NIPEC
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An Roinn Sláinte
Männystrie O Poustie
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A REVIEW OF

Delegation in Practice

Enabling People to Live Well 'Closer to Home'

ANNEX 3

Engagement of Practice Experience of Delegation to Social Care Practitioners in People's Own Homes

Contents

The overarching report: A Review of Delegation in Practice: Enabling People to Live Well 'Closer to Home' incorporates learning from a number of Annex reports incorporated within the document. This document is Annex 3 and provides an overview of **engagement with stakeholders in Northern Ireland (NI) to ascertain what delegation of healthcare interventions to social care practitioners looks like in practice.**

1. Background

Safe and effective delegation is an important component of the delivery of health and social care across NI. Delegation of healthcare interventions to social care practitioners has been a topic of much discussion and whilst guidance and support tools are in place, and it is known that delegation takes place on a regular basis, there remains a view that it is problematic, inconsistent and fraught with professional and organisational challenge. The Chief Nursing Officer (CNO) in seeking to address these challenges, established an oversight group with a number of task and finish groups to consider specific aspects and identify possible solutions. Within this structure the Delegation of Healthcare Interventions Task and Finish Group is chaired by Linda Kelly, Northern Ireland Practice and Education Council (NIPEC) and Dawn Ferguson, Interim Executive Director Nursing Midwifery, Allied Health Professions (AHP), Southern Health and Social Care Trust (SHSCT). In the initial stages of this project, the task and finish group commissioned two pieces of work: one for a team-based approach to delivering care that includes consideration of personal assistants (PAs) employed under Direct Payments; and a second, on delegation of healthcare interventions to social care practitioners employed by the Health and Social Care Trusts (HSC Trusts) and independent care providers. This paper reports on the latter in respect of delegation of healthcare interventions to social care practitioners.

2. Introduction

In December 2024, the Department of Health (DoH) issued a three-year plan for health and social care in NI to: stabilise, reform and deliver.[1] The plan recognises that person-

[1] doh-hsc-3-year-plan.pdf

centred care requires a stable workforce, appropriately trained and supported to deliver safe and responsive care at the right time and in the right place. This approach requires people across the system to understand each other's role and in doing so, to work collaboratively with mutual respect and recognition.

In understanding and respecting each other's role and responsibility there is opportunity to work more efficiently, effectively and improve the experience for the person receiving care and support, which must always be the ultimate goal. Evidence has shown that there is a strong argument for delegation, assuming that conditions are met, as such; that it can be done appropriately and safely. Where that is the case, it was said to benefit social care practitioners, registered clinicians and those accessing care and support services. In particular, it can mean timely, flexible delivery of interventions and procedures, better continuity of care and more person-centered care (Skills for Care Research, 2022)[2]. Most importantly, delegation used to its maximum potential offers the opportunity for an improved experience of care for the person by minimising the number of professionals who come in and out of their daily living environment, allowing for a more consistent, familiar and trusted relationship-based routine. It may also in some instances contribute to reduced anxiety and a greater sense of independence, choice and control.

Interpretations of delegation of health care interventions across the health and social care sector are wide-ranging and the governance structures and processes for delegation are varied. The need for a more consistent approach has been recognised for a number of years with engagement and proposals led by NIPEC and the Northern Ireland Social Care Council (Social Care Council) dating back to 2018. In Spring 2024, Registered Nurses Learning Disability, highlighted concerns through various formal and informal channels in respect of processes and practices for delegation of nursing and health care tasks. These concerns are related to delegation of increasingly complex tasks and the associated implications for the delivery of safe and effective care consistent with professional registration requirements.

[2] Skills for Care and Association of Directors of Adult Social Services (ADASS) (2022) *The state of the adult social care sector and workforce in England*. Skills for Care: Leeds

The voice of the person receiving services and the voices of their families is critical to decisions being made about who delivers their care on a day to day basis. We fully recognise therefore the importance for the task and finish group to consider the implications of what is being recommended by this report in the context of findings and recommendations that will come from the parallel project referenced above that will include representation from people who use services and their families.

The HSC Trusts, as the provider; and in some instances, the commissioner, of health and social care services remain responsible for the duty to care and the overall management of the package of care that is delivered, this includes delegated healthcare interventions. Delegation is defined by the Nursing and Midwifery Council (NMC) in its supplementary information to the NMC Code (2018)[3] as:

> *the transfer to a competent individual, of the authority to perform a specific task in a specified situation,*

and by the Office of Social Services (OSS) in its circular 02/2018[4] as:

> *the entrusting of a task which would usually be carried out by one person as part of their professional role to another competent person,*

and by the Health and Care Professions Council (HCPC) in its regulatory guidance as:

> *to ask someone else to carry out a task on your behalf.*

This report reflects engagement with a range of key stakeholders to ascertain what delegation of health care interventions to social care practitioners looks like in practice, it reports on what gaps exist and makes recommendations for improvements that would strengthen the process and governance for delegation.

[3] The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council
[4] Circular-OSS-02-2018.pdf

3. Terms of Reference

Whilst the original draft terms of reference included work associated with identifying population healthcare needs and implications for workforce planning these were refined in line with the allocated resource and timescale (see Appendix One) and agreed as follows:

1. Scope the processes and structures, policies and procedures established within HSC Trusts to support safe delegation of health care to social care practitioners employed by HSC Trusts, and employed by independent care providers;

2. Work collaboratively across social work/social care and healthcare professionals to consider what works well and not so well within the current model of delegation of health care to social care practitioners;

3. Benchmark the current model against best practice standards for governance, accountability and partnership working set out by regulatory and professional bodies regarding delegation of health care interventions; and

4. Report to the Delegation of Healthcare Interventions task and finish Group on findings and make recommendations to inform a future sustainable model for delegation of health care to social care workers, reflecting multi-professional working to meet the health care needs of people.

4. Methodology

This workstream has been jointly commissioned by NIPEC and the Social Care Council through the Health and Social Care Leadership Centre associate service. Pamela Craig and Marian O'Rourke were appointed to the project on the basis of their relevant knowledge and experience (see Appendix 2).

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. This work is outlined below, and whilst not an exhaustive list, provides the basis on which recommendations are made as to a way forward for improvement.

A programme of engagement with relevant stakeholders was delivered in March and April 2024 (see Appendix 3), this included meetings with the 5 HSC Trusts, Independent Health and Care Providers (IHCP), independent care providers, 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.

5. Frame of Reference

Consideration of safe and effective delegation must take account of the frame of reference in which the intervention is to take place. In looking for points of reference that inform delegation of health care interventions to social care practitioners there are a range of safeguards and supports in place:

5.1. Statutory regulation

Nurses, midwives and nursing associates across the UK are registered with the NMC and are required to work to their code and be accountable for their practice and behaviour. Social workers and social care practitioners in NI are registered with the Social Care Council and are required to work to their standards of conduct and practice.[5] Similar arrangements apply in Scotland and Wales whilst in England social workers are registered with Social Work England but no such arrangements are in place for regulation and registration of social care practitioners. AHPs, including physiotherapists, occupational therapists and speech and language therapists are

[5] Standards-for-Social-Workers.pdf, Social-Care-Workers.pdf

registered across the UK with HCPC and also work to standards of conduct, performance and ethics.

Regulation of Nurses and Midwives:

The NMC Code (2018) sets out expectations of people on the register when they delegate to others. These requirements apply regardless of who the activity is being delegated to. This may be another registered professional, a non-registered colleague, or a patient or carer. There is therefore the expectation that people on the NMC register are accountable for their decision to delegate interventions and duties to others, and to achieve this, they must:

- ✓ only delegate interventions and duties that are within the other person's scope of competence, making sure that they fully understand the instruction;
- ✓ make sure that everyone they delegate interventions to are adequately supervised and supported so they can provide safe and compassionate care; and
- ✓ confirm that the outcome of any intervention delegated to someone else meets the required standard.

