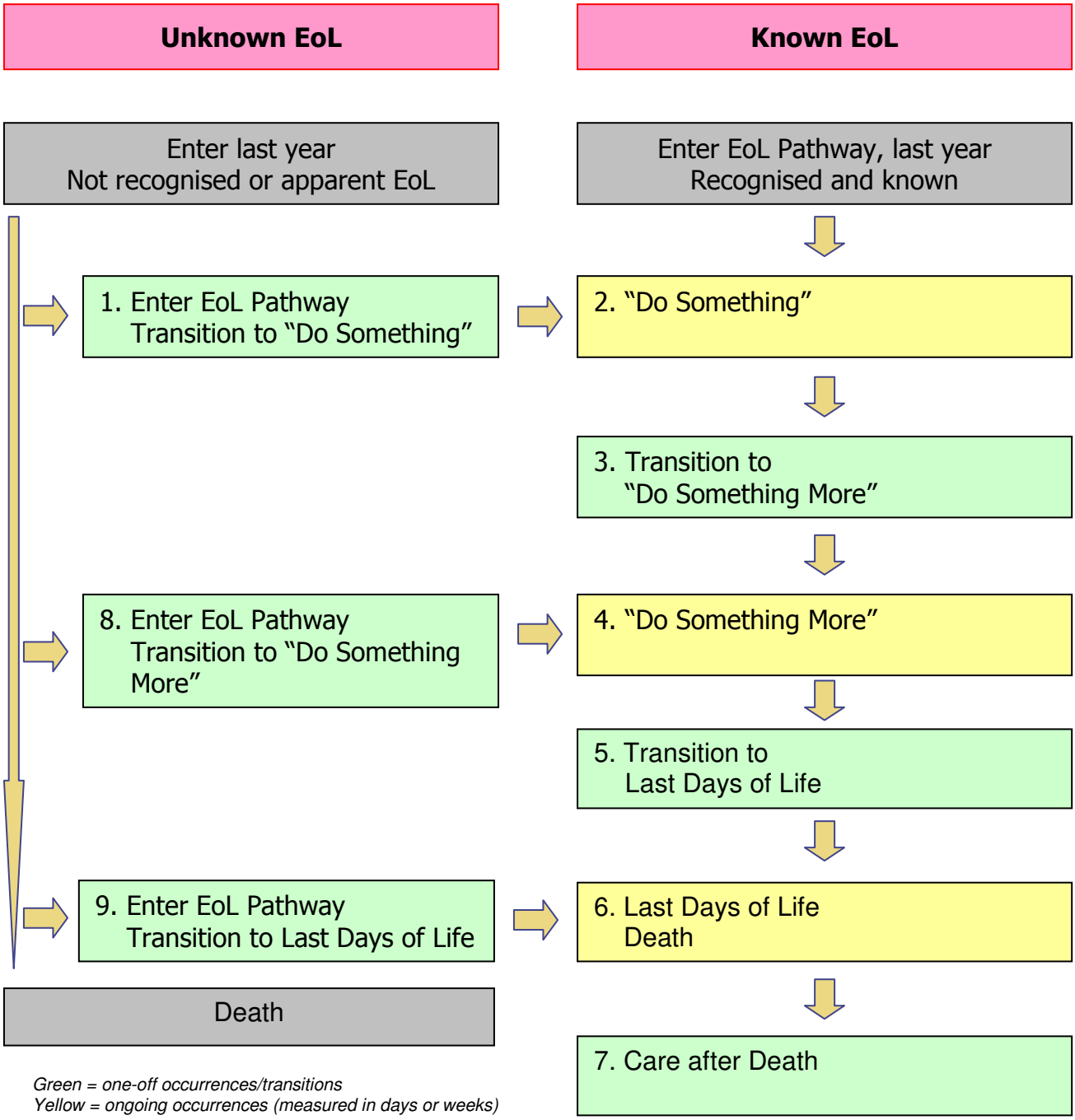
Functional Analysis:
End of Life Care
(reviewed November 2011 – North of Tyne)

Generic Points along the Pathway



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

*Italics = Common Core Competence [Function references denoted in *red]*

Contents

Section 1: Context

This document builds on the National End of Life Care Programme's earlier commissioned work to develop modelling tools for EoLC. The original piece of work explored the skill needs to support individuals in their last year of life in community settings in each of 5 trajectories of need (cancer, organ failure, other terminal, frailty and sudden death), and can be found at http://www.endoflifecare-intelligence.org.uk/end_of_life_care_models/skills_for_health.aspx.

Following an expression of interest, North of Tyne was selected as an "early adopter" site who would use Functional Analysis and population systems modelling to aid aspects of their service improvement. The Functional Analysis was facilitated through Skills for Health, and in this instance focussed on a generic EoLC trajectory for patients in any EoLC setting, acute or non-acute.

This report provides a record of the workforce assumptions that were ultimately used. It was informed by the extensive earlier work with practitioners in East Midlands, and a subsequent review session with practitioners from North of Tyne in November 2011. Overall it had the involvement either wholly or in part of 50 health and social care practitioners, including 11 from North of Tyne.

End of Life Care Pathway Functions

At each point along the end of life care pathway shown on the front page, functions and National Occupational Standards (NOS) which support people in end of life care and their carers have been identified from the Skills for Health 'Health Functional Map'. The functions have been grouped together in clusters to represent how they are used together and these are indicated by headings in pink shading.

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.

*Italics = Common Core Competence [Function references denoted in *red]*

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.

It is crucial to note that the functions and competences identified in the following pages have been assigned a skill level that reflects that particular element of care. It is not reflective of a "generic worker" or "specialist practitioner" as these roles will all have a mix of skill requirements across generic, enhanced and in some cases specialist, as determined by the definitions above.

Each function and NOS has been given a skill-level indication, but this in no way implies an equal amount of provision. In many instances there may only be a small amount of specialist input and a larger amount of generic and/or enhanced, and in others it will be the opposite dependant on the point of the pathway.

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.

The original piece of work based in the East Midlands went a stage further by identifying approximate timings for each function undertaken. This meant that once the link was made with the system model developed alongside it, it became possible to start to put a cost on the provision of end of life care services and model changes. Timings have been removed from this current piece of work, in order that the focus could be on what needs doing, and at what skill level.

Skills for Health "Health Functional Map' (HFM)

The functions and NOS (competences) identified and their associated prefixes have been drawn from the HFM (Autumn 2010) which is available on the SfH website (www.skillsforhealth.org.uk). The titles of the functions and competences, cannot be changed.

Issues and Actions arising from the Functional Analysis Workshop

This section aims to reflect key aspects of questioning and discussion that came out of the workshop which informed this review work. It provides a useful context to underpin the workbook and in conjunction with the footnotes indicated throughout a much richer picture of the workforce needs expressed.

