End of Life Care Core Capabilities Framework

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Contents

Tier Descriptors

Tier 1

Those that require general end of life care awareness, focusing on a community development, asset-based approach to care, which is a grassroots approach that builds on a community's existing strengths and resources, rather than focusing on deficits and problems.

This tier outlines the underpinning knowledge and skills required by all health and social care staff to enable them to support people who are approaching the end of their life, as well as their family, friends and carers. The aim is to ensure that those affected are enabled to access any available support and to plan effectively for their current and future health and care needs. As end of life care is 'everyone's business, this tier is also relevant to those who have limited contact with people approaching the end of their life.

A community development, asset-based approach to care encourages people to think about and ask 'what is important to me?' and how this can be achieved with care and support from health and social care professionals. This might include looking at what the person approaching the end of can do, what their family, friends, loved ones and carers can do; and the potential of the community to provide care and support.

The tier may also be relevant to you if:

- You are a member of the public
- You have been diagnosed with a life limiting condition
- You support someone with a limiting life condition
- You work in the adult health and social care sector but have limited contact with anyone approaching the end of life

Examples of indicative roles in Tier 1 (please note that this is a representative, but not exhaustive list)

- Volunteer
- Administrator
- Personal Assistant
- Care Worker
- Healthcare Support Worker

Tier 2

Health and social care professionals who require fundamental knowledge of how to provide person-centred, high quality end of life care as they often encounter people who need such support within their working environment. However, they do not work in services where the primary role is to provide specialist palliative and end of life care for people approaching the end of life, their family and carers.

The tier will be relevant to you if:

- You work in an adult health or social care setting where most of the people you support are not approaching the end of their life, but some are. For instance, you might work on an acute hospital ward, older mental health in-patient ward, a GP's surgery or in a care home, or domiciliary care services.
- You work in adult health or social care and provide supervision and/or professional support to other professionals.
- You do not work in adult health or social care, but your professional role means you often provide support for people approaching the end of their life. You might be a religious leader, work for a community development project or offer art or activity therapy to people approaching the end of life.

Examples of indicative roles in Tier 2 (please note that this is a representative, but not exhaustive list)

- Nursing Associate
- Community Support Worker
- Primary care staff

Tier 3

Health and social care professionals require in-depth knowledge of how to provide care and support for a person approaching the end of life because they work in services that primarily offer care and support for people approaching the end of their life, their family and carers.

The tier will be relevant to you if:

- You work in adult health or social care. Most of the people you support are approaching the end of life. For instance, you may work in a hospice or in a palliative care service, nursing home or within a specialist service that supports people living with life limiting conditions e.g. dementia specialist nurse, neurology etc. You work in adult health or social care and provide supervision and professional support to other professionals. Most of the people they provide care and support for are approaching the end of life.
- You work in adult health and social care and provide supervision and professional support to other professionals. Most of the people they provide care and support for are approaching the end of life.
- You work in adult health or social care. Most of the people you support are not approaching the end of life, but some are. You act as the lead for end of life care within your team or organisation.

Examples of indicative roles in Tier 3 (please note that this is a representative, but not exhaustive list)

- Social worker
- Allied Health Professional
- Dementia Specialist Registered Nurse
- Senior Clinician
- Service Lead/Manager
- Practice Educator

End of Life Care Core Capabilities Framework

Capability 1. Person-centred end of life care			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) have an awareness of when a person may be nearing the end of their life, including that this can be hard to predict	✓	✓	✓
b) be be able to engage in conversation with a person, their families and/or carers, or their representatives when they, the person, may be nearing the end of life	✓	✓	✓
c) understand and respect that individuals are experts in their own lives	✓	✓	✓
d) understand and be willing to support the diverse needs and wishes of individuals, that may differ from your own and others' views	✓	✓	✓
e) understand that person-centred care includes all elements of an individual's life that are important to them, not just their symptoms, recognising that the person's needs may change frequently, and be able to respond to changes appropriately	✓	✓	✓
f) understand who is important to the person and who and what is important to them	✓	✓	✓
g) understand the part they play in the person's end of life care and know where to seek support	✓	✓	✓
h) understand the importance of a support system from which the person and those important to them may benefit	✓	✓	✓
i) understand the importance of listening to a person's experiences and story as they approach the end of life	✓	✓	✓

