PART III:

CAPACITY BUILDING IN COMMUNITY-BASED END-OF-LIFE CARE

CHAPTER 10

END-OF-LIFE CARE COMPETENCES FOR ALL: BUILDING A CROSS-CUTTING CORE COMPETENCY FRAMEWORK FOR HEALTH AND SOCIAL CARE PROFESSIONALS IN THE COMMUNITY

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End-of-life care (EoLC) should be the business of all health and social care professionals. Education and training on EoLC should therefore target all levels of the healthcare system. Core competency frameworks in palliative care (PC), and EoLC, will inform training programmes by detailing essential training contents and expected learning outcomes. Core competency frameworks have a role to play in the standardisation of quality across curricula. In order to guide the formulation and assessment of the Jockey Club End-of-Life Community Care (JCECC) Project capacity building programme in Hong Kong communities, a cross-cutting EoLC core competency framework for all health and social care professionals was developed, based on international competency frameworks. The JCECC Project competency framework should also guide future development of EoLC curricula. This chapter starts with clarifying the educational priorities of the JCECC Project in relation to establishing relevant core competency frameworks. An overview is presented of international PC and EoLC competency frameworks. This is followed by a discussion on the important framework properties that are relevant to the JCECC Project. The last part of the chapter describes the establishment and properties of the JCECC End-of-Life Care Core Competency Framework.

BACKGROUND

THE PRESSING NEED OF EDUCATION FOR EoLC IN HONG KONG

PC and EoLC have become a highly specialised service in Hong Kong and, consequently, so has its training. PC training is mainly provided through qualification-based continuing professional education to doctors and nurses who are preparing to work as specialists in this field. In 2016, around 40 doctors and 600 nurses were providing specialist PC in Hong Kong (Cheung, 2016; Hospital Authority [HA], 2017). In the same year, approximately 80% of the 46,000 deaths that occurred in Hong Kong were due to chronic diseases. The argument to upskill more PC specialists is compelling; however, the responsibility to care for patients facing life-limiting diseases should not be vested only in PC specialists.

The World Health Assembly (WHA) resolutions on PC, published in 2014, affirmed the importance of integrating PC into all levels of the healthcare system (WHA, 2014). Responding to this, healthcare practitioners in Hong Kong called upon the government to develop a local PC policy to promote better integration of PC into the local healthcare system (Chan, 2018). In 2017, the HA proposed a shared-care model for PC, which emphasises collaboration between PC specialists and non-specialists (HA, 2017). These initiatives all underscore the pressing need for training to be provided for health and social care professionals who are not specialised in PC.

In Hong Kong, EoLC topics are not yet integrated into the fabric of undergraduate curricula for relevant health and social care professionals. Despite continuing professional education, such as diploma or certificate courses, and workshops being offered by professional bodies and academic institutions, the content of training programmes varies. Moreover, low awareness of the need for upskilling and less-than-adequate competences have been consistently reported among health and social care professionals (Chan, 2014; Cheung et al., 2018; Hong, Lam & Chao, 2013; Lau, 2017). Although social workers have been recognised as key providers of PC services in HA, there is no specialised training currently targeted at them (Chan, 2014). In light of these training gaps, generalist training for health and social care professionals has become the priority in the JCECC Project capacity building programme. In particular, the University of Hong Kong (HKU) focuses on capacity building in the community, with a specific emphasis on psychosocial care at end of life (EoL). Before developing a training programme, it was recognised that, as a prerequisite, a competency framework needed to be established that articulated the competences required in the provision of quality EoLC (Gómez-Batiste, Lasmarías, Connor & Gwyther, 2017). As there is no published EoLC competency framework available in Hong Kong, the project team first established a contextually relevant framework before developing capacity building programmes.

OVERVIEW OF PC AND EoLC COMPETENCY FRAMEWORKS

Competency is defined as an integration of knowledge, skills, values and attitudes that underpin an individual's actual performance in particular situations (Gamondi, Larkin & Payne, 2013a). On the other hand, *competence* refers to the potential that an individual can successfully carry out a required set of actions (Orchard & Bainbridge, 2016). A PC competency framework sets out competency domains, which are required by healthcare professionals to be able to provide quality PC. In each competency domain, competences (plural form of *competence*) are defined in terms of knowledge, skills and attitude. A competency domain can contain different competence descriptors, and the required levels of proficiency (low to high proficiency). Thus, a competency framework can be used to guide curriculum development by suggesting learning topics and expected learning outcomes, and define the competences required for various proficiency levels.

