NIPEC
Northern Ireland Practice & Education Council

Department of Health
An Roinn Sláinte
Männystrie O Poustie
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A REVIEW OF

Delegation in Practice

Enabling People to Live Well 'Closer to Home'

Executive Summary

1.0 PURPOSE AND CONTEXT

The Reset Plan, published by the Minister in December 2024[1], Stabilisation, Reform and Delivery, Reset and Recovery Plan 2024 sets out a vision for a Neighbourhood Care Model that delivers services as close as possible to people's homes. The aim is to enable individuals, including those with complex care needs, multiple conditions or frailty, to live healthy independent lives at home or in a place they consider home, whilst reducing avoidable hospital admission to acute hospitals or care homes. Over the years healthcare delivery models in Northern Ireland (NI) have shifted significantly. A growing number of people now have complex, long-term health conditions and many of these individuals are supported in their own homes rather than in clinical settings. As a result, the care they require is both complex and ongoing, often involving health interventions traditionally delivered by registered nurses. Delegation of health interventions, mainly by the registered nurse, is commonplace across Health and Social Care (HSC) Trusts, Independent Service Providers (ISPs) and third-party agencies in NI. When done well, it enables timely, flexible, and person-centred care, improves continuity and maximises workforce capability by utilising our collective workforce skills efficiently. Indeed, all HSC Trusts and Domiciliary Care ISPs should all be working within relevant Regulations and associated Minimum Standards when delegating nursing interventions are being utilised, namely:

- The Domiciliary Care Agencies Regulations (Northern Ireland) 2007[2];
- Domiciliary Care Agencies, Minimum Standards (Version 1.1: August 2021)[3];
- The Nursing Agencies Regulations (Northern Ireland) 2005[4];

1 Department of Health (2024) *Reset and Recovery Plan.* Belfast: DoH
2 Department of Health (2007) *Domiciliary Care Agencies Regulations (Northern Ireland).* Belfast: DoH
3 Department of Health ((2021) *Domiciliary Care Agencies, Minimum Standards (version 1.1: August 2021.* Belfast: DoH
4 Northern Ireland (2005) *The Nursing Agencies Regulations (Northern Ireland) 2005.Statutory Rules of NI, No. 175.* Belfast: The Stationary Office

- Nursing Agencies, Minimum Standards (2008)[5]; and
- Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003[6].

Delegation is not simply a transfer of tasks but a complex clinical and professional judgement that requires staff to understand competence, risk, scope of practice, and accountability.

However, practice is inconsistent, governance arrangements vary and there is particular uncertainty where healthcare interventions are delivered under Direct Payments (DPs) legislation. DPs legislation currently relates to the provision of social care rather than healthcare and falls under the review of HSC Trusts. Notwithstanding this, DP arrangements may fall within the scope of RQIA regulation where DP funding is used to procure services that are otherwise subject to regulatory oversight. This sits under HSC Trusts Governance arrangements and typically is not registered by Regulation and Quality Improvement (RQIA) inspection. RQIA regulates registered nurse supply, outside of HSC Trusts in the community. However, RQIA does regulate private nursing agencies operating in NI where they supply registered nurses into a range of care settings. Rising complexity of care, especially in community settings including Special Education Schools (SEN), recent media and professional concerns (including those raised by Registered Nurses Learning Disabilities (RNLD) in Spring 2024) underline the need for a coherent, region-wide approach.

Within NI the overall model of community care has evolved, with a much needed, strong emphasis on social care provision, however, with less emphasis on expanding the healthcare support to meet the rising complexity of clinical needs as people are cared for in a home setting. This means:

- Social care practitioners are now supporting many interventions that blur the lines between health and social care;
- Registered nurses remain professionally accountable for delegating clinical interventions, yet they do not have line-management authority or professional governance over the social care staff who carry them out;

5 Department of Health Social Services and Public Safety (DHSSPS) (2008) *Nursing Agencies, Minimum Standards (2008)* Belfast: DHSSPS

6 Northern Ireland (2003) *Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003*.SI 2003/431 (N.I. 9)

- Training to undertake delegated tasks is often facilitated on a one to one basis as social care practitioners are not currently required to undertake specific levels of training in supporting healthcare needs;
- This creates gaps in oversight, supervision and quality assurance, because the people performing the healthcare interventions are not managed, trained, or appraised by the nursing teams responsible for clinical governance and delegation; and
- Nursing delegation in the community by registered nurses must be undertaken in line with relevant Regulation and Standards, although recognised as being dated.

In practical terms, nurses are routinely delegating healthcare interventions, such as; medication administration, enteral feeding, pressure area care or specialised monitoring, without having direct/indirect supervision or oversight of staff competency, training pathways or ongoing practice standards of the staff they are delegating to. As part of multi-disciplinary teams there is an established principle of cross professional supervision with separate line management and governance arrangements that could apply in these circumstances. However, our engagement with stakeholders has indicated that this does not happen on many occasions.

This misalignment between responsibility and authority makes clinical accountability more challenging and puts pressure on governance systems and nursing staff to do the right thing for people whilst maintaining assurances around safety of the delegation function.

2.0 COMMISSION AND SCOPE

In December 2024, the Chief Nursing Officer (CNO) established an Oversight Group and commissioned NIPEC to lead a Task and Finish Group to examine delegation of healthcare interventions to:

- Social care practitioners employed by Trusts and third-party providers, and Personal Assistants (PAs) employed through Direct Payments.

This work focused primarily on nurse-to-social-care delegation, as the relationship where the majority of healthcare delegation in peoples own homes takes place, but draws experience and transferable learning for other registered professions, such as Allied Health Professions (AHPs). It considered legislation, policy, regulation, education and training and lived and working experience across adult and children's services.

This overarching report: A Review of Delegation in Practice: Enabling People to Live Well 'Closer to Home' includes learning from a number of Annex reports incorporated within this document.

3.0 METHODOLOGY

A mixed-methods approach included:

- Desk-based reviews of legislation, policy, regulatory standards, and organisational processes;
- Qualitative interviews and co-design workshops with staff, ISPs, PAs, and people who draw on care and support;
- Insights gathered from co-design workshops involving staff and service users;
- Coproduction projects to test resources, decision tools and recording mechanisms;
- Scoping surveys; and
- A demonstrator project (IMPACT with CILNI) focused on delegation to PAs in Southern HSC Trust.

4.0 CO-DESIGN, CO-PRODUCTION, COMMUNICATION AND ENGAGEMENT

A wide-ranging programme of communication, engagement and co-design has been fundamental to co-production of this work, ensuring the voices, experiences and expertise of those most affected shaped every stage of the review. This included meaningful involvement of people who draw on care and support, families, PAs, social care practitioners, social care managers, social workers, registered nurses and professionals across all programmes of care, as well as ISPs, education partners and regulatory bodies. Engagement methods were intentionally diverse and surfaced real-world practice challenges, emotional and relational aspects of care and the systemic barriers that cannot be identified through policy analysis alone. People with lived experience and staff alike, are eager for change that enables them to provide the optimum care for the population we serve. See Section 14 of main report for Co-Design, Co-production, Communication and Engagement.

5.0 KEY FINDINGS

1) Practice and Governance Variability

Delegation happens daily but with wide variation in interpretation, decision processes, documentation and oversight across and within Trusts and ISPs. Current NI legislation provides for the making of DPs in respect of the provision of social care service; nevertheless, PAs are supporting health interventions in practice. Nurses, people drawing on care and PAs report uncertainty and inconsistency in receiving and delivery of this practice.

The Department of Health (DoH) policy and guidance for home care provision has not been updated in many years and is potentially out of sync with requirements today. Identified governance gaps in relation to the delegation of healthcare interventions include; unclear accountability routes, supervision (direct and indirect) arrangements, monitoring arrangements, escalation routes (especially out of hours), and uneven access to information systems (e.g., Encompass is not accessible for ISPs). Differences in governance processes, accountability arrangements, documentation, and interpretation of roles, responsibilities and accountabilities is leading to fragmented practice. This work identified that delegation under DPs is particularly affected due to: legislative ambiguity, interpretation of definitions of what constitutes social care and healthcare, inconsistent Trust approaches and a lack of clarity re: oversight and professional and clinical governance lines.

2) Models of Care and Local Arrangements

In practice, delegation of healthcare primarily takes place between Nursing and Midwifery Council registered nurses and Northern Ireland Social Care Council registered practitioners when providing healthcare in people's own home. There are two NI delegation documents to guide safe delegation between nurses and social work/social care practitioners, detailed further in section 12.2 of main report.

- Deciding to Delegate: A Decision Support Framework for Nursing and Midwifery (NIPEC, 2019)[7] and
- Framework for delegation of complex tasks to social care workers in Northern Ireland (DoH, 2018)[8]

7 Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) (2019) *Deciding to Delegate: A Decision Support Framework for Nursing and Midwifery.* Belfast: NIPEC

8 Department of Health (2028) Circular (OSS 2/2028: *The framework for the delegation of complex tasks to social care workers in Northern Ireland.* Belfast: DoH

AHPs strategic position in NI, indicates that delegation of healthcare only takes place between the *registered practitioner* and those *support practitioners* employed under their supervision model and students. They do provide professional advice and referral onwards to other professionals and care practitioners, users and families. A process mapping exercise of the flow of healthcare delegation to support people to live healthy lives at home highlighted significant variation in workforce models and processes for social care and healthcare staff across Trusts and within different programmes of care. In relation to Direct Payment, it is also important to note that PAs are not registered social care staff and therefore mandatory training to build social care practitioner skills and knowledge is not explicitly applicable to them.

In recognition of the challenges that exist, examples of structured support have been established in some organisations e.g. The Western Health and Social Care Trust (WHSCT) Delegated Task Panel; Northern Health and Social Care Trust (NHSCT) complex care pathway. Panels can build organisational learning and provide assurance for complex cases but do not transfer accountability, which remains with the delegating nurse. Most routine decisions proceed outside panel structures using local decision aids. Regional pathways or models of governing oversight are not standardised, resulting in lack of role clarity, for example concerns were raised regarding, who is delegating where social workers often lead care planning for health interventions. Structures across organisations and programmes of care vary significantly regarding processes for assessment, risk assessment, competency assessment and delivery of care plans.

It is important to note that not all professions, utilise the NI Single Assessment Tool (NISAT) assessment and care planning process, which is the framework to support multi-disciplinary team assessment and care planning. In practice it is often the Social Worker who is discharging the care management function, which can involve them in all aspects of care, which can be beyond their professional remit.

3) Lived Experience

The lived experience of people in receipt of services reports inconsistency in models of care and practice across HSC Trusts. Different interpretations of legislation and local practice mean that people are receiving their healthcare interventions differently depending on their postcode.

See section 7 of main report. Moreover, the lived experience of staff providing the care indicates that delegation is happening in different ways, through different processes, with different arrangements across different HSC Trusts. The potential resulting inequity undermines fair access, risks unwarranted variation and service user and staff confidence.

4) The Importance of Valuing Human Rights in Delegated Healthcare

Valuing human rights is central to safe, ethical, and person-centred delegation of healthcare interventions. Delegation must never be viewed solely as a workforce mechanism; it is fundamentally an issue of respecting and protecting the rights, dignity and autonomy of the person receiving care. At its core, a human-rights-based approach recognises individuals as active partners rather than passive recipients of care. This means ensuring that people are fully informed, meaningfully involved and able to express choice and control over who delivers their care, how it is delivered and what risks they are willing to accept.

Embedding human-rights principles also strengthens safety and accountability within delegated healthcare. The rights to dignity, respect, privacy and protection from harm require that those who carry out delegated healthcare interventions are competent, supported and appropriately supervised. Crucially, valuing human rights helps to avoid inequity and unwarranted variation in access to healthcare, issues strongly highlighted through lived-experience evidence as part of this report development.

5) Workforce Capacity and Confidence

While delegation supports efficient use of skills, nursing staff report uncertainty regarding, the capabilities of the social care workforce who are required to undertake some delegated interventions, training levels and regulatory expectations, resulting in limited confidence when delegating healthcare interventions. Workforce pressures across community services particularly within community nursing and within ISPs can increase reliance on delegation arrangements and amplify concerns regarding effective oversight and monitoring.

