

What is the Gold Standards Framework in Primary Care?

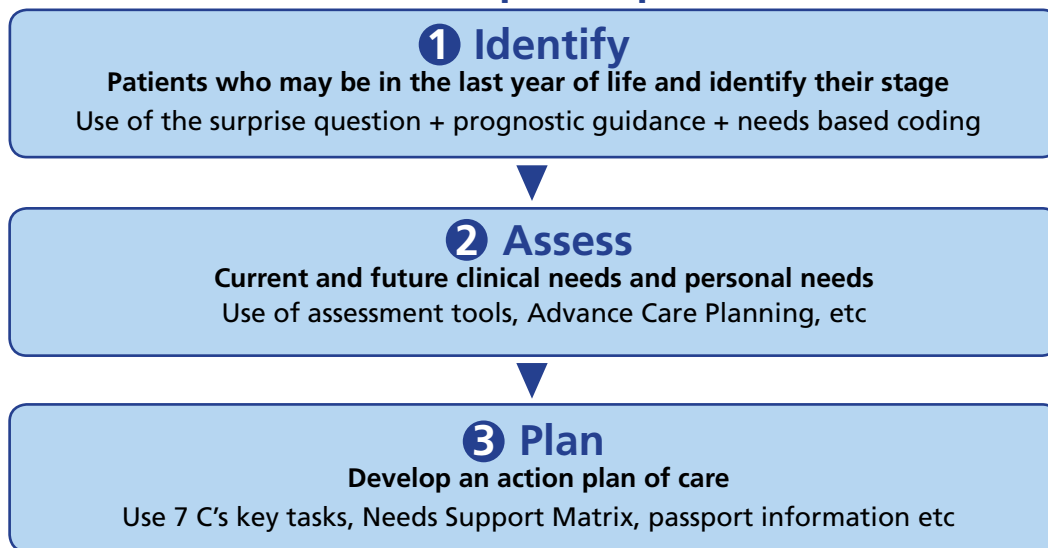
1 Aim – GSF is a framework to deliver a 'gold standard of care' for all people nearing the end of life

'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

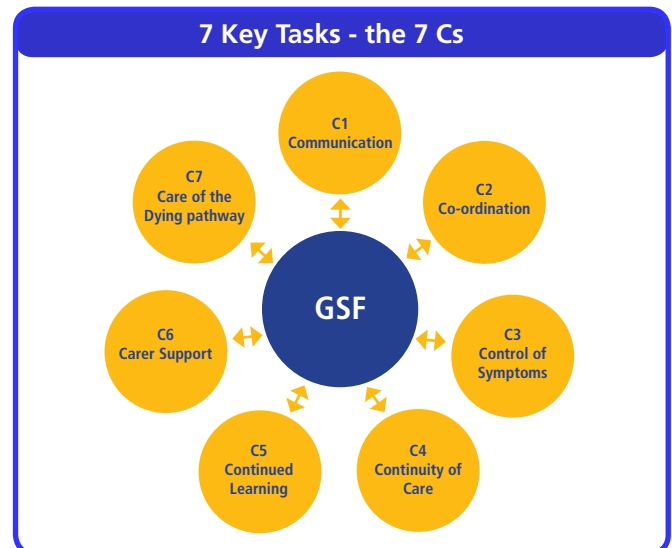
- End of Life Care is important. It affects us all
- 1% population die/year- mainly elderly non-cancer patients.
- Too few people die at home or their place of choice.
- Hospital admissions and deaths are expensive and may be preventable - care must be brought closer to home.
- Everyone is involved in 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

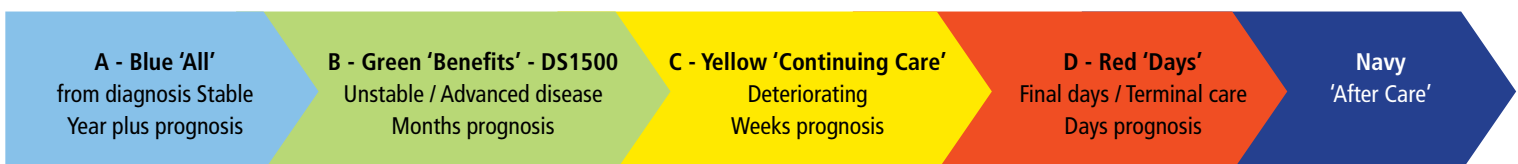
To provide for patients with any final illness:

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 a hospice, you will provide specialist palliative care services and support to patients and their families in the local community. You may not be aware how important you are in supporting GSF, and how much you can do to help practices and care homes to provide high quality home care. Working more closely with primary care teams can help you also, avoid duplication for patients, and ensure better communication within the community. Your affirmation of the role of generalists in end of life care is important, and your support with advice and education is crucial. We are all doing our best to work towards a Gold Standard of care.

Key Issues and suggestions for you

- Ensure Primary care teams know if you think patients should be on the **GSF / palliative care register** and their stage
- Consider using the **needs based coding** (ABCD as overleaf) and update this as needed
- Have a system in place to **update out of hours services** about changes on discharge
- Ensure carers know how to **access help** and support locally, to **avoid crises** and unnecessary hospital admissions
- Advise the GP when you feel **anticipatory prescribing** may be appropriate and if particular medication is recommend
- Information about **all aspects of care** is useful to primary care, including carer needs, end of life discussions, benefits etc

The 7 Cs for Hospices

C1 Communication

Practices have a **register** of patients near the end of life which allows teams to prioritise care. The Prognostic Indicator Guidance, including the 'surprise question' is one of the tools to identify patients for the register.
 (Would you be surprised if this patient were to die in the next 12 months?)

Multi-disciplinary meetings are held at least 3 monthly by 85% of practices to discuss patients on the register.

C2 Co-ordination

Record **key contacts** e.g. usual DN(s) and GPs (not just senior partner) and their contact information. Liaise closely about changes and discharges. GP reception staff are highly trained, often aware of the GSF patients and GP movements, so can be a useful link.

C3 Control of Symptoms

Ensure there is **easy access** locally to specialist palliative care advice for GPs, nurses, community matrons, care homes, out of hours clinicians, ambulance staff and pharmacists.

C4 Continuity and Cross boundary Working

Passport information describes accessible brief patient details which enable the patient and family to access good care wherever they are, e.g. in A&E with no other notes. Have clear systems in place for **liaison** with other professionals e.g. out of hours services, pharmacists, hospital and specialist nurses, ambulance staff.

C5 Continued learning

GSF encourages reflection on individual cases to improve systems of care. Identify **local needs across primary care** and offer appropriate solutions.

C6 Carer Support

Ensure **carers** are supported on discharge for a smooth transition and seamless care. Ensure carers have the opportunity to discuss or read about what may happen at the **end of life** and how to deal with this.

C7 Care in the dying phase

Ensure the **systematic approach** taken such as the Liverpool Care Pathway or GSF minimum protocol is transferable to all settings. Offer the patient realistic choices of place of care, document and act on their preferences.

Practical Tips for Consideration

- Offer to go to **practice multidisciplinary team meetings** to discuss a patient or lead a brief educational session on a subject identified by the practice team. Attending meetings allows a greater understanding of primary care issues too.
- **Advance Care Plan:** Check if patients already have one in place. If not, offer the chance to have an ACP discussion and inform the practice team of the outcomes including preferred place of care and resuscitation decisions.
- Work closely with **care homes**, treating staff as partners in care, liaising on discharges. Ensure clear lines of access for residents to your services.
- **Case based learning** is highly effective so take every opportunity to offer advice and increase individuals' basic knowledge of symptom assessment and control.
- **Reflect** on individual cases, complex and straight forward, to learn how hospice systems could improve care for the benefit of patients and all involved in care.

Suggestions for Good Practice

- Hospice letters can help GPs know that they should include patients on the GSF register and possible prognosis or stage of their condition
- Hospice letters can give brief details of discussions and all aspects of care, also making clear if particular anticipatory drugs are appropriate for the individual and prompt GPs to consider providing them early.