Different PC competency frameworks for health and social care professionals have already been developed in different parts of the world. In 2012, a review conducted by the All Ireland Institute of Hospice and Palliative Care (AIIHPC) identified 29 competency frameworks developed in the UK, US, Canada, Australia and Northern Ireland (Connolly, Charnley, Regan & AIIHPC, 2012). New frameworks have been published since this review to address different care settings and target groups, and to meet the needs of different populations (e.g. Health Education England, Skills for Health & Skills for Care, 2017; McCallum et al., 2018; Sousa & Alves, 2014; Stanyon, Goldberg, Astle, Griffiths & Gordon, 2017).

Three key aspects that influence scope and application of a competency framework have been identified:

1. ***Targeted professional groups.*** For which discipline(s) is (are) the competency framework designed? Does the framework target single or multiple disciplines?
2. ***Competence levels.*** What levels of competences should be included? How are levels of competences defined?
3. ***Competence domains and contents.*** What are the essential competency domains and competences that should be included? How should competences be categorised into competency domains?

These three aspects interact with each other in order to determine the scope and application of a competency framework. The following section discusses these aspects of competency frameworks individually. They are then considered in terms of the selection of reference frameworks for the JCECC Project.

TARGET PROFESSIONAL GROUPS

The proliferation of interdisciplinary competency framework in PC and EoLC. Countries with advanced development in PC and EoLC have already developed competency frameworks to address the needs of a range of disciplines (medicine, nursing, occupational therapy, physiotherapy, emergency health services, dietetics, speech and hearing therapy, midwifery, pharmacy, pastoral care, social work, clinical psychology and healthcare assistants).

There are two broad types of frameworks: discipline-specific and interdisciplinary. Discipline-specific frameworks target PC competences for a specific discipline. Examples of these are the core competencies in PC social work, developed under the European Association of Palliative Care (EAPC) (Hughes, Firth & Oliviere, 2015) and the competency framework for nurses, developed by the Palliative Care Nurses New Zealand (2014). Interdisciplinary frameworks, on the other hand, are cross-cutting, such that they are relevant to, and can be applied across, multiple disciplines. Their frameworks focus on core competency domains in PC, which are common to all health and social care professions.

During the last decade, there has been a proliferation of interdisciplinary common core competency frameworks in PC and EoLC, including the Palliative Care Competence Framework developed in Ireland (Palliative Care Competence Framework Steering Group, 2014); the *Core competencies in palliative care: An EAPC White Paper on palliative care education* (Gamondi et al., 2013a); the *Common core competences and principles for health and social care workers working with adults at the end of life* in the UK (UK Department of Health, 2009); the *End of life care core skills education and training framework* in the UK (Health Education England et al., 2017); the *Developing a palliative care competency framework for health professionals and volunteers: The Nova Scotian experience* in Canada (McCallum et al., 2018); and the *Core competencies: A framework of core competencies for palliative care providers in Africa* (African Palliative Care Association, 2012).

The collaborative nature of PC and EoLC, coupled with growing recognition of the value of interdisciplinary learning in facilitating effective collaborative practice, might have underpinned this development. On the other hand, this could be a manifestation of the heightened national level impetus to enhance cross-discipline and cross-sectoral collaboration in countries with more advanced development of PC services. In the EAPC White Paper on Palliative Care Education (Gamondi, Larkin & Payne, 2013a, p. 90), it was stated that:

> At the core of good collaborative practice is the ability to understand and respect boundaries of practice, to know when and how to refer for expert advice and intervention where necessary, and to ensure a meaningful communication flow of relevant information through the team, in order to provide quality care for the patient and family. One of the challenges of collaborative work is to share a common philosophy of care and common goals.

Notably, competencies in interdisciplinary frameworks are written in common language and avoid specialist terms, so that different disciplines in health and social care can relate to them (UK Department of Health, 2009; Gamondi et al., 2013a). The use of common core learning domains transcending all professional groups can also "assist in developing a consistent approach to cross-sectoral and cross-discipline learning" (Palliative Care Australia, 2010, p. 5).

Common competences as a unique feature in interdisciplinary framework. From the perspective of competence-based models in interprofessional education, Barr (1998) classified three types of competences important to interprofessional practices. An interdisciplinary competency framework should incorporate all three types of competences.

The first competence type identified by Barr (1998) is "common competences", which are shared by all professions and can only be found in frameworks with an interdisciplinary focus.

The second competence type is "collaborative competences", which require each profession to work with others (Barr, 1998). The Interprofessional Education Collaborative (IPEC) in the US published four core competency domains in interprofessional practice: teams and teamwork, interprofessional communication, understanding roles and responsibilities, and values and ethics for interprofessional practice (IPEC, 2011). Collaborative competences of similar contents are embedded as core competences in most frameworks, regardless of whether they are discipline-specific or interdisciplinary. Some frameworks have collaborative practices as a stand-alone competency domain, while others integrate collaborative competences into other domains.

