



# **A Desk top Review to Identify a Set of Principles to Govern Decision Making in Self-Directed Support**

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## **Executive Summary**

In recent years Self-Directed Support (SDS) alongside related policy initiatives such as Direct Payments (DPs) has been among the most significant developments in welfare provision in the UK and internationally. SDS and DPs are considered key components of the move towards 'Personalisation', which has been defined as a way of thinking about health and social care that puts people at the centre of the process of meeting their needs as an alternative to traditional 'top down' directly provided approaches to service delivery. Current SDS policy, which incorporates DPs, began to be rolled out in Northern Ireland in 2015. The main aims of this desk top review were to identify national and international approaches to governance arrangements for safe delegation of health and social care tasks and duties by registered professionals to service users and carers within SDS arrangements to support person centred care and provide case studies to exemplify these approaches.

The following summary outlines the main findings from the desk top review. It was found that there was a general acceptance within the literature that SDS and related initiatives can offer service users and carers greater control, choice and flexibility over the services they receive to meet their needs than traditional directly provided services. Whilst progress has been achieved, it is evident that the prevailing climate of austerity, and recent cutbacks in service provision have tended to limit the take up and impact of SDS and Personalisation. It has also been argued that traditional 'top down' models of health and social care delivery are unsuitable for developing person-centred practice and that achieving effective implementation of SDS requires total system transformation and organisational culture change (Rowlett, 2019). It was found that the type of positive risk taking associated with SDS that can lead to increased service user choice and the growth of local community based 'bottom up' service development was a, 'difficult culture shift' for organisations and professionals given their responsibilities for safeguarding (Glendinning et al, 2008b, p.33).

The findings indicated that many registered health and social care professionals had a range of concerns about the implementation of SDS including anxieties about safeguarding, risk of financial abuse and clinical concerns about the potential for harm and negative impact on service quality. It was evident that concerns about such risks have raised anxiety and created uncertainty among practitioners about

their professional accountability and legal liability and fuelled fears they will be personally blamed if things go wrong. It was also understood that anxieties about risk have been a significant factor affecting practitioner attitudes to SDS, which has led to risk averse practice and a reluctance by some social work and nursing staff to delegate health and social care tasks to non-registered individuals including carers and personal assistants. The findings indicated that empirical research focusing on the risks associated with SDS has been limited and there was a need for further in-depth study in this field. While there is no clear evidence of increased risk resulting from the introduction of SDS, neither is there evidence that none exists and in consequence the review highlighted the need for close monitoring by organisations of the implementation of SDS.

In the absence of clear evidence from research it has been argued that government guidance about principles and practice protocols can help reduce confusion and uncertainty surrounding risk in SDS and the barriers presented for practitioners (Manthorpe et al. 2011, p.34). The review found a number of recent case examples of sets of principles and guidance protocols developed both for specific groups of registered professionals including nursing and social work staff and other examples designed to be applicable across disciplines in different parts of the UK. Although they do not explicitly address or provide guidance for delegation in the context of SDS, most case examples tend to identify general principles to inform decision making. The review also found two case examples that outline sets of principles explicitly designed to address the specific requirements of SDS. Both of these examples highlighted principles considered to be more consistent with SDS philosophy and the type of 'positive risk taking' or 'risk enablement' it is felt organisations and registered professionals need to adopt to engage service users and carers in this process.

Overall, the findings indicated that decision making and delegation by registered professionals in the context of SDS is a relatively new field of development in which principles and guidance protocols remain to be fully developed and researched in relation to their effectiveness in addressing risk and ensuring peoples' safety. Alongside clear principles and guidance protocols designed in collaboration with service users and carers the findings suggested that the development of local risk enablement panels could provide effective operational frameworks for supporting

health and social care practitioners in making decisions about delegation in the SDS process, particularly in complex individual situations involving significant risk.

# **A Desk top Review to Identify a Set of Principles to Govern Decision Making in Self-Directed Support**

## **1.0 Introduction**

1.1 This review was undertaken as part of a wider project to ensure that the process of delegation by registered health and social care professionals in Northern Ireland was consistent with the requirements of professional codes and standards and supported the highest possible level of service user/patient safety. The main aims of the desk top review were to:

- Identify national and international approaches to the governance arrangements for safe delegation of health and social care tasks and duties that are delegated from registered professionals to service users and carers within Self-Directed Support (incorporating Direct Payments) arrangements to support person centred care;
- Provide case studies to exemplify these approaches.

1.2 In addition, it was agreed with NISCC and NIPEC representatives who commissioned the project that the review would:

- Focus on self-directed support covering Adults and Children and include the following domains: Safeguarding Risks, Financial Risks and Clinical Risks and Risks to Quality of Care;
- Identify a set of Principles to govern decision making in relation to the delegation of tasks;
- Consider national and international literature with a primary focus on literature and examples drawn from the UK;
- Consider information from a range of health and social care professions.

1.3 The report outlines the data sources and search strategy applied in this review. The study presents an overview of the main characteristics of self-directed support and associated initiatives including direct payments, which have become key components of the movement towards Personalisation in health and social care in both the UK and internationally. Together with

highlighting the positive opportunities and benefits for service users, carers, practitioners and organisations offered by self-directed support, the main challenges facing the effective implementation of this policy are summarised. This is followed by an analysis of issues of greatest concern highlighted by registered health and social care professionals in implementing self-directed support and delegating tasks and duties to service users and carers including non-registered professionals. The discussion considers different domains of risk for both practitioners and organisations including those relating to safeguarding, financial probity and clinical/quality of care matters.

- 1.4 The final section presents an analysis of case examples of sets of principles across disciplines and UK regions that have been developed to govern decision making in relation to the delegation of tasks and duties. The analysis explores similarities and differences between case examples and identifies sets of principles considered to be more consistent with the philosophy of self-directed support including promoting risk enablement and supporting person centred care. The review concludes with a brief discussion of additional measures health and social care organisations may need to consider in order to operationalise self-directed support in practice and achieve an appropriate balance between risk enablement and ensuring safe practice.

## **2.0 Data sources and search strategy applied in the desk top review**

- 2.1 Several methods were used in this desktop review to identify relevant studies and contextual material: A search was undertaken of on-line bibliographic databases including Social Care Online, Applied Social Sciences Index and Abstracts (ASSIA) and PubMed. Searches were also carried out using relevant UK government websites including the Department of Health & Social Care (England), Department of Health (Northern Ireland), Health and Social Care Integration Directorate, (Scottish Government), Health and Social Services (Welsh Government). Various terms are used in the literature to describe policy and practice relating to self-directed support and the issues and principles relevant in this context to delegation of tasks by professional health and social care staff. Consequently, the search queries consisted of terms and combinations of terms considered to best describe the aims of the desk top review including Self-Directed Support, Direct Payments, Personalisation, Principles, Decision Making and Delegation. In order to ensure the review was as comprehensive as possible a manual search was also undertaken of 4 journals: *Health and Social Care in the Community*, *The British Journal of Social Work*, *Journal of Integrated Care*, and *The Journal of Adult Protection*.
- 2.2 The initial search retrieved a very large volume of academic journal articles and policy documents relating to personalisation, direct payments and self-directed support. The search also retrieved an extensive body of documentary material from health and social care organisations in different parts of the UK that was relevant to the aims of the study including general principles and guidance protocols relating to delegation by registered professionals. A review of abstracts, and where appropriate, the initial pages of documentary evidence, indicated that empirical research on delegation, decision making and the application of principles by registered professionals in self-directed support including risks associated with practice in this field was more limited.
- 2.3 Given the short length of time available to conduct the desktop review a pragmatic decision was taken to prioritize the following material as most relevant to the stated aims of the review:



- Published academic and documentary sources that highlight key practice issues for registered health and social care professionals involved in implementing self-directed support and direct payments within the UK context.
- Published documentary sources which identify principles and guidance for implementing self-directed support and direct payments.
- Whilst the study references international sources where appropriate, the review primarily focuses on literature and case examples from within the UK context.

