Leicestershire Partnership NHS Trust

Delegation Policy

This policy describes the process for delegating tasks to colleagues within or working in partnership with Leicestershire Partnership NHS Trust.

Key Words:	Delegation	
Version:	5	
Adopted by:	Quality assurance Committee	
Date Adopted:	19 February 2019	
Name of Author:	Debbie Leafe	
Name of responsible Committee:	Clinical Effectiveness Group	
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Expiry date:	1 August 2021	
Target audience:	All clinicians	
Type of Policy	Clinical ✓	Non Clinical
Which Relevant CQC Fundamental Standards?	9,10,12	

Contents

Version control and summary of changes

Version number	Date	Comments (description change and amendments)
Original Document	May 2012	Amended to reflect LPT, LCR CHS and Leicester City CHS amalgamation
Version 3	January 2015	Updated to reflect latest policy template and the development of Assistant Practitioners and their role in administering medication. Comments adopted from consultation.
Version 4	December 2015	Updated to reflect changes to practice and facilitate safe yet more efficient development of clinical roles. Incorporated role of Technical Instructor. Updated to reflect fundamental care standards.
Version 5	August 2018	Update to reflect the role of the Trainee Nursing Associate. Placed onto latest template.

For further information contact:

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Equality Statement
Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.

This applies to all the activities for which LPT is responsible, including policy development and review.

Due Regard

LPT must have **due regard** to the aims of eliminating discrimination and promoting equality when policies are being developed. Information about due regard can be found on the Equality page on e-source and/or by contacting the LPT Equalities Team.

Please refer to appendix 10 which provides a detailed overview of the due regard undertaken in support of this activity.

Definitions that apply to this Policy

Accountability	The principle that individuals, organisations and the community are responsible for their actions and may be required to explain them to others
Apprentice / Apprenticeships	They are [individuals enrolled on] an integrated work based training and development programme designed around the needs of employers, reflecting required knowledge and competencies which lead to nationally accredited qualifications.
Assistant Practitioner	An Assistant Practitioner is a worker who competently delivers health and social care to and for people. They have a required level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. The Assistant Practitioner would be able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals. The Assistant Practitioner may transcend professional boundaries. They are accountable to themselves, their employer, and, more importantly, the people they serve.
Competence	A bringing together of general attributes – knowledge, skills and attitudes. Skill without knowledge, understanding and appropriate attitude does not equate to competent practice. Thus, competence is 'the skills and ability to practice safely'
Delegation	The transfer to a competent individual, the authority to perform a specific task in a specified situation that can be carried out in the absence of the registered practitioner and without direct supervision
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
Health Care Support Worker	For the purposes of this paper the term 'Health Care Support Worker' describes a non registered clinical member of staff who has a role or task delegated to them by the registered practitioner.
People/person/patient	The terms people/person/patient have been used to represent all recipients of care including children and young people

Registered Practitioner	A professional who is on a register for that particular profession, i.e. the Health Professions Council (HPC) or the Nursing and Midwifery Council (NMC).
Responsibility	A form of trustworthiness: the trait of being answerable to someone for something or being responsible for one' conduct.
Student	A person who is studying at a university or other place of higher education. Denoting someone who is studying in order to enter a particular profession.
Therapy Support Worker	Therapy Support workers (also known as occupational therapy assistants/rehabilitation assistants/technical instructor) assist registered occupational therapists in their day to day duties.
Trainee Nursing Associate	A nursing associate is a new member of the nursing team who will provide care and support for patients and service users. This role is being used and regulated in England and it's intended to address a skills gap

Abbreviations used within this Policy

CQC	Care Quality Commission
HCSW	Health Care Support Worker
LCAT	Leicester Clinical (Procedure) Assessment Tool
LPT	Leicestershire Partnership NHS Trust
NA	Nursing Associate
RCN	Royal College of Nursing
TAP / AP	Trainee Assistant Practitioner / Assistant Practitioner
TI	Technical Instructor

1.0. Purpose of the Policy

1.1 The purpose of this policy is to address key issues in the process of delegation within LPT encompassing nursing and other healthcare professionals, for example from:

- registered staff to registered staff;
- registered staff to Health Care Support Workers;
- registered nurses to Trainee Nursing associates
- registered health care worker to social care worker, family outreach worker, learning support worker;
- within or across teams/agencies;
- within or across professions;
- bands of staff such as from band 4 to 3 and from 3 to 2 under the supervision of a registered health care professional.

