3. Evidence that GSF helps reduce hospitalisation in all settings (admissions, hospital deaths, hospital bed days, rapid discharges home, re-admissions etc).


GSF helps reduce hospitalisation, enabling more to live and die in their preferred place of care. By taking a more proactive approach, with earlier identification and assessment of needs, teams undertaking GSF find that hospitals, admissions, deaths and lengths of stay are significantly reduced. This has been a consistent finding in all GSF Evaluations in all settings, particularly in care homes and primary care, where some homes and practice show a halving of hospital deaths and crisis admissions.

Reducing hospitalisation however is a very complex area and requires consistent change across a wide range of areas: including for example in a care home it requires effective training and communication to all staff including bank and night staff, effective documentation of ACP discussions an preferred place of care for all residents, development of care homes policies, implementation of preventative measures, communication with GPs and out of hours providers and regular reflection and audit to review progress. In hospitals reduced hospitalisation is incorporated into means of reducing length of stay, rapid discharge and transition home and reducing readmissions, many of which require complex interventions, improved communication and good community support.

1. Evidence from Intrinsic GSF Evaluation Audit

Acute hospital data

There is strong evidence of reduced length of stay across all early phases of the GSF Acute Hospital Programme. Data is taken from the GHK independent Evaluation using Before and After GSF After Death Analysis for 15 deaths and 15 discharges (ref see GHK phase 3 and phase 4 report on GSF evidence section website).


There is also anecdotal evidence from some hospitals of reduced readmissions- pending further data. On completion of the Phase 3 AH training programme – Average Length of Stay (LOS) for all the hospitals was reduced by 3 days (from 18 to 15 days).

Plan Living Well and Dying Well

- Living well
- Enabling more to live well at home + reducing hospitalisation
- Dying Well
- More dying at home or where they choose
Phase 3 Data - LOS on 2b ward was reduced by 8 days

Phase 3 LOS on 6a, 6b was reduced by 4.5 and 13 days

Phase 3 LOS on ward 4 was reduced by 15 days

Phase 4 LOS on ward 1a was reduced by 7 days

Phase 4 LOS for ward 2 was reduced by 4 days

Phase 4 LOS on ward 1a was reduced by 7 days
Primary care Data – Summary from the first 10 GSF Accredited practices 2015

Care Homes

Following GSF care Homes training and accreditation, cumulative before and after ADA analysis for care homes shows reduction on hospital deaths and admissions - see Summary of Evidence and project based audits for further details. Cumulated Care Homes results Phases 7-12.
GSF Update on Evaluations and Evidence no 3 Sept

Increasing home deaths, reducing hospital deaths and improving advance care planning in GSF care homes.

a) Reductions in hospital deaths and emergency admissions enabling people to live and die in their care home are sustained long term following use of the GSF Care Homes Training program. 75% of first time GSF accredited homes achieved over 80% home death rate. This level is sustained over time with care homes who have undergone a third round of GSF Accreditation demonstrating continued improvements in home death rate, with 89.63% of residents remaining in their care home until the end of their life, and 100% of residents in these care homes being offered ACP discussion. On the third round GSF accreditation 64.28% (n=14) of these care homes achieved between 90 and 100% home death rate and 21% of those had a 100% home death rate. (Data from Round 15 GSF accreditation & reaccreditation report August 2015).

![Graph of Place of Death](image)

Cumulative GSF Care Homes ADA results for first time, second time and third time accredited care homes 2015
b) Crisis admissions and length of stay in hospital Crisis admissions in the last six months of life in 45 care homes were evaluated prior to and following participation in the Gold Standards Framework Care Home Programme. Outcome measurement showed a significant reduction from 44.4% of care home resident admissions to hospital in the last six months of life to 12% admissions. Hospital bed days fell from 87 to 36 (58%).

c) Advance Care Planning Following GSF Accreditation, homes reported offering 100% of residents an advance care plan discussion GSF data shows that 96% (n=441) of those residents who died, had an Advance Care Plan in place (Barking the Havering & Redbridge project, Phase 10 data from 45 care homes. 2014/15).


Positive Response from Care Home Staff undertaking GSF Care Home programme Qualitative interviews with Nurses, health care assistants and managers regarded the training and support afforded by the GSFCCH programme to inform EoLC for older residents positively. The framework has the potential to promote a coordinated approach to EoLC for older people. In the post accreditation period, there is a need for ongoing support and development to help embed the key tenets of the GSFCCH in the culture of caring.

Three core themes were identified: (i) a positive regard for the GSF for care homes (GSFCH); (ii) challenges around end of life care for older people; and (iii) difficulties in using the GSFCCH.


3. Other Published literature/ qualitative feedback

See extensive published literature on use of GSF in care Homes and Summary of Evaluations