Leicester, Leicestershire and Rutland (LLR) Framework for Integrated Personalised Care

Part B - Practice Guidance

1.0 Introduction.

1.1 This Practice Guidance is for registered practitioners, commissioning staff and provider organisations engaged in the planning and provision of health and social care support to individuals.

1.2 The LLR Framework for Integrated Personalised Care supersedes the LLR Health and Social Care Protocol (2014) and is underpinned by the LLR Person-Centred Leadership Framework. It has been developed to support the undertaking of tasks on behalf of a partner agency in a way that is safe, appropriate and equitable. Therefore, the following sections are designed to facilitate constructive and effective dialogue, supported by national legislation and guidance, between partners across the LLR Integrated Care System to achieve this end.

1.3 The LLR Framework for Integrated Personalised Care is comprised of two parts:

- Part A- Management Guidance
- Part B- Practice Guidance

1.4 This Part B- Practice Guidance identifies the elements required to support appropriate delegation and aims to help registered practitioners and commissioning workers understand the decision-making process involved in safe and effective delegation of a task from one provider /organisation to another.

1.5 It is important to note that registered practitioners are professionals who are regulated by statute and so are specifically accountable to their regulatory body as well as to their employer. This guidance does not circumvent any standards for delegation set by their regulatory body, which they are required to meet (e.g. the Nursing and Midwifery Council (NMC) for nurses, midwives and health visitors, and the Health and Care Professions Council (HCPC) for physiotherapists, occupational therapists, dieticians, speech and language therapists).

1.6 A range of Statutory Frameworks and Guidance documents which underpin and inform decision making around the delegation of support tasks between

Health and Social Care, including any limitations, are outlined in Part A-Management Guidance which sets out the following principles:

1.7 Principles:

- **Care and Support is person-centred.** Discussions and decisions around care requirements will involve the person where possible and their families and carers. The principle of supporting people in their home where-ever possible will apply. To achieve this, services will be delivered in an integrated way to meet the person's health and social care needs. This will ensure that care is well co-ordinated and provides a better patient experience. This approach will provide continuity because the person will continue to have the involvement of support they are already familiar with where possible and appropriate, with a view to building system resilience and optimising health, wellbeing and independence. (Home First Principles)

- **Efficient use of resources.** Care will be delivered ensuring the best value for money; this relates particularly to call frequency and workforce skills. We will aim to utilise wider services, including reviewing any health or social care services the person is already receiving and utilising wider community services and resources, including the use of Assistive Technology.

- **Trusted assessment.** Trust is established through constructive and transparent dialogue between partners. Trusted assessment reduces the need for multiple or duplicate assessments, streamlines the experiences for people and ensures the efficient use of system resources.

- **"If you're there and competent to perform a task, then do it!"** This long-standing LLR principle supports the previous two. This is a reciprocal arrangement between Health and Social Care meaning that staff from Health may undertake some Social Care tasks and staff from Social Care may undertake some Health tasks, following appropriate training and assessment of competency. Where additional ad hoc tasks become regular occurrences, it may be necessary to re-evaluate the effectiveness of a care plan and modify a care package accordingly.

- **Timely, effective reviews of care and care planning.** A person's needs will fluctuate, and it is important to ensure that commissioned care is effective, responsive and constitutes value for money.

- **MDT decision making.** For care to be holistic and personalised the perspectives of all relevant professional disciplines should be represented in

discussions with service users and families/carers. The MDT is empowered and supported to make decisions.

- **Asset-based approach to care planning**. Commissioned care should promote independence and support people to maintain health and well-being. People should be supported to self-care wherever possible.

- **Make Every Contact Count.** All conversations present opportunities for care-givers to assess the health and wellbeing of patients, citizens and their carers; signposting and referring to appropriate services or support groups as appropriate.

- **Effective clinical governance.** There will be appropriate clinical oversight of care from the most appropriate clinical service, including specific clinical governance for the actual activity or task being delegated, either primary care or community nursing for patients in receipt of these services.