1. Advance Care Planning

Participants felt this was critical to the process of End of Life Care but it was difficult to see the process within the Health Functional Map. Advance care planning is described as part of the Common Core Competences for EoLC as the following:

AG2: Contribute to care planning and review (Function B3.1.1)
AG1: Develop, implement and review care plans for individuals (Function B14.2)
CHS167: Obtain valid consent and authorisation (Function B1.1).

All of these competences feature throughout the workbook at both transition (assessment and planning) and ongoing (care delivery) points.

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. Within this, competence CHS48: Communicate significant news to individuals has been specifically included as appropriate.

A further element of communication relates to the need to maintain records and this is encompassed within LANTRA CU6: Maintain communications and records within the organisation and HSC21: Communicate with, and complete records for individuals, both of which feature throughout the workbook.

4. Education

Education and development of others was noted as being a key element underpinning the effective delivery of end of life care across all trajectories and as such this is included within the underpinning principles.

5. Gold Standards Framework

It was suggested that future cross-referencing to the GSF definitions might be a useful development in terms of what each point of the pathway represents.

*Italics = Common Core Competence [Function references denoted in *red]*

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 – please see the appended Common Core Competence Mapping (Appendix 1). All points of the pathway have functions which encompass the common core competences denoted by the function reference being shown in **red**, the competences themselves being shown in ***italics***.

Section 2:
EoLC Functional Analysis:

GENERIC

Underpinning Principles

*1.2 Communicate effectively *HSC21: Communicate with, and complete records for individuals* *HSC31: Promote effective communication with, for and about individuals*
*1.1 Develop methods of communicating[5] *HSC41: Use and develop methods and systems to communicate, record and report* 1.3 Support individuals to communicate HSC369: Support individuals with specific communication needs
1.4 Develop relationships with individuals HSC233: Relate to, and interact with, individuals
6.1 Ensure your own actions support equality of opportunity and diversity HSC234: Ensure your own actions support the equality, diversity, rights and responsibilities of individuals *6.3 Develop a culture that promotes equality of opportunity and diversity, and protects individuals *HSC3116: Contribute to promoting a culture that values and respects the diversity of individuals* *HSC45: Develop practices which promote choice, well-being and protection of all individuals* *HSC452: Contribute to the development, maintenance and evaluation of systems to promote the rights, responsibilities, equality and diversity of individuals*
3.5.1 Ensure your own actions reduce risks to health and safety ENTO HSS1: Make sure your own actions reduce risks to health and safety
H1.1.5 Provide leadership[16] M&L B8: Ensure compliance with legal, regulatory, ethical and social requirements
*5.1.1 Act within the limits of your competence and authority *HSC24: Ensure your own actions support the care, protection and well-being of individuals* *HSC35: Promote choice, well-being and protection of all individuals*
*C2.4 Enable people to address issues relating to their health and wellbeing *HSC366: Support individuals to represent their own needs and wishes at decision making forums* *C2.6 Act on behalf of an individual, family or community *HSC368: Present individuals' needs and preferences*
H1.3.2 Develop relationships with individuals M&L D2: Develop productive working relationships with colleagues and stakeholders
*2.1.1 Develop your own practice *HSC23: Develop your knowledge and practice*
*2.1.2 Reflect on your own practice[17] *HSC33: Reflect on and develop your practice* 2.1.3 Make use of supervision GEN36: Make use of supervision
*2.2.1 Support the development of the knowledge and practice of individuals *HSC43: Take responsibility for the continuing professional development of self and*

*Italics = Common Core Competence [Function references denoted in *red]*

others
F4.1 Determine the learning needs of individuals to enable management of their health and wellbeing PE6: Identify the learning needs of patients and carers to enable management of a defined condition
F4.4 Enable individuals to develop the knowledge and skills to manager their own health needs* PE5: Develop relationships with individuals that support them in addressing their health needs
1.5 Provide information, advice and guidance* GEN14: Provide advice and information to individuals on how to manage their own condition
*5.2.3 Promote the values and principles underpinning best practice *HSC3119: Promote the values and principles underpinning best practice*

Notes:

5. intended for communication with individuals with specific difficulties such as an inability to speak, but could include people with dementia or learning disabilities
16. includes confidentiality
17. includes making use of supervision as a way of supporting the individual providing support

* relevant to both health and social care

Point 1: Enter EoL Pathway – Transition to "Do Something"

This is a one-off occurrence on the pathway.

TRIGGERS: Eg diagnosis, clinical instability, pain/symptom relief needed, mobility support needed, some assistance with personal care needs, frequent use of OOH's and/or frequent admissions to hospital

	G	E	S
Plan assessment			
A2.1 Plan assessment of an individual's health status CHS38: Plan assessment of an individual's health status			
Carry out assessment			
*A2.4 Assess an individual's needs arising from their health status **HSC414: Assess individual needs and preferences* *PE3: Work with individuals to evaluate their health status and needs *B1.1 Obtain valid consent for interventions or investigations **CHS167: Obtain valid consent or authorisation*			
*B2.2 Obtain information from indirect sources about an individual's health status and needs[10] **EUSC02: Obtain supporting information to inform the assessment of an individual*			
*A2.4 Assess an individual's needs arising from their health status **GEN75 Collaborate in the assessment of the need for, and the provision of, environmental and social support in the community*			
B2.3 Request investigations to provide information on an individual's health status and needs *CHS106: Request imaging investigations to provide information on an individual's health status and needs (other investigations, dependent on context)			
B5.1 Obtain specimens from individuals CHS7: Obtain and test specimens from individuals			
B8.1 Undertake physiological measurements CHS19: Undertake routine clinical measurements			
3.5.2 Protect individuals from abuse[19] HSC240: Contribute to the identification of the risk of danger to individuals and others			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			

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EoLC Functional Analysis

Early management			
*1.2 Communicate effectively *CHS48: Communicate significant news to individuals*			
A2.4 Assess an individual's needs arising from their health status PE3: Work with individuals to evaluate their health status and needs *C2.1 Encourage behaviour change in people and agencies to promote health and wellbeing *HSC398:Contribute to assessing the needs of individuals for therapeutic programmes to enable them to manage their behaviour*			
A2.5 Agree courses of action following assessment CHS45: Agree courses of action following assessment to address health and wellbeing needs of individuals			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC225: Support individuals to undertake and monitor their own healthcare* *HSC412: Manage provision of care services that deals effectively with transitions and significant life events* HSC382: Support individuals to prepare for, adapt to and manage change			
B3.1.2 Enable individuals to make health choices and decisions PE1: Enable individuals to make informed health choices and decisions			
B3.4.2 Refer individuals to services for treatment and care GEN59: Direct requests for assistance, care or treatment using protocols and guidelines			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			
1.5 Provide information, advice and guidance* GEN14: Provide advice and information to individuals on how to manage their own condition			
Make diagnosis of end of life			
B7 Interpret and report on findings from investigations CHS83: Interpret the findings of healthcare investigations			
A2.3 Assess an individual with a suspected health condition CHS40: Establish a diagnosis of an individual's health condition			
1.2 Communicate effectively[1, A] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			
Receive referral			
B3.4.1 Receive and direct requests for health care assistance using protocols and guidelines GEN59: Direct requests for assistance, care or treatment using protocols and guidelines GEN58: Receive requests for assistance, treatment or care			