The Minimum Standards set out in DoH Home Care guidance, Nursing Agency Regulations and including the Departmental Regulatory Standards, which RQIA inspect, do not reflect the wide scope of interventions that are provided for people drawing on care and supported by social care practitioners.

As detailed; Regulation and Quality Improvement Authority and Legislation, Standards | Regulation and Quality Improvement Authority and Annex 6 Delegation in Practice.

The relevant Regulations and Minimum Standards for regulated services, which RQIA inspects, provide a framework for staff training requirements; however, this guidance is not exhaustive. Responsibility therefore remains with each service provider to ensure that staff receive training that is appropriate and proportionate to the roles and responsibilities they are required to undertake. Whilst this workforce may receive additional training (and reported often do have additional training) it is not currently standardised or accredited. Registered social care staff are not currently employed to deliver healthcare interventions and are not required to undertake specific educational levels, to achieve healthcare interventions. Unlike Healthcare Support Workers (HCSWs) who work under the direct and indirect supervision of registered nurses or AHP's within HSC Trusts. The DoH Social Care Workforce Strategy (2025–2035) (2024)[9] and NISCC Care in Practice (CiP) Framework (2024)[10] introduce standardised qualification framework, including an entry-level qualification, training and progression pathways. The new Level 2 Certificate in Safe and Effective Health and Social Care Practice offers a baseline; however, this is currently voluntary and focused initially on new staff commencing employment and will take many years to roll out based on the proposed model. Moreover, this currently does not have input to training from healthcare professionals nor focus on the wide scope of commonly delegated healthcare interventions. Any additional training required to deliver healthcare tasks should be delivered at the point of delegation. The Level 2 Certificate is approved by Council for the Curriculum, Examinations and Assessment (CCEA) and will become mandatory within the life of the Social Care Workforce strategy (2025–2035) (DoH, 2024).

6) Independent Service Provider Experience

Care Providers report inconsistent Trust expectations (e.g., medication administration thresholds differ between Trusts) and report lack of support, variable training access, poor communication, including lack of access to Encompass, emerging clinical risks (e.g., cytotoxic medications support), inadequate information in care plans, and unclear escalation channels often results in defaulting to Out of Hours (OoH)/ Emergency Department (ED). Moreover, ISPs report lack of access to the HSC learning platform and resources.

9 Department of Health (2024) *Social Care Workforce Strategy 2025-2035.* Belfast : DoH
10 Northern Ireland Social Care Council (NISCC) (2024) Care in Practice (CiP) Framework. Belfast: NISCC

The challenges expressed limits safe, efficient delegation and undermines continuity of care and collaborative working. Registered domiciliary care agencies and nursing agencies may be at risk of breaching regulatory requirements where they are involved in delegated nursing tasks without comprehensive and robust governance arrangements in place. This includes, but is not necessarily limited to, the absence of clear accountability, appropriate training and competency assurance, effective supervision, and ongoing monitoring to ensure that care is provided in a safe, effective, and well-led manner.

7) Regulatory Standards vs. Operational Reality

Regulators Nursing and Midwifery Council (NMC), Health and Care Professionals Council (HCPC), General Medical Council (GMC) and NISCC set out standards for registered professional set out in detail under section 11 of main report. In relation to nurses and midwives, the Nursing and Midwifery Council (NMC) Code (2018)[11] is in the process of being reviewed and updated and is focusing on the particular challenges faced by the workforce under delegation standards. The NISCC Standards of Conduct and Practice (NISCC, 2021)[12] will also be reviewed within the next twenty four months. The range of professional regulatory guidance share core principles: safety, competence, clarity of instructions/supervision and retained accountability. However, confusion persists on occasions, because local policies, workforce planning and delivery models, training access and information systems are not uniformly aligned to the standards.

8) Legislation and Other Jurisdictions

England and Wales have updated national legislation, enabling DPs for healthcare with principles of safety, competence and shared decision-making. Scotland's DP legislation focuses on social care. Despite reforms elsewhere, implementation challenges remain common (governance, training, accountability) across all jurisdictions. National guidance frameworks for safe and person centred delegation (beyond DPs) has been developed in England, Scotland and Wales and is applicable to all professions and practitioners across the range of delegation roles and responsibilities. NI has issued *professional specific* delegation guidance/frameworks (the NIPEC Decision to Delegate Framework (NIPEC, 2019) and the OSS Framework (DoH, 2018) outlined under section 12) but stakeholder engagement has highlighted a lack of understanding of how the frameworks align.

11 Nursing and Midwifery Council (NMC) (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. London: NMC

12 Northern Ireland Social Care Council (NISCC) (2021) Standards of Conduct and Practice for Social Care Practitioners. Belfast: NISCC

The Minimum Standards for Domiciliary Care Agencies (DoH, 2018) plus related regulations (DoH, 2007) and commissioning guidance are dated (The Practice of Delegation of Healthcare Guidance Documents , as per Table 4 main report) and do not reflect the changing population demographic health and social care needs, current scope of role requirements in social care settings or the strategic shift to care *closer to home*. The Departmental Minimum Standards for Domiciliary Care Agencies is currently under consideration and should explicitly incorporate delegation of healthcare interventions, including appropriate clinical governance and escalation arrangements.

6.0 CONCLUSIONS

Delegation of healthcare interventions is a critical enabler for the Strategic Reset Plan's vision of care *Closer to Home* and vital to meeting growing care demand of people with health and social care needs and enabling people to live more independently and reduce avoidable attendances to secondary care. NI has pockets of good practice, but system level inconsistency in legislative interpretation, clinical and professional governance, workforce planning and delivery models, education and digital access, all create avoidable risk and variability. People drawing on care, PAs, registered social care staff, and registered professionals want clarity, consistency, and confidence so that the right care is delivered by the right person, at the right time, in the right place by staff with the right skills, knowledge and attitudes.

Professional and workforce willingness exists, but uncertainty, inconsistent systems, and operational barriers hinder safe, effective delegation.

Collective leadership is required at all levels within the HSC system to deliver a coordinated regional approach, with aligned governance arrangements, commissioning, consistent agreed standards of education and clearer legal/policy decisions to enable delegation of the right person-centred care, provided by the right person, in the right place, at the right time.

This review has highlighted the degree of earnestness from the service users and practitioners alike, for this work to progress at pace, to improve user experience and enable safe, effective and person-centred delegation of healthcare interventions, supporting people to live as independently as possible at home and in their communities. In taking forward this work, an Equality Screening should be undertaken in line with standard practice.

8.0 RECOMMENDATIONS (HIGH-LEVEL)

1. Establish a Multi-Professional Delegation Approach for NI:

- Establish a multiprofessional delegation governance framework as a valuable tool that could strengthen local governance, support consistent decision-making and provide clearer organisational and professional endorsement for the delegation of healthcare interventions;
- Standardise Core Processes Regionally, ensuring explicit role, responsibilities and accountability across all registered healthcare professionals and social care practitioners and those who draw on care and support;
- Develop common tools for decision-making, recording, communication, competence assessment, individual assessment/risk assessment, care planning, monitoring, documentation, and escalation; Ensure the tools reflect the decision making and preferences of the person drawing on care and support.
- Specify workforce competence, delegation procedures, communication standards, and evaluation/monitoring requirements in Minimum Standards and Regulation; and
- Provide clarity of clinical and professional governance arrangements to support safe effective person-centred care and delegation of care, safe effective Supervision (direct and indirect), communication, monitoring of outcomes and timely escalation of concerns to ensure the right care in the right place at the right time, by the right person with the right skills, knowledge and behaviours.

2. Workforce Capability and Capacity:

- Agree standards for Education for skills, knowledge and levels of practice to support safe delegation of routine healthcare interventions and enable access across all sectors;
- Embed the CiP framework to recognise and accredit competencies relevant to delegated healthcare where appropriate; taking account of prior learning/experience. Ensure regulated healthcare and social care professionals' input to the design and delivery of the healthcare and social care training;
- Expand shared, accessible regional learning resources on delegation (including independent sector access to agreed modules);
- Develop clear roles, responsibilities and accountability arrangements to ensure safe oversight of delegation including informed decision-making supporting person centred choice; and
- Consider Workforce planning and delivery models to ensure adequately resourced and skilled workforce and accountability structures for safe healthcare delegation from Nursing staff to Social Care Practitioners. This should include development of PAs roles as critical enablers in meeting the care needs under DP legislation.

3. Legislative and Policy Review:

- Review NI legislation on the use of DPs for healthcare interventions and associated governance/accountability;
- Ensure ongoing DoH reviews of domiciliary care standards and care management guidance explicitly address delegation of healthcare interventions;
- Ensure that any delegation frameworks or guidance complement and align with the Regulations and associated Minimum Standards that apply to regulated agencies involved in delegated practice; and
- Contribute to the review and updating of the NMC Code in relation to the delegation of healthcare interventions and further regulatory guidance.

4. Digital Enablement and Information Flow:

- Improve information sharing and explore appropriate read/access solutions for ISPs to support safe delegation, monitoring, and escalation.

5. Culture, Leadership, and Co-production:

- Recognise that often differentiation between health and social care interventions is not always possible as they are often interdependent, a collaborative framework should enable shared accountability with service users to develop true empowerment and joint decision making;
- Shift policy and practice from risk avoidance to risk enablement, anchored in person-centred principles, supervision and reflective practice, respecting the human rights of the person drawing on care and support; and
- Continue co-production and evaluation of practice with people who draw on care, PAs, and frontline practitioners to refine tools and protocols and build trust. Embedding a culture of multiprofessional collaboration and positive risk enablement.

6. Equality Screening:

- Future work emanating from this report will require further examination of equality screening requirements and related issues in line with standard practice.

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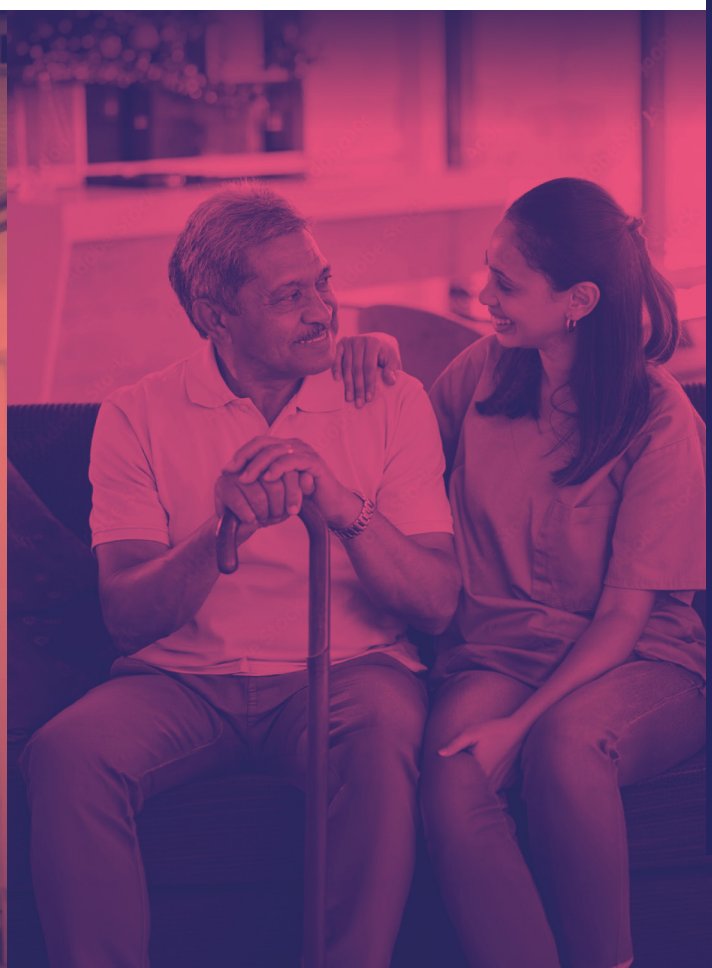


1 BACKGROUND

Delegation of health and social care interventions occurs across multiple professional groups within Health and Social Care (HSC) Trusts, care settings and third-party agencies. Evidence demonstrates that, when undertaken appropriately and safely, delegation delivers significant benefits for registered social care practitioners (previously referred to as care workers), registered nurses/clinicians and individuals accessing care and support services. These benefits include timely and flexible delivery of interventions, enhanced continuity of care, and a more person-centred approach (Skills for Care, 2022)[13]. Despite these advantages, interpretations of delegation vary considerably across the health and social care sector in Northern Ireland (NI) and governance structures and processes remain inconsistent.