The third type of competence in Barr's framework (Barr, 1998) is "complementary competences", which refer to competencies specific to one profession that are complementary to competencies specific to other professions. In other words, these are discipline-specific competences that have an interprofessional application. In reality, each discipline will contribute to the same care domain with knowledge and skills unique to their discipline. "Complementary competences" are the focus in discipline-specific frameworks, but they can also be incorporated into an interdisciplinary framework. In the competency frameworks in Nova Scotia and Ireland, complementary competences for individual disciplines are elaborated on in each competency domain (McCallum et al., 2018; Palliative Care Competence Framework Steering Group, 2014). Mapping complementary competencies for each discipline into an interdisciplinary framework has the merit of fostering an interprofessional understanding regarding roles and responsibilities of each profession, articulating with same frame of reference.

Figure 10.1 depicts how these three types of competences manifest themselves in discipline-specific and interdisciplinary frameworks. Basically, complementary and collaborative competences are central to all discipline-specific competency frameworks. On the other hand, an integral part of interdisciplinary frameworks accentuates common competences with collaborative competences (with or without additional complementary competences specified for each discipline involved). This discussion does not imply unconditional preference for interdisciplinary frameworks, as the two framework types serve different purposes. The former focuses on building a common foundation of competences across disciplines, whereas the latter focuses on specific roles and contributions most relevant to a single discipline.

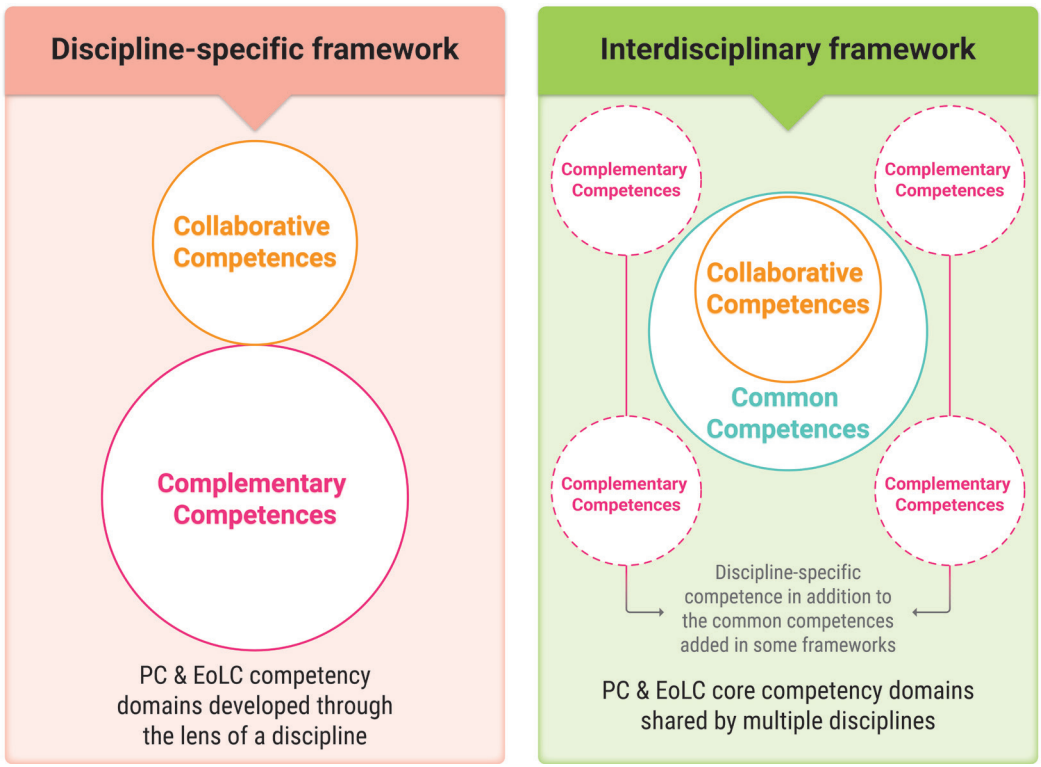

Figure 10.1 Types of Competences in Discipline-Specific and Interdisciplinary Competency Frameworks in Palliative and End-of-Life Care

