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Adult Social Care: **Delegated Healthcare Activities Innovation in Practice**

South Yorkshire Integrated Care Board

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Contents

This Innovation in Practice outlines a core part of the South Yorkshire Integrated Care Board (ICB) Health and Social Care Integration Programme, and represents a system-wide approach to embedding delegated healthcare activities (DHA) across community-based care settings. The work spans home care, care homes and integrated neighbourhood teams, with a strong focus on enabling safe, effective and person-centred care. At its heart, the project responds to long-standing workforce pressures, increasing complexity of need in community settings, and the ambition to reduce avoidable hospital admissions and delayed discharges through better use of the whole workforce.

1. About the organisation

South Yorkshire ICB operates across four local authority areas: Sheffield, Barnsley, Doncaster and Rotherham, covering 36 neighbourhoods, 186 general practices, five acute hospital trusts and over 6,000 VCSE organisations. The footprint includes community mental health trusts, ambulance services and a diverse social care provider network.

Partnerships for this project

The DHA workstream has involved a wide range of partners, including:

- local authorities: Sheffield City Council, Barnsley Council, Doncaster Council and Rotherham Council
- health partners: primary care networks, Sheffield Teaching Hospitals and community nursing teams
- providers: Home Instead, Be Caring and Crossroads Care
- educational institutions: Sheffield College, Sheffield Hallam University, University of Sheffield, University of Derby and University of Lincoln
- national bodies: Skills for Care, DHSC, NHSE and ADASS
- voluntary and community sector: carer organisations and personal assistant networks.

Changes impacting the work

Recent across the board ICB structural changes and leadership uncertainty have created challenges for continuity. There is a risk of losing key individuals who hold critical knowledge and relationships for DHA implementation. This instability has slowed decision-making and delayed scalability.

To mitigate this, the programme lead is seeking support through partners to formalise business continuity of activity. Maintaining momentum and knowledge retention remains a priority during this transitional period. The current plan is for this work to be passed to key partners to continue this work and retain the intelligence source.

2. Summary of the delegated healthcare activity project

This Innovation in Practice outlines a core part of the South Yorkshire Integrated Care Board (ICB) Health and Social Care Integration Programme, and represents a system-wide approach to embedding delegated healthcare activities (DHA) across community-based care settings. The work spans home care, care homes and integrated neighbourhood teams, with a strong focus on enabling safe, effective and person-centred care. At its heart, the project responds to long-standing workforce pressures, increasing complexity of need in community settings, and the ambition to reduce avoidable hospital admissions and delayed discharges through better use of the whole workforce.

The project brings together workforce redesign, governance development and educational innovation, ensuring that delegated healthcare activities are supported by clear clinical oversight, robust decision-making frameworks and accessible training pathways. It is explicitly aligned with the national Care Workforce Pathway and the enhanced care worker role category, helping to translate national policy into practical, locally deliverable models. Rather than viewing DHA as an isolated intervention, the programme positions delegation as part of a broader cultural and system shift towards integrated working, shared accountability and mutual trust between health and social care professionals.

Initially piloted in Sheffield, the programme has been deliberately designed with scalability in mind. Learning from pilot sites is being used to inform a phased roll-out across South Yorkshire, with the intention of creating a consistent yet flexible approach that can respond to different local contexts. Alongside local implementation, the work is also generating insight and evidence to contribute to regional and national conversations about delegated healthcare activities, workforce sustainability and future models of care.

3. What inspired this approach?

The project was inspired by:

- workforce pressures across health and social care, including recruitment challenges and the need for upskilling
- the development of the 'Connecting the Unconnected' (Author Jo Cameron), a strategic, evidence-based, integrated-workforce approach using quality service improvement and redesign (QSIR) methodology
- national policy drivers, such as the Lord Darzi report 'Independent Investigation of the National Health Service in England' (2024) and 'Fit for the Future: 10 Year Health Plan for England' (2025) advocating:
  - hospital-to-home care shift
  - analogue-to-digital transformation
  - sickness-to-prevention approach.
- fragmented systems and inconsistent governance for delegation, creating barriers for providers and professionals.

4. How was the innovation developed?

The innovation was:

- built on national frameworks:
  - Skills for Care's 'Delegated healthcare activities: Guiding principles for health and social care in England' (revised November 2024)
  - Department of Health and Social Care (DHSC) Care Workforce Pathway and enhanced care worker role category
- informed by local intelligence from Sheffield College, higher education institutions (HEIs) and provider networks
- supported by QSIR methodology, which provided structured tools for stakeholder analysis, root cause identification and sustainability planning.

