

## What is the Gold Standards Framework in Primary Care?

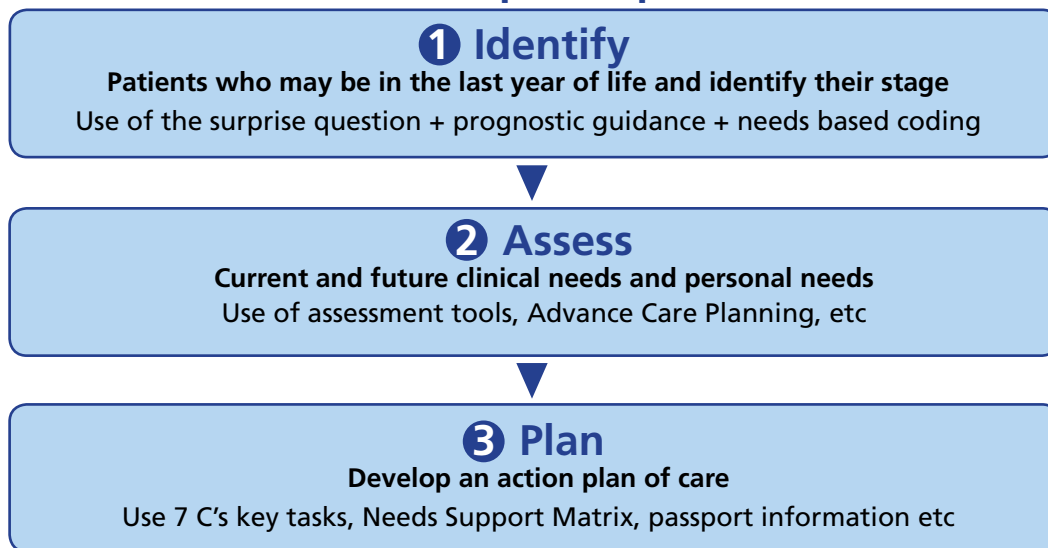
**1 Aim – GSF is a framework to deliver a 'gold standard of care' for all people nearing the end of life**

**'It's about living well until you die'**

GSF is a systematic common-sense approach to formalising best practice, so that quality end of life care becomes standard for every patient. It helps clinicians identify patients in the last year of life, assess their needs, symptoms and preferences and plan care on that basis, enabling patients to live and die where they choose. GSF embodies an approach that centres on the needs of patients and their families and encourages inter professional teams to work together. GSF developed originally for primary care and is now extensively used by GP practices throughout the UK. The GSF Care Homes Training Programme was developed from this in 2004 and is widely used, the GSF Acute Hospitals work is well underway and spread continues to other settings in the UK and worldwide. The Next Stage GSF Primary Programme from June 09 has new tools, resources, quality improvement training and even more focus on aligning with the needs and choices of patients and carers.

**"Its less about what you know and more about what you do and how you do it"**

### 3 Simple Steps



#### Key Messages

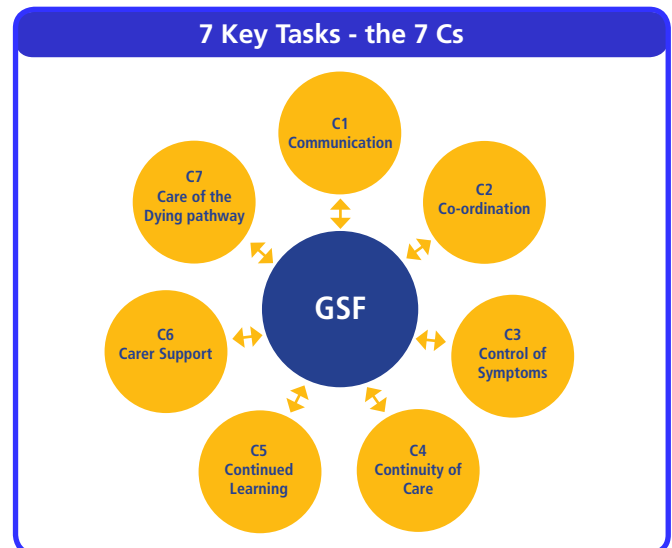
- End of Life Care is important. It affects us all
- 1% population die/year- mainly elderly non-cancer patients.
- Too few people die at home or their place of choice.
- Hospital admissions and deaths are expensive and may be preventable - care must be brought closer to home.
- Everyone is involved in end of life care - most care is from the usual generalist provider
- GSF helps improve the quality and coordination of care provided by generalists across different settings.