COMPETENCE LEVELS: A THREE-TIERED APPROACH TO INTEGRATE PC AND EoLC INTO HEALTHCARE SYSTEMS

The resolutions on PC established by the WHA in 2014 urged countries to integrate core competencies of PC into undergraduate and postgraduate curricula, to ensure that all health and social care professionals possess the necessary knowledge and skills to provide at least a basic level of PC and EoLC to patients who need it (WHA, 2014). More importantly, it is now widely recognised that patients with life-limiting diseases have varying levels of PC needs that require services provided by people with different levels of PC expertise. Addressing these needs often requires flexible collaboration between PC specialised teams and care teams of other specialties, including primary care. For instance, some patients have persistent and complex care needs throughout their illness trajectory, which require ongoing involvement of specialist PC teams. Others may experience complex conditions only at some points in the course of their illness, and thus require only episodic interventions from specialist PC teams, while continuing to be cared by a primary care team. Yet others may follow an expected progress throughout their illness and can be well managed by non-specialists who provide generalist PC (Irish Association for Palliative Care, 2018; McCallum et al., 2018; Palliative Care Australia, 2005). Apart from a minimum level of basic knowledge in PC, intermediate level of training should therefore be tailored and provided to non-specialists according to their roles and responsibilities, care settings and involvement in patients' illness trajectories and the PC continuum.

There is an increasing use of a three-tier approach to PC, which has informed international efforts to include different levels of competences in PC competency frameworks. As early in 2001, the National Advisory Committee on Palliative Care in Ireland published a three-tier framework for PC and EoLC services, with the levels of specialisation in PC being "Palliative care approach", "General palliative care" and, lastly, the highest level, "Specialist palliative care" (Department of Health and Children, 2001). Similar three-tiered approaches have been outlined more recently in national strategies published in UK and Australia, and also in the EAPC White Paper on Palliative Care Education (Gamondi et al., 2013a; Palliative Care Australia, 2018; UK Department of Health, 2008).

Drawing on the three-tier frameworks, **Table 10.1** summarises the definition of each level of PC and EoLC, and the required training in each respective level. The first level "Palliative care approach" refers to a minimum level of core basic knowledge and attitudes in PC and EoLC that all health and social care professionals should have. The second level, "General palliative care", is a set of basic skills in PC and EoLC that should be practised by health and social care professionals who are not specialised in PC, but who frequently deal with patients with life-limiting diseases. They should be supported and advised by specialist PC team(s). Lastly, the third level, "Specialist palliative care", refers to specialised PC and EoLC services provided by health and social care professionals as their sole role. Specialist PC team(s) demonstrate high levels of expertise in managing complex symptom management and spiritual, psychosocial and bereavement care.

Table 10.1 ***Three-Tier Approach to Palliative Care Adapted from Definitions in the Frameworks of the UK and EAPC (UK Department of Health, 2009; Gamondi et al., 2013a)***

LEVELS	DEFINITION	REQUIRED SKILLS AND KNOWLEDGE
Tier 1 Palliative care approach	Basic principles and practice in PC practised by health and social care professionals who infrequently have to deal with end-of-life care. This is integrated into the care of patients with progressive and advanced diseases in settings not specialised in PC/EoLC.	Core competences in PC in terms of knowledge and attitudes that should be demonstrated by all health and social care professionals. All professionals should also know when and how to access to specialist services or seek expert advice. Core competences should be integrated in undergraduate medical and nursing professional education, and should be taught to social care professionals through undergraduate training or continuing professional education if they did not receive this basic education in their undergraduate studies.
Tier 2 General palliative care	Intermediate level of PC that is practised by health and social care professionals who work in settings not specialised in palliative or end-of-life care but frequently or regularly have to deal with patients with end-of-life issues and provide palliative and end-of-life care as part of their role.	Additional specialist training is needed to enable health and social care professionals to apply the learnt knowledge into their care and develop good basic skills in multiple palliative and EoLC competences. Health and social care professionals in this level are in a good position to identify those patients in need of palliative and integrate Advance Care Planning (ACP) discussion early in the care pathway. These competences can be, but not necessarily, taught in undergraduate studies. They can also be taught in postgraduate learning or through continuing professional education.
Tier 3 Specialist palliative care	The highest level of PC, which is practised by health and social care professionals who work in settings specialised for palliative and end-of-life care, and provide palliative and end-of-life care as their main role. Service settings providing specialist PC may also provide consultative support services to other health and social care professionals involved in the care of people with life-limiting disease.	Qualification-based training is needed, and specialists have to be equipped with competences to work closely with multidisciplinary team to provide integrated care to patients with complex needs that are more than routine symptom management needs. These can be taught at postgraduate level or boosted through continuing professional education.

