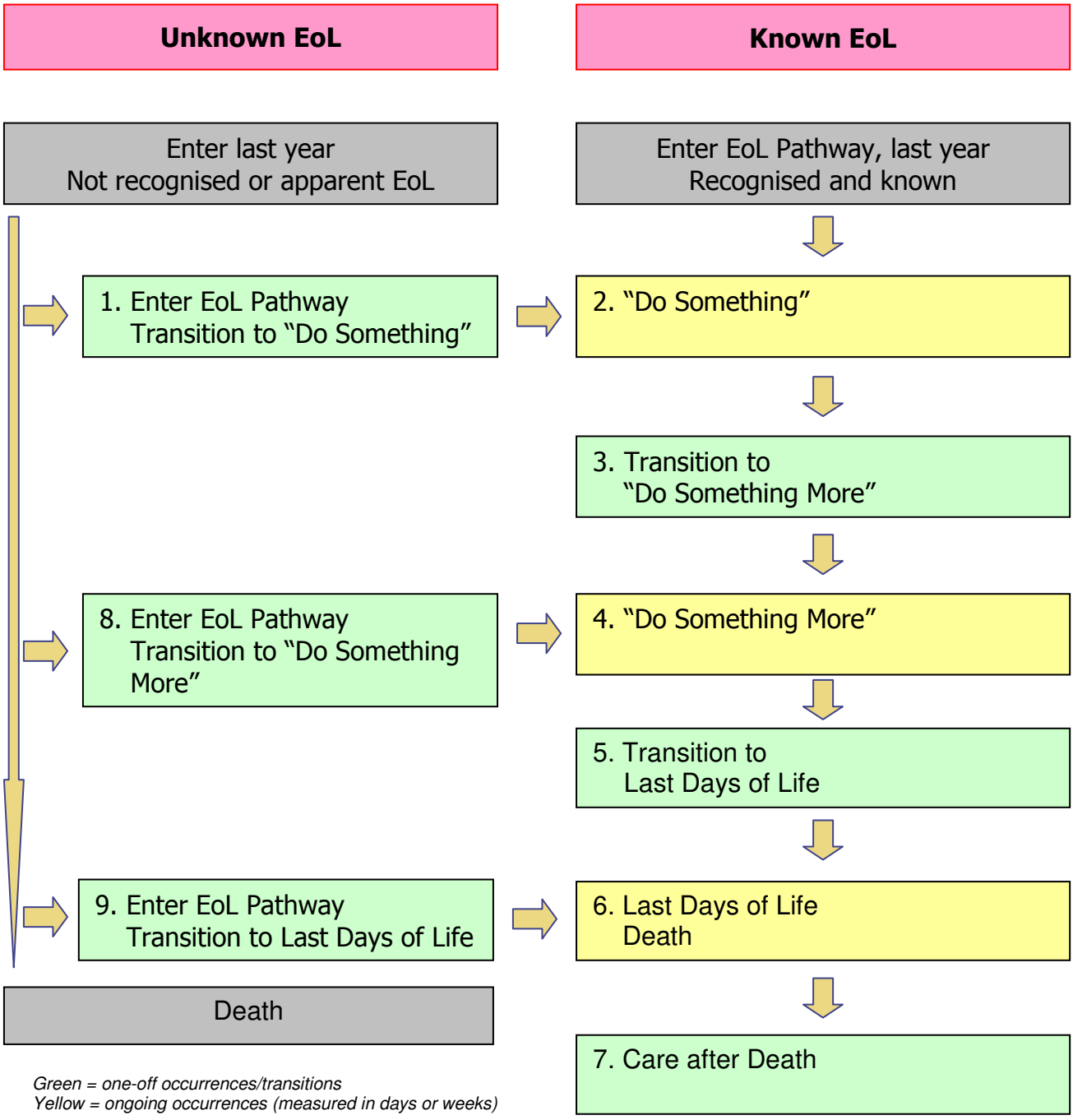
End of Life Care
Systems Modelling Project
(East Midlands)

Functional Analysis - Generic Points along the Pathway



Green = one-off occurrences/transitions
Yellow = ongoing occurrences (measured in days or weeks)

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Context

This piece of functional analysis work has been undertaken as part of the National End of Life Care Programme's work to inform the development of a tariff for EoLC. Whole Systems Partnership and Skills for Health were commissioned to work in partnership with NHS East Midlands to inform this development which was focused on the East Midlands region. WSP undertook the system modelling aspects and SfH the underlying workforce/functional analysis.

This report provides a record of the workforce assumptions that were ultimately used. It was informed over an initial period of 3 months in late summer 2010. Following road-testing of the system model a further "confirm and challenge" session took place in January 2011 to ensure the functional analysis had maintained its integrity in the light of any changes to the system. Overall we had the involvement either wholly or in part of 39 health and social care practitioners.

