directors of adass
adult social services

skillsforcare

# Delegated healthcare activities and the commissioning of adult social care

## Key findings from the Association of Directors of Adult Social Services (ADASS) sector engagement

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CARE

# Introduction

Regionally and nationally, the Association of Directors of Adult Social Services (ADASS) has a longstanding interest in delegated healthcare activities. Members have been keen to realise delegation's potential benefits for people who access care and support, while also being clear that implementation should always be safe, legal and financially equitable between health and care partners.

ADASS was therefore delighted to be one of the organisations supported by Skills for Care in 2022 to develop policy and practice tools in advance of new voluntary guiding principles for delegated healthcare activities, due to be published by the Department of Health and Social Care (DHSC) in the spring of 2023.

ADASS' project focussed on how delegated healthcare activities can or should be factored into local commissioning arrangements. How should directors of adult social services (DASS) and their teams address delegated activities in their commissioning of services? What are the relevant legal and regulatory frameworks? How should delegated activities support integrated working or joint commissioning? How can delegation support efficiency, without facilitating cost shunting?

Answering these questions in robust commissioning arrangements is part of establishing the context, support, guidance and governance within which delegation options can be offered as part of truly personalised care. Individual delegation decisions must be person-centred, involving the person receiving care, supported by others if necessary. (Where a person is unable to make these decisions for themselves, the principles of the Mental Capacity Act should be followed and decisions made in the person's best interest.) Good commissioning can go a long way to promoting the positive and collaborative culture, with personalisation at its heart, that is essential for delegated activities. Delegation, in turn, can have a valuable role in growing collaborative and person-centred culture and practice (see 5 and 6 below).

The project led to the production of a top tips support document for ADASS members in December 2022. This key findings document is designed to summarise learning from the project for a broader set of social care partners, and support implementation of the national voluntary guiding principles.

## Key definitions

Skills for Care defines a delegated healthcare activity as follows:

- A delegated healthcare intervention is a health intervention or activity usually of a clinical nature, that a registered healthcare professional delegates to a paid care worker. The type of delegated healthcare activity will depend on the agreed protocol in your organisation and/or local health and care system. A registered healthcare professional remains accountable for the appropriateness of the delegation and ensuring that the person they are delegating to can do the task.[1]

The Nursing and Midwifery Council define delegation and accountability as follows:

- Delegation is defined as the transfer to a competent individual, of the authority to perform a specific activity in a specified situation.
- Accountability is the principle that individuals and organisations are responsible for their actions and may be required to explain them to others.[2]

## Project design

The project began with a call out to councils in May 2022, asking if they either had practice they wished to share or concerns they wanted to see covered in the research. The project also reached out to health partners and providers in order to ensure a rounded perspective on the state of delegation and the roles of adult social care commissioning in shaping its future. These approaches led to over 20 interviews with senior council commissioners and service managers, as well as colleagues in community health services, providers of homecare and residential services, the Care Quality Commission (CQC) and the Primary Care, Community Services and Strategy Directorate of DHSC.

On the basis of the interviews, a webinar was held in August 2022 to deliberate three key themes that had arisen from the research: workforce, area based frameworks and law and guidance. The event was chaired by Dawn Wakeling (DASS, London Borough of Barnet), as one of the priority co-leads for sustainable health and care systems at ADASS.

Given the nature of the project design, the observations made in this document should be treated as indicative of experiences, concerns and ambitions within social care as regards to commissioning and delegated healthcare activities. The project did not attempt a comprehensive survey or stocktake.



1 Delegated healthcare activities: guide for social care employers and managers (Skills for Care).
2 Delegation and accountability: supplementary information to the NMC Code (Nursing and Midwifery Council).

# Key findings

## 1. Practice varies widely and some social care leaders believe many arrangements to be ad hoc rather than strategic and robust.

In 2021-2, York Consulting conducted research into delegated activities on behalf of Skills for Care. It included local authorities, providers, clinical commissioning groups (CCGs) and strategic organisations, and concluded that, "the structures and processes for delegation are fragmented…. [delegation] often takes place through informal agreements and on a case-by-case basis".[3] ADASS work in this area confirms a widespread sense of fragmentation and informality among social care leaders and commissioners. It is by no means universal – many were addressing or had already gripped the issue with partners in their areas – but in some places there was anxiety about possible drift.

COVID was given as one reason for unplanned change. The pandemic was believed to have accelerated the introduction of delegated healthcare activities into residential services, as providers took on clinical activities in order to minimise the number of health professionals coming in and out of care homes. Some local authority leaders felt that they were in catch-up mode.