1.2 Specific tasks are not listed. Successful delegation of medications relies upon the assessment of the individual patient, and the non-registered practitioner coupled with the healthcare professional's clinical judgement and must be in line with Medicines Management Training.

1.3 Within the Health and Social Care Protocol (2014) there is a process for delegation of tasks to Social Services funded carers which must be utilised when delegating care, ensuring that the task, the care setting and the level of the task is in accordance with the protocol.

2.0. Summary and Key Points

2.1 This policy provides the recognised process that will apply within LPT to ensure safe, effective delegation of tasks and duties. It is summarised as follows:

ACTION	RATIONALE
1. Identify task to be delegated	To establish a clear pathway for delegation.
2. Assess task considering predictability, clinical risk and complexity	To develop appropriate training.
3. Identify skills and knowledge required	To identify appropriate delegate and level and amount of training required.
4. Identify suitable person to act as delegate	To enable delegated task to be carried out safely and within the scope of professional bodies, codes and guidelines.
5. Assure that the delegate is competent.	To ensure delegates are adequately trained for the task.
6. Agree delegation and complete relevant documentation	To provide a clear and concise record of training given and task delegated.
7. Agree a feedback and escalation system to include; • Frequency • Effectiveness • Documentation • Reassessment timescales	To demonstrate accountability has been maintained by those delegating. To maintain a cycle of assessment and evaluation. To support the delegate.

2.2 Tools to support the process of delegation for specific circumstances can be found with the appendices.

3.0. Introduction

3.1 Health Service providers are accountable to both the criminal and civil courts to ensure their activities conform to legal requirements.

3.2 The law imposes a duty of care on practitioners when it is 'reasonably foreseeable' that they might cause harm to patients through their actions or their failure to act.

3.3 This duty of care forms a legal liability with regard to the patient, and registered practitioners must ensure that they perform competently. The person who delegates the task is accountable for the appropriateness of the delegation (RCN 2017).

3.4 Registered professionals delegating a task must ensure that the task has been appropriately delegated which means that:

- The task is necessary and delegation is in the patient's best interest;
- The person who the task is delegated to (such as Trainee Assistant Practitioner (TAP), Assistant Practitioner (AP) ,Health Care Support Worker (HCSW), Student or Therapy Support Worker), Trainee Nursing Associate (TNA) understands the task and how it is to be performed;
- The person who the task is delegated to (see indicative but not exhaustive selection above) has the skills and abilities to perform the task competently;
- The person who the task is delegated to (see indicative but not exhaustive selection above) accepts the responsibility to perform the task competently.

3.5 Health Care Support workers, Therapy Support Workers, Assistant Practitioners and Trainee Nursing Associates have a duty of care and are subject to the same liability as a trained professional. When delegating to any HCSW the registered professional has a professional and legal requirement to protect both the HCSW and the patient. It is recognised that the delegation of tasks may be to other staff groups, such as technical instructors and nursery nurses and, as such, processes need to be in place to ensure safe and effective delegation.

3.6 It is recognised that one aspect of successful work/caseload management is the delegation of tasks. Delegation is a way to appropriately and consistently provide direction to staff. By delegating properly, it is possible to expand employee's skills and expertise which will enable them to become more productive and self-reliant which improves morale and motivation.