End of Life Care Pathway Functions

At each point along the end of life care pathway shown on the front page, functions have been identified from the Skills for Health 'Health Functional Map' which supports people in end of life care and their carers. These functions can subsequently identify the detailed competences required at each point (although this was outside of the scope of this project). The functions have been grouped together in clusters to represent how they are used together.

Carrying out these functions requires different levels of skills irrespective of who carries out that function. Healthcare workers, social care workers, volunteers, carers or the individual nearing their end of life may carry out the functions themselves.

There are three levels of skill identified for this Pathway, they are:

- **Generic skills**: meaning care or support not requiring training at a qualified or specialist level, and being taught in relation to a specified individual.
- **Enhanced skills**: meaning tasks requiring competence that might be typical of a qualified member of staff, and where skills are transferable across a number of individuals with similar needs.
- **Specialist skills**: meaning tasks that require knowledge of direct relevance to the condition(s). These may relate to the primary condition, the secondary condition or palliative care.

Each point along the end of life care pathway is either a 'one off occurrence' or an 'ongoing occurrence'.

- A 'one off occurrence' may happen only once along the pathway but might take days, weeks or months to complete, e.g. a diagnosis make take several visits to the G.P. or specialist over many days and transition from 'do something' to 'do something more' may take several months. An individual nearing their end of life may also have several acute episodes resulting in care at home or admission to hospital during their journey along the pathway but each episode is a 'one off occurrence'.
- An 'ongoing occurrence' might last for several days or weeks and they are relatively stable points along the pathway where the level of care does not change significantly.

It is important to note that timings for ongoing points are all stated per day. This does not imply daily input at that level, but may reflect a longer time given on a weekly or less frequent basis.

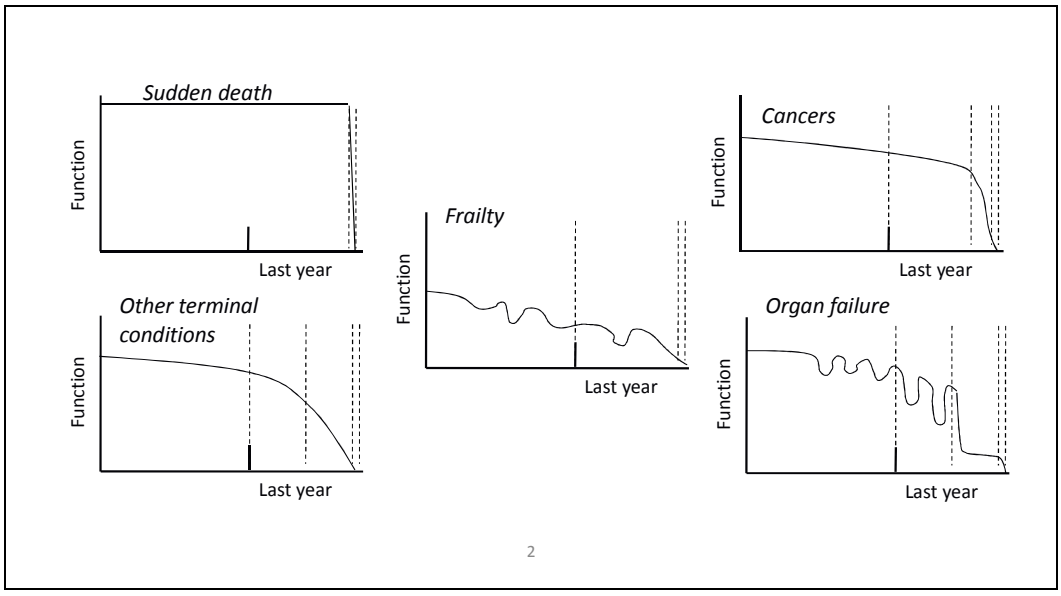
The timings in minutes indicated at each level of skill are calculated differently depending on the point on the pathway and the functions for example:

- Point 1: One-off Enter EoLC Pathway – cumulative time over the period of assessment, diagnosis and care planning
- Point 2: "Do Something" – the time taken over one day, where for assessment using generic skills is daily (eg 60 minutes per day) and enhanced skills weekly (eg 30 minutes x 1 day per week = 4.3 mins per day)
- Point 3: One-off Transition to "Do Something More" – cumulative time over the period of transition
- Point 4: "Do Something More" – the time taken over one day, (eg. where development and monitoring of the care plan will happen periodically but implementation occurs daily, e.g. 4 visits per day of 20 minutes = 80 mins per day).
- Point 5: One-off Transition to Last Days of Life – cumulative time over the period of transition (assessment and support)
- Point 6: Last Days of Life/Death – the time taken during the period of one day
- Point 7: One-off Care After Death – cumulative time, expressed in minutes
- Point 8: One-off Enter EoL Pathway – Transition to "Do Something More" – cumulative time over the period of transition
- Point 9: One-off Enter EoL Pathway – Transition to "Last Days of Life" – cumulative time over the period of transition

Trajectories

Within the overall systems modelling project there was a strong consensus that it should proceed on the basis of identifying needs at different points along the pathway. The data required to populate the model would, however, still need to be based on national statistics for 'cause of death' which are condition based, but would be grouped in five End of Life Care trajectories.