j) be able to support decision making in the best interests of people who lack the capacity to communicate their wishes, taking into account their previously expressed preferences, values and needs, particularly in situations where dementia, or other conditions impact their ability to consent or make decisions.		✓	✓
k) be able to empower and support people manage to their care and support and to make decisions based on their own experience, utilising professional support and guidance		✓	✓
l) be able to to assess the needs, concerns and priorities of people and those important to them in a person-centred way, and support them to meet these needs		✓	✓
m) be able to support individuals identify and manage risk, enabling positive risk taking as appropriate		✓	✓
n) be able to work with people and others to develop a realistic person-centred end of life care plan that balances disease-specific treatment with the care and support needs and wishes of the person		✓	✓
o) be able able to recognise and suggest ways to overcome potential barriers people may face in accessing end of life care		✓	✓
p) understand and seek to manage, through advocacy or other methods, the potential service or organisational constraints and challenges a person-centred approach to end of life care may present		✓	✓

Capability 2. Communication in end of life care			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) understand the importance of discussing dying, death and bereavement, and expressing wishes and preferences associated with this	✓	✓	✓
b) know how to communicate one's own worries and concerns and assert one's own wishes about dying and the care provided, and be able to engage in activities to support this	✓	✓	✓
c) be able to talk about death, dying and bereavement and actively listen to others	✓	✓	✓
d) be able to communicate sensitively with people and those important to them on a range of complex matters relating to end of life care, in a non-judgemental, empathetic, genuine, collaborative and supportive manner that is appropriate to them and the situation	✓	✓	✓
e) be able to use **active listening** skills and open questions to support people and those important to them to express their feelings, preferences and needs alongside their strengths and abilities	✓	✓	✓
f) understand the different barriers to communication at end of life, including where someone has additional care, support or communicate needs e.g. learning disabilities, cognitive impairment, neurodiversity, sensory impairment, or where a situation makes it difficult to communication effectively e.g. noisy, distressing, emergency environments, and have strategies in place e.g. use of technology/aids to support communication, to overcome these barriers	✓	✓	✓

g) know where to seek advice about difficult and complex matters or situations	✓	✓	✓
h) understand how different values and beliefs, including religious and cultural values and beliefs may impact on communication and views of the dying process	✓	✓	✓
i) be able to to communicate appropriately, using appropriate methods, with people facing bereavement	✓	✓	✓
j) understand that sensitive communication includes the need to respect wishes of those who do not want to have open discussions about their condition or end of life and that the ability and desire of individuals and those important to them to discuss end of life care issues may change over time	✓	✓	✓
k) understand why silence is an important part of communication in end of life care, and feel confident in the value of silence, particularly in situations where there may be communication difficulties, e.g. dementia	✓	✓	✓
l) be able to use communication skills to ensure end of life care plans, and advance care plans, are understood and shared		✓	✓
m) be able to share information about the person's condition, prognosis and support available to make informed decisions in a way that is accessible and uses appropriate language, and be able to communicate uncertainty		✓	✓
n) be able to manage conflict (setting aside sufficient time to have these conversations), where it arises, between the person and those important to them regarding end of life care or advance care planning (differences between statements and decisions) choices. Work sensitively towards a resolution and access mediation and advocacy services where appropriate. This may include IMCA need to reference potential frameworks such as MCA Adult Safeguarding		✓	✓