4.0. Duties within the Organisation

4.1 **The Trust Board** has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

4.2 **Trust Board Sub-committees** have the responsibility for ratifying policies and protocols.

4.3 **Divisional Directors and Heads of Service** are responsible for ensuring that there are clear policies and protocols that give authority for individuals to perform the tasks and that this is reflected within their job description.

4.4 **Managers and Team leaders** are responsible for:

- Ensuring appropriate measures are put into place to ensure that the process of delegation is carried out safely.
- Ensuring that the policy is disseminated widely.

- Ensuring local audit is conducted in the areas of work they are responsible for to ensure that the process of delegation is being carried out in an appropriate manner and sharing findings using governance processes.

- Addressing areas of weakness and ensuring that action plans are developed where necessary.
- The implementation of the policy within their clinical area.

- Ensuring that the delegation process is rigorous and adheres to this policy.

- Correctly identifying the strengths and weaknesses of staff and ensuring that training and support are accessed to enable appropriate delegation.

4.5 **Responsibility of Staff in relation to Mental capacity**

- Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment is delivered. Consent can be given verbally and / or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.

- In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following;

- Understand information about the decision
- Remember that information
- Use the information to make the decision
- Communicate the decision

4.6 **Staff are also responsible for the following**

- Registered staff are responsible for the safe and appropriate delegation of tasks to others. (NMC 2015, Pearmain 2010, Chartered Society of Physiotherapists 2012).

- All healthcare professionals who are delegated a task are responsible for ensuring that they do not accept responsibility for any task where they are unskilled or where insufficient explanation of the task has been given.

- All staff are responsible for the assessment of risk when delegating to another or accepting delegation themselves.

- Staff, to whom an aspect of care is delegated, must understand their limitations and recognise when they should not proceed with care should the circumstances, within which the task has been delegated, change.

- There must be a regular feedback process in place between the registered practitioner and the delegate. Good communication between staff members will ensure that care remains appropriate and timely and patient safety is not compromised.

- Staff are responsible for maintaining their records of competency which can be produced when requested.

- Registered nurses and all HCSWs including Trainee Nursing Associates and Assistant Practitioners must be aware of the delegation of specific tasks that are considered to have a greater risk of potential patient harm. These include the delegation of insulin and insulin analogues and low molecular heparins and enteral feeding.

- The delegation and administration of medicines to and by student nurses will be in accordance with appendix 5.

- The staff member delegating the care must be assured that the delegate is competent to perform the required care.

- Non LPT staff who are being trained by and delegated tasks by a member of LPT staff should hold the example paperwork shown in appendix 1.

- The person delivering the care must adhere to standards of record keeping in line with their profession and that of LPT.

- The registered professional must review the patient's plan of care at appropriate intervals to ensure that the care being delivered remains appropriate and document that they have done so in the patient record. For example for frequently delegated tasks such as insulin administration the patient should be reviewed at least 4 weekly by the registered practitioner and the appropriateness of the delegation considered. It is not necessary for each and every entry made by an unregistered practitioner to be countersigned.

- The person who makes an entry in the record is accountable for any entry that they make.

5.0 Delegation

5.1 Delegation can be defined as the entrusting of a task to another person.

5.2 The delegate has a responsibility:

- For agreeing to undertake the task in accordance with their competence and instructions from the person delegating.

- To communicate changes and conditions, which affect their competency, they have a right to refuse to undertake that delegated task.

- To escalate untoward patient changes and circumstances.

5.3 The registered practitioner can delegate responsibility for a specific task. However, the assessment, planning and evaluation remain the responsibility of that practitioner.

5.4 Health care staff can delegate to social care workers under the direction of the Health and Social Care Protocol (2014).

"It is the health care worker's responsibility for any health care tasks that they delegate. It is the responsibility of the health care worker to monitor the care being given to their patient by social care workers and for the risk management of such delegated tasks".

