develop new skills. They also state that delegation benefits from having a training lead willing to take ownership, with a commitment to keeping training and competencies monitored, refreshed and up to date. From the clinical side, effective delegation benefits from regular supervision, helping staff to stay confident, comfortable and supported while delivering the intervention.

3.24 The above gives rise to a view from consultees that greater integration and a well-resourced and stable workforce would be valuable in enabling and promoting effective delegation. Consultees are not confident that the system/sector as it stands provides the right foundations. In their view, providers often invest time and finances in training employees only to lose them shortly afterwards. They have difficulty locating clinical contacts or replacements for contacts that have moved on, which can impact on decision-making and, ultimately, on care and safety.

> *"We are currently facing the worst recruitment and retention crisis I've ever seen. We're facing competition from other areas and struggling to hold down staff. A recent issue is staff being lured away by the Amazon golden handshake." (Strategic organisation)*

Funding

3.25 Consultees describe the funding structures around nursing, residential and home care as very variable, with delegation adding another layer of complexity. In particular, there is evident scepticism about whether the move towards greater delegation is driven by the positive impacts it can generate for people supported and the workforce, or whether the motivation is mainly financial. As mentioned earlier, providers argue that they feel increasingly pressured to take on additional tasks, but that this is not matched by additional funding, financial incentives or resources. As such, it is very difficult for them to compensate their workers for taking on extra responsibilities.

3.26 The operational differences between privately funded and LA commissioned care were highlighted here. An organisation representing homecare providers stated that because of how the latter is funded and resourced, it can be extremely difficult for homecare workers to take on additional/delegated tasks without introducing an element of risk.

> *"If you look at the routine of an LA homecare worker. Their caseload can mean they only have around 30 minutes per client. That's 30 minutes to do everything, wash, feed them, take them to the toilet, administer any medication. If you keep adding onto that, it's going to have some serious knock-on effects." (Strategic organisation)*

3.27 Consultees spoke of a "backdoor mission creep", i.e. a gradual shift towards more complex care delivery, but without the accompanying support, training or finances. This has the potential to disadvantage people supported and remove or restrict their access to registered professionals, such as District Nurses.

> *"It is all being dressed up as being best for individuals but if it was just about the quality of care, why not also transfer the funding to the care sector? Our residents have spent their lives paying taxes and national insurance contributions. They are entitled to be treated by a District Nurse. They are suffering because they pay to live in a residential home. More and more things are being shifted onto us, but no one is discussing the financial delegation that should be going with it." (Care provider)*

3.28 The issue of insurance was also raised as a substantial barrier for care providers. Insurance rates were said to have increased significantly over the last two years. This has been challenging in itself, but if providers are also on the delivery of care with an enhanced risk attached to it, there is a further impact on premiums. Several consultees argued that any examination of delegation practices needed to include a review of the current insurance landscape and the impact it can have on service delivery. Some insurance companies directly link their premiums to providers' CQC rating, automatically increasing rates if they fall to "Requires improvement" or "Inadequate". This again highlights another challenge associated with the absence of standardised protocols and frameworks. As discussed previously, there is a degree of

uncertainty around standards and the level of control the provider has in meeting delegation guidelines (due to the influence of external parties). There were some instances where this had led to a provider's CQC assessment and rating being negatively impacted and subsequently, an increase in their insurance premium.

> *"Insurance has gone up considerably since the start of Covid, in some cases by more than 100%. The more you do, the higher the premium. Some homecare providers are simply unable to get the insurance." (Strategic organisation)*

4 CREATING THE RIGHT CONDITIONS FOR DELEGATION

Introduction

4.1 Despite the challenges explained in the preceding chapters, consultees were broadly supportive of the move towards greater delegation and were able to provide examples of where it had worked well. There was also a broad consensus across the consultees in terms of the ingredients or key conditions required for effective delegation.

Examples of delegated healthcare interventions pilots and programmes[8]

Insulin and diabetes management

4.2 When citing delegated activities, consultees most frequently spoke of diabetes management and insulin administration. In some settings, these tasks have been delegated for several years and it has become standard and well-established practice. Explained in the box that follows, the Delegation of Insulin Administration programme[9], was said to by consultees to be a trailblazer and that one had clear and comprehensive frameworks for competencies and governance.