*Italics = Common Core Competence [Function references denoted in *red]*

Advance Care Planning			
*B17 Work in collaboration with carers in the caring role *HSC227: Contribute to working in collaboration with carers in the caring role* *HSC387: Work in collabroation with carers in the caring role* *HSC427: Assess the needs of carers and families*			
B3.1.2 Enable individuals to make health choices and decisions* PE1: Enable individuals to make informed health choices and decisions			
*B14.2 Implement care plans/programmes *AG1: Develop, implement and review care plans for individuals*			
B3.1.1 Plan activities, interventions or treatments to achieve specified health goals[2] *AG2: Contribute to care planning and review* *CHS97: Organise a programme of support following withdrawal from treatment* CHS41: Determine a treatment plan for an individual			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			
F4.1 Determine the learning needs of individuals to enable management of their health and wellbeing PE6: Identify the learning needs of patients and carers to enable management of a defined condition			
1.5 Provide information, advice and guidance* GEN14: Provide advice and information to individuals on how to manage their own condition			
B3.4.2 Refer individuals to services for treatment and care GEN59: Direct requests for assistance, care or treatment using protocols and guidelines			

Notes:

1. recording information centrally for sharing with colleagues
2. describes advance care planning
10. includes other agencies, including social care, GPs etc
19. includes arrangements for young children, older children with disabilities, frail partners, etc

* relevant to both health and social care

A communication of outcome, not making the diagnosis

Point 2: "Do Something"

This is an ongoing occurrence on the pathway.

	G	E	S
Implement care plan			
B14.1 Co-ordinate the implementation and delivery of treatment plans[6] CHS88: Co-ordinate the implementation and delivery of treatment plans			
B15.6 Administer medication to individuals CHS3: Administer medication to individuals B15.8 Support individuals to self-medicate MH36: Support individuals to administer their own medication			
B15.10 Manage stocks of medication CHS1: Receive and store medication and products (These NOS mainly focus on provision of pharmacy services – some of what is needed to support the individual is covered in MH36, above)			
*B14.2 Implement care plans/programmes[21, B] *AG1: Develop, implement and review care plans for individuals*			
B14.3 Deliver therapeutic activities (64 NOS – please select from www.skillsforhealth.org.uk according to context)			
B3.3.4 Prepare environments and resources for use in health care activities* GEN6: Manage environments and resources for use during healthcare activities			
B16.1 Support individuals during and after clinical/therapeutic activities GEN5: Support individuals undergoing healthcare activities			
*B16.2 Support individuals who are distressed *HSC226: Support individuals who are distressed*			
C2.4 Enable people to address issues relating to their health and wellbeing HSC330: Support individuals to access and use services and facilities			
B16.3 Assist individuals in undertaking activities GEN15: Support individuals in undertaking their desired activities			
B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment[11] HSC27: Support individuals in their daily living HSC345: Support individuals to manage their financial affairs HSC344: Support individuals to retain, regain and develop the skills to manage their lives and environment *B11.2 Maintain fluid levels and balance in individuals *CHS17: Carry out extended feeding techniques to ensure individuals nutritional and fluid intake*			

*Italics = Common Core Competence [Function references denoted in *red]*

*B14.4 Undertake personal care for individuals HSC216: *Help address the physical comfort needs of individuals* *HSC218: Support individuals with their personal care needs* *HSC219: Support individuals to manage continence* *CC09: Enable individuals to effectively evacuate their bowels*			
B16.3 Assist individuals in undertaking activities[4] HSC215: Help individuals to maintain mobility			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC412: Manage provision of care services that deals effectively with transitions and significant life events* HSC382: Support individuals to prepare for, adapt to and manage change			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC225: Support individuals to undertake and monitor their own healthcare*			
*B16.5 Support individuals and carers to cope with the emotional and psychological aspects of healthcare activities *MH37: Recognise, respect and support the spiritual well-being of individuals*			
B16.5 Support individuals and carers to cope with the emotional and psychological aspects of healthcare activities HSC332: Support the social, emotional and identity needs of individuals			
*B17 Work in collaboration with carers in the caring role *HSC227: Contribute to working in collaboration with carers in the caring role* *HSC387: Work in collaboration with carers in the caring role*			
B17 Work in collaboration with carers in the caring role *HSC227: Contribute to working in collaboration with carers in the caring role* *HSC387: Work in collabroation with carers in the caring role* *HSC427: Assess the needs of carers and families* GEN20: Enable carers to support individuals			
*B16.5 Support individuals and carers to cope with the emotional and psychological aspects of healthcare activities *MH7: Develop, implement and review programmes of support for carers and families*			
*C2.4 Enable people to address issues relating to their health and wellbeing *HSC366: Support individuals to represent their own needs and wishes at decision making forums* *C2.6 Act on behalf of an individual, family or community *HSC368: Present individuals' needs and preferences*			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			

1.5 Provide information, advice and guidance[12] GEN14: Provide advice and information to individuals on how to manage their own condition CHS56: Provide clinical information to individuals			
Monitor care plan			
B11.8 Monitor an individual's physiological condition[23] (5 NOS) B3.6.1 Monitor individuals following treatments CHS47: Monitor and assess patients following treatments			
B3.1.3 Review and modify plans to address specified health goals (9 NOS) B3.6.2 Monitor an individual's progress in managing health conditions (13 NOS)			
B4.2 Evaluate the delivery of care plans to meet the needs of individuals CHS53: Evaluate the delivery of care plans to meet the needs of individuals			
B4.3 Evaluate treatment plans with individuals and those involved in their care CHS89: Evaluate treatment plans with individuals and those involved in their care			
*B14.2 Implement care plans/programmes[6, B] *AG1: Develop, implement and review care plans for individuals*			
B15.9 Manage an individuals medication to achieve optimum outcomes[13] CHS74: Manage an individual's medication to achieve optimum outcomes			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			

Notes:

1. recording information centrally for sharing with colleagues
4. this is to enable people to keep mobile both within their home and outside, so could include using a wheelchair or walking stick outside, or continuing to be able to go to the bathroom on their own, or to feed themselves
6. could include equipment
11. includes information and advice around non health issues such as access to welfare benefits, housing adaptations etc
12. includes signposting individuals to other sources of expertise
13. includes reviewing medication on a regular basis
21. the people with specialist/enhanced skills are providing the service while the people with generic skills are acknowledging need and signposting
23. if this means monitoring the specific condition then it's a specialist skill but if it's the individual self-monitoring their overall health, it's a lower level skill