Capability 3. Support for carers			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) understand what it means to be a 'carer'	✓	✓	✓
b) understand what support, services and resources are available, including practical and emotional support services, and know how to access them, and make referrals when appropriate	✓	✓	✓
c) understand how to access support for family conflicts	✓	✓	✓
d) be able able to recognise and understand the changes that occur in the dying process	✓	✓	✓
e) be able to access a Carer's Assessment and resultant support, where this is available, and understand the duty of local authorities to undertake carers' assessments	✓	✓	✓
f) be able to offer support to someone who is bereaved and grieving (including anticipatory grief), and understand the stages of grief	✓	✓	✓
g) be able to offer guidance and/or training to carers on practical aspects of care e.g. providing good mouth care, supporting people to eat and drink what they want, when they want		✓	✓
h) understand that carers may need support to recognise they have taken on a caring role, and that they may not wish to identify as a carer, even though they provide care		✓	✓
i) understand and value the importance of recognising the expertise of carers, families and friends and important others, and support them to continue performing tasks should they wish to do so		✓	✓
j) be able to recognise where a child or young person has taken on a caring role and refer to appropriate support services		✓	✓
k) be able to communicate effectively with carers to support them express themselves freely		✓	✓
l) understand the impact of, and different factors that may affect carers' response to, death grief, loss and bereavement		✓	✓
m) understand the need to be sensitive to carers' changing circumstances and needs, and adapt care and support accordingly		✓	✓
n) be able to support those important to the person to maintain their relationships		✓	✓
o) be able to explain to families their role in best interest decision making and sensitively support those important to the person when they are substitute decision makers on behalf of the person approaching end of life when they are unable to make their own decisions.		✓	✓

p) be able to undertake appropriate bereavement needs assessment			✓
q) understand how conflicts may arise between people and those important to them and be able to navigate these complex relationships			✓
r) be able to evaluate models and theories of loss and grief			✓
s) be able to provide additional support around practical issues to family and carers where death has been unexpected, e.g. post mortems, coroners, death verification and certification procedures			✓

Capability 4. Equality, diversity and inclusion in end of life care			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) understand the Equality Act 2010 and how protected characteristics may impact on the provision of end of life care	✓	✓	✓
b) understand how bereavement and the grieving process may affect people differently	✓	✓	✓
c) know how to talk about one's own beliefs and values and recognise that they may differ from those of others	✓	✓	✓
d) be able to listen to and support people who may hold different beliefs and values, or have had different life experiences	✓	✓	✓
e) be able to distinguish between spirituality and religion	✓	✓	✓
f) understand the significance of diversity, including the impact that a person's beliefs, customs, faith, life circumstances, religion, social norms, spirituality, sexuality and values can have on their preferences, their choices and the care provided, and be able to assess, support and meet these needs and preferences, where possible	✓	✓	✓
g) understand how a person's awareness of spirituality may change as they approach death	✓	✓	✓
h) be able to identify and challenge poor, unethical or discriminatory practice	✓	✓	✓
i) be able to recognise, assess and respond to the end of life care needs for people with a variety of diagnoses and in a variety of services and community environments		✓	✓

j) be able to find and facilitate access to appropriate specialist services or support groups to support peoples' diverse needs		✓	✓
k) understand the impact of the wider determinants of health on the health and wellbeing of people and those important to them, and how these may lead to health inequalities		✓	✓

Capability 5. Developing end of life care skills within the community			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) understand that supporting someone at the end of life and those important to them goes beyond health and social care intervention	✓	✓	✓
b) understand the huge potential the community has to offer in providing end of life care support, e.g. how the community can enable people to stay in, or return to, their own home, and the various support services the community has to offer	✓	✓	✓
c) understand that different personal skills, qualities and experiences could be valuable to individuals and those important to them in meeting their social, intellectual, spiritual, emotional, psychological or physical needs	✓	✓	✓
d) be able to engage in local community support schemes that offer services to people and those important to them – either to offer or access support	✓	✓	✓
e) understand what is meant by a 'support system' (family, friends and others around a person), and the value a support system can bring	✓	✓	✓
f) be able to develop the practical skills of caring e.g. how to lift and move a person in a safe way	✓	✓	✓
g) understand the concept and principles of a community development, **asset-based approach** to end of life care		✓	✓
h) understand that people should be seen within the context of their own community and be supported to participate and contribute to this as they wish, and is practicable		✓	✓
i) understand how local community schemes could benefit people and those important to them		✓	✓