#### 2.4 The following material was generally excluded:

- Academic and documentary sources prior to 2000.
- Source material and studies relating to self-directed support and related matters not published in English.
- Research and documentary sources not directly relevant to the aims of the study.

To fulfil the aims of the review a total of 71 papers were analysed.

### **3.0 Findings**

#### **3.1 (*Self-Directed Support (Incorporating Direct Payments)*)**

3.1.1 In recent years Self-Directed Support (SDS) alongside related policy initiatives such as Direct Payments (DPs) have been among the most significant developments in welfare provision in the UK and internationally (Rabiee et al., 2009; Lymbery, 2014; Pearson, 2017; Stevens et al., 2018). The main strategic policy driver in Northern Ireland, 'Transforming Your Care', underlines the importance of promoting SDS and DPs as part of health and social care reform (DHSSPS, 2011). Whilst DPs have been available in Northern Ireland since the 1990's (DHSS, 1996), successive government policy and legislative initiatives including the Carers and Direct Payment Act (Northern Ireland) 2002 have sought to encourage take up of opportunities for service users to directly purchase services appropriate to meeting their needs. Current SDS policy, which incorporates DPs, began to be rolled out Northern Ireland in 2015 (McNeill and Wilson, 2016; HSCB, 2018). SDS and DPs are considered key components of the move towards 'Personalisation', which has been defined as a way of thinking about health and social care that puts people at the centre of the process of meeting their needs as an alternative to traditional 'top down' directly provided approaches to service delivery (Manthorpe et al., 2011; Lymbery, 2014; McNeill and Wilson, 2016). Personalisation aims to provide greater choice, control and flexibility to people who use health and social care services and puts partnership and co-production at the heart of service provision ((McNeill and Wilson, 2016; Pearson et al., 2017). Whilst internationally there are variations in terminology and sometimes labels have been used interchangeably, personalisation can be viewed as an umbrella term to encapsulate various approaches to person-centred provision including SDS and DPs (Glendinning, 2008a; Pearson et al., 2017).

3.1.2 The following definition contained in the Scottish Government's (2010) Strategy for Self-Directed Support captures succinctly the distinctions that will be used in this report to differentiate DPs and SDS and the concepts of person centred choice and control, which are central to these initiatives.

*'Self-directed support is a term that describes the ways in which individuals and families can have **informed choice about the way support is provided** to them. It includes a range of options for exercising those choices. Through a co-production approach to agreeing individual outcomes, options are considered for ways in which available resources can be used so people can have greater levels of control over how their support needs are met, and by whom. The choice may include taking a **direct payment**, having a direct payment managed by a third party, or directing the **individual budget** to arrange support from the local authority or from a commissioned provider. The choice can also be for a combination of these'. (p.67)*

- 3.1.3 While there are differences in the way SDS is being operationalised across the UK, there are broad similarities in approach and in the concepts and principles underpinning the strategic direction of service development. In Northern Ireland the current approach being taken to SDS outlined below is similar to the approach currently being rolled out in Scotland:

*(Self-Directed Support in Northern Ireland: HSCB (2018))*

- 3.1.4 *Self-Directed Support is a way of providing social care support that empowers individuals to have informed choice about how support is provided to them with a focus on working together to achieve individual outcomes. Self-Directed Support enables individuals to choose how their support is provided and gives them as much control as they want over their Personal Budget.*

*An individual's personal budget can be:*

- i. Taken as a Direct Payment,*
- ii. A Managed Budget (where the Trust holds the budget, but the individual is in control of how it is spent),*
- iii. The Trust can arrange a service, or*
- iv. You can choose a mixture of these options –*



*How does it work?*

*The introduction of Self-directed Support means that once a Trust agrees that an individual needs social care support they can work together with their key worker to agree how care is provided, that best meets their assessed needs. If the person you care for needs help to organise their support they can ask the Trust, family members or a friend to help with this.*

*HSCB (2018, p.1)*

### 3.1.5 Opportunities and Challenges

The review of the research literature indicates that across the UK and internationally SDS and related person centred initiatives tend to offer not only similar opportunities but also present similar challenges to health and social care organisations and registered professionals seeking to implement them (Simon-Rusinowitz, 2007; Putters et al., 2010; Steketee, M. 2013; Pearson et al., 2017). Together with acknowledging the many potential benefits of SDS the literature highlights the complex organisational, financial and professional challenges, including ensuring service user safety, that surround translating policy into practice and achieving effective implementation of these initiatives in both adult and child care services (Slasberg, et al., 2014; Stalker, et al., 2015; Wilson and McNeill, 2016; Eccles, and Cunningham, 2016). The evidence indicates that achieving effective implementation of SDS will require major change to current organisational and practice cultures in all regions of the UK.

3.1.6 It is generally accepted that SDS and related initiatives can offer service users and carers greater control, choice and flexibility over the services they receive to meet their needs than traditional directly provided services (Spandler and Vick, 2006; Baxter et al., 2008). Research studies on the impact of Direct

Payments in both adult and child care sectors have highlighted the benefits of greater control and choice in enabling more tailored support to address needs in a way that can have a very positive impact on both service users and carers' well-being (Leece and Leece, 2011; Arksey and Baxter, 2012). Netten et al. (2012), for example, carried out a randomised control trial, which reported that use of individual budgets (a variation of DPs) was associated with enhanced quality-of-life measures across a range of service user groups including people with mental health problems, learning disability and older people. Another major positive advantage of SDS is that it facilitates an outcomes-based focus to health and social care that promotes the citizen's voice in the planning, design and delivery of integrated and more citizen focused services (Netten et al., 2012; Person et al., 2017). Although take-up rates of SDS and DPs have gradually increased in the UK there has been regional variation in the extent to which local schemes have been utilised by users of services (Priestley et al., 2007; Arksey and Baxter, 2012). Recent research by Pearson et al. (2017) in Scotland found that little had changed in the type of services people were receiving and that services organised and provided through the local authority remained the dominant mode. Pearson and Ridley (2016) have observed that the prevailing climate of austerity, and cutbacks in service provision have tended to limit the take up and impact of SDS and personalisation more generally. It is also evident that a range of organisational and practitioner level issues, as outlined below, have continued to be significant contributing factors impeding development in this area that need to be addressed if SDS and related initiatives are to be further progressed.

- 3.1.7 Rowlett (2009) has argued that traditional models of health and social care delivery are unsuitable for developing person-centred practice and that achieving effective implementation of SDS requires total system transformation and culture change. Cambridge (2008), observes that, 'for organisations to become more person-centred, new methods of working at the macro as well as micro-organisational level are required' in order to achieve a fundamental shift from top-down, service-led and centrally directed health and social care provision (p. 107). A review of research evidence by Mitchell and

Glendinning (2007) observed that achieving change at this level involved a, 'a transfer of power and responsibility for managing risk away from services and organisations to individuals, service users and families' (p. 299). A report in 2009 by the Association of Directors of Social Work also observed that successful implementation of SDS, 'will depend upon a re-framing of social care and corporate practice, commissioning and service delivery' (ADSW, 2009 p3.).