1.8 The LLR Framework for Integrated Personalised Care builds upon the best practices but deliberately avoids a defined task approach in favour of a Multi-Disciplinary Team (MDT) approach to support planning which is both person centred and an effective support of the individual in meeting their needs and desired outcomes and represents value for money.

2.0 What do we mean by delegation?

2.1 The LLR Framework for Integrated Personalised Care aims to support the undertaking of tasks on behalf of a partner agency in a way that is safe, appropriate and equitable. This is a reciprocal arrangement between Health and Social Care, referred to as ***'delegation'***, meaning that staff from Health may undertake some Social Care tasks and staff from Social Care may undertake some Health tasks. These are referred to as ***'delegated tasks.'***

2.2 The healthcare tasks that are delegated to adult social care may be delegated to social care workers who provide services to all people in all settings (i.e., people's own homes, day care centres, registered care homes, supported living units).

2.3 All staff should receive appropriate training and be assessed for competency for any delegated task that they are requested and agreed to undertake.

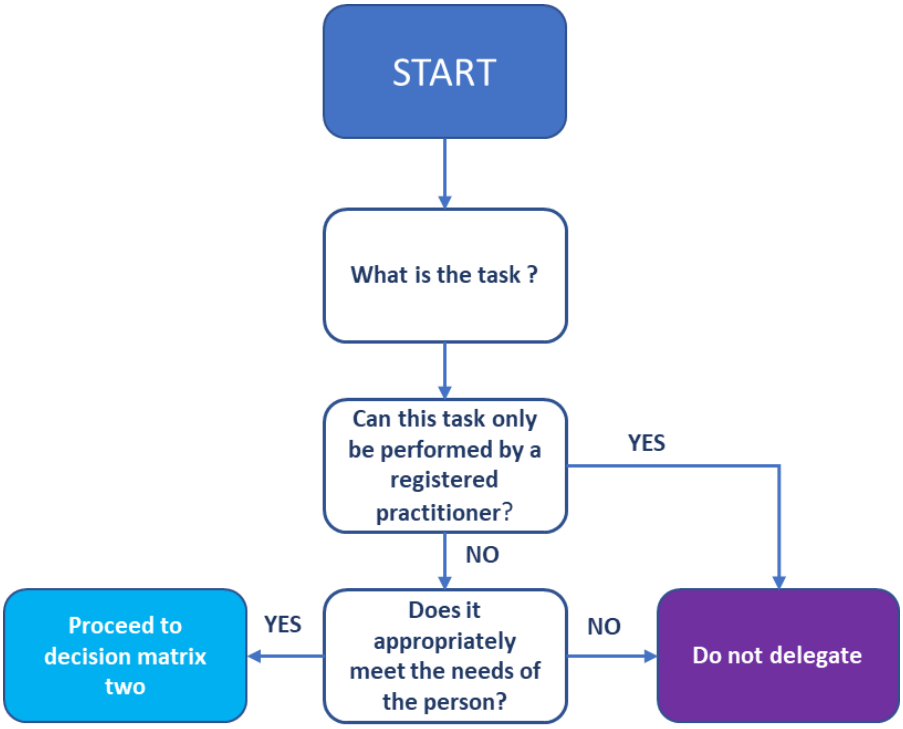
2.4 Formal clinical oversight will be maintained over the person's health needs in relation to any delegated healthcare task. Additionally, any agreed financial cost and recovery associated with a commissioned support package will be appropriately apportioned to the organisation accountable for the delivery or delegation of the said task.

3.0 A robust process for delegation.

3.1 Delegation should be recognised as something that is a considered process and properly supported. This will help ensure that the support needs of the person are always paramount, that tasks taken on by Health and Social Care workers are appropriate, and that individual workers are provided with relevant training and assessed as competent to perform the task.

3.2 The decision-making flowchart below can be helpful in thinking through the initial steps of the process:

Decision Matrix One- Can the task be delegated?