The characteristics of these trajectories are illustrated in the following profiles of reducing function during the last year of life.



Skills for Health "Health Functional Map' (HFM)

The functions identified and their associated prefixes have been drawn from the HFM which is available on the SfH website (www.skillsforhealth.org.uk). The titles of the functions cannot be changed, although the HFM has now undergone a major review in order to reflect a more modern approach to healthcare. The functions within this EoLC work remain valid and SfH can assist with any conversion work required.

October 2010
(revised following "Confirm and Challenge" workshop on 31 January 2011)

Issues and Actions arising from the Functional Analysis Workshops

This section aims to reflect key aspects of questioning and discussion that came out of the workshops and individual meetings which informed this work. It provides a useful context to underpin the individual trajectory workbooks and in conjunction with the footnotes attached to function statements used throughout will provide a much richer picture of the workforce needs expressed.

1. Advance Care Planning

Participants felt this was critical to this process of End of Life Care but it was difficult to see the process within the Skills for Health functional map. Advance Care Planning is described in to competence CM A4 "Plan, implement, monitor and review therapeutic interventions with individuals who have a long term condition and their carers" which is found within *Function B1.1.4 Plan activities, interventions and treatment to achieve specified health goals* in the Health Functional Map. This function has been included at each of the transitional points of the pathway.

ACP is deemed to include mental capacity assessments, power of attorney, etc.

2. Transitional Points / Care Planning and Delivery

Whilst the pathway used illustrates care planning and care delivery as essentially separate points (one-off or ongoing) it is important to note that they are not intended to be mutually exclusive. Assessment and planning will be continuous whilst care is being delivered in order to continue to maximise the health benefits to the individual. However, transition from one state to another is deemed only to occur once, eg "Do Something More" to "Last Days of Life/Death".

For example: in managing crises to avoid hospital admissions when an individual is at Points 2 and 4 ("Do Something" / "Do Something More") on the pathway they may have a health crisis where they are admitted to hospital or are managed at home. For an individual nearing their end of life at Point 4 this would mean a reassessment, as part of the assessment process described at Point 3: Transition to "Do Something More", so an individual may move between the two points several times during their end of life pathway. Once a reassessment has taken place there may be a need for additional care at Point 4, on either a permanent or temporary basis. This all falls within advance care planning.

3. Communication

Within this context it is essential that the individual communicating information, particularly significant news, ensures that the recipient has taken in and understands what is being said. This is included in the competences found within 1.2 and 1.3 of the Health Functional Map. *Function 1.2: Communicate effectively* has been included as an underpinning principle for the whole pathway. *Function 1.3: Communicate significant news to individuals* has been included as appropriate.

4. Care Plan or Treatment Plan

A treatment plan is usually understood to mean a plan to resolve/treat a specific issue/problem whereas a care plan is concerned with the whole person and how they wish to live their life. For the sake of the functional map 'treatment plan' and 'care plan' are used interchangeably – this does not apply at competence level where the distinction can be made.

5. Early advice re benefits, housing etc

It was seen as critical to ensure this was available early on, so that individuals and their carers were not worrying about money etc at a very stressful time in their lives, and when they would want to be concentrating on more important things. These competences are

found in the Health Functional Map at *B2.9.5 Support people in their daily living*, along with competences around supporting people to eat and drink, use assistive technology, access support networks etc. This function features throughout the pathway as part of the ongoing points (ie "Do something", "Do something more" and "Last days of life/death").

6. Identification of vulnerable people who will be affected by the death

When the person dying has close to them, and probably cares for, people who are vulnerable, it will be necessary to start to put in place arrangements for those people to be cared for after the death, both for their own sake but also for the peace of mind of the person who is dying. This could be young children, or grown up children with disabilities, or a frail partner. These competences are found in the Health Functional Map at *4.5 Contribute to the identification of the risk of danger to individuals and others* and have been placed at the transition points of the pathway. See also "Allowances for Extra Time", page 8, below.

