**National End of Life Care Programme**
**End of Life Care Systems Modelling Project (East Midlands)**

**EoLC Stories that informed the Description of Workforce Needs Using Functional Analysis (2010-11)**

## Ongoing care plan review and accessing resources

Following several heart failure admissions an elderly gentleman with co-morbidities was involved in a discussion about his patient status and goals of care. At this point he indicated that he did not wish to return to hospital for active treatment, and that his preferred place of care was at home. In spite of this, it was observed that he was not managing well at home which was in a rural area and where he lived alone.

The decisions taken from this were subsequently presented to the advanced heart failure multi-discplinary team (MDT).

A subsequent visit revealed that the gentleman was really not coping at home and the decision was taken to access a palliative care bed in the local community hospital. During this time an assessment for Continuing Care funding would be undertaken in order that he could be cared for in a setting which was more in keeping with his wishes. After a period of 2 to 3 weeks this was achieved by him being moved to a care home.

The patient was involved in the decisions about his care throughout, with his family being made aware of his wishes and plans.

Clearly it is important that the skills and opportunity that support the individual in making his own health choices are available. *Enable individuals to make health choices and decisions regarding their own health or the health of others* is a function which appears at every transition point of the functional analysis work. It has been stressed that it is important to continue to review these decisions as an individual's condition progresses and by taking a pathway approach, this has been reflected.

In respect of ensuring the appropriate funding is in place to open up appropriate opportunities for care, the function *Arrange access to resources needed to support planned healthcare/lifestyle programmes* has also been included across the EoLC trajectories. This would facilitate the assessment for CHC funding which was the key to achieving this gentleman's main aim – to stay out of an acute setting.

**Want to find out more?** Further detail on how we worked with health and social care professionals to describe the care needed for individuals in their last year of life in community settings can be found on the NEoLCP Intelligence Network site (http://www.endoflifecare-intelligence.org.uk/end_of_life_care_models/skills_for_health.aspx).

More detail about the use of functions and competences as a way of reviewing and designing your teams based on patient need can be found at www.skillsforhealth.org.uk, or by contacting pippa.hodgson@skillsforhealth.org.uk.