6.0 Delegation Process

6.1 Identification of the skills and knowledge needed to carry out the delegated task will determine the most appropriate staff member to carry out the task.

6.2 Agreement of delegation by both the professional delegating and the delegate is essential to establish where accountability and responsibility for undertaking the tasks lies.

6.3 Patients care must be reassessed at appropriate intervals by the registered professional to ensure that delegation is appropriate.

7.0 Accountability/Responsibility of Delegation

7.1 Professional accountability is fundamentally concerned with weighing up the interest of patients and clients in complex situations, using professional knowledge, judgement and skills to make a decision and enabling the professional to account for the decision made.

7.2 Delegation to non-registered staff entails the delegating professional being responsible to ensure:

- The delegate is competent to carry out the care required.
- That appropriate levels of supervision and support are in place.
- That it is in accordance with professional standards and the employing organisation's policies, procedures and guidelines.

7.3 Both registered and non-registered members of staff are accountable for their actions and have social, ethical and legal contractual accountability and are responsible for the tasks they undertake. They must not work outside their level of competence.

7.4 The registered professional always retains accountability and responsibility for appropriate delegation.

8.0. Training and competency

8.1 There is no training requirement identified within this policy in relation to delegation per se.

8.2 Delegation will be determined by professional consideration of the complexity of the task, situational predictability of the patient and the competence of the individual to whom the task will be delegated.

8.3 Should training be required in a particular task or skill to allow successful delegation to take place this must be sourced through or delivered using the appropriate resources from within the organisations training portfolio. The Ulearn system will identify: who the training applies to, delivery method, the update frequency, learning outcomes and a list of available dates to access the training.

8.4 A record of the staff training will be recorded on the Ulearn system.

8.5 The use of LCAT (Leicester Clinical Assessment Tool) (McKinley, R.K et al 2008) is encouraged to assess competence in key clinical procedures. Directorates within the organisation have developed a number of competencies and identify those requiring LCAT assessments.

8.6 Competency must be agreed by the LCAT assessor / trainer and the delegate. Knowledge and skills may be assessed by the use of the "Show Me You Know – Show Me You Can" form which is used as an adjunct to LCAT. See appendix 2 as an example.

8.7 Records of training and competence must be kept by the individual registered or non-registered professional and the LCAT assessor.

9.0 Monitoring Compliance and Effectiveness (See appendix 4)

9.1 The appropriate directorate Patient Safety Group will review incidents and complaints including SI's relating to inappropriate delegation of tasks as per local directorate arrangements.

9.2 Findings and learning from incidents and complaints will be shared across LPT services.

10.0 Standards/Performance Indicators

This policy will support the following fundamental standards

STANDARD	KEY PERFORMANCE INDICATOR
CQC – Regulation 9	Evidenced by ensuring work is correctly delegated and monitored with changes to care delivery made as necessary.
CQC – Regulation 10	Evidenced by the use of assessment of competence which includes checking for dignity and respect
CQC - Regulation 12	Evidenced by the provision of appropriate training provision for staff, together with supervision registers and appraisals and with the need for staff to maintain records of delegation and competence.

11.0 References and Bibliography

Chartered Society of Physiotherapy (2012). Code of Professional values and Behaviours. CSP. London.

HCPC (Health and Care Professions Council) http://www.hcpc-uk.org Accessed 09.12.15

Leicester, Leicestershire and Rutland Health and Social care Protocol (2014), Leicestershire Partnership NHS Trust, Leicester City Council, Leicestershire County Council, Rutland County Council.

McKinley R.K et al (2008) Development of a Tool to Support Holistic Generic assessment of Clinical Procedural Skills. Medical Education 42 619-627.

NMC(Nursing and Midwifery Council), 2015, The Code: Standards of conduct, performance and ethics for nurses and midwives. NMC. London

NMC (Nursing and Midwifery Council), 2010., Standards for Medicines Management. NMC. London

Pearmain H. (2010). Code of Ethics and Professional Conduct for Occupational Therapists. College of Occupational Therapists. London.