7. Supporting people who are distressed

The over-riding consensus is that everyone who comes into contact with the individual nearing their end of life and their family and friends should be able and prepared to do this, regardless of their role. This has been included as an enhanced skill that workers are expected to have. Function *B2.9.2 Support individuals who are distressed* is included at all ongoing points in the pathway, plus Point 7: Care After Death.

8. Managing conflict

There are times when there may be conflicting views between family members or within professional teams about the best course of action for an individual. Whilst in some circumstances these may spill over into conflict it may be better take a preventative approach and describe it as *G1.3.3 Develop productive working relationships with contacts and stakeholders*. This has been included as an underpinning principle throughout.

9. Social Care

Where a function specifically refers to health care but social care is also relevant this is marked with an asterisk*.

10. Record-keeping

Although this could be seen as an underpinning principle it does take time which needs to be costed so has been put in at almost every point of the pathway, as *F1.2.2 Input data and information for processing*. There was broad consensus on how long this would take but it was noted that it would depend on the system in use. If all members of staff from all organisations were able to use the same ICT system this would save significant amounts of time. The assumptions of time for these purposes assumed an effective system across one organisation, such as Systm1 used in East Midlands within the community health team, and that staff members didn't spend significant amounts of time travelling to a place where they could input data, rather than using a laptop at the individual nearing their end of life's home or in their car straight afterwards (see later paragraph on travelling time).

11. Organ donation

It is usually only possible to consider organ donation when an individual dies in an acute setting, rather than the community settings described in these pathways. This would more likely form part of a trauma pathway, and it would be essential that the decision that nothing further can be done for an individual nearing their end of life be taken before a separate individual raised the possibility of organ donation with the family.

12. Staff Support

Whilst not directly related to individuals nearing their end of life it is recognised that working in End of Life Care can be difficult and emotionally demanding on staff. Relevant functions and competences can be found in the Health Functional Map at

H2.2 Reflect on and evaluate your own values, priorities, interests and effectiveness – Gen36 Make use of supervision. This has been included as an underpinning principle throughout.

13. Carers

It may be useful to note that unpaid carers were not involved in this work and that any issues raised came from the insights of health and social care colleagues.

Within the working document the focus was on the skills required in terms of carer support. This may be in the form of family / friends / neighbours who provide unpaid care for the person who is dying and have their own support needs. Alternatively it could be a paid carer or night support service. Carers often have good knowledge about the individual nearing their end of life, their likes and dislikes and possible preferences around end of life care, though it should not be assumed that the carer can always speak for and represent the individual, depending on the quality of their relationship.

There were four specific issues arising about support for carers which were

i. whilst the individual is still alive it may be appropriate for the individual nearing their end of life and carer to receive support from different people, to ensure that carer's needs are not subsumed by those of the individual nearing their end of life. Broadly the same level of skill and amount of time would be needed for this, so it would not affect the overall amount of time needed;
ii. support for carers can mean emotional support for the situation – an enhanced skill – or practical help such as doing the shopping and taking the dog for a walk, which frees up time for the carer to care, which is shown as a generic skill
iii. the amount of time allowed for supporting carers after death is small. This reflects the immediate support required as part of the EoLC pathway of the person who has just died. Some carers will need much more extensive support and in all cases time should be allowed for some kind of follow up care later on, such as a conversation with a GP, as part of their ongoing care of that individual nearing their end of life. This has been allocated within the pathway for sign-posting activity for all except the Frailty trajectory (see paragraph on Point 7: Care After Death).
iv. in the last days of life (Point 6) 1440 minutes have been allowed per day for 24 hour care. In some cases this may be a carer but it could also be a night support service, provided by paid staff or volunteers, from the NHS, private or voluntary sector providers. It was noted that at this point a confident generic worker will reduce the requirements for enhanced care, and that specialist care is likely to consist mostly of providing expert advice.

14. Overnight care

At Point 4 on the pathway it is assumed that a proportion of individuals will need an overnight support service, as described above. Within both the organ failure and other terminal pathways estimations have been made about the proportion of individuals nearing their end of lifes and carers who will need this support by this stage, which are included in the narrative but not the tables of figures. It has been assumed that the system model will adjust for the balance of paid/unpaid carer support in order to inform costings.

15. Respite Care

Whilst an individual is at Points 2 and 4 in the pathway they may receive respite care. It is assumed that the individual nearing their end of life will still need the same functions carried out to provide their care, and the assessment for, and co-ordination of, respite care would be carried out at Points 1 and 3 as part of developing the care plan.

16. Contingencies

This relates to the need to ensure any costing, care hours or residential respite placement may need to ensure it has a contingency amount built in to cover additional unpredictable amounts in the event of events such as:

- Carer breakdown (informal) due to hospitalisation etc
- Domiciliary care hour - sudden increase (also known as one-offs) due the person being unwell and needing the carer to remain in the property longer than commissioned for

Emergency respite placements can incur transportation costs as well as placement costs as social care transportation has to be commissioned.

