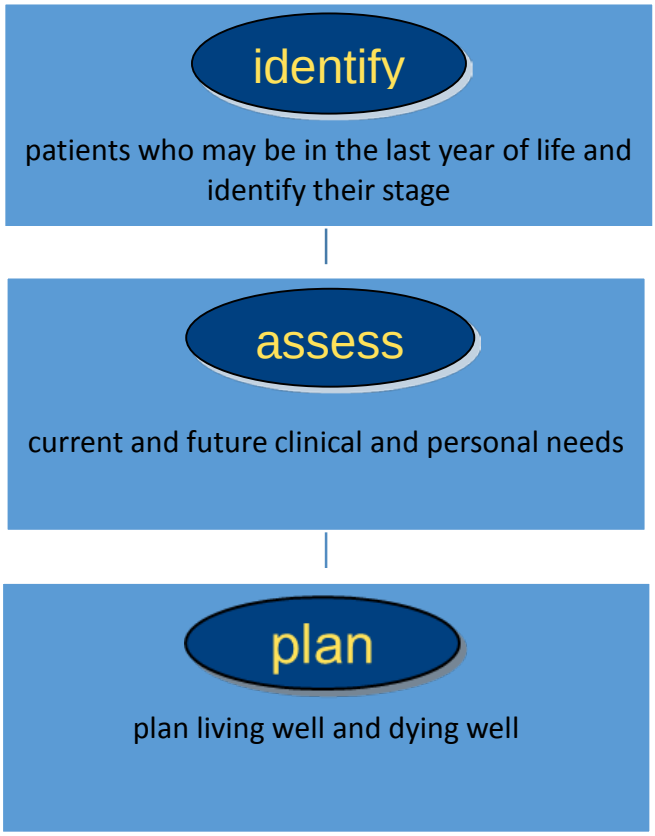
How GSF can help GP practices with their CQC Inspections in End of Life care

The GSF Centre has been working with national policy leads & CQC to help improve end of life care delivered by GP practices. Now GSF can help you develop and provide evidence of good practice in End of Life care to support you in your CQC practice Inspections



The key steps of GSF encourage practices to

1. **Identify the right patients**
2. **Assess their clinical and personal Needs**
3. **Plan Living well reducing hospitalisation and Plan Dying well (last days of life)**

NOTE
The GSF Key Ratio that is measured and increases during the Going for Gold programme & accreditation is a key part of CQC EOLC 5 questions – see over

Doing the 3 steps of GSF will help you meet the requirements of CQC when assessing end of life care in your practices.

GSF Accredited practices are likely to be well regarded by CQC inspectors. CQC also has recently approved GSF Hospital Programmes as the approved accreditation scheme for hospitals.

See the information below from CQC to help you meet the EOLC requirements in your practice.

End of Life Care in CQC GP practice inspections

The information below is from the CQC Guidance, written by Dr Stephen Richards (with titles in blue added to demonstrate link with GSF)**.** See Link for CQC mythbuster 38 EOLC in general practice:

http://www.cqc.org.uk/content/gp-mythbuster-38-end-life-care

"GP practices have an essential and unique role in care giving and in coordinating good quality end of life care."

This mythbuster has been written by Dr Stephen Richards, GP Regional Advisor for London with the help and support of colleagues both within and outside CQC. It provides information about end of life care, the GP practice's role and how we will look at this important issue on our inspections.

Approximately 500,000 people (1%) will die in England each year and this is set to increase with an ageing population. In addition to physical symptoms such as pain, breathlessness, nausea and increasing fatigue, people who are approaching the end of life may also experience anxiety, depression, social and spiritual difficulties. Managing these issues properly requires effective multidisciplinary working and information sharing between GPs, other generalists and specialist teams, whether the person is at home, in hospital or elsewhere. See End of life care for adults (NICE Quality Standard)

Patients are 'approaching the end of life' when they are likely to die within the next 12 months. This includes patients whose death is imminent (expected within a few hours or days). The five priorities and accompanying guidance inform CQC's inspections.

Guidance for CQC inspections

They are summarised below, with information about what they expect to see when they inspect GP practices.

1. **IDENTIFY THE RIGHT PATIENTS - (GSF Step 1)**

The possibility that a person may die within the coming days or hours is **recognised and communicated** clearly, decisions about care are made in accordance with the person's needs and wishes, and these are reviewed and revised regularly.
The 'Find your 1%' campaign supports GPs to identify patients who are likely to die within 12 months. Most GPs provide the new enhanced service to identify and register the 2% of patients at risk of admission to hospital. Identifying people at the end of life enables care

planning and communication and service coordination. GPs should have a palliative care register to support this. Cancer patients generally have better access to palliative care and GPs should ensure access to care for all who need it, not just those with cancer.

> **When we inspect** we are likely to ask how many patients in your practice who died in the last year were included on your palliative care/GSF/QOF register (key ratio) and how many of these had non-cancer conditions

2. COMMUNICATING AND PLANNING - (GSF Step 2 Assess Clinical needs and Step 3 Plan Living well)

Sensitive **communication** takes place between staff and the person who is dying and those important to them.

Training in communication, person centred approach and symptom control and services available is needed to improve care for all. A 2012 Ibid survey of GPs found that 35% had never initiated a conversation about end of life care with a patient.

> **When we inspect** we will consider how the practice uses the palliative care register and team meetings to improve coordination and communication with others involved in a person's care.

3. ASSESSING PERSONAL NEEDS OF PATIENTS (GSF Step 2 Assess Personal Needs and Advance Care Planning offered to every appropriate patient)

The dying person, and those identified as important to them, are **involved in decisions** about treatment and care.

GP planning and discussions should support people to make choices about their preferred place of death. The proportion of people dying in their preferred place of death has increased, but there is still a disparity between the actual and preferred place of death.

> **When we inspect** we will
> - want to understand how the practice records discussions about patients' needs, wishes and preferences (advanced care planning discussions) and how it ensures they are enacted or fulfilled
> - ask how many of your patients died where they wished to (preferred place of care) and in each setting (home, hospital, care home, hospice, other)

4. ASSESS NEEDS OF CARERS, INVOLVE AND SUPPORT THEM (GSF STEP 2+3)

The **people important to the dying person are listened to** and their needs are respected. Relatives and carers can have a significant role in caring for the dying; GPs should recognise this role and provide support to carers and the bereaved.

> **When we inspect** we will ask how practices support the family and carers of patients at the end of life and in bereavement.

5. PLAN CARE IN FINAL DAYS (GSF Step 3- Plan Dying well)

Care is tailored to the individual and delivered with compassion – with an individual care plan in place.
GPs should coordinate making and following an individualised care plan.

> **When we inspect** we will look for evidence of supporting patient's individualised care plans.