---

[8] Additional examples from YCL desk research can be found at Appendix B.
[9] https://www.diabetes.org.uk/Professionals/Resources/shared-practice/pharmacy-and-medicines/delegation-of-insulin-administration
https://trenddiabetes.online/wp-content/uploads/2021/01/C0584-Frequently_Asked_Questions_FAQs_in_the_Delegation_of_Administration_of_Insulin-TBM-v2.pdf

Diabetes UK, the NHS and other stakeholders developed a voluntary framework to support the expanded capacity of insulin administration through community teams.

The Delegation of Insulin Administration Programme seeks to put in place a structured and safe mechanism for health and care staff, who are not registered nurses, to take delegated responsibility for administering insulin to adults receiving care in the community.

The documents and supporting materials developed as part of the framework are based on best practice, input from stakeholders and an expert working group, together with the experience of eight national exemplar sites that have successful rolled out insulin administration programmes (Shropshire, Tameside and Glossop, Hertfordshire, Sirona Care and Health, North Tees and Hartlepool, Sheffield Teaching Hospitals, Barnet, Enfield and Haringey, and East Kent Hospitals University Foundation Trust). The materials include a comprehensive competency frameworks, management and employee checklists, a sample policy document FAQs and tip sheets.

Prior to the launch of the framework, East Sussex Healthcare NHS Trust had run a successful pilot of insulin delegation in care homes and district nursing. The pilot was carried out in 2019, involving 14 care homes and one respite care service. The key benefits were as follows:

1. **Cost and time saving for District Nurses:** the pilot demonstrated a significant reduction in the number of visits on the District Nurses', with substantial financial savings.
2. **Enhanced cross-sector working:** the pilot was designed collaboratively by the District Nursing team, the specialist diabetes team and health and social care representatives. This multi-disciplinary approach helped engender good practice, knowledge sharing and the identification of key learnings for improvement.
3. **Patient-centred care and positive resident experience:** delays in insulin administration, heavy caseloads, and District Nurse travel obligations were all reduced/avoided, leading to a reduction in acute diabetes complications.

Living Well at Home Programme: Blended Roles Trailblazer

4.3 In 2019, health and social care partners in Greater Manchester set up the Blended Roles Trailblazer to explore innovative solutions to system-wide issues and mobilise local teams to rapidly test the solutions. In doing this, they identified ways in which they could work in a more integrated way across health and social care at a neighbourhood level.

4.4 The focus was on optimising care workers' roles by delegating certain healthcare interventions (e.g. pressure area care and wound dressing) and developing joint care frameworks. These supported co-operation, coordination and information sharing to streamline systems and ensure individuals had a single point of contact.

4.5 The Trust developed planning documentation and assessments, support and communication policies, a competency framework and clinical governance procedures. Homecare staff were trained by District Nurses and then given further training specific to individual high-intensity users of pressure area care support.

4.6 Benefits of the project included continuity of care, reductions in users' waiting times for interventions, improved communications between providers and district nurses, and improved job satisfaction for homecare staff. It is also estimated to have safely reduced District Nurse visits by around 21%[10].

One Gloucestershire: Integrated Care System

4.7 In May 2018, NHS England announced that Gloucestershire was to become one of 14 Integrated Care Systems (ICS) in England. One Gloucestershire[11] is the working name given to the voluntary partnership between local NHS and care organisations working to deliver joined-up care to communities.

4.8 Under Goal 1 of the programme – "Primary Care at Scale: Partnerships and Integration" – a number of different pilots and projects are being undertaken to explore collaborative working in delivering place-based care.

4.9 One such project aims to develop the knowledge and practical skills of domiciliary care workers with regard to specific clinical tasks. The Fundamentals of Care project[12] is delivered through a series of weekly workshops designed to support the delivery of complex care within the community. Key outcomes of the training include participants having an awareness of prevalent long-term conditions, recognising deterioration and knowing when and how to access specialist advice or intervention.