Over the past year, delegation of healthcare interventions under Direct Payments (DPs) has attracted; service user, carer and family concerns, as well as media and political attention. Delegation of healthcare interventions to Personal Assistants (PAs) through DPs offers individuals greater choice, control, and flexibility in managing their care. However, challenges are posed by the current DP legislation which reference usage for social care interventions only, and the lack of consistent approaches across NI regarding region-wide implementation.

In Spring 2024, Registered Nurses in Learning Disability (RNLDs) raised concerns through both formal and informal channels, regarding healthcare delegation practices under DPs. Specifically, they highlighted the increasing complexity of interventions being delegated and the implications for delivering safe, effective care in line with professional registration/regulatory requirements. These concerns underscored potential governance challenges and variations in practice beyond DPs, including situations where registered nurses delegate healthcare interventions to social care practitioners employed within Trusts or by third-party care providers.

13 Skills for Care (2022) *The State of Adult Social Care Sector and Workforce in England*. (Annual report 2022).

In response to these challenges, the Chief Nursing Officer (CNO) established an Oversight Group with several workstreams, outlined in Figure 1, page 22. As part of this initiative, NIPEC was commissioned to lead a Task and Finish Group focusing on the delegation of healthcare interventions to social care practitioners employed by Trusts and third-party care providers and PAs employed through direct payments. This group, was co-chaired by Professor Linda Kelly, Chief Executive of the Northern Ireland Practice and Education Council (NIPEC) and Dawn Ferguson, Executive Director of Nursing and AHPs, Southern Health and Social Care Trust (SHSCT), until replaced by Grace Hamilton, Executive Director of Nursing and AHP (SHSCT), in September 2025. The membership was representative across professions and organisations. Details of the Project Initiation Document is available here, including the Terms of Reference and membership. The governance arrangements for the Task and Finish Group are outlined in Figure 1.

In addition, increased concerns were raised relating to complex healthcare interventions provided by classroom assistants in special education settings. While this issue is being considered through a separate project group, transferable learning and recommendations will be integrated through overarching governance reporting structures and processes via the Oversight Group.

2 INTRODUCTION

Increasing demands on health and social care provision and increasing clinical complexity are creating unprecedented challenges for health and care systems and their workforce. There is a need to work in more integrated teams, reflecting collaboration in: utilisation of staff, skills, knowledge and structures, as key enablers to maximise workforce potential, in order to meet changing demands for people who have both health and social care needs.

These must be considered alongside the regulatory and governance frameworks that underpin safe care. The ability to delegate, assign and supervise are critical competencies and underpin the practice of each individual health and social care practitioner. Delegation is not new; and often it occurs routinely across many work environments, as an informal function. Its purpose is to ensure:

- Individuals receive timely, appropriate and safe care that reflects their needs, wishes and promotes their independence and wellbeing;
- Staff resources are utilised effectively ensuring staff with the right skills, knowledge and attitudes to meet health and social care needs and improving outcomes;
- Work is shared appropriately based on their scope of practice, fairly, ensuring allocation of right care, by the right people, at the right time, in the place;
- Staff feel valued and motivated; and
- Productivity is maximised, supporting the optimisation of successful outcomes.

The Minister strategic plan issued in December 2024[14], sets out three pillars: Stabilise, Reform and Deliver as the basis for tackling **multiple financial and service challenges**, aiming to create a "high quality, sustainable, safe" health and social care system. The follow up DoH Health and Social Care Reset Plan (DoH, 2024), operationalises implementation of the 3-year plan. The strategic vision for NI, includes a neighbourhood care model that delivers services as close as possible to people's homes.

14 Department of Health (2024) *Health and Social Care NI Reset Plan.* Belfast: DoH

The aim is to enable individuals, including those with complex care needs, multiple conditions or frailty, to live healthy independent lives at home or in a place they consider home, whilst reducing avoidable hospital admission. This approach also encompasses care in appropriate settings such as classrooms and educational facilities.

Over many years, the model of community-based care has changed significantly. This has resulted in a multiagency and multi professional approach to meeting health and social care needs to support people live independently at home. The demographic shift towards an ageing population, alongside increasing prevalence of multi-morbidities and long-term conditions, means that more people with complex clinical needs are now supported in their own homes rather than in hospital or specialist settings. This has resulted in an expansion of clinical healthcare interventions being delivered in community environments.

However, the service design focus has been on the much-needed additional support for social care, to help support people live fulfilled lives as part of their community. What is becoming increasing clear, is the blurred lines between social well-being and meeting healthcare needs to support independent living. Consequently, a substantial volume of health-related interventions, traditionally met in clinical settings, are now being met at home with support through the social care model and on some occasions input from nurses and/or from healthcare professionals. Domiciliary care workers were requesting more support from nurses.

The policy driver care "as close as possible to people's front doors", clearly signals a shift towards supporting people at home and in their communities, and to promote greater independence. Achieving this objective will, by necessity, require, a focus on service redesign, through collaborative community care models. This is happening now and will increase in the future to meet the strategic reform agenda; however, the current model presents a structural challenge for clinical and professional governance. Registered nurses remain professionally accountable for the delegation (as per Nursing and Midwifery (NMC) Code) (NMC, 2018)[15], assessment of competence and oversight of healthcare interventions yet they have no line-management responsibility for the social care workforce undertaking these.

15 Nursing and Midwifery Council (NMC) (2018) *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.* London: NMC

Nurses therefore hold accountability without a clear direct line of authority to: direct practice standards, mandate training or interventions enforce competency-based supervision (direct and indirect) within current model.

As the complexity of delegated interventions increases, this misalignment between responsibility, authority and oversight is becoming more pronounced. It creates:

- Variability in practice across providers and individual carers;
- Limitations in clinical and professional assurance, as nurses report difficulty in directly influencing staffing, training or performance management within current model; and
- Increased risk exposure for the staff and people drawing on care and support, given that quality, safety and accountability mechanisms are not fully aligned with the current care model.

This context highlights the need for a refreshed approach to community-based clinical and professional governance and a rebalancing of workforce capability to ensure safe, sustainable delivery of complex care in the home environment. To develop a culture in which delegation is routinely and appropriately undertaken:

- Clear and consistent protocols of authority and oversight are essential to support collaboration among the wide range of health and social care practitioners involved in delivering care at home;
- Robust multiprofessional and interagency governance and accountability frameworks are critical to ensuring safe, appropriate care, foster collaborative workplace models and to ensure those delivering care have the right skill, knowledge and attitudes; and
- These frameworks must reflect person-centred principles, comply with relevant legislation and policy, uphold professional regulatory standards and align with organisational requirements.

This report presents the findings of the **Delegation of Healthcare Interventions in People's Own Home, Task and Finish Group**. The group was established to consider the ongoing challenges in delegation of healthcare intervention practices and to develop recommendations that enable people to live as independently as possible in their own homes.

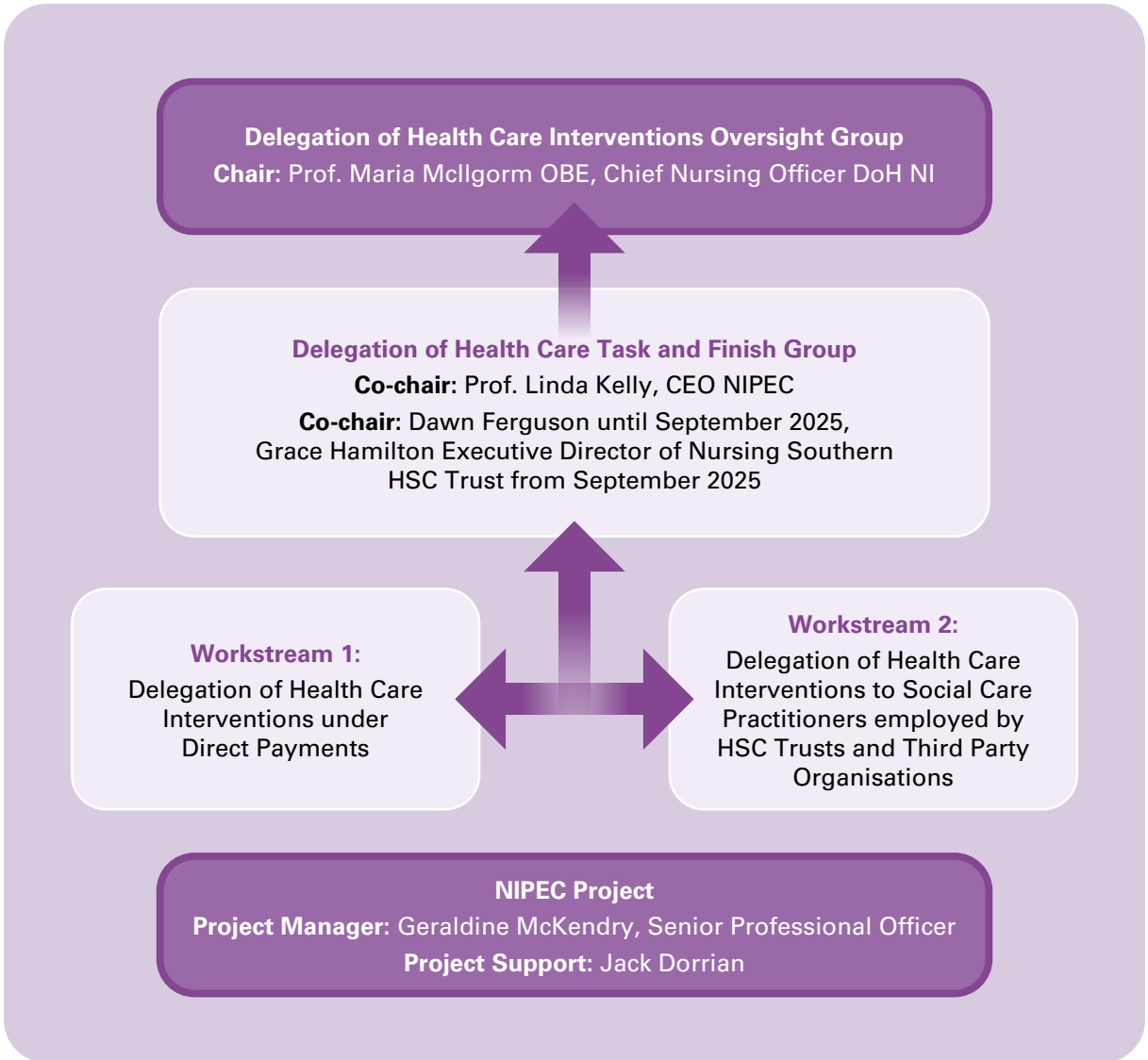
Its work is guided by the principle of delivering the right care, in the right place, at the right time, by the right person with the right skills, knowledge and attitude and supported by timely, safe, and effective delegation of healthcare interventions. This report outlines the:

- findings based on Terms of Reference objectives;
- improvement work undertaken as part of the learning through the project lifespan; and
- recommendations for future development of delegation structures, processes and outcomes to meet population needs.

3 GOVERNANCE STRUCTURE

A comprehensive programme of engagement and communication supported the delivery of the workplan, across people who draw on care and support, professionals across all programmes of care, social care staff and PAs, staff side organisations and professional bodies, education providers, and relevant organisations across NI and the UK/Ireland. Robust reporting was enabled through the following governance structure:

Figure 1 Governance Structure



4 SCOPE

This report examines the current practices in relation to delegation of healthcare interventions between registered nurses, professionals and social care practitioners. It considers the current legislation, policy, education and regulatory guidance, user and staff experience. While much of the work focuses on delegation by registered nurses and professionals to members of the multidisciplinary team, the findings and recommendations primarily refer to delegation of healthcare interventions between registered nurses and social care practitioners employed under the Direct Payment Schemes, commonly referred to as DPs hereafter. However, learning can be considered by all registered professionals when examining the governance, safety and quality of collaborative working.