It is important for DASSs to have an up to date understanding of where in their areas delegation is taking place, in what forms and with what consequences – including financial consequences. The contexts are complex and include, but are not limited to, primary care networks (PCN) - delivery of Enhanced Health in Care Homes, multi-disciplinary teams, the development of hybrid services and more partnership working between mental health trusts and the independent sector.

(Note that some local authorities have S75 partnerships with the NHS under which they commission Continuing Health Care (CHC) services on behalf of the NHS. Care plans are likely to include some NHS-funded care and support that is non-clinical. Although NHS-funded, such care and support would not involve delegation of individual activities from a healthcare professional and would not therefore fall within the remit of the delegation arrangements referred to in this project.)

DASSs may wish to check whether, where delegation protocols and governance are in place, these are still clear in light of any subsequent service reconfiguration or fresh commissioning. Are they in line with the latest guidance from professional bodies such as the National Midwifery Council (NMC) or other relevant bodies? For example, the voluntary England framework developed by Diabetes UK, the NHS and other stakeholders to allow expanded capacity to community teams who administer insulin to patients was published in 2021, and has been updated with new elements, including checklists.[4]

3 Research into social care workers undertaking healthcare activities (Skills for Care, February 2022).

4 Delegation of insulin administration, Diabetes UK.

DASSs may also consider evidence of how local arrangements have worked in practice, and the experiences of staff and people who access care and support. Critically, are these delegated arrangements still operating with active leadership from senior care colleagues, and their counterparts in health and their provider colleagues? Experience nationally suggests that staff may fall back into familiar professional roles where encouragement to take on new ways of working is not regularly refreshed and support given.

DASSs may review delegation practice and plans as part of their overall commissioning and market shaping responsibilities, particularly as delegation relates to understanding the market, promoting quality, personalisation, promoting integration with local partners and – depending on your area-appropriate ambitions – transformation.

## Voices from our engagement:

"I think we've drifted into this territory through the pandemic rather than thought it through from a more legal and risk perspective."

"My gut feel is it's probably in my area. We're doing it without even kind of noticing that we're doing it."

"I suspect we're seeing unconscious delegation."

"There wasn't an understanding at multiple levels across the system of reciprocal arrangements for the delivery of support… all of the activities and costs [were] being pushed onto social care commissioners and providers."

## 2. Emerging evidence from practice points towards a positive role for delegated healthcare activities in effective personalised care, given the right circumstances and governance.

Properly planned delegation can help ensure scarce and expensive clinical resources remain where they are most needed and can enhance the personalisation of care. It "must always be in the best interest of the patient and not performed simply to save time or money" (Royal College of Nursing).

Evidence suggests that people receiving delegated healthcare activities are often pleased with the arrangements, finding them less stressful and more convenient than administration by a health care professional. It is worth noting, however, that the evidence base is somewhat limited and focussed on situations in which the activity is delegated to a familiar figure in the individual's care.[5]

Individuals' preferences and choices cannot be assumed. All guidance should reinforce the importance of obtaining consent; and above and beyond this, assessment and decision making should be person-centred, ensuring that the views and wishes of the individual and/or their representative are sought and taken into account. The fairness and consistency of these conversations and subsequent decisions should be reviewed against protected characteristics and type of health need.

It is also important to recognise that the appropriateness or inappropriateness of delegation cannot be decided simply on the basis of the clinical complexity of the activity but must have regard to the whole context of the individual's needs and circumstances.

### Voices from our engagement:

"Keeping people at the centre of all decisions should be the most important thing. ICSs need to make it happen seamlessly."

"Will everyone receiving health activities feel as safe in the hands of people who aren't nurses?"

"You must record the reasons behind decisions."

"People like it' [staff and people receiving services]."

5 For a review of evidence relating to the views of people receiving delegated healthcare activities, see Delegation of healthcare activities to personal assistants (2017) op cit.

## 3. Legislation prescribing the circumstances in which local authorities can provide healthcare services, normally the responsibility of the NHS, should be front of mind when delegation and commissioning decisions are taken, and should be clearer to more front line staff.

Section 22 of the Care Act 2014 sets out the circumstances in which local authorities may meet health needs that are normally the responsibility of the NHS. In effect, it sets the boundary between local authority responsibilities for provision of means tested care and support, and the responsibilities of the NHS for the provision of free health care, prohibiting local authorities from meeting, providing or arranging a service or facility that the NHS is required to provide. However, it allows for exceptions to this prohibition where two conditions are met: where the activity is incidental and ancillary to the care being provided (sometimes referred to as a 'quantity' test); and where the activity is of a nature which a local authority could be expected to be able to provide (sometimes referred to as a 'quality' test).