Pet care costs – in the event of the person requiring hospitalisation or emergency placement (this is a property protection duty for local authorities).

Safeguarding processes can also at times incur further costs.

Functions which cover aspects of contingencies have been included (eg *B2.9.5 Support individuals in their daily living, B2.10.3 Support carers to manage their own needs)*, although specific additional time has not been factored in.

17. Dementia

The groups looking at different trajectories made different assumptions about dementia in terms of who they would liaise with at different stages in the pathway, so that if they were dealing directly with carers the time allowed would not vary according to whether the individual nearing their end of life had dementia. Where it was viewed that additional time would be required for caring for individuals nearing their end of life with dementia, a replacement timing is given in brackets ().

18. Cancer

It was noted that some individuals nearing their end of life remain on a course of treatment whilst having been put on the EoLC pathway. The skills in relation to delivery of this care fall outside of the scope of this exercise to articulate the workforce needs for delivering quality EoLC,

19. Organ Failure

It was noted that some transitions will occur in an acute setting as individuals nearing their end of life go in for planned interventions. There is therefore an ongoing need for primary-secondary care working and inreach services to give continuity of input. Acute input has not been included in this work, but inreach is reflected.

20. Point 6: "Last Days of Life/Death"

There was a strong feeling that 24/7 care should be in place at this point at a generic skill level. This would correspondingly reduce the need for enhanced and specialist time and also facilitate greater numbers of people dying in their place of choice. Assuming a good care plan was in place, timings were agreed for all trajectories: 1440 minutes at generic, 200 minutes at enhanced, 5 minutes at specialist (in relation to the condition).

21. Point 7: "Care After Death"

Frailty: Timings in this instance are comparatively high due to anticipated higher levels of vulnerability and need of the bereaved. It was noted that as system improvements take place, some of this investment may be re-deployed to earlier points.

B2.8.14 Managing Stocks of Medication: Participants felt that as part of the Gold Standard Framework, all individuals nearing their end of life would have pre-emptive drugs in place at the point of death, some of which would be controlled drugs. It was acknowledged that generally some medications including controlled drugs would remain in the place of death once no longer required and therefore need managing. This was agreed to require 30 minutes at an enhanced level of skill for all trajectories.

General functions/timings: It was felt that skill requirement and input after death would be similar in all instances, and as such each trajectory was amended to reflect this. This assumed that whilst a condition specialist might provide input at this point, the skill need would be at enhanced level.

22. Inclusion of Entry Point 8 (into "Do Something More) and 9 (into "Last Days of Life)

These entry points have been included across all trajectories, although it was acknowledged that in many cases it would be better for individuals nearing their end of life to be put onto the EoLC pathway sooner.

23. Differences between trajectories in patterns of delivery of care

In the course of the functional analysis clinicians indicated a number of differences in where care tends to be delivered, or the fact that individuals nearing their end of life may be following two pathways concurrently. These observations, and how they have been dealt with, are noted within the text of individual pathways.

24. Allowances for extra time

There are a number of functions where there could be a requirement for extra time and/or resources according to circumstances which are outside the specific disease trajectories; these are

1. Record keeping – see above

2. Time spent travelling to the individual nearing their end of life, which could be quite significant in rural areas. Due to the localised nature of this, travelling has not been included in workforce timings. However it is possible to reflect this in the context of the overall systems model by adjusting the percentage of time spent patient-facing.

3. Bariatric patients: individuals who are significantly overweight will require more time and equipment, including stronger beds, and have a higher incidence of co-morbidities.

4. Organ Failure / overnight care: it was noted at Point 4 that approximately 15% of patients will require overnight support – assume 7.5 hours x 3 nights per week; and at Point 6 that approximately 50% of patients will require overnight support – assume 7.5 hours x 7 nights per week. These would be in addition to timings stated.

5. Other Terminal / overnight care: it was noted at Point 4 that 75% of patients will require overnight support at 7.5 hours. This would be in addition to timings stated.

6. Unexpected versus expected death: an unexpected death requires more time after death, in that there are more people to liaise with, prepare reports etc. Once an individual is on a particular disease pathway death is inevitable and thus to be expected. In some cases it is more obvious to clinicians than family and carers that someone is likely to die soon, and when the individual dies family and carers will describe the death as unexpected. This can lead to the involvement of the coroner and a more complex situation for all to deal with, including family and carers. It may be that better preparation of family and carers for what is likely to happen may be helpful.

7. Late entry onto any trajectory: when an individual enters the End of Life pathway very late it may be necessary to very quickly identify vulnerable people who will be affected by the death, such as frail partners, young children etc. In extreme cases this may mean arranging a place of safety for someone at immediate notice.