RCN (Royal College of Nursing) (2017) *Accountability and delegation: A guide for the nursing team*. RCN. London

Appendix 1

Leicestershire Partnership NHS
NHS Trust

RECORD OF COMPETENCE – NON LPT STAFF

The delegate will undergo appropriate training and once assessed as competent may carry out the delegated task.

Name of Trainer ……

Name of Delegate ……..……

Skill / task trained to be competent in……..

……

Summary of the key points covered within the competency (attach any additional frameworks used if required)

……..……..……

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Task agreed to be carried out by the delegate ……..……..

……..……

Date of competency assessed ……...……

Patient /patient group requiring the care ……..……

Frequency of review of Competency……

Date competency to be next reviewed ……..……

Signature of **PERSON DELEGATING** ……..……

Signature of **TRAINER** ……

Signature of **DELEGATE**
……

A COPY OF THIS IS TO BE RETAINED BY TRAINER, DELEGATE, PERSON DELEGATING AND THEIR LINE MANAGERS

Appendix 2

Learners Name:	**Competency: To undertake and record routine vital sign measurements** This competency is adapted from Skills for Health - Standard CHS19.2012(Accessed Jan 2016)

DESCRIPTOR OF CLINICAL SKILL: This competency covers taking and recording vital sign measurements as part of the individual's assessment and care plan.

- Measurements include Blood Pressure, pulse rates, pulse oximetry, temperature & respiratory rates.
- For use within Inpatient units, care homes, clinics, day centres and the individuals own home.
- The competency is intended to cover adults only across CHS & AMH/LD divisions.

SHOW ME YOU KNOW:	**Date achieved**	**Assessor: Print Name and sign**
The reasons for measuring vital signs.		
The common conditions and circumstances of when you would take and record vital signs.		
The difference between systolic and diastolic blood pressure and what is happening to the heart in each reading .		
The normal limits of blood pressure, pulse, respiration rate, temperature and oxygen saturation levels are in a healthy adult.		
Examples of factors which can affect blood pressure, pulse, temperature, respiration and oxygen saturation readings.		
What is meant by pyrexia, hyper-pyrexia and hypothermia.		
The common pulse point sites used for taking a manual pulse.		
What your immediate actions would be if vital signs findings are outside of the normal or individual's set ranges.		
The importance of correctly following early warning systems and protocols eg: Track and Trigger and reporting abnormal findings to the relevant qualified practitioner.		
The importance of recording clearly, accurately, and correctly any relevant information in the care record.		

SHOW ME YOU CAN:

This is assessed using the LCAT assessment tool. The assessor will apply their expertise with due consideration of the context of practice eg a domestic , clinic, ward based setting. The assessor will be informed by national standards and trust policy in relation to the skill being assessed. You may have been issued with a full LCAT booklet which you should use to record your assessments.

POLICY OR NATIONAL OCCUPATIONAL STANDARDS or GUIDANCE

LCAT Assessor Assessment Guidance

Based on National Occupational Standard CHS 19.2012

The learner must show you they:

1. Apply standard precautions for infection prevention and control and apply other necessary health and safety measures
2. Check the individual's identity and confirm the planned action
3. Give the individual relevant information, support and reassurance in a manner which is sensitive to their needs and concerns
4. Gain valid consent to carry out the planned measurement
5. Take the measurement at the prescribed time and in the prescribed sequence
6. Use the appropriate equipment in such a way as to obtain an accurate measurement
7. Reassure the individual throughout the measurement and answer questions and concerns form the individual clearly, accurately and concisely within own sphere of competence and responsibility
8. Refer any questions and concerns from or about the individual relating to issues outside your responsibility to the appropriate member of the care team
9. Seek a further recording of the measurement by another staff member if you are unable to obtain the reading or if you are unsure of the reading
10. Observe the condition of the individual throughout the measurement
11. Identify and respond immediately in the case of any significant changes in the individual's condition
12. Recognise and report without delay any measurement which falls outside of normal levels
13. Record your findings accurately and legibly in the appropriate documentation
14. Clean used equipment and return to usual place of storage after use
15. Dispose of waste and disposable equipment appropriate

