the gold standards framework®

End of Life Care: Planning Ahead

Using a population health approach to meet the needs of our population.

Prof Keri Thomas
Founder & Chair, GSF
Chair, Coalition of Frontline Care
For People Nearing The End Of Life

Everyone deserves Gold Standard End of Life Care

New Care Talk Awards

The Coalition of Frontline Care for People Nearing the End of Life

sponsoring 2 new awards -

THE INTEGRATED CARE SYTEMS AWARD

-significant improvements and inspirational care for older people nearing the end of life across the wider ICB population, whole system joined-up working, affirming generalist frontline teams etc.

Deadline April 29th

https://www.palliativecareawards.co.uk/nominate/

THE PARTNERSHIP WORKING ACROSS HEALTH AND SOCIAL CARE AWARD

-exemplary collaboration across the health and social care sectors, with tangible and sustainable benefits for people nearing the end of life.

OTHER AWARDS - *care homes, hospices, palliative care teams, fundraising, nursing etc.*

Agenda

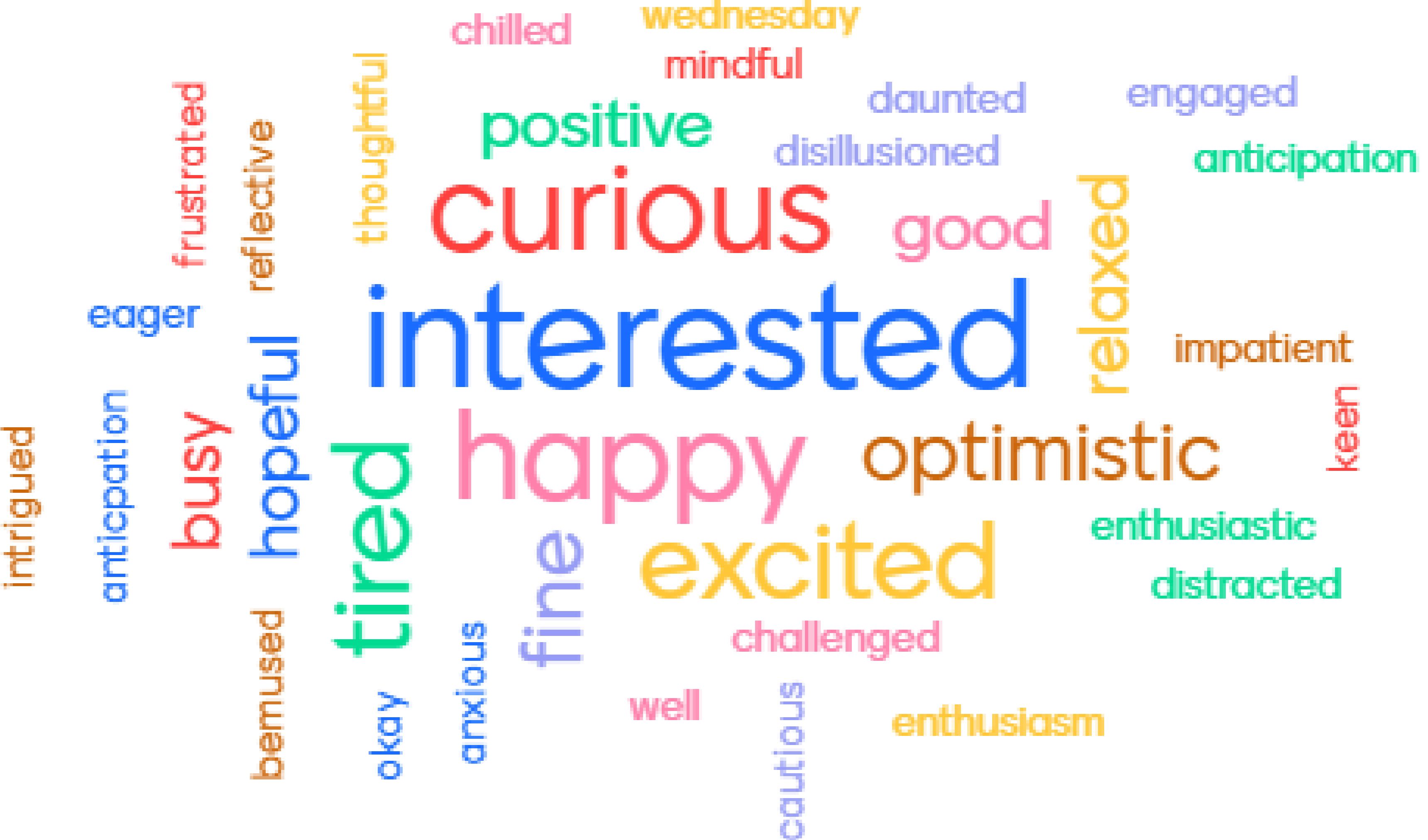
10.30am	Welcome & Introduction	Prof Keri Thomas & Dr Julie Barker
10.35am	Population based systems for the last years of life - optimising value and minimising waste	Prof Sir Muir Gray
10.55am	Why should ICBs prioritise EOL Care?	Dr Julie Barker
11.15am	Role of GSF as a springboard for change. Case study: Dudley	Dr Joanne Bowen
11.45am	Q&A Discussion Panel – Interactive	
12pm	Finish	

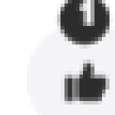
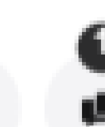
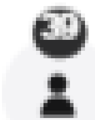
Join at https://www.menti.com/alagc7ipjnuf

Mentimeter

Ice Breaker: What one word describes how you are feeling right now?

77 responses



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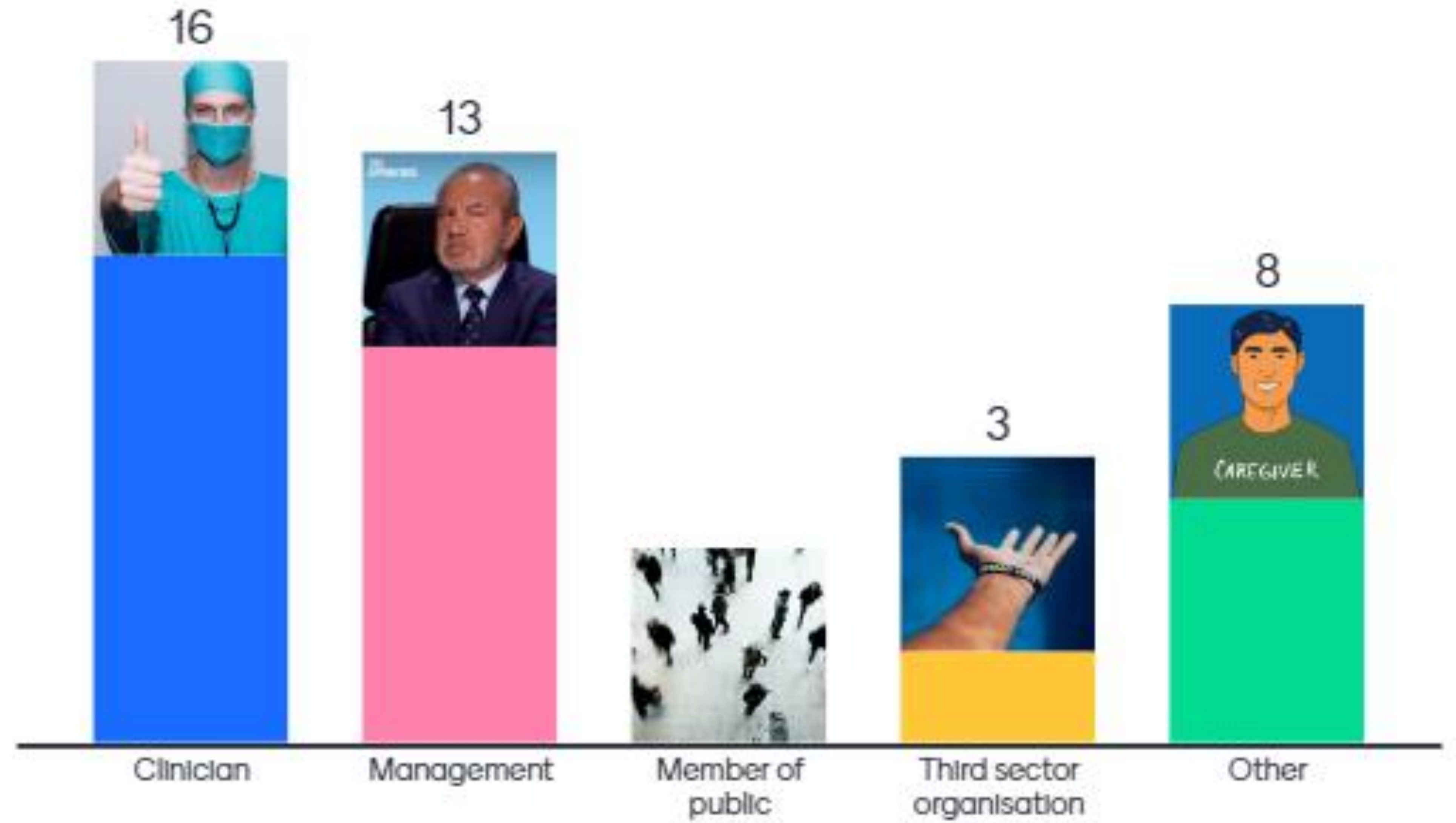
What is your role in your ICS?



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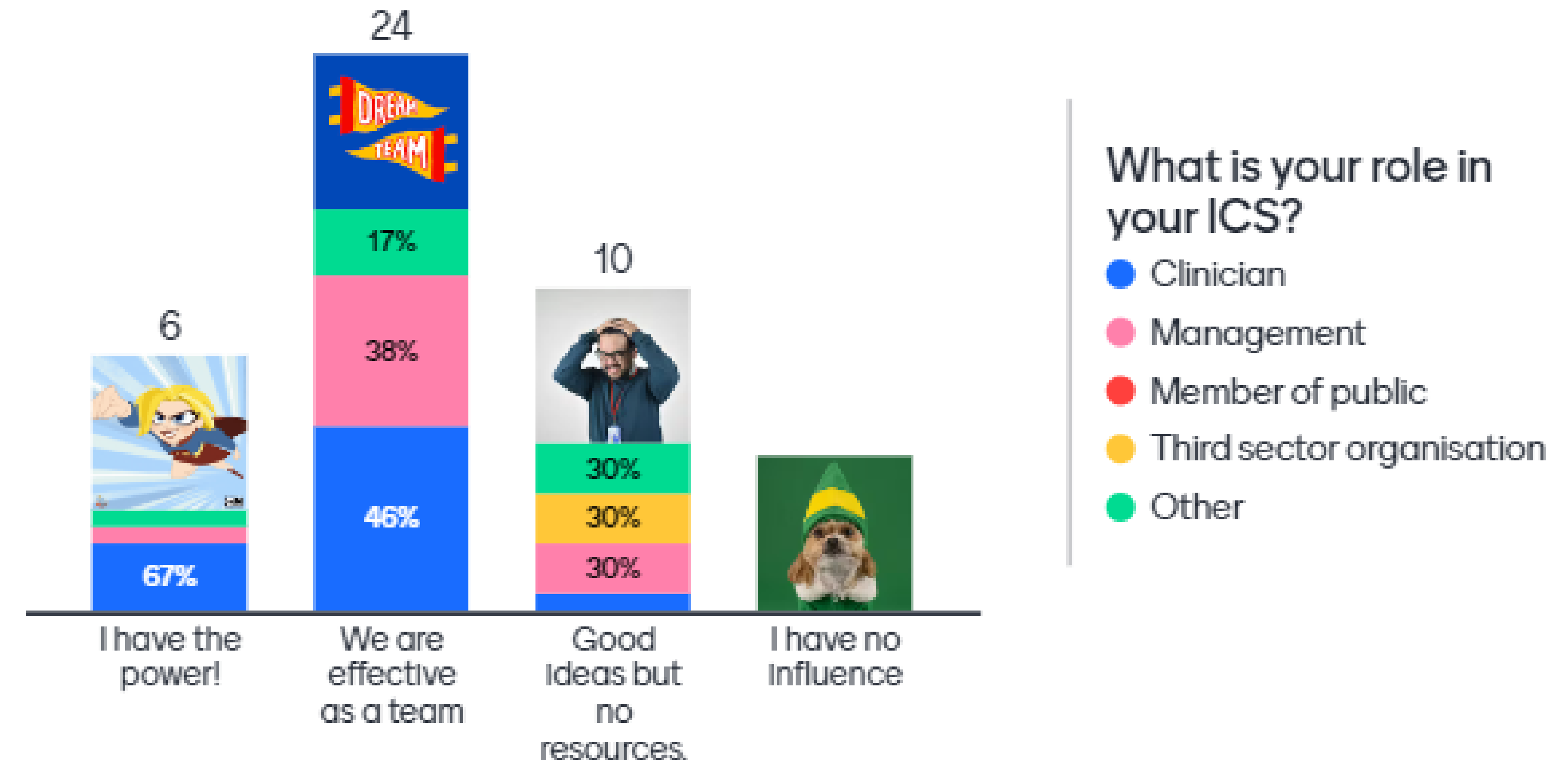
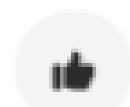
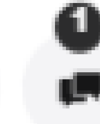
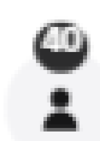
Mentimeter

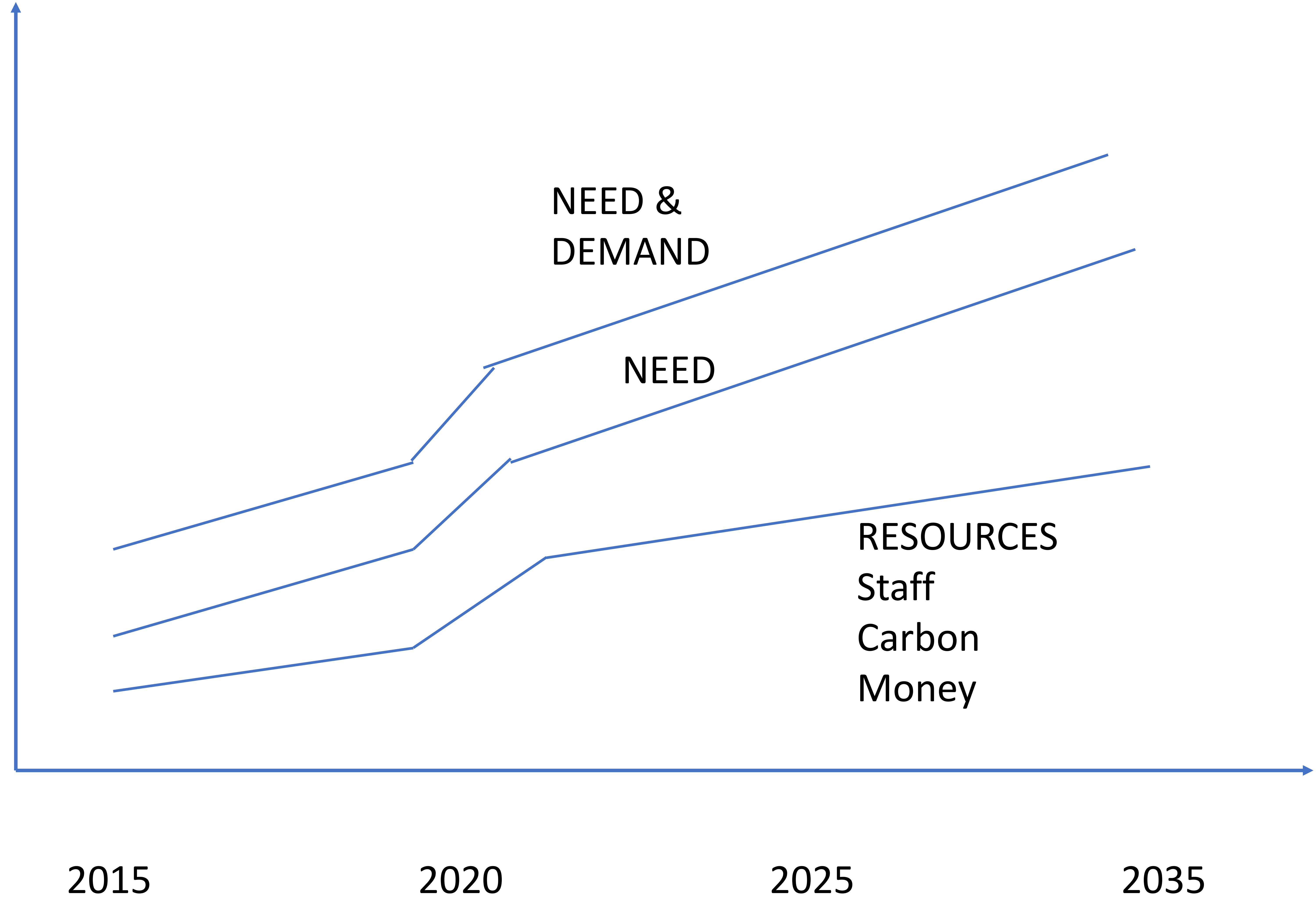
How do you feel about your ability to improve end of life care in your area?