3.3 In some instances a task may not be considered appropriate for delegation, either for a specific patient or on a broader basis. Some tasks must be done by a registered nurse and cannot be delegated. Typically, these tasks might include:

- Administration of intravenous (IV) drugs
- Some complex dressings for wounds
- Insertion or removal of an indwelling urinary catheter
- Syringe drivers

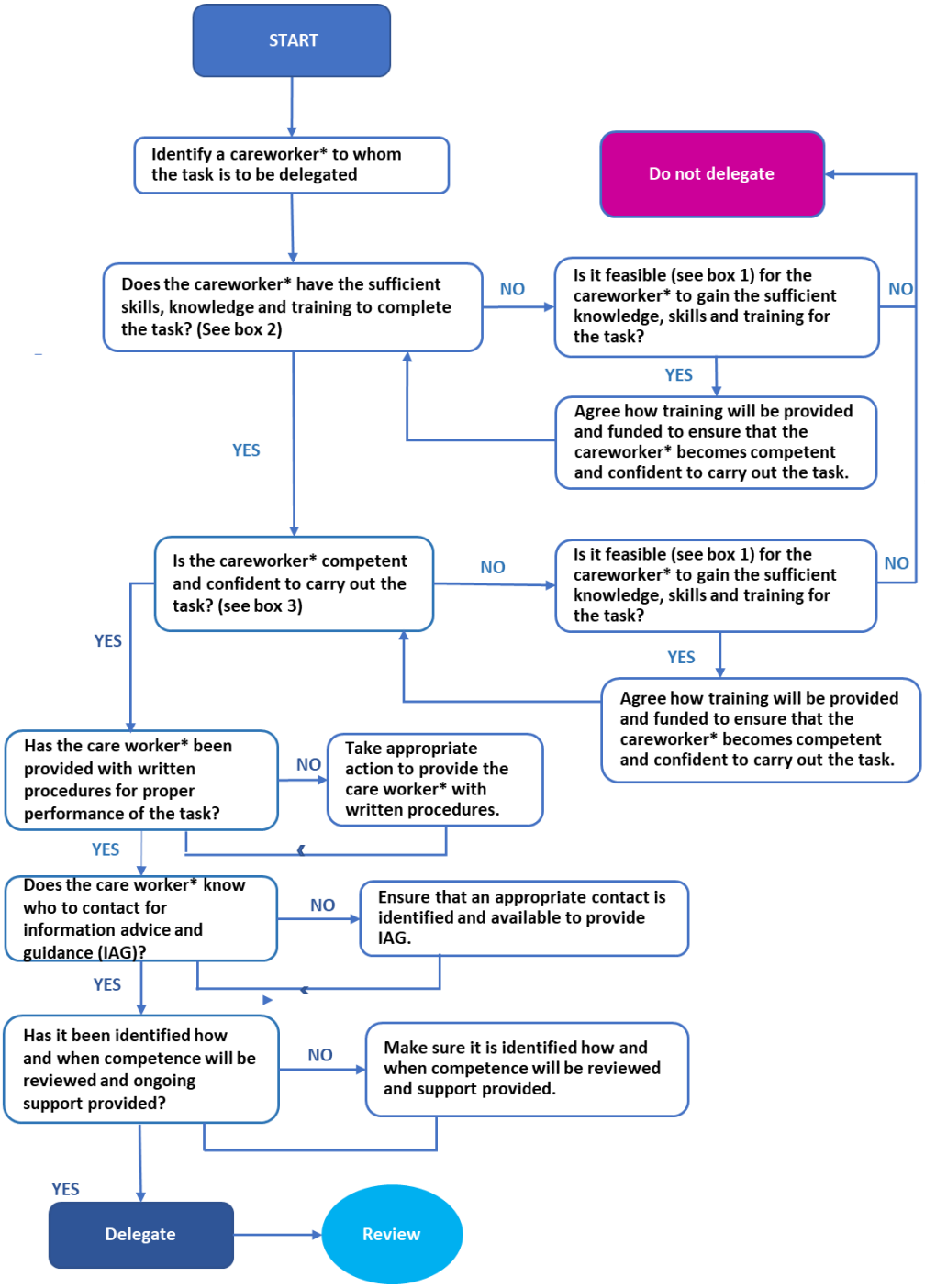
This is not an exhaustive list and there will be a corresponding range of tasks that are the exclusive remit and domain of Adult Social Care.