* relevant to both health and social care

B generic skills relate primarily to the implementation of care plans

Because of the nature of the disease some patients are almost always receiving treatment, which may underlay these activities

Point 3: Transition to "Do something more"

This is a one-off occurrence on the pathway.
TRIGGERS: Eg increasing clinical instability, pain/symptom relief needed, extended personal care needs, increased mobility support needs

	G	E	S
Assessment			
3.5.2 Protect individuals from abuse[19] HSC240: Contribute to the identification of the risk of danger to individuals and others			
*A2.4 Assess an individual's needs arising from their health status *HSC414: Assess individual needs and preferences* PE3: Work with individuals to evaluate their health status and needs *B1.1 Obtain valid consent for interventions or investigations[28] *CHS167: Obtain valid consent or authorisation* B2.1 Obtain information from individuals about their health status and needs (No appropriate underpinning NOS)			
*B2.2 Obtain information from indirect sources about an individual's health status and needs *EUSC02: Obtain supporting information to inform the assessment of an individual*			
B2.3 Request investigations to provide information on an individual's health status and needs CHS106: Request imaging investigations to provide information on an individual's health status and needs (other investigations, dependant on context)			
B2.1 Obtain information from individuals about their health status and needs (7 NOS) B2.4 Investigate factors influencing an individual's health status (NOS relate to family history)			
A2.4 Assess an individual's needs arising from their health status PE3: Work with individuals to evaluate their health status and needs *C2.1 Encourage behaviour change in people and agencies to promote health and wellbeing *HSC398:Contribute to assessing the needs of individuals for therapeutic programmes to enable them to manage their behaviour*			
*A2.4 Assess an individual's needs arising from their health status *GEN75: Collaborate in the assessment of the need for, and the provision of, environmental and social support in the community*			
B7 Interpret and report on findings from investigations CHS83: Interpret the findings of healthcare investigations			
*B17 Work in collaboration with carers in the caring role *HSC227: Contribute to working in collaboration with carers in the caring role* *HSC387: Work in collabroation with carers in the caring role* *HSC427: Assess the needs of carers and families*			
B5.1 Obtain specimens from individuals[29] CHS7: Obtain and test specimens from individuals			
B8.1 Undertake physiological measurements[29] CHS19: Undertake routine clinical measurements			
1.2 Communicate effectively[1]			

*Italics = Common Core Competence [Function references denoted in *red]*

LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			
Develop and agree care plan – Advance Care Planning			
*1.2 Communicate effectively *CHS48: Communicate significant news to individuals*			
B3.1.1 Plan activities, interventions or treatments to achieve specified health goals[2] *AG2: Contribute to care planning and review* *CHS97: Organise a programme of support following withdrawal from treatment* CHS41: Determine a treatment plan for an individual			
B3.3.4 Prepare environments and resources for use in health care activities* GEN6: Manage environments and resources for use during healthcare activities			
*B14.2 Implement care plans/programmes[6] *AG1: Develop, implement and review care plans for individuals*			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment HSC382: Support individuals to prepare for, adapt to and manage change			
B4.3 Evaluate treatment plans with individuals and those involved in their care CHS89: Evaluate treatment plans with individuals and those involved in their care			
Referral			
B3.4.1 Receive and direct requests for health care assistance using protocols and guidelines GEN59: Direct requests for assistance, care or treatment using protocols and guidelines GEN58: Receive requests for assistance, treatment or care			
B3.4.2 Refer individuals to services for treatment and care GEN59: Direct requests for assistance, care or treatment using protocols and guidelines			
B3.2.5 Arrange services and support with other healthcare and service providers[6 22 *] GEN38: Arrange access to services identified in the individual's rehabilitation plan CHS98: Arrange services and support with other health care providers			

Notes:

1. recording information centrally for sharing with colleagues
2. describes advance care planning
6. could include equipment
19. incl arrangements for young children, older children with disabilities, frail partners, etc
22. at this stage in the pathway this could include arranging access to funding such as Continuing Health Care which is a specialist skill
28. includes valid consent
29 at this point there would be very little need for investigative techniques unless it was to explore other conditions such as a urinary tract infection

* relevant to both health and social care

*Italics = Common Core Competence [Function references denoted in *red*]*

Point 4: "Do something more"

This is an ongoing occurrence on the pathway.

	G	E	S
Receive referral			
B3.1.2 Enable individuals to make health choices and decisions* PE1: Enable individuals to make informed health choices and decisions			
Implement the care plan			
B3.3.4 Prepare environments and resources for use in health care activities* GEN6: Manage environments and resources for use during healthcare activities			
B14.1 Co-ordinate the implementation and delivery of treatment plans[6] CHS88: Co-ordinate the implementation and delivery of treatment plans			
*B14.2 Implement care plans/programmes[21] *AG1: Develop, implement and review care plans for individuals*			
B14.3 Deliver therapeutic activities (64 NOS – please select from www.skillsforhealth.org.uk according to context)			
B16.1 Support individuals during and after clinical/therapeutic activities GEN5: Support individuals undergoing healthcare activities			
*B14.4 Undertake personal care for individuals *HSC216: Help address the physical comfort needs of individuals* *HSC218: Support individuals with their personal care needs* *HSC219: Support individuals to manage continence* *CC09: Enable individuals to effectively evacuate their bowels*			
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*B16.2 Support individuals who are distressed *HSC226: Support individuals who are distressed*			

*Italics = Common Core Competence [Function references denoted in *red]*

C2.4 Enable people to address issues relating to their health and wellbeing HSC330: Support individuals to access and use services and facilities			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC412: Manage provision of care services that deals effectively with transitions and significant life events* HSC382: Support individuals to prepare for, adapt to and manage change			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC225: Support individuals to undertake and monitor their own healthcare*			
B16.5 Support individuals and carers to cope with the emotional and psychological aspects of healthcare activities MH37: Recognise, respect and support the spiritual well-being of individuals			
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B17 Work in collaboration with carers in the caring role *HSC427: Assess the needs of carers and families* GEN20: Enable carers to support individuals			
*B16.5 Support individuals and carers to cope with the emotional and psychological aspects of healthcare activities *MH7: Develop, implement and review programmes of support for carers and families*			
B15.6 Administer medication to individuals CHS3: Administer medication to individuals B15.8 Support individuals to self-medicate MH36: Support individuals to administer their own medication			
B15.10 Manage stocks of medication[20] CHS1: Receive and store medication and products (These NOS mainly focus on provision of pharmacy services – some of what is needed to support the individual is covered in MH36, above)			
B3.3.4 Prepare environments and resources for use in health care activities*[7] GEN6: Manage environments and resources for use during healthcare activities			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			
1.5 Provide information, advice and guidance[12] GEN14: Provide advice and information to individuals on how to manage their own condition CHS56: Provide clinical information to individuals			