8. The need for translation if the individual does not have English as their first language.

25. Education

Education was noted as being a key element underpinning the effective delivery of end of life care across all trajectories. Whilst the use of functions lends itself to further work in this area, it falls outside of the scope of the currently project.

Mapping Against Common Core Competences

The "Common core competences and principles for health and social care workers working with adults at the end of life" were published to underpin the National End of Life Care Strategy. The principles and competences outlined in that document form a common foundation for all workers whose work includes care and support for people approaching, and at, the end of their lives, whether their primary involvement is healthcare related or social care and support.

All of the defined common core competences have been covered by the functions identified as part of the functional analysis work, with a few reasonable exceptions. Checking took place for appropriateness/consistency on the occurrence of the core competences throughout the analysis.

Following consultation at one of the functional analysis workshops, these functions have now all been addressed and included as shown – please see the appended Common Core Competence Mapping (Appendix 7). All trajectories have functions which encompass the common core competences denoted by the function reference being shown in **red**.

Additional underpinning principles:

1. Function 4.2: Ensure your own actions support the care, protection and wellbeing of individuals (HSC24)
   Promote choice, wellbeing and the protection of all individuals (HSC35)
2. Develop your knowledge and practice (HSC23 – Function H2.1)
3. Take responsibility for the continuing professional development of yourself and others (HSC43 – Function H3.5)

General functions:

4. Support individuals to represent their own needs and wishes at decision-making forums (HSC366 – Function C2.3.3) – addressed through HSC368 – Function C2.3.4 which is included as an underpinning principle and where appropriate in pathway points
5. Use and develop methods and systems to communicate, record and report (HSC41 – Function 1.1) – other similar functions included
6. Carry out extended feeding techniques to ensure individuals' nutritional and fluid intake (CHS17 – Function B2.3.2) – part of general delivery of care plan.

Some are service development not care pathway (and therefore need noting, but not including as part of the pathway):

7. Develop practices which promote choice, wellbeing and protection of all individuals (HSC45)
8. Contribute to promoting a culture that values and respects the diversity of individuals (HSC3116 – Function 2.4)
9. Promote the values and principles underpinning best practice (HSC3119)
10. Contribute to the development, maintenance and evaluation of systems to promote the rights, responsibilities, equality and diversity of individuals (HSC452 – Function 2.3)

Appendices

Trajectories:
1. Cancer
2. Frailty
3. Organ failure
4. Other terminal
5. Sudden death

Quality Assurance:
6. Summary of timings across all trajectories and points
7. Common Core Competence Mapping
8. Workshop participants

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Trajectory and System Point Comparison

		frailty					organ failure					other terminal					sudden death					cancer			
		G	E	S	=		G	E	S	=		G	E	S	=		G	E	S	=		G	E	S	=
1 entry transition to do something	one-off mins	125	465	285	875		100	280	365	745		205	495	660	1360							110	150	125	385
dementia			480		480		140	360	495													150	175		
2 do something	mins per day	205	153	51	409		137	131	33	301		275	210	18	503							10.4	16	5.4	31.8
dementia					0			139	40													17	17.6		
3 transition to do something more	one-off mins	65	360	510	935		100	300	420	820		120	375	330	825							35	220	70	325
dementia					0			360	480																
4 do something more	mins per day	605	112	67	784		354	180	36	570		985	190	100	1275							69	63.4	28	160.4
dementia					0				41																
5 transition to last days	one-off mins	320	300	60	680		110	300	120	530		80	400	310	790							20	135	60	215
dementia					0			340	135																
6 last days of life / death	mins per day	1440	200	5	1645		1440	200	5	1645		1440	200	5	1645		1440	200	5	1645		1440	200	5	1645
dementia					0																				
7 care after death	one-off mins	20	325	0	345		20	235	0	255		20	235	0	255		20	235	0	255		20	235	0	255
dementia			355		355			265					265										265		
8 entry transition to do something more	one-off mins	125	465	285	875		100	280	635	1015		205	495	750	1450							100	380	245	725
dementia			480		480			360	735													140	420	255	
9 entry transition to last days of life	one-off mins	125	465	285	875		100	280	635	1015		205	495	810	1510		85	605	130	820		100	380	245	725
dementia			480		480		140	360	735													140	420	255	
totals (excl dementia)		3030	2845	1548	7423		2461	2186	2249	6896		3535	3095	2983	9613		1545	1040	135	2720		1904	1779.4	783.4	4467

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East Midlands EoLC Systems Modelling Project – Functional Mapping
EoLC Common Core Competences