#### 5 Goals of GSF

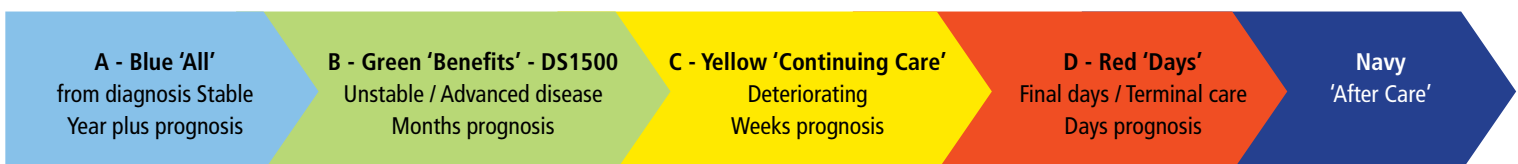
To provide for patients with any final illness:

1. Consistent high quality care
2. Alignment with patients' preferences
3. Pre-planning and anticipation of needs
4. Improved staff confidence and teamwork
5. More home based, less hospital based care

#### 7 Key Tasks - the 7 Cs



**Needs based coding – using the 'surprise question' to predict main areas of need and support required**



For details contact the National GSF Centre, based at Walsall tPCT  
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**'GSF is the bedrock of generalist palliative care'**  
DN Norfolk

## What does it mean to you?



**STOP! THINK! - IS THIS PATIENT IN THE LAST YEAR OF LIFE? What difference can I make?**  
**IDENTIFY, ASSESS and PLAN care according to the needs of the patient and carer.**



As specialist nurses and community matrons you may work both with patients and also at a strategic level. Linking across organisations you are in a key position to use knowledge of GSF to share good practice. GSF can promote your work within practice teams. You have a key role in facilitating team work and including other professionals, to optimise care for patients, families and carers. The Next Stage GSF 'Going for Gold' aims to bring all practices up to the level of the best by 2012 and includes a quality improvement training programme which you may offer to facilitate.

**Work strategically** with the PCT to ensure procedures and policies are in place eg for prescribing guidance and anticipatory prescribing, out of hours protocol, nurse verification of death, Advance Care Planning and DNAR policies, urgent access to equipment and syringe drivers, integrated care pathway for the dying, home support for patients and carers, social services and benefits advice, systems for sharing information across organisations etc. You may be able to enable these working with the QOF team, audit department, training department, district nursing leads, LMC and practice based commissioning groups.

**Specialist nurses can often enable the district nurses and GPs to provide best quality care**  
**Together we can ensure a gold standard of care for every patient nearing the end of life.**

## Key issues for you and top tips

- Ensure GSF is extended for all patients in the last year of life, with at least 20% non-cancer patients on the register
- Assess the proportion of patients on the register compared with all deaths – we suggest at least 20% of all deaths
- Advance Care Planning offered to all appropriate patients.
- Practice meetings - cover all aspects using checklist/ SCR1 encourage note-taking and action plan to focus effort.
- Encourage reflective practice and use to inform future education, especially following admissions or death.
- Liaison with A&E, Medical Assessment Units and wards can prevent some admissions, help discharge planning and reduce length of stay.
- Ensure practices have a system in place to offer bereavement support and advice following all deaths.
- Ensure EOLC features in all new staff job descriptions and inductions.
- Include GSF, palliative register coding, ACP, in training provided by you as a specialist or as part of your service

## The 7 Cs for Specialists and Nurses

**C1 Communication** Tool: Prognostic Indicators. The register identifies patients to prioritise care. **Needs based coding** as overleaf is now recommended. It is helpful to routinely consider which need category you feel a patient is in at each encounter. If you identify patients not yet added to the register or if coding stage changes, inform the practice.  
Attend **multidisciplinary team meetings** to discuss your patients. Encourage all clinicians to attend with representatives from reception or admin. Invite wider team members.  
Take opportunities for brief education.  
**Advance Care Planning:** Ensure you can offer an ACP discussion. Inform the practice team and out of hours services of any outcomes e.g. preferred place of care and resuscitation. Document patient wishes clearly.

### C2 Co-ordination

Encourage each practice to agree a coordinator and lead clinician. District nurses are often in an ideal position to do this.

### C3 Control of Symptoms

Nurses are key patient advocates to ensure early and effective symptom control. Use assessment tools eg PEPSI COLA, PACA, SPARK etc and the GSF Needs Support Matrix Tool links care to areas of need.

### C4 Continuity and Cross boundary Working

Ensure practices have a system to **update out of hours** services (OOH) when needs change or drugs given. **Share information** with your hospice or hospital, if the patient wants to die there. Work closely with staff in **care homes**. Ensure easy **access to your team's advice** and link care homes with other local services. Note particularly those doing the GSF Care Homes Programme.

### C5 Continued learning

Tool: Traffic Lights SEA. Encourage non-judgemental **team reflection** after deaths or admissions. Consider use of the GSF training programmes for primary care and care homes in your area. Encourage measurement of care to show improvement. Signpost training.

### C6 Carer Support

Avoid crises and un-necessary admissions by ensuring carers have access to help and support early, e.g. equipment, practical help, OOH contacts, benefits, formal carer's assessment, information about the end of life and coping with this.

### C7 Care in the dying phase

Offer realistic choices of place of care, document and act on patient preferences where possible. Advise the GP when anticipatory prescribing may be appropriate.

## How can GSF help you?

- Helps you work with GP, DNs and Practice teams
- Helps identify stage and needs of patients
- Helps anticipate possible issues early
- Helps communication across boundaries of care
- Improves collaboration and reduces conflict
- Improves your job satisfaction, morale

## Examples of good practice on Website



**"We work really well with all our GSF practices now and we all enjoy providing a better standard of care"**