Appendix 3

Drug Administration Guidelines for Student Nurse Participation in the Administration of Medicines

This chart does not apply to Patient Group Directions

"Student nurses cannot supply and/or administer medicines under a PGD even if under direct supervision" (NMC2010)

Medication Administrative Route	Level of Student Participation	Signatory in Patient Documentation
Oral Drugs -To include inhaled medicines, eye drops, bladder instillations and topical medication *(Not Controlled Drugs)*	Students can prepare, check and administer under direct supervision	1 registered nurse & participating student
Rectal administration of medicines e.g. suppositories and enemas	Students can check and administer under direct supervision ***(nurse to carry out pre-administration checks e.g. DRE)***	1 registered nurse & participating student
Oxygen Therapy	Student may set up and set rate under direct supervision	1 registered nurse & participating student
Subcutaneous Injections *(Not Controlled Drugs)*	Students can prepare, check and administer under direct supervision	1 registered nurse & participating student ***(Inpatients = 2 registered nurse signatures)***
Intramuscular Injections *(Not Controlled Drugs)*	Students can prepare, check and administer under direct supervision	1 registered nurse & participating student ***(Inpatients = 2 registered nurse signatures)***
Clear Intravenous/Subcutaneous Infusion of Fluids *(No additives or mixing)*	Student may set up under direct supervision ***(registered nurse to connect, set rate and commence infusion)***	1 registered nurse & observing student ***(Inpatients = 2 registered nurse signatures)***
Controlled Drugs: Oral	Students can check and administer under direct supervision	1 registered nurse & participating student ***(Inpatients = 2 registered nurse signatures)***
Controlled Drugs: Subcutaneous Injection *(No additives or mixing)*	Students can check and administer under direct supervision	1 registered nurse & participating student ***(Inpatients = 2 registered nurse signatures)***
Controlled Drugs: Intramuscular Injection	Students can check and administer under direct supervision	1 registered nurse & participating student ***(Inpatients = 2 registered nurse signatures)***
Intravenous/Subcutaneous Drug Infusions with additives or mixtures	Student can only OBSERVE this process	1 registered nurse ***(Inpatients = 2 registered nurse signatures)***
Controlled Drugs: Intravenous Drugs	Student can only OBSERVE this process	1 registered nurse ***(Inpatients = 2 registered nurse signatures)***
Intravenous bolus drugs and intravenous additives *(including pre prepared infusion bags)*	Student can only OBSERVE this process	1 registered nurse ***(Inpatients = 2 registered nurse signatures)***
Blood and Blood products	Student can only OBSERVE this process	2 registered nurses

Direct supervision: The student is observed by a registered nurse (who takes accountability for the student's actions) throughout the preparation, calculation, checking patient, administration and disposal of medication, equipment and completion of documentation.

Accountability and responsibility: The registered nurse is accountable in all instances. They have the responsibility to make a professional judgement that the student participating in the procedure of medicine management has appropriate knowledge of the drugs they are checking and administering.

Student signature: Students are required to sign all drug administrations that they participate in to demonstrate their involvement in the process.