	Core Competence	**Ref Function**	**EM Project Modelling Point** (UP = underpinning principle)								
			1: Entry (1)	**2: Do**	**3: Transition**	**4: Do More**	**5: Transition**	**6: Last Days**	**7: After Death**	**8: Entry (2)**	**9: Entry (3)**
Communication Skills											
HSC21	Communicate with and complete records for individuals	1.2	UP	UP	UP	UP	UP	UP	UP	UP	UP
HSC31	Promote effective communication with, for and about individuals	1.2	UP	UP	UP	UP	UP	UP	UP	UP	UP
HSC366	Support individuals to represent their own needs and wishes at decision-making forums	C2.3.3	Covered by other general supporting functions								
HSC368	Present individuals' needs and preferences	C2.3.4	UP	UP	UP	UP	UP	UP	UP	UP	UP
HSC41	Use and develop methods and systems to communicate, record and report	1.1	Covered by 1.2 Communicate effectively (throughout)								
CHS48	Communicate significant news to individuals	1.3	x		x		x	x	x	x	x
			Also covered by: B2.9.10: Support individuals to prepare for, adapt to and manage change (throughout) 1.2: Communicate effectively (throughout)								
Assessment and Care Planning											
EUSC02	Obtain supporting information to inform the assessment of an individual	A2.2.2	x		x					x	x
HSC398	Contribute to assessing the needs of individuals for therapeutic programmes to enable them to manage their behaviour	A2.8.5	x		x		x			x	x
GEN75	Collaborate in the assessment of the need for, and the provision of, environmental and social	A2.8.6	x		x		x	x		x	

	Core Competence	**Ref Function**	**EM Project Modelling Point** (UP = underpinning principle)								
			1: Entry (1)	**2: Do**	**3: Transition**	**4: Do More**	**5: Transition**	**6: Last Days**	**7: After Death**	**8: Entry (2)**	**9: Entry (3)**
	support in the community										
HSC414	Assess individual needs and preferences	A2.8.5	x		x		x			x	x
HSC427	Assess the needs of carers and families	A2.8.7	x		x		x			x	x
Symptom management, maintaining comfort and wellbeing											
HSC24	Ensure you own actions support the care, protection and wellbeing of individuals	4.2	UP	UP	UP	UP	UP	UP	UP	UP	UP
HSC227	Contribute to working in collaboration with carers in the caring role	B2.10.1		x		x	x	x			
HSC216	Help address the physical comfort needs of individuals	B2.9.6		x		x					
HSC218	Support individuals with their personal care needs	B2.9.6		x		x					
HSC219	Support individuals to manage continence	B2.9.6		x		x					
BSC225	Support individuals to undertake and monitor their own healthcare	B2.9.11		x		x					
HSC35	Promote choice, wellbeing and the protection of all individuals	4.2	UP	UP	UP	UP	UP	UP	UP	UP	UP
HSC287	Work in collaboration with carers in the caring role	B2.10.1		x		x	x	x			
CHS17	Carry out extended feeding techniques to ensure individuals' nutritional and fluid intake	B2.3.2	Covered as part of implementing care plan								
CC09	Enable individuals to effectively evacuate their bowels	B2.9.6		x		x					
CHS164	Manage pain relief for an individual	B2.3.3						x			
HSC45 (Service)	Develop practices which promote choice, wellbeing and protection of all individuals	2.3									

	Core Competence	**Ref Function**	**EM Project Modelling Point** (UP = underpinning principle)								
			1: Entry (1)	**2: Do**	**3: Transition**	**4: Do More**	**5: Transition**	**6: Last Days**	**7: After Death**	**8: Entry (2)**	**9: Entry (3)**
HSC387	Work in collaboration with carers in the caring role	B2.10.1		x		x	x	x			
CHS97	Organise a programme of support following withdrawal from treatment	B1.1.3	x (Care Plan-ning)		x (Care Plan-ning)		x			x (Care Plan-ning)	x (Care Plan-ning)
Advance Care Planning											
HSC328 /AG2	Contribute to care planning and review	B1.1.3 / B3.1.6	x	x	x	x				x	X
HSC416 /AG1	Develop, implement and review care plans for individuals	B1.1.3 / B3.1.6	x	x	x	x				x	X
CHS167	Obtain valid consent or authorisation	A2.2.1	x		x					x	X
Overarching values and knowledge											
HSC23	Develop your knowledge and practice	H2.1	UP	UP	UP	UP	UP	UP	UP	UP	UP
HSC226	Support individuals who are distressed	B2.9.2		x		x		x	x		
HSC3116 (service)	Contribute to promoting a culture that values and respects the diversity of individuals	2.4									
HSC33	Reflect and develop your practice	H2.2	x	x	x	x	x	x	x	x	X
HSC3119 (service)	Promote the values and principles underpinning best practice										
HSC384	Support individuals through bereavement	B2.9.15							x		
			Also B2.9.10 Support individuals to prepare for, adapt to and manage change (throughout)								
HSC385	Support individuals through the end of life process	B2.9.14						x	x		
HSC428/ MH7	Develop, implement and review programmes of support for carers and families	B2.10.3		x		x			x		
HSC43	Take responsibility for the continuing professional development of yourself and others	H3.5	Covered by H2.1 Develop your knowledge and practice (throughout)								