*Italics = Common Core Competence [Function references denoted in *red]*

Monitor the care plan			
B15.9 Manage an individuals medication to achieve optimum outcomes CHS74: Manage an individual's medication to achieve optimum outcomes			
B11.8 Monitor an individual's physiological condition (5 NOS) B3.6.1 Monitor individuals following treatments CHS47: Monitor and assess patients following treatments			
B3.1.3 Review and modify plans to address specified health goals (9 NOS) B3.6.2 Monitor an individual's progress in managing health conditions (13 NOS)			
B4.2 Evaluate the delivery of care plans to meet the needs of individuals CHS53: Evaluate the delivery of care plans to meet the needs of individuals			
B4.3 Evaluate treatment plans with individuals and those involved in their care CHS89: Evaluate treatment plans with individuals and those involved in their care			
*B14.2 Implement care plans/programmes[6] *AG1: Develop, implement and review care plans for individuals*			
1.5 Provide information, advice and guidance[12] GEN14: Provide advice and information to individuals on how to manage their own condition CHS56: Provide clinical information to individuals			

Notes:

1. recording information centrally for sharing with colleagues
4. is to enable people to keep mobile both within their home and outside, so could include using a wheelchair or walking stick outside, or continuing to be able to go to the bathroom on their own
6. could include equipment
7. includes syringe driver
11. includes information and advice around non health issues such as access to welfare benefits, housing adaptations etc
12. includes signposting individuals to other sources of expertise
20. controlled drugs must be managed/removed in conjunction with a practitioner defined by the 1968 Medicine Act
21. the people with specialist/enhanced skills are providing the service while the people with generic skills are acknowledging need and signposting

* relevant to both health and social care

Point 5 – Transition to Last Days of Life

This is a one-off occurrence on the pathway.

TRIGGERS: Eg fulfils criteria for prognosis indicators for LCP, multiple organ failure, discharge from hospital for last days, prognosis indicators for LCP. Patient may be in the end stages of a chronic illness.

	G	E	S
Assessment of care needs / Advance care planning			
3.5.2 Protect individuals from abuse[19] HSC240: Contribute to the identification of the risk of danger to individuals and others			
A2.4 Assess an individual's needs arising from their health status PE3: Work with individuals to evaluate their health status and needs *C2.1 Encourage behaviour change in people and agencies to promote health and wellbeing *HSC398:Contribute to assessing the needs of individuals for therapeutic programmes to enable them to manage their behaviour*			
A2.4 Assess an individual's needs arising from their health status *GEN75 Collaborate in the assessment of the need for, and the provision of, environmental and social support in the community*			
*B17 Work in collaboration with carers in the caring role *HSC427: Assess the needs of carers and families*			
*B14.2 Implement care plans/programmes[2C] *AG1: Develop, implement and review care plans for individuals*			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC412: Manage provision of care services that deals effectively with transitions and significant life events* HSC382: Support individuals to prepare for, adapt to and manage change			
Support people			
*1.2 Communicate effectively *CHS48: Communicate significant news to individuals*			
*B17 Work in collaboration with carers in the caring role *HSC227: Contribute to working in collaboration with carers in the caring role* *HSC387: Work in collaboration with carers in the caring role*			
B17 Work in collaboration with carers in the caring role *HSC427: Assess the needs of carers and families* GEN20: Enable carers to support individuals			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			
1.5 Provide information, advice and guidance[12] GEN14: Provide advice and information to individuals on how to manage their own condition CHS56: Provide clinical information to individuals			
B3.1.2 Enable individuals to make health choices and decisions* PE1: Enable individuals to make informed health choices and decisions			

*Italics = Common Core Competence [Function references denoted in *red]*

B14.1 Co-ordinate the implementation and delivery of treatment plans[6] CHS88: Co-ordinate the implementation and delivery of treatment plans			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC412: Manage provision of care services that deals effectively with transitions and significant life events* HSC382: Support individuals to prepare for, adapt to and manage change			
1.5 Provide information, advice and guidance[12] GEN14: Provide advice and information to individuals on how to manage their own condition CHS56: Provide clinical information to individuals			
1.5 Provide information, advice and guidance* GEN14: Provide advice and information to individuals on how to manage their own condition			

Notes:

1. recording information centrally for sharing with colleagues and becomes higher as the patient enters the Liverpool Care Pathway
2. advance care planning
6. could include equipment
12. includes signposting individuals to other sources of expertise
19. includes arrangements for young children, older children with disabilities, frail partners, etc

* relevant to both health and social care

C including advanced decision making

Point 6 – Last Days of Life/Death

This is an ongoing occurrence on the pathway.

This is drawn from the Liverpool Care Pathway	G	E	S
Care within last days of life			
*1.2 Communicate effectively *CHS48: Communicate significant news to individuals*			
*A2.4 Assess an individual's needs arising from their health status[8] *GEN75: Collaborate in the assessment of the need for, and the provision of, environmental and social support in the community*			
*B14.4 Undertake personal care for individuals *HSC216: Help address the physical comfort needs of individuals* *HSC218: Support individuals with their personal care needs* *HSC219: Support individuals to manage continence* *CC09: Enable individuals to effectively evacuate their bowels*			
B15.6 Administer medication to individuals CHS3: Administer medication to individuals B15.8 Support individuals to self-medicate MH36: Support individuals to administer their own medication			
B15.10 Manage stocks of medication[20] CHS1: Receive and store medication and products (These NOS mainly focus on provision of pharmacy services – some of what is needed to support the individual is covered in MH36, above)			
*B16.2 Support individuals who are distressed *HSC226: Support individuals who are distressed*			
B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment[11, 24] HSC27: Support individuals in their daily living HSC345: Support individuals to manage their financial affairs HSC344: Support individuals to retain, regain and develop the skills to manage their lives and environment *B11.2 Maintain fluid levels and balance in individuals *CHS17: Carry out extended feeding techniques to ensure individuals nutritional and fluid intake*			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC412: Manage provision of care services that deals effectively with transitions and significant life events* HSC382: Support individuals to prepare for, adapt to and manage change			
B16.5 Support individuals and carers to cope with the emotional and psychological aspects of healthcare activities MH37: Recognise, respect and support the spiritual well-being of individuals			
B16.5 Support individuals and carers to cope with the emotional and psychological aspects of healthcare activities HSC332: Support the social, emotional and identity needs of individuals			
*B17 Work in collaboration with carers in the caring role *HSC227: Contribute to working in collaboration with carers in the caring role* *HSC387: Work in collaboration with carers in the caring role*			