What is your role in your ICS?
- Clinician
- Management
- Member of public
- Third sector organisation
- Other

Prof Sir Muir Gray
Director
Oxford Value & Stewardship Programme
Population based systems for the last years of life - optimising value and minimising waste
Everyone deserves Gold Standard End of Life Care


NEED &
DEMAND
NEED
RESOURCES
Staff
Carbon
Money
2015
2020
2025
2035

There are four main causes of increasing need and demand

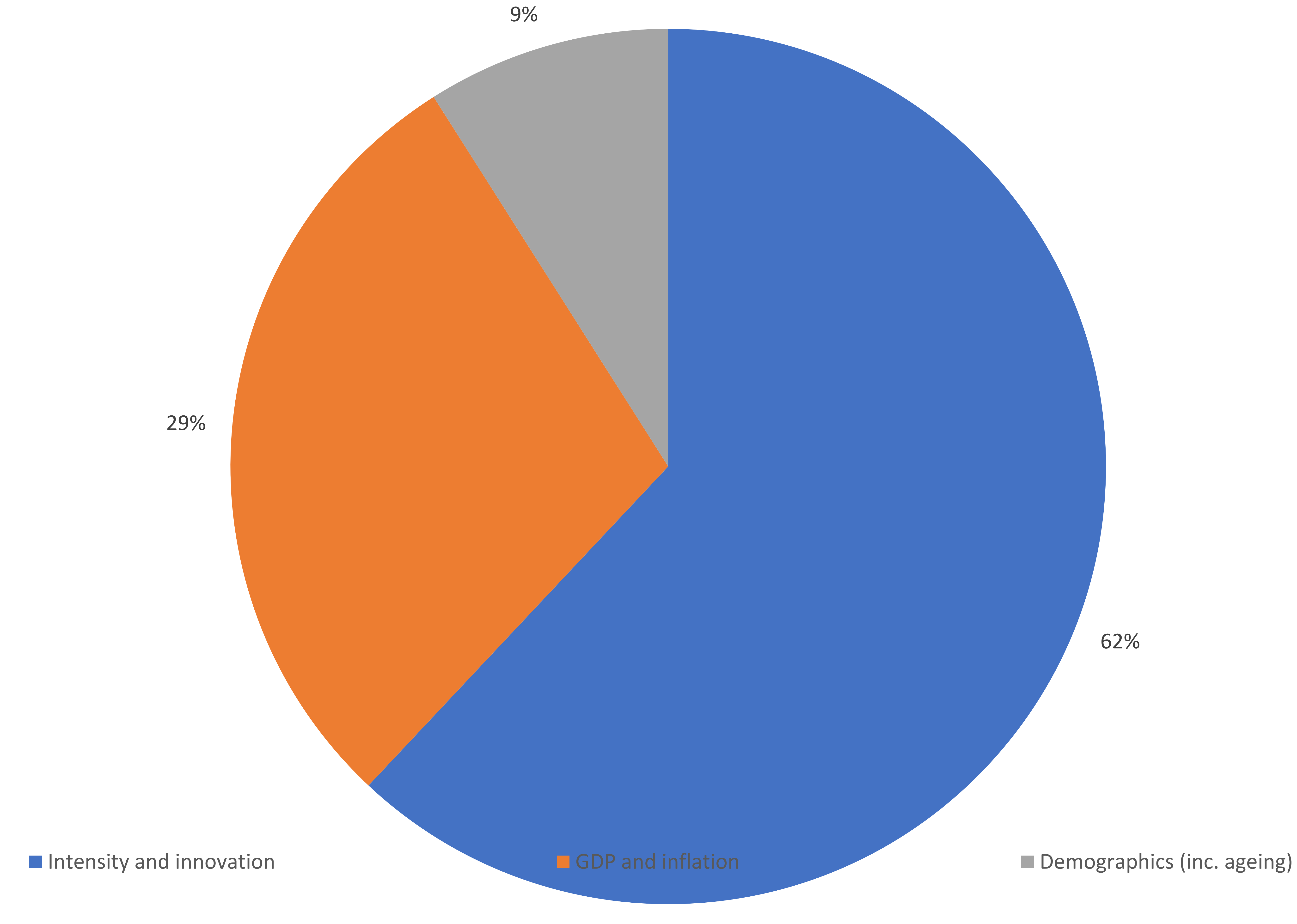
1. Population ageing

2. New diseases and conditions eg Covid and MGUS

3. New interventions which may create a new need or may change the threshold for intervention

4. The *‘relentless increase in the volume and intensity of clinical practice’*

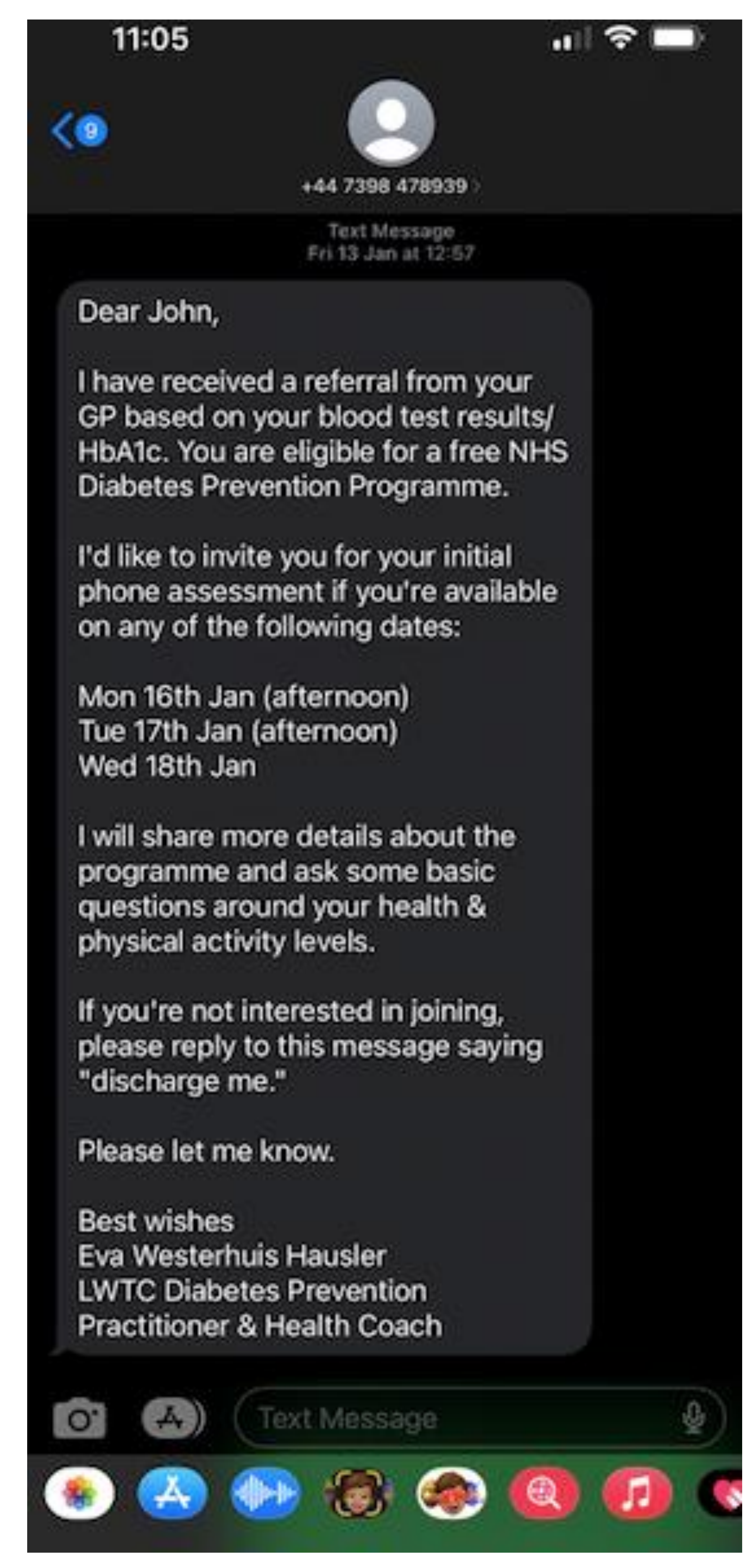
The main driver of demand is not population ageing



Source: Office for Budget Responsibility
https://obr.uk/docs/dlm_uploads/Health-FSAP.pdf

New diseases and conditions

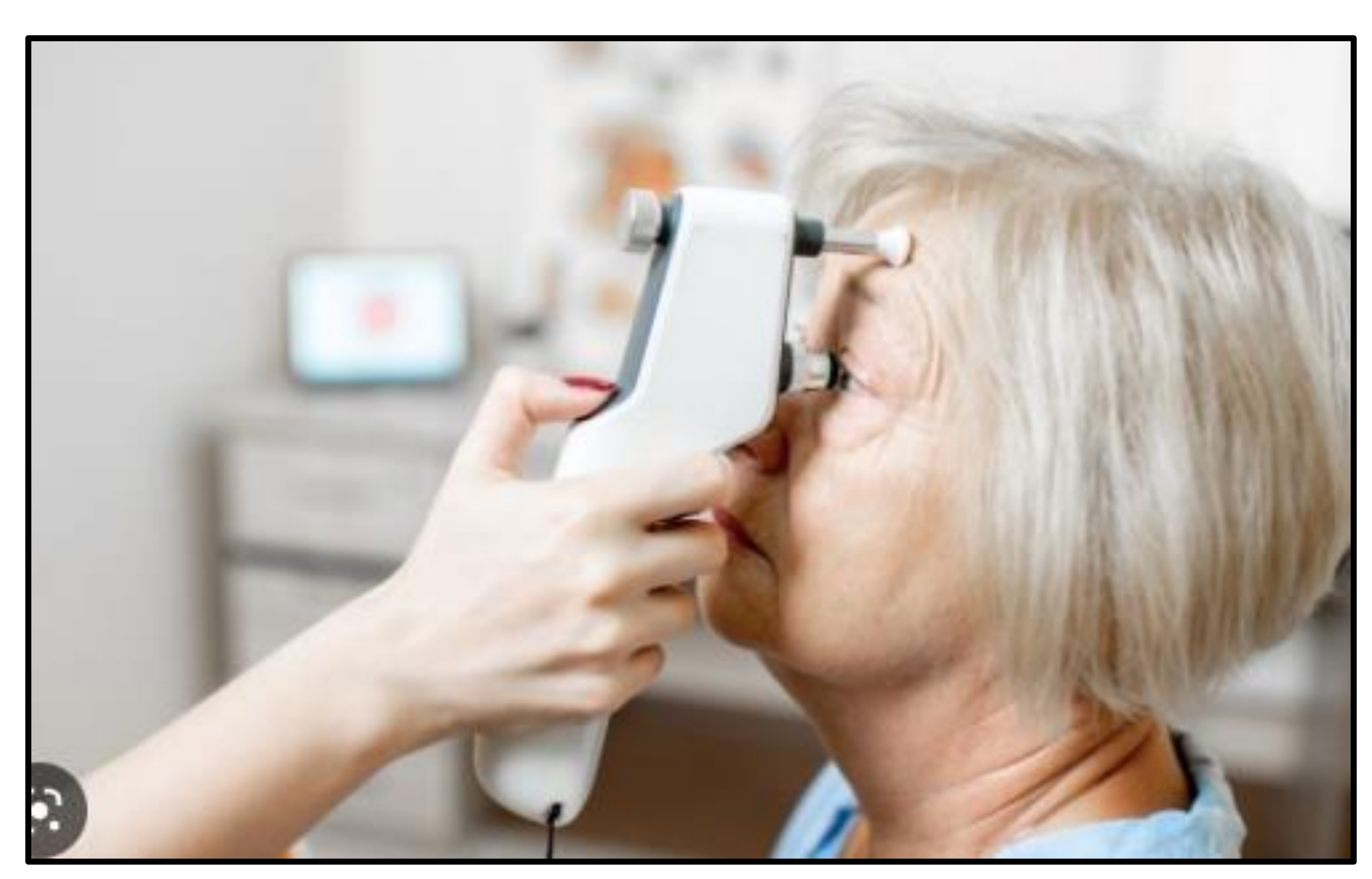
Pre diabetes – male aged 78, BMI 23 , based on a single reading of HbA1c 43 in a blood test done for a reason other than concern about pre diabetes



New diseases and conditions - MGUS Monoclonal Gammopathy of Undetermined Significance

... acid 70 mg weekly along with Vitamin D supplementation. As part of routine blood tests performed for osteoporosis they performed blood test to look for abnormalities in blood with a protein electrophoresis and serum free light chain analysis. These often indicate abnormalities in the immune system which can sometimes contribute to fragility fractures. The results of these tests show a very minor abnormality with low level presence of IgG kappa paraprotein which was too small to quantify. Your light chain ratio is also mildly out with the normal range. These abnormalities are very subtle. Often when these abnormalities are picked up in routine blood tests we recommend that these tests are checked on an annual basis and I recommend that your GP performs them

New Interventions and Technologies – in the UK a decision was made not to introduce screening for glaucoma but the development of a low cost equipment has resulted in every optician now measuring intra ocular pressure



"The relentless increase in the volume and intensity of clinical practice "

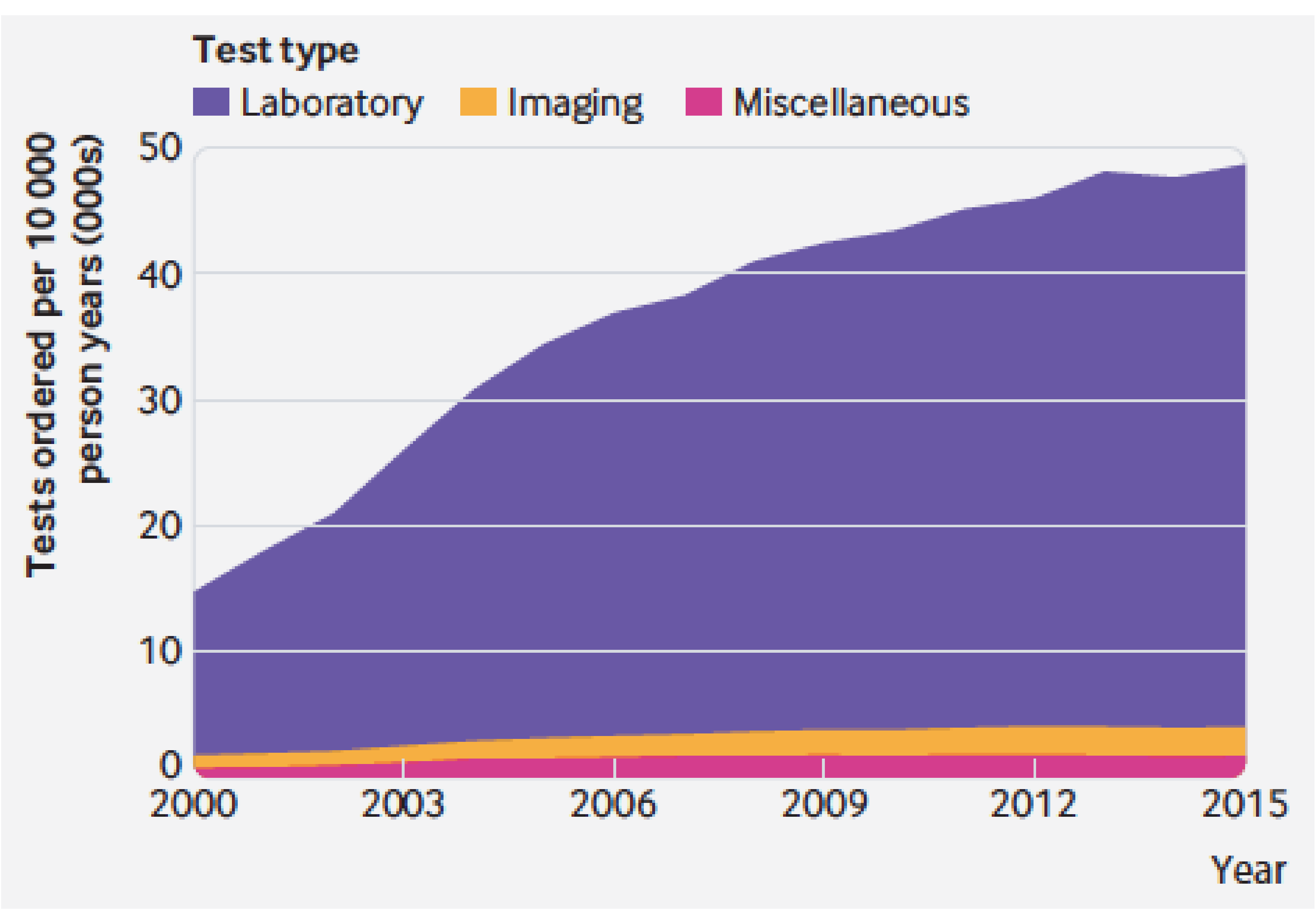


Fig 2 | Temporal trends in total test use by test type

IF A GP REQUESTS A BLOOD TEST 'HAEMOGLOBIN' , THEY GET 29 BLOOD VARIABLES REPORTED INCLUDING "LIVER TEST' 'KIDNEY TEST' 'THYROID TEST ' AND 'BONE TEST'

THERE ARE SIMILAR INCREASES IN CT AND MRI WHICH PICK UP FALSE POSITIVES

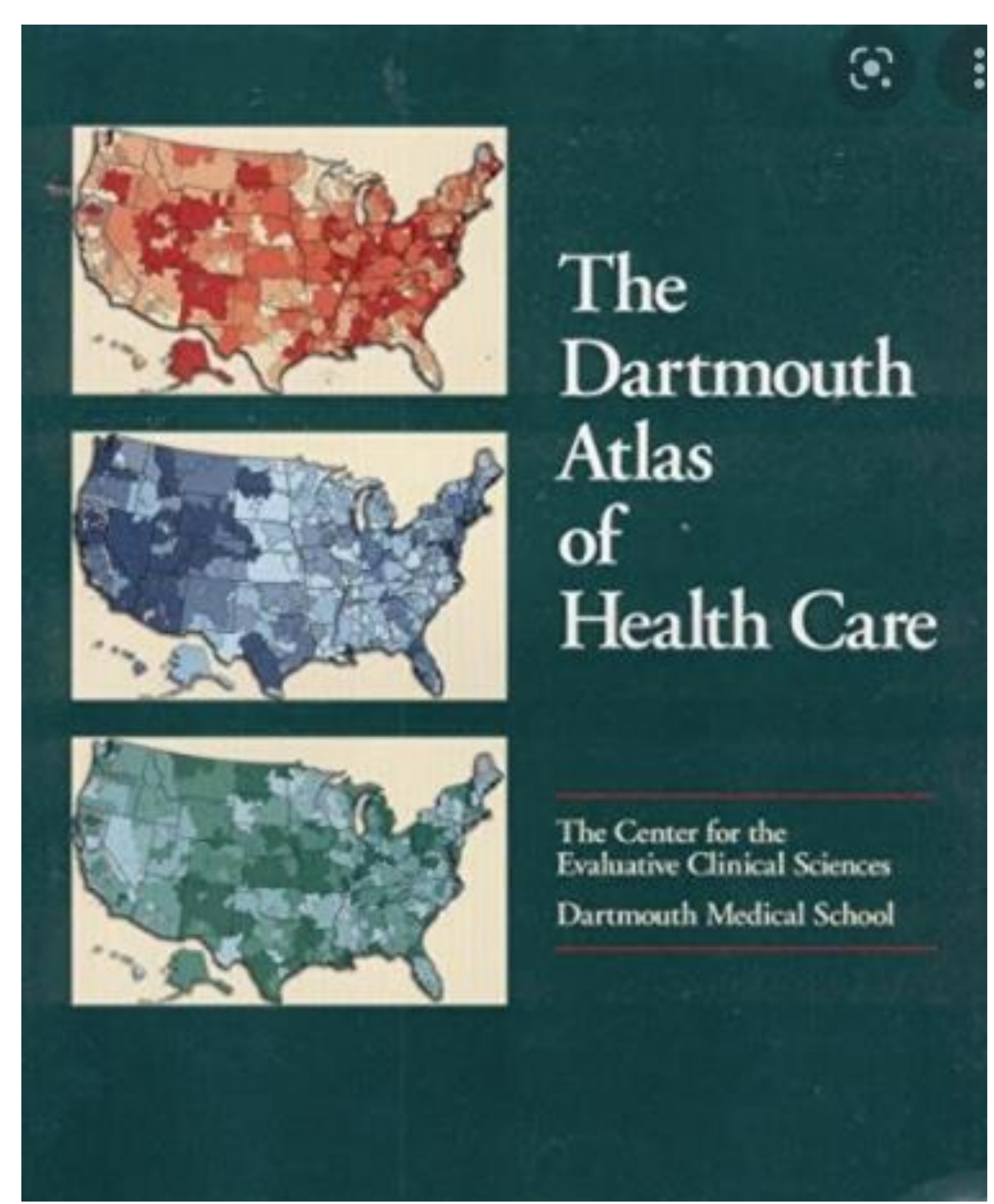
In the next decade need and demand will increase by at least 20 % so what can we do?

Well, we need to continue to
1. Prevent disease, disability, dementia and frailty
 to reduce need
2.Improve outcome by provide only effective, evidence based interventions
3. Improve outcome by increasing quality and safety of process
4. Increase productivity by reducing cost

These measures reduce need and improve efficiency but they have not addressed three huge problems

The first is unwarranted variation in healthcare ie *”Variation in utilization of health care services that cannot be explained by variation in patient need or patient preferences*.”