j) understand and be able to map the community assets available and how to access these to inform own practice, other staff and individuals and those important to them		✓	✓
k) be able to support people and those important to them to access local community groups and services and to understand the benefit this could bring		✓	✓
l) be able to support people and those important to them to consider their network of support (referred to as a 'caring network') which may extend beyond immediate family and friends		✓	✓
m) be able to develop the practical skills of people and those important to them to enhance networks, including saying yes to offers of help and learning how to ask for help		✓	✓
n) understand the value of multi-disciplinary teams involving and including people from outside health and social care, e.g. community development workers, community leaders, individuals and their caring networks		✓	✓
o) be able to understand, engage with, influence and strengthen the community to provide support for people approaching the end of life and those important to them			✓
p) be able to promote and support effective relationships between communities, public bodies, voluntary organisations and other agencies that facilitate wellbeing at end of life for people, groups and communities			✓
q) be able to facilitate learning opportunities for community development in relation to end of life care			✓
r) be able to cascade information and skills in relation to community development in end of life care to colleagues, people and those important to them			✓
s) be able to identify and overcome barriers to community development in end of life care			✓
t) be able to promote the benefits of developing community skills and engaging with the local community amongst colleagues and senior managers/board members in relation to improving outcomes for people approaching the end of life and those important to them			✓

Capability 6. Assessment and care planning in end of life care			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) understand the importance of having the person's experiences, wishes and priorities at all stages of assessment, planning and decision making, and be able to support the person to express their wishes and preferences	✓	✓	✓
b) be able to encourage and support people to make decisions based on their own experience, utilising professional support and guidance or be able to identify the most appropriate person to support decision making for those who may lack mental capacity to make a specific decision at a specific time.	✓	✓	✓
c) understand the person has a right to change their mind regarding the sort of the care they want and make unwise decisions	✓	✓	✓
d) understand the importance of choice, and the options available in, planning for end of life and future care needs e.g. where care will take place, decisions to refuse some treatments, funeral planning, organ donation, may lack mental capacity, lasting power of attorney	✓	✓	✓
e) understand how to plan for end of life care and future care for self or others, and how to access specialist support services	✓	✓	✓
f) know where to access advance care documentation	✓	✓	✓
g) understand the content of peoples' care plans and advance care plans and the impact this has on care and support offered		✓	✓
h) understand that prognosis is often uncertain and the importance of parallel planning		✓	✓
i) understand when an end of life or advance care plan would be appropriate and be able to identify individuals who may benefit from these plans early		✓	✓

j) understand that people and those important to them have a choice in who they choose to discuss assessment and care planning with		✓	✓
k) be able to contribute to the assessment of a variety of needs people and those important to them may present in a person-centred, holistic, private and dignified way, using role-appropriate assessment tools, understanding the advantages and disadvantages of such tools		✓	✓
l) be able to provide information on **advance decision** planning for people and those important to them and check understanding		✓	✓
m) understand how a person's beliefs, customs, faith, lifestyle, religion, social norms, spirituality and values may affect assessment and end of life care planning		✓	✓
n) understand why and how a person's capacity will affect how assessment and end of life care planning takes place and when a mental capacity assessment may be required		✓	✓
o) know the importance of considering and acting on the observations and judgements of family and carers when planning end of life care, integrating their observations into assessment and care plans		✓	✓
p) understand why assessments and care plans need to be reviewed regularly and in partnership with others, including the person and those important to them taking account of the changing needs and wishes of people		✓	✓
q) understand that some people will not wish to be involved in the care planning process, and respect this decision		✓	✓
r) be able to support and record decisions about advance care planning, understanding the difference between advanced decisions and advance statements		✓	✓
s) be able to use communication aids where appropriate to aid assessments		✓	✓
t) be able to communicate and share information in a person's care plan or advance care plan effectively with their permission with appropriate others, including ensuring that individuals'		✓	✓

decisions, including advance care plan status and do not attempt cardiopulmonary resuscitation (CPR) instructions, can be seen ‘at a glance’			
u) understand the pathophysiology of common disorders, diseases, conditions and symptoms experienced at the end of life			✓
v) be able to involve families in the agreement and review of risk management strategies where appropriate			✓
w) be able to provide family with clear rationales for decisions made and make assessments openly			✓
x) understand how to work in the best interests of a person unable to participate in decision making			✓
y) understand the complex variety of needs that should be considered when planning end of life care with people and those important to them			✓