3.4 Whilst many care providers will be contracted to undertake delegated tasks in line with the Framework, all tasks must still be formally identified and

accepted by the provider. Additionally, competency to carry out the task safely and appropriately must be established.

3.5 The decision matrix below can be helpful in identifying the steps required to ensure clarity around the task being delegated, who will be undertaking the delegated task and assurance that they have been assessed as having the skills and competency required to do so.

Matrix 2: Delegation to Health and Social Care workers-



Box 1: Feasibility
Feasibility includes consideration of time constraints, resources, capabilities and cost.

Box 3: Competence and confidence
When considering if the care worker* is competent and confident to carry out the task, note the following:

• Does the provider organisation/employer consider themselves to be confident and competent to carry out

Box 2: Knowledge, skills and training.
Determine whether the careworker* has sufficient knowledge, skills and training bearing in mind the following:

- **Has the care worker* been trained to carry out the task?**
- **When was the training last given?**
- **Has the task changed since training and has training been updated?**

**Careworker refers to any person delivering care and support in a paid professional capacity, including staff working for Domiciliary agencies or individuals through Direct payments, Residential Homes and other building based service provision*.

worker, and clinical review of the person's needs.

4.2 The approach to provision of appropriate training and assessment of competence of care workers for delegated healthcare tasks is likely to vary from one locality to another and will need to be proportionate to the specific task. The following are the key components to be considered in order to establish an appropriate local system for training and assessment of competence:

- Identification of the healthcare tasks to be delegated.
- Identifying and agreeing the knowledge and skills required to achieve competence in each task (see 4.4).
- Development of training materials for each task.
- Identification of how and by whom the knowledge training will be delivered and assessed and the standard it will be assessed against.
- Identifying how and by whom the skills training will be delivered, competence assessed and the standard it will be assessed against.
- Identifying how achievement of competence will be recorded.
- Identifying how and when any refresher training and reassessment of competence will be provided.
- Identifying ongoing support requirements.
- Identifying a process to follow when a care worker does not achieve the required competence.
- Identifying any associated risks related to delivery of the task and providing relevant training for the care worker to know how to deliver the task safely, avoiding injury to the person and to themselves.

4.3 To support the requirements identified in 4.2 above, there are a range of Learning and Development courses available to Providers.

4.4 Tasks that can be delegated from the NHS to Social Care are categorised as either generic or specific. These terms relate to the type of training that is required to be undertaken by care workers before they are deemed competent to carry out the task.

- Generic – once the care worker has undertaken training for a generic task, they will be deemed competent to carry out that task with all and any individuals that require it.
- Specific – these are tasks that require care workers to undertake one to one training for each and every individual person before they are deemed competent to carry out that task only with the individual that requires it.

4.5 Generic training will focus on the seven tasks identified as those most frequently used by a group of service providers. These tasks are:

- Task 1 - Apply steroid based creams at above 1%
- Task 2 - Administer eye / ear drops, for individuals that need artificial tears or medication except pre or post operatively
- Task 3 - Monitor the condition of the skin where there is a risk of pressure ulcers developing and refer to a health worker if required (specific to care homes)
- Task 4 - Assist individuals to eat who are at risk of choking and where the risk is managed by a standard plan of care (e.g. thickened fluids, softened diet)
- Task 5 - Use of NHS provided equipment to lower the risk of pressure sores
- Task 6 - Manage stoma, colostomy, ileostomy and urostomy care systems
- Task 7 - Undertake blood sugar finger prick test for diabetics where included in their plan of care and take appropriate follow up action

4.6 The training will be operated and administered through LPT training. All training will be delivered by a Registered Nurse and will be competency based. Training options available to care providers consequent to the completion of the Training Needs Analysis and covid-19 risk assessment will be:

One day classroom training

This session covers the 7 generic tasks across a one-day classroom session. The competency of each delegate will be assessed through them providing a practical demonstration to the trainer. This training can be delivered in any location where a suitably sized and risk assessed venue can be provided. This will include on care provider's premises and in LPT training facilities. Wherever possible a no cost venue will be sourced.