3.1.8 Research evidence from the USA tends to support the view that, 'when organisations possess managerial trust, goal clarity, less red tape and less political oversight, they tend to engage in more [positive] risk-taking behaviour' (Hall and Jennings, 2008, p 700). However, Glendinning et al., (2008b) has argued that the type of positive risk taking associated with SDS that can lead to increased service user choice and the growth of local community based 'bottom up' service development is a, 'difficult culture shift' for organisations and professionals given their responsibilities for safeguarding (p. 33). A number of researchers have also asserted that the nature of risk management in this field cannot develop as a 'bolt on' to traditional systems of health and social care (Kunkel and Nelson, 2006; Glasby, 2008; Manthorpe et al., 2008). Manthorpe et al's. (2011) study of the research literature concluded that in the UK organisational systems and processes had not kept pace with the values underpinning SDS and further change was required within agencies to facilitate roll out of policy in this area.

3.1.9 At the level of individual practice, research studies in the field of personalisation across a range of countries with different service user groups have emphasized that the quality of interpersonal relationships frontline practitioners succeed in establishing with service users and their carers is a significant factor in promoting successful outcomes (O'Brien et al., 2005; Kunkel and Nelson, 2006; Manthorpe et al., 2008; Mustafa, 2008; Ottmann et al., 2009). For example, research by Ottmann et al. (2009) found that families participating in a five-year study of consumer-directed care for service users with disabilities in Australia highlighted trust, good communication and positive relationships as being instrumental in the effectiveness of the support they

received. However, Pearson et al. (2017, p.3) have noted that since, 'its inception, SDS has been described as an "evolving concept", poorly understood by many practitioners and often confused with DPs' (Ridley et al., 2011). In the UK a number of studies have reported ambivalence and scepticism among practitioners about the value of DPs as a component of government policy in promoting 'personalisation' (Leece and Leece, 2011).

3.1.10 Concerns have also been expressed by practitioners that SDS will leave service users, 'open to increased levels of risk by fragmenting the current system, dismantling current safeguards and leaving people to sink or swim by themselves' (Positive Futures, 2016). The evidence from the literature indicates that anxieties about risk and negative impact on the quality of care have been a significant factor affecting practitioner attitudes, which has led to risk averse practice and a reluctance to delegate by some social work and nursing staff (Gillen and Graffin, 2010; SCIE, 2013; Stevens et al., 2018). Stevens et al's. (2018) recent study of personalisation and DPs in three local authorities in England reported that practitioner concerns about safeguarding risks had negatively impacted on implementation. SCIE's (2013) review of research also found that staff, 'working within health and social care fragmented systems where risk management strategies are focused on protecting the organisation are also less likely to feel confident and supported in their practice' and 'may fear blame or liability' (p. 28).

3.1.11 Before turning to an examination of sets of principles and guidance protocols for decision making and delegation that have been designed to guide practice by registered professionals, minimise risk and ensure service user safety it is important to consider in more detail the nature and complexity of risk within the SDS process. Consequently, the following section presents an analysis of practitioner concerns focusing particular attention on those domains relevant to the aims of the study including safeguarding, financial risks and concerns about clinical and quality of care issues in SDS.

### **3.2 Risks and Responsibilities Associated with Delegation and Ensuring People's Safety: Implications for Registered Health and Social Care Professionals**

3.2.1 A review of the national and international literature indicates that the concerns of registered professionals (delegators) about risks associated with SDS and their responsibilities surrounding the delegation of tasks and duties to service users, carers and non-registered professionals (delegates) span a number of distinct yet interrelated domains of practice. It is important to be aware of the limitations of applying lessons from international research to the UK context as systems, structures and terminology relating to personal budgets and consumer-directed support may be different and it may not be a case of comparing like with like. Nevertheless, the evidence does indicate a number of common concerns among practitioners including anxieties about safeguarding, risk of financial abuse and clinical concerns about the potential for harm and negative impact on service quality. It is also evident from the literature that concerns about such risks have raised anxiety and created uncertainty among practitioners about their professional accountability and legal liability and fuelled fears they will be personally blamed if things go wrong.

#### **3.2.2 Safeguarding Risks**

Glendinning et al's. (2008a) research identified that a central concern for many registered professionals was how to ensure duty of care and fulfil safeguarding responsibilities whilst promoting an approach to social care design and delivery that aims to increase people's individual choice and control. This study, which evaluated the views of professional practitioners and management staff involved in implementing an individual budget pilot programmes across thirteen English local authorities, highlighted a number of potential safeguarding risks and related concerns including:

- *poorer quality services (particularly the use of untrained, unregulated PAs)*
- *budget management and employment responsibilities*
- *misuse of funds*
- *financial abuse from family or paid carers*



- *neglect or emotional abuse*
- *physical harm*
- *breakdown of care arrangements and contingency planning*
- *extent of local authority responsibility for providing back-up if arrangements fail.*

### 3.2.3 Glendinning et al. (2008a, p.33).

SCIE's (2013) review of research on enabling risks and ensuring safety reported that a significant proportion of the discussion concerning the implementation of SDS (in this case personal budgets) in England focused on concerns about safeguarding. The review identified three main factors that made the issue of safeguarding important to debates about the development of SDS and delegation by registered professionals as follows:

- The possibility of increasing risks (both positive and potentially negative) for sections of the population who have already been demonstrated to be at risk of abuse or neglect.*
- The possibility that current debates on personalisation, risk and safeguarding may make people using services and/or their families or carers reluctant to take advantage of new opportunities for independence, choice and control.*
- Risk aversion on the part of health and social care practitioners (often motivated by concerns about mental capacity and physical risk) may have implications for the implementation of SDS*

(SCIE, 2013, p.5).

### 3.2.4 Mitchell & Glendinning's (2007) research on risk perceptions and risk management in adult social care reported that studies tended to concentrate on risk in relation to mental capacity and competence of people with mental health problems, physical risks for older people, and people with learning disabilities. SCIE's (2013) review of the evidence found that a tendency to be risk averse in adhering to safeguarding processes had resulted in some frontline practitioners making decisions about DPs for people based on generalised views about the capacity or 'riskiness' of certain groups (particularly people with mental health problems) without adequate

engagement with the individual or understanding of their circumstances’ (p. vi & vii). The SCIE (2013) review also acknowledged that empirical research in this field to date has been limited and in particular there had been, ‘a lack of specific research focusing on service users’ experience of support services and how they perceive and manage risk’ (p. 49). Furthermore, it is evident that much of the attention in this field has tended to focus on adult safeguarding and there has been little research on risk in the context of use of SDS or DPs in services for children (Kelly, and Dowling, 2015; McNeill and Wilson, 2016).