4.10 Three cohorts have been through the programme, with anecdotal feedback suggesting improvements in practice. Care workers have become more adept at recognising the signs of deterioration during home visits and have improved their knowledge of escalation processes. They report feeling more valued and are deriving greater job satisfaction.

---

[10] https://gmprimarycarecareers.org.uk/wp-content/uploads/blended-roles-slides-for-summit-final.ppt
[11] https://www.gloucestershireccg.nhs.uk/wp-content/uploads/2020/03/Gloucestershire-ICS-Primary-Care-Strategy-V1.0.pdf
[12] https://www.proudtocareglos.org.uk/the-care-hub/proud-to-learn-training/the-fundamentals-of-care-programme/

Key factors to support effective delivery

4.11 Consultees agreed that for delegation to operate with maximum effectiveness, efficiency and safety, it needs to be sustainable and supported by structures that are embedded within integrated health and social care systems. Rather than being treated as part of 'a project', it should be treated as a component of ongoing quality and service improvement.

4.12 Consultees were also pleased that Skills for Care had chosen to take stock of delegation within their sector and to hear from those involved about the opportunities and challenges it presents.

> *"An examination of this is really timely. With Covid, we had to use workarounds across the social care system. There are things that you do that you have to but ideally, you wouldn't continue to operate that way. There are areas where it works really, really well but it's not consistent. It's not a feasible way to operate. You need something robust and somewhere that services or regions can go to say, 'this doesn't seem to sit right against the guidelines.'" (Care provider)*

4.13 In addition to the above, the following factors were cited as being fundamental to the success of delegation:

- **Buy-in from delivery staff:** providers and social care staff need to be willing and committed to taking on additional responsibilities and not feel that they have been coerced into doing so. As the process requires a degree of blending and restructuring of roles and different ways of working, delegation activity benefits from a preparatory or planning stage to mobilise the delivery partners and ensure they are comfortable with, and understand, the rationale for the change. System restructures, or centralised activities undertaken to stimulate and/or standardise delegation processes, should include a preparatory phase to secure buy-in and communicate the benefits of the change.

  > *"There needs to be an appetite for it right across the system, from care managers and their staff to the Primary Care Team. You need the stakeholders onboard and robust processes, governance and oversight in place. Those involved have to want to do it. There needs to be an examination of the barriers, organisationally and operationally, but also within the hearts and minds of the culture." (CCG)*

- **Buy-in from individuals receiving care, families and the general public:** changes in how care is delivered need to be supported by, and acceptable to, those receiving it. Delegation guidelines consistently state that consent for the delegation to occur needs to be obtained and documented, either from the individual concerned or a family member/advocate. Consultees' experiences of this have been mixed, with some reporting resistance from family members (less so individuals themselves) who need convincing about the rationale for the

delegation and the knowledge and skills of the care worker to whom the tasks have been delegated.

> *"We had had some concerns raised by families. One piece of feedback from the Learning and Disability review from families was, 'We feel like we get short-changed when the healthcare professional gets too busy and delegates to a support worker who may have only been here a month. How can that be safe for my relative?'" (Care provider)*

Clear and standardised governance, policies and frameworks: successful delegation relies on clear roles and responsibilities, definitions and protocols. *"I have spent several months on and off researching this and looking at what others are doing but there are no handy policies that you can just refer to…We've got the answer but divided out in various different parts and someone needs to pull it together." (Care provider)*

- **Collaborative, integrated working:** partnership-based working, involving GP practices, primary care teams, pharmacies and care providers, was highlighted as a driver of effective delegation. Consultees stressed that all those involved should seek to recognise the nuances involved in delivering care across different settings (residential, nursing, homecare etc.) and how caregiving roles can vary within each. Any national frameworks, and the consultation work underpinning it, should take this into account.