Regulation of AHPs:

Key Principles of AHP Delegation Position Statement

1. Accountability

"You must only delegate work to someone who has the knowledge, skills and experience needed to carry it out safely and effectively. You must continue to provide appropriate supervision and support to those you delegate work to."

2. ***Competence***

The individual delegated to, must have the necessary training, skills, and experience. Competence must be assessed, not assumed. If competence is not

yet achieved, the AHP registrant must provide training and supervision to that individual.

3. ***Supervision and Support***

The level of supervision depends on the task and the individual's experience. Some tasks require direct oversight, while others allow for more independent working.

4. ***Clarity of Communication***

There should be a clear rationale for delegation documented, with the scope and limits of the delegated task clearly defined. AHP registrant's contact details should be provided to allow feedback and resolution of any issues.

5. ***Legal and Ethical Considerations***

Delegation must comply with HCPC regulations, employer policies, and ethical standards. AHP registrants must not delegate tasks that require professional judgment beyond the skills of the individual performing them.

Regulation of Social Workers

The Social Care Council Standards of Conduct and Practice for Social Care Workers (2015) sets out the standards required of social workers, including being accountable for the quality of work and taking responsibility for maintaining and improving knowledge and skills, this includes:

- ✓ Taking responsibility for work delegated to you, recognising and working within the limits of your knowledge, skills and experience

- ✓ Recognising that you remain responsible for the work that you have delegated to other workers

- ✓ Recognising and respecting the roles and expertise of workers from other disciplines and agencies and working in partnership with them

- ✓ Undertaking relevant training and learning to maintain and improve your knowledge and skills and meeting the Social Care Council Post Registration Training and Learning Requirements in line with your job role.

Regulation of Social Care Practitioners:

The Social Care Council Standards of Conduct and Practice for Social Care Workers (2015) sets out the standards required of social care practitioners, including being accountable for the quality of work and taking responsibility for maintaining and improving knowledge and skills, this includes:

- ✓ Taking responsibility for work delegated to you, recognising and working within the limits of your knowledge, skills and experience;

- ✓ Recognising that you remain responsible for the work that you have delegated to other workers;

- ✓ Recognising and respecting the roles and expertise of workers from other disciplines and agencies and working in partnership with them; and

- ✓ Undertaking relevant training and learning to maintain and improve your knowledge and skills and meeting the Social Care Council Post Registration Training and Learning Requirements in line with your job role.

5.2 Supporting Frameworks/Guidance

Deciding to Delegate: A Decision Support Framework for Nursing and Midwifery (NIPEC, 2019).[6]

NIPEC co-produced and launched this framework in 2019 for nurses and midwives in collaboration with the Social Care Council. The framework aligns with the Social Care Council's role to support the development of the social care

[6] Delegation in Nursing and Midwifery | NIPEC

workforce. The framework is used to support the decision-making process for nurses and midwives in delegation of health care interventions. It recognises the responsibility of organisations, and individuals employing nurses and midwives, to ensure appropriate arrangements are in place to support safe, effective, and person-centred delegation decisions. The framework identifies three requirements for consideration in ensuring safe and effective decisions about delegation by nurses and midwives:

- ✓ Firstly, the care environment needs to be considered, ensuring that adequate and appropriately skilled staff, alongside an appropriate model of care with adequate resources are in place;

- ✓ Secondly organisational governance arrangements need to be place, including: accessible policy and procedures that meet professional standards; alongside appropriate job descriptions that accurately reflect the scope of practice and are supported with appropriate learning and development opportunities; as well as clear processes for escalation where concerns are identified; and

- ✓ Thirdly, consideration is given to the professional, legislative and regulatory requirements that impact the delegation decision and process, these include responsibilities of both the delegator and the delegatee.

In seeking to make a decision, it is assumed that accountability and responsibility has been addressed, that an assessment of the person's needs has been undertaken and that a clear process for escalation is in place, should a concern be raised. A matrix to support decision making is included in the framework to provide guidance and assurance that all necessary aspects have been considered in the decision-making process (see Appendix Four).

Framework for delegation of complex tasks to social care workers in Northern Ireland (Office of Social Services Circular 02/2018)

The circular was launched by OSS in 2018 to address key issues in delegation within the context of social care and social work services and includes a framework to support the decision-making process for delegation to social care practitioners. This framework is intended for social care practitioners, social workers, their managers and their employers. It may also be used by other professionals who delegate a health or social care intervention to a social worker or social care practitioner.

The framework states: 'The delegator is responsible for their decision to delegate an intervention to a social care practitioner/social worker. A professional who delegates an intervention to a social care practitioner is not accountable for the decisions and actions of the practitioner who carries out the intervention. The social care practitioner is accountable for the intervention that they accept to undertake and for their actions in respect of performing these interventions'. This aligns with the Royal College of Nursing (RCN) advice and guidance to nurses that the responsible nurse is accountable for the decision to delegate. The social care practitioner is accountable to their employer and to the Social Care Council as their regulator. The framework sets out a detailed process and set of questions/considerations to support safe decision making for delegation (see Appendix Five).

Multi-Professional Delegation Governance Framework (MDGF) – Draft 2020. (NIPEC/NISCC, unpublished).

Following the launch of the NIPEC framework and the OSS circular, NIPEC and the Social Care Council further collaborated with the sector to develop a framework to support good governance and accountability arrangements for supporting safe delegation across an integrated health and social care system.

The draft MDGF sets out the value-based principles required for collective leadership and collaboration in supporting delegation. It identifies a range of supporting enablers that need to be in place for person-centred decision making, these include: legislative, policy and regulatory requirements as well as shared understanding of workforce roles and competences. The framework document

also includes a helpful self-assessment checklist for governance arrangements (see Appendix Six). A number of factors, including the Covid-19 pandemic have impacted on the development of this multi-professional delegation framework. The draft framework has been shared with the CNO and the CSWO and it was agreed that further work was required to inform the final version, including the current review of Delegation of Healthcare Intervention.

Royal College of Nursing (RCN) Accountability and Delegation guide 3 (RCN, 2023).[7]

The guide provides supplementary guidance to nurses, nurse associates and midwives in reaching decisions on delegation.

HSC Trust operational policies and governance arrangements

Each of the HSC Trusts have varying levels of formalised structures, processes and policies that directly and indirectly support arrangements for delegation of health care interventions. These arrangements are explored in more detail in the subsequent section of this report.

Overall, in considering the current frame of reference for delegation it is clear that both formal and informal arrangements are required to be in place to support the decision-making process for delegation to happen. However, challenge and confusion remain. The missing element therefore appears to be twofold: firstly, whilst there is separate regional guidance for nurses and midwives and for social services staff, the awareness and uptake of these is patchy; and secondly, attempts to support implementation of this in practice and develop a supportive culture for delegation through the draft MDGF, has proved challenging, incomplete and unpublished.

[7] Accountability and delegation guide | Royal College of Nursing

6. Engagement Findings and Discussion - Common Themes

Engagement with a range of stakeholders has allowed for detailed discussion on both common and specific aspects of arrangements for, and experience of, the process for delegation of health care interventions to social care practitioners. Given the integrated nature of care provision, discussion during this engagement has sometimes included comments about delegation in contexts that are out of scope. Some of these comments have been included in this paper where it was considered relevant to the wider review agenda. Whilst each of the HSC Trusts and the independent care providers have outlined varying arrangements in place for delegation, it was evident that a range of themes were common to all. This paper therefore outlines the common themes that emerged from the engagement discussions.