Capability 7. Practical and emotional support for the person approaching the end of life			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) be able to ascertain from a person what would make them comfortable and respond to this appropriately	✓	✓	✓
b) understand the importance of promoting and maintaining the dignity of someone approaching the end of life	✓	✓	✓
c) understand that the needs of people approaching the end of life in relation to food and drink may significantly reduce, especially within the last days of life, a that the focus of eating and drinking is on pleasure, as opposed to nutritional and hydration needs	✓	✓	✓
d) understand the support that carers require to appreciate that the needs of people approaching the end of life in relation to food and drink may significantly reduce	✓	✓	✓
e) be able to discuss and listen to others' feelings and recognise and accept these may be different to your own	✓	✓	✓
f) know how and where to direct person for more support	✓	✓	✓
g) understand the process, types and different expressions of loss including loss, bereavement, grief and mourning		✓	✓
h) be able to support people with thoughts associated with death and dying		✓	✓
i) understand the factors that could affect a person's view of dying, including their physical, emotional, psychological, spiritual, cultural and religious needs		✓	✓

j) be able to undertake initial risk assessment of mental health and emotional needs including signs of depression		✓	✓
k) be able to demonstrate an awareness of the impact of dying		✓	✓
l) be able to assess when people need to be alone		✓	✓
m) be able to recognise and respond to peoples' concerns, fears and anxiety		✓	✓
n) be able to provide emotional, physical and psychological support to people to maintain comfort and well-being, including good mouth care e.g. keeping lips moist		✓	✓
o) be able to support a person to eat and drink, what they want, for as long as they wish and are able to, and take appropriate action to rectify problems individuals may have with eating and drinking, recognising that not all potential solutions are likely to be helpful or appropriate		✓	✓
p) be able to provide people, through the use of networks and partnerships, with information on a range of resources, information and support available, how they might be accessed, and the potential risks and benefits		✓	✓
q) understand the importance of relationships as a person nears the end of life, and be able to support a dying person to maintain these relationships		✓	✓
r) understand the need to be sensitive to the person's changing circumstances, and adapt care and support accordingly		✓	✓
s) understand how to access advocacy services for people		✓	✓
t) understand internal and external coping strategies of people when facing death and dying			✓
u) understand the psychological effects of the dying phase/last days of life for a person and the key theories and models relating to loss and grief			✓

v) be able to recognise complex grief, and refer to psychological services where appropriate			✓
w) be able to advocate on behalf of the person to ensure their voice is heard in family disagreements			✓
x) understand guidance, risks and benefits, and ethical considerations associated with a person's food and drink related needs, including that related to clinically assisted nutrition and hydration, including prescribed oral nutritional supplements			✓

Capability 8. Symptom management in end of life care			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) understand common symptoms associated with approach to end of life	✓	✓	✓
b) be able and willing to listen to a person, and their families or carers, (if the person themself is unable to communicate) describing their symptoms and know how to direct them for more help	✓	✓	✓
c) know who to contact if symptoms or pain are not being managed well	✓	✓	✓
d) know how to support a person to access medicines or other treatment, especially at weekends and holidays	✓	✓	✓
e) understand how different factors can alleviate or exacerbate pain and discomfort		✓	✓
f) be able to assess level of needs relating to symptom control and the appropriate tools to use, particularly if the person has communication issues or cognitive impairment e.g. Abbey Pain Tool, PAINAD etc		✓	✓
g) understand the importance of a holistic understanding and assessment of the person's perception of their symptoms and the impact this may have on their choices		✓	✓
h) understand the range of therapeutic options available including practical support or psychological therapy, for symptom management available to them and any potential risks and benefits		✓	✓
i) understand that symptoms have many causes and that different causes may require different approaches to treatment, care and support		✓	✓