The three levels of competence are termed basic, intermediate and advanced/specialist levels in some frameworks (e.g. Martine, Nuria, Philip & Francoise, 2004), while in other frameworks they were divided into competences required by "all", "some" and "few" practitioners (e.g. Palliative Care Competence Framework Steering Group, 2014). For simplicity, competence levels are only divided into generalist and specialist levels (e.g. Health & Social Care Northern Ireland, 2016). Not all frameworks cover all competence levels. For instance, the UK and EAPC core competency frameworks only stipulate a minimum level of competence expected of all health and social care professionals (UK Department of Health, 2009; Gamondi et al., 2013a).

COMPETENCE DOMAINS AND CONTENTS: CONVERGENCE TO A SET OF CORE SKILLS

A PC competency framework sets out competency domains to reflect the values and principles underpinning PC. However, with reference to interdisciplinary frameworks, the coverage of competency domains across frameworks varies in relation to local PC practice or performance standards, as well as the scope of target groups and proficiency levels designated in the framework. Categorisation of domains also varies across frameworks. There are a few approaches to categorising PC competency domains, such as dividing competences into generic skill areas, grouping competences into different phases in the "patient journey", or distilling competences into different aspects of interaction involved in PC (Scottish Partnership for Palliative Care, 2007). Categorisation of generic skill aspects is most common in interdisciplinary frameworks. Despite the international variations, frameworks that target a minimum level of competence generally have common aspects, including PC principles, communication, enhancing physical comfort, addressing psychosocial–spiritual well-being, collaborative practice, care planning and decision-making at EoL (UK Department of Health, 2009; Gamondi et al., 2013a; Gamondi, Larkin & Payne, 2013b). Frameworks that extend to intermediate or specialist levels may include other domains such as leading organisations, education, advocacy, research and auditing (African Palliative Care Association, 2012; Health Education England et al., 2017; McCallum et al., 2018).

Regarding competency content, some frameworks classify competences in terms of knowledge, skills and attitude (KSA) (e.g. Health & Social Care Northern Ireland, 2016); however, the absence of a KSA classification is not uncommon in frameworks that only present generic competences. One of the drawbacks to not using this classification is the risk of overlooking one or more KSA attributes, which may lead to low proficiency. Tools to assess competencies have also been developed from some competency frameworks, e.g. the evaluation toolkit developed by Whittaker, Broadhurst & Faull (2015), which is based on the UK Common Core Competences and Principles for Health and Social Care Workers Working with Adults at the End of Life.

Table 10.2 summarises the properties of six interdisciplinary PC and EoLC competency frameworks, as well as two assessment tools developed from the UK common core competency framework, which was reviewed by the HKU project team. It should be noted that only five of the reviewed publications in the list were published by the time the JCECC Project framework was built in 2015.

Table 10.2 *Summary of Key Interdisciplinary Competence Framework Documents Reviewed*

DOCUMENT	COUNTRY	TARGET GROUP(S)	COMPETENCY DOMAINS AND COMPETENCES
Palliative care competence framework (Palliative Care Competence Framework Steering Group, 2014)	Ireland	12 disciplines in health and social care	Six competency domains: 1. Principles of PC 2. Communication 3. Optimising comfort and quality of life 4. Care planning and collaborative practice 5. Loss, grief and bereavement 6. Professional and ethical practice in the context of palliative care
Common core competences and principles for health and social care workers working with adults at the end of life (UK Department of Health, 2009)	UK	All disciplines involved in supporting people approaching EoL	Five competency domains: 1. Overarching values and knowledge 2. Communication skills 3. Assessment and care planning 4. Symptom management, comfort and well-being 5. Advance Care Planning
Evaluation toolkit: Assessing outcomes of end of life learning events (Whittaker et al., 2015)	UK	All disciplines involved in supporting people approaching EoL	A self-assessment toolkit based on the competency framework developed by the UK Department of Health (2009)
Palliative and end-of-life care competency assessment tool (Health & Social Care Northern Ireland, 2016)	Northern Ireland	All disciplines involved in PC and EoLC	A self-assessment tool developed using the competences from the Northern Ireland Cancer Network Framework for Generalist and Specialist Palliative and End-of-Life Care Competency (as cited in Palliative Care Competence Framework Steering Group, 2014) mapped to the five competency domains of the framework developed by the UK Department of Health (2009). Competences are categorised into knowledge, skills and attitude.
Core competencies in palliative care: An EAPC White Paper on palliative care education (Gamondi et al., 2013a, 2013b)	Europe	All health and social care professionals	Ten competency domains are as follows: 1. Application of PC approach 2. Enhancement of physical comfort of patients 3. Address patient's psychological needs 4. Address patient's social needs 5. Meet patient's spiritual needs 6. Respond to the needs of family caregivers 7. Clinical and ethical decision-making 8. Care coordination and interdisciplinary team 9. Interpersonal and communication skills 10. Practice self-awareness and undergo continuing professional development