6.1 Demographic Changes and Models of Care

The health and social care workforce in NI, with an aging population and growing demand for services, needs to evolve, ensuring that workforce plans are responsive to future demand for health care services, including the role of delegation within that plan. People also now expect delegation to be used in support of wider life choices in preferred places of care, to ensure a sustainable model of interprofessional and interagency care. The pattern of more complex care being delivered at home and people living longer is an important factor contributing to a range of strategies, including the wide-ranging reform that is taking place under the auspices of strategic reform boards across both adult and children's services. The programme for reform therefore has the challenge of ensuring that learning and understanding gained from projects such as this on health care delegation, finds its way to, and connects with decisions being made about models for care delivery and commissioning of services, alongside adequately equipping the workforce tasked with providing the care safely, effectively and with compassion.

It has been acknowledged that much work is being done to ensure that future models of social care take account of changing demography and expectations of the person who is in receipt of that care. The stakeholders in this review discussed the important

principle of primacy of home as the desired care setting and how strategic issues can sometimes conspire against this, such as withdrawal of pharmacy support for Monitored Dosage Systems (MDS) which help to reduce risk associated with the incorrect dosing of medication by non-registrant staff. Challenges also arise where training and monitoring cannot be always easily provided for delegation to take place in homecare settings and this can restrict a person's quality of life.

There was celebration across stakeholder groups that people with a range of health care conditions which can sometimes present as 'complex health care needs', are living long enough to move across programmes of care throughout their lifespan. Some of the challenges experienced by people receiving care, and staff providing care, during transition through HSC Trust programmes of care are described under the Governance section of this paper.

Working with 'complexity' of care needs, is common across many job roles in the health and social care system, with members of the multi-professional team bringing unique skills and expertise. In some instances, delegation of health care interventions from a health care professional to a social care practitioner may be the appropriate response, enabling the right person, with the right skills to be available at the right time, in the right place. However, often the systems in place for supporting social care practitioners to work to their maximum potential within their scope of practice is challenging due to lack of understanding of regional processes to support health care delegation and/or concerns regarding meeting regulatory standards for the health care practitioner.

In this respect it is important to have clear protocols and record the decision to delegate health care interventions, particularly where challenging aspects have been considered, often described as complex care, the record should outline the basis of the decision to delegate. Based on feedback from engagement, coming to a shared understanding of what constitutes "complexity" is an important conversation for the people involved in assessing and delivering a person's care needs.

6.2 Workforce – Emerging Roles, Registration

Workforce capacity is a well-documented concern across the entire HSC system and the pressures within nursing, AHPs, social work and social care are known and are being addressed in a range of contexts beyond the scope of the task and finish group. It is however important to note aspects from the discussions with the stakeholders that directly link to or impact on the challenges and opportunities that come with delegation of healthcare interventions.

Nursing workforce

Nursing in community care settings, where much of the social care workforce operate, is often stretched beyond capacity. It is notable that whilst workforce pressures in nursing could drive up reliance on delegation of health care interventions, it was reported there is sometimes reluctance to do so, in the perceived absence of policy directives, robust governance and assurances of levels of competence within social care and adequate nursing capacity to monitor outcomes. In these discussions there did not appear to be widespread knowledge across nursing structures of the OSS circular 02/2018 which provides policy directive, and in some places, there appears to be limited understanding of the workforce developments taking place across the social care sector. Whilst there was greater awareness of the NIPEC framework across nursing, this did not always extend to its usage. It is our belief that whilst knowledge of these processes may not address all the challenges presented in health care delegation, mutual understanding of each other's capabilities and capacity are an important foundation for finding solutions to the challenges currently identified in the system.

Social care workforce

Capacity within the social care workforce is difficult to quantify as there is less stability and varying levels of training. That said, there is opportunity within the

implementation of the DoH Social Care Workforce Strategy[8] to collaborate with nursing colleagues in upskilling the social care workforce in safe delivery of routine health care interventions where the outcome has been considered predictable. This requires an individual comprehensive health care assessment and risk assessment, care planning, clarifying scope of responsibilities, to reach a position that is acknowledged and trusted by all. Stakeholders described a range of situations where routine health care interventions were delegated to social care practitioners in a safe and effective manner. More 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 health care and social care practitioners, within delegation protocols and good governance arrangements; again, this is already happening in some areas. Examples described included care provided to people living at home in receipt of 24-hour complex care packages both in adult and children's services.

Social care practitioners are not expected to make decisions outside of those delegation protocols using independent clinical judgement. It is our view that improved awareness and implementation of local delegation policies and governance arrangements will provide assurances that could help improve confidence and encourage a more collaborative culture for delegation.

Non-regulated workforce

Whilst out of scope of the project, non-regulated healthcare assistants and school classroom assistants were discussed during our stakeholder engagement, including the accountability of these workers compared to that of registered social care practitioners who work under a code of practice. We have passed the detail of this feedback to the task and finish group for redirection to appropriate workstreams for consideration.

[8] hsc-workforce-strategy-2016.pdf

The issue of staff moving out of regulated roles into unregulated roles in direct payments and community and voluntary sectors was raised by some HSC Trust stakeholders. Concerns included the risk that these staff could move into direct payment roles, where there is limited oversight of competency issues. Whilst this was reported, it is important to note that in many situations there are direct payment processes in place that provide robust reviews and ensure that PAs receive appropriate training before undertaking the delegated interventions outlined in the care plan. The HSC Trusts highlighted the limited number of contacts monitoring officers who often can't directly observe care being delivered due to capacity limitations and therefore have to rely on spot checks, thus limiting assurance.

Schools workforce

A particular concern around delegation within special schools was also highlighted and this will be shared with the separate working group established under the Delegation Oversight Group to review issues of delegation in this setting.

7. Governance and Assurance / Commissioning Frameworks

Stakeholder discussions highlighted variation in both governance, guidance, and practice arrangements where health care professionals delegate to social care practitioners employed both within the same organisation and by independent care providers. Within NI, the responsibility for social care provision sits across a range of departmental policy directorates and is delivered across all programmes of care within the HSC Trusts. Stakeholders shared the challenge of having a streamlined system and process for delegation in this context. However, it is important to note and highlight again that the regulated health care professional, as the delegator, will remain accountable for the overall management of the person's delegated health care, maintaining openness, transparency and candour. They are accountable for their decision to delegate and to undertake appropriate actions to ensure safe delegation. This is balanced with the social care practitioner taking responsibility for work

delegated to them as well as recognising and working within the limits of their knowledge, skills and experience; in line with their standards of conduct and practice. In addition, it is important to recognise the person receiving the care is also responsible for agreeing to the care provision and whose voice is critical to a quality experience.

Across the region, as previously stated, stakeholders described significant variation in the decision-making process and practice of delegation of health care interventions. They also described variation in application of the commissioning model when care is secured through a 'block contract' with selected independent care providers. In this respect providers expressed concern that there is sometimes a lack of communication about the clinical nature of the person's needs, which is required to enable assurance as to whether delegation is appropriate or not. This variation was reported by HSC Trusts across programmes of care and by independent care providers.

7.1 Assurance Frameworks

In seeking to understand the frame of reference that informs how and when delegation happens in the delivery of health care interventions, we explored stakeholder knowledge and use of the frameworks described above.

The NIPEC, *Deciding to Delegate: A Decision Support Framework for Nursing and Midwifery (NIPEC, 2019),* is the most commonly understood and used framework, though not universally so. Overall there is a general awareness that this framework exists, particularly across the nursing profession in HSC Trusts but also known by managers with a social work or allied health professional background. There was a greater degree of variation in terms of usage or application of the framework both across HSC Trusts and within Trusts across programme of care. The level of usage ranges from: the framework being used to directly inform a formal decision-making process for delegation in complex cases to; no discernible reference to the framework in any delegation process though some of the core components are considered, such as attention to the intervention, the needs of the person and the capability of the social care practitioner.