It was developed initially through task and finish groups focused on:

- integrated neighbourhood teams – workforce
- governance
- commissioning and re-engineering of financial flow, Sheffield City Council
- educational development and the Care Workforce Pathway
- Pilot Site 1: Be Caring/Community Nursing - prevention of falls and admission to hospital through physical activity and community nursing
- Pilot Site 2: Home Instead - non-invasive ventilation (NIV) and cough assist
- Pilot Site 3: advanced practitioner project/Care Home.

Was this a new approach or adapted from elsewhere?

The approach was adapted from national guidance but tailored specifically to South Yorkshire's integrated workforce modelling and informed by 'Connecting the Unconnected'. While the principles of delegated healthcare activities were already outlined in national frameworks, the implementation in South Yorkshire introduced several innovative elements.

These included: the creation of a shared training hub to provide real-life simulation environments for social care professionals; and the exploration/development of long-arm supervision models to facilitate healthcare student placements in social care settings, with a view to testing this approach for DHA education, i.e. teaching, competency and ensuring safe clinical oversight.

These features represent a significant step forward in bridging the gap between health and social care, making the approach both locally responsive and nationally aligned.

Cultural shift

The project emphasises cultural transformation across health and social care, fostering trust and collaboration between sectors to enable safe delegation and person-centred care.

Development and implementation steps

Task and finish groups were established for:

- Integrated Neighbourhood Teams (INT) workforce/commissioning
- governance
- re-engineering of financial flow
- educational development and the Care Workforce Pathway
- Pilot Site 1: provider/primary care/acute trust – community nursing
- Pilot Site 2: provider/Sheffield College, Sheffield Teaching Hospital/advanced practice
- Pilot Site 3: project – care home (nursing led)/advanced nurse practitioner project
- lived experience: real life – live case studies (ongoing)
- research – Sheffield Hallam University.

Pilot sites:

- Home Instead: created a training hub using grant funding for real-life simulation and development of the NIV cough assist/respiratory elements of DHA
- Be Caring: focused on physical activity, i.e frailty/prevention, supported with a Sports England initiative and Sheffield Hallam University – Physical Activity Clinical Champions (PACC) training. DHA with Sheffield Teaching Hospital – Community Nursing team modelling integrated approach in personalised care
- Care Home pilot: embedded an advanced nurse practitioner to explore DHA training alongside proof of concept for advanced practitioners in social care settings, i.e. prescriber capability.

Educational design:

- Sheffield College consulting with wider partners on educational content to ensure suitability for future care delivery – roundtable events with stakeholders
- modular development – covering whole-system awareness, governance, clinical/social care roles and regulatory obligations – specialised areas of delivery, e.g. dementia
- alignment with Level 4 Apprenticeships (Skills England)
- social care placement expansion across South Yorkshire – toolkit developed and delivered with and by providers, Sheffield City Council, Social Care Placement Expansion toolkit.

Evaluation plan:

- Plan, Do, Study, Act (PDSA) cycles for iterative learning
- ongoing reporting/activity into project board and escalations for support
- ASPYRE – platform for governance tracking and sustainability scoring (subject to ICB organisational changes)
- full research report undertaken by Sheffield Hallam University for sharing and public viewing
- student-based reviews of experiences and cultural shifts.

Collaboration and Inclusion

Stakeholders:

Local authorities:

- initial focus area – Sheffield
- phased inclusion 2026, Barnsley Metropolitan Borough Council, City of Doncaster Council and Rotherham Metropolitan Borough Council.

Providers:

- Home Instead
- Crossroads Rotherham
- Porterbrook
- The Glen
- Silvercare
- Flourish
- Kirklees and Calderdale Care Association
- Be Caring.

Higher education institutions:

- Sheffield College
- Sheffield Hallam University
- University of Sheffield
- University of Derby
- University of Lincoln.

National bodies:

- Skills for Care
- DHSC
- National Health Service England (NHSE)
- ADASS.

Engagement methods:

- stakeholder workshops – developing ‘Connecting the Unconnected’
- task and finish groups
- development of communities of practice – standard operating procedure (SOP) development
- social care placement expansion project for healthcare student learning.

Early outcomes and learning

- positive engagement from providers and HEIs
- interest in enhanced care worker roles linked to DHA
- student feedback: placements in social care broadened understanding beyond acute settings
- governance tools: decision tree and SOP templates in development
- commissioning intentions influence
- connectivity into primary care model development
- connectivity into community nursing model development.