> *"We absolutely need greater consultation across the system to get the standards right across the different care environments. Guidance can be focused on one specific care environment (e.g. care homes) and care home and homecare are very different. Even though some of the clients looked after are similar, it's not the same role at all…And if you look at residential social care, you're going to have differences again. The way medication is administered is different, the way you dispose of things is different. What can seem like minute details can have a big impact." (Strategic organisation)*

- **Clear communication:** consultees stated that arrangements should be in place to give those undertaking delegated tasks timely access to registered nurses/practitioners for advice and guidance. This, they argue, should be in addition to escalation protocols (which should be specified in the delegation guidelines). Out of hours support should be available, through services such as Pando[13], even for non-urgent tasks (e.g. checking wounds) to mitigate against worsening conditions and the need for escalation.

- **Training, monitoring and competency assessment:** there was broad agreement that a consistent and validated system of training, guidance and supervision for delegation is needed. Where relevant, completion of the training should be

[13] https://hellopando.com/nhs/

officially recognised as part of a care worker's professional development[14]. Ideally, managers should also undertake the training to provide additional support to their workers. Appendix B provides an example of where training, monitoring and assessment standards have been built into a delegation programme.

- **Financing and contracts:** it was argued that delegation should be accompanied by appropriate funding and that care workers should be recompensed for expanding their roles. There was also support for service level agreements clearly outlining roles and responsibilities and commitments to training and supervision, with some consultees arguing for penalties if these were not met. Several LAs made the case for joint funding models (i.e. between LAs and CCGs) and collaborative exploration to identify the resources available and the levers that can be used to provide solutions.

Wider systemic considerations

4.14 Consultees generally felt that the delegation of healthcare needs to be examined, not in isolation, but as part of the wider context and the ongoing challenges (and potential solutions) faced by the health and social care sector. The ways in which delegation develops, is delivered and functions in practice, is linked with widely debated systemic issues relating to:

- Standardisation of care and prevention.
- Greater integration and joint-working practices.
- Professionalisation of the care workforce.

4.15 It was argued by a number of stakeholders that the standard of care provided in the UK needs to be raised and made more consistent. Part of raising these standards should be around creating solutions to provide proactive, rather than reactive care, including greater analysis around health and service trends to support and inform collaborative strategies for prevention.

4.16 Similarly, the argument for increased delegation was believed to support the argument for a higher skilled, more qualified care workforce. Although the Care Certificate was valued, for a number of stakeholders, it did not go far enough, with some arguing that the UK should be paving the way towards greater professionalisation of the care sector and moving in the direction of registration. Training the workforce, as standard, to a certain level would effectively reduce the need for delegation and mitigate the risk of avoidable harm. Linked to that is the ever-growing need to focus on solutions to tackle the recruitment and retention issues faced by the sector, creating more attractive job propositions and a stable workforce.

4.17 A major component of delegation delivery is coordination and joint working between health and social care, which requires a degree of restructuring and adaptation of

[14] It was observed that delegation training received by care workers is often not accredited. *"When training is provided, they will hand out a certificate of attendance and deliver the theory to the staff, but the training has no CPD credit." (LA).*

current roles and working practices. Stakeholders believed the groundwork for and mechanisms to deliver delegation are already, at least partly, in place. For example, existing integration and devolution activity, Sustainability and Transformation Plans, Direct Enhanced Services and Primary Care Networks could be capitalised on and developed through the lens of delegation to build the system around it.

4.18 Further consultation around the issue of delegation was not only welcomed but felt necessary by several stakeholders to build robust structures and delivery mechanisms. As above, it was emphasised that this should be sector-wide, covering all settings and the full range of lived experiences.

5 APPENDIX A: EXAMPLES OF EXISTING DELEGATION LEGISLATION, STANDARDS AND POLICIES

Health and Social Care Act (2008)

5.1 The primary focus of the Health and Social Care Act 2008 was to create a new regulator (the CQC) whose purpose was to provide registration and inspection of health and adult social care services together for the first time, with the aim of ensuring safety and quality of care for service users.

5.2 Regulation 18 of the Act deals specifically with staffing issues to ensure providers deploy experienced and competent individuals, stipulating that:

- Providers must ensure there are enough suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times.
- Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities.
- Staff should be supported in acquiring further qualifications and be able to demonstrate to regulators that they meet the required professional standards.