Delegation within social work is less common than delegation of health care interventions. The *Framework for delegation of complex tasks to social care workers in Northern Ireland* (Office of Social Services Circular 02/2018) is known mainly within the social work profession and rarely within nursing teams. It does not appear to be well known within the social care workforce. While the circular provides direction on delegation in social work to social care practitioners, it covers all delegation and refers to use by other professionals who may delegate a health or social care intervention to a social worker or social care practitioner and this aspect is not well known or utilised.

The NMC professional codes of conduct and practice were referenced by the stakeholders with an appreciation that these support and guide health care delegation. In particular, nurses were acutely aware of their responsibility to their code and in some instances, fear of non-compliance with the NMC code and supplementary guidance seems to steer some nurses away from defining what they were doing as delegation, and instead identify it as advice and support, outside of the guidance. Based on the feedback from staff during our engagement, this seems to occur more in settings where they could not provide ongoing monitoring of care, for example, in classroom settings, supported living, residential homes, direct payments and day centres where normally there are no registered nurses directly employed. Whilst staff we engaged with, were aware of the standards of conduct and practice for social care practitioners and their status as a regulated workforce, there appeared less appreciation of the weight of assurance that this carries alongside the NMC code for Nursing and Midwives which advises the following requirements of the registrant:

If you're delegating a task, it's your responsibility to make sure that:

- delegation does not harm the interests of people in your care;
- the task is within the other person's scope of competence;
- the person you are delegating to understands the boundaries of their own competence;
- the person you are delegating to understands the task;

- the person you are delegating to is clear about the circumstances in which they must refer back to you;
- you take reasonable steps to identify any risks and whether any supervision might be necessary; and
- you take reasonable steps to monitor the outcome of the delegated task.

The draft *Multi-Professional Delegation Governance Framework (MDGF) – Draft 2020.* (NIPEC/NISCC, unpublished) was not well known as it has not been issued, but when described in the short presentation provided to stakeholders, all parties felt that this would be an extremely useful tool in guiding and supporting local policies and procedures. It was also recognised as providing permission for delegation of health care interventions with support from policy, professional and employer domains.

7.2 Complexity and Predictability of Interventions

In addition to exploring the professional frame of reference for delegation of health care interventions, there was much debate about what constituted 'complex' and 'routine care' and the benefits and risks associated with having a regionally agreed prescribed list of interventions which could be safely delegated. The consensus arising from the discussion across sectors was that a list would be hard to define, and would not lend itself well to the spectrum, fluctuation of individual care needs and complexity of risk and unpredictability of outcomes, which could be present in some interventions. Stakeholders commented that;

"Lists of tasks for delegation is not considered helpful or appropriate, as the focus must remain on the requirement to drive for improving personalisation of care and maintaining sight of the person's needs and the importance of delegation within that. To achieve a social care outcome often delegation is a key factor."

An example often quoted by stakeholders was in relation to stoma care. It was outlined that the stoma may be longstanding and therefore care predictable,

whereas in other cases it may be a new stoma or may be associated with less well-known or new stoma products, not then lending itself well to delegation. In addition, there was variation in types of health care interventions that are considered acceptable for delegation e.g.:

> "*There is variation across Trusts, for example one Trust does not delegate any PEG feeding, and yet other Trusts are happy that this is delegated"*

Based on engagement discussions, there needs to be a shared understanding of the complexity of a health care intervention, which requires 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. It was recognised that some interventions relating to eating and drinking and eliminating are normal social activities and there was debate about what could be regarded as within the social care practitioner's role and scope of practice, especially if scaffolded by training provided or previous practice experience and on-going professional development supported within the Social Care Council's Care in Practice (CiP) framework, which is described at a later point in this paper.

Pharmacy withdrawing from provision of Monitored Dosage Systems is an issue that was highlighted repeatedly to have a major impact on the ability of social care practitioners to provide safe care.

> *"The home environment can have many distractions for care workers to be able to concentrate on administering medications correctly and there is potential for the person and their family to interfere with the medication bottles and containers.*"

As highlighted earlier in the report, complexity is a term that is commonly used in a range of contexts and working with complexity features across a wide range of job roles including health and social care. Common understanding of what is considered 'complex' is therefore important and this report would advocate for

conversations and reflection on local practices to be had across professional forums and in multi-disciplinary teams to explore 'complexity' specific to the practice context and particularly in the context of health care delegation.

Healthcare interventions can be complex or routine and can sit within the scope of roles across the multi-disciplinary team, for example moving and handling, nutrition or elimination can range right across the continuum of care and complexity, some of which require delegation and others which are within the social care role.

7.3 Independent Provider Arrangements

Independent care providers described a challenging environment of having to adapt to different practices and approaches depending on which HSC Trust was commissioning their service. In addition, the independent care providers all operate within their own scope of business, whilst many also seek to act collectively through the Independent Health and Care Providers (IHCP) association. Some advised they have different thresholds for the number of medications they will accept within a care plan, some limit to three and others up to six. For some providers, medication administration is only accepted as a delegated intervention where the medicines are provided within a pharmacy issued MSD. New challenges are emerging such as cytotoxic medications being taken at home with associated risks around correct disposal of waste. While the following interventions are often delegated to independent care providers - medication administration, stoma care, enteral feeds, continence care and tracheostomy care – there were reports of little confidence around the HSC Trust oversight and governance of this. Some HSC Trusts reported a reluctance to delegate to the independent sector because of difficulties with monitoring, especially if the provider was believed to have little or no nursing infrastructure, then often the health care interventions remained within the Trust.

"We have a sense that there is limited interest from Trusts in extending scope of delegation. The sense was that Trusts are

cautious of and lack confidence in delegating some tasks. There was a feeling that Trust staff feel safer using in house domiciliary care for more complex care delivery and that there is a reluctance to relinquish control."

When agreement is reached that care should be delegated, stakeholders expressed concern regarding of incidents where limited communication made it difficult to instigate care. For example, care plans being described and limited to an address alongside a formula stating "4x2x7", when care is required four times per day by two people on a daily basis. In some instances, no name, programme of care, age, gender, care conditions or needs were shared prior to care commencing. This seemed to happen more frequently in block contracts for commissioned care.

"This is a dehumanising approach and very difficult for social care practitioners to manage safely"

The other concerning key governance issue commonly reported was an inability to effectively escalate concerns or changing care needs especially during out of normal hours of working. Care plans did not always provide a single point of contact as outlined by stakeholders;

"In home care escalation is likely to be to a key worker who may not be a nurse and might not understand the significance of the escalation. Assessed Year in Employment Social Workers (AYE SWs) often cover out of hours periods leading to a vulnerability around cases escalated in that time period. Escalation processes to the Trust are not always robust or consistent. We are worried about the availability of a single Trust point of contact for raising concerns about care and deterioration of clients. We are often given a run around which often meant that it was easier to escalate to GP OOH and ED."

It is important to note that HSC Trusts work to the requirements of the OSS AYE Circular 2/2015 and the Social Care Council's guidance on The Assessed Year in Employment for Newly Qualified Social Workers in NI[9] alongside a range of service standards set by the Regulation, Quality and Improvement Authority (RQIA)[10]. Reporting of experiences as noted here highlights the importance of ensuring good understanding across the system of governance requirements for staff and for the services that they deliver.

Whilst the rollout of Encompass across the HSC Trusts may provide some opportunity for streamlining processes and identification and recording of delegation decisions, however, even if this becomes possible, its impact will be limited to services within HSC Trusts as the system is not accessible to the independent sector. Currently the Encompass system roll out is reported by independent stakeholders to be having a detrimental impact on communication being provided, partly due to the embedding of new systems, plus some HSC Trusts were reported to be using an Encompass light version which does not have full functionality. HSC Trusts, where Encompass implementation is at a more advanced stage are reporting improved flow of communication. Feedback indicated that it is frustrating and inefficient that the independent sector does not have some level of access to the Encompass system. The benefits realisation is recognised by stakeholders and would be extended if the system could be adopted fully across HSC sectors.