Skills for Health

	Core Competence	**Ref Function**	**EM Project Modelling Point** (UP = underpinning principle)								
			1: Entry (1)	**2: Do**	**3: Transition**	**4: Do More**	**5: Transition**	**6: Last Days**	**7: After Death**	**8: Entry (2)**	**9: Entry (3)**
HSC452 (service)	Contribute to the development, maintenance and evaluation of systems to promote the rights, responsibilities, equality and diversity of individuals	2.3									
HSC412	Ensure individuals and groups are supported appropriately when experiencing significant life events and transitions	B2.9.10	x	x	x	x	x	x	x	x	X

Functional Analysis Participants

Please note: *this list represents those who were involved either wholly on in part in the functional analysis process related to this project. Some of these individuals will have been involved consistently throughout; others may have provided specialist insights for subsequent testing in wider consensus sessions.*

Name	Title	Organisation
Andy Fawcett	Community Charge Nurse	LCR Community Health Services
Avril Robinson		Derbyshire County Council
Benny Rossi	Clinical Support Services and Neurological Lead	LOROS
Carol Gent	Care Centre Co-ordinator	Motor Neurone Disease Care Centre
Cate Hollinshead	Education Manager, Derbyshire Workforce Development Team	Derby Hospitals NHS Foundation Trust
Cathy Gorman		NHS Derby City
Christine Collymore	Project Manager	Skills for Care
Clare Barnes	District Nurse	LCR Community Health Services
Denise Mackey		Derbyshire County Council
Denise Middleton		LCR Community Health Services
Donna Gristwood	Manual Handling Social Care Team	Northamptonshire County Council
Fran Platts	Therapy Lead for Neurological Rehabilitation (North)	Nottinghamshire Community Health
Gavin Jinks	Training and Education Officer	Derby City Council
Geraldine Harris	Health Safety/ Manual Handling Advisor	Northamptonshire County Council
Gill Bradley	DayCare Leader	Bassetlaw Hospice
Jag Bains	Head of Service – Intermediate Care	Leicester City Council
Jane Connell	Regional Care Development Advisor	MND Association
Jane Scrafton	Nurse Specialist Heart Failure	Lincolnshire PCT
Jane Winn	Start Northampton MH Advisor	Northamptonshire County Council
Jo Kavanagh	Nurse Director	East Midland Cancer Network
Joanne Merritt		Northamptonshire Primecare's End of Life Rapid Response Service
Julie Seddon	Workforce Planning and Development Manager	Lincolnshire Workforce Advisory Board
Karen Bussooa	EoL Strategy Project Manager	Derby Hospitals Foundation Trust
Karen Hamilton	Practice Development Facilitator	LOROS
Katie Anderson	Service Manager Older and Disabled Person Services	Leicestershire County Council
Kim Barr	Complex Case Manager	Lincolnshire PCT
Lesley Tooley	Clinical Education Lead	North West Locality
Lorraine Garner	Community Nursing Service Manager	Bassetlaw Community Health
Maxine Leeson	District Nurse	LCR Community Health Services
Melanie Weatherly	Manager	Walnut Care (domiciliary care)
Phil Simmonds	Snr Staff Development Officer	Derbyshire County Council
Philippa Graham	Education Facilitator	LOROS
Rachel Major	Community Nurse/DN Student	

Rachael Gavin	Heart Failure Complex Case Manager	Lincolnshire Community Health Services
Rebecca Warren	Contract Manager	Northamptonshire Primecare's End of Life Rapid Response Service
Sandra Wright	Workforce Development and Planning Manager	Northamptonshire Local Healthcare Community Workforce Team
Sarah Grandy	Community Services Manager	LCR Community Health Services
Sharan Watkinson	Workforce Development and Planning Manager	Lincolnshire Workforce Advisory Board
Steph Austin	Head of Clinical Quality (Community Care) - Commissioning	LCR Community Health Services

Chris Sutcliffe	Strategic Workforce Development Manager	NHS East Midlands
Darren Lodge		Whole Systems Partnership
Pippa Hodgson	Regional Director	Skills for Health
Jane Goodwin	Development Manager	Skills for Health
Sheila Hawkins	Workforce Competence Advisor	hosted by LLR Workforce Team