Care Act (2014)

5.3 The Care Act stipulates that local authorities must provide or arrange services that help prevent people developing needs for care and support, or which delays/prevents people deteriorating such that they would need ongoing care and support. It combined various existing pieces of legislation which previously shaped how social care was delivered.

5.4 The Care Act 2014 was designed to be a simpler, modern law for 21st century care and support focussing on the individual needs of people. The aim was to make the law fair and more consistent, removing certain anomalies that treated particular groups of people differently to create a single route for determining entitlement, which works for all groups of people in all circumstances. The Act was therefore intended to remove the chance of discrimination and unfair treatment taking place when assessing care needs and provision.

5.5 The Act clearly states the steps that must be followed to work out this entitlement, to help people better understand the process. It follows the person's "journey" in the care and support system. The Act introduced:

- National care and support eligibility criteria for both adults and carers.
- Accessibility to information and advice that both adults and carers need to make good choices about care and support.
- Rights to independent advocacy in some circumstances.
- Personal budgets and rights to request a direct payment.

- New responsibilities about making the transition from children's services to adult social care.
- New responsibilities about provider failure, for example, if a care home closes.
- Support for people who move between local authority areas.

5.6 https://www.legislation.gov.uk/ukpga/2014/23/section/79/enacted

Welsh Government – Third Party Delegation Framework (2016)

5.7 The Welsh Government published a governance framework in 2016, which is designed to help assess whether suitable governance arrangements are in place for the delegation of care from registered professionals employed by NHS Wales to third party support workers. According to this framework, the following applies:

- The person who is responsible for the decision to delegate should follow the assessment process as outlined in the All-Wales Guidelines for Delegation (NLIAH 2010).
- This involves assessing the task and the individual undertaking it, carrying out a risk assessment and following up with a review of how well the delegated task was performed.
- The employer of the support worker (e.g., agency, care home, third sector provider) should be aware of, and agree to the training, assessment and ongoing supervision/monitoring of the task(s) delegated.
- The delegator remains responsible for the patient's care overall but is not accountable for the decisions and actions taken by the delegatee.

5.8 As part of this framework, the following nationally agreed competencies were established:

- Routine management of compression hosiery for a stable person with lymphoedema.
- Routine management of anti-embolic compression hosiery.
- Medication by support workers.
- Supporting adults who require home enteral tube feeding via a gastrostomy feeding tube.

5.9 https://gov.wales/sites/default/files/publications/2019-07/third-party-delegation-the-required-governance-framework.pdf

NHS England – Delegation of healthcare tasks to personal assistants (2017)

5.10 In 2017, NHS England published a framework outlining the requirements for supporting appropriate delegation of healthcare tasks from registered practitioners to personal assistants (PAs). It is designed to help registered practitioners understand the rationale for delegation and to help CCGs develop clear protocols for ensuring safe and appropriate delegation to PAs.

5.11 The framework is not specifically intended to cover issues relating to agency carers or other support workers, although many of the principles could be applied to them. It was informed by work carried out in NHS organisations between 2014 and 2016, supported by Skills for Health.

5.12 The framework urges CCGs to put in place clinical governance frameworks to regulate delegation, with clear guidance as to which tasks can and can't be delegated, how training and assessment of competence will be provided, and how clinical reviews of patients' needs will be undertaken.

5.13 https://www.england.nhs.uk/wp-content/uploads/2017/06/516_Delegation-of-healthcare-tasks-to-personal-assistants_S7.pdf

Royal College of Nursing (2017)

5.14 In 2017, the Royal College of Nursing (RCN) issued a guide for nursing teams explaining the principles of accountability and delegation. It includes a step-by-step guide to ensure delegation only takes place when it is safe and appropriate to do so. The principles of delegation in accordance with the RCN are as follows:

- Delegation must always be in the best interest of the patient and not performed simply in an effort to save time or money.
- The support worker must have been suitably trained to perform the intervention.
- Full records of training given, including dates, should be kept.
- Evidence of competence assessment should be recorded, preferably against recognised standards such as National Occupational Standards.
- There should be clear guidelines and protocols in place so that the support worker is not required to make a standalone clinical judgement.
- The role should be within the support worker's job description.
- The team and any support staff need to be informed that the activity has been delegated.
- The person who delegates the activity must ensure that an appropriate level of supervision is available.
- Ongoing development to ensure that competency is maintained is essential.
- The whole process must be assessed for the degree of risk.