j) understand that symptom and pain management should be organised around the needs of the individual, and delivered in a coordinated manner		✓	✓
k) be able to support the person retain dignity during symptom management		✓	✓
l) understand the importance of, and know how to provide regular symptom relief and measure its effectiveness		✓	✓
m) understand when to refer concerns about a person's symptoms to specialist colleagues		✓	✓
n) understand local and national policy relating to medicines management, including in relation to prescribed nutrition products		✓	✓
o) understand physiological processes associated with end of life common symptoms and when death is approaching			✓
p) be aware of current evidence-informed strategies to inform holistic assessment and management of symptoms associated with end of life in accordance with the individuals needs			✓
q) understand the use of anticipatory treatments			✓
r) be able to evaluate the significance of a person's own perception of their symptoms			✓
s) be able to work in partnership with others, including the person and those important to them to develop an end of life care plan which balances disease-specific treatment with care and support that meets the individual's needs and wishes			✓
t) understand the World Health Organisation's analgesic ladder and apply appropriately in accordance with local and national guidelines			✓
u) understand implications of co-morbidities and how to manage them, and be able to set appropriate care goals			✓
v) understand methods of medication administration and where appropriate, administer in line with the person's changing status and within appropriate scope of one's role responsibilities			✓

Capability 9. Working in partnership with health and care professionals and others			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) know who is involved in a person's end of life care and be able to work in partnership with them to deliver care in a coordinated way organised around the person's needs, knowing who to contact with any issues or questions	✓	✓	✓
b) be able to work in partnership with others, exploring and integrating the views of wider multi-disciplinary teams to deliver care in a coordinated way, showing an understanding the role of others, to meet the needs of the person and those important to them		✓	✓
c) be able to share information, including that which relates to a person's wishes, in a timely and appropriate manner with those involved in the person's end of life care, considering issues of confidentiality and ensuring that where information is already available, the person is not asked to provide the same information repeatedly		✓	✓
d) understand referral criteria and processes for referral to specialist services to meet the needs of people and those important to them		✓	✓
e) understand the potential emotional impact of death and dying upon others and provide support		✓	✓
f) be able to develop self and others in relation to end of life care			✓
g) be able to engage in challenging conversations with other professionals, demonstrating a commitment to partnership working to facilitate care			✓

Capability 10. Maintain own health and wellbeing when caring for someone at the end of life			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) understand the importance of caring for yourself and others providing caring roles	✓	✓	✓
b) understand the potential emotional impact of death and dying on oneself and others involved in caring for the person at end of life	✓	✓	✓
c) know how to access support to help oneself and others involved in caring for the person at end of life, including accessing a support system	✓	✓	✓
d) understand the potential impact the death of a person may have on one's own feelings		✓	✓
e) understand the importance of making good use of the support available (for example through formal supervision or informally from colleagues), reflecting on practice, identifying learning needs and accessing further support for such needs		✓	✓
f) be able to offer support to colleagues		✓	✓
g) understand what is mean by 'emotional **resilience**' and be able to access support to build this		✓	✓
h) understand how one's own experiences, views and beliefs relating to death, dying, loss and bereavement may affect the care provided to individuals		✓	✓
i) understand one's own role and the limits of own knowledge and competence, and know where to seek support		✓	✓

j) understand the potential impact of frequent exposure to death and bereavement			✓
k) understand own behaviours and attitude and the effect it may have on others			✓

Capability 11. Care after death			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) understand how to register a death and inform local services/central departments e.g. banks, DVLA, passport office	✓	✓	✓
b) be able to carry out care after death in a way that promotes dignity and respects the person's wishes, culture and religious practices, including preparing the body for family and carer visits where appropriate		✓	✓
c) understand and follow legal and ethical requirements, agreed ways of working, processes and procedures following death		✓	✓
d) understand which organisations should be contacted following a person's death, and the purpose of such contact		✓	✓
e) understand the precautions needed, including use of protective clothing, when undertaking the care and transfer of deceased people, including those with specific high risk diseases and conditions		✓	✓
f) understand how the physical changes after death may affect laying out or moving someone, and act accordingly		✓	✓
g) understand what details need to be recorded when caring for and transferring a deceased person, including recording property and valuables		✓	✓