Controlled Drugs: Any substance or product specified in parts 1, 2 and 3 of schedule 2 and 3 of the misuse of drugs act 1971 e.g. diamorphine and midazolam. For these drugs there are strict procedures relating to the administration, prescribing, dispensing and storage (NHS Leicestershire County and Rutland (LCR) Controlled Drugs Policy)

Monitoring compliance and effectiveness

Appendix 4

Page Ref	Minimum Requirements	Self-Assessment evidence	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
Appendix 1 3 4 5	Ensure that delegation is recorded using the correct documentation as described in appendices 1, 3, 4 and 5 of this policy.	Sections 4.4, 4.5, 4.6	Review by team managers of records of delegation drawn from current caseloads as part of audit calendar.	Community Managers / Ward Matrons / Therapy Managers	Every year
13-14	Ensure that staff are competent to deliver delegated tasks / care as described in the appropriate clinical skills competency framework	Sections 8.2, 8.3, 8.4, 8.5	Discussion at appraisal between line manager and staff member as part of review of training	Line Managers	Annual
14	Review of incidents/ complaints by divisions to identify issues of inappropriate delegation.	Sections 9.1, 9.2	Collection of data via safeguard system. Directorate Patient Safety Group to review who will manage and feed to Clinical Effectiveness group.	By exception reporting to the Clinical Effectiveness Group	Monthly

Appendix 5

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay.
The NHS will provide a comprehensive range of services

The following core principles apply:

Shape its services around the needs and preferences of individual patients, their families and their carers	✓
Respond to different needs of different sectors of the population	✓
Work continuously to improve quality services and to minimise errors	✓
Support and value its staff	✓
Work together with others to ensure a seamless service for patients	✓
Help keep people healthy and work to reduce health inequalities	x
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	✓

Appendix 6

Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Shelley Jacques	Clinical Governance Lead Leicester City PCT – Original document
David Leeson	Clinical Education Lead CHS/MHSOP – Version 3
David Leeson & Victoria Peach	Clinical Education Lead & Lead Nurse – Version 4
Debbie Leafe and David Leeson	Clinical education Leads – Version 5

Circulated to the following individuals for comment

Name	Designation
Sarah Latham	Lead Nurse CHS In patients
Tracy Yole	Lead Nurse CHS Community
Stephanie O'Connell	Lead Therapist CHS
Claire Armitage	Lead Nurse AMH/LD
Joanne Wilson	Lead Nurse FYPC
Caroline Barclay	Nurse Consultant CHS
Anthony Oxley	Head of Pharmacy LPT
Colin Bourne	Clinical Education Lead MHSOP
Lesley Tooley	Clinical Education Lead CHS/MHSOP
Elaine Liquorish	Clinical Educator CHS

Due Regard Screening Template **Appendix 7**

Section 1	
Name of activity/proposal	Delegation of Tasks
Date Screening commenced	14th August 2018
Directorate / Service carrying out the assessment	CHS Quality and Governance
Name and role of person undertaking this Due Regard (Equality Analysis)	Debbie Leafe
Give an overview of the aims, objectives and purpose of the proposal: Update the policy for the process of delegation of tasks.	
AIMS: Ensure that tasks are delegated safely	
OBJECTIVES: To ensure that patient safety is maintained by adherence to a process of safe delegation.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	No impact
Disability	Dyslexia will need to be considered in terms of delegation of some written/numerical tasks and the extra reasonable support that might be necessary.
Gender reassignment	No impact
Marriage & Civil Partnership	No impact
Pregnancy & Maternity	Pregnancy will need to be considered in terms of delegation of moving and handling of patients/loads.
Race	No impact
Religion and Belief	No impact
Sex	No impact
Sexual Orientation	No impact
Other equality groups?	No impact

Section 3

Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.

Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	**X**

Section 4

If this proposal is low risk please give evidence or justification for how you reached this decision: The impact is low as LPT already have adequate safeguards in place to support staff where disability or pregnancy may be a factor needing to be considered within the framework of delegation.

Signed by reviewer/assessor	D.Leafe	**Date**	14.08.18
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Sue Elcock	**Date**	28/1/19

Appendix 8

DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	Delegation Policy	
Completed by:	Debbie Leafe	
Job title	Clinical Education Lead	**Date 14/08/18**

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, adoption of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	**Debbie Leafe**
Date of approval	**14.08.18**