5 METHODOLOGY

A mixed-methods approach was adopted to inform the development of this report. The methodology comprised the following components:

- Desk-based scoping review of relevant policy, guidance, organisational structures and operational processes;
- Qualitative interviews with staff, ISPs, PAs, and people who draw on care and support;
- Insights gathered from co-design workshops involving staff and service users;
- Coproduction projects undertaken to test decision-making tools and recording mechanisms in practice;
- Scoping Surveys; and
- A demonstrator project (IMPACT and CILNI) focused on delegation to PAs in Southern HSC Trust.

See section 14 for Report: Co-design Co-production, Communication and Engagement.

Each section of this report is structured in alignment with the objectives described in the Terms of Reference, with cross-references provided to the relevant annexes. The overarching findings and recommendations presented in Section 15 synthesise the collective evidence and learning generated across all Annex reports.

6 AIM AND OBJECTIVES

6.1 Aim

The aim was to enable people to live as independently as possible at home, through providing the right care, in the right place, at the right time, by the right person and supported by the timely, safe and effective delegation of healthcare interventions.

6.2 Objectives

To understand current practices and identify viable pathways to enable safe and effective delegation of healthcare interventions to social care practitioners or in support of PAs employed through direct payments where relevant:

I. To consider the current DoH legislation and policies in place in NI, including Legal Advice for Delegation of healthcare interventions under DPs.

II. To consider legislation and policies in other jurisdictions.

III. To consider models of best practice in other jurisdictions.

IV. To consider the standards and guidance set out by regulatory and professional bodies regarding delegation of healthcare by healthcare professionals.

V. Consider the training and development currently provided at pre-registration and post-registration to support safe delegation of healthcare interventions.

7 REPORT ON OBJECTIVES

7.1 *Objective 1*

To understand current practices and identify viable pathways to enable safe and effective delegation of healthcare interventions to social care practitioners or in support of PAs employed through direct payments where relevant. Delegation of Healthcare to PAs via Direct Payments (Annex 1 and Annex 2).

Delegation of healthcare interventions to PAs employed through direct payments is occurring across NI HSC Trusts in both adult and children's services. Practice patterns vary, encompassing longstanding ('historical') arrangements that have operated for many years as well as newly established packages of care. The NI Carers and Direct Payments Act 2002[16], Carers and Direct Payments Act (Northern Ireland) 2002 and associated Direct Payments Scheme guidance clarify that direct payments cover assessed personal social services, not healthcare and the subsequent Personal Social Services and Children's Services (Direct Payments) Regulations (NI) 2004 (S.R. 2004 No. 120)[17]. made in exercise of the powers in the 2002 Act. Despite this position, this report has confirmed that in the practice of supporting people to live independently at home, PAs are currently supporting healthcare interventions via DP pathways across Trusts in NI. Delegation is not simply a transfer of tasks but a complex clinical and professional judgement that requires staff to understand competence, risk, scope of practice, and accountability.

16 Northern Ireland Assembly (2002) *The NI Carers and Direct Payments Act (Northern Ireland) 2002*. Belfast: The Stationary Office

17 Department of Health, Social Services and Public Safety (Northern Ireland) (2004) *The Personal Social Services and Children's Services (Direct Payments) Regulations (Northern Ireland)* 2004. Statutory Rules of Northern Ireland No. 120. Belfast: The Stationary Office

7.1.1 Methodology

A scoping exercise was undertaken in August 2024, to determine the scale and nature of delegated healthcare interventions supported by DPs across the HSC Trusts. A 27-item electronic survey completed by Trust representatives sought to:

- Gain an understanding of the number of service users where healthcare interventions were being supported through DPs;
- Identify types of interventions being delegated and the programmes of care and services involved;
- Capture governance arrangements and quality assurance mechanisms around delegation of healthcare interventions; and
- Inform further discussions and decision-making.

Figure 2 outlines reported findings from the survey, including: types of healthcare interventions; numbers of clients per Trust; and specialty areas where DPs were utilised for healthcare interventions in August 2024.

7.1.2 Learning from the survey

Full report available as Annex 1. The survey provided an insight at a given time up to January 2025, it is very likely the number of healthcare interventions undertaken have changed over the past year. All HSC Trusts completed this exercise and provided both valuable and comprehensive information. The findings demonstrated a marked variation and differences in the information reported across the HSC Trusts regarding oversight and accountability for the delegation of healthcare interventions to PAs. In addition, significant variance was notable in the approximate number of reported service users, and programmes of care where healthcare tasks are being supported through DPs. All Trusts indicated an appetite for clearer guidance regarding legislation and use of DPs.

Figure 2 Scoping Survey HSC Trust Returns: Healthcare Interventions under Direct Payments

Scoping Survey HSC Trust Returns: Healthcare Interventions under Direct Payment– August 2024		
Trust	**No of clients**	**Speciality**
Trust 1	91	Learning Disability Adult Services, Children's Community Services
Trust 2	96	Learning Disability Adult Services, Children's Community Services, Mental Health Adult Services
Trust 3	65	Learning Disability Adult Services, Children's Community Services, Physical Disability Adults Services Older People Services
Trust 4	20	Learning Disability Adult Services, Children's Community Services
Trust 5	66	Learning Disability Adult Services, Children's Community Services, Physical Disability Adults Services Older People Services

Type of Interventions		
Administration of Medicine	Tracheostomy Care	Enteral Tube Feeding
Urinary Catheter Care	Bowel Management	Complex Manual Handling
Emergency Medicine for Epilepsy	Oxygen Therapy	Vital Sign Monitoring
Nebulisers	Oral Suctioning	BiPAP/CPAP
Diabetes Management	Palliative and end of life support	

7.1.3 Co-Design Workshops

In addition to the survey, the Task and Finish Group convened a series of workshops and meetings with people with lived experience, both those receiving care through DPs and those providing it, along with managers from social care and community nursing. This rich engagement offered valuable insights into what is working well and where significant challenges remain.

Key themes highlighted the importance of:

- Meaningful involvement of people who draw on care and support in shaping and reviewing their support plans, that goes beyond consultation to true decision making, including risk assessment and impact of not meeting needs, in not providing the preferences of people receiving the service;
- Clear communication and role clarity, access to care and support plans, particularly around responsibility for healthcare interventions and agreed escalation routes when concerns arise;
- Access to appropriate skills development and training for PAs, ensuring they can safely deliver delegated interventions; and
- Comprehensive, shared care plans that provide a consistent understanding of goals, expectations, responsibilities and desired outcomes across all parties.

ACTION: NIPEC, a service user, an unpaid family carer and the Centre of Independent Living (CILNI) undertook to process map from referral and access for Direct Payment support relating to healthcare interventions, details of which would be recorded within or otherwise directly linked to the service user's Support Plan (as outlined within the Self Directed Support (SDS) framework). This work will inform improvement in the process, insight for training and development and a resource for sharing on the NIPEC website for Nursing professionals and others who wish to access it.

7.1.4 Key Learning

Key Learning
Scoping survey and Workshops on healthcare interventions provided under Direct Payments
There are a wide range of activities being undertaken by PAs under DPs that could be considered healthcare interventions.
The NI legislation indicates that DPs should be used for social care support and there is currently no specific NI framework governing the delegation of healthcare interventions to PAs under DPs.
There are variation of interpretation and application of DPs legislation for care interventions across HSC Trusts in NI and within programmes of care.
Concerns have been raised by people who draw on care and support regarding the lack of communication, clarity of legislation and variation in practice across Trusts and within programmes of care.
Registered nurses are concerned that they cannot fully meet the regulatory requirements, as set out in the NMC Code for nurses and midwives under current legislation and guidance.
Where healthcare interventions are supported, the governance processes and accountability to support PAs and monitor outcomes of interventions is unclear and varies across HSC Trusts and programmes of care.

7.2 Lived Experience of Healthcare support through Direct Payments

The lived experience of people in accessing services reports inconsistency in models of care and practice across Trusts in NI. Different interpretations of legislation and local practice mean that people receive their healthcare interventions differently depending on their postcode. Moreover, the experience of staff providing the care indicates that delegation is happening in different ways, through different processes, with different arrangements across different Trusts. The potential resulting inequity, undermines fair access, introduces unwarranted variation and service user and staff confidence.

Individuals have raised concerns regarding having their needs met in ways that support their independence. People with complex health and care needs require a timely response to this; given many are life limited there is a duty of care to protect them from prolonged policy/organisational/professional debates. The delays in addressing this issue could place vulnerable people in situations where they have no recourse other than reach out to media or pursue legal action.

Concerns have also been raised by families and carers who are in receipt of DPs, with a perception that vital care is being withheld or when care is deemed not available under the Direct Payments Scheme. For some, this is resulting in increased personal anguish and impacting negatively on their family life. Hence, there is a desire to gain greater clarity around current legislation. Families have also expressed challenges within the system, especially around periods of transitioning between services and when their identified needs change. This was highlighted in a TV documentary: (Up Close, 2024)[18] Up Close examines why families are calling for reform of a crucial care option | UTV | ITV News

7.2.1 The Importance of Valuing Human Rights in Delegated Healthcare

Valuing human rights is central to safe, ethical, and person-centred delegation of healthcare interventions. Delegation must never be viewed solely as a workforce mechanism; it is fundamentally an issue of respecting and protecting the rights, dignity and autonomy of the person receiving care. When healthcare interventions are delivered in people's homes, classrooms or community settings, the balance of power, privacy and control shifts closer to the individual. This places an even greater responsibility on organisations and professionals to ensure that all delegation decisions uphold the highest human-rights standards.

18 *Examines why families are calling for reform of a crucial care option (2024)* Up Close. ITV 12th November 2024. Available at: ITVX

At its core, a human-rights-based approach recognises individuals as active partners rather than passive recipients of care. This means ensuring that people are fully informed, meaningfully involved and able to express choice and control over who delivers their care, how it is delivered and what risks they are willing to accept. It requires that delegation supports, not restricts, the right to independent living, family life, participation in community and personal autonomy. People's preferences, cultural identity, communication needs and lived experience must be integral to every stage of assessment, planning, training, supervision and review.

Embedding human-rights principles also strengthens safety and accountability within delegated healthcare. The rights to dignity, respect, privacy and protection from harm require that those who carry out delegated healthcare interventions are competent, supported and appropriately supervised. This includes ensuring safe information sharing practices, clearly defined accountability protocols, proportionate risk-enablement and robust mechanisms for raising concerns. Delegation must always be necessary, proportionate and the least restrictive option to achieve the agreed outcomes.

Crucially, valuing human rights helps to avoid inequity and unwarranted variation in access to healthcare, issues strongly highlighted through lived-experience evidence as part of this report development. Postcode variation, inconsistent governance and unclear processes create barriers to individuals exercising their rights.

A rights-based approach demands fairness and non-discrimination, ensuring that people receive equitable care irrespective of location, provider, diagnosis or funding mechanism (including DPs). It also requires reasonable adjustments to meet additional needs, including disability-related, cultural, linguistic or cognitive requirements.

By embedding human rights into every aspect of delegation: policy, training, decision-making, governance and workforce planning, health and social care partners can ensure that delegated healthcare interventions are not merely clinically safe, but also ethically sound, empowering and aligned with the broader strategic goal of enabling people to live well, safely and independently at home and in their communities. Ultimately, valuing human rights is not an "add-on"; it is the foundation of safe healthcare delegation and the measure by which success must be judged.

7.2.2 Demonstrator Project – IMPACT in Partnership with Centre for Independent Living NI (CILNI): Delegating Healthcare Interventions to Personal Assistants using Direct Payments

Recognising that individuals who both *draw on support* and *provide care*, are best placed to shape learning to advance this work, the Task and Finish Group partnered with a demonstrator project led by IMPACT (Improving Adult Care Together), in collaboration with Centre of Independent Living Northern Ireland (CILNI), and co-produced by a person with lived experience of use of DPs. The initial plan was to establish partnership working with IMPACT, NIPEC and relevant stakeholders, to undertake a quality improvement initiate to understand challenges and enable safe and collaborative delegation of healthcare interventions within DPs. However, whilst clarification of application of DP legislation continues, it was agreed that this was not possible. Based on the learning from this work, there is a clear appetite to further explore a regional, collective approach to enable governance structures and processes to meet the needs of people in receipt of DPs. The IMPACT project progressed to explore the challenges and opportunities associated with delegating healthcare interventions to PAs employed through DPs in NI, in the Southern Health and Social Care Trust.