Jack Wennberg



PROBLEMS OF THE MUSCULO-SKELETAL SYSTEM

Map 22: Rate of anterior cruciate ligament reconstruction expenditure per 1000 population by PCT

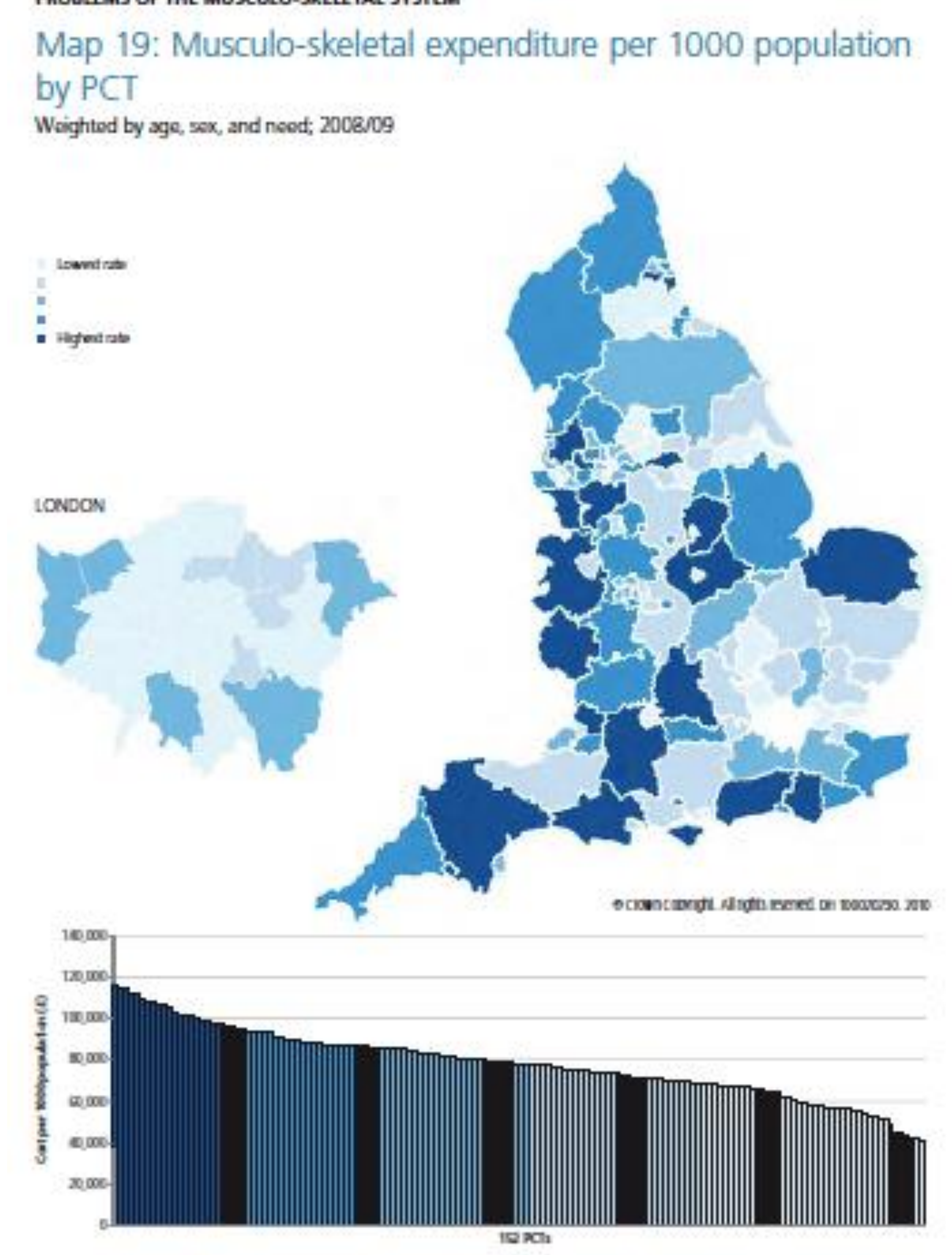
Weighted by age, sex, and need; 2008/09

Lowest rate

Highest rate

LONDON

152 PCTs



Unwarranted variation reveals two other problems

THESE ARE FROM THE NHS ATLAS OF VARIATION BUT FIND ANY LOCAL DATA

Percentage of all deaths in an area that occur in hospital, by local authority, 2006–2008

sepho
South East Public Health Observatory

Legend

Lowest value

Area	Value
Northampton	54.1
Northumberland	58.9
Norwich	49.8
Nottingham	63.0
Nuneaton and Bedworth	63.8
Oadby and Wigston	55.8
Oldham	62.4
Oxford	52.3
Pendle	58.2
Peterborough	52.9
Plymouth	45.7
Poole	54.7
Portsmouth	55.5
Preston	59.0
Purbeck	62.5
Reading	56.7
Redbridge	71.1
Redcar and Cleveland	60.9
Redditch	63.2

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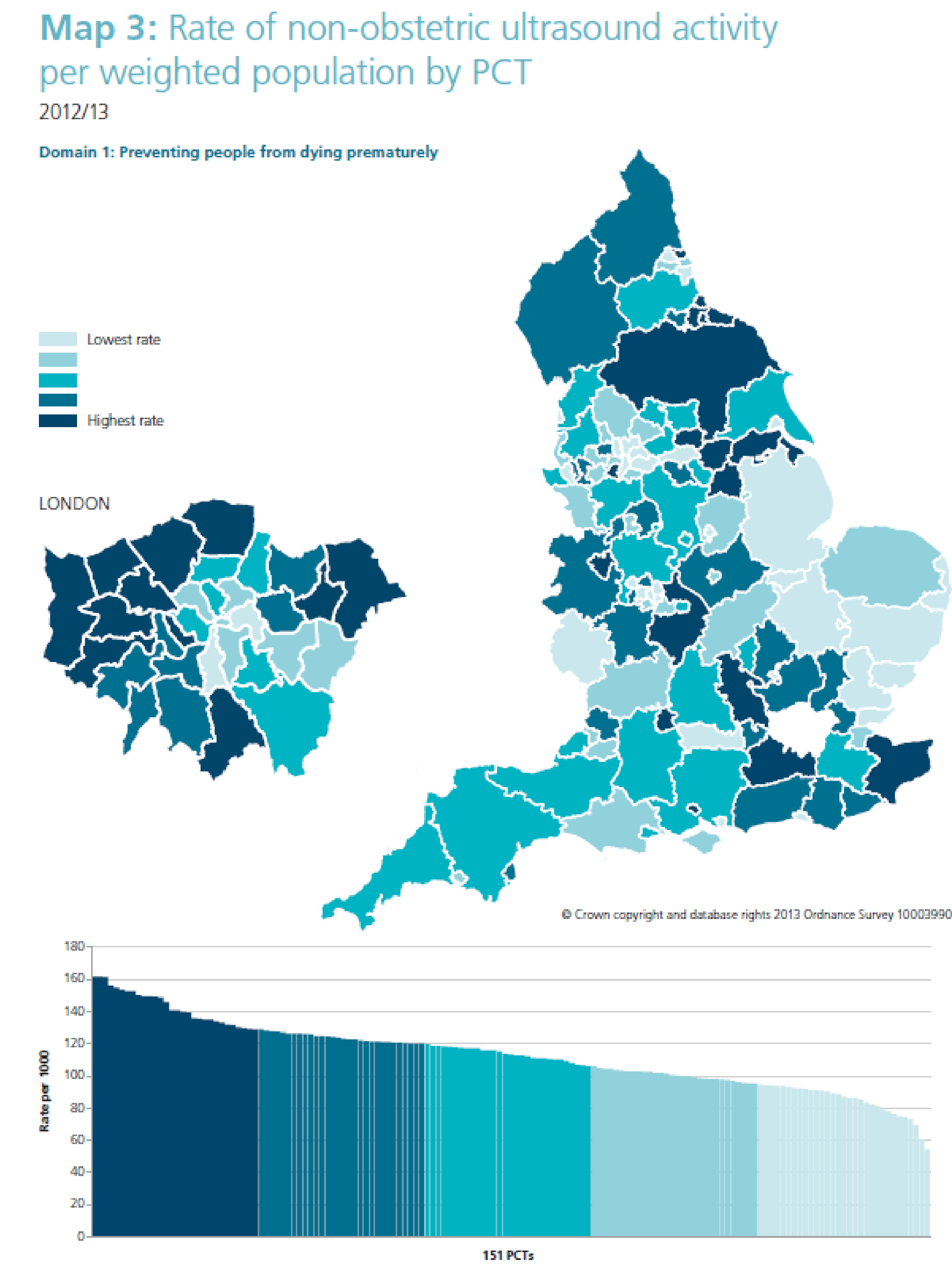
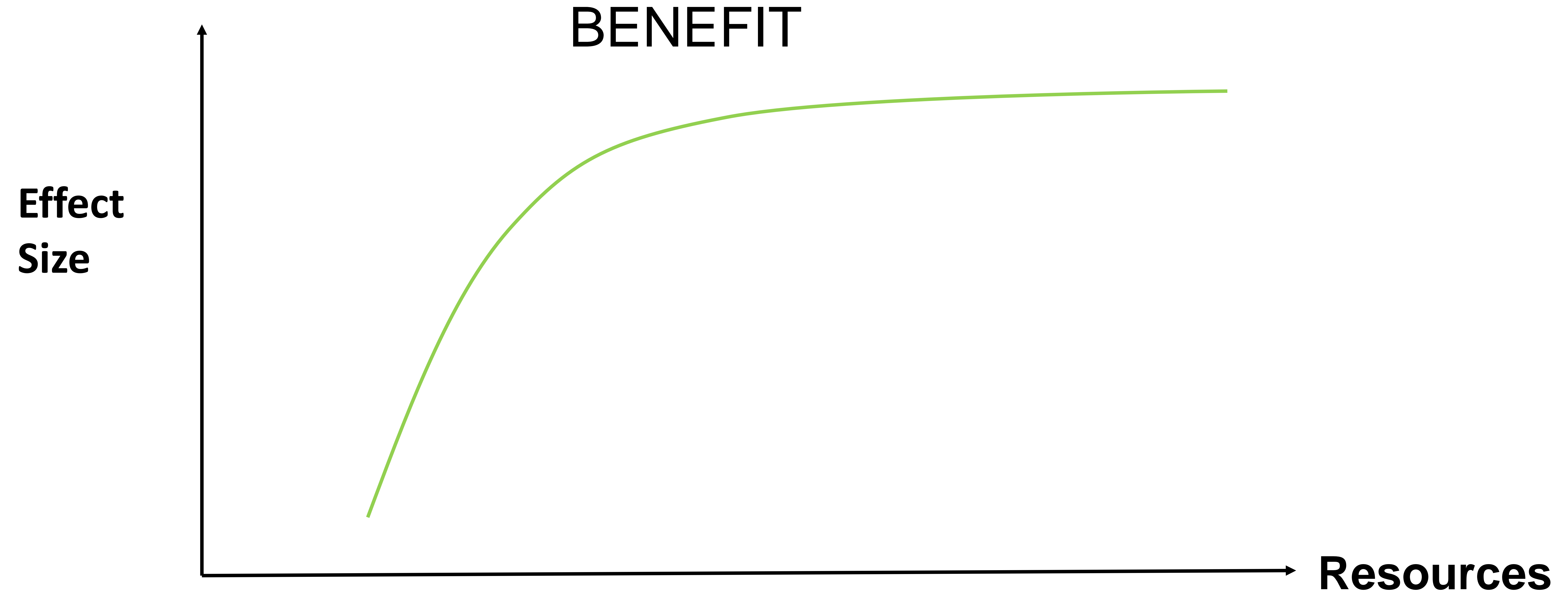
78
72
66
60
54
48
42

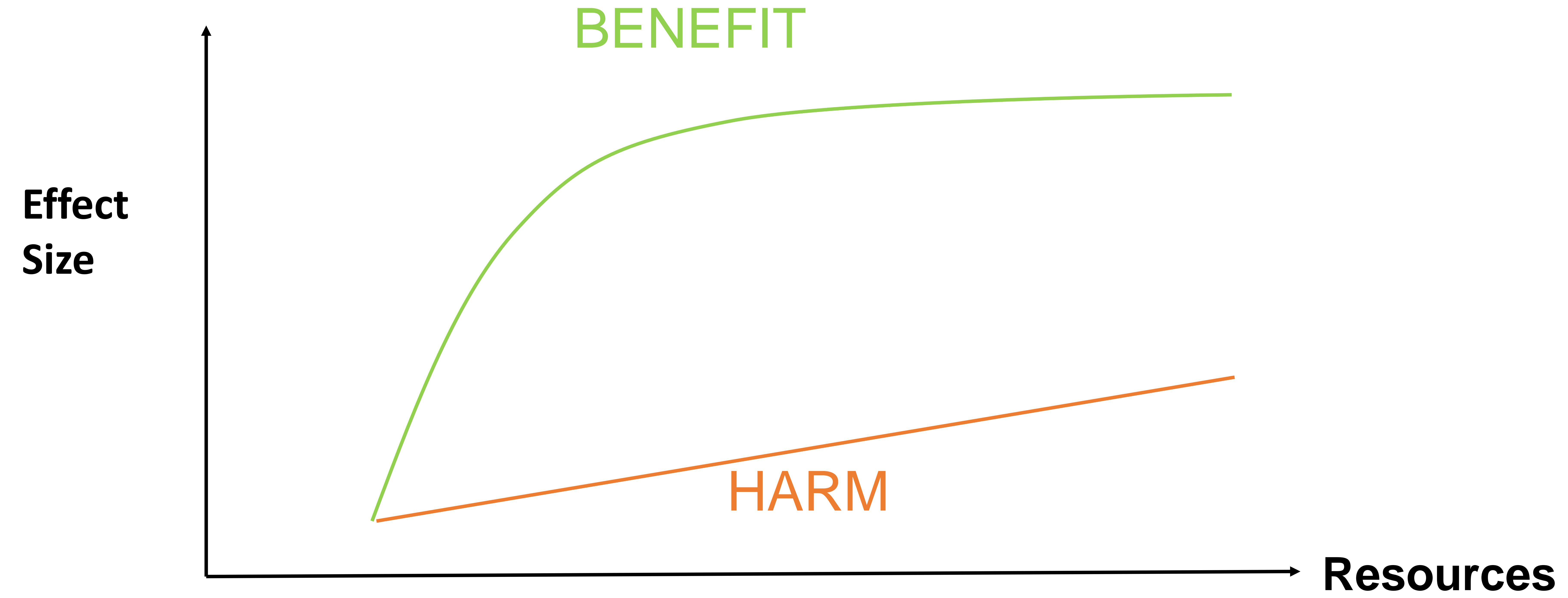


The second problem is overuse and waste and it is not controlled simply by funding only interventions that have evidence of cost effectiveness because of the need to consider the optimal use of cost effective interventions



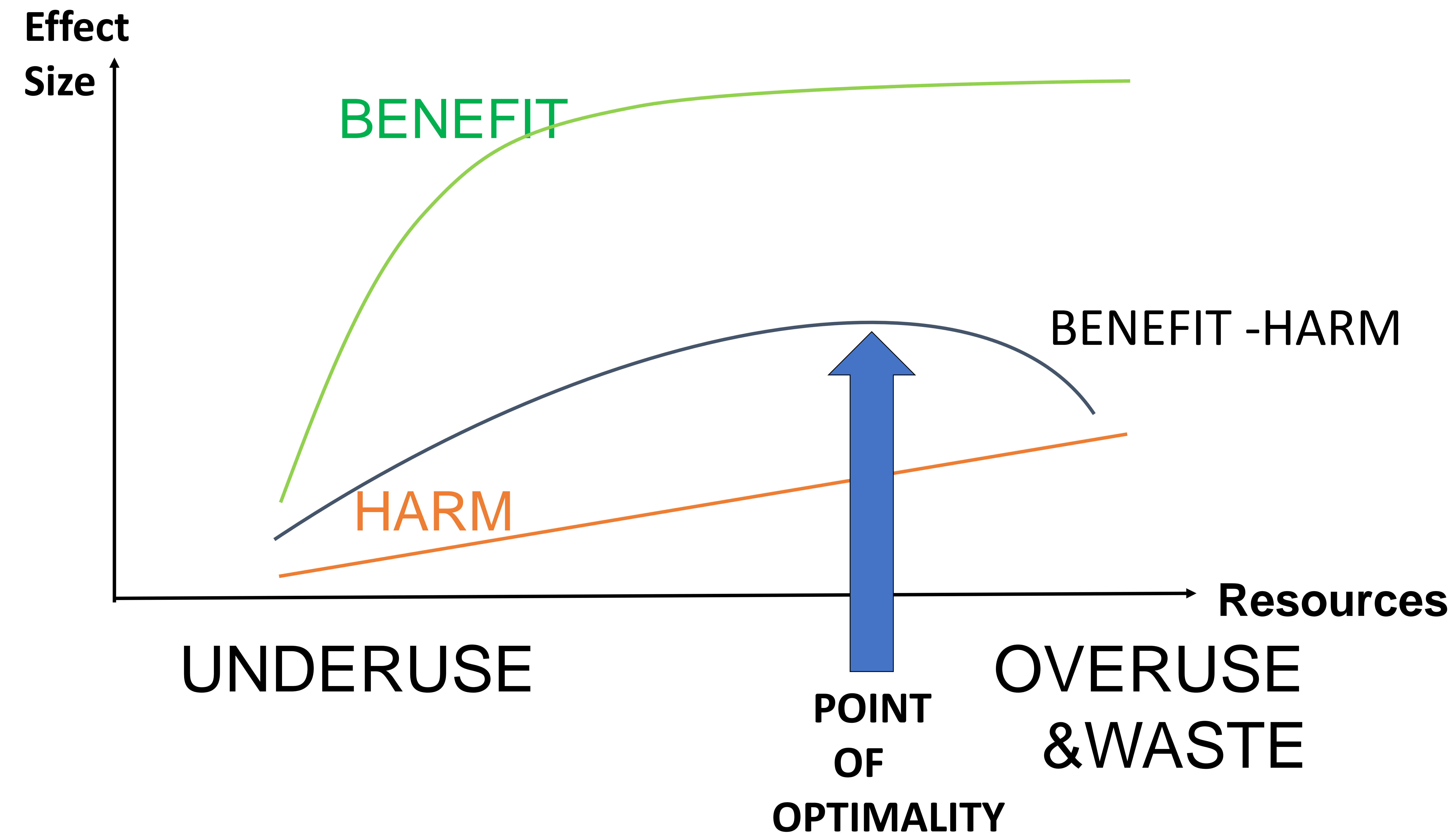
Avedis Donabedian first described how increased investment in even an intervention of proven cost effectiveness followed
The Law of Diminishing Returns