The quantity test allows local authorities to take on health activities where "doing so would be merely incidental or ancillary to doing something else to meet needs". A health care activity may be delegated where its delivery will be supplemental or subsidiary to the social care activity.

The quality test allows for local authorities to take on health activities where "the service or facility in question would be of a nature that the local authority could be expected to provide". In forming a judgement, consideration must be given to the intensity, complexity or unpredictability of the health need, and whether meeting it would draw the local authority beyond its functions and competence.[6] A local authority's services and capabilities are likely to evolve over time – taking on delegated activities may itself be part of that change – so this will be relevant in determining the 'nature' test. Fundamentally, in choosing to take on any delegated health activities under the exception provisions – the provisions allow rather than require local authorities to accept delegated tasks that fall within the conditions described in section 22 - the local authority must be satisfied that it has identified and can manage the relevant risks and be willing to accept legal responsibility for the performance of the activity, subject to the retention of the overall responsibility by the NHS.

Social workers within multi-disciplinary teams (MDTs) will have extensive training in legal literacy to support decision making at the health and social care boundary. You may wish to consider which other members of the wider care workforce in your area would benefit from training in order to understand the legal conditions for delegated activities. Where local authorities have provided such training, a key objective has been to enable staff in a variety of roles to identify and potentially challenge isolated and questionable instances of delegation. For example, situations may have developed in which home care staff are undertaking no personal care but are carrying out medication-only visits. These would fail the 'quantity' test of being incidental and ancillary activities, placing the local authority on the wrong side of the legal line, and allowing practice to fall into a regulatory blind-spot (CQC does not inspect medication only visits as they are not in



6 Some local authorities and health partners have found it helpful to draw on The National framework for NHS continuing healthcare and NHS-funded care (DHSC, July 2022) in distinguishing health and social care needs.

## Voices from our engagement:

"Without an understanding of the legal context, the front line tends just to be rolled into agreement."

"Things have evolved organically. I suspect some councils have been sailing close to the wind."

"Medication only visits by social care are outside of the provisions of section 22. But they happen. What does this tell us?"

"Our framework provides clear identification of the principles, statutory duties and national guidance that underpin and inform decision making and the delegation of support activities between health and social care."

## 4. Delegating healthcare activities to commissioned care providers may have regulatory and institutional impacts, so it is important to work with individual providers and provider forums to clarify where changes need to be made to registration, insurance and medicines policies.

Care providers' CQC registration must be up to date and in line with their current activities, even if they do not intend to provide those services on a regular or permanent basis.[7] Where care providers have responsibilities for medicines support in the community they must have robust processes for medicines-related safeguarding incidents, in line with Regulations 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where delegated healthcare activities are being undertaken that are relevant to medicines support, these must be separately detailed in the medicines policy, and any issues reported and reviewed with commissioners in line with that policy in order to identify trends or emerging risks (see NICE Guideline NG67).[8]

CQC has recently published guidance on the provision of nursing in adult social care that covers delegated nursing activities and sets out the conditions in which a nurse employed by one registered provider may request a member of staff employed by a different registered provider to carry out a nursing activity on their behalf. The request must be to an individual member of staff, not to the provider as a whole. Providers, in turn may only allow their individual staff to take on such delegated activities where they are assured that staff have sufficient support, training and competency to undertake them.[9]

### Voices from our engagement:

"Identify all of your stakeholders, including provider organisations, and involve them from the outset."

7 Registration under the Health and Social Care Act 2008: scope of registration: regulated activities (CQC, May 2022).
8 Managing medicines for adults receiving social care in the community, NG67 (NICE, 2017).
9 Nursing in Adult Social Care: CQC brief guide (CQC, December 2022).

## 5. Delegating healthcare activities to care staff can have a positive role in workforce recruitment and retention, and should be linked to recognition and rewards.

When considering extending delegation into a specific commissioned service, or across a range of services, it is important to engage with providers and unions at an early stage to understand their views and any concerns. Delegation is a process of agreement, rather than a process that can be driven wholly from the top down, and it should be designed with the skills, insights and ambitions of staff in mind.

Experience from some well-designed programmes suggests that extending the range of activities which care staff are supported to undertake can be empowering, improving levels of job satisfaction. For example, delegation may be an effective way of addressing day to day frustrations in care management, can empower your front line, and can encourage greater respect and understanding between care workers and health professionals.