7.4 HSC Trust Arrangements

The Western Health and Social Care Trust (WHSCT) have a structured approach for agreeing permission to delegate through a delegation panel, but this is limited in the main to direct payments/children's services and complex adults' care as described below in models of care arrangements, therefore is used in small proportion of cases. Most cases of delegation do not require panel discussion and organisational cover as they are agreed using a decision matrix based on

[9] AYE-Guidance-for-Registrants-and-Employers.pdf
[10] Regulation and Quality Improvement Authority - RQIA

NIPEC guidance. The process used in the Northern Health and Social Care Trust (NHSCT), described in section 4, Models of Care Arrangements below, for tendering for complex cases, was highlighted as good practice by some stakeholders, where a mini tender process is used.

In both HSC Trusts referenced above, there was description of routine and effective multi-disciplinary working, other HSC Trusts mentioned care management models where staff work well within their distinct job roles to assess, plan and support a person's needs which may have a level of complexity. The need for multi-disciplinary working was recognised, and in many cases specified routine interventions are delegated on an on-going basis to a competent individual with arrangements in place for escalation if required. There was also a need in some cases, beyond children's services, particularly in highly complex 24-hour care cases and personal assistant care packages, for multi-disciplinary considerations of specified complex intervention to support the responsible professional in a decision to delegate.

7.5 Children's Services

The strongest governance processes described, were within children's services. In each HSC Trust representatives from children's services relied on the NIPEC Framework and decision-making matrix. A multi-disciplinary approach was described and a process whereby a risk assessment was undertaken and documented, including what aspects of care should be delegated and what could not be delegated. This helped formulate a written care plan with escalation processes to be shared with the family and provider of care.

7.6 Transitions

The HSC Trusts' described particular issues at transitions across programmes of care especially children's to adult, and from physical disability to older people's services. It was noted that people with a learning disability requiring care, remain in that programme of care across their lifespan, providing more stability.

Infrastructure and resources vary across teams in terms of the capacity to monitor and support cases. The support available across programmes of care varies with more practice educators in children's and learning disability services than in physical disability and older people's services despite the latter making up the majority of cases held by named workers.

Overall it was considered that, despite the challenges outlined, there are elements of good governance and support frameworks for appropriate delegation of health care interventions available. The desire therefore is to strengthen their application. In our discussions, stakeholders have told us that they recognise that current commissioning and contracting processes do not allow for sufficient consideration of these principles that underpin safe and effective delegation of health care. It was considered, that this undermines the safety and effectiveness of the decisions being made but with strengthening of a regional approach and use of consistent frameworks this could be addressed and improved. However, it should also be noted that transitions across programmes of care, as outlined above, present particular commissioning challenges in providing continuity of care that may include delegated health care interventions.

8. Models of Care and Delegation Arrangements

As previously noted there is variation in approach as to models of care across the HSC system and therefore diversity in approaches used to manage health care delegation decisions. Some examples of decision to delegate processes were shared, in the main this process was not clear for the majority of delegation of health care interventions across HSC Trusts and independent care providers.

The WHSCT model includes a multidisciplinary Delegated Task Panel chaired by the Assistant Director for Professional Nurse Governance and Safe and Effective Care. The panel meets on a monthly basis to consider a small number of cases where delegation may be appropriate and facilitates a supportive discussion about whether to delegate or not, the discussions are formally recorded. In doing this the Trust believes this provides organisational support to the professional in cases where the

decision to delegate is more complicated and allows for a robust multi-disciplinary discussion.

In discussion with NIPEC it was advised that registered nurses had previously raised concerns with the RCN and NIPEC regarding clarity of accountability for decision making and ongoing monitoring of outcomes, under the panel structure, and the requirement for registrants to comply with the NMC code of conduct. The panel does not make the decision, only advises and supports; the decision to delegate remains with the responsible professional. The panel is clear that it hands back to the presenting professional, who is usually a registered nurse, the responsibility and accountability for ensuring consent and safe delegation, following the multi-disciplinary discussion. The majority of cases brought to the panel are where there are conflicting issues related to duty of care and employment liabilities, and responsibilities under direct payments requiring organisational discussion and relate mostly to children and adults with complex needs living at home or when a young person is at transition stage from children to adult services. The HSC Trust described tension that occurred when there was media coverage of specific cases, and the requirement to provide organisational cover for decisions made through the panel discussion, thus driving up corporate ownership.

Cases that come to the Delegated Task Panel are not routinely reviewed unless there is a change in circumstances requiring a review of decision. The panel discuss approximately four cases per month, typically made up of two reviews, one emergency and a new case.

The majority of decisions made by staff to delegate don't 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.

A key benefit of the panel described by the HSC Trust staff as part of the engagement process, is the multi-disciplinary and shared advice and support for the decision, thus creating a permissive culture for safe and appropriate delegation with a focus on

personalisation of the need/ask as opposed to scope or limitations of the intervention. The panel has built a collective body of knowledge and experience of complex issues associated with delegation and how these might be addressed or resolved. This is beneficial for both positive decisions to delegate and instances where delegation has not been supported. The process brings a collective opportunity for combining organisation and professional responsibility and accountability.

The NHSCT, explained their structure for 'complex care plans', how a nurse is involved in: the assessment/risk assessment, development of the care plan in collaboration with the agency delivering the plan; agreeing costs; resources required; and is involved in the training and subsequent support and monitoring of the package. This is used only in the most complex cases where there is a significant amount of health care being delegated. In this process, following a needs assessment by the district nursing sister there is a conversation with the operational line manager and the professional nurse manager to discuss and determine the best option for care delivery. Interventions are differentiated into health care and social care interventions with the community nurse retaining accountability for health care interventions delegated.

In terms of common process across the region, most described social workers as writing the care plan. In specific aspects of the care plan it can become somewhat confused as to who is delegating, this was debated within engagement meetings and felt that it was not always clear. For example, in the case of enteral feeding, it was debated whether it is the enteral feeding co-ordinator or the nurse. Some HSC Trusts described how health care is being delegated, which can sometimes be through social work lines due to organisational structures and it was reported that issues may sometimes arise in recognition of changed clinical risk and the need for escalation.

When health care interventions are required, some HSC Trusts only commission from agencies who have a nursing infrastructure, although it is acknowledged that the extent of nursing support they provide may not always be known. Lists of interventions for health care delegation are not considered helpful or appropriate as the focus must remain on the requirement to drive for improving personalisation of care and maintaining sight of the person's needs. This was highlighted in the context of

recognising the potential importance of health care delegation in achieving this for the individual receiving care. To achieve a social care outcome as well as meeting health care needs, often delegation is a key enabling factor.
Some Trust stakeholders discussed concerns about confusion around what delegation is and their accountability therein. This particularly related to care provision by direct payment workers and classroom assistants and tended to occur in cases where no robust or ongoing monitoring was provided.

A major issue for all of the stakeholders is lack of regionalisation of processes and structures related to care plan documentation, commissioning models, tariffs, training and interventions that are deemed social care versus health care. For example, in one HSC Trust, older people's care plans go through brokerage but mental health and learning disability programmes of care don't follow the same process. It is again worthy of noting in the context of the lived experience of staff in informing the much needed and welcomed programme of reform.