TYPES AND LEVELS OF COMPETENCE INCLUDED IN COMPETENCY DOMAINS		
COMMON (SHARED/OVERLAPPED)	COMPLEMENTARY (DISCIPLINE-SPECIFIC)	COLLABORATIVE
A minimum level of competences shared by the 12 disciplines	Competences in each domain are further differentiated into three levels for "all", "some" and "few" practitioners for each discipline	Included in the domain of "care planning and collaborative practice"
A minimum level of competences expected of all health and social care professionals		
A minimum level of competences expected of all health and social care professionals		Included in the domain of "Advance Care Planning"
Two levels of common competences are stipulated, with the first level targets on generalists and the second targets on specialists in PC and EoLC	Included in the subdomain of "teamwork"	
In each competency domain, constituent competences expected of all professions are described		Included mainly in the domain of "practice comprehensive care coordination and interdisciplinary teamwork across all setting where PC is offered"

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DOCUMENT	COUNTRY	TARGET GROUP(S)	COMPETENCY DOMAINS AND COMPETENCES
End of life care core skills education and training framework (Health Education England et al., 2017)	UK	Competences are defined at three tiers, with the first tier for general public, second and third tiers for health and social care professionals in general	Fourteen domains are as follows: 1. Person-centred EoLC 2. Communication in EoLC 3. Equality, diversity and inclusion in EoLC 4. Community skills development in EoLC 5. Practical and emotional support in EoLC 6. Assessment and care planning in EoLC 7. Symptom management in EoLC 8. Working in partnership with others 9. Support for carers 10. Maintain own health and well-being 11. Care after death 12. Law, ethics and safeguarding 13. Leading EoLC services and organisations 14. Improving EoLC quality through policy, evidence and reflection
Developing a palliative care competency framework for health professionals and volunteers: The Nova Scotian experience (McCallum et al., 2018)	Nova Scotia, Canada	22 disciplines in health and social care, and volunteers	The six competency domains developed in the Ireland Core Competency Framework (Palliative Care Competence Framework Steering Group, 2014) are adopted and seven extra domains are added to reflect the values of the Nova Scotia Health Authority: 1. Cultural safety 2. Last days and hours 3. Self-care 4. Education 5. Evaluation 6. Research 7. Advocacy
Core competencies: A framework of core competencies for palliative care providers in Africa (African Palliative Care Association, 2012)	Africa	Various professional care providers (doctors, nurses, clinical officers, social workers, spiritual care providers) and community care providers	Competency domains in line with the African Palliative Care Association Standards for Providing Quality Palliative Care across Africa: 1. Organisational management 2. Holistic care provision 3. Education and training 4. Research and management of information There are subdomains under each of the four competency domains, and competences are categorised into knowledge, skills and attitude.

TYPES AND LEVELS OF COMPETENCE INCLUDED IN COMPETENCY DOMAINS			
	COMMON (SHARED/OVERLAPPED)	COMPLEMENTARY (DISCIPLINE-SPECIFIC)	COLLABORATIVE
	Two levels of common competences are defined for professional workers; one level targets professionals who infrequently work with EoL patients, the other level targets professionals who are not specialists in EoLC, but require in-depth knowledge of EoLC because they frequently work with individuals approaching EoL		Included in the domain of "working in partnership with health and care professionals and others"
	A minimum level of competences shared by the 22 disciplines in health and social care, and volunteers	For each discipline, complementary competences or competency domains are additionally added	Included in the domain of "care planning and collaborative practice"
	Three levels (basic, intermediate and specialist) of competences are designed in each competency domain for PC providers and community care workers separately		Included in subdomains under the domain of "holistic are provision"

BUILDING THE JCECC PROJECT EoLC COMPETENCY FRAMEWORK

Based on the information presented earlier, the UK and EAPC core competences frameworks were chosen as key references when constructing the JCECC Project framework. They were chosen because these frameworks involved only core competency domains that related to all disciplines. This focus matches the JCECC Project objective of building a solid foundation of knowledge across health and social care professionals. Moreover, the assessment toolkit developed by Whittaker et al. (2015), which is based on the UK framework, provides a sound basis for the project team to develop an assessment tool for the JCECC Project capacity building programme.

Five principles in the JCECC Project community-based EoLC programme also underpin the development of the JCECC Project End-of-Life Care Core Competency Framework:

1. Care in and by the community;
2. Respecting choice and autonomy;
3. Family as service unit;
4. Holistic care with an emphasis on psychosocial care, and
5. Evidence-based practice.