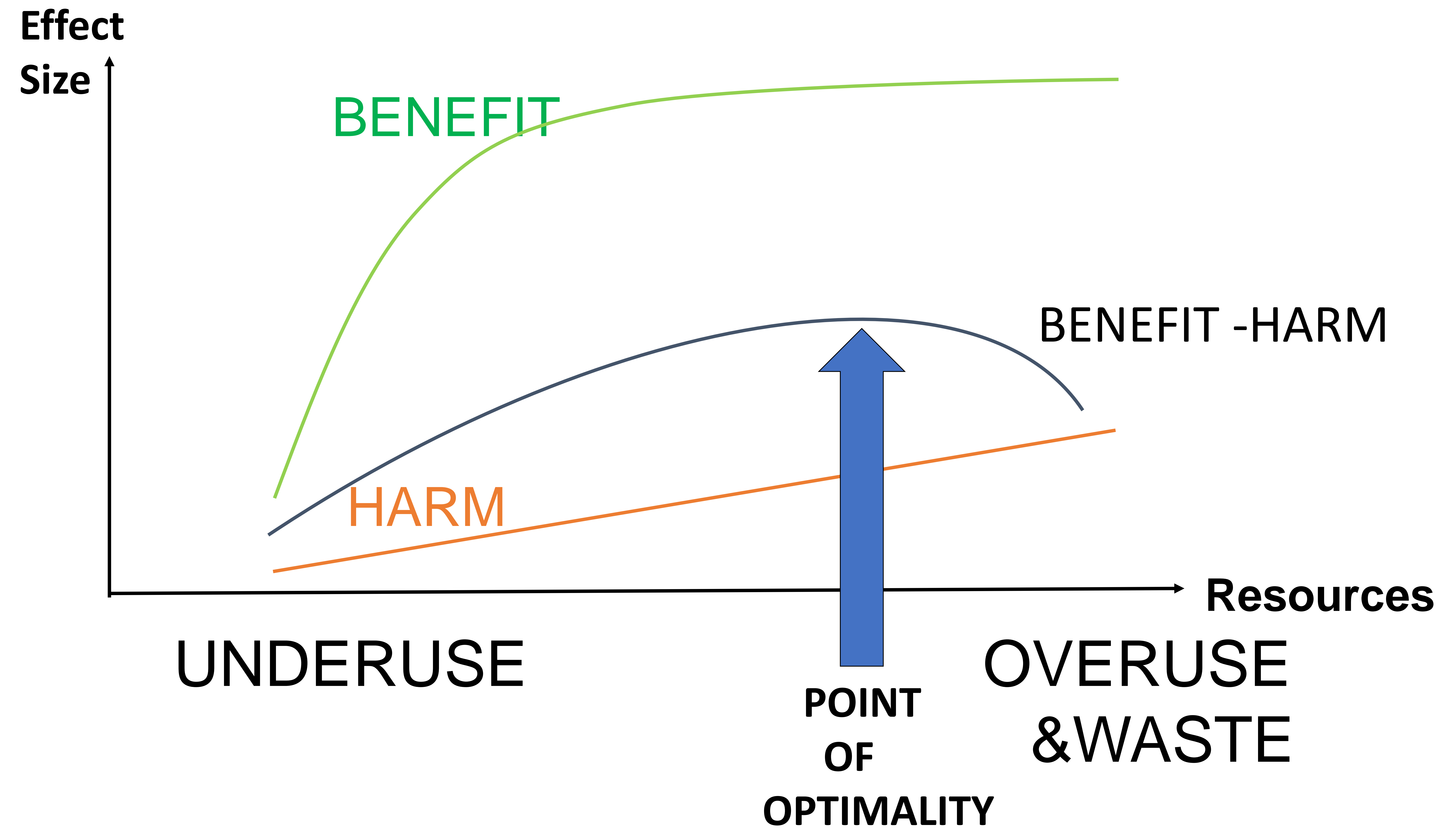
Avedis Donabedian also taught us that all health care causes harm, and the more you do, the more harm it does



The benefit is a little higher and the harm a little lower if quality is higher but the basic shapes are the same

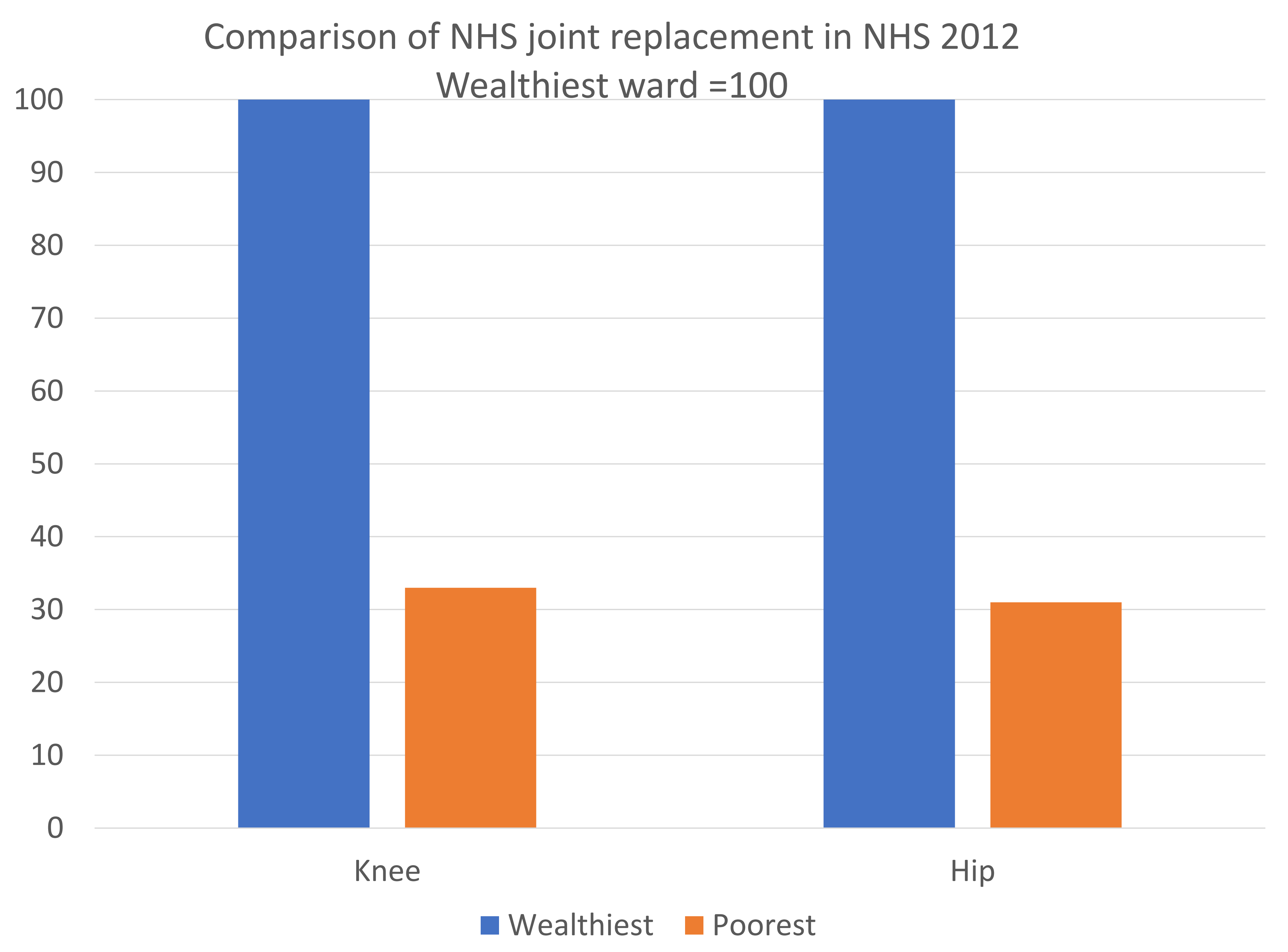
And he defined a Point of Optimality beyond which resources are wasted and would give greater value if used on another segment of the population




Effect
Size
BENEFIT
BENEFIT -HARM
HARM
Resources
UNDERUSE
OVERUSE
&WASTE
POINT
OF
OPTIMALITY

The third problem is Underuse of high value interventions which results in

1. **Preventable disability and death** often combined with
2. **inequity**



A new paradigm is needed – Value Based Healthcare

Four perspectives of value as defined by the G20

personal value *- appropriate care to achieve a patient's personal goals*
allocative value *- equitable resource distribution across all populations and within each population across all patient groups*
technical value *- achievement of best possible outcomes with available resources; it is important to emphasise that this means using the resources for all the people in need in the population not just those who reach the service and become patients, for example focusing on all the people in with hip pain, not just those people who have had a hip replacement. This means that technical value also includes measurement and minimisation of inequity*
social value *- contribution of healthcare to social participation and connectedness*

There are four types of waste in healthcare

1. Waste left after a job has been done.
2. Waste due to low technical efficiency.
3. Waste when intervention do not achieve outcomes that matter or do more harm than good
4. Waste due to opportunity costs where waste is the use of resources that would produce more value if used for
   *another purpose for that sub-group of the population or
   *another subgroup of the population.

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A.,

life.[36] Early introduction of palliative care also led to less aggressive end-of-life care, including reduced chemotherapy and longer hospice care. Given the trends toward aggressive and costly care near the end of life among patients with cancer, timely introduction of palliative care may serve to mitigate unnecessary and burdensome personal and societal costs.[20,37]

An integrated palliative and respiratory care service for patients with advanced disease and refractory breathlessness: a randomised controlled trial

Irene J Higginson, Claudia Bausewein, Charles C Reilly, Wei Gao, Marjolein Gysels, Mendwas Dzingina, Paul McCrone, Sara Booth, Caroline J Jolley, John Moxham

This trial provides support for a more integrated approach to management of breathlessness within a breathlessness support service, which improves patient mastery without affecting overall care costs. The recorded

Here is the new agenda to increase value by shifting resources from lower value which may be zero value where the resources are being wasted to higher value activity

- Define population segments with a common need such as people with respiratory disease and allocate resources optimally
- Design the system for each population sub-group for example for people with COPD
- Ensure each individual makes decisions to optimise personal value
- Deliver value for the population and all the individuals in need equitably through networks
- Create the culture of stewardship, with a governance process that promotes collective responsibility with clinicians responsible for optimizing the use of the resources their population segment's budget and clinical time

LEVELS OF CARE	BUREAUCRACIES			
	PUBLIC		PRIVATE	
	NHS	local	drug	insurance
self-care				
informal care				
generalist care				
specialist care				
super-specialist care				

TO 3D HEALTHCARE

SEGMENTS OF THE POPULATION DEFINED BY NEED

People in the last year of life
People with back pain
People with asthma

LEVELS OF CARE

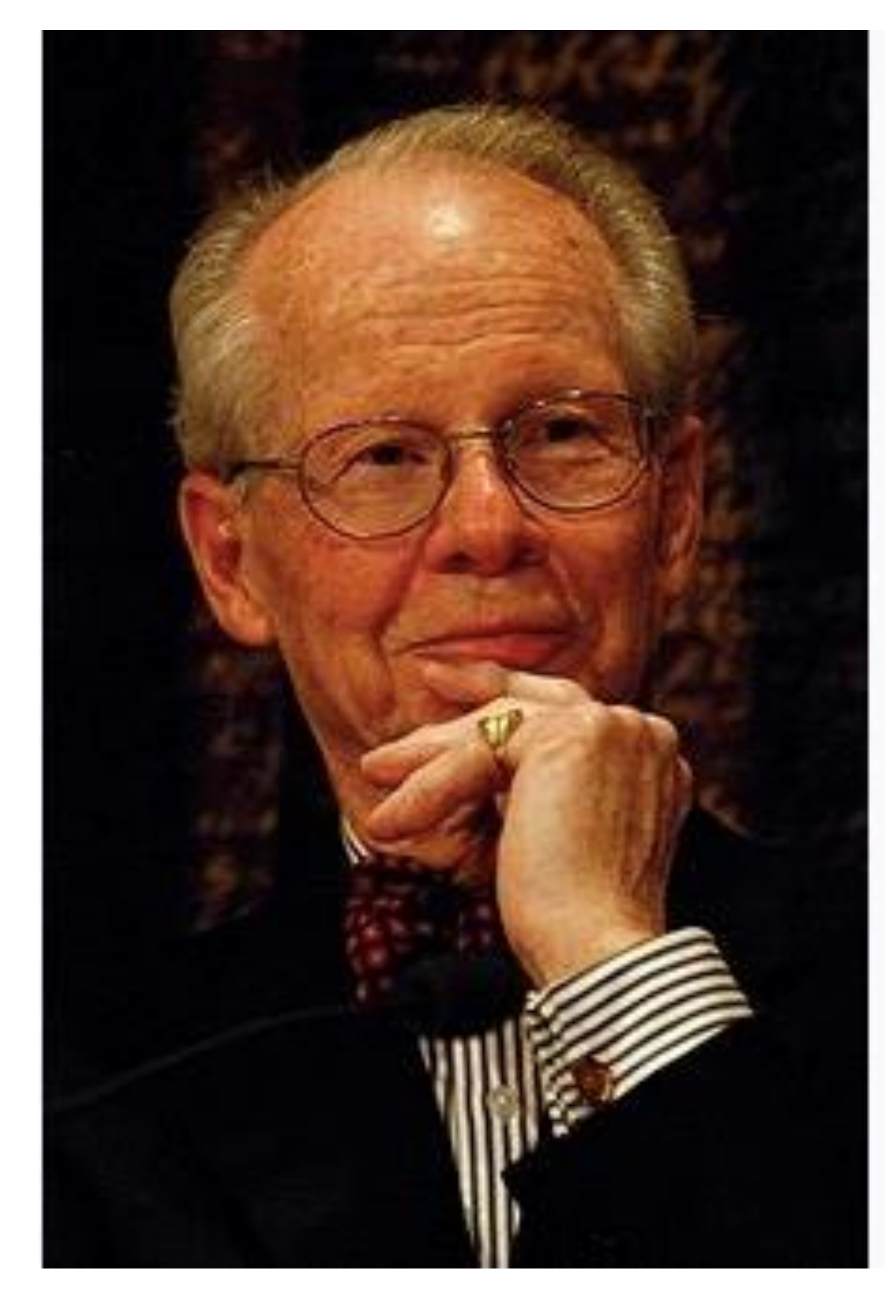
self-care
informal care
generalist care
specialist care
super-specialist care

BUREAUCRACIES
NHS local drug insurance
PUBLIC PRIVATE

Design the system for each population sub-group

‘if the market is a marvel, then why do we need firms?
But then the question can be turned around.
If internal organisation enjoys advantages over markets, then why is not all production carried out in one big firm?’

Source: The Economics of Transaction Costs
Oliver Williamson and Scott E Masten (1999)
Joint Winner of the Nobel Prize for Economic Science 2009



Oliver Williamson

Source: Wikimedia

Healthcare is too complex for bureaucracies or markets, alone or working together to provide the solution - what is needed is a **SYSTEM**

The principles of system design for Better Value Healthcare are that, in designing a system, it is necessary to

- Define the scope of the programme
- Define the population to be served
- Reach agreement on the aim and objectives of the service
- For each objective, to find one or more criteria
- For each of the criteria, identify levels of performance that can be used as quality standards
- Identify all the resources used to create a system budget
- Define all the partners to engage in a Clinical Network
- Produce a system specification
- Prepare a plan to build the system

Setting the aim, for example in a system for people in the last year of life

to enable dying well as well as living well

When asked to set objectives clinicians and representatives of people with the problem usually focus on clinical objectives adapted forthe population

To reduce the incidence of Type 2 diabetes

To diagnose type 2 diabetes promptly and accurately

To treat type 2 diabetes effectively with minimal side effects

To enable the person with type 2 diabetes to be confident in their management and minimise psychological adverse side effects of diagnosis

To reduce the risk of complications from Type 2 diabetes

The objectives for a population based system for living and dying well

to identify people in the last year of life
to promote and enable indiviudals to express their preferences clearly
to provide intensive support to those who need it most

However there are five other objectives the clinical group responsible for and to the population need to adopt

To reduce the incidence of Type 2 diabetes

To diagnose type 2 diabetes promptly and accurately

To treat type 2 diabetes effectively with minimal side effects

To enable the person with type 2 diabetes to be confident in their management and minimise psychological adverse side effects of diagnosis

To reduce the risk of complications from Type 2 diabetes

To minimise the effects of deprivation and inequity

To make optimal use of resources

To educate all the relevant professionals, for example pharmacy assistants and care home staff about type 2 diabetes and its management

To promote and support research

To produce an annual report for the population served

3 . Ensure each individual makes decisions that optimise personal value

The value **this** patient
places on benefits & harms of the
options and on risk taking

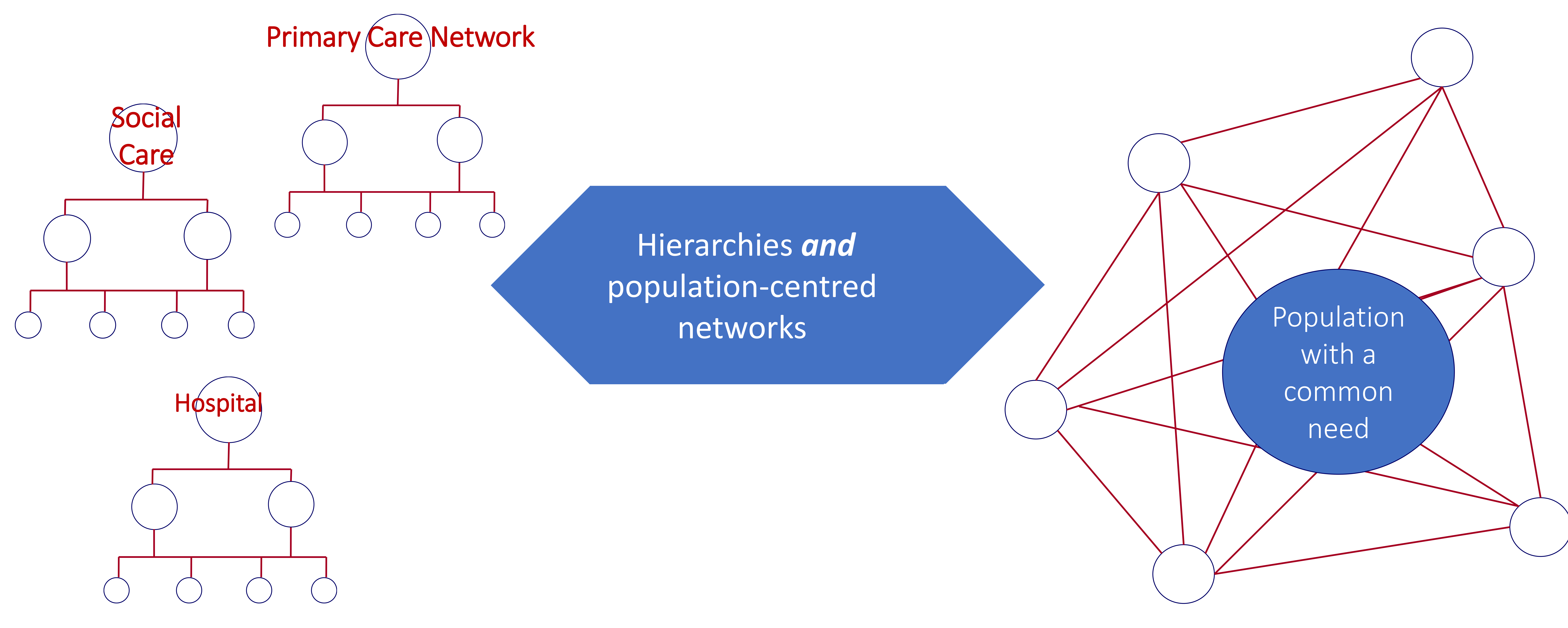
Evidence,
Derived from the
study of groups
of patients

Decision

Patient
Report of
the impact
of the
decision on
problem
that was
bothering
them most

The clinical condition of **this** patient; other
diagnoses, risk factors including genomic
information and in particular their problem,
what bothers them psychologically & socially

4. Deliver value for the population and all the individuals in need equitably through networks



5. Create the culture of stewardship and collective responsibility

Elinor Ostrom realised that the Tragedy of the Commons is not inevitable.