- 3.2.5 It has also been argued that a mismatch between SDS and adult safeguarding policies has created problems in resolving issues in this context. For example, Fyson (2009) has observed that, although they share the same fundamental principles about the need to be person-centred and empowering, SDS and safeguarding policies have been developed within quite separate paradigms. Although empirical research remains limited, there is some evidence to indicate that, ‘as a result of systems not always joining up, fragmented guidelines and working practices may pose a risk’, to both delegators and delegates and impede the effective implementation of SDS (SCIE, 2013, p.23). For example, a research study by Alaszewski and Alaszewski (2005), which focused on person centred planning in the UK context for people with learning disabilities, found that although agencies had both empowerment and safeguarding policies, they were rarely fully integrated concluding that, ‘it is important that a common approach is adopted and a uniform approach agreed’ in these areas (p.191). Similarly, research by Hunter et al. (2012) in Scotland, which focused on three SDS test sites found that initially, ‘self-directed support and adult protection had not been joined up’ and ‘those responsible for adult safeguarding had not been engaged with the changes (p.1). Duffy and Gillespie (2009) have argued that the principles that underpin SDS, and safeguarding are not mutually antagonistic and that SDS in fact, ‘offers an ideal model for responding to complex cases of vulnerability and abuse where careful risk-management and person-centred practice are essential’ (p. 1). Indeed in Duffy and Gillespie’s (2009) view SDS can create, ‘the correct framework for preventing abuse by strengthening citizenship and

communities' and 'make life safer for people by getting them in control of their life and away from harmful environments' (p.40).

3.2.6 In Northern Ireland the Adult Safeguarding Policy: Prevention and Protection in Partnership (2015) highlights the need for careful governance in managing SDS and arrangements for DPs in the context of safeguarding and identifies the responsibilities of all those who have a role in managing or monitoring contracts:

3.2.7 *'HSC Trusts must provide advice and guidance to adults who may be at risk who are commissioning their own care, for example those in receipt of direct payments or self-directed support, outlining what they should expect from their service provider in terms of governance arrangements and good safeguarding practice'* (p. 27).

3.2.8 However, the above policy does not identify a set of principles to underpin decision making in SDS by registered health and social care practitioners nor provide a comprehensive framework to guide practice in delegating tasks and duties to service users and carers to help ensure safe practice.

### 3.2.9 Financial Risks

The evidence from the literature indicates that anxieties about the potential within SDS for increased financial abuse, fraud and corruption have been prominent concerns for both registered professionals and health and social care organisations throughout the UK and internationally. Concerns that service users will mispend their money or be exploited by carers or other service users leading to risk of harm or resulting in negative impact on their wellbeing have been summarised by Manthorpe et al. (2011, p.26) as follows:

- *Among some there is the view that extending choice may mean that people will spend public money on items or services that could be seen as 'frivolous' (perhaps because non-traditional services may be viewed as non-essential) – this could also be a problem if public opinion does not support such choices;*
- *That there are higher risks of fraud among users;*

- *That service users and carers share this worry about risks of exploitation, and that it might be carried out by other users;*
- *Fear that users' families/carers will be able to commit fraud or abuse users more easily and that insistence or guidance about checking any criminal record in respect of people directly employed by service users is not enforceable (Disclosure Scotland).*

3.2.10 In a review of the international literature Pike et al. (2016) found that in order to address the potential for fraud and minimise risk there had been a tendency for some health and social care organisations to adopt overly elaborate bureaucratic systems of SDS financial management that were complex and time consuming to operate. SCIE's (2013) review concluded that such corporate approaches to financial risk management can lead frontline practitioners to become overly concerned with, 'protecting organisations from fraud when administering direct payments. This reduces their capacity to identify safeguarding issues and enable positive risk taking with people who use services' (p.vi). Another concern was that 'top-down' approaches to financial management may dilute the aim of promoting person centred choice and control, and serve to jeopardise the successful implementation of SDS and development of local 'bottom up' initiatives (SCIE, 2013).

3.2.11 Rowlett and Deighton's (2009) case study of the financial management of DPs in Lincolnshire County Council found that in order to protect the council from fraud, 'an unworkable [audit] system had been put in place that diverted staff energies away from focusing on risk issues with individuals and working in partnership with service users to achieve health and social care outcomes' (p.135). In this case it was felt that the authority's exposure to risk could be reduced by removing unnecessary and ineffective controls and that the closer partnership working with service users that resulted created fewer problems, and in a number of cases actually helped facilitate the identification of misuse of funds (Rowlett and Deighton, 2009). Manthorpe et al's. (2011) study of SDS in Scotland reported that each of the three SDS test site areas included in the survey were actively working to reduce

bureaucracy and to make the financial processes easy and ‘light touch’ (p.5). A ‘light touch’ approach would appear to be consistent with policy in relation to the financial management of direct payments in Northern Ireland. Article 17.4 of the Carers and Direct Payments Act (Northern Ireland) 2002 (p.40) for example, states that:

*‘Each Trust should set up financial monitoring arrangements that will be required to meet **minimum agreed audit standards**, to fulfil its responsibility to ensure that public funds are spent on the intended services. CIPFA have produced guidance for Trusts on this point. Before people decide to accept direct payments, Trusts should discuss with them the information they will be expected to provide and the way in which monitoring will be carried out. **Trusts should aim to keep audit arrangements as simple and easy to understand as possible**’.*

- 3.2.12 A study by van Ginneken et al. (2012), which researched the use of personal budgets in the Netherlands, revealed some evidence of fraud although it was noted that while the frauds were not large in terms of total revenue, they, ‘were sufficiently newsworthy to stimulate public debate on the matter’ (Cited in Pike et al., (2016), p. 59 ). Nevertheless, empirical evidence from research in this area has been quite limited. Pike et al’s. (2016) recent review of the international evidence, for example, concluded that, ‘there is virtually no evidence concerning risks and cost outcomes’ in this field (p.61). Manthorpe et al’s. (2011) study had also concluded that in relation to preventing fraud there was, ‘very little evidence about the best ways to monitor SDS but there are suggestions that what is across the board ‘light touch’ monitoring may enhance risks at a number of levels’ including administration burdens and cost overruns (p.5). This suggests the need for a proportionate and balanced approach to the financial management of risks in SDS that reduces the potential for financial abuse to individuals and corporate risk to the organisation but at the same time provides sufficient flexibility for practitioners to work in partnership to empower service users to have maximum choice and control in meeting their health and social care needs.

### 3.2.13 Clinical Risks and Risks to Quality of Care

In addition to anxieties about financial risk the literature indicates that registered professionals tend to have significant concerns about delegating tasks and duties to non-registered individuals including personal assistants and carers. In recent years a number of studies have noted a global trend towards increased delegation of tasks and duties by registered nursing staff to non-registered professionals (Gillen and Graffin, 2010). Together with increased costs and lack of resources, Gillen and Graffin (2010) have observed that the, 'global shortage of qualified nurses and the ageing nursing population has resulted in a growing dependency on non-qualified (*i.e. not registered nurses*) personnel to provide certain aspects of patient care' (p.1). Throughout the UK DPs, for example, are commonly used to purchase care from non-registered individuals such as carers and personal assistants who may lack appropriate qualifications (McNeill and Wilson, 2016; Pearson, et al. 2017). A study by Leece and Leece's (2011) of DP implementation in England noted an apparent contradiction between government policy that has led to increased regulation of registered health and social care professionals and the fact that the service users can use DPs to employ staff without safeguards.