The initiative was prompted by the CILNI following observations of a variance in practice across HSC Trusts and a lack of a shared understanding of the legislation guiding this practice. Together this often results in, an increasing number of people in receipt of DPs who were unable to access delegated healthcare interventions. Together this issue was particularly evident during transitions for children and young adults with disabilities, significantly affecting their ability to exercise choice and maintain control over the care and support required to live independently.

In September 2024, the IMPACT Project focused on examining practice in the following areas:

- The experiences of people who draw on care and support;
- Practitioners' perspectives and insights;
- What is working well; and
- What needs to change.

7.2.3 Methodology:

Using a system thinking approach and the **ICEBERG** analogy (outlined in Annex 2), the report surfaces visible issues while also uncovering deeper cultural and relational dynamics. Three bespoke surveys and co-produced engagement sessions across lived-experience, professional and practitioner communities informed a set of learning themes and emerging recommendations outlined in the report: "*Enabling Good Lives, Not Just Managing Tasks: Addressing Challenges in Delegating Healthcare Interventions to Personal Assistants Using Direct Payments in NI*" (IMPACT, 2025).

7.2.4 Learning from the IMPACT imitative

Full report is available as Annex 2: Delegating Healthcare Interventions to Personal Assistants using Direct Payments.

This report surfaced complex, and at times, conflicting realities about the delegation of healthcare tasks to PAs through DPs in NI. It has amplified the voices of those often-unheard people drawing on care and support, PAs and frontline professionals and revealed the underlying cultural, relational and systemic dynamics that shape current practice.

What has emerged is not a lack of willingness, but a lack of clarity, consistency and confidence. There is strong support for more flexible, person-centred approaches to care. However, this is often overshadowed by organisational fear, fragmented systems, and professional uncertainty. This report does not offer a single solution. Rather, it offers evidence-informed insights, shared principles, and actionable recommendations to guide collective improvement. These insights reveal that the challenges around delegation are not simply technical or procedural they are cultural, relational, and systemic.

A strong theme emerged around choice and control. Respondents valued the autonomy to make decisions about how their care was delivered but expressed concern that current systems often override their preferences.

> *"I want to live my life on my terms, but I constantly feel like I have to ask for permission. That's not choice - that's gatekeeping."*
>
> Lived experience respondent

> *"We've been using direct payments for years, but still no one can explain what's allowed and what's not."*
>
> Lived experience respondent

> *"I trust my PA more than I trust a stranger from the Trust. She knows my routine, she knows my triggers, she knows what I need without me having to explain it over and over."*
>
> Lived experience respondent

> *"Having the same person each day helps me feel safe and in control."*
>
> Lived experience respondent

> *"They told me we don't do that' — but no one said who does."*
>
> Lived experience respondent

A recurring theme was professional/practitioner accountability and organisational risk. Practitioners described concerns about liability, particularly where delegation occurred outside formal governance structures

> *"I want to support people to stay at home and be cared for by someone they know. But without clear oversight, it's hard to delegate and still feel professionally safe."*
>
> Healthcare Practitioner respondent

> *"We want guidance that reflects the real world, something we can use with confidence, not just refer to in theory."*
>
> Healthcare practitioner respondent

> *"No one sees the emotional weight of doing this work at home, on your own."*
>
> PA survey respondent

If challenges are to be addressed meaningfully, it requires more than updated guidance; it calls for trust building, role clarity, shared responsibility, and emotional recognition.

It suggests the need for a focus on the following actions to steer the broader reform agenda forward together:

- People who draw on care want to have choice, continuity and control in making decisions about their care. Explicit arrangements for delegated healthcare interventions should be available to them;
- Practitioners are committed to providing safe and effective care, but they experience uncertainty around delegation frameworks, professional accountability, and the legal context of practice;
- There is a need to support develop and enhance the role of personal assistants in NI; and
- Transitions between children's and adult services are frequently disjointed, with significant impacts on continuity of care influenced by different approaches to practice and service design.

7.2.5 Key Learning

Key Learning
Demonstrator Project – IMPACT in Partnership with Centre for Independent Living NI (CILNI)
There is a need to establish a shared, multi-professional framework for delegation in the context of DPs.
Shift from risk avoidance to risk enablement, supported by supervision, reflection, leadership, skills development/education and training.
Enhance training, support, and wellbeing pathways for PAs.
Create simple, accessible guidance and advocacy for all involved.
Embed co-produced, relationship-based approaches to decision-making and improvement.

Action: Co-design Workshop

In order to share the importance of shared decision making a number of animation videos are being developed by a person with lived experience of DPs to inform training and promote the importance of risk enablement. Consideration is being given to use in delegation training for nursing staff and made available to a wider audience. In addition, these will be considered as an accessible resource on the NIPEC Delegation Governance Framework Website, reflecting the lived experience of people utilising care and support via DPs.

8 OBJECTIVE 1

To understand current practices and identify viable pathways to enable safe and effective delegation of healthcare interventions to social care practitioners or in support of PAs employed through direct payments where relevant: Delegation of Healthcare to Social Care Practitioners Employed Within Trusts or Third-Party Provider Organisations (Annex 3)

The Task and Finish Group established a second workstream focusing on the challenges and opportunities associated with the delegation of healthcare interventions to social care practitioners employed by HSC Trusts and through Third Party Care Provider Organisations. Working in partnership, the NISCC and NIPEC utilised associate support employed through HSC Leadership Centre. This workstream focused on collaborative working practices across social work/social care and healthcare professionals to consider what works well, not so well within the current model of delegation of healthcare to social care practitioners employed in Trusts or by third-party care providers.

8.1 Methodology

This workstream was led by two Associate Consultants, jointly commissioned by NIPEC and NISCC through the Health and Social Care Leadership Centre. A registered nurse and a social worker were appointed to the project on the basis of their relevant knowledge and experience. Following clarification and agreement on the terms of reference, a desktop review of relevant policies, frameworks and guidance was undertaken to establish a frame of reference for the project. A programme of engagement with relevant stakeholders was delivered in March and April 2024, this included meetings with the five HSC Trusts, Independent Health and Care Providers (IHCP), ISP, the Social Care Council and related bodies including the Leaders in Social Care Partnership. Across the spectrum of engagement, the authors sought representation from programmes of care in both children and adult services and from both the statutory and independent sectors. Regular updates and discussion with a core sub-group of the task and finish group was used to focus the project and help shape the report.

8.2 Learning from NIPEC and NISCC shared project

Full report available as Annex 3.

This comprehensive report recognises that delegation of healthcare interventions to social care practitioners, whilst happening on a regular basis, remains an area of contention that requires direction and clarity. It states that it is important to have a culture of collective leadership and responsibility that is embedded throughout the health and social care system. The report mainly focuses on the delegation of healthcare interventions from nurses to social care practitioners as the area that is most commonly practiced (rather than delegation by the wider multiprofessional team). The report does reflect the recent position statement relating to delegation for AHPs within NI and recognises that there is transferable learning for all those providing care for the people living in their own homes. The findings are highlighted under the following themes:

8.2.1 Demographic changes and models of care

NI's health and social care workforce is operating within a context of significant demographic change, characterised by an ageing population and increasing complexity of care needs. Individuals increasingly expect care to be delivered in ways that support their broader life choices and preferred care settings, reinforcing the need for integrated, interprofessional and interagency approaches. Complex care is now routinely delivered by a wide range of professionals, each bringing distinct expertise. In many cases, delegating specific healthcare interventions from registered health professionals to skilled social care practitioners is both appropriate and necessary. This ensures the right person, with the right skills, is available at the right time and in the right place, thereby enhancing continuity, safety, and efficiency in care delivery. However, challenges in collaborative working, stem from limited clarity of regional legislation and policy guidance, governing healthcare delegation and concerns about regulatory compliance among healthcare professionals. Strategic decisions can also unintentionally disrupt safe delegation practices, for example, the withdrawal of pharmacy-supported Monitored Dosage Systems (MDS), which help reduce medication administration risks for non-registered staff. Additionally, difficulties in providing competency based training, direct/indirect supervision and ongoing monitoring within home-care environments can further restrict delegation.

8.2.2 Workforce emerging roles, registration

Nursing workforce: Nursing in community care settings, where much of the social care workforce operate, is often stretched beyond capacity. This report noted, whilst workforce pressures in nursing could drive up reliance on delegation of healthcare interventions, there is sometimes reluctance to do so, in the perceived absence of policy directives, robust governance and assurances of levels of knowledge, skills and competence within social care workforce and adequate nursing capacity to oversee and monitor outcomes. This report highlighted the importance of mutual understanding of each other's roles, responsibilities, capabilities and capacity as an important foundation for finding solutions to the challenges currently identified in the system.

Social Care Workforce: This report noted that in the context of delegation of healthcare interventions, capacity within the social care workforce is more difficult to quantify as there is less stability and varying levels of education and training. Stakeholders described a range of situations where routine healthcare interventions were delegated to social care practitioners in a safe and effective manner. It is suggested that complex interventions can also be carried out in care settings by trained and competent individual social care staff, as part of individualised care planning and collaborative working across healthcare and social care practitioners, within delegation protocols and good governance arrangement. There is opportunity within the implementation of the DoH Social Care Workforce Strategy (DoH, 2024) to collaborate with nursing colleagues in upskilling the social care workforce in the safe delivery of routine healthcare interventions where the outcome has been considered predictable. This requires an individual comprehensive healthcare assessment and risk assessment, care planning, clarifying scope of responsibilities, to reach a position that is acknowledged and trusted by all.

8.2.3 Governance and assurance/commissioning frameworks

To understand how delegation is applied in the delivery of healthcare interventions, the report discussed with stakeholders' their familiarity with the relevant frameworks. The Delegation in Nursing and Midwifery | NIPEC (2019) was the most widely recognised, particularly among nursing staff, though its use varies significantly across and within Trusts. In some areas, it is applied systematically to guide complex delegation decisions; in others, delegation occurs informally with only partial consideration of the framework's core principles. The Office of Social Services Circular (2019), which outlines delegation guidance for social workers/ social care workers, is primarily known within the social work profession and is rarely referenced by nursing teams or the wider social care workforce.

Those interviewed also referred to the NMC Code (2018), as strongly influencing nursing practice in relation to delegation. In some settings, particularly where ongoing monitoring is difficult, such as supported living, day centres, or services commissioned through direct payments, nurses reported hesitancy to use the term "delegation." Instead, they framed their input as advice or support due to concerns about meeting regulatory obligations. Although staff were aware that social care practitioners operate within regulated standards of conduct, there was less recognition of how this provides assurance equivalent to that offered by the NMC Code (2028). Staff indicated that a multiprofessional delegation governance framework would be a valuable tool that could strengthen local governance, support consistent decision-making and provide clearer organisational and professional endorsement for the delegation of healthcare interventions.

In relation to what constitutes complex and routine care, the consensus was that a list would be hard to define, due to fluctuation of individual care needs, complexity of risk and unpredictability of outcomes. Instead, there needs to be a shared understanding of the complexity of a healthcare intervention through a holistic perspective and the influence of personal, situational and environmental factors beyond the intervention itself, e.g. multi occupancy households or instability of the person's conditions.

8.2.4 Independent Provider Arrangements

Engagement with Independent Care Providers highlighted challenges of inconsistent delegation practices across HSC Trusts, requiring them to adjust to differing expectations, thresholds, and procedures e.g. some limit the number of medications they will manage, while others only accept delegated medication administration when medicines are supplied in pharmacy-issued MDS. Medication administration, stoma care, enteral feeding, continence care and tracheostomy care are frequently delegated and emerging challenges are presenting such as safe handling and disposal of cytotoxic medications used at home. Care providers recognised the increasing risk and complexity and noted Trust oversight and governance are inconsistent. Moreover, Care Providers expressed challenges with poor communication and incomplete care plans (e.g., only a home address and scheduling formula), unclear escalation routes, especially outside normal working hours, often resulting in default escalation to GP out-of-hours or emergency departments. While Encompass offers potential for improved communication and delegation recording within HSC Trusts, as the independent sector lacks access, early rollout has hindered communication on occasions. There is an opportunity to link this work with the wider advance care planning work.