"If those using the resources are allowed to manage those common pooled resources themselves, then sustainability is possible. They become stewards. '

Her approach is called the Governance of Complex Economic Systems

Joint Winner of the Nobel Prize for Economic Science 2009

Stewardship is to be responsible for preserving and improving a resource which one does not own for future generations

Accounting for Value

A value report for the 'Die Well' domain

in the North East Essex Health & Wellbeing Alliance

End-of-life population budget

Data was available from four sources of funding for the care for people in the last year of life in NEE: expenditure on hospital admissions, St Helena Hospice charitable funds, St Helena Hospice NHS grant-funded expenditure, and the NHS continuing healthcare fast-track pathway. In 2018/19, total expenditure from these four sources was £39,884,297. The majority of expenditure for people in the last year of life was due to ***admissions to hospital amounting to £30 million (19% of the total expenditure on hospital admissions), of which £26.5 million was expenditure on emergency admissions to hospital in the last year of life, comprising 37% of the total expenditure on emergency admissions.***

If all general practices could be supported to achieve the characteristics of high MCCR usage practices, the potential for re-investment is about £422,138 for people with cancer in the last year of life and £1,728,754 for people with non-cancer conditions in the last year of life; the total being £2,150,892.

- Build a movement for change by communicating the findings of this report, in an appropriate format, within the NHS and wider, including with the public.
- Identify people at the end-of-life, listen to them and share their preferences so we can fulfil them.
- Take our agreed outcomes, measure them, and reflect and act on them on a regular basis to enable us to track improvements in value.
- Trial a rolling series of projects to impact the number of emergency hospital admissions, whilst better fulfilling people's end of life preferences, reducing possible inequities of outcomes and using resources more efficiently.

Editorials

Population-based, person-centred end-of-life care:

time for a rethink

REFRAMING END-OF-LIFE CARE IN A CHANGING CONTEXT

The way we care for people in the last chapter of their lives has been said to be a litmus test for our society. Lifespan now outstrips healthspan, and, with increasing complexity, symptom burden, and rising mortality, the context of end-of-life care (EOLC) is changing and broadening. It is time for a new approach — a reframed, inclusive, big-picture population-based approach to EOLC to meet the challenges

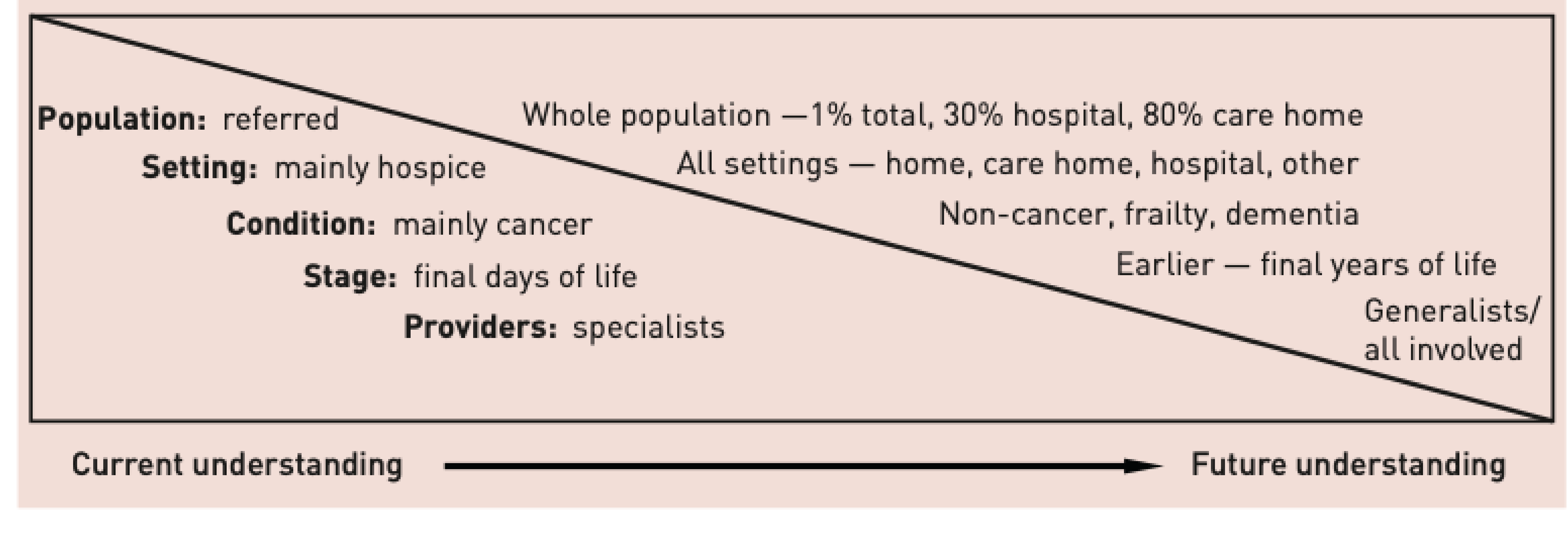


Figure 1. A population-based approach to end-of-life care.

Questions?

Dr Julie Barker
Associate Medical Director
Why should ICB partners prioritise Quality End of Life Care?
Everyone deserves Gold Standard End of Life Care

Join at Menti.com with code: **71 22 11 3**

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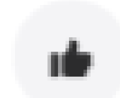
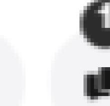
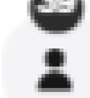
Mentimeter

What one word would best describe how much priority is currently given to providing high quality end of life care in your area.

76 responses

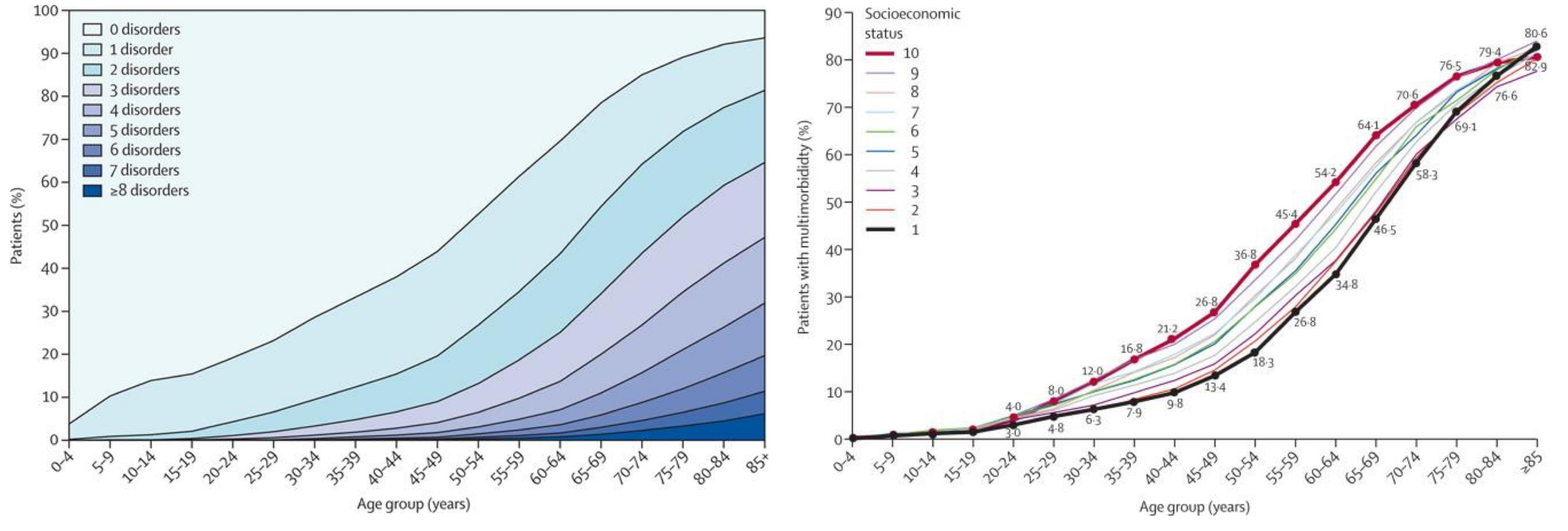




Prioritise quality of life over prolonging it for elderly, Chris Whitty tells medics

England's chief medical officer says more realistic conversations needed about some treatments' side-effects

He also urged families not to shy away from conversations with older relatives about health choices such as the extent to which they would want medical interventions to be escalated in an emergency. These discussions could be mediated by a GP, Whitty suggested, and need not be "frightening conversations". "If you talk to older people, they will all want to have this conversation," he said.

Individual chronic conditions accumulate with age- multimorbidity. This is accelerated by deprivation. Overlap with frailty but not the same.



Barnett et al 2012- UK data.

FACT:

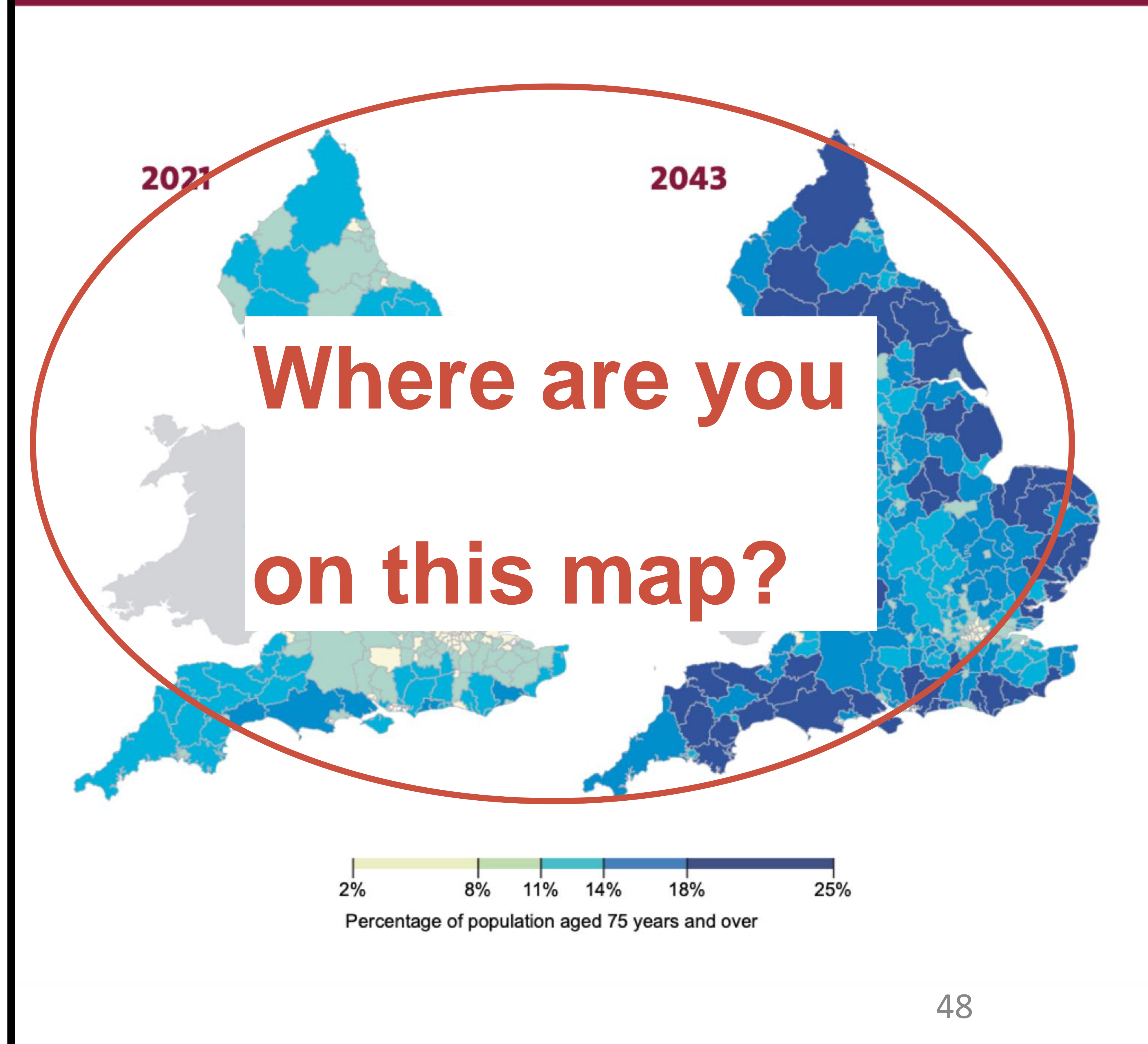
We are getting older and living with more multi-morbidity than ever before.

So we need to think & do differently adapt & ensure that we are doing the right things for our population.

1. This report is about improving quality of life rather than longevity

3. Urban areas are not where the growth in older people is occurring; more peripheral areas are where the increase in need will be seen

11. Improving quality of life in older age sometimes means less medicine, not more



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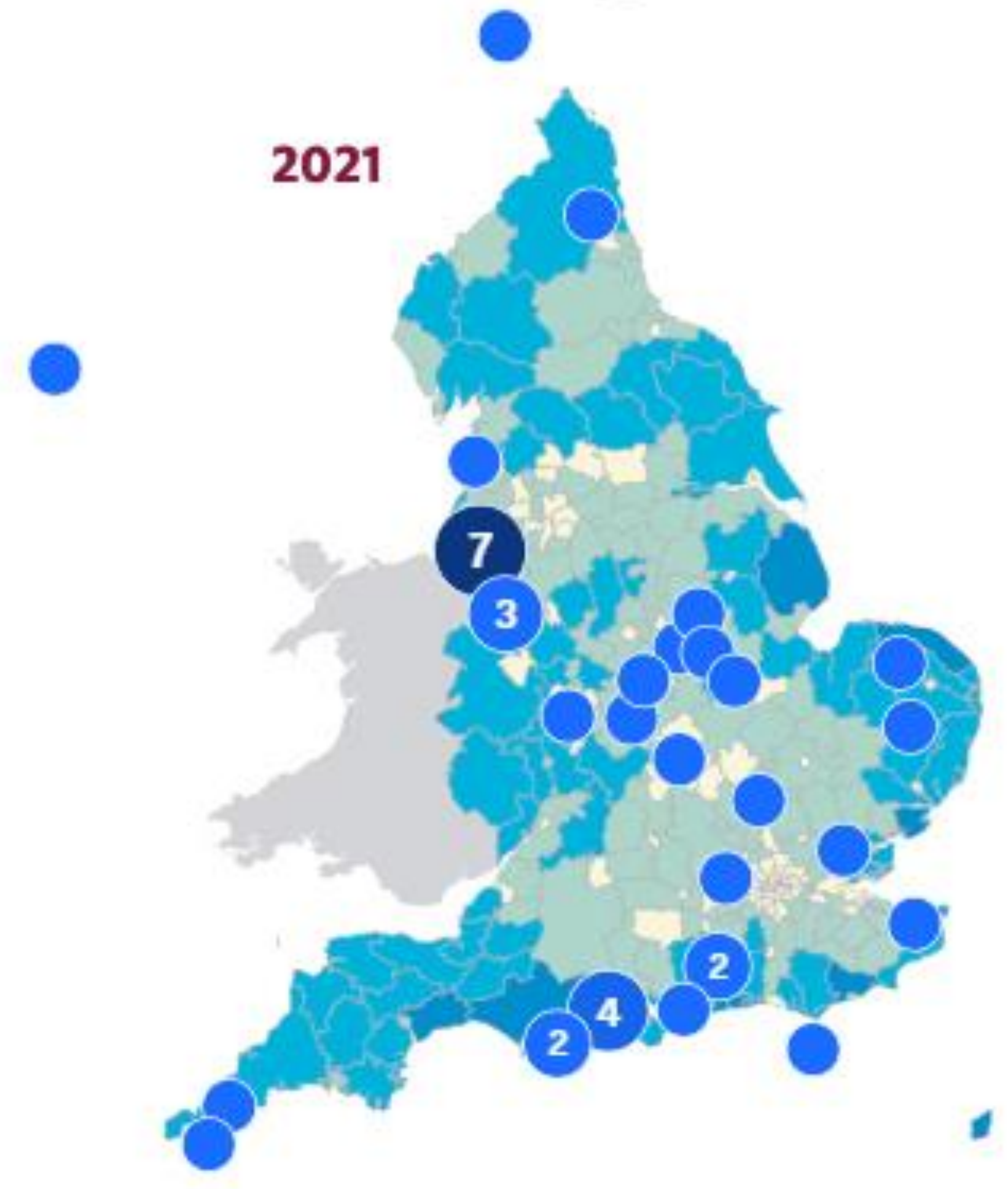
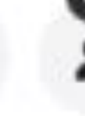




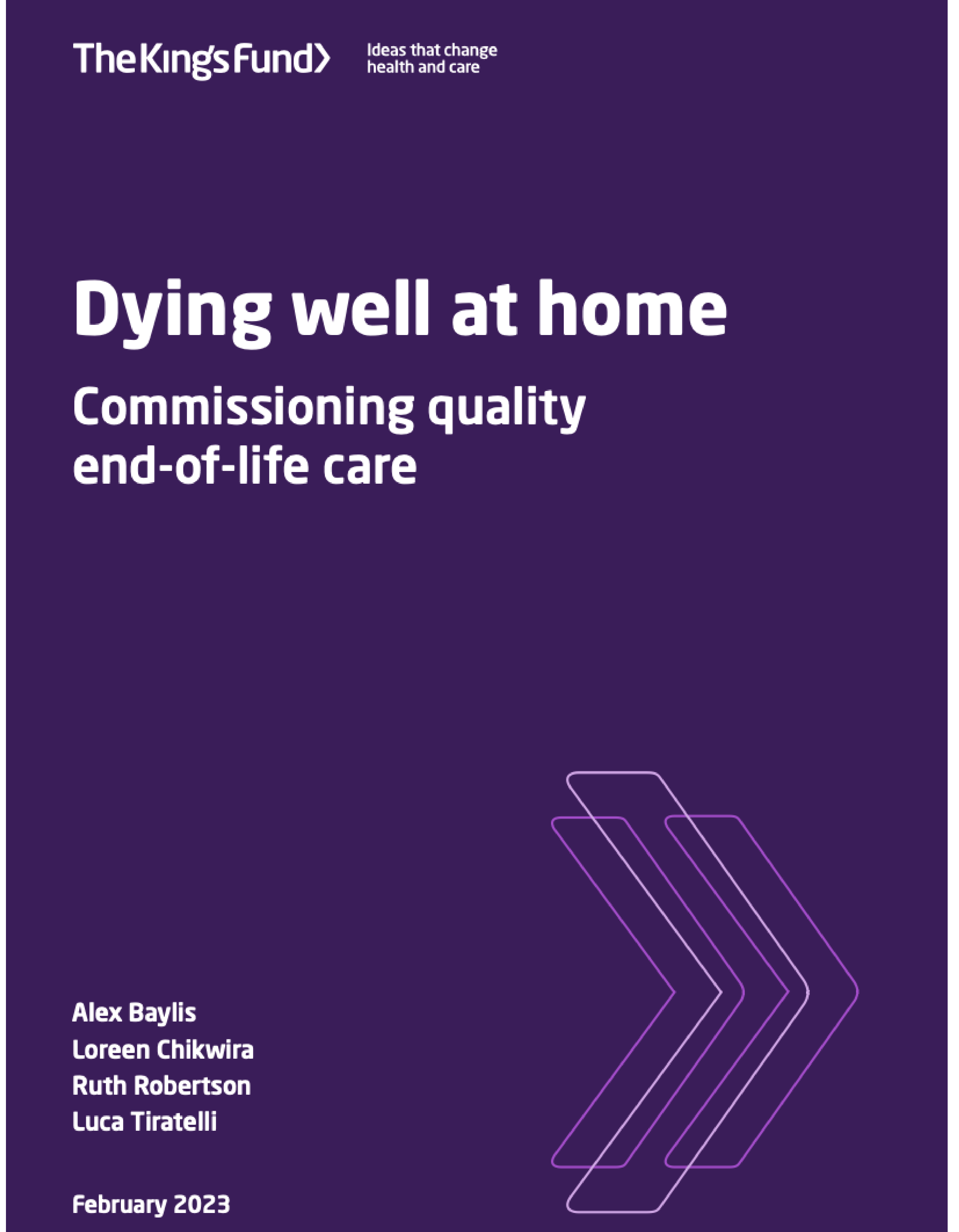
11. Improving quality of life in older age sometimes means less medicine, not more

It is essential that all patients, but especially those in later old age, are able to have realistic discussions with their doctors about whether more treatment will improve quality of remaining life. ***Some treatments may extend life but at the expense of reducing its remaining quality and independence; the decision about how to balance these should be the patient's.*** This needs full and realistic information from their medical advisors. Examples might be major operations, or chemotherapy, or continuing drugs which have side effects and whose principal aim is to extend life, or repeated admissions to hospital. In medicine it is often easier to do more things, even when it is far from clear that quality of life will increase as a result. Over-treatment is as inappropriate as under-treatment in all patients, including older patients.