Capability 12. Law, ethics and safeguarding			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) understand the provisions of the Mental Capacity Act in relation to end of life care	✓	✓	✓
b) understand the concepts of **statements of wishes and preferences**, **informed consent**, best interest decisions, advance care plans and advance decision to refuse treatment, lasting power of attorney for health and finance, in relation to mental capacity	✓	✓	✓
c) understand one's own role in safeguarding individuals	✓	✓	✓
d) know who to contact regarding legal, ethical or safeguarding issues, or to who to escalate to		✓	✓
e) understand the legal and ethical requirements and agreed ways of working that protect the rights of people at the end of life, and know how to access expert advice regarding these		✓	✓
f) understand legal and ethical aspects of decision-making to inform discussions within the multi-professional team, and with the person, families and carers			✓
g) be able to recognise when mental capacity has reduced to the extent that others will determine care and treatment for the person at the end of life			✓
h) understand the process of addressing conflicts and continuing differences of opinion including seeking a second opinion, facilitating communication and when a court ruling needs to be sought			✓

Capability 13. Leading end of life care services and organisations			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) be able to provide support for colleagues to develop their skills and confidence when working with people at the end of life and those important to them		✓	✓
b) be able to provide effective supervision and support regarding end of life care, enabling team members to manage their own feelings, reflect on practice and improve service delivery		✓	✓
c) be able to facilitate workers to offer support and guidance to each other regarding caring for people at the end of life, such as debriefing, making relevant resources accessible		✓	✓
d) be aware of local and national policies shaping the delivery of end of life care and how these influence service delivery			✓
e) be able to implement, local and national policies shaping the delivery of end of life care and influence service delivery			✓
f) be able to implement evidence-based research, innovations and developments in end of life care			✓
g) be able to anticipate and prepare for the future by scanning for ideas, best practice and emerging trends that will have an impact on outcomes for individuals at the end of life			✓
h) be able to build a skilled and competent end of life care workforce through assessing learning and development needs and evaluating programmes and systems to meet these needs			✓

i) be able to implement strategies to empower and support staff involved in the delivery of end of life care to ensure positive outcomes for the person and others			✓
j) be able to critically reflect on methods for measuring the end of life care service against national indicators of quality			✓
k) understand the importance of collecting quality assurance information including from the person and those important to them, and act on feedback received			✓
l) understand how integrated service provision that crosses traditional boundaries achieve better outcomes for the person, including integrating with the community			✓
m) be able to analyse how reflective practice approaches can improve the quality of end of life care services			✓
n) be able to analyse the features of effective partnership working within own work setting			✓
o) understand how legislation and regulation influence partnership working, including how information is shared			✓
p) understand the importance of demonstrating leadership in delivering compassionate person-centred care			✓
q) be able to promote team practices that champion diversity, equality and inclusion			✓
r) be able to analyse how reflective practice approaches can improve the quality of end of life care services			✓
s) be able to support others to reflect on practice in end of life care, and use outcomes of this to improve service delivery			✓

Capability 14. Improving quality in end of life care through research evidence, evaluation and reflective practice			
The individual must:	**Tier 1**	**Tier 2**	**Tier 3**
a) be able to reflect on practice and learn from experience	✓	✓	✓
b) be able to participate in service reviews, research and surveys, including service satisfaction surveys	✓	✓	✓
c) understand how evidence can be collected and used to develop and improve the care provided for the person and those important to them and improve service delivery e.g. learning from complaints	✓	✓	✓
d) know where to obtain information about local policy and evidence-based practice		✓	✓
e) be aware of current guidance and evidence to inform assessment and decision making		✓	✓
f) be able to judge the value of information e.g. according to its source or evidence base		✓	✓
g) be able to analyse how local and national policy and the outcomes of research in end of life care can inform and impact on workplace practices and care delivery			✓
h) understand principles and underpinning rationale of initiatives to facilitate better end of life care			✓
i) understand the options available to further develop research skills such as advanced practice, clinical academia and research roles			✓
j) be able to evaluate how a plan or policy in end of life care can support individuals and those important to them			✓
k) be able to evaluate own care service delivery involving people and those important to them			✓

l) understand how to critically review evidence to determine relevance to own decision-making			✓
m) be able to critically reflect on how the outcomes of national and international research can inform your workplace practices and service delivery			✓
n) understand how to use the National End of Life Care Intelligence Network data and other data sources to determine population needs and highlight any inequalities			✓
o) understand ways to address end of life population needs across health and social care and organisational boundaries			✓