8.2.5 Models of care and delegation arrangements

Feedback from stakeholder engagement and review of models of care confirmed that delegation approaches vary significantly across HSC Trusts and ISPs, with decision-making processes often unclear or inconsistently applied. Variability exists also across programmes of care (e.g., older people vs. mental health/learning disability vs children's) reinforcing the need for reform aligned with staff experience. Some examples of models to support delegation included: the Western Health and Social Care Trust Delegated Task Panel which provides a multidisciplinary forum for supporting complex delegation decisions, offering organisational assurance. It *advises* but does not assume accountability, this remains with the delegating nurse. Most cases involve complex home-based care or transition between children's and adult services. The majority of decisions made by staff to delegate do not go through the panel; where cases are straightforward a Decision Flow Chart is used. Common and routine interventions including stoma and catheter care are often considered as part of the social care role unless assessed as requiring specific oversight by registered nurses. Whilst there is much support for this model, a number of staff have expressed concern that the accountability for delegation remains with the registered nurse whilst advice is provided by a senior multiprofessional forum.

The Northern Health and Social Care Trust uses a structured approach for highly complex care packages, involving nursing assessment, risk assessment, care-plan development, training, and monitoring. Accountability for delegated healthcare interventions remains with community nurses.

Stakeholders indicated that regional delegation pathways can be unclear, particularly where care planning is led through social work structures, causing confusion over who is formally delegating. Some Trusts will only commission agencies with nursing infrastructure, though the level of nursing oversight varies.

A major system-wide issue is the lack of regional consistency in care planning, commissioning processes, training pathways: knowledge and skills of social care practitioners carrying out delegated tasks and clarity of social and healthcare interventions. However, this report has identified the difficulty in differentiating (if possible) between health and social care interventions as they are so closely linked and dependent upon each other, and equally critical to the wellbeing of the service user drawing on support.

8.2.6 Education and Training for Social Care Practitioners

Education and training to ensure practitioners with the right knowledge and skills are essential for safe delegation. Some stakeholders expressed reluctance to delegate healthcare interventions due to uncertainty about the training and capability of social care practitioners. The DoH Social Care Workforce Strategy (2025–2035) and the CiP framework (2024) introduce standardised entry-level training and clear development pathways for the social care workforce. However, currently induction and basic training remain inconsistent across statutory and ISPs and whilst the Practice Educator role is valuable, it is not available to a large proportion of Trust staff and not accessible to the Independent Sector. Moreover, while Independent Care Providers do not have access to the HSC learning platform the Social Care Council Learning Zone is accessible to all providers, PAs and the public.

There is a need to improve awareness and understanding of the Minimum Standards that social care practitioners work to and the training and support that is in place for this workforce. The CiP framework, as it becomes populated with both accredited qualifications and recognised in-service training, has the potential to support social care practitioners to develop relevant practice experience, knowledge and skills that may support them to undertake delegated healthcare interventions. Nursing and AHP input to the development and delivery of this training would be advantageous.

However, currently there is no requirement for social care staff to hold these qualifications and the new Level 2 Safe and Effective Health and Social Care Practice certificate, which addresses mandatory training requirements is for new staff entering the social care workforce. Stakeholders who engaged in discussions, expressed the need for shared training resources, consistent standards, a recognised and accredited level of competence to improve safe delegation, recognising employers still hold responsibility for role-specific training. This alongside the provision of individual competency based training and supervision could drive up professional confidence in delegating a range of individualised healthcare interventions, in particular, supporting the majority of delegation where care needs are stable. In turn, this would realise the benefit of affording the HSC Trust nursing and AHP staff the opportunity to support education and training for the more complex care plans where there is a degree of healthcare risk and unpredictability and requirement for professional monitoring.

Action: Co-design Workshop
In addition, members of the Task and Finish Group liaised with members of a Regional Group led by the Strategic Planning and Performance Group (SPPG) to understanding the current Home Care provision in both the Statutory and Independent Sector.

The workstream: focusing on **Complex Tasks in Home Care** provided comprehensive insight to the scope and volume of care being commissioned and provided by social care practitioners in peoples own homes across NI. The review findings aligned to the learning from the delegation including:

- The need to update the Legislation/Policy & Procedures in relation to Homecare which is outdated and does not reflect the current model of Home Care;
- Lack of clarity in terms of definitions, including the difference between a Health and Social Care task in Homecare;
- Regional consensus in relation to the definition of 'complex' presented significant challenges in delivering against the objectives agreed;
- The need for engagement with the Independent Sector and those who use the service to inform the future home care service model; and
- Further training to be considered by NIPEC and NISCC.

In addition to routine social and personal care provided the review scoping identified the following interventions routinely undertaken by social care practitioners:

- Skin pressure checks;
- Compression stockings;
- Colostomy Care;
- Continence;
- Catheter Care; and
- Prompting, supervision and administration of medicines including eye drops and ear drops, creams, nebulisers and on occasions.
  control drugs and cytotoxic medication;
- Tracheostomy clean; and
- Non-Invasive Positive Pressure Ventilation (NIPPY), Continuous Positive Airway Pressure (CPAP), Oxygen.

This information gathered over 2024 provides a comprehensive oversight to inform understanding of the type of healthcare interventions being undertaken by social care practitioners across all Trusts in NI. NIPEC and NISCC to consider further learning and training development;

8.2.7 Key Learning

Key Learning
Delegation of Healthcare to Social Care Practitioners employed within Trusts or Third-Party Provider Organisations
The draft Multi-professional Delegation Governance Framework (MDGF) for Nursing, Midwifery and Social Services, Revised December 2023 should be updated in light of findings of this report, for joint approval and issuing by the Chief Nursing Officer and the Chief Social Work Officer. When published, HSC Trusts and ISP should undertake the self-assessment checklist and agree an action plan to strengthen professional and organisational governance arrangements for safe delegation of healthcare tasks as appropriate.
Standard protocols and tools should be developed to support a regional approach to: training, skills development, decision making, competency assessment, individual assessment/risk assessment, care planning, monitoring and escalation processes to support safe for delegation of healthcare interventions.
Commissioning and contracting of social care should include review of contracts awarded to providers to ensure they look for and support enablers for a more person-centred focus, as referenced in the Draft Multiprofessional Governance Framework (unpublished), including workforce competence for safe healthcare delegation, clear procedures for healthcare delegation, good communication process and robust evaluation and monitoring systems.
The pathways within the CiP Framework should be strengthened to recognise and support learning and development that reflects the competencies required to support safe and effective delegation of healthcare interventions, and drive up confidence in delegation and undertaking of delegated healthcare tasks.
An easily accessible regional educational resource should be developed to support understanding and application of multi-professional delegation of healthcare.
Regional approaches to delegation of healthcare interventions need to be incorporated in and align with the work of strategic reform boards across both children and adult services and included in reviews of related Minimum Standards.
The DoH review of the Minimum Standards for homecare (domiciliary care) agencies should reflect the requirements for the social care workforce regarding delegated healthcare intervention.
Implementation of professional workforce strategies need to ensure appropriate levels of resource for training on healthcare delegation, monitoring of delegated interventions, and support for collaborative models of care delivery that recognise and value the contribution of the social care workforce.

9 OBJECTIVE 2

To consider the current DoH Legislation and Policies in place in NI, including legal advice for delegation of healthcare interventions under direct payments Legislation and Policy

Legislation within NI specifies a distinction between 'healthcare' and 'social care'. DPs legislation provides for the provision of a particular social care service. This classification of healthcare or social care in practice can cause ambiguity or misperceptions and as a result, a review of current legislation is necessary. Clarification on the legislation was formally requested in January 2025, in order to enable a collective approach to taking this work forward. Different legal opinions have been provided by CILNI to the oversight group. Trusts have received individual legal advice that has shaped decision making. The Task and Finish Group transferred responsibility for this objective within their Terms of Reference to the Delegation of Care Oversight Group at the outset of this project. The DoH Oversight Group, agreed to established a specific workstream to consider the legislative position in consultation with Departmental legal advisors.

10 OBJECTIVE 3

To consider Legislation and Policies in other jurisdictions (Direct Payments) (Annex 4)

Within the United Kingdom four countries; England, Wales, Scotland and Northern Ireland, each country has local health and social care legislation requirements, policies and provision criteria for care. Each country have distinct guidance due to devolved health systems.

10.1 Methodology

A desktop scoping exercise was undertaken to better understand the legislation in respect to healthcare provision under DPs. Section 12 focusses on the wider policy and guidance relating to delegation of healthcare to social care practitioners in UK jurisdictions.

10.2 Learning from scoping of Direct Payment legislation and policies in other jurisdictions, full report available as Annex 4

DPs in healthcare, often referred to as Personal Health Budgets, aim to give people more choice and control over how their health needs are met. However, adoption, implementation, and regulatory frameworks differ significantly across the UK nations, creating distinct challenges. England, and Wales have updated their legislation for direct payments over recent years and they are both available to support healthcare. The updated legislations focus on principles of safety, competence, accountability and in best interest, with an emphasis on person centered care and shared decision making. Scotland Direct Payment Legislation (2014) applies to social care and not healthcare.

The scoping exercise has confirmed that, despite updating policy/legislation, there remains challenges across all UK jurisdictions.

- In England, The Health and Social Care Act (2022)[19] as part of the integrated care board introduced measures to provide greater joined up working for those who rely on multiple different services. There are a number of

19 Great Britain (2022) *Health and Care Act 2022*. London: The Stationary Office

guidance documents: NHS England (2022)[20] *Guidance on direct payments for healthcare* and (NHS England, 2023)[21] *Guidance on direct payments to personal assistants.* These are intended to support Integrated Care Boards (ICBs) to apply direct payments for healthcare regulations;

- The Social Services and Well-being (Wales) Act (2014) along with a number of additional supporting frameworks; (NLIAH, 2010)[22]; (Welsh Government, 2014[23]; 2016[24] and 2024[25]); and
- Scotland Self-directed Support (Direct Payments) (Scotland) Regulations (2014)[26] and accompany the Social Care (Self-directed Support) (Scotland) Act 2013[27].

Key Learning

Legislation and policies in other jurisdictions (Direct Payments)

England legislation enables Direct Payments to be used for Healthcare Interventions. It was updated to reflect the introduction of ICBs in July 2022 and revised again in July 2025.

Wales legislation enables Direct Payments to be used for Healthcare Interventions. The legislation was updated in 2025 to be extended to Continuing Healthcare.

Scotland Legislation for Direct Payments (2014) focuses on social care.

NHS England has provided specific guidance to clarify roles, responsibilities and accountability of staff involved of delegation of healthcare interventions under personal payments.

Despite updating policy/legislation in other jurisdictions, there remains challenges in the implementation of delegation of healthcare interventions under DPs.

20 NHS England (2022) *Guidance on direct payments for healthcare: Understanding the regulations.* Leeds: NHS England
21 NHS England (2023) *Personal health budgets: Delegation of healthcare tasks to personal assistants.* Leeds: NHS England
22 National Leadership and Innovation Agency for Healthcare (NLIAH) (2010) All Wales Guidelines for Delegation. Cardiff: NLIAH
23 Wales (2014) *Social Services and Well-being (Wales) Act 2014* . Cardiff: National Assembly for Wales
24 Welsh Government (2016) *Delegating third party tasks (WHC?2016/025).* Cardiff: Welsh Government.
25 Welsh Government (2024) *National framework for commissioning care and support: Code of Practice (WHC/2024/0234)* Cardiff: Welsh Government
26 Scottish Government (2014) *Scotland Self-directed Support (Direct Payments) (Scotland) Regulations 2014.* Edinburgh: Scotland
27 *Scottish Parliament (2013) Social Care (Self-directed Support) (Scotland) Act 2013.* Edinburgh: The Stationary Office

11 OBJECTIVE 4

To consider the standards and guidance set out by regulatory and professional bodies regarding delegation of healthcare by healthcare professionals (Annex 5)

Regulators set out standards for registered professionals to work towards and safeguard the public. For nurses this is the NMC Code. Within the context of delegation, regulatory standards and guidance consider professional scope of practice to ensure registered staff work within legal boundaries and uphold ethical principles. Standards aim to ensure that only competent individuals perform delegated tasks, reducing the risk of harm to patients or service users, by clarifying responsibility for delivery of care and accountability for outcomes of that care.

Moreover, regulatory standards can promote a consistent approach across professions and settings, ensuring that delegation decisions are based on competence, supervision and clear communication. Safe delegation standards enable staff to work effectively across and within multidisciplinary settings, using skills appropriately and reassuring the public that care is delivered by qualified individuals under proper oversight.