Greater use of advance care plans can help avoid over-treatment. Out-of-hours doctors, hospital clinicians and carers may be less familiar with someone's wishes.

***Consider how your area is training your front line staff* in conversations designed to avoid over-treatment………..**

Commissioning


The King's Fund
Ideas that change health and care

Dying well at home

Commissioning quality end-of-life care

Alex Baylis
Loreen Chikwira
Ruth Robertson
Luca Tiratelli

February 2023

Classification: Official

Publication reference: PR1673

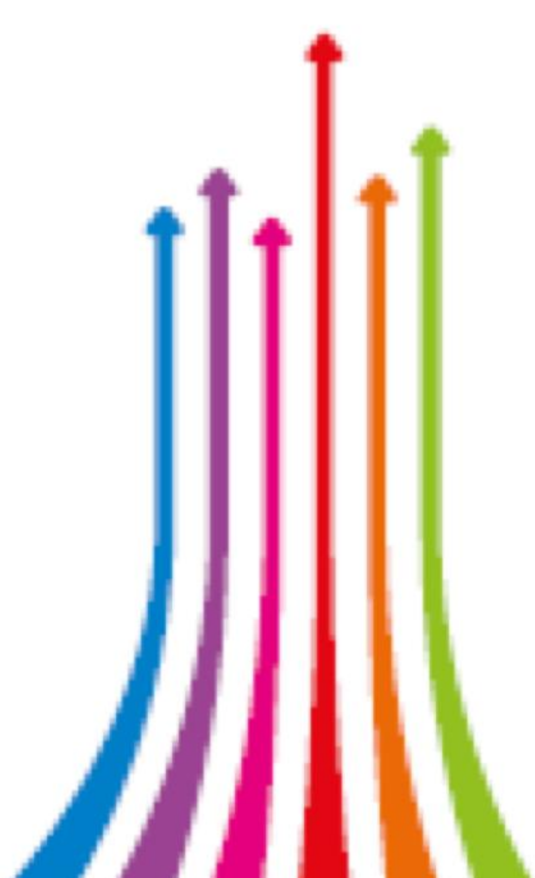
Palliative and End of Life Care

Statutory Guidance for Integrated Care Boards (ICBs)

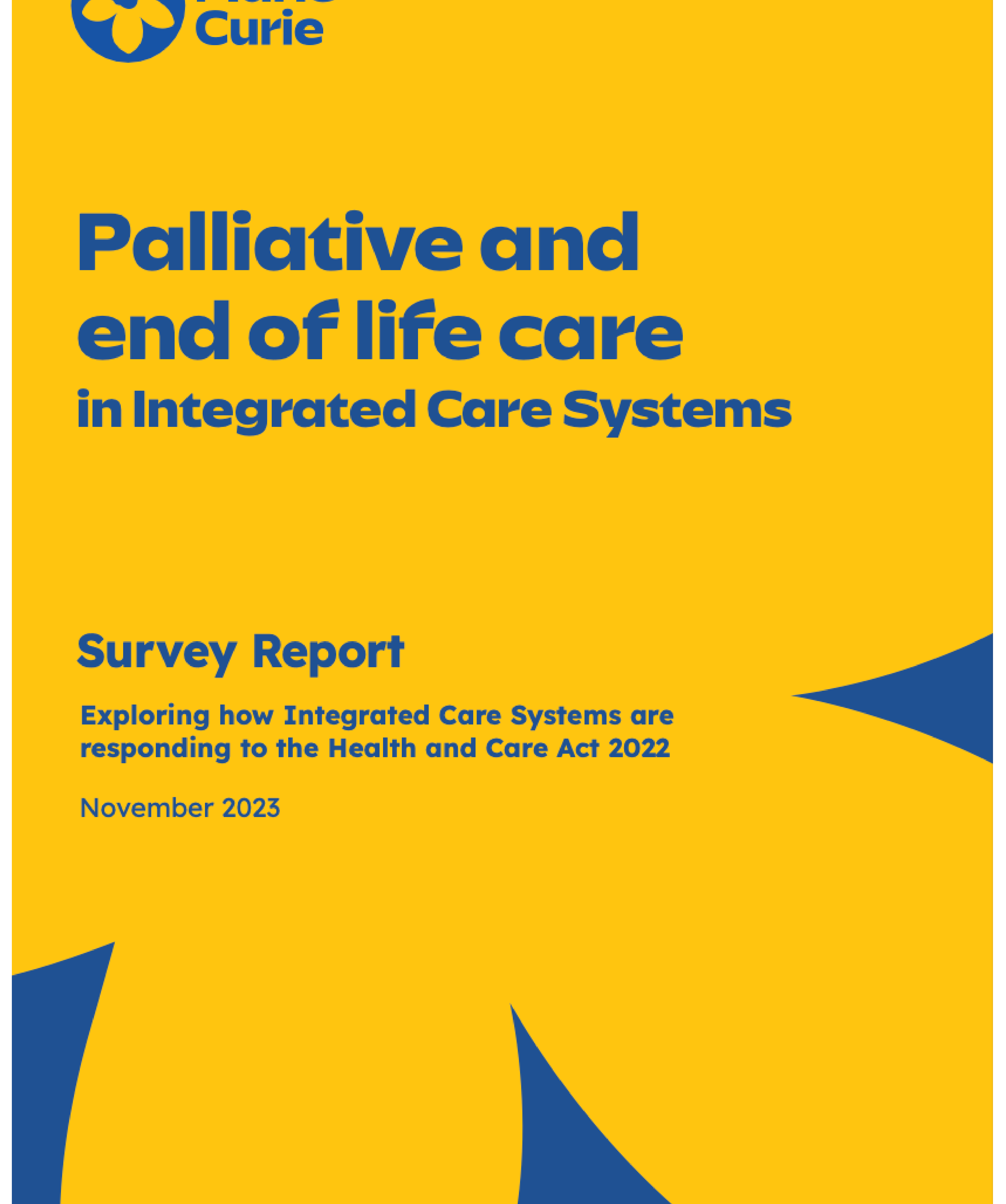
29 September 2022

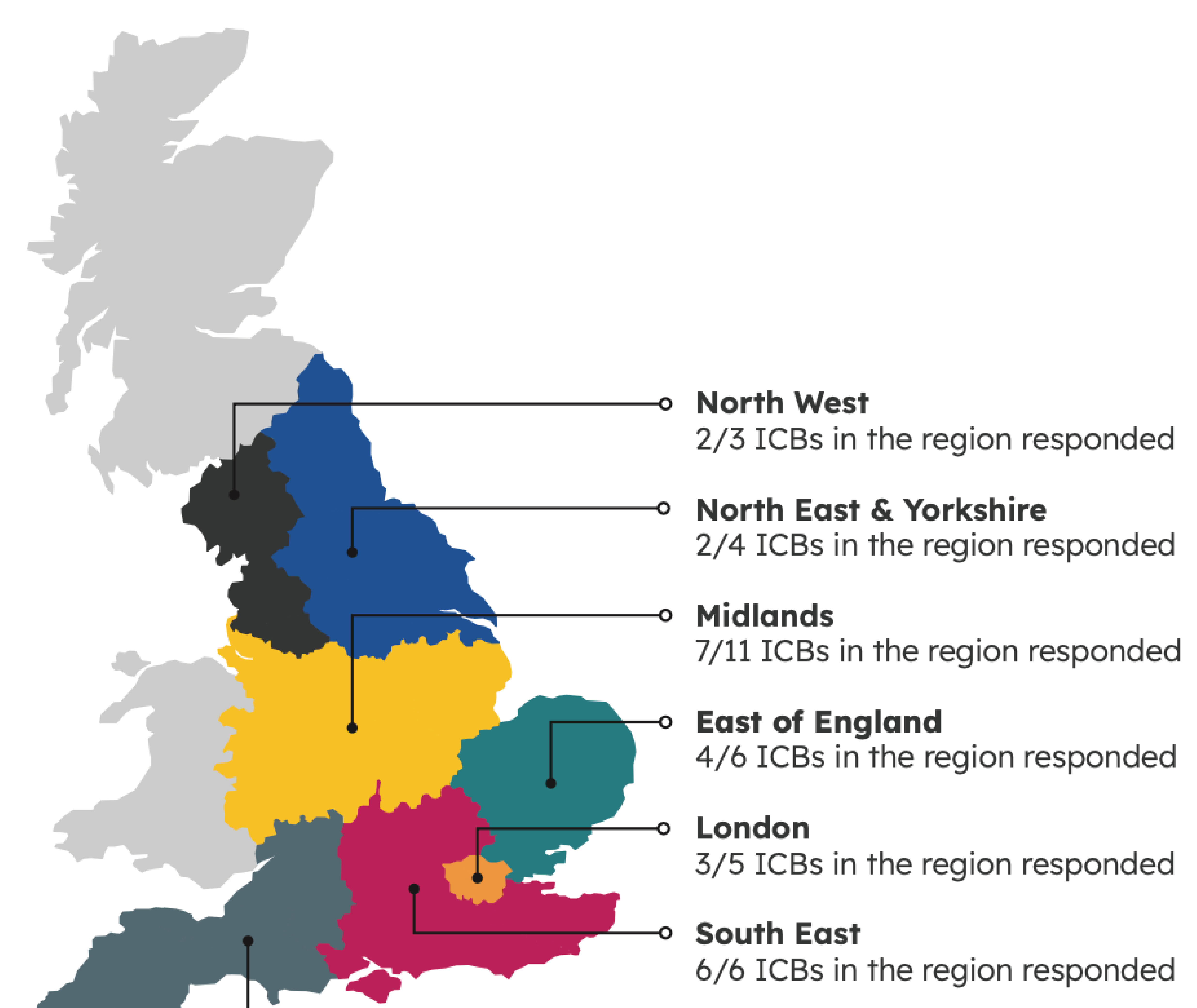
Optimising the Ambitions Partnership and Framework

"I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)."



[Ambitions Self-Assessment Tool]





Everyone deserves Gold Standard End of Life Care.

Key findings

The survey of ICBs across England highlighted the following key themes in relation to palliative and end of life care (PEoLC):

1. Lack of a consistent strategic focus on PEoLC services

More than a quarter of ICBs in our survey told us their Integrated Care Strategy does not cover PEoLC and almost one in five told us their Joint Forward Plan does not do this.

2. Improvements required to fully understand population health need

Whilst the vast majority of systems (92%) feel they have at least moderately understood the PEoLC needs of their population, only 35% of systems report having a significant or full understanding of population health need.

3. Significant gap in understanding and addressing PEoLC inequalities

Understanding and addressing inequalities in access to and experience of PEoLC is a major gap for most systems, with two thirds of respondents yet to complete an Equalities and Health Inequalities Impact Assessment, as required in NHS England's statutory guidance on the new legal duty.

4. Workforce and funding are key barriers to PEoLC service improvement

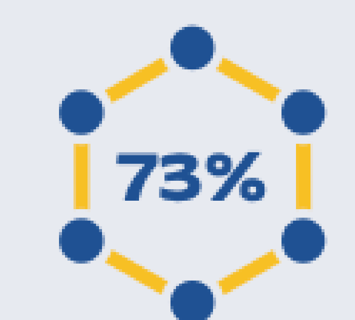
Workforce and funding issues are considered the most significant barriers to effectively delivering and improving PEoLC services. Only 3% of ICB respondents have fully or significantly assessed the required workforce to deliver services effectively.

5. Appetite for additional support to demonstrate the benefits of PEoLC investment

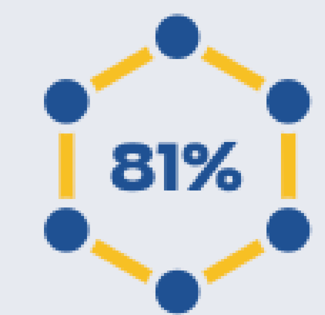
Most systems would welcome additional resources and support to demonstrate the potential value of additional investment in PEoLC services.

Quantitative responses

Leading and shaping PEoLC services



Of ICBs responded that their Integrated Care Strategy covers PEoLC

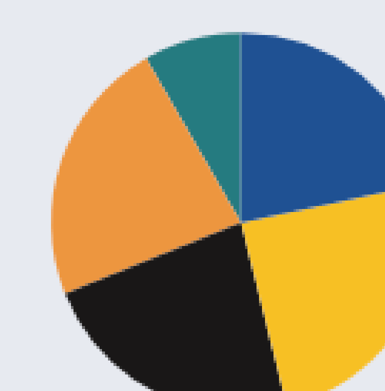


Of ICBs responded that their Joint Forward Plan covers PEoLC

Types of support ICBs feel they could benefit from to meet the PEoLC legislation include evidence on value case (76%) and good practice case studies (36%)

ICBs engage with a range of stakeholders including people with lived experience, specialist palliative care providers e.g. charitable hospices, VCSEs and local authorities to develop PEoLC services

Do you engage with the following to define PEoLC strategies and commissioning needs?



- People with lived experience
- Specialst pallative care providers
- VCSE
- Local authorities
- Other

Commissioning PEoLC services

Understanding Population Health Need

92%

Of ICBs reported that they understand the PEoLC needs of their local population to at least a **moderate** extent.

However, only **35%** reported that they **significantly** or **fully** understand PEoLC population health needs.

Meeting Population Health Needs

100%

Of ICBs reported that local PEoLC services meet local population need to at least a **moderate** extent.

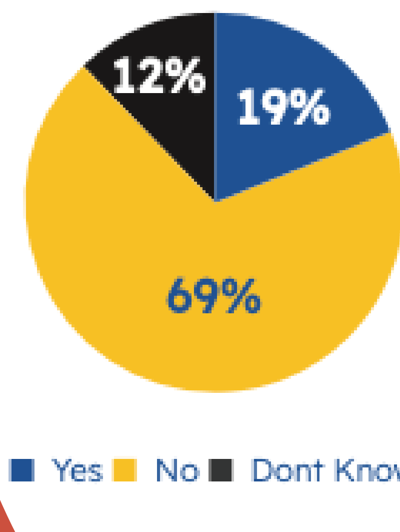
However, only **38%** reported that local services **significantly** or **fully** meet population needs.

77%

Of ICBs have conducted a self assessment against the PEoLC Ambitions.

69%

Of ICBs have not completed an Equalities and Health inequalities impact assessment and action plan on PEoLC.



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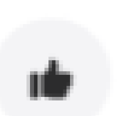
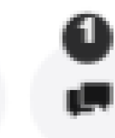
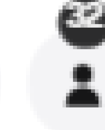
Join at https://www.menti.com/alagc7ipjnuf

Mentimeter

What are the most important factors in providing high quality end of life care?

Example of prioritisation at 'PLACE' Notts

Nottingham and Nottinghamshire

Proposed Approach

- Embed an approach which delivers a core service to our people, but tailoring the size and shape at PCN level 'proportionate universalism'[i]
- Prioritise the areas and population groups of most need through a PHM approach, including those living in the most deprived areas, people living with frailty, those in vulnerable or inclusion groups and those experiencing severe multiple disadvantage.
- Identifying and addressing the 'care gap' in effective anticipatory care and increasing uptake of secondary prevention interventions to provide a holistic, personalised approach to care

Outcomes

- Increase in number of people being cared for in an appropriate care setting (navigation and flow)
- Reduction in avoidable and unplanned admissions to hospital and care homes (Proactive care)
- Increase in healthy life expectancy (maintaining wellness for longer)
- Access to the right primary and community based health and care services first time (Referral optimisation)

Priority Areas

- CVD (Heart Failure, Stroke, CHD, hypertension)
- Respiratory (COPD/ Pneumonia)
- Cancer
- EoL
- - Frailty/Dementia/Falls

- - Delirium and Confusion
- - Cellulitis
- Sepsis

- Mental health
- *Maternity/CYP
- *Diabetes
- *MSK

The King's Fund | Policy brief

How can ICBs improve end-of-life care for people who die at home?

What families and carers told us about end-of-life care

Recently bereaved families and carers said commissioners need to ensure that:

- staff are consistently compassionate – trained in caring skills, as well as clinical skills
- there is good communication, so that patients and carers are fully involved and fully supported
- all the services involved are well co-ordinated and seamless
- people know what to expect, the range of services available for them and how to access them
- services meet the specific needs of people from different ethnic and religious groups.

Key findings (23 Feb 23)

Commissioning end-of-life care for people dying at home needs to improve.
ICB leaders should ensure that commissioners:

- understand patient, carer and community experiences
- track needs and act on inequalities
- include generalist and social care in quality monitoring
- convene partners to collaborate on improvement.