3.2.14 A number of studies have highlighted that in delivering SDS to service users registered nursing and social care staff may be involved in delegating tasks and duties that require complex nursing and personal care procedures to non-registered individuals including carers and personal assistants. For example, in a research study focusing on the use of DPs for children with disabilities many of the young people had complex health and social care needs requiring interventions by caring staff skilled in providing often quite invasive levels of personal care, such as enteral feeding via nasogastric or PEG tubes (McNeill and Wilson, 2016). Once again empirical research in this area is limited and very few studies have examined the long-term impact of SDS and DPs on clinical risks and quality of care. An international study by Ottmann et al. (2009) found some evidence that at least in the initial stages, 'consumer directed support does not increase the risk to vulnerable consumers' (p 466). Research produced by the OECD also reported that

while, 'there may be other quality problems - there is no indication of older persons being neglected when relying on consumer-directed rather than agency-based care' (Lundsgaard, 2005, p 29). Although empirical evidence may be limited, perceptions about SDS among registered practitioners remain crucial and anxieties surrounding the potential for increased clinical risk and reduced quality of care may continue to pose professional, ethical and legal challenges for practitioners and concern they will be blamed for poor practice or when mistakes occur (Cipriano, 2010).

3.2.15 It is evident that many social workers have similar concerns to registered nursing colleagues about the risks associated with the roll out of SDS although literature specifically relating to delegation is less well developed (Manthorpe et al., 2014). For example, a number of studies have reported ambivalence among social workers about the value of SDS in promoting 'personalisation' and the merits of encouraging up-take of DPs against a background of prolonged financial austerity, which may result in undermining the quality of traditional forms of service delivery (Lymbery, 2014; Brookes et al., 2015). It is evident that research in this field has tended to focus on adult services. One research study in Northern Ireland on the use of DPs with children with disabilities reported that criticisms among some practitioners (Patterson, 2010; Ellis, 2014) focused on anxieties about financial resourcing in the current climate of austerity and concerns that, as take-up increases, existing collective services will be undermined, leading ultimately to poorer quality and choice and less effective provision (McNeill and Wilson, 2016, p.3).

3.2.16 The literature outlined above provides evidence that registered professionals have a range of concerns about implementing SDS and its associated risks including those related to delegation of tasks and duties. One of the main challenges for decision making by registered professionals in this context surrounds uncertainty about how risk and 'risky behaviour' is defined as, 'whether a risk is worth taking can be viewed very differently by service users, their carers and practitioners' (SCIE, p.50). Given that SDS is still at a relatively early stage of being rolled out the empirical evidence relating to

risk, which might help to inform practitioners and organisations is also limited. Service users' perceptions about risk have been under researched and the evidence is unclear whether they share professional concerns and apprehensions or to what extent risk impacts on practice in delivering SDS. SCIE's (2013) review of research, for example, concluded that although there was no clear evidence of increased risk resulting from the introduction of SDS (personal budgets) neither was there evidence that none existed, and in these circumstances there was a need for close monitoring by organisations of the implementation of this process. In the absence of clear evidence from research Manthorpe et al. (2011) have argued that government guidance about principles and practice protocols can help reduce confusion and uncertainty surrounding risk in SDS and the barriers presented for practitioners (p.34). The next section presents a comparative analysis of case examples of guidance protocols that have been developed for practitioners and identifies sets of principles considered to be consistent with the philosophy of SDS.



### **3.3 Case Examples of Principles to Govern Decision Making in the Delegation of Tasks and Duties by Registered Health and Social Care Professionals:**

3.3.1 The following section presents a comparative analysis of case examples of principles that have been developed to govern decision making in relation to the delegation of tasks and duties by registered health and social care professionals. The review found a number of recent case examples of sets of principles and guidance protocols developed both for specific groups of registered professionals including nursing and social work staff and other examples designed to be applicable across disciplines in different parts of the UK. The section begins with a discussion of case examples that identify general principles to inform decision making but do not explicitly address or provide guidance for delegation in the context of SDS. This is followed by a discussion of two case examples outlining sets of principles explicitly designed to address the specific requirements of SDS. Both examples highlight principles considered to be more consistent with SDS philosophy and the type of 'positive risk taking' or 'risk enablement' it is felt organisations and registered professionals need to adopt to engage service users and carers in this process. The analysis concludes with a brief discussion of some further measures, including additional procedural guidance and the establishment of risk enablement panels organisations may need to consider in order to operationalise SDS in practice and achieve an appropriate balance between positive risk taking and ensuring safe practice.

3.3.2 Whilst an extensive body of literature has emerged within nursing focusing on delegation of tasks and duties by registered nursing professionals to non-registered staff, this has tended to focus on clinical risks and concerns about maintaining quality of care more generally rather than the specific challenges posed by SDS and DPs (Gillen and Griffin, 2010; Magnusson et al, 2015). For example, this has included studies concerning the implications of delegation for skills mix and role expectations, the administering of medication and perceptions of impact on quality of care delivered by health care

assistants (Gillen and Graffin, 2010; Keeney et al., 2005; Dickens et al., 2008; Magnusson et al, 2015, p. 46). Of relevance to the current roll out of SDS there has also been considerable focus in the nursing literature on the general risks associated with delegation by registered staff nurses relating to their professional accountability and legal liability in such situations. The present UK *Code: Professional Standards of Practice and Behaviour for Nurses and Midwives* emphasises the importance of delegation and is clear that staff are expected to be 'accountable for *[their]* decisions to delegate tasks and duties to other people' and must:

- 11.1 *only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions*
- 11.2 *make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care, and*
- 11.3 *confirm that the outcome of any task you have delegated to someone else meets the required standard.*

(Nursing and Midwifery Council, 2015, p.10).

- 3.3.3 Commenting on nurses' professional accountability and legal responsibilities  
Dimond (2008) (quoted in Gillen and Graffin, 2010) states that, "it is the personal and professional responsibility of each practitioner who delegates activities to ensure that the person to carry out that activity is trained, competent, and has the necessary experience to undertake the activity safely" (p. 570). Gillen and Graffin (2010) also note that although they do not specifically relate to nursing delegation in the context of SDS, the UK has developed definitions covering delegation more generally. The latest guidelines on accountability and delegation produced by the Royal College of Nursing (RCN, 2017) for example, emphasize that registered nursing delegators remain responsible for the overall management of the service user and accountable for their decision to delegate. At the same time the guidelines also state that the delegator, "will not be accountable for the decisions and actions of the delegatee" and that employers have 'vicarious

liability' for their employees – “provided the employee is working within their sphere of competence” (p.5).

3.3.4 Although guidance protocols for social workers were found in relation to delegating authority in specific areas of practice including foster care/looked after children, there were fewer examples of general sets of principles and guidelines of the type developed for registered nurses and midwives (Trafford CYPS, 2013). For example, the latest Code of Practice for Social Care in Wales (2017) outlined below contains a section outlining underpinning principles and providing guidelines to be followed in delegating tasks:

Practice Guidance for Social Workers Registered with Social Care Wales  
Delegating tasks to others: (Social Care Wales, 2017, p. 29).

*Delegation involves asking a colleague to undertake a task on your behalf. In the right circumstances, delegation can support service delivery and contribute to staff development. Although you will not be accountable for the decisions and actions of those to whom you delegate, you will still be responsible for the overall management of the task, and accountable for your decision to delegate. When you delegate a task, you must be satisfied that delegating the task complies with legal, regulatory and organisational requirements.*

*You should:*

- *be satisfied that you have the authority to delegate the task*
- *be satisfied that the benefits of delegating the task outweigh any risks*
- *be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills required*
- *pass on sufficient information about the task to the person to whom you are delegating*
- *ensure that the person to whom you are delegating has access to appropriate supervision*
- *ensure that consent is gained from the individual using services, where necessary*

- *monitor practice and intervene if the person to whom you have delegated is not able to carry out the task safely.*

3.3.5 Although the Welsh guidelines for registered social workers contain differences in wording, the principles underpinning delegation and decision making in this context are broadly similar to those for registered nurses. For example, the guidelines state that the benefits of delegation must be considered to outweigh any risks and that delegators should ensure that consent is gained from the individual services users, where necessary. A similar emphasis is placed on the delegator retaining responsibility for the overall management of the task and being accountable for the decision to delegate.