11.1 Methodology

A desktop scoping review of standards, guidance and codes of practice for registered health and social care practitioners provided by regulatory organisations NMC, Health and Care Professionals Council (HCPC), General Medical Council (GMC), NISCC was carried out to inform the Task and Finish Group report and recommendations.

11.2 Learning from scoping of standards and guidance set out by UK regulatory professional bodies regarding delegation of healthcare by healthcare professionals, full report available as Annex 5

Across the GMC, NMC, HCPC and NISCC, the common thread in guidance on delegation is the emphasis on patient safety, competence and accountability. While each regulator frames its standards slightly differently, they all require professionals to:

- Assess competence before delegating tasks;
- Provide clear instructions and appropriate supervision; and
- Retain overall responsibility for care outcomes.

However, despite regulator professional standards across all the professions for healthcare delegation, staff continue to experience challenges in applying these in practice, for the reasons detailed in this report. Regulators can provide clear guidance, but confusion persists because the legislation and policy, workforce models, protocols and processes, training and interprofessional cultures around delegation are not yet consistent, accessible or aligned. The challenges are organisational and operational, not necessarily regulatory.

The NMC are reviewing the NMC Code (2018) which was developed 10 years ago. NMC have received a lot of intelligence that the NMC Code (2018) in relation to delegation does not fit with how nurses are currently practicing to address and meet the transformation required. Delegation has been identified as a specific area for the NMC to focus on and to develop guidance for delegation in addition to the revised Code.

ACTION: In recognition of the challenges identified by registered nurses regarding practice of delegation and meeting regulatory standards, NIPEC are currently:

- updating a Delegation website to include Frequently Asked Questions (FAQs), resources and tools to support best practice; and
- developing a recording tool to guide and capture decision making regarding delegation of healthcare interventions to social care practitioners. This is being tested in all five HSC Trusts.

Key Learning

Standards and guidance set out by UK regulatory and professional bodies

Across the GMC, NMC, HCPC, and NISCC, provide standards and guidance for the relevant registered professionals. The common thread in guidance on delegation is the emphasis on patient safety, competence and accountability.

It is essential that local policies and protocols interpret and embed the principles set out by regulators. While GMC, NMC, HCPC, and NISCC provide high-level standards, these must be translated into practical steps that fit the workforce models and organisational context.

12 OBJECTIVE 5

To consider models of best practice of delegation of healthcare interventions in other jurisdictions (Annex 6)

Evidence and national guidance indicate that when structured, competency based and adequately supervised, delegation can deliver measurable benefits. Persistent challenges remain however, including inconsistent governance, unclear accountability, training gaps, and limited workforce planning between health and social care sectors. In order to learn from policy development to inform safe and effective delegation, a review of current practice guidance for the delegation of healthcare interventions to social care practitioners and personal assistants, across the four UK jurisdictions and the Republic of Ireland was undertaken.

12.1 Methodology

The approach adopted for this report was a desk-based scoping review. The methodology did not include a detailed review of DPs legislation which is available Section 9. These findings are based on secondary sources and publicly available guidance.

12.2 Learning from scoping of models of best practice of delegation of healthcare interventions in other jurisdictions (Including NI) full report available as Annex 6

Northern Ireland: Understanding NI's arrangements is essential because health and social care governance, professional regulation, and delegation frameworks differ across the UK. NI operates an integrated Health and Social Care system with its own statutory guidance, workforce structures, and accountability mechanisms. Without establishing what applies locally, any comparison risks misinterpretation, overlooking unique legal duties or proposing models that are incompatible with NI's regulatory context.

Although not specific to the delegation of healthcare tasks, NI DoH policies and legislation in table 3 below outlines the expected roles and responsibilities of staff, along with the skills and knowledge required to deliver safe and effective care. In doing so, it provides a framework for determining what constitutes appropriate delegation of healthcare activities. NI has a number of professional specific guiding frameworks and guidance for home care provision are that are significantly out of date and not reflective of the scope of practice relating to healthcare support undertaken by social care practitioners and PAs:

Table 3: Northern Ireland Policy/Guidance for Domiciliary Care

- Carers and Direct Payments Act (Northern Ireland) 2002;
- The Personal Social Services and Children's Services (Direct Payments) Regulations (Northern Ireland) 2004;
- Domiciliary care access criteria 2008 - ECCU;
- 2010: Circular HSC (ECCU) 1/2010 Care Management, Provision of Services and Charging Guidance (currently under review);
- Domiciliary care service registration (Northern Ireland) - GOV.UK; and
- Domiciliary Care Agencies Minimum Standards 2011 – (currently under review).

This evolution of frameworks within NI demonstrates a trajectory from basic home help in 1980 to a regulated and integrated domiciliary care system today. However, work carried out by SPPG commencing April 2024 identified variances across Trusts in terms of commissioned services and the interventions currently being undertaken by social care practitioners. This review confirmed the outdated extant NI circular is not reflective of the current home care model. The Care Management Circular and Domiciliary Care Standards are currently being reviewed by the DoH. This process should enable consideration of the process for delegation of healthcare interventions to social care practitioners and the required skills and knowledge to undertake this care safely and effectively.

Other Jurisdictions: The practice of delegation of healthcare is well established across all UK and Republic of Ireland jurisdictions, supported by numerous policy positions and guidance documents that broadly reflect the same principles and standards outlined in Table 4.

England, Scotland and Wales have adopted a multiprofessional approach and updated their national guidance for delegation of healthcare across all professionals within the recent years as outlined in table 4. Ireland, like NI have adopted professional specific frameworks, however they have established a national education framework which sets minimum education and training standards for support grades who may be delegated routine tasks, following completion of a nationally recognised foundation of knowledge and skills for personal care and support tasks.

Table 4 The Practice of Delegation of Healthcare Guidance Documents

Country	Date	Guidance Documents
England	2024	skillsforcare. Support-for-leaders-and-managers Delegated-healthcare-activities
	2017	Personal health budgets: Delegation of healthcare tasks to personal assistants
	2022	"Clinical responsibility when delegating roles – NHS e Referral Service"
Wales	2020	Practicing Appropriate Delegation All Wales Guidelines
Scotland	2024	Making Delegation Safe and Effective
Northern Ireland	2019	Deciding to Delegate: A Decision Support Framework for Nursing and Midwifery
	2019	Framework for delegation of complex tasks to social care workers in Northern Ireland
	2024	The Advisory Committee of Allied Health Professions (ACAHP) Position Statement on Delegation
Ireland	2025	NMBI-Code-of-Professional-Conduct-and-Ethics.pdf (CORU) Delegation guidance-for-registrants

A limited review of the research evidence was considered and detailed in Annex 6.

Association of Directors of Adult Socials Services (ADASS) Guidance on Delegated Healthcare (England) highlights that delegation of healthcare tasks in social care settings can be safe and effective when well-governed, but current practice is often inconsistent and under-resourced. Key issues reported include:

- Unfunded cost-shifting: 84% of Directors report social care staff undertaking NHS tasks without funding;
- Training gaps: 67% report delegation occurring without adequate training or supervision;
- Accountability concerns: Lack of clarity over responsibility creates risk-averse practice; and
- Safety risks: Staff may collect health data but lack the clinical judgment to escalate concerns.

York Consulting / Skills for Care Research (2022) carried out an exploratory study which examined how social care workers undertake delegated healthcare tasks across England:

- Both identify significant inconsistency and fragmentation in how delegated healthcare tasks are delivered across social care settings;
- Both highlight unclear accountability between health and social care, creating risk and uncertainty;
- Both point to inadequate or inconsistent training for social care staff performing delegated healthcare tasks;
- Both stress the need for clearer governance structures, standard procedures, and formalised delegation agreements; and
- Both acknowledge increased pressure on the social care workforce to take on clinical tasks traditionally performed by health professionals.

12.2.1 Key Learning

Key Learning
Standards and guidance set out by UK regulatory and professional bodies
The NI governing legislation and guidance for home care provision is significantly out-of-date and does not reflect the current scope of social care practitioners, nor a sustainable model of care to meet the Ministerial strategy of provision of care, closer to home.
NI and Ireland have adopted frameworks and guidance for delegation of healthcare interventions that are professional specific, whereas England, Scotland and Wales Guidance span all professions.
Significant guidance (broadly following the same principles) exist across the UK and Ireland, however application of the guidance is inconsistent and lacks clarity.
The following is recommended to support effective delegation across professions and teams: • Establishing clear governance and accountability frameworks, supported by formal agreements between health and social care organisations; • Implementing competency-based training and regular review mechanisms; • Ensuring ongoing supervision and clinical oversight by a registered practitioner, with escalation protocols; • Shared workforce planning across sectors to ensure population health needs are met by the right person; with the right skills, at the right time, in the right place to support safe, high quality sustainable model; • Developing shared, co-produced protocols, care planning, communication and decision-support tools; and • Embedding risk management, monitoring and evaluation within all delegation models.

13 OBJECTIVE 6

Consider the training and development currently provided at pre-reg and post-registration to support safe delegation of healthcare interventions (Annex 7)

Delegation of healthcare interventions is a critical skill for healthcare professionals because it directly impacts patient safety, quality of care and team efficiency. Ensuring that both professional and social care staff are trained in the principles and practice of delegation is essential for delivering safe, effective, and person-centred care. Delegation is not simply a transfer of tasks but a complex clinical and professional judgement that requires staff to understand competence, risk, scope of practice, and accountability. Without structured training, staff may lack the confidence to delegate appropriately or may avoid delegation altogether, limiting flexibility and undermining the efficient use of the workforce.

As models of care continue to shift toward supporting people with increasingly complex needs at home and in community settings, the ability to delegate safely becomes a critical enabler of responsive, person-centred care. This will become ever more important as we increase care in community as part of the NI Neighbourhood model of care. Training also strengthens interprofessional understanding by clarifying the roles, responsibilities, and regulatory standards that guide both health and social care practitioners, reducing uncertainty and preventing unsafe variation in practice. Ultimately, investing in robust delegation training enhances workforce capacity, supports professional assurance, and ensures that individuals receive timely, competent care from the most appropriate member of the team.

It is important that effective delegation ensures that tasks are assigned to individuals who are competent and authorized to perform them, while maintaining accountability and oversight. Appropriate training in delegation helps professionals understand legal, ethical and professional boundaries, ensuring that care is delivered safely, efficiently and in line with best practice standards. Higher Education Institutions (HEI); Queens University Belfast (QUB), Ulster University (UU) and Open University (OU) provide professional pre-registration and post-registration education programmes in NI.

13.1 Methodology

The approach adopted for this report was a desk-based scoping review and discussion with Education Providers.

13.2 Learning from scoping of training and development currently provided at pre-registration and post-registration to support safe delegation of healthcare interventions full report available as Annex 7

Pre-registration Training: As part of this work the group scoped the provision of education in pre-registration programmes relating to the topic of delegation, included as part of their curriculum within undergraduate graduate study across all fields of nursing practice, as outlined in Figure 3. This identified that all pre-registration programmes for nursing and midwifery include education on the professional role in supporting safe and effective delegation.

Figure 3: Nursing and Midwifery

Integration of Delegation in Nursing Education			
Higher Education Institutions	**Undergraduate Year 1**	**Undergraduate Year 2**	**Undergraduate Year 3**
Queens University Belfast	✓	✓	✓
Ulster University	✗	✓	✓
Open University	✗	✗	✓

Post-registration Training Nursing and Midwifery: Delegation is not a static skill as it requires ongoing development as healthcare practices, technologies, policies and regulations evolve. QUB and UU, as providers of post-registration education, for nursing and midwifery staff, have confirmed that where relevant they incorporate education on delegation within their post-registration programmes. In addition, post-registration training on delegation is available to all HSC Trust staff regionally, at all levels of practice, through a short course programme on Learn HSCNI. This eLearning session, *Demystifying Delegation* provides a theoretical approach to delegation, with an emphasis on delegation within a team and multi-disciplinary setting. It is best suited to those in a managerial or supervisory role and references the Deciding to Delegate Framework NIPEC (2019) and the OSS (2018) inclusion of direct payments is not part of this delivery. A number of HSC Trust led training programmes are also available locally, to those staff and managers working directly with direct payments.