It is also important to be realistic about workforce rewards and terms and conditions. A significant and permanent change in an employees' duties may trigger job-evaluations with implications for grading and salaries. Ultimately, the increased costs of a care workforce re-purposed to take on roles of greater complexity will need to be addressed as part social care's conversation with health partners locally, as well as with national government.

### Voices from our engagement:

"It helps with seeing roles as stepping stones to other roles."

"Provide leadership and space for working things out at the front line."

## 6. Getting training and competency assessments right is challenging, so prepare carefully and resource adequately.

Consistent, high-quality training for care staff is crucial for delegated healthcare activities. Planning, providing, tracking and reviewing this training is therefore a central activity for health and care partners wishing to practice or extend delegation. Challenges typically relate to supply, quality, review and competence checking.

Demand can easily outstrip supply. Time spent delivering and receiving training has the potential to cancel out potential efficiency and consistency benefits. A large number of staff may require one to one training, and where there are high levels of staff turnover or a heavy reliance on agency staff, training may not be feasible.

Partly to address this supply problem, some areas divide healthcare activities into two categories: one category for which training equips care workers to undertake the activity on other patients going forward if their individual circumstances are appropriate – the training is 'portable' or 'generic'; and one category for which the training is designed and delivered around the health needs of a particular individual – the training is 'bespoke' or 'specific', and the competency it provides does not extend beyond its specific application.[10]

It is important to work closely with providers and provider forums to agree arrangements for delivery of training, for approval of prior learning and for competency checking, including intervals. Providers have existing systems and expertise in scheduling and auditing training. They are also likely to have existing arrangements for back-fill, and the payment of staff for attending training and refreshers that new arrangements for delegated activities training should build on and confirm. The experience of many areas is that trainer skills are crucial to success, so specific roles have been created and resourced. A number of areas have used the Better Care Fund to resource additional training as they have looked at broadening access to health-related training for social care staff.

Any healthcare professional who is delegating activities to a care worker must have had sufficient training and management support to understand the context in which they propose to delegate. In deciding whether a care worker is competent and confident to take on the activity, the healthcare professional must be satisfied that the care worker has an appropriate level of ongoing supervision in their role and knows what to do if the person's needs change. Encouragingly, one reported benefit of delegation is improved understanding between health and care professionals of their respective roles and contributions.[11]

10 For example, see Framework for Integrated Personalised Care, Part B, Leicester (Leicestershire and Rutland, 2022).

11 For example, see 'Blended roles trailblazer: learning from Tameside's experience' (Tameside Metropolitan Borough and NHS Tameside and Glossop CCG, 2020).

## 7. Agreeing shared narratives for delegation between social care, health and provider partners, as well as shared policies and procedures, is important, requires a long-term commitment and involves a willingness to have difficult conversations about funding.

Councils, health partners and providers that operate under delegation frameworks testify to the long-term commitment required and the challenges that arise in agreeing or refreshing them. They raise formidable systems leadership challenges. To meet them it may be helpful to invest in skilled external facilitation and allow sufficient time for a process that builds trust by working through points of difficulty.

Financing and cost allocation are likely to be challenging. In recent years, some social care leaders have raised questions about cost equity and transparency. For example, in 'unpicking' their local arrangements, a local authority spoken to for this project identified that specialist service providers for people with complex needs had arranged to take on delegated healthcare activities from the NHS and were passing on the full cost of the package to the local authority. Going forward, these anomalies will need to be identified and addressed.

Partnership agreements will ultimately need to address system costs, such as training and its oversight and management, and costs incurred through additional staffing time. Where activities are relatively straightforward and can be undertaken quickly by care staff alongside planned care activities, individual re-charging mechanisms between health and social care may be disproportionate. However, where the complexity of the delegated healthcare activity(s), or their personalised context, means that they cannot be incorporated within the existing care and support plan, a new support plan should be agreed, in which the apportioning of any additional commissioned time can be set out and used for subsequent re-charging.

Above and beyond the procedural elements put in place by any framework, such as provisions for costs, resolution mechanisms, training agreements and so on, frameworks need to express their aims and principles clearly in ways that secure the support and confidence of all staff. For example, Leicester, Leicestershire and Rutland have introduced a communications programme with staff that focusses on core values.[12]

[12] See LLR's staff training resource: FIPC Main 01 4 - YouTube.

## Voices from our engagement:

"The reality is it will require better relationships than most areas have, because they're going to have to suddenly start to address these issues that haven't actually been addressed before."

"There are higher unit costs for health activities."

"Systems move at the speed of trust. Sometimes you have to go slow to go fast."

"Social care providers should be an equal at the table."