5.15 https://www.rcn.org.uk/professional-development/publications/pub-006465

Nursing and Midwifery Council (2018)

5.16 The Nursing and Midwifery Council released an updated Code of Conduct in 2018, which includes guidance on the delegation of healthcare tasks. According to this, staff are accountable for their decisions to delegate tasks and duties to other people, and as such, they should:

- Only delegate tasks and duties that are within the other person's scope of competence.
- Ensure that everyone they delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care.
- Confirm that the outcome of any task they have delegated meets the required standard.

5.17 https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

Trend Diabetes and NHS England: Delegation of insulin administration project resources (2020)

5.18 The Delegation of Insulin Administration project was developed by NHS England in partnership with Trend Diabetes. It is designed to provide a voluntary framework under which suitably trained health and social care workers, including health and care support workers and healthcare assistants, could administer insulin to adults whose diabetes is stable.

5.19 Trend Diabetes was commissioned to develop resources for the project, including an e-learning module, policies and a competency framework.

5.20 The resulting documents and supporting materials are based on best practice, input from stakeholders and an expert working group, as well as the experience of eight national pilot sites. They include the following:

- Final letter of delegation of insulin administration.
- Sample document for the delegation of insulin administration.
- Checklist for health and care workers who are delegated responsibility to administer insulin to adults.
- Competency framework and workbook for blood glucose monitoring and subcutaneous insulin administration.
- Frequently asked questions.

5.21 https://diabetestimes.co.uk/nhs-england-delivers-insulin-delegation-administration-resources/

All Wales Medicines Strategy Group (2020)

5.22 The All-Wales Medicines Strategy Group (AWMSG) advises the Welsh Government on issues relating to the use, management and prescription of medicines to ensure patients receive appropriate care. In June 2020, the AWMSG released guidance intended for the use of health boards, care homes and nursing professionals in relation to the delegation of medicine administration to healthcare or social care support workers. It states that "the law does not prevent care support workers from administering medicines in any setting providing they are acting in accordance with the directions of an appropriately trained prescriber". While medicine administration has to date traditionally been carried out by a registered nurse, there are now new

approaches to the delivery of care, and thus the following guidance has been issued by the AWMSG:

- The registered nurse is accountable for ensuring that medicines support is appropriately delegated to competent care support workers who have completed appropriate training.
- They should only delegate tasks and duties that are within the care worker's scope of competence.
- They should ensure the delegatee is adequately supervised.
- The care support worker should not provide any support with medicines unless this task has been delegated to them and the patient has undergone a needs and risk assessment.
- Care organisations should ensure that care support workers have access to the appropriate accredited education to support individuals with their medicines whilst not under the direct supervision of a registered nurse.
- The organisation will accept responsibility for all tasks undertaken by the care support worker, providing they are competently trained and are compliant with the agreed local written policies and procedures.
- The delegating organisation has vicarious liability for its employees.
- Care support workers must have completed one of the identified specific education units at Credit and Qualifications Framework for Wales Level 3 as a minimum or be able to demonstrate training to the equivalent.
- Additionally, an appropriate recognised accredited unit of learning in relation to supporting individuals with medication must be achieved.

5.23 https://awmsg.nhs.wales/files/guidelines-and-pils/all-wales-guidance-for-health-boards-trusts-and-social-care-in-respect-of-medicines-and-care-support-workers-pdf/

Jersey Care Commission: Personal Care and Clinical Tasks Guidance for Adult Social Care (2021)

5.24 The Jersey Care Commission (JOC) is an independent, regulatory body which inspects care services provided by the Government of Jersey. The services they regulate include care homes providing nursing and personal care or personal support for people with a range of health and social care needs, care provided to people in their own homes, adult day care services and residential and other services for children and young people.