9. Education and Training

Education and training are a critical component of delivering safe and effective care. The NMC standards of proficiency for registered nurses prepare nurses to "safely and effectively lead and manage the nursing care of a group of people, demonstrating appropriate prioritisation, delegation and assignment of care responsibilities to others involved in providing care". The recently launched DoH Social Care Workforce Strategy 2025-2035[11] and the CiP framework[12] in December 2024, introduced new standardised entry level training for people coming into the social care workforce. The CiP framework also provides pathways for both formal qualifications alongside professional development opportunities. Whilst significant improvements have been achieved in recent years with regard to the qualifications profile of the social care workforce it remains that basic induction training varies across statutory and independent sectors. The introduction of the Level 2 Certificate in Safe and Effective

[11] https://www.health-ni.gov.uk/publications/social-careworkforce-strategy-2025-2035

[12] Care in Practice Framework: A framework to support career progression for the social care workforce - NISCC

Practice within the CiP framework provides the opportunity for, and assurance of, a common baseline on which to build training and learning for more specialised competence. It is critical therefore that the implementation of the social care workforce strategy in this regard is rolled out across both statutory and independent sectors. This will of course require both time and investment for such impact to be realised across the system and a collaborative approach to managing expectations and current need is an important part of the developmental journey.

Some stakeholders both within HSC Trusts and independent providers, whilst recognising integrated structures of the care system, described a reluctance to delegate health care interventions, based on lack of confidence in the training level of social care practitioners,

> *"In an integrated health and social system there would be more delegating and commissioning where there is confidence in the training of social care practitioners."*

As previously noted, there is a need to improve awareness and understanding of the 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, will strengthen both competence and confidence. It is important for senior leaders and managers, as well as operational managers, to be aware of and support implementation and embedding of the framework into practice.

Specific training on understanding delegation of health care interventions is limited, with some provided by RCN for nursing registrants over the 24/25 year and a few pockets of training in provider organisations. The HSC Leadership Centre provides a short multi-professional awareness raising programme, Demystifying Delegation. Whilst generic in nature, it references the NIPEC framework and the OSS circular and supports the principles therein. This programme however, is only accessible to HSC Trust staff. HSC Trusts describe an over-reliance on E-learning for training provided to social care practitioners which does not afford opportunities for direct skills-based training.

One HSC Trust sought to balance this by introducing some group face-to-face training with sign off for attaining competency with individualised follow-up training on the specific needs of the particular individual, recognising that within health care delegation, training should be delivered by a person who is competent to carry out the intervention themselves. This approach requires intensive resources, both for a physical facility to undertake this training and availability of trainers and assessors. It is accepted that some clinical scenarios are difficult to simulate such as choking, replacement of dislodged tracheostomy, and administration of rectal diazepam and therefore on-site one to one training and assessment is required. It is also recognised that where there are interventions required such as tracheostomy care for particular individuals training can be delivered to a group covering theory with this supplemented by supervision with the person in receipt of care.

An audit undertaken in one HSC Trust demonstrated that there is a gap between perceived and actual knowledge of health care delegation and that following education there was a significant increase in understanding of risks; staff confidence and intention to document decision making. Stakeholders would welcome an accessible learning resource on health care delegation that provides a consistent body of knowledge for all.

The independent sector highlighted that they do not have access to the HSC learning platform which would improve standardisation of training. They also noted that they aren't resourced for training in the same way statutory services are and have issues accessing enough training licenses. Whilst this is a general perspective it, in effect, has impact on training required for developing an understanding the principles of health care delegation and skills-based training for specific interventions. It is important for the system to come together in this respect and look for opportunities and solutions that will improve access to standardised awareness raising and training on the principles of and requirements for safe delegation as well as skills-based training for healthcare interventions that may be approved for delegation. This does not negate the employer's responsibility, in commissioned services, to provide appropriate training, development, support and supervision specific to the needs of the individual in delivering safe and effective care.

Within HSC Trusts many stakeholders referred to the benefits of practice educators, within for example, learning disability, children's and physical and sensory disability services where training can be provided to social care staff, supporting the growing complexities of care needs as people live into older age. This resource is limited and not universal across programmes of care and is not available to the independent sector.

There appears to be a more consistent approach to education within children's services where there is often theory-based and practice-based training, including the competency being first demonstrated by the registrant, followed by observation and assessment of the competency in practice by the social care practitioner, prior to documented sign off. This process is used whether it is for in house staff, third party, or for education staff. In adult services usually, training is delivered by the delegator or the independent care provider's nursing staff who sign off the competency. It will be important for the Social Care Council to work across the statutory and independent sectors to ensure the CiP framework recognises and supports the diversity of this range of training provision. It is also important to recognise that the CiP framework will seek to balance training on health care competencies with core social care competencies that support the unique and specific role of the social care practitioner.

The CiP framework was discussed in terms of the opportunity and potential that it might present for social care practitioners to develop relevant practice experience, knowledge and skills that may support them when being considered to undertake delegated health care interventions. It is important to be clear at this point that there is no requirement for social care staff to hold qualifications, and the new Level 2 Safe and Effective Practice certificate, which addresses mandatory training requirements is for new staff entering this workforce. It is also important to note that a significant proportion of the social care workforce already have relevant practice-based knowledge and skills developed through practice experience and in-service training, as well as a significant number who have attained relevant Level 3 qualifications.

Stakeholders agree that it is important for this existing knowledge and expertise to be known, recognised and valued across the health and social care system. It is recognised that not all social care practitioners will choose to take up further training and that the accreditation of prior learning and experience should be recognised to its full potential. When discussed, it was agreed that there is an appetite to develop further the social care workforce, in both the statutory and independent sectors, with a recognised and accredited level of competence. This could drive up professional confidence in delegating a range of health care interventions, supporting the majority of delegation where care needs are stable, and affording more choice to people in terms of living with independence and autonomy. 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 health care risk and unpredictability and requirement for professional monitoring.

10. Conclusion and Recommendations

It is clear from our engagement that one of the key issues that sits at the heart of effective delegation of health care interventions is the need for mutual respect and understanding of each other's roles and the potential for supporting a person to live their life in a way that optimises their wellbeing and allows for them to partner in the choices being made about their care and the support that they require. In order to achieve this, it is important to have a culture of collective leadership and responsibility that is embedded throughout the health and social care system. For the delegator: having the confidence to delegate health care interventions is as important as having the competence to make that decision. Equally important for the delegatee, is having the confidence to accept a delegated health care intervention alongside the competence to deliver that intervention safely and with good care. The person receiving the health care, needs to know and trust that these two people are working in partnership, with knowledge, skill and permission to do so. It is in these circumstances that safe and effective delegation can help to make care better.

The findings outlined and discussed above indicates that delegation of health care interventions to social care practitioners, whilst happening on a regular basis, remains an area of contention that requires direction and clarity. It will be helpful for that clarity to come from both the centre of the HSC system and from the governance structures that sit across the operational delivery of care. In applying the principles of person-centred care, it is important for the HSC system to support participation and partnership in coming to a decision about who is best placed to deliver health care interventions and whether delegation is appropriate. This requires an approach within professions and both an organisational and professional culture of permission, support, accountability and assurance. Permission to delegate health care interventions to social care practitioners requires confidence in the capability of the social care workforce and recognition of the potential that this workforce has to offer, now and into the future, in delivering skilled and person-centred care as part of the multidisciplinary team. There is opportunity for learning from the findings of this project to inform the NMC review of delegation guidance that is currently open.

The terms of reference for this project asked for recommendations to inform a future sustainable model for delegation of health care interventions to social care practitioners, reflecting multi-professional working to meet the health care needs of people. The following recommendations take account not only of the findings from our engagement with key stakeholders but also a pragmatic understanding of existing approaches to delegation that meet professional standards of good practice and good governance. The findings and recommendations of this report are presented to the Task and Finish Group for health care delegation, to consider within the wider scope of the Terms of Reference.

Recommendations:

1. 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.

2. When published, HSC Trusts and independent care providers should undertake the self-assessment checklist and agree an action plan to strengthen professional and organisational governance arrangements as appropriate.

3. Standard protocols and tools should be developed to support a regional approach to: training, decision making, competency assessment, individual assessment/risk assessment, care planning, monitoring and escalation processes for delegation of healthcare interventions.

4. 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 MDGF, including workforce competence for safe health care delegation, clear procedures for health care delegation, good communication process and robust evaluation and monitoring systems.

5. 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 health care interventions, and drive up confidence in delegation.

6. An easily accessible regional educational resource should be developed to support understanding and application of multi-professional delegation of health care.

7. Regional approaches to delegation of health care 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.

8. The DoH review of the minimum standards for homecare (domiciliary care) agencies should reflect the requirements for the social care workforce regarding delegated health care intervention

9. Implementation of professional workforce strategies need to ensure appropriate levels of resource for training on health care delegation, monitoring of delegated interventions, and support for collaborative models of care delivery that recognise and value the contribution of the social care workforce.

Appendix One

TERMS OF REFERENCE

Delegation of healthcare interventions to social care practitioners employed by Trusts or Third-Party Organisations Subgroup 2025

Title	**Delegation of healthcare interventions to social care practitioners employed by Trusts or Third-Party Organisations, Subgroup 2**
Author	**Pamela Craig and Marian O'Rourke,**
Status	**Approved**
Version	**2**
Version issue date	**March 2025**
Review date	**May 2025**

1. Introduction

Delegated healthcare activities are sometimes called 'tasks' or 'interventions usually but not exclusively of a clinical nature, that a regulated healthcare professional delegates to a registered social care practitioner.

"Delegation is defined as the transfer to a competent individual, of the authority to perform a specific task in a specified situation." (NMC)

Evidence has shown that there is a strong argument for delegation, assuming that conditions are met such that it can be done appropriately and safely. Where that is the case, it was said to benefit social care practitioners, registered clinicians and those accessing care and support services. In particular, it can mean timely, flexible delivery of interventions and procedures, better continuity of care and more person-centred care. **(Skills for Care Research into social care workers undertaking healthcare interventions)**

Delegation for certain healthcare interventions is reportedly becoming more prevalent with the increase of people living at home with co-morbidities and more complex healthcare needs. However, interpretations of delegation of healthcare across the health and social care sector are wide-ranging and the governance structures and processes for delegation are varied.

When an intervention is being considered for delegation the Trust/provider organisation remains responsible for the person's overall management and has a duty of care requiring that a reasonable standard of care is exercised when providing support (or omitting to provide support) that could foreseeably harm others. Duty of care also includes respecting the person's wishes and protecting and respecting their rights.

Effective multi-professional and interagency governance and accountability processes are critical to facilitating safe and effective delegation that provides clarity of process and meets the needs of people using services and staff delegating care or delivering the care. The governance and accountability framework within which delegation operates needs to consider:

- Person centred approaches that put people, families and communities at the heart of health, care and wellbeing;
- Northern Ireland legislation and policies guidance;
- Professional regulatory standards and codes of conduct;
- Trust/organisational policies and procedures and contractual arrangements; and
- Collaborative workforce practice models.

Regulated healthcare professionals are regulated by statute and specifically accountable to their regulatory body, as well as to their employer. Registered nurses are guided in delegation through professional and regulatory frameworks, such as; the Nursing & Midwifery Council (NMC) The Code; professional standards of practice and behaviour for nurses, midwives and nursing associates1 (NMC, 2018), Deciding to Delegate: A Decision Support Framework for Nursing and Midwifery2 (NIPEC, 2022)

and the Royal College of Nursing (RCN) Accountability and Delegation guide 3 (RCN, 2023) along with all other existing local HSC Trust operational policies and governance arrangements. Registered social care practitioners are guided in delegation through professional and regulatory frameworks, such as: the Northern Ireland Social Care Council (Social Care Council) Standards of Conduct and Practice for Social Care Practitioners; OSS Circular 2/2018 – The framework for the delegation of complex tasks to social care workers in NI, along with all other existing local HSC Trust operational policies and governance arrangements.

This framework is intended for social care practitioners, social workers, their managers and their employers. It is also intended for use by any health and social care professional who delegates a health or social care intervention to a social worker or social care worker.

This framework states: 'The delegator is responsible for their decision to delegate an intervention to a social care worker/social worker. A professional who delegates an intervention to a social care worker is not accountable for the decisions and actions of the worker who carries out the intervention. The social care worker is accountable for the intervention that they accept to undertake and for their actions in respect of performing these interventions'.

The NMC Code (2018) sets out expectations of people on our register when they delegate to others. These requirements apply, regardless of who the activity is being delegated to. This may be another registered professional, a non-registered colleague, or a patient or carer. These expectations are that people on the NMC register be accountable for their decision to delegate interventions and duties to others and to achieve this they must:

- only delegate interventions and duties that are within the other person's scope of competence, making sure that they fully understand the instructions;
- make sure that everyone they delegate interventions to are adequately supervised and supported so they can provide safe and compassionate care; and

- confirm that the outcome of any intervention delegated to someone else meets the required standard.

Discussions have focused on potential governance challenges or variation of practice and guidance where health care professionals delegate to social care practitioners employed both within the same organization and by third party care providers.

Within Northern Ireland, the policy and operational responsibility for Social Care provision sits within the responsibility of Social Care Policy Directorate at the DoH and is (usually) operationally managed within the Social Care Directorates within Trusts. However, the regulated healthcare professional is the **delegator** who will remain accountable for the overall management of the person's delegated healthcare maintaining openness, transparency and candour. They are accountable for their decision to delegate and to undertake appropriate actions to ensure safe delegation. (the healthcare professional may include nurses, midwives, AHPs, medical staff).

2. Purpose

As part of the overall governance project structure for Delegation of Healthcare Interventions Project this subgroup will focus on the delegation of healthcare interventions to social care practitioners employed by Trusts or by third party organisations. This subgroup will not focus on delegation of healthcare interventions under Direct Payments however it will consider transferable learning for the subgroup specifically focusing on the delegation under direct payments as part of the overarching project structure**.**

3. Accountability and Reporting Arrangements

Regular updates will be provided to the Delegation of Healthcare/Nursing Interventions Task and Finish Groupon progress in achieving objectives for this subgroup, aligned to the agreed timescales of overall project plan.

4. Aim

To support the Task and Finish Group inform their overall aim to: enable people to live at home as independently as possible, 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 health care.

Specifically, to seek to understand the current model within Trusts for delegation of healthcare interventions to social care practitioners providing care and make recommendations to inform a sustainable model to meet this population needs in the future.

5. Objectives:

1. Scope the processes and structures, policies and procedures established within Trusts to support safe delegation of healthcare to social care practitioners employed by Trusts, and employed in third party organisations who provide care;

2. Work collaboratively 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;

3. Benchmark the current model against best practice standards for governance, accountability and partnership working set out by regulatory and professional bodies regarding delegation of healthcare interventions; and

4. Report to the Delegation of Healthcare/Nursing Interventions Task and Finish Group on findings and make recommendations to inform a future sustainable model for delegation of healthcare to social care workers, reflecting multi-professional working to meet the healthcare needs of people.

Appendix Two

Author Profiles:

Pamela Craig

Pamela, a registered nurse, works part-time with Nursing and Midwifery Council as the NI Regulation Advisor. Pamela is currently appointed to the HSC Leadership Centre associate list. Prior to these current appointments Pamela worked as an Assistant Director in NHSCT in a range of roles where she was AD nursing lead for regulation, education and workforce and prior to that as AD for Primary and Community Care Services. During this time delegation of complex health care required Pamela and her team of Senior Nursing Leads to develop policies and processes to promote and manage complex 24-hour care plans allowing people to live independently at home.