3.3.6 In Northern Ireland current NISCC (2015) Standards of Conduct and Practice for registered social workers and social care workers make explicit reference to the need to adopt a positive approach to risk taking as integral to respecting the rights of service users, ‘while seeking to ensure that their behaviour does not harm themselves or other people’ (p. 13). The NISCC Code also adopts a similar general approach to delegation to that taken by the Nursing and Midwifery Council (2015) and the RCN (2017):

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

*6.15 Recognising that you remain responsible for the work that you have delegated to other workers;*

NISCC (2015, p. 18).

3.3.7 While the NISCC Code, like the Welsh guidelines for social work delegation, also emphasize the continuing responsibility of delegators to monitor and intervene if there are concerns about safety, the guidance contains no specific references to SDS or principles that should underpin positive risk taking and delegation specifically in this context (NISCC, 2015).

3.3.8 The review found a number of recent case examples of general principles and delegation guidelines in different parts of the UK designed to be both applicable across different disciplines and consistent with established codes

of conduct and practice standards from relevant professional bodies: For example, the Welsh Governance Framework outlined below is designed to be used primarily by managers to promote more citizen focused services.

### Third Party Delegation: The required governance framework (Welsh Government, 2016)

Together with identifying the need for good governance arrangements at both individual practitioner and management levels the Framework, as illustrated by the case vignette 'JD' (below), highlights both the complexity of delegation, and the challenges and risks involved in achieving effective governance across professional and organisational boundaries.

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Where Citizen Centred Care has been achieved	
	<p><i>JD is a very sociable 22 year old who lives with her parents. She is severely disabled, a wheelchair user, has quadriplegic cerebral palsy and hydrocephalus, and has had many medical problems in the past. She also has had scoliosis, a hip dysplasia which gives her pain, and is fed using a PEG. Up until 19yrs of age, JD received respite along with support from the Paediatric Community Nursing Team. On transition to adult services a number of issues arose which denied her access to routine adult respite and adult day services. Within the existing community PEG feeding was being undertaken by paid carers, and had been for some time, however the complexity of JD's presenting needs complicated the delivery of care by social service staff. A multi-professional risk assessment and management plan was in place in readiness for JD to access services.</i></p> <p><i>The challenge for local services at the time was that Social Services did not agree that PEG feeding was within their remit and refused her access unless trained registered nurses accompanied her to respite. However there was already a recognised risk management plan in place.</i></p> <p><i>The family complained to the Ombudsman and Welsh Government resulting in the commissioning of an organisation called Kafka Brigade UK. This is an independent not- for- profit action research team specialising in organisational bureaucratic dysfunction</i></p> <p><i>The experience of the family highlighted the need to ensure a more consistent and effective approach to PEG feeding, that is centred on the needs of the service user.</i></p> <p><b>Identified Actions:</b></p> <p><i>Training to be provided for staff to undertake PEG feeding including medicine administration and routine PEG care.</i></p> <p><i>To develop a joint Service Level Agreement between health and the local authority</i></p> <p><i>Due to an inconsistent approach to community PEG feeding across Wales a review of PEG feeding practices was directed by the then the Welsh Assembly Government.</i></p>
<p><b>Outcomes:</b></p> <p><i>An agreed joint PEG protocol was formulated and is in current use. There have been no clinical incidents.</i></p> <p><i>All respite and day services staff partake in a rolling education programme.</i></p> <p><i>Independent sector care providers are checked to ensure that their staff are appropriately trained.</i></p> <p><i>Up-to-date care plans and risk assessments are in place for each PEG-using client.</i></p> <p><i>The All Wales Task &amp; Finish Group reviewed guidance and a consultation document called The All Wales Competency Framework to support Adults who require Home Enteral Tube Feeding via a Gastrostomy Feeding Tube</i></p> <p><i>Last but by no means least, JD enjoys access to a variety of community activities, local respite supported by a dedicated cohort of paid care staff specifically trained in PEG management. This is a bespoke person-centred package jointly overseen by Health and Social care.</i></p>	

3.3.9 Even though it does not directly exemplify SDS or reference what governance arrangements were in place to monitor nursing care plans this is a helpful example of how different services can work together. The following extract from the document below illustrates how the Framework is designed to

provide guidance to managers on the process for supporting, 'safe and sustainable integrated working across sectors and the governance each stakeholder requires to have in place to maintain an integrated approach to the prudent delegation of tasks to meet the wishes of individuals receiving care' (Welsh Government, 2016, p.2).

*How to use this Framework:*

*This framework is based on the current available guidance and support materials within Wales and draws specifically on the guidance that will support successful safe delegation. The Framework is designed to be used primarily by managers developing integrated working across Health and Social Care, as a self-assessment checklist. It is divided into 5 areas:*

*i. National Standardised Approach*

*ii. Health Boards*

*iii. Local Authorities*

*iv. Joint Partnership Agreements*

*v. Third Party Providers*

*Each area includes elements that need to be in place and links and references to supporting tools and resources.*

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2. Health Boards
<i>Prompts for consideration</i>
<ul style="list-style-type: none"> <li>• The registered health professional works to a job description and competencies required by the service and are supported through clinical supervision, appraisal, personal development and training plans.</li> <li>• The registered health professionals job description specifies the main elements of the role and includes the delegation of tasks to support staff both directly managed and contracted by health and to third party support staff who are supporting an integrated assessment, planning and review plan of care for an individual.</li> <li>• Tasks suitable for delegation are identified and agreed as part of the integrated assessment and plan of care. Example of a tool for identifying suitable / not suitable tasks for delegation see Appendix 1 Governance Framework for development of the Health and Social Care Support Worker Role in Adult Services 2012.</li> <li>• Example of good practice documentation within complex care delegation to delegate medication administration using a specialist technique, undertaken by Aneurin Bevan University Health Board is within Appendix 1</li> </ul>

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3. Local Authorities
<i>Prompts for consideration</i>
<ul style="list-style-type: none"> <li>• Commissioning intentions and contractual agreements that support third party delegation from NHS registered health professionals.</li> <li>• Joint integrated contract monitoring systems and processes with the Health Board</li> </ul>

3.3.10 The Welsh Framework reflects common themes in the SDS literature in emphasizing the need for an integrated approach to citizen involvement in assessment, care planning and review. The Framework also outlines the

respective responsibilities and accountability of delegators in decision making in delegation including use of professional judgement on tasks which can and cannot be delegated and the need to ensure appropriate training supervision and monitoring of delegates. Whilst the Welsh Framework makes brief reference to the need to record cost and funding/direct payments (Welsh Government, p. 6), it does not detail the principles that should underpin decision making nor provide a framework to facilitate positive risk taking by registered professionals to guide their decision making in delegating tasks in SDS to service users, carers and non-registered individuals.