By adapting the two referenced frameworks, the JCECC Project End-of-Life Care Core Competency Framework was developed with seven competency domains. Modifications were undertaken with consideration of the aforementioned competency principles, while also reflecting the unique features of the JCECC Project capacity building programme (e.g. emphasis on psychosocial care) and adapting some competences to fit local contexts (e.g. removing items on the Gold Standards Framework and using local terms for medical orders). Before the final version was endorsed, the framework underwent several rounds of review by the JCECC Project HKU team, which ensured that it was considered by professionals with a range of backgrounds (medicine, nursing, social work and psychology).

The seven domains of the JCECC framework encompass core competencies commonly shared by all health and social care professionals in providing quality EoLC:

1. Overarching values and knowledge;
2. Communication skills;
3. Symptom management, maintaining comfort and well-being of patients and families;
4. Psychosocial and spiritual care;
5. End-of-life decision-making;
6. Bereavement care; and
7. Self-care and self-reflection.

While the framework comprises mainly common competences, collaborative competences have been incorporated into the domain of "communication skills". Complementary competences are not the focus of the capacity building programmes of HKU. However, two of the JCECC Project partners target education programmes for doctors and nurses (see Haven of Hope Christian Service in Chapter 6 and CUHK Jockey Club Institute of Ageing in Chapter 12). The education programmes include topics on initiating ACP, Advance Directives (AD) and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). Thus, complementary competences are incorporated into the current framework. The framework takes a particular emphasis on strengthening psychosocial care and communication-related competences in EoLC by embedding two levels of competences (fundamental and intermediate levels). The fundamental level provides basic knowledge on necessary theories supporting evidence-based psychosocial and bereavement care. Application of these theories reflects the learning outcomes in the intermediate level. It should also be noted that some competences are relevant to multiple domains but are categorised under only one domain, to reflect the domain in which they have the most prominent impact. The competency statements of each domain are discussed next.

1. ***Overarching values and knowledge.*** Professionals have a basic understanding of societal and cultural influences on EoLC, the ethical issues in EoLC and basic knowledge on available EoLC services and support that can be provided in different settings.
2. ***Communication skills.*** Professionals understand the central role of effective communication in quality EoLC. They can communicate sensitively and openly with patients at EoL, and their family members, to support person-centred care. They are able to use effective communication skills with other team members in interdisciplinary EoLC teams to promote efficient information sharing and collaborative practices.
3. ***Symptom management, maintaining comfort and well-being of patients & families.*** Professionals have basic knowledge about common distressing physical symptoms in EoL, and awareness of the multidimensional factors contributing to this distress. They can demonstrate basic competences in assessing and helping patients and family members manage these symptoms.
4. ***Psychosocial and spiritual care.*** Professionals are aware of the significance of evidence-based psychosocial and spiritual care in EoLC, and can incorporate psychosocial–spiritual assessment as an integral part of a holistic assessment of patients and family members to facilitate individualised care planning. When patients and family members have indicated psychosocial–spiritual distress, professionals are able to support them with evidence-based interventions and knowledge about other support services.
5. ***EoL decision-making.*** Professionals are aware of the significance of respecting choices and maximising autonomy of patients in EoL. They also possess basic knowledge about legal and ethical issues surrounding EoLC in order to help patients and family members make EoL-related decisions. For intermediate learners, professionals should also be competent in assisting patients and family members resolve conflicts surrounding EoL decisions.

6. ***Bereavement care.*** Professionals are aware of the importance of supporting family members of EoL patients through the grieving process. While most bereaved family members can deal with loss with their own resources and support from friends and family, a minority may experience difficulties in their grieving. Professionals should possess the necessary knowledge and skills to assess bereavement care needs and provide support when needed. For intermediate learners, professionals should also be competent in intervening with bereaved individuals with evidence-based practices.
7. ***Self-care and self-reflection.*** Professionals should acknowledge their limitations in the face of death and be aware of the possible influence of involvement in EoLC on their own values and emotions. They should also demonstrate understanding about the significance of self-reflective practice in the delivery of good EoLC.

Table 10.3 presents the component competences under each domain and provides an indication of the type and level of each competency item. A 38-item multidimensional EoLC competence assessment tool was subsequently developed based on this competency framework. It covers six of the domains, with each competency item rated on a 10-point Likert scale between 1 (not competent at all) and 10 (very competent). The remaining domain on self-care and self-reflection is measured by the Self-Competence Scale in Death Work (SC-DW) (Chan, Tin & Wong, 2015). The assessment package has been adopted in the outcome evaluation of the JCECC Project capacity building programme delivered by HKU. The evaluation findings are presented in Chapter 13.