Bitesize training

This option allows delegates to attend sessions no longer than 60 minutes during which specific tasks will be taught and competencies assessed. Which tasks are taught can be agreed through the completion of the Training Needs Analysis. It will be possible to attain competency in more than one task in a single bitesize session where generic tasks are closely associated. Delegates

will be able to achieve compliance with all 7 generic tasks through attending a number of bitesize sessions over a period of time.

It is anticipated that bitesize training will usually take place on care provider premises at a time which causes least disruption to service provision. Bitesize training may also be delivered through MS Teams as long as it is possible to check competency virtually.

Blended learning

This option allows delegates to access virtual learning opportunities, such as video presentations and e-learning. Such learning may be sourced directly through LPT or from other sources. The LPT Learning & Development Technology Enhanced Learning Team can create and edit video content as required and can also develop e-learning packages. Having accessed virtual learning, delegates will be required to undertake a competency check either face to face or through MS Teams.

Standalone competency checking

Where a delegate, or group of delegates, report through their Training Needs Analysis that they have already attained the skills required to undertake the generic tasks, they will be able to access a competency check. Skills may have already been acquired through clinical practice in current or previous roles. Rather than attend IPCF training, delegates will be offered the opportunity to demonstrate competency and if competent can be signed off as such.

Competency checks can be completed through a face to face meeting or where assessed as appropriate through virtual means such as MS Teams.

Approval of prior learning (APEL)

Where a delegate, or group of delegates, report through the Training Needs Analysis that they have previously attended other training related to the generic tasks, they will be asked to provide documentary evidence. Any evidence provided will be checked by LPT and where acceptable, this will accepted as evidence of accreditation of prior learning and the delegate can be signed off as competent. Evidence must demonstrate that competence was checked and demonstrated. Training must have been attended within the previous 3 years.

Where training has been attended, but competency not checked, the delegate will be able to submit evidence of training attended and request a competency check.

5.0 Roles, responsibility and accountability.

5.1 Accountability for delegation is a consideration for all those involved, including senior managers, registered practitioners and commissioners.

5.2 Delegated tasks will be identified and agreed through the locality MDT (usually the Integrated Neighbourhood Team). It is anticipated that the majority of these will be straightforward and appropriate, with the relevant training and assessed competency, and will be clearly incorporated into the support plan without alteration. Where the task cannot be incorporated into the support plan without alteration, the MDT will agree a new support plan, apportioning the cost of any additional commissioned time. **See Appendix A.**

5.3 A registered practitioner who delegates a task remains accountable for the appropriateness of the delegation and ensuring that the person who does the work is able to do it. They cannot delegate that accountability. However, provided the decision to delegate is made appropriately they are not accountable for the decisions and actions of the organisation or associated Health and Social Care workers to whom they delegate. The individual organisation is accountable for accepting the delegated task and responsible for their actions in carrying it out in line with the training received.

Clinical oversight

5.4 Clinical governance needs to include arrangements for ongoing clinical oversight and contact arrangements for advice and reassessment. This is particularly important where a patient's needs are known to be changing or fluctuating, but it must be in place in all circumstances.

5.5 MDT decisions to delegate tasks to social care must take account of clinical risk and the clinical record reflect the outcome decision in respect of managing the complexity of that risk-

Primary Care – for patients not in receipt of community nursing or therapy service. For tasks that do not require specific training, such as medication prompts, the Primary Care practice associated with the Integrated Neighbourhood Team that oversees the individuals assessment/support plan will retain clinical governance and ongoing oversight, as appropriate, for the delegated task.

Community Health Services: For patients who are open to this service, Community Health Services will retain clinical oversight as appropriate, for the delegated task. In such circumstances where the activity is an ongoing support need, but the patient is no longer open to CHS, arrangements will be made to transfer this responsibility to the patients Primary Care practice.

6.0 Governance.

6.1 Governance arrangements for the Framework for Integrated Personalised Care are through the Integrated Personalised Care Board (IPCB), which is a Sub-group of the Primary Community and System Design Group.