*Italics = Common Core Competence [Function references denoted in *red]*

*B14.2 Implement care plans/programmes *AG1: Develop, implement and review care plans for individuals*			
B14.3 Deliver therapeutic activities (64 NOS – please select from www.skillsforhealth.org.uk according to context)			
*B11.3 Establish and maintain pain relief *CHS164: Manage pain relief for an individual*			
*B18.1 Support individuals through the process of dying *HSC385: Support individuals through the end of life process* B18.2 Conduct last offices for the deceased HSC239: Contribute to the care of a deceased person			
B3.1.3 Review and modify plans to address specified health goals (9 NOS) B3.6.2 Monitor an individual's progress in managing health conditions (13 NOS)			
B3.3.4 Prepare environments and resources for use in health care activities*[7] GEN6: Manage environments and resources for use during healthcare activities			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			

Notes:

1. recording information centrally for sharing with colleagues and becomes higher as the patient enters the Liverpool Care Pathway
7. includes syringe driver
8. includes as assessment of the location/home, such as whether the patient is upstairs
11. includes information and advice around non health issues such as access to welfare benefits, housing adaptations etc
20. controlled drugs must be managed/removed in conjunction with a practitioner defined by the 1968 Medicine Act
24. could include drinking
25. part of the skill lies in knowing when to provide care and when it is better (more caring) to leave the person alone.

Point 7 – Care After Death

This is a one-off occurrence on the pathway.

	G	E	S
Care after death			
B8.2 Investigate system/organ function[18] HCS5: Investigate the structure, function or performance of an organ or physiological system			
*1.2 Communicate effectively *CHS48: Communicate significant news to individuals*			
B15.10 Manage stocks of medication[20] CHS1: Receive and store medication and products (These NOS mainly focus on provision of pharmacy services)			
*B16.2 Support individuals who are distressed *HSC226: Support individuals who are distressed*			
*B18.1 Support individuals through the process of dying[3] *HSC385: Support individuals through the end of life process*			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC412: Manage provision of care services that deals effectively with transitions and significant life events* HSC382: Support individuals to prepare for, adapt to and manage change			
B16.5 Support individuals and carers to cope with the emotional and psychological aspects of healthcare activities MH37: Recognise, respect and support the spiritual well-being of individuals			
*B18.3 Support individuals through bereavement[26] *HSC384: Support individuals through bereavement*			
*B16.5 Support individuals and carers to cope with the emotional and psychological aspects of healthcare activities *MH7: Develop, implement and review programmes of support for carers and families*			
1.5 Provide information, advice and guidance[12] GEN14: Provide advice and information to individuals on how to manage their own condition CHS56: Provide clinical information to individuals			
B18.4 Collect and transport deceased individuals and body parts GEN61: Collect and transport deceased individuals and body parts			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			

Notes:

1. recording information centrally for sharing with colleagues
3. includes last offices
12. includes signposting individuals to other sources of expertise
18. includes verification of an expected death
20. controlled drugs must be managed/removed in conjunction with a practitioner defined by the 1968 Medicine Act
26. additional time is allowed to support individuals through bereavement if the bereaved individual has dementia, rather than the person who has just died

*Italics = Common Core Competence [Function references denoted in *red]*

Point 8: Enter EoL Pathway – Transition to "Do Something More"

This is a one-off occurrence on the pathway.
TRIGGERS: Eg increasing clinical instability, pain/symptom relief needed, extended personal care needs, increased mobility support needs

	G	E	S
Plan assessment			
A2.1 Plan assessment of an individual's health status CHS38: Plan assessment of an individual's health status			
Carry out assessment			
*A2.4 Assess an individual's needs arising from their health status *HSC414: Assess individual needs and preferences* PE3: Work with individuals to evaluate their health status and needs *B1.1 Obtain valid consent for interventions or investigations[28] *CHS167: Obtain valid consent or authorisation* B2.1 Obtain information from individuals about their health status and needs (No appropriate underpinning NOS)			
*B2.2 Obtain information from indirect sources about an individual's health status and needs[10] *EUSC02: Obtain supporting information to inform the assessment of an individual*			
*A2.4 Assess an individual's needs arising from their health status *GEN75: Collaborate in the assessment of the need for, and the provision of, environmental and social support in the community*			
B2.3 Request investigations to provide information on an individual's health status and needs CHS106: Request imaging investigations to provide information on an individual's health status and needs (other investigations, dependant on context)			
B5.1 Obtain specimens from individuals CHS7: Obtain and test specimens from individuals			

B8.1 Undertake physiological measurements CHS19: Undertake routine clinical measurements			
3.5.2 Protect individuals from abuse[19] HSC240: Contribute to the identification of the risk of danger to individuals and others			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			
Early management			
*1.2 Communicate effectively *CHS48: Communicate significant news to individuals*			
A2.4 Assess an individual's needs arising from their health status PE3: Work with individuals to evaluate their health status and needs *C2.1 Encourage behaviour change in people and agencies to promote health and wellbeing *HSC398: Contribute to assessing the needs of individuals for therapeutic programmes to enable them to manage their behaviour*			
A2.5 Agree courses of action following assessment CHS45: Agree courses of action following assessment to address health and wellbeing needs of individuals			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC412: Manage provision of care services that deals effectively with transitions and significant life events* HSC382: Support individuals to prepare for, adapt to and manage change			
B3.1.2 Enable individuals to make health choices and decisions* PE1: Enable individuals to make informed health choices and decisions			
B3.4.2 Refer individuals to services for treatment and care GEN59: Direct requests for assistance, care or treatment using protocols and guidelines			
1.5 Provide information, advice and guidance* GEN14: Provide advice and information to individuals on how to manage their own condition			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			

Make diagnosis of end of life			
B7 Interpret and report on findings from investigations CHS83: Interpret the findings of healthcare investigations			
A2.3 Assess an individual with a suspected health condition CHS40: Establish a diagnosis of an individual's health condition			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			
Assessment of care needs			
3.5.2 Protect individuals from abuse[19] HSC240: Contribute to the identification of the risk of danger to individuals and others			
A2.4 Assess an individual's needs arising from their health status PE3: Work with individuals to evaluate their health status and needs *C2.1 Encourage behaviour change in people and agencies to promote health and wellbeing *HSC398: Contribute to assessing the needs of individuals for therapeutic programmes to enable them to manage their behaviour*			
*A2.4 Assess an individual's needs arising from their health status *GEN75: Collaborate in the assessment of the need for, and the provision of, environmental and social support in the community*			
*B17 Work in collaboration with carers in the caring role *HSC427: Assess the needs of carers and families*			
*B14.2 Implement care plans/programmes *AG1: Develop, implement and review care plans for individuals*			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC412: Manage provision of care services that deals effectively with transitions and significant life events* HSC382: Support individuals to prepare for, adapt to and manage change			