Table 10.3 ***JCECC End-of-Life Care Core Competency Framework for Health and Social Care Professionals in the Community***

Domain 1: Overarching values and knowledge	» Understanding of societal and cultural influence on EoLC (Com-F) » Understanding on how to handle ethical issues in EoLC (Com-F) » Demonstrating knowledge on EoLC options in different settings (Com-F) » Understanding available community-based EoLC support services, and knowing how to access and collaborating with these services in their care for patients facing EoL (Com-F) » Maintaining professional boundaries when helping patients and families (Com-F)
Domain 2: Communication skills	» Listen to and talk with patients and family members on topics surrounding EoLC issues (Com-F) » Communicating psychosocial and spiritual concerns with patients and family members (Com-F) » Recognising and addressing patient's and family members' communication cues (Com-F) » Facilitating communication among patients, family members and care team (Collab-F) » Collaborating with other disciplines in the interdisciplinary EoLC team and appreciating respective roles of other professions in providing EoLC (Collab-F)

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Domain 3: Symptom management, maintaining comfort and well-being of patients and families	» Recognising signs of approaching death (Com-F) » Helping patients with pain and distressing symptoms (Com-F) » Communicating with patients about anxieties over the dying process and what will happen (Com-F) » Working with family members in caregiving (Com-F) » Using non-pharmaceutical, complementary and alternative therapies in helping patients with distressing symptoms (Com-F)
Domain 4: Psychosocial and spiritual care	» Demonstrate understanding on the needs and challenges experienced by patients and family caregivers across illness trajectories (Com-F) » Using holistic assessment with patients and family members (Com-F) » Applying individualised end-of-life care plan (Com-F) » Providing information of other support services to patients and caregivers when needed (Com-F) » Understanding the benefits of evidence-based psychosocial interventions in EoLC (Com-I) » Applying evidence-based psychosocial interventions (Com-I)
Domain 5: End-of-Life decision-making	» Understanding legal issues relating to EoLC (Com-F) » Find out patient's wishes over care decisions should they lose capacity (Com-F) » Understanding the benefits of Advance Care Planning (ACP) (Com-F) » Preparing patients and family for the death by discussing unfinished business, wishes regarding after-death care, funeral and ritual, and body disposition (Com-F) » Build consensus and mediate conflicts between patients and families regarding EoLC decision (Com-I) » Initiating ACP discussion (Comp) » Discussing and preparing Advance Directives (AD) and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) with patients and their families (Comp)
Domain 6: Bereavement care	» Understanding theories of grief, mourning and bereavement (Com-F) » Differentiating normal and complicated grief reactions (Com-F) » Offering bereavement counselling to bereaved families and individuals (Com-I)
Domain 7: Self-care and self-reflection	» Demonstrating emotional and existential competences towards death (Com-F) » Acknowledge the significance of self-reflective practice in the delivery of good EoLC (Com-F)

Notes: Competence type-competence levels: Competence type: Com=common, Collab=collaborative; Comp=complementary

Competence level: F=fundamental, I=Intermediate

LEARNINGS, REFLECTIONS AND THE WAY FORWARD

This competency framework is the first step to fully integrate EoLC into the Hong Kong healthcare system. It predominantly concerns basic levels of competence that correspond to the level of "palliative and end-of-life care approach" in the three-tier framework for PC education. The Hong Kong community requires more competent health and social care professionals with EoLC training that goes beyond the foundation level to provide "generalist PC and EoLC" in collaboration with specialist services. There remains a large gap in advanced training available for professionals other than doctors and nurses. To fill this, the current JCECC End-of-Life Care Core Competency Framework could readily be expanded to provide intermediate level training for non-specialists of other disciplines, as well as an advanced level of training for professionals working in specialist palliative and end-of-life care services (particularly social workers and allied health professionals). Given the complexity of competencies involved in higher levels of education, and the high likelihood that interdisciplinary practice will be required in settings which frequently deal with patients with life-limiting diseases, the competencies should be systematically defined in terms of KSA, and collaborative competences should be given greater emphasis.

CONCLUSION

The initiative to establish a core competency framework in EoLC is the first of its kind in Hong Kong. It contributes to capacity building in EoLC by suggesting a minimum level of competences in EoLC required by all health and social care professionals to provide quality EoLC in a range of settings. The cross-cutting nature of the framework also helps to cultivate a common language on EoLC among professional groups, which in turn paves the way for effective interdisciplinary collaborative practices in EoLC. The application of the framework in education planning and programme evaluation helps in promoting consistency across diverse education programmes, and aligns JCECC training content with the international standards.

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