Challenges identified:

- competency sign-off remains inconsistent
- funding flows and Continuing Health Care (CHC) restrictions create barriers
- cultural shifts
- organisational changes
- uncertain future for programme leads.

Unexpected positives:

- rapid development of training hubs and placement models
- national interest in advanced practice integration – visit from CEO of the Queens Institute of Community Nursing (QICN)
- regional interest in strategic approach – Skills for Care DHA event, York 2025
- Baroness Casey – approach and information shared through Sheffield Adult Care Collaboration visit 2025
- advanced practitioners in social care settings, i.e. prescriber capability.

Ongoing challenges

- South Yorkshire ICB structural changes creating uncertainty and risk of losing key leadership expertise
- financial architecture redesign still in progress:
  - commissioning of DHA – CHC and funding
  - budgetary constraints – ICB and local authority funding.
- navigation of Section 22 of the Care Act and legislative context
- cultural shift in professional attitudes towards delegation requires sustained effort
- data sharing barriers have also created difficulties in record sharing.

Next steps

- full evaluation of pilot sites and publication of governance models
- expansion of training hubs and virtual learning offers
- embedding delegation modules in HEI curricula
- continued engagement with Skills for Care and DHSC to inform national scalability.

5. Who has it helped or affected?

Impact and outcomes for people drawing on care and support

- greater autonomy and choice: people can remain in their preferred setting (home or care home) while receiving safe clinical interventions such as catheter care, cough assist and wound care
- improved continuity and confidence: DHA reduce delays and duplication, preventing individuals from becoming 'lost in the system', and supporting a smoother hospital-to-home transition
- person-centred care: engagement in decision-making and consent processes ensures care aligns with individual needs and preferences.

For frontline staff and teams

- upskilling and career progression: care workers are gaining new health professional supported skills through DHA training, creating pathways into the enhanced care worker role within the Care workforce Pathway
- empowerment and confidence: staff report feeling more valued and capable of delivering complex care safely, supported by governance and competency frameworks
- healthcare professionals awareness: development of trust in relationships between health and social care workforces by supporting learning and development in settings.

For leaders, partners and external collaborators

- financial: early indicators suggest reduced reliance on hospital-based care, alongside development of fairer CHC, though re-engineering financial flows remains a challenge.
- time/resource efficiency: shared governance structures and training hubs reduce duplication and speed up competency sign-off
- business delivery: providers can now offer more complex care packages, supporting timely hospital discharge and community-based care
- building relationships: stronger integration across health and social care through:
  - pilot sites – Home Instead, Be Caring, Sheffield City Council and Sheffield Teaching Hospital
  - shared training hubs for real-life simulation and competency sign-off
  - development of SOPs and governance models.

Illustrative examples

- **Pilot Site 1:** supporting carers to encourage physical activity, linking physiotherapy expertise with community-based care
- **Pilot Site 1:** developing community nursing-based areas of DHA
- **Pilot Site 2:** home Instead created a training unit using grant funding to simulate real-life care scenarios, fostering symbiotic learning between students and registered professionals
- **Pilot Site 3:** embedded an advanced practitioner in a care home to explore DHA training for care staff, bridging gaps between nursing and social care.

6. What helped make this possible?

Foundations and enablers

- Access to funding and resources: Home Instead successfully accessed grant funding from Sheffield City Council to create a community training centre in Sheffield. The ambition is to develop a community asset that can provide a sustainable approach to training for DHA. Launched in 2024, the centre enables care professionals to expand their care knowledge, developing specialisms in diabetes, catheter care, wound care, bowel care and other long-term health conditions.
- Local leadership and system alignment: governance was embedded within the South Yorkshire ICB Health and Social Care Integration Programme, aligning with Lord Darzi report 'Independent Investigation of the National Health Service in England' (2024) and 'Fit for the Future: 10 Year Health Plan for England' (2025). This created a strong mandate for change and cultural shift.
- National frameworks: the project adopted Skills for Care's 'Delegated healthcare activities: Guiding principles for health and social care in England' (revised November 2024) and the DHSC Care Workforce Pathway, ensuring consistency with national policy and supporting the development of the enhanced care worker role category.