6.1 The IPCB will:

i) Receive reported issues from staff having practical problems with the use of the Framework

ii) Discuss and agree on how reported issues should be dealt with

iii) Oversee dissemination, promotion of rulings made and issue of new guidance

iv) Oversee updates to the Framework and issue and promote new versions of the Framework

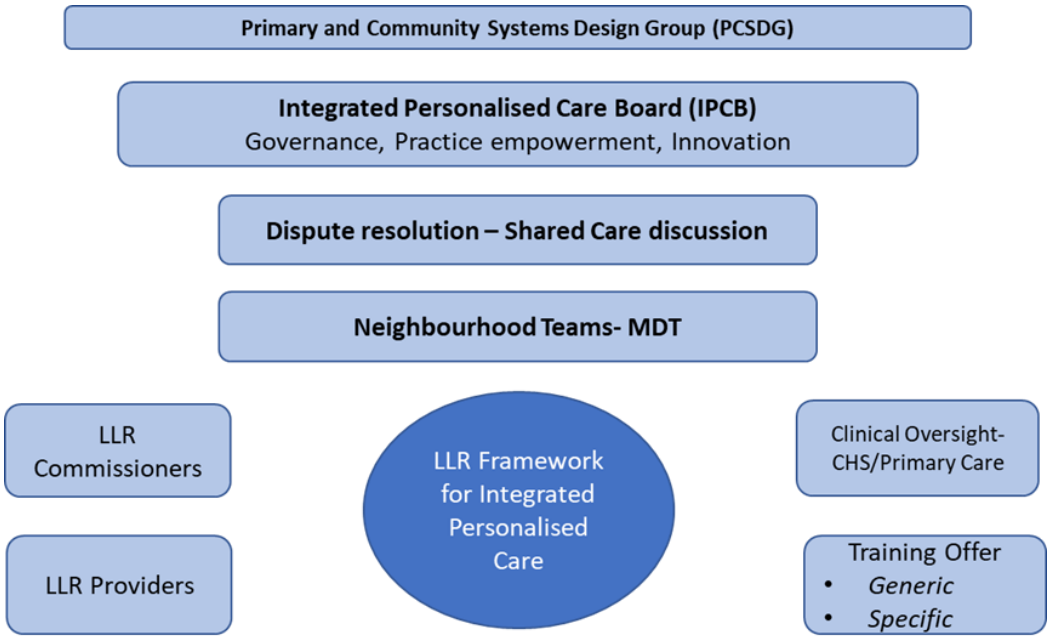
v) Monitor use of the Framework, with particular regard to its impact on the nine equality strands.