Aligning our objectives with new NHSEngland 2024/25 delivery for PEOLC – Draft in Progress

	Improving Access		Improving Quality	Improving Sustainability	
NHS Medium-term priorities	**STOP avoidable distress through identification and early intervention**	**SHIFT to digital and community through integration**	**SHARE the best to improve patient and carer experience**	**STRENGTHEN the hands of the people we serve**	**SUPPORT our local partners**
Priorities for Palliative and End of Life Care	Improved identification of palliative and end of life care needs Responsive community services	Integrated Neighbourhood Team approaches New models of care	Evidence into policy and practice	Personalised care planning / ACP and care co-ordination	Collaborative commissioning Oversight / accountability and meaningful metrics
	24/7 models of specialist palliative care			Health inequalities	
Enablers	Data and insight Identification processes IT infrastructure Training	Workforce Digital Strategic planning / commissioning / Pricing / payment systems	Existing resources Data and insight Innovation & Research	Training	Established network Improvement expertise

PEoLC Delivery Plan

Priority		Outputs and Measures 2024/25
1. Improving Access	1.1. P... 2 month... nd support pla... 1.2. Staff, patients and carers can access the care and advice they need, whatever time of day 1.3. Equitable access to PEoLC for all, focussing on locally identified under-served populations	1.1. Th... tified and X% of people offered ... ompared to baseline ... vided ... 1.... pallia... ss all region... 1.2.3. Phase 2: 7-day face to face specialist palliative car... 1.3.1. PEoLC SCNs can evidence improved access for loc... ... populations from a baseline.
2. Improving Quality	2.1. High quality palliative and end of life care for all, irrespective of condition or diagnosis 2.2. A confident workforce with the knowledge, skills and capability to deliver high quality PEoLC 2.3. High quality PEoLC across all systems	2.1 PEoL... mproved quality for locally identified priority groups from a baseline 2... d staff confidence, knowledge and skills in PEOLC from a b... 2.3.... od or outstanding in all domains 2.3.2 ... nadequate 2.3.3 P... mproved patient/carer experience from a baseline.
3. Improving Sustainability	3.1 PEoLC is sustainably commissioned 3.2 The PEoLC workforce is fit-for-purpose, now and in the future 3.3. Personalised and community focused approaches are fundamental to improving the PEOLC experience	3.1 Framework for best practice commissioning and funding for PEoLC embedded in at least 50% o... ICSs in each region 3.2. Each ICS has a workforce plan for PEoLC and demonstrates year on year improvement 3.3.1 X% increase in referrals ... 3.3.2 Each PCN has an identified social prescribing lead for PEoLC 3.3.3 ICSs evidence improved patient experience in personalised and community focused approach...s to PEOLC

Patient Identification

24/7 support & co-ordination

ACP including TEP

Workforce:

Training & Confidence

Strategy

Editorials

Population-based, person-centred end-of-life care:

time for a rethink

Population: referred — Whole population —1% total, 30% hospital, 80% care home

Setting: mainly hospice — All settings — home, care home, hospital, other

Condition: mainly cancer — Non-cancer, frailty, dementia

Stage: final days of life — Earlier — final years of life

Providers: specialists — Generalists/ all involved

Current understanding → **Future understanding**

Figure 1. A population-based approach to end-of-life care. BJGP March 2018. K Thomas, M Gray

We should measure what matters, but it matters who chooses the measures

Research in the spotlight

25 March 2024

Measuring the overall performance of Healthcare Providers

Spring budget: ‘The focus on productivity in turn shines a light on the performance of providers as the main way we measure how ‘productive’ the NHS is.’

What do we know about what matters most to patients & their families?

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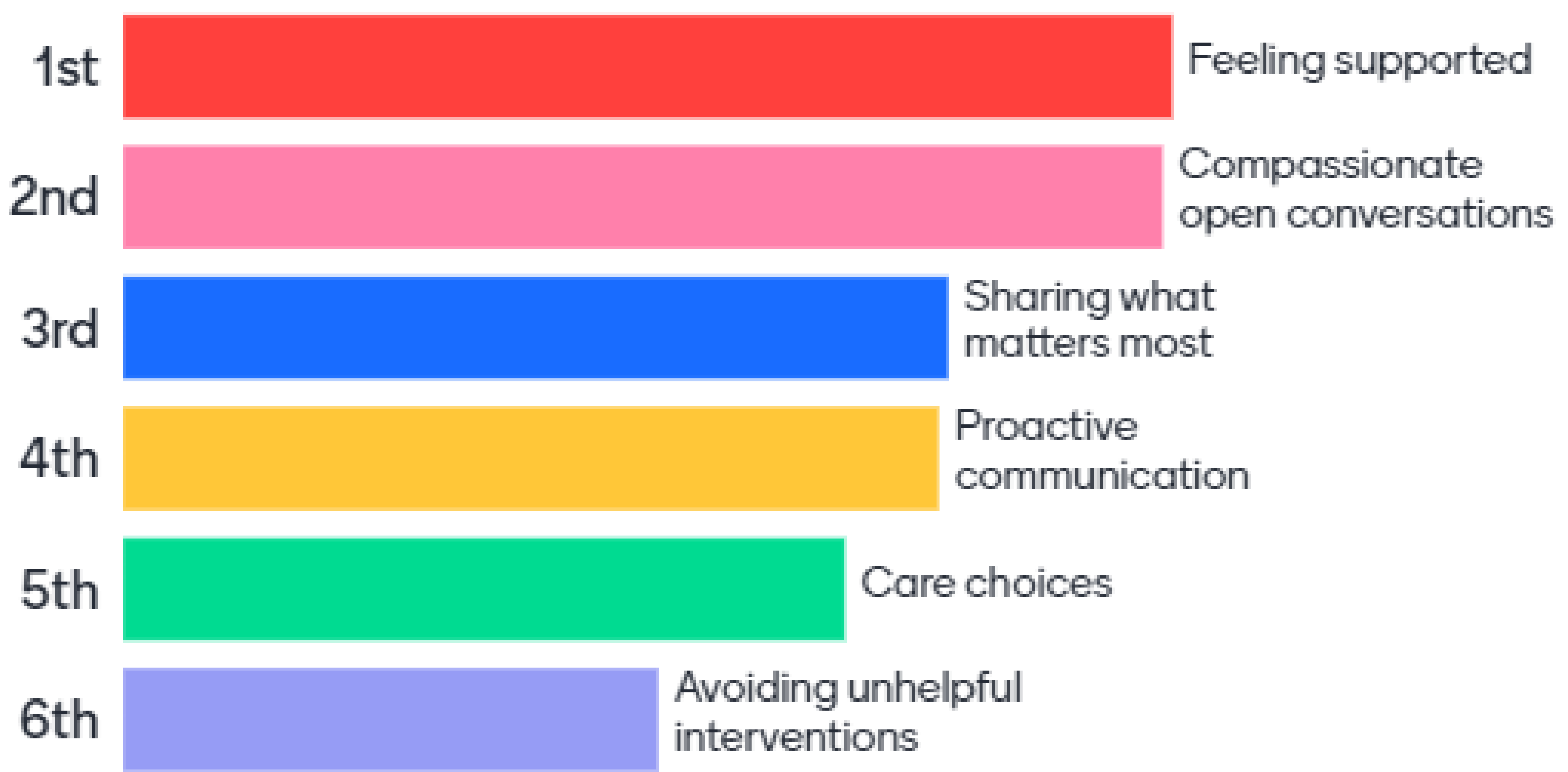
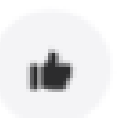
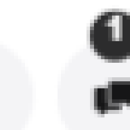
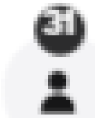
Join at https://www.menti.com/alagc7ipjnuf

Mentimeter

What are the most important factors in providing high quality end of life care?



Qualitative Review of Advance Care Planning at End of Life.

- Opportunities for identification often missed
- Advance Care Planning Conversations not consistently offered
- Information sharing & EPaCCS improving but patchy
- Care co-ordination & escalation response (Respect Audit) often missing
- Strong patient-centric GP leadership positively affects care *
- Patient outcomes closely associated to the above

What Families are saying..

'She was clear on what she wanted and everyone made that happen.'

The fact that the doctors & carers knew Dad well gave us huge comfort but we were offered help much too late.

'He was just left to die and no-one told us what was happening'. Hospital admission for several weeks, no ACP

Everyone deserves Gold Standard End of Life Care.

Social care is a minefield, so disjointed.
They should be made to have a quality standards for the money they get.

'The carers didn't have a clue' (Fast track CHC contracted company)

Compassionate Sheffield

Peoples' experiences of Palliative & EOL Care Jan 2024

The benefits of taking a compassionate approach

Through connecting and supporting Sheffield's individuals, communities and organisations to harness the power of compassion, together we can create a happier and healthier city.

Finding our patients & using data to reduce inequality

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

A - Blue	B - Green	C – Yellow	D - Red
'All' from diagnosis	'Benefits'- DS1500	'Continuing Care'	'Days'
Stable	**Unstable / Advanced disease**	**Deteriorating**	**Terminal phase/ Final days**
Year plus prognosis	Months prognosis	Weeks prognosis	Days prognosis

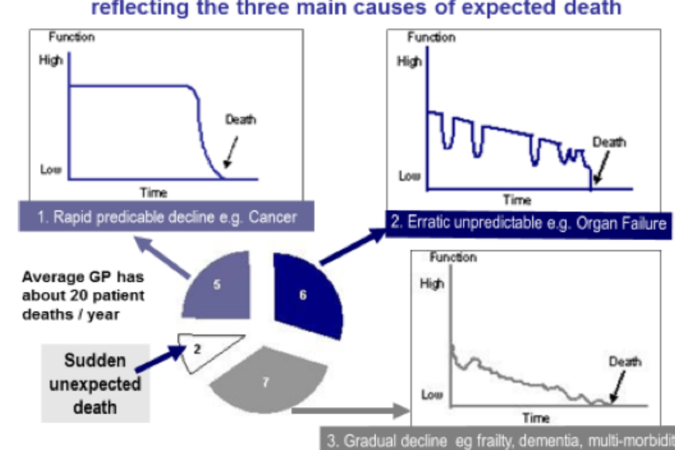
The Gold Standards Framework
Proactive Identification Guidance (PIG)

The National GSF Centre's guidance for clinicians to support earlier identification of patients nearing the end of life, leading to improved proactive person-centred care.

GSF PIG 7th Edition June 2022 Keri Thomas, Max Watson (HUK), Julie Armstrong Wilson and the GSF team
For details see http://www.goldstandardsframework.org.uk, https://www.goldstandardsframework.org.uk/PIG, https://www.gsfinternational.org.uk/pig-tool

Proactive Identification Guidance – identifying patients' decline earlier, enabling more proactive care.
This updated 7th edition of the GSF Proactive Identification Guidance or PIG (previously known as the GSF Prognostic Indicator Guidance), aims to enable the earlier identification of people who may need additional supportive care as they near the end of their life (see GMC and NICE definition of end of life care), to include final year of life as well as final days. This includes people with any condition, in any setting, given by any care provider (not just those needing specialist palliative care), following any trajectory of decline for expected deaths (see below). Additional contributing factors when considering prediction of likely needs include underlying co-morbidities, current mental health and social care provision etc.

Three Trajectories of Illness (Lynn et al)
reflecting the three main causes of expected death



Why is it important to identify patients early?
Earlier identification of people who may be in their final stage of life leads to more proactive person-centred care as recommended in the NHSE Long term Plan (2019) and NICE guidance (2021). Earlier recognition of decline leads to earlier anticipation of likely needs, better planning, fewer crisis hospital admissions and care tailored to peoples' wishes, with better outcomes enabling more people to live and die where they choose. Once identified, people are included on a

Definition of End of Life Care General Medical Council
GMC - https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life
NHS - https://www.nhs.uk/conditions/end-of-life-care/what-it-involves-and-when-it-starts/
The GMC definition of End of Life Care, used by the NHS, NICE and others is 'People are 'approaching the end of life' when they are **likely to die within the next 12 months**. This includes people whose death is imminent (expected within a few hours or days) and those with:

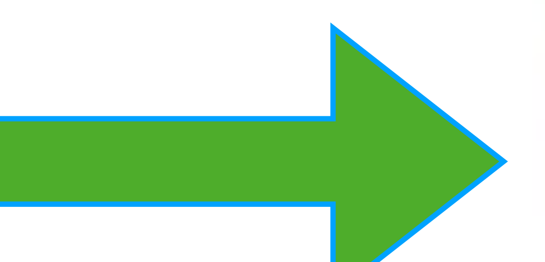
- Advanced, progressive, incurable conditions.
- General frailty and co-existing conditions that mean they are expected to die within 12 months.
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition.
- Life threatening acute conditions caused by sudden catastrophic events.'

NICE Guidance in End of life care 2021 Identification
https://www.nice.org.uk/guidance/qs13/chapter/Quality-statement-1-Identification
'Statement 1 Adults who are likely to be approaching the end of their life are identified using locally developed systems.'
NICE Service Delivery 2019 https://www.nice.org.uk/guidance/ng142
Services should develop systems to identify adults who are likely to be approaching the end of their life e.g., using tools such as GSF proactive identification guidance (PIG).

SARS COVID 19 infections can cause rapid decline, emphasising the importance of early advance care planning and screening. Contributing factors include age, multi-morbidity, BAME and social status, etc. Pulse oximetry SpO2 of 92% or under triggers immediate treatment - more information see NHS guidance or https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30193-0/fulltext.

GSF Proactive Identification Guidance Flow-chart

Proactive Identification Guidance – GSF PIG Flow-chart

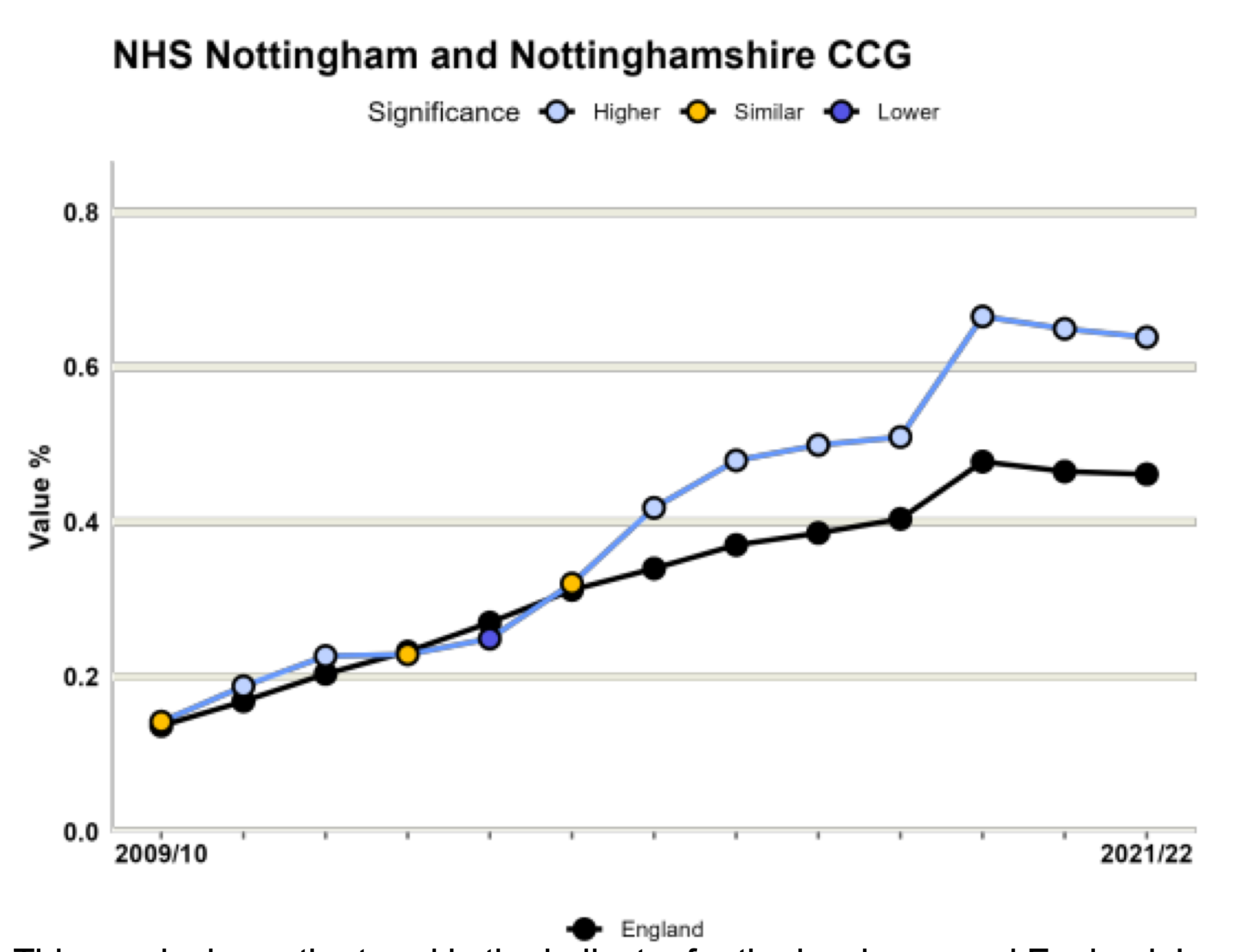


Advance Care Planning (ACP)

1. **Think**- about the future - what is important to you, what you want to happen or not to happen if you became unwell
2. **Talk**- with family and friends, and ask someone to be your proxy spokesperson or Lasting Power of Attorney (LPOA) if you could no longer speak for yourself
3. **Record**- write down your thoughts as your own ACP, including your spokesperson and store this safely
4. **Discuss** your plans with your doctor, nurses or carers, and this might include a further discussion about resuscitation (DNAR or Respect) or refusing further treatment (ADRT)
5. **Share this** information with others who need to know about you, through your health records or other means, and review it regularly.

Community: General Practice

The percentage of patients in need of palliative care / support, as recorded on PEoLC Registers, irrespective of age (QOF data)



This graph shows the trend in the indicator for the local area and England. Local values are colour coded by whether the value is worse (higher) or better (lower) than England in combination with the level of confidence that their value is statistically different from the value for England

Background

The PEoLC Register is an indicator of the extent to which patients are being recognised by their general practitioner (GP) as approaching the end of their life. Approximately 75% of deaths can be anticipated. Early identification and initiation of conversations about what matters most to the person enables personalised care and support planning, including advance care planning.

Data and intelligence

Commissioners and providers should review this indicator in combination with other indicators, in particular deaths at home and in a care home. These can be found in the PEoLC Profiles and The Place of Death Factsheet. The data for this Quality Outcome Framework (QOF) measure is provided at CCG and general practice level on the National General Practice Profiles.

Local consideration and actions

When interpreting this indicator ICSs should consider:

- how do these levels of identification compare with the demographic and disease profiles in each place?
- does the data reveal inequity of identification based on age, diagnosis, ethnicity, deprivation or other factors?
- can the levels of identification and offer of personalised care and support planning be improved?
- what lessons can be shared by those places with high levels of identification and conversations offered?
- is there adequate support for unpaid carers involved in looking after the person at home?