5.25 In 2019, the JOC released the Personal Care and Clinical Tasks Guidance for Adult Social Care, which was published to promote best practice across adult social care and to ensure that all relevant stakeholders are aware of their responsibilities when arranging, managing, delegating or providing care. It applies to individuals and organisations who arrange or provide care to adults receiving care from services which are registered under the Regulation of Care (Regulated Activities) (Jersey) Law 2018.

This includes homecare services, day care services, care home services and registered care/support workers who are self-employed or employed directly by individuals.

5.26 It includes a section titled 'Delegatable Tasks' which outlines nursing tasks, which in appropriate circumstances can be delegated to care/support workers. It also includes a list of tasks that are not acceptable for delegation. According to this guideline, the following tasks can be delegated, provided suitable training and assessment has taken place:

- Capillary blood test.
- Contraceptive devices.
- Gastrostomy/jejunostomy Care.
- Administration of certain medicines.
- Non-invasive ventilation.
- Temperature recording.
- Obtaining urine samples.

5.27 https://carecommission.je/wp-content/uploads/2019/03/JCC-Guidance-personal-care-and-clinical-tasks-adult-social-care-ratified-20190314.pdf

All Wales Delegation Guidelines

5.28 National guidelines have been developed to assist in the management and practice of appropriate delegation. They have been developed primarily to support clinical staff, however, the principles can be applied to all staff groups. These national guidelines will clarify and support the delegation process and aim to:

- Support staff to delegate appropriately.
- Support staff development.
- Support compliance with regulatory and governance frameworks.
- Provide a shared understanding and a common approach to delegation.
- Articulate individual and organisational accountability.
- Utilise workforce resources and skills more appropriately.
- Develop and increase staff motivation.
- Increase efficiency and effectiveness.
- Reduce waste, variation and harm.
- Respond to changing needs in healthcare.

5.29 The development of these guidelines used the approach set out below. This sought to ensure they were developed on a firm evidence base, accessed expertise from within and outside Wales, and complied with professional and legal requirements:

- A review of the literature to identify best practice in delegation was completed. This included scrutiny of the regulatory codes of conduct and practice. The analysis of the information revealed useful resources which have been used to support the development of these guidelines.
- The involvement of clinical and managerial staff was essential to inform and influence the content and structure of these guidelines. Staff representing clinicians, trade unions, professional organisations and the education sector participated in the consultation. The representatives were asked to consider, amend, challenge and identify gaps in the draft guidelines. The information from the consultation process was collated and themed to reflect a consensus view on each of the guidelines. The guidelines were subsequently revised in response to the information received. The views of the individuals who attended the two consultation events was further sought on the revised guidelines for final validation.
- Legal Advice was sought on the issues arising from the process of delegation and the associated implications. In particular, legal advice was provided on the principles of accountability for delegation and on the consequential issues such as vicarious liability.
- Advice was sought from Professional Regulators and incorporated.

5.30 http://www.wales.nhs.uk/sitesplus/documents/829/all%20wales%20guidelines%20for%20delegation.pdf

5.31 https://heiw.nhs.wales/files/weds-practicing-appropriate-delegation/all-wales-guidelines-for-delegation-2020/

6 APPENDIX B: PILOT PROGRAMMES AND CASE STUDIES

Oxfordshire County Council – Upskilling the Homecare Workforce Pilot (2017)[15]

6.1 A new model to allow for the delegation of appropriate healthcare tasks and enable faster response times was piloted in Oxfordshire for an eight-week period in 2017. Participants in this pilot were two homecare providers on the Oxfordshire County Council approved provider list and the Oxford Health NHS Foundation Trust. The objective of the pilot was to increase capacity by integrating clinical and care delivery.

6.2 A care protocol allowing the Oxford CCG to delegate a certain set of responsibilities to paid carers under a formal and structured process was put in place. Healthcare tasks were risk assessed and separated into different categories depending on the level of training required.