Support people			
*1.2 Communicate effectively *CHS48: Communicate significant news to individuals*			
*B17 Work in collaboration with carers in the caring role *HSC227: Contribute to working in collaboration with carers in the caring role* *HSC387: Work in collaboration with carers in the caring role*			
B17 Work in collaboration with carers in the caring role GEN20: Enable carers to support individuals			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			
1.5 Provide information, advice and guidance[12] GEN14: Provide advice and information to individuals on how to manage their own condition CHS56: Provide clinical information to individuals			
B3.1.2 Enable individuals to make health choices and decisions* PE1: Enable individuals to make informed health choices and decisions			
B14.1 Co-ordinate the implementation and delivery of treatment plans[6] CHS88: Co-ordinate the implementation and delivery of treatment plans			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC412: Manage provision of care services that deals effectively with transitions and significant life events* HSC382: Support individuals to prepare for, adapt to and manage change			
1.5 Provide information, advice and guidance[12] GEN14: Provide advice and information to individuals on how to manage their own condition CHS56: Provide clinical information to individuals			
1.5 Provide information, advice and guidance* GEN14: Provide advice and information to individuals on how to manage their own condition			

Develop care plan – Advance Care Planning			
*B17 Work in collaboration with carers in the caring role *HSC427: Assess the needs of carers and families*			
B3.1.2 Enable individuals to make health choices and decisions* PE1: Enable individuals to make informed health choices and decisions			
*B14.2 Implement care plans/programmes *AG1: Develop, implement and review care plans for individuals*			
B3.1.1 Plan activities, interventions or treatments to achieve specified health goals[2] *AG2: Contribute to care planning and review* *CHS97: Organise a programme of support following withdrawal from treatment* CHS41: Determine a treatment plan for an individual			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			
F4.1 Determine the learning needs of individuals to enable management of their health and wellbeing PE6: Identify the learning needs of patients and carers to enable management of a defined condition			
1.5 Provide information, advice and guidance* GEN14: Provide advice and information to individuals on how to manage their own condition			
B3.4.2 Refer individuals to services for treatment and care GEN59: Direct requests for assistance, care or treatment using protocols and guidelines			

Notes:

1. recording information centrally for sharing with colleagues
6. could include equipment
10. includes other agencies, including social care, GPs etc
12. includes signposting individuals to other sources of expertise
19. includes arrangements for young children, older children with disabilities, frail partners, etc
28. includes valid consent

* relevant to both health and social care

Point 9: Enter EoL Pathway – Transition to "Last Days of Life"

This is a one-off occurrence on the pathway.

TRIGGERS: Eg increasing clinical instability, pain/symptom relief needed, extended personal care needs, increased mobility support needs

	G	E	S
Plan assessment			
A2.1 Plan assessment of an individual's health status CHS38: Plan assessment of an individual's health status			
Carry out assessment			
*A2.4 Assess an individual's needs arising from their health status *HSC414: Assess individual needs and preferences* PE3: Work with individuals to evaluate their health status and needs *B1.1 Obtain valid consent for interventions or investigations[28] *CHS167: Obtain valid consent or authorisation* B2.1 Obtain information from individuals about their health status and needs (No appropriate underpinning NOS)			
*B2.2 Obtain information from indirect sources about an individual's health status and needs[10] *EUSC02: Obtain supporting information to inform the assessment of an individual*			
*A2.4 Assess an individual's needs arising from their health status *GEN75: Collaborate in the assessment of the need for, and the provision of, environmental and social support in the community*			
B2.3 Request investigations to provide information on an individual's health status and needs CHS106: Request imaging investigations to provide information on an individual's health status and needs (other investigations, dependant on context)			
B5.1 Obtain specimens from individuals CHS7: Obtain and test specimens from individuals			

*Italics = Common Core Competence [Function references denoted in *red]*

B8.1 Undertake physiological measurements CHS19: Undertake routine clinical measurements			
3.5.2 Protect individuals from abuse[19] HSC240: Contribute to the identification of the risk of danger to individuals and others			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			
Early management			
*1.2 Communicate effectively *CHS48: Communicate significant news to individuals*			
A2.4 Assess an individual's needs arising from their health status PE3: Work with individuals to evaluate their health status and needs *C2.1 Encourage behaviour change in people and agencies to promote health and wellbeing *HSC398:Contribute to assessing the needs of individuals for therapeutic programmes to enable them to manage their behaviour*			
A2.5 Agree courses of action following assessment CHS45: Agree courses of action following assessment to address health and wellbeing needs of individuals			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC412: Manage provision of care services that deals effectively with transitions and significant life events* HSC382: Support individuals to prepare for, adapt to and manage change			
B3.1.2 Enable individuals to make health choices and decisions* PE1: Enable individuals to make informed health choices and decisions			
B3.4.2 Refer individuals to services for treatment and care GEN59: Direct requests for assistance, care or treatment using protocols and guidelines			
1.5 Provide information, advice and guidance* GEN14: Provide advice and information to individuals on how to manage their own condition			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			

Make diagnosis of end of life			
B7 Interpret and report on findings from investigations CHS83: Interpret the findings of healthcare investigations			
A2.3 Assess an individual with a suspected health condition CHS40: Establish a diagnosis of an individual's health condition			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			
Assessment of care needs			
3.5.2 Protect individuals from abuse[19] HSC240: Contribute to the identification of the risk of danger to individuals and others			
A2.4 Assess an individual's needs arising from their health status PE3: Work with individuals to evaluate their health status and needs *C2.1 Encourage behaviour change in people and agencies to promote health and wellbeing *HSC398:Contribute to assessing the needs of individuals for therapeutic programmes to enable them to manage their behaviour*			
*A2.4 Assess an individual's needs arising from their health status *GEN75: Collaborate in the assessment of the need for, and the provision of, environmental and social support in the community*			
*B17 Work in collaboration with carers in the caring role *HSC427: Assess the needs of carers and families*			
*B14.2 Implement care plans/programmes *AG1: Develop, implement and review care plans for individuals*			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC412: Manage provision of care services that deals effectively with transitions and significant life events* HSC382: Support individuals to prepare for, adapt to and manage change			

Support people			
*1.2 Communicate effectively *CHS48: Communicate significant news to individuals*			
*B17 Work in collaboration with carers in the caring role *HSC227: Contribute to working in collaboration with carers in the caring role* *HSC387: Work in collaboration with carers in the caring role*			
B17 Work in collaboration with carers in the caring role GEN20: Enable carers to support individuals			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			
1.5 Provide information, advice and guidance[12] GEN14: Provide advice and information to individuals on how to manage their own condition CHS56: Provide clinical information to individuals			
B3.1.2 Enable individuals to make health choices and decisions* PE1: Enable individuals to make informed health choices and decisions			
B14.1 Co-ordinate the implementation and delivery of treatment plans[6] CHS88: Co-ordinate the implementation and delivery of treatment plans			
*B16.4 Support individuals to retain, regain and develop the skills to manage their lives and environment *HSC412: Manage provision of care services that deals effectively with transitions and significant life events* HSC382: Support individuals to prepare for, adapt to and manage change			
1.5 Provide information, advice and guidance[12] GEN14: Provide advice and information to individuals on how to manage their own condition CHS56: Provide clinical information to individuals			
1.5 Provide information, advice and guidance* GEN14: Provide advice and information to individuals on how to manage their own condition			