Action: In recognition of the issues that were being raised by registered nurses, the NI Post Graduate Education Commissioning Group requested the Royal College of Nursing (RCN) and Clinical Education Centre (CEC) to develop two further programmes for nurses and midwives in NI. The RCN have successfully delivered training in 2024/25 on Nursing Delegation - Understanding the registered nurse role to five separate cohorts this year focusing on registered nurses in senior roles. In addition, the CEC on request, have developed a programme, Awareness of Delegation for levels of practice available for 5-7. As outlined below, in Figure 3.

Figure 4: Post-registration Training on Delegation

Learn HSCNI	eLearning: "Demystifying Delegation"
RCN (Levels of Practice 8-9)	Nursing Delegation - Understanding the Registered Nurse Role *Delivered from January - March 2025
CEC (Levels of Practice 5-7)	Awareness of Delegation *Delivered from September 2025
HSC Trust Led	Various local HSC Trust led study arrangements, ranging from: • 1-day in person bespoke study for those managers and nurses working directly with Direct Payment Schemes. • Additional resources and information held locally through Share Point or other equivalent shared platforms. • Induction, individual coaching and mentoring arrangements.

Other Professional Groups: The inclusion of delegation in education and training programmes for social workers, social care practitioners and AHPs has also been explored, as detailed in Annex 7. Whilst there is no specific training on delegation in Social Care, the requirement is to build competence in their role and against the Standards (NISCC,2019)[28]. NISCC confirmed that the principles of delegation and the impact on their role is embedded within the broad training programmes for Social Work at pre-registration, and more explicitly addressed within post-registration training.

28 Northern Ireland Social Care Council (2019) *Standards of Conduct and Practice for Social Care Workers.* Belfast: NISCC

With regard to, the training and development currently provided at pre-registration and post-registration to support safe delegation of healthcare interventions. The current suite of vocational qualifications available to social care practitioners in NI is under review. As the social care workforce is currently role rather than qualification based, there is no requirement for pre-registration training. The level 2 certificate in safe and effective practice, as an entry level qualification, is currently available and will become mandatory at a future date. Social Care Practitioners currently undertake a range of continuous professional learning opportunities appropriate to their role and pathway of care.

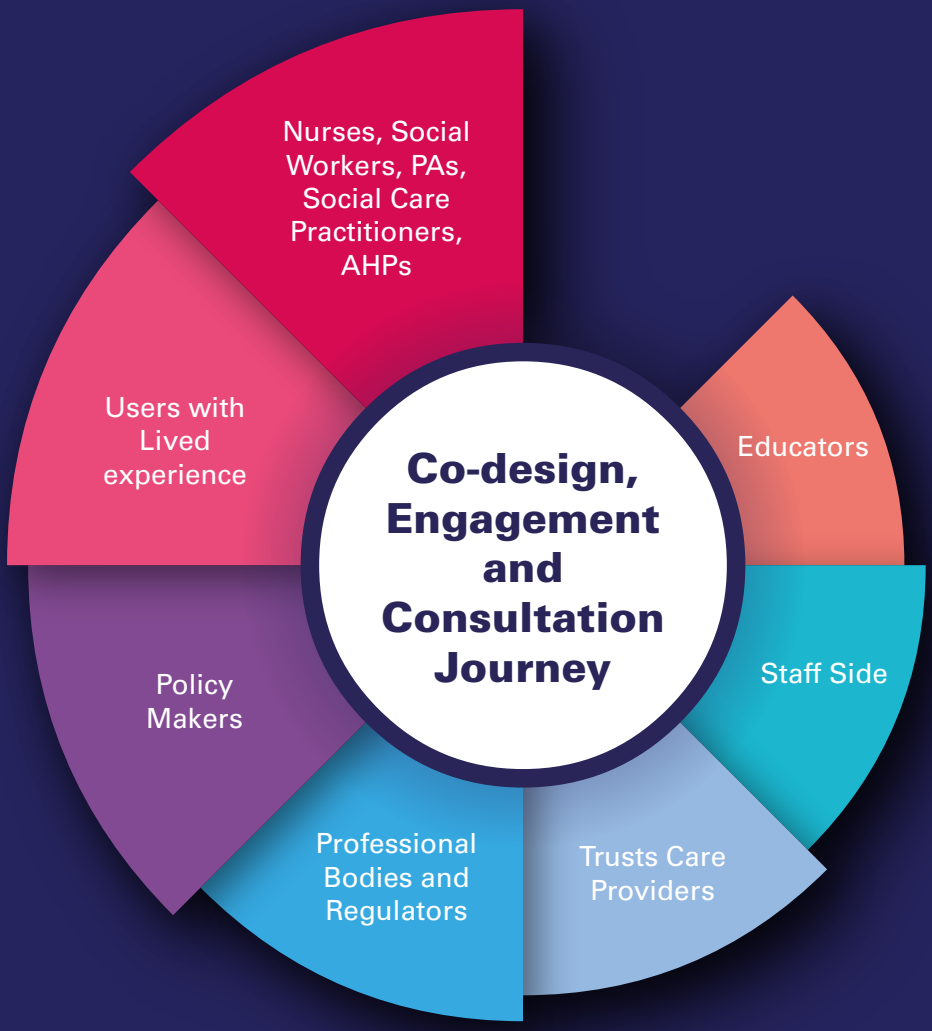
AHPs develop competence in delegation progressively across pre-registration education, early career consolidation and advanced and leadership level post-registration education. At undergraduate level education for AHPs, delegation is introduced as part of professional practice, ethics and interprofessional working. This provides the essential knowledge base to ensure graduates understand their accountability and responsibilities from point of registration. Core areas of undergraduate education include; professional accountability and legal frameworks, principles of safe and effective delegation to support workers, communication and supervision skills, interprofessional education and team based care. Postgraduate education develops delegation capability at a strategic, leadership and system level.

Key Findings
Standards and guidance set out by UK regulatory and professional bodies
In NI Nursing and Midwifery professions have comprehensive training for their role in delegation, at pre and post-registration education. Training and development have been strengthened through the development of programmes by the RCN and CEC.
Whilst there is no specific training on delegation in Social Care, NISCC confirmed that the principles of delegation and the impact on their role is embedded within the broad training programmes for Social Work at pre-registration, and more explicitly addressed within post-registration training.
AHPs develop competence in delegation progressively, across pre and post-registration education.

14 CO-DESIGN, CO-PRODUCTION, COMMUNICATION AND ENGAGEMENT

A wide-ranging programme of communication, engagement and co-design has been fundamental to co-production of this work, ensuring the voices, experiences and expertise of those most affected shaped every stage of the review.

This included meaningful involvement of people who draw on care and support, families, PAs, social care practitioners, social care managers, social workers, registered nurses and professionals across all programmes of care, as well as ISPs, education partners and regulatory bodies. Engagement methods were intentionally diverse: and surfaced real-world practice challenges, emotional and relational aspects of care and the systemic barriers that cannot be identified through policy analysis alone. People with lived experience and staff alike, are eager for change that enables them to provide the optimum care for the population we serve.



Scoping and insight
Determine workflows, tools, structures and readiness to identify challenges and opportunities.

Story Sharing
Share real life cases and examples to increase curiosity about experience, challenges and solutions.

Co-Design and Co-Producing
Share challenges, best practice, solutions and benefits of working together.

Test Solutions
Work across sectors to test our selected solutions while guiding employees and users through usage and adjustments.

Learning and Sharing
Implement change, monitor outcomes and refine to inform future direction.

15 CONCLUSION AND RECOMMENDATIONS

Delegation of healthcare interventions is a critical enabler for the Strategic Reset Plan's vision of care C*loser to Home* and vital to meeting growing care demand of people with health and social care needs and enabling people to live more independently and reduce avoidable attendances to secondary care. NI has pockets of good practice, but system level inconsistency in legislative interpretation, clinical and professional governance, workforce planning and delivery models, education and digital access, all create avoidable risk and variability. People drawing on care, PAs, social care staff, and registered professionals want clarity, consistency, and confidence so that the right care is delivered by the right person, at the right time, in the right place by staff with the right skills, knowledge and attitudes. Professional and workforce willingness exists, but uncertainty, inconsistent systems, and operational barriers hinder safe, effective delegation.

Collective leadership is required at all levels within the HSC system to deliver a coordinated regional approach, with aligned governance arrangements, commissioning, consistent agreed standards of education and clearer legal/policy decisions to enable delegation of the right person-centred care, provided by the right person, in the right place, at the right time. This review has highlighted the degree of earnestness from the service users and practitioners alike, for this work to progress at pace, to improve user experience and enable safe, effective and person-centred delegation, supporting people to live as independently as possible at home and in their communities.

15.1: Recommendations – High Level (reflecting the learning and the recommendations outlined in the Annex reports linked to this document)

Overall, a coordinated regional approach, grounded in a refreshed multi-professional framework, aligned commissioning, consistent education and clearer legal/policy direction decisions will enable safe, effective, and person-centred delegation, supporting people to live as independently as possible at home and in their communities. In taking forward this work, an Equality Screening should be undertaken in line with standard practice.

8.0 RECOMMENDATIONS (HIGH-LEVEL)

1. Establish a NI Multi-Professional Delegation Approach for NI:

- Establish a multiprofessional delegation governance framework as a valuable tool that could strengthen local governance, support consistent decision-making and provide clearer organisational and professional endorsement for the delegation of healthcare interventions;
- Standardise Core Processes Regionally, ensuring explicit role, responsibilities and accountability across all registered healthcare professionals and social care practitioners and those who draw on care and support;
- Develop common tools for decision-making, recording, communication, competence assessment, individual assessment/risk assessment, care planning, monitoring, documentation, and escalation; Ensure the tools reflect the decision making and preferences of the person drawing on care and support.
- Specify workforce competence, delegation procedures, communication standards, and evaluation/monitoring requirements in Minimum Standards and Regulation; and
- Provide clarity of clinical and professional governance arrangements to support safe effective person-centred care and delegation of care, safe effective supervision (direct and indirect), communication, monitoring of outcomes and timely escalation of concerns to ensure the right care in the right place at the right time, by the right person with the right skill, knowledge and behaviours.

2. Workforce Capability and Capacity:

- Agree standards for Education for skills, knowledge and levels of practice to support safe delegation of routine healthcare interventions and enable access across all sectors;
- Embed the CiP framework to recognise and accredit competencies relevant to delegated healthcare where appropriate; taking account of prior learning/experience. Ensure regulated healthcare and social care professionals' input to the design and delivery of the healthcare and social care training;
- Expand shared, accessible regional learning resources on delegation (including independent sector access to agreed modules);
- Develop clear roles, responsibilities and accountability arrangements to ensure safe oversight of delegation including informed decision-making supporting person centred choice; and
- Consider Workforce planning and delivery models to ensure adequately resourced and skilled workforce and accountability structures for safe healthcare delegation from Nursing staff to Social Care Practitioners. This should include development of PAs roles as critical enablers in meeting the care needs under DP legislation.

3. Legislative and Policy Review:

- Review NI legislation on the use of Direct Payments for healthcare interventions and associated governance/accountability;
- Ensure ongoing DoH reviews of domiciliary care standards and care management guidance explicitly address delegation of healthcare interventions;
- Ensure that any delegation frameworks or guidance complement and align with the Regulations and associated Minimum Standards that apply to regulated agencies involved in delegated practice; and
- Contribute to the review and updating of the NMC Code in relation to the delegation of healthcare interventions and further regulatory guidance.

4. Digital Enablement and Information Flow:

- Improve information sharing and explore appropriate read/access solutions for ISPs to support safe delegation, monitoring, and escalation.

5. Culture, Leadership, and Co-production:

- Recognise that often differentiation between health and social care interventions is not always possible as they are often interdependent, a collaborative framework should enable shared accountability with service users to develop true empowerment and joint decision making;
- Shift policy and practice from risk avoidance to risk enablement, anchored in person-centred principles, supervision and reflective practice, respecting the human rights of the person drawing on care and support; and
- Continue co-production and evaluation of practice with people who draw on care, PAs, and frontline practitioners to refine tools and protocols and build trust. Embedding a culture of multiprofessional collaboration and positive risk enablement.

6. Equality Screening:

- Future work emanating from this report will require further examination of equality screening requirements and related issues in line with standard practice.

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