Governance structure

- task and finish groups were established for:
  - governance and clinical oversight
  - education and workforce redesign
  - financial flow re-engineering.
- connected governance: inclusive boards with representation from South Yorkshire ICB, local authorities, providers, universities and Skills for Care
- SOPs: developing collaboratively through task and finish groups, covering training, competency sign-off and escalation processes
- system visibility: governance milestones and sustainability scores are tracked via the ASPYRE platform, enabling transparency, risk escalation and progress monitoring.

Training and competency

- for care workers, training modules in development are to include:
  - system awareness (ICB/DHSC roles)
  - clinical and social care structuring – e.g. governance and competency
  - regulatory obligations
  - activity-specific skills, e.g. catheter care, cough assist, wound care, diabetes management and basic observations
  - module specialism to align to Care Workforce Pathway, e.g. dementia.
- for delegating professionals: education – the skill of delegation is being embedded into a module on university curricula (Sheffield Hallam and University of Sheffield), preparing registered professionals before qualification.

Competency assessment: Based on the Care/Clinical Competency Assessment Tool (CCAST) Health and Social Care Competency Framework, with ongoing review and refresh cycles. Competency sign-off remains a major barrier due to inconsistent processes across providers.

Clinical oversight

- sign-off process: delegation decisions are documented in care plans, including risk management, escalation routes, and monitoring arrangements
- supervision: long-arm supervision models are tested in pilot sites for placements
- supervision: clinical oversight is to be modelled to ensure care workers have access to advice and support from delegating professionals
- escalation: 24-hour helpline examples, e.g. NIV and cough assist, have been discussed and highlighted as best practice for urgent queries. However, this is not in place.

Barriers and Solutions

- Insurance limitations: providers like Home Instead cannot train external staff due to liability concerns – the proposed solution is shared satellite training hubs across health and social care.
- Funding complexity: CHC funding prescriptive; work is underway to re-engineer financial flows and coordinate funding routes (ICB, NHSE and local authorities). Subject was raised at national steering group as an obstacle to funding care delivery of DHA.
- Cultural shift: the understandable resistance from some healthcare professionals is being addressed through awareness raising, education, engagement and inclusion of the delegation to social care professionals in modular form in HEI curricula. Also, the subject was raised at national steering group for central government recognition and support to remedy.

Data and impact monitoring

- data collection: evaluation reports are planned for pilot sites, measuring:
  - safety and quality outcomes
  - workforce confidence and retention
  - financial and resource efficiencies.
- system visibility: governance and progress have been uploaded to ASPYRE platform for monitoring, risk escalation and transparency.

7. What might others learn from this project?

- Start with governance and culture: building trust between health and social care is essential. Without clear governance, delegation can stall. Embedding governance early – through SOPs, decision trees and competency frameworks –creates confidence for both delegators and care workers.
- Integration is a cultural shift, not just a process: moving from 'hospital to home' requires mindset change across sectors. Engagement with universities to include delegation in curricula has been pivotal for preparing future professionals.
- Shared learning accelerates progress: communities of practice and pilot sites have shown that collaboration between providers, commissioners and educators creates practical, scalable solutions.

A further critical lesson from this programme is the value of long-standing system leadership and trusted relationships. With more than three decades of experience working in Health and Social Care, mainly across South Yorkshire, Jo Cameron brought invaluable insight, credibility and connections to the DHA programme. Her deep understanding of local contexts, combined with longstanding professional networks, enabled early buy-in, strong cross-sector collaboration and sustained engagement. This networked leadership was instrumental in aligning partners, overcoming barriers and supporting meaningful, system-wide change, and should be an important consideration for other areas seeking to achieve similar outcomes.

Top tips for other ICSs considering similar work:

1. co-produce from the start: Involve providers, commissioners and people with lived experience early to shape realistic models
2. pilot before scaling: Use PDSA cycles to test training and governance in small settings before regional rollout
3. invest in shared training hubs: Physical and virtual hubs reduce duplication and provide assurance for competency sign-off
4. plan for financial flow redesign: Funding barriers will slow progress – address these alongside governance
5. use system improvement tools: QSIR methodology helped us structure analysis, stakeholder engagement and sustainability planning.

What aspects are still evolving or being tested?

- Competency sign-off: this remains the biggest barrier. Informal training provided by healthcare in community and competency frameworks varies. Positive example: Care/ Clinical Competency Assessment Tool (CCAST) Doncaster.
- Financial architecture: work is in an embryonic state to re-engineer funding flows between CHC, NHSE and local authorities, mainly due to organisational changes occurring in ICBs and NHSE since April 2025.
- Education integration: delegation modules are in development within HEI for curricula but cannot move forward until governance and professional body adoption is embedded nationally.
- Satellite training hubs: insurance restrictions mean shared hubs are still being negotiated.
- Training affordability: in some cases, specialist training such as cough assist costs up to £5,000, which many providers cannot afford. This highlights the need for shared funding models and regional training hubs to ensure equitable access.
- Commissioning intentions: ensuring integrated commissioning is being engineered to ensure care delivery is considered a joint activity and supported by the system.