Develop care plan			
*B17 Work in collaboration with carers in the caring role *HSC427: Assess the needs of carers and families*			
B3.1.2 Enable individuals to make health choices and decisions* PE1: Enable individuals to make informed health choices and decisions			
*B14.2 Implement care plans/programmes *AG1: Develop, implement and review care plans for individuals*			
B3.1.1 Plan activities, interventions or treatments to achieve specified health goals[2] *AG2: Contribute to care planning and review* *CHS97: Organise a programme of support following withdrawal from treatment* CHS41: Determine a treatment plan for an individual			
1.2 Communicate effectively[1] LANTRA CU6: Maintain communications and records within the organisation HSC21: Communicate with, and complete records for individuals			
F4.1 Determine the learning needs of individuals to enable management of their health and wellbeing PE6: Identify the learning needs of patients and carers to enable management of a defined condition			
1.5 Provide information, advice and guidance* GEN14: Provide advice and information to individuals on how to manage their own condition			
B3.4.2 Refer individuals to services for treatment and care GEN59: Direct requests for assistance, care or treatment using protocols and guidelines			

Notes:

1. recording information centrally for sharing with colleagues
6. could include equipment
10. includes other agencies, including social care, GPs etc
12. includes signposting individuals to other sources of expertise
19. includes arrangements for young children, older children with disabilities, frail partners, etc
28. includes valid consent

* relevant to both health and social care

EoLC Functional Analysis (Upgraded Autumn 2011) - Common Core Competences Mapping

			EoLC Pathway Point								
	Ref Function	**Underpinning Principle**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Communication Skills											
HSC21: Communicate with, and complete records for individuals	1.2	X	X	X	X	X	X	X	X	X	X
HSC31: Promote effective communication with, for and about individuals	1.2	X									
HSC366: Support individuals to represent their own needs and wishes at decision making forums	C2.4			X							
HSC368: Present individuals' needs and preferences	C2.6	X		X							
HSC41: Use and develop methods and systems to communicate, record and report	1.1	X									
CHS48: Communicate significant news to individuals	1.2		X		X		X	X	X	X	X
Assessment and Care Planning											
EUSC02: Obtain supporting information to inform the assessment of an individual	B2.2		X		X					X	X
HSC398: Contribute to assessing the needs of individuals for therapeutic programmes to enable them to manage their behavior	C2.1		X		X		X			X	X
GEN75: Collaborate in the assessment of the need for, and the provision of, environmental and social support in the community	A2.4		X		X		X	X		X	X
HSC414: Assess individual needs and preferences	A2.4		X		X					X	X
HSC427: Assess the needs of carers and families	B17		X	X	X	X	X			X	X
Symptom management, maintaining comfort and wellbeing											
HSC24: Ensure your own actions support the care, protection and well-being of individuals	5.1.1	X									
HSC227: Contribute to working in collaboration with carers in the caring role	B17		X	X	X	X	X	X		X	X
HSC216: Help address the physical comfort needs of individuals	B14.4			X		X		X			

*Italics = Common Core Competence [Function references denoted in *red]*

HSC218: Support individuals with their personal care needs	B14.4			X		X		X			
HSC219: Support individuals to manage continence	B14.4			X		X		X			
HSC225: Support individuals to undertake and monitor their own health care	B16.4		X	X		X					
HSC35: Promote choice, well-being and the protection of all individuals	5.1.1	X									
HSC387: Work in collaboration with carers in the caring role	B17		X	X	X	X	X	X		X	X
CHS17: Carry out extended feeding techniques to ensure individuals nutritional and fluid intake	B11.2			X		X		X			
CC09: Enable individuals to effectively evacuate their bowels	B14.4			X		X		X			
CHS164: Manage pain relief for an individual	B11.3							X			
HSC45: Develop practices which promote choice, well-being and protection of all individuals	6.3	X									
CHS97: Organise a programme of support following withdrawal from treatment	B3.1.1		X		X					X	X
Advance Care Planning											
AG2: Contribute to care planning and review	B3.1.1		X		X					X	X
AG1: Develop, implement and review care plans for individuals	B14.2		X	X	X	X	X	X		X	X
CHS167: Obtain valid consent or authorisation	B1.1		X		X					X	X
Overarching values and knowledge											
HSC23: Develop your knowledge and practice	2.1.1	X									
HSC226: Support individuals who are distressed	B16.2			X		X		X	X		
HSC3116: Contribute to promoting a culture that values and respects the diversity of individuals	6.3	X									
HSC33: Reflect on and develop your practice	2.1.2	X									
HSC3119: Promote the values and principles underpinning best practice	5.2.3	X									
HSC384: Support individuals through bereavement	B18.3								X		
HSC385: Support individuals through the end of life process	B18.1							X	X		
MH7: Develop, implement and review programmes of support for carers and families	B16.5			X		X			X		

*Italics = Common Core Competence [Function references denoted in *red]*

HSC43: Take responsibility for the continuing professional development of self and others	2.2.1	X									
HSC452: Contribute to the development, maintenance and evaluation of systems to promote the rights, responsibilities, equality and diversity of individuals	6.3	X									
HSC412: Manage provision of care services that deals effectively with transitions and significant life events	B16.4		X	X		X	X	X	X	X	X

*Italics = Common Core Competence [Function references denoted in *red]*

Participants: North of Tyne Review
14 November 2011

Name	Title	Organisation
Lesley Robson	Palliative Care Clinical Nurse Specialist	NHS Newcastle
Kathryn Hall	Clinical Lead: End of Life Care / GP	Collingwood Medical Group
Paul Paes	Consultant, Palliative Medicine / Head of Service	Northumbria Healthcare NHS Foundation Trust
Christine Lowthian	Head of Commissioning	NHS North of Tyne
Alexa Clark	Consultant in Palliative Medicine	Newcastle Upon Tyne Hospitals NHS Foundation Trust Community Health
Kathleen Moir	Commissioning Support Manager	NHS North of Tyne
Pam Copiel	GP / Palliative Care Lead	Bridges Medical Practice
Ruth Marshall	Clinical Business Change Lead	NHS North of Tyne
Julie Tekin	Macmillan Clinical Nurse Specialist	
Chris Drydale	Manager Care Services	NCC
Elizabeth Kendrick	Chair, End of Life Clinical Innovation Team	NHS North East

Jane Goodwin		Skills for Health
Andrew Lovegrove		Skills for Health
James Stephens		Skills for Health

*Italics = Common Core Competence [Function references denoted in *red]*