6.3 The first category included warfarin administration, compression hosiery, TED stocking application and inhaler administration. These tasks were classed as Level 1 Portable Tasks. Carers who became proficient in them received a Portable Skills Passport, meaning they could deliver these tasks in the community. Tasks in the other categories were more involved and included stoma and catheter care, and administering oxygen and emergency medication. These tasks were deemed patient-specific and not transferrable to other scenarios by care workers.

Nefyn Pilot Programme – Upskilling Health and Care Workers to Provide Additional Capacity in the Community (2020)[16]

6.4 A partnership between a GP surgery and the homecare provider Gofal Seibiant in rural Wales has provided social care workers with support to undertake basic observations with patients in their own homes. The training included taking a pulse, pulse oximetry (checking oxygen saturation levels in the blood), heart rate, blood pressure and taking a temperature. The homecare workers taking part in the pilot were not expected to make any clinical decisions but rather to facilitate observations.

6.5 The pilot was evaluated by the Welsh Institute for Health and Social Care, University of South Wales and PRIME Centre Wales in July 2021.

[15] https://www.ncctc.co.uk/download_file/197/194

[16] Welsh Institute for Health and Social Care & the University of South Wales, Upskilling Health and Care Workers to Provide Additional Capacity in the Community: A Service Evaluation of the Nefyn Pilot, 2021. Available at: https://pure.southwales.ac.uk/ws/portalfiles/portal/5509306/REPORT_Upskilling_Health_and_Care_workers_in_the_Community_FINAL_JULY_21_002_.pdf

7 APPENDIX C: DELEGATION OF INSULIN ADMINISTRATION PROGRAMME – SUMMARY OF TRAINING AND MONITORING STANDARDS[17]

7.1 Clear entry criteria for trainees required and compliancy with the mandatory training required by their employer organisations.

7.2 The registered nurse/registered practitioner must ask the healthcare worker (HCW) to confirm that they are willing to perform the task following training and with ongoing monitoring and supervision.

7.3 All modules of the training need to be completed and the task may only be delegated once competency is signed off by an experienced registered nurse/registered practitioner who will then act as a mentor.

7.4 The registered nurse/registered practitioner is accountable for ensuring that the HCW to whom they are delegating an insulin administration task is competent, based on their professional judgement and supported by the framework of e-learning and supervision which accompanies the policy. They must therefore ensure the delegated HCW is trained and has been assessed as competent.

7.5 It is vital that the register nurse/registered practitioner make sure the HCW has the ability to access advice and guidance from them on a regular basis (e.g. monthly clinical supervision and regular huddles to discuss cases) as part of a mentoring relationship - and the ability to access ad-hoc advice when needed so they can provide safe and compassionate care.

7.6 Competence should be reviewed on a six-monthly basis, or in response to any incidents occurring and/or being reported. If there has been break in practice for more than three months, refreshed training and updated competency assessment is required before the delegation of duties can recommence.

7.7 The competency assessment should be completed five times as part of the initial training and then once at six-monthly intervals by the registered nurse/practitioner.

7.8 A signed confirmation or verification of training (including e-learning) and competence assessment by the registered nurse/registered practitioner must be obtained from the HCW as assurance that the training and assessment of competence was successfully completed.

7.9 The HCW should have access to advice and guidance on a regular basis (e.g. monthly clinical supervision and regular huddles to discuss diabetes cases) as part of a mentoring relationship, and the ability to access ad hoc advice when needed.

7.10 Registers must be maintained to record the following:

- A register of registered nurses and registered practitioners willing and able to delegate administration, held by Community Nursing.
- A register of HCWs deemed competent, held by District Nursing.

[17] https://diabetes-resources-production.s3.eu-west-1.amazonaws.com/resources-s3/public/2020-12/C0584-Sample_Policy_for_the_Delegation_of_Insulin_Administration-TBM-AKJ-v2.1.pdf

- Records of e-learning completion, competency assessment, completion of checklist and final sign-off, held in the care homes' training records.
- Annual review of registers undertaken by care homes through self-declaration and audited through random selection by the care home and Community Nursing.