Choose view PBP/PCN/Practice

PBP | PCN | Practice

PBP

Bassetlaw | Nottm City | Mid Notts | South Notts

PCN

Rushcliffe
Nottingham West
Arnold & Calverton
Newark
Byron
Arrow Health
Retford And Villages
Sherwood

End of life summary
EoL % of pop
Respect form
EoL pts aged 65+
EoL pts in a Care Home
Care Home res summary

End of life | Nottingham & Nottinghamshire ICB | All PCNs

EoL pts	EoL pts 65+	EoL in CH	Recorded PPD	Respect form	EPaCCs
8,729	7,659	3,739	4,467	6,132	3,130
0.7%	3.4%	46.4%	51.2%	70.2%	35.9%

PBP/PCN/Practice	EoL	% EoL	EoL 65+	% EoL 65+	CH pop	EoL CH	% EoL CH	PPD	% EoL pts with PPD	Respect	% Respect form	EPaCCS	% EPaCCs
City South	115	0.3%	96	1.5%	103	30	29.1%	65	56.5%	80	69.6%	60	52.2%
Synergy Health	151	0.4%	138	2.1%	220	60	27.3%	73	48.3%	114	75.5%	77	51.0%
Ashfield North	483	0.9%	421	4.2%	523	237	45.3%	244	50.5%	388	80.3%	236	48.9%
Mansfield North	573	1.0%	478	4.1%	415	205	49.4%	154	26.9%	281	49.0%	268	46.8%
Clifton & Meadows	171	0.5%	148	2.8%	216	66	30.6%	96	56.1%	123	71.9%	78	45.6%
Nottingham City East	207	0.3%	168	2.4%	186	53	28.5%	109	52.7%	122	58.9%	89	43.0%
Sherwood	532	0.8%	463	3.4%	470	204	43.4%	221	41.5%	391	73.5%	223	41.9%
Raleigh	238	0.8%	194	5.5%	108	48	44.4%	97	40.8%	112	47.1%	99	41.6%
Arnold & Calverton	205	0.6%	193	2.4%	185	62	33.5%	104	50.7%	156	76.1%	84	41.0%
Ashfield South	298	0.7%	256	3.2%	297	116	39.1%	148	49.7%	207	69.5%	118	39.6%
Bulwell & Top Valley	300	0.6%	262	3.8%	351	132	37.6%	182	60.7%	218	72.7%	111	37.0%
Bestwood & Sherwood	341	0.6%	292	3.9%	376	149	39.6%	187	54.8%	265	77.7%	123	36.1%
Rushcliffe	1,186	0.9%	1,088	3.6%	1,032	632	61.2%	642	54.1%	942	79.4%	419	35.3%
Aspire	256	0.6%	214	4.3%	185	73	39.5%	132	51.6%	151	59.0%	89	34.8%
Newark	738	0.9%	696	3.8%	502	312	62.2%	346	46.9%	544	73.7%	252	34.1%
Rosewood	317	0.6%	282	3.1%	296	128	43.2%	173	54.6%	229	72.2%	105	33.1%
Nottingham West	1,215	1.1%	1,113	4.8%	797	644	80.8%	808	66.5%	956	78.7%	393	32.3%
Arrow Health	298	0.8%	276	3.1%	248	152	61.3%	176	59.1%	229	76.8%	84	28.2%
Larwood & Bawtry	117	0.3%	102	1.4%	306	42	13.7%	62	53.0%	67	57.3%	31	26.5%
Byron	364	0.9%	325	4.5%	429	242	56.4%	250	68.7%	306	84.1%	86	23.6%
Retford And Villages	300	0.5%	257	1.9%	491	93	18.9%	108	36.0%	151	50.3%	61	20.3%
Newgate Medical Group	86	0.3%	73	1.1%	201	41	20.4%	50	58.1%	62	72.1%	12	14.0%
Radford & Mary Potter	238	0.6%	124	7.0%	117	18	15.4%	40	16.8%	38	16.0%	32	13.4%

ACP : Respect Plans
Targeted actions

Choose view
PBP/PCN/Practice

PBP | PCN | Practice

PBP

Bassetlaw | Nottm City
Mid Notts | South Notts

PCN

- Rushcliffe
- Nottingham West
- Arnold & Calverton
- Newark
- Byron
- Arrow Health
- Retford And Villages
- Sherwood

- End of life summary
- EoL % of pop
- % Respect Form
- EoL pts aged 65+
- EoL pts in a Care Home
- Care Home res summary

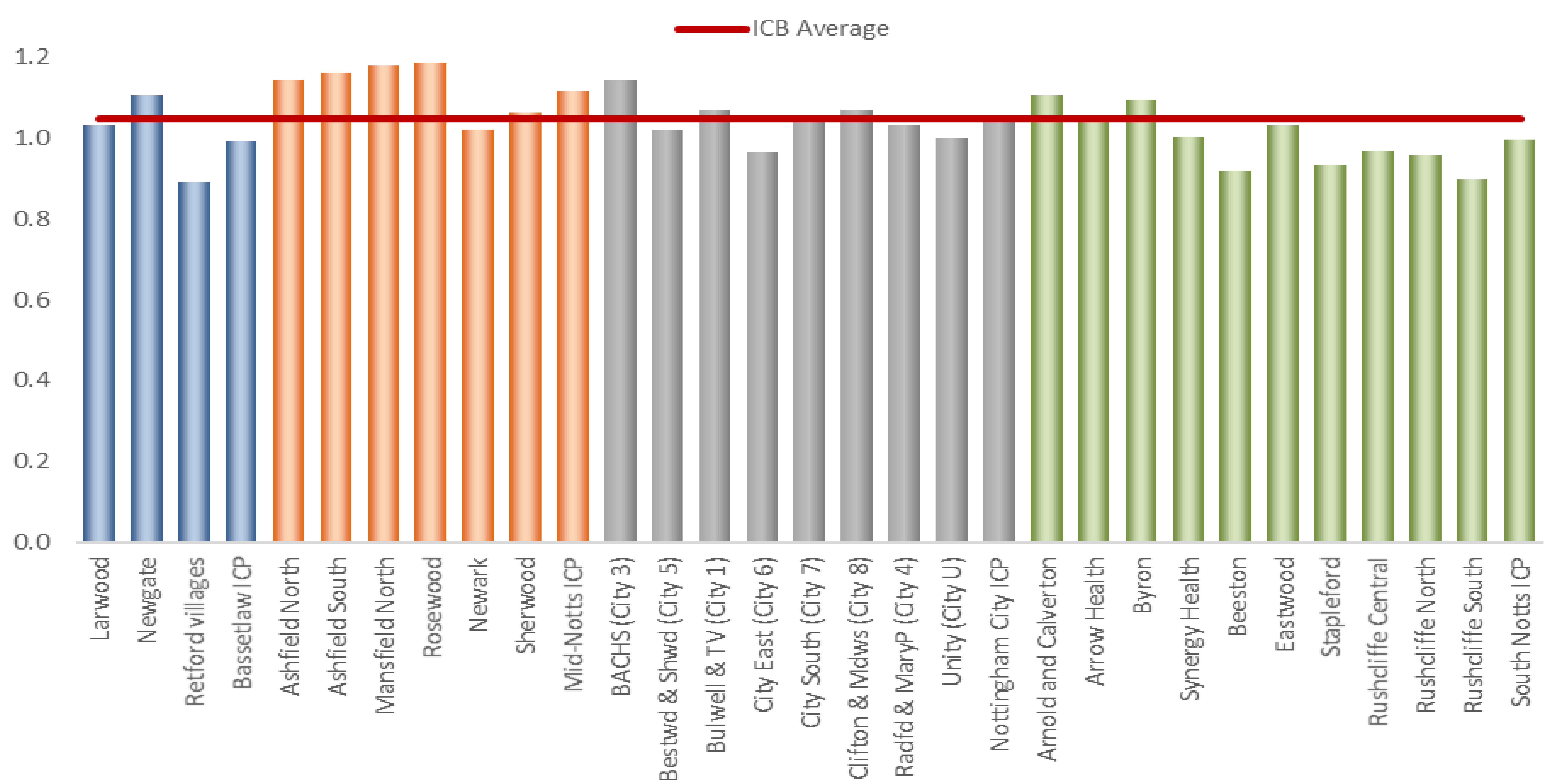
End of life | Nottingham & Nottinghamshire ICB | All PCNs

Bassetlaw | Mid Notts | Nottingham City | South Notts

% of EoL patients with a ReSPECT form

ICB Average: 70.2%

PCN	%
Byron	84.1%
Ashfield North	80.3%
Rushcliffe	79.4%
Nottingham West	78.7%
Bestwood & Sherwood	77.7%
Arrow Health	76.8%
Arnold & Calverton	76.1%
Synergy Health	75.5%
Newark	73.7%
Sherwood	73.5%
Bulwell & Top Valley	72.7%
Rosewood	72.2%
Newgate Medical Group	72.1%
Clifton & Meadows	71.9%
City South	69.6%
Ashfield South	69.5%
Aspire	59.0%
Nottingham City East	58.9%
Larwood & Bawtry	57.3%
Retford And Villages	50.3%
Mansfield North	49.0%
Raleigh	47.1%
Radford & Mary Potter	16.0%


Ratio of Emergency Admissions within 90 days of death to number of deaths in last 12 months
ICB Average
1.4
1.2
1.0
0.8
0.6
0.4
0.2
0.0
Larwood
Newgate
Retford villages
Bassetlaw ICP
Ashfield North
Ashfield South
Mansfield North
Rosewood
Newark
Sherwood
Mid-Notts ICP
BACHS (City 3)
Bestwd & Shwd (City 5)
Bulwell & TV (City 1)
City East (City 6)
City South (City 7)
Clifton & Mdws (City 8)
Radfd & MaryP (City 4)
Unity (City U)
Nottingham City ICP
Arnold and Calverton
Arrow Health
Byron
Synergy Health
Beeston
Eastwood
Stapleford
Rushcliffe Central
Rushcliffe North
Rushcliffe South
South Notts ICP

Data Intelligence - NHS Future, EOL Workspace

the gold standards framework®

OHID Data packs

The ICS Palliative Care and End of Life Data Packs, have been designed by Office for Health Improvement and Disparities (OHID) in partnership with NHSE. These data packs have been designed to support ICSs to better understand and interpret data, including information on health inequalities. The packs will support ICSs to undertake a needs assessment and to improve palliative and end of life care services.

Sort by Name

- East of England
- London
- Midlands
- North East and Yorkshire
- North West

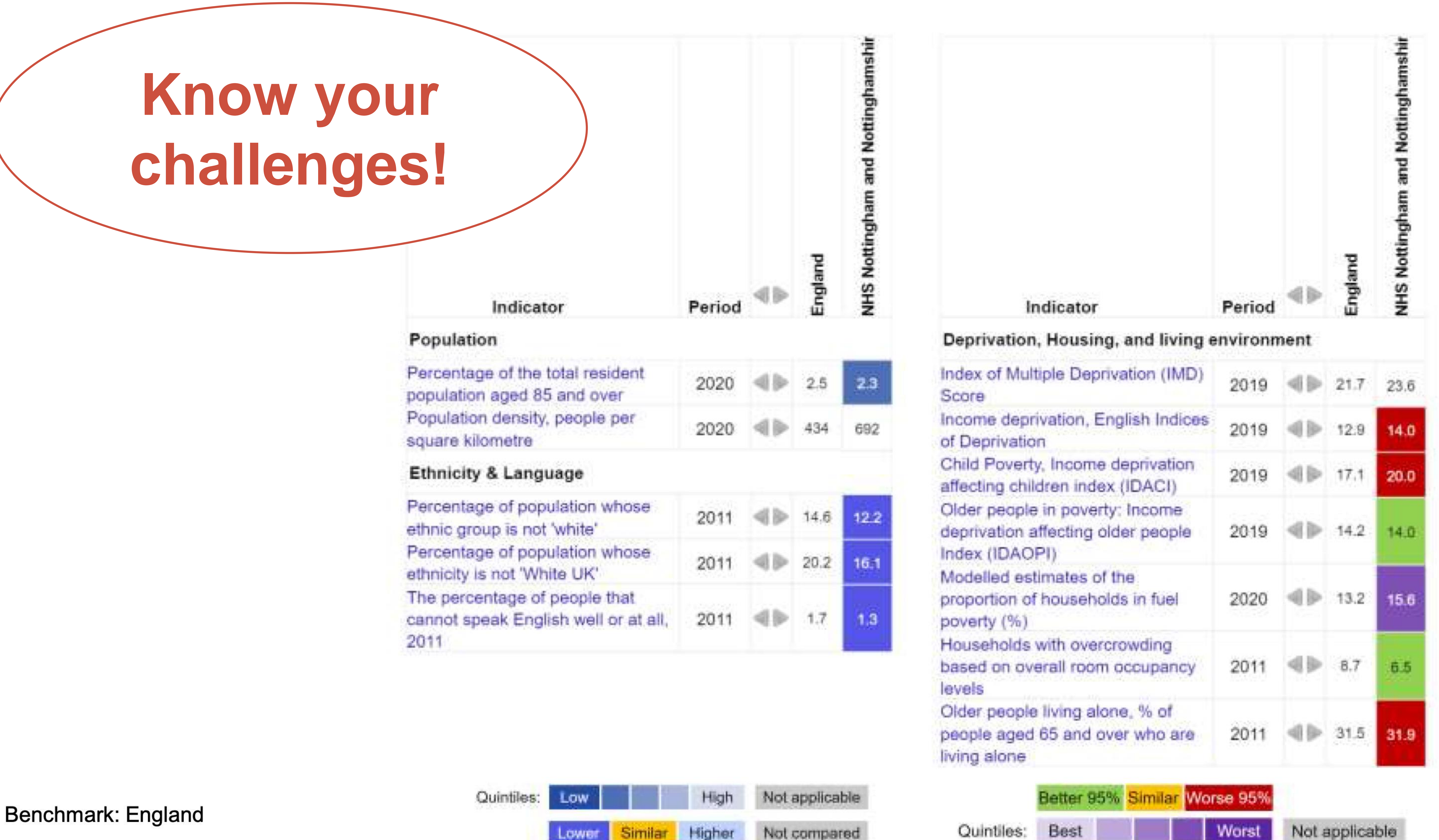
Office for Health Improvement & Disparities

ICS Data Pack: Palliative and end of life care

Nottingham and Nottinghamshire Health and Care

Published 7 March 2023
Version 2

Needs assessment: Inequalities between CCG populations



Indicator	Period	England	NHS Nottingham and Nottinghamshir
Population			
Percentage of the total resident population aged 85 and over	2020	2.5	2.3
Population density, people per square kilometre	2020	434	692
Ethnicity & Language			
Percentage of population whose ethnic group is not 'white'	2011	14.6	12.2
Percentage of population whose ethnicity is not 'White UK'	2011	20.2	16.1
The percentage of people that cannot speak English well or at all, 2011	2011	1.7	1.3

Indicator	Period	England	NHS Nottingham and Nottinghamshir
Deprivation, Housing, and living environment			
Index of Multiple Deprivation (IMD) Score	2019	21.7	23.6
Income deprivation, English Indices of Deprivation	2019	12.9	14.0
Child Poverty, Income deprivation affecting children index (IDACI)	2019	17.1	20.0
Older people in poverty: Income deprivation affecting older people Index (IDAOPI)	2019	14.2	14.0
Modelled estimates of the proportion of households in fuel poverty (%)	2020	13.2	15.6
Households with overcrowding based on overall room occupancy levels	2011	8.7	6.5
Older people living alone, % of people aged 65 and over who are living alone	2011	31.5	31.9

Benchmark: England

Available from the OHID Local Health Profile

Mansfield North

Information Pack

Palliative Care / End of Life

PCN Data as at 04/08/2023	EOL Register	On EOL register and no preferred place of death recorded	% with no preferred place of death recorded
Meden Medical Services	115	85	73.9%
Oakwood Surgery	275	230	83.6%
Orchard Medical Practice	105	55	52.4%
Pleasley Surgery	15	5	33.3%
Sandy Lane Surgery	50	30	60.0%
St Peters Medical Practice	10	5	50.0%
Mansfield North	570	410	71.9%
Mid Notts	2,890	1,660	57.4%
Data rounded to the nearest 5			

August 2023

PCN Data as at 04/08/2023	EOL Register	On EOL register and no preferred place of death recorded	% with no preferred place of death recorded
Ashfield North	475	235	49.5%
Ashfield South	295	155	52.5%
Mansfield North	570	410	71.9%
Rosewood	305	160	52.5%
Newark	705	370	52.5%
Sherwood	540	330	61.1%
Mid Notts	2,890	1,660	57.4%
Data rounded to the nearest 5			

To identify missing patients see eHealthScope – workflow – EOL management

Accessing and Using the 'EPaCCS' template

Fill in different pages depending on what stage patient is at, (tabs at the top)

Tick the GSF stage prognosis box as appropriate. This records that they are on the EPaCCS register

EPaCCS | Initial information | Blue stage | Green stage | Amber stage | Red stage | After Death | Change log

Advance Care Planning

GSF stage A (blue) - year plus prognosis ☐ Advance Care Planning

This is me alzheimers.org.uk

Notts EOL Toolkit

Personalised Care and Support Assessment F12

Accessible Information Standard F12

Record Allergy or Sensitivity | View Allergies and Sensitivites | View PPC / PPD status

Preferred place of care — Discussed with patient ☐

Preferred place of death — Discussed with patient ☐

Indicators

Moderate frailty ☐

Severe frailty ☐

Dementia ☐

Multiple organ failure ☐

Clinical Frailty Scale F12

MHSOP & Dementia F12

Click the link at the bottom of page to access a new 'ReSPECT' form

ReSPECT / DNACPR

Resuscitation discussed: with Patient ☐ with Carer ☐

Blank ReSPECT Form

What Matters Most

Sharing Advance Care Plans & TEPs

the gold standards framework®

Thinking Ahead - Advance Care Planning Discussion

Advance Care Planning Tool v 1

GSF Advance Care Planning Discussion Paper

We wish to be able to provide the best care possible for all residents and their families, but to do this we need to know more about what is important to them and what are their needs and preferences for the future.

The aim of any discussion about thinking ahead, often called an Advance Care Planning Discussion, is to develop a better understanding and recording of their priorities, needs and preferences and those of their families/carers. This should support planning and provision of care, and enable better planning ahead to best meet these needs. This philosophy of 'hoping for the best but preparing for the worst' enables a more proactive approach, and ensures that it is more likely that the right thing happens at the right time.

This example of an Advance Statement should be used as guide, to record what the patient DOES WISH to happen, to inform planning of care. In line with the new Mental Capacity Act, this is different from a legally binding refusal of specific treatments, or what a patient DOES NOT wish to happen, which is called an Advance Decision (sometimes previously called a Living Will).

Ideally an Advance Care Plan should be discussed to inform future care at an early stage, preferably on admission to a home. Due to the sensitivity of some of these issues, some may not wish to answer them all, or may quite rightly wish to review and reconsider their decisions later. This is a 'dynamic' planning document to be adapted and reviewed as needed and is in addition to Advanced Directives, Do Not Resuscitate plan, or other legal document.

Patient Name:	Date completed:
Address:	Care Home:
	GP Details
…B: Hosp / NHS no:	Hospital contact:

Family members involved in Advance Care Planning discussions:

Name: **Contact tel:**

Name of healthcare professional involved in Advance Care Planning discussions:

Role: **Contact tel:**

Patient signature	Date
Next of kin / carer signature (if present)	Date
Care home / Healthcare professional signature	Date
Review date:	

ACP Feb 2010 vs 192 (3) - © National Gold Standards Framework Centre England 2008 Date: March 09

ReSPECT Recommended Summary Plan for Emergency Care and Treatment for:

Preferred name: Sample

SAMPLE FORM

1. Personal details

Full name: Sample name	Date of birth: 1.1.1972	Date completed: 1.1.2006
NHS/CHI/Health and care number: 45449845616651	Address: John house, Leamington, cv231xx	

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Medical history: hypertension

Current issues: COVID 19

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

None in place

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort — Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

Prioritise sustaining life – 'whatever it