Data measures and outcomes

- Qualitative feedback: students reported placements in social care broadened their understanding beyond acute settings.
- Quantitative indicators: early audits show increased uptake of enhanced care worker roles and reduced delays in hospital discharge.
- System visibility: ASPYRE platform tracks governance milestones and sustainability scores, enabling transparent progress monitoring.
- Research: health Innovation research being undertaken by Sheffield Hallam University for 18 months to explore: advanced nurse practitioner role, safe and effective DHA for social care staff to include training, fit for purpose education, incorporation into existing workforces and governance frameworks.

If the project were repeated, what would be done differently?

- Secure funding earlier: financial flow redesign should run in parallel with governance development.
- Simplify competency frameworks: current models are complex, so a streamlined, nationally endorsed approach could reduce professional resistance.
- Actively encourage the registration of social care workforce – locally and nationally to reduce professional resistance.
- Overcome scalability issues against organisational change: While pilots were successful, scaling was delayed by system-level changes – future projects should anticipate this.

8. What next?

Scaling and refinement

The next phases will focus on scaling DHA beyond Sheffield to other South Yorkshire localities, using insights from the pilot sites. This work will include:

- rolling out shared training hubs and virtual learning models to improve access and consistency
- publishing governance toolkits and SOPs developed through task and finish groups
- embedding delegation modules into health and social care curricula at universities to prepare future professionals
- continuing to refine competency frameworks for simplicity and national alignment.

New development: advanced practice integration

A significant addition is funding for Nicola Bindley, NIHR Fellow, Advanced Nurse Practitioner. Over the next 12 months, Nicola will:

- undertake a three-day hosted position at Bennfield House (Doncaster) as an advanced nurse practitioner
- support educational development and governance for DHA alongside Sarah Fisher, Advance Practitioner Lead, South Yorkshire ICB
- lead an advanced practice project to explore the potential of advanced nurse practitioners in care homes, attracting national interest from Stephanie Lawrence, CEO of QICN, who will visit later this month.

Regular updates from Nicola and Sarah will feed into overall project meetings, ensuring alignment and shared learning.

Measuring longer-term impact

Plans include:

- full evaluation of pilot sites, measuring workforce confidence, hospital discharge times and uptake of enhanced care worker roles
- monitoring sustainability scores and governance milestones via the ASPYRE platform for system-wide visibility
- assessing financial flow redesign and its effect on CHC spend and improving equity in funding. Work is ongoing in looking at CHC training for both social care and health teams.

Opportunities for involvement

- Providers and commissioners can join communities of practice to co-produce SOPs and share learning.
- Educational institutions are invited to collaborate on curriculum development and placement expansion.
- National partners and ICSs can access published governance models and evaluation reports to replicate successful approaches. Updates will be shared through Skills for Care networks, South Yorkshire ICB integration forums and regional conferences.

The overarching aim is to create a scalable, replicable model that strengthens workforce capability, embeds cultural change and delivers person-centred care closer to home.

9. Skills for Care involvement

How Skills for Care supported the work

- Frameworks and guidance: the organisation's resources, such as 'Delegated healthcare activities: Guiding principles for health and social care in England' (revised November 2024), informed governance structures and decision-making processes.
- Task and finish groups: Skills for Care participated in the Educational Development and Care Workforce Pathway group alongside HEIs and apprenticeship trailblazer member, the Institute for Apprenticeships and Technical Education (IFATE), helping to design training models and competency frameworks.
- Stakeholder engagement: Skills for Care was listed as a core stakeholder in the Working Together Pathway for DHA, supporting integration between health and social care systems.
- ICB including Jo Cameron, Programme Lead, South Yorkshire ICB, Keith Hughes, Primary Care Network Project Delivery Manager and Sarah Fisher Professional Lead for Advancing Practice, South Yorkshire ICB attended and presented at Skills for Cares Delegated Healthcare Roadshow in Yorkshire.

Skills for Care's involvement ensured that South Yorkshire's DHA work remained connected to national standards, supported workforce redesign and contributed to creating scalable, replicable models for integrated care.