vi) Oversee training and delegation/competence sign off processes and programmes

vii) Identify new areas for joint and delegated working

viii) Receive themes from shared care panel for shared learning

6.2 Governance arrangements are illustrated below:



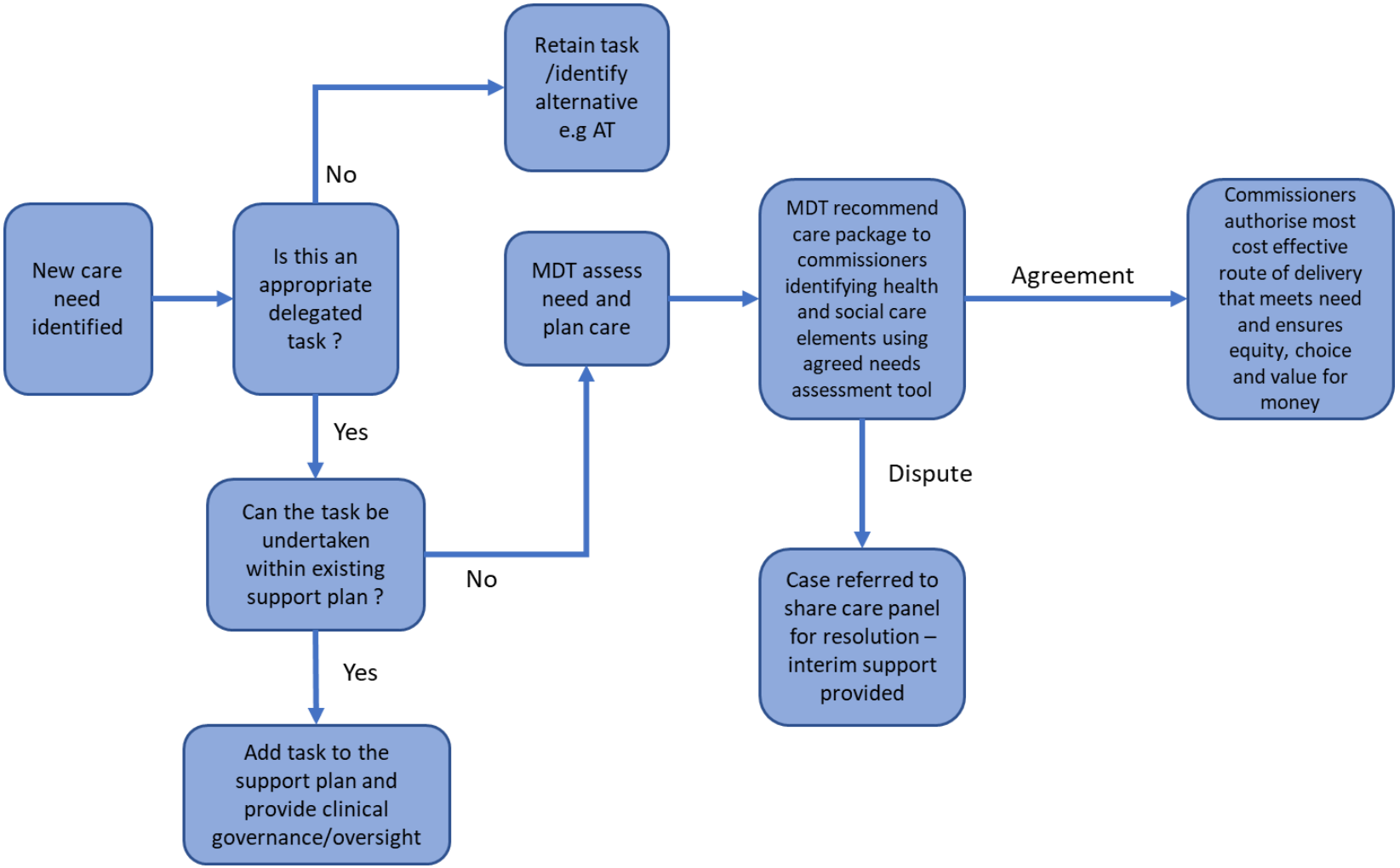
7.0 Escalation:

7.1 Where consensus around assessment or care planning has not been achieved through a meeting of the MDT (i.e. Integrated Neighbourhood Team), a Shared Care forum for MDT discussions as per local arrangements will be convened for resolution. Decisions from the Shared care discussion will be documented and shared with the Integrated Personalised Care Board, which provides overall governance responsibility for this Framework. Documented decisions will form the basis of 'best practice' to support and inform future Integrated Neighbourhood Team decision making in similar circumstances.

7.2 Where cases are joint funded, disputes will be taken via Midland & Lancashire Commissioning Support Unit using the existing LLR inter-agency resolution policy.

7.3 Where a healthcare task has been identified, care must not be disrupted and, where there is an identified gap in services, additional care will be commissioned and delivered by health services without prejudice until a funding decision is made.

Appendix A


New care need identified
Is this an appropriate delegated task ?
No
Retain task /identify alternative e.g AT
Yes
Can the task be undertaken within existing support plan ?
No
Yes
Add task to the support plan and provide clinical governance/oversight
MDT assess need and plan care
MDT recommend care package to commissioners identifying health and social care elements using agreed needs assessment tool
Agreement
Commissioners authorise most cost effective route of delivery that meets need and ensures equity, choice and value for money
Dispute
Case referred to share care panel for resolution – interim support provided

Shared Care process