3.3.11 In total, the above findings indicate the need for further development of working principles and practice guidelines for registered professionals involved in implementing the roll out of SDS and DPs. Among the significant barriers to development here as Pearson et al. (2017) have observed is that organisational cultures have tended to lag behind the rolling out of SDS policy and that the principles of, 'co-production, where the design and delivery of services are shared between the service user and provider (Barker, 2010), have so far struggled to form a part of mainstream practice' (p.2). This view is shared by Macaskill (2015) who observes that practitioners and managers in the adult care sector, for example, have continued to be risk averse and reluctant to delegate tasks because of the type of concerns about risk outlined earlier including, 'fear of error or failure not least from external scrutiny, including the media' (p.2). Arguably, such concerns about risk have tended to dominate professional and organisational guidance protocols for delegation and decision making in a way that has been unhelpful for developing a more positive approach to risk enablement consistent with SDS philosophy.

3.3.12 The case for health and social care organisations to take a more positive approach to risk taking in implementing SDS has been made in a number of recent publications, which have also identified sets of principles for practice considered to be more in keeping with SDS philosophy. For example, Positive Futures (2016) have developed a risk enablement framework to promote a more person centred and positive approach to risk taking within SDS that puts the service user at the heart of the process. The risk enablement framework



developed by Positive Futures (2016) was co-produced with service users and takes as its starting point that, 'adults seen as "at risk" often feel excluded from decisions about their lives' (Thistle Foundation, 2007). In summary the principles that underpin the Positive Futures (2016) framework includes the following:

Risk Enablement Framework Principles: Positive Futures (2016)

- See the person first - *The focus of every organisation that provides support services for individuals should be on the wishes and needs of the individual. Seeing the person first" means valuing the person as a unique individual with their own gifts, skills and capabilities. The individuals we spoke to wanted professionals to understand what is important **to** them and how they want their life to be, rather than focusing solely on what is important **for** them. This includes being involved in, and having control over, the decision making process whenever possible (p.4).*
- The right to self-determination - *Along with seeing the person first, we must also "hear" what they have to say. This will include hearing about risks the individuals deem acceptable to themselves, even if this worries family or professionals. It is important to remember that no professional or organisational risk assessment process should prevent or inhibit the individual's right to make their own decisions and to live their life in the way they choose. Again, this should be done in partnership with the individual and their "circle of support" where there is a question about an individual's ability to make decisions for themselves (p.5).*
- Work in partnership to share the responsibility for risk - *It should go without saying that partnership working is fundamental to building relationships with the people we support. On a more practical level, this involves working alongside the individual being supported, taking time to clarify details of potential risks and the individual's understanding of these, and what this will enable them to achieve. You should also be clear about your own role and what the individual and family can expect from you in the decision making process. This should also include an explanation of the risk assessment*



*process that is being recorded and who will be consulted as part of the process (p.6).*

3.3.13 The Positive Futures (2016) framework emphasizes the need for service users and carers to be fully involved with health and social care practitioners in developing SDS and person centred care and refining the processes and mechanisms for managing risk and ensuring safety. The framework also stresses the need for organisations, ‘to change culture to change practice’ and move away from a ‘blame culture’ that encourages risk averse practice to one that embraces a positive approach to risk enablement and promotes the flexibility and choice in providing person centred support envisaged in SDS (Positive Futures, 2016, p.7). Nevertheless, for registered professionals working within integrated health and social care structures operationalising SDS principles and managing risk effectively can clearly present significant challenges given the uniqueness of each individual service user’s circumstances and the often highly complex situations in which practice takes place.

3.3.14 While endorsing the need for the type of person centred approach emphasized in the Positive Futures (2016) framework, Macaskill (2014) has identified a set of seven principles based on a human rights paradigm that aim to address the complexity and practice challenges surrounding decision making and delegation in SDS. Taking into account these complexities, Macaskill’s (2014) set of principles aims to, ‘place the individual and their rights at the heart of all choices around risk’ (p.7). In operationalising these principles Macaskill (2014) emphasizes the importance of adopting a proportionate approach to assessing risk and the primacy of the individual in all decision making, which it is argued should be embedded in the, ‘principles of involvement, informed choice and collaboration which are the heart of self-directed support’ (p.7). The following table identifies how these principles might be operationalised in practice:

Principles of Decision Making and Risk Enablement in SDS based on a Human Rights Paradigm (Macaskill, 2014).

<b>Benefit</b>	<i>When making a decision all parties must seek to ensure that any restriction on the wishes of an individual should always be for the benefit of that individual.</i>
<b>Least Restriction</b>	<i>Care should be taken to ensure that any restriction on an individual should be as limited as possible and should be <b>proportionate</b> to achieving any agreed outcomes such as safety and security. They should not be 'a sledgehammer to crack a nut' but reasonable and proportionate. Risk planning should select actions which are the least restrictive of the supported individual's freedom, ability to choose and exercise control over their life and support.</i>
<b>Involvement and Participation</b>	<i>At all times of the risk enablement dialogue the wishes and feelings of the adult should be paramount albeit not necessarily overriding. The supported person should be fully involved in considering their risks and how they will be managed. If the supported person identifies the key risks alongside the professional and others then all parties will have a better awareness of the relevant risks and will be better placed to manage those risks.</i>
<b>Collaboration</b>	<i>It will also be important that an individual's carers, family and advocates are involved in the process of risk assessment and enablement whilst recognising that there may be inevitable tensions between parties when individual risk is being considered. The views of others should not, however, dominate those of the individual themselves.</i>
<b>Support and Communication</b>	<i>It is recognised that making decisions and planning around risk will require the supported individual to be assisted to understand the nature of the risk being debated and that this support should be provided in an accessible and appropriate manner.</i>
<b>Fairness</b>	<i>The supported individual should not be treated in a manner which is less favourable to any other citizen. Supported individuals are adults who have the right to make mistakes and exercise choice which others might disagree with. A balance needs to be struck between safeguarding and risk tolerance and where possible the individual should be treated in the same manner as any citizen who is not receiving support.</i>
<b>Equality</b>	<i>Every individual is unique and the characteristics that form individual identity should be recognised in all risk assessment and planning. The race and ethnicity, the religion and belief, the sexual orientation, age, gender, etc. of supported individuals will all play an important part in informing and influencing decisions around risk enablement. There is no one size fits all approach to risk planning and enablement.</i>

3.3.15 In Northern Ireland, as outlined earlier, the system of SDS provides a number of options including DPs, a Managed Budget (where the Trust holds the budget, but the individual is in control of how it is spent), Trust arranging services directly, or a mixture of these options. This means that a set of

principles and protocols to guide decision making in SDS need to be sufficiently comprehensive to encompass delegation of tasks by registered practitioners to not only service users and family carers but also non-registered professionals such as personal assistants (PAs). The latest set of guidelines for delegation of healthcare tasks to PAs produced by NHS England (2017), which apply to both adult and childcare sectors state that, 'the ability for individuals to employ their own PA or carer is one of the biggest opportunities presented by personal health budgets,' and central to, 'creating care and support arrangements that are personalised and responsive to their individual needs and circumstances (p.4 and 5). The NHS England (2017) guidelines stipulate that alongside principles of delegation local governance frameworks for delegating healthcare tasks to PAs might usefully include:

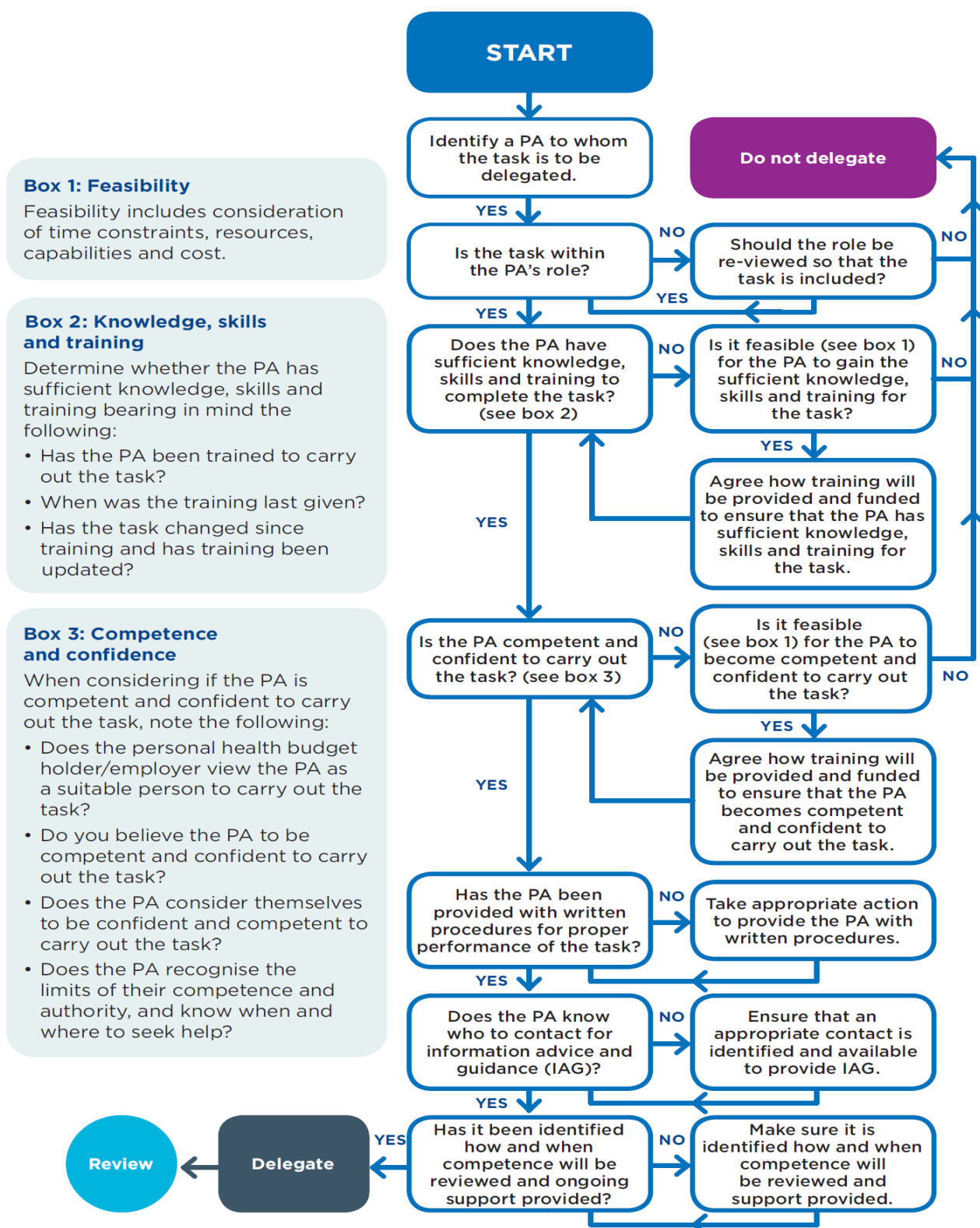
- *clarification of roles, responsibilities and accountability*
- *the process to be followed in considering delegating tasks to PAs and how decisions should be made*
- *an indicative list of healthcare tasks that might commonly be considered for delegation to PAs (it must be made clear that this is indicative only and that each decision must be made in relation to individual needs and circumstances)*
- *identification of the model of training and monitoring of PAs who carry out delegated health tasks*
- *any generic training that will be provided to PAs in core competencies*
- *identification of the related training required for each healthcare task and how competency will be assessed and signed off*
- *how ongoing support and advice will be provided to PAs*
- *the process for review and reassessment of competence.*

NHS England (2017, p.8)

3.3.16 The NHS England (2017) guidelines were informed by key learning points gained from the experience of NHS organisations involved in developing approaches to delegation and include a very useful flowchart entitled 'Delegation of healthcare tasks to personal assistants within personal health

budgets and Integrated Personal Commissioning' (NHS, 2017) to illustrate the decision-making process for delegation of healthcare tasks to PAs (See below):

## Matrix 2: Assessment of the personal assistant



3.3.17 It is important to remember that principles and guidelines for decision making and delegation in SDS remain under researched in terms of their efficacy in managing risk and ensuring safety. It has also been argued that given the potential complexity and difficulties of evaluating acceptable level of risks agencies may need (along with a set of principles and practice guidelines) to establish additional processes to facilitate decision making and the delegation of tasks depending on individual situations and what level of support service users and carers may require. Rowlett (2009), for example, has identified that possible options might range from a light-touch approach, through risk enablement panels, to a full adult safeguarding process (p.353). Risk enablement panels, which have been established in some parts of the UK, usually consist of service users and carers and all those professionals concerned with providing person centred support, risk management and safeguarding for an individual (SCIE, 2013, p. 45). The emphasis of risk enablement is on supporting positive risk taking while maintaining duty of care, facilitating shared decision making and ensuring safe practice. Tyson (2010) has argued that risk enablement panels are a constructive method of helping with challenging or particularly complex decisions that may occur as part of the support plan validation process, 'where perceptions of risk can be explored and risk-averse practice challenged' (Tyson, p 15).

## **4.0 Summary**

- 4.1 The evidence identified in this review indicates that SDS and associated policy initiatives such as DPs have the capacity to provide person centred care to services users and carers to address their health and social care needs in a way that provides choice and control and promotes independence more than traditional approaches of service delivery. The review suggests that both positive risk taking and safeguarding principles need to be an integral part of the SDS process, including support planning, review and decisions on how best to manage DPs. The evidence also highlights a number of barriers at both practitioner and organisational levels that present obstacles to the effective implementation of SDS policy. Among these barriers the review found that registered professionals concerns about the delegation of tasks and risks associated with SDS are common in health and social care organisations throughout the UK. Concerns were reported across a number of practice domains including safeguarding, financial probity, ensuring safe clinical practice and maintaining good quality of care. Consequently, in order for SDS to be implemented effectively it is important for organisations and registered professionals to achieve an appropriate balance between managing risk and promoting choice and control for service users and carers.
- 4.2 The review identified a number of case examples of guidance protocols, which included sets of principles for decision making and delegating tasks and duties that were consistent with SDS philosophy and designed to encourage risk enablement by practitioners while ensuring safe practice. Decision making and delegation by registered professionals in the context of SDS was identified as a relatively new field of development in which principles and guidance protocols remain to be fully developed and researched in relation to their effectiveness in addressing risk and ensuring peoples' safety. Also, the nature and complexity of implementing SDS in situations where each service user and carer's situation is different will inevitably continue to present challenges for practitioners in making decisions about appropriate delegation of tasks. Alongside clear principles and guidance protocols designed in collaboration with service users and carers the development of local risk enablement panels could provide effective operational frameworks for

supporting health and social care practitioners in making decisions about delegation in the SDS process, particularly in complex individual situations involving significant risk.



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