Marian O'Rourke

Marian, a registered social worker, was, prior to retirement, the Director of Regulation and Standards with the Social Care Council until end of December 2024. In her role as Director Marian had led work alongside colleagues in NIPEC on the development of the Multi-professional Delegation Governance Framework for Nursing, Midwifery and Social Services (Draft) submitted to DoH in December 2023. Marian and her team in the Social Care Council also led work on the development of the Care in Practice Framework for Social Care launched in December 2024 under the auspices of the DoH Social Care Workforce Strategy 2025 – 2035. Marian is currently appointed to the HSC Leadership Centre associate list.

Appendix Three

Engagement Schedule March-April 2025		
Organisation	**Person**	**Role**
Western Health and Social Care Trust	Carina Boyle	Assistant Director for Governance and Social Work Lead, Mental Health and Physical Disability
	John McGarvey	Assistant Director, Professional Nurse Governance and Safe and Effective Care
	Alison Irvine	Personalisation Development Officer
Southern Health and Social Care Trust	Michelle Grimley	SLT Disability Day Care Co-ordinator
	Maureen Roberts	Learning Disability Nurse Consultant
	Julianne Lee	Senior Manager Patient Safety
	Monica McAlister	Assistant Director Older Peoples Services
	Claudine McComiskey	Head of Service Home Care
Connected Health	Claire Scott	Clinical Governance Nurse Manager
	Rebecca Vogel Faulkner	Director of Technology & Special Projects, Senior Leadership Team
IMPACT	Barbara Campbell	Senior Improvement Coach
Northern Ireland Social Care Council	Mervyn Bothwell	Professional Adviser for Care in Practice Framework
	Sharon Foster	Professional Officer for Social Care Qualifications and Training

Belfast Health and Social Care Trust	Janine Gordon,	Divisional Social Worker
	Grace Redhill	Divisional Social Worker Social Care and MDTs
	Michelle Curran	Consultant Nurse LD
	Eamonn McErlane	Service Manager Social Work and Self-Directed Support
	Clayre Thompson	Service Manager Mental Health SW
	Gillian McAleer	Divisional Nurse Adult Social Care and Community MDTs
	Colette Johnston	Senior Manager Intellectual Disabilities
Northern Health and Social Care Trust	Amanda Williamson	Head of Domiciliary Care Services
	Ashley Ramsey	Professional Lead Nurse
	Lynne Vercoe-Rodgers	Senior Nurse Children's services
South Eastern Health and Social Care Trust	Joanna Burns	Assistant Director PCOP (Social Work Lead)
	Julie Kirkpatrick	Assistant Director Children and Young People's Health Care, Children's Health
	Barbara Tate Trainee	Consultant Nurse Learning Disability

	Lucy Laverty	Lead nurse CCN and Complex Health, Children's Health - Child Health
Independent Health and Care Providers Association	Jacqui Timoney	Member, Strabane and District Caring
	Heather Murray	Member, Optimum Care
	Alex McIntyre	Member, Optimum Care
	Heather Sleator	Associate Consultant IHCP
	Pauline Shepherd	CEO, IHCP
Leaders in Social Care Partnership	Sarah Browne	Chair, Social Care Council member.
	Alison Simpson	Extra Care
	Carina Boyle	Western HSCT
	Clodagh O'Brien	Belfast HSCT
	Claire Crawford	South Eastern HSCT
	Catherine Maguire	Social Care Council
	Paul Rooney	Social Care Council
	Mervyn Bothwell	Social Care Council
	Rita McCullough	Social Care Council

Appendix Four

TABLE 1: DECISION SUPPORT MATRIX

Assumptions:

1. Accountability and responsibility have been considered and assured.
2. A person centred plan of nursing or midwifery care is in place, based on an assessment of nursing/midwifery needs guided by appropriate risk assessments, which has been **developed and agreed** with the person receiving care. Where capacity is compromised, the plan should be guided by the person's known preferences, or by the person(s) with parental responsibility/legal guardian.
3. Processes are in place to allow immediate escalation of need or concern, should the circumstance arise.

Key:

- All green – delegate
- One or more amber and no red – professional judgement and mitigating action required
- One or more red – do not delegate

Potential for [patient/client] harm	Low Risk of Harm	Medium Risk of Harm	High Risk of Harm
Can the limits of the task be clearly described without decision making?	Clear task limits – Does not involve decision making beyond the scope of the task	Task has limits that may change within described parameters using decision support	Critical and analytical decision making necessary
Has the delegatee appropriate knowledge, skills and confidence to carry out the task?	Competent and Confident	Requiring some additional knowledge and skills development and /or expressed need for some additional supervision	Not competent and / or not confident
What level of person-centred communication to the delegatee is required?	Simple communication required about the task and expected outcome	Some complex communication required about the task and expected outcome	Complex communication required about the task and expected outcome
Complexity of care	**Uncomplicated**	**Medium levels of complexity**	**Highly Complex**
Can the task be performed in systematic steps?	Yes	Yes - some with decisions required between steps	No – critical and analytical decision making necessary between steps
Does the task require modification?	No	Some with directed decision support	Yes - Critical and analytical decision making necessary
Predictability of the outcome	**Highly predictable**	**Medium levels of predictability**	**Low predictability**
Is the outcome of the task predictable?	Yes	Predictable under certain conditions	No
Is the condition of the person receiving care stable?	Yes - Stable	Prone to fluctuation within predictable described limits	No - Unstable
Are there timely feedback mechanisms to confirm the outcome?	Yes	Yes but a delay may occur in feedback of outcome – some mitigation may be needed	No

Appendix Five

OSS Circular 02/2018: The Decision-Making Framework for the Delegation of Specific Tasks to Social Care Workers

STEP 1 ASSESSMENT OF THE TASK:

What is the task? Describe:		
Can this task only be performed by a registered HSC professional?	**Yes Do Not Proceed**	**No**
Is delegation in the best interest of the person?	**Yes**	**No Do Not Proceed**
Have you gained consent? If appropriate have you assessed capacity and the best interests of the service user?	**Yes**	**Do Not Proceed**

STEP 2 ASSESSMENT OF THE SOCIAL CARE WORKER:

Can you identify a social care worker/social worker to whom the task can be delegated	**Yes**	**No Do Not Proceed**
Does the function of undertaking the task lie within the agency/operational procedures of the employer of the social care worker/social workers? Can the procedures be reviewed to include this?	**Yes**	**No Do Not Proceed**
Does the task lie within the social care workers/social workers job role? Can the job role be reviewed to include this?	**Yes**	**Do Not Proceed**
Does the service user view the social care worker/social worker as a suitable person to carry out the task?	**Yes**	**No Do Not Proceed**
Does their employer view the social care worker/social worker as a suitable person to carry out the task	**Yes**	**No Do Not Proceed**
Is the social care worker/social worker competent and confined to carry out the task or is it feasible for the worker to become competent and confident?	**Yes**	**No Do Not Proceed**

Can you provide the worker with written procedures for the task?	**Yes**	**No Do Not Proceed**
Does the social care worker/social worker recognise and understand the limits of their competence and role authority and do they know when and where to seek further help or support?	**Yes**	**No Do Not Proceed**
Does the social care worker/social worker know who to contact for ongoing supervisory guidance, advice and support (including out of hours)?	**Yes**	**No Do Not Proceed**

STEP 3 ASSESSMENT OF THE TRAINING REQUIRED:

Has the training required been identified for the specific task to be delegated?	**Yes**	**No Do Not Proceed**
Can the required training be provided to the social care worker/social worker?	**Yes**	**No Do Not Proceed**
Has the social care worker/social worker been assessed and confirmed as competent to undertake the task?	**Yes**	**No Do Not Proceed**
Are there confirmed arrangements for on-going support of the social care worker/social worker?	**Yes**	**No Do Not Proceed**
Are there arrangements for updating the training and on-going reassessment of competence of the social care worker/social worker?	**Yes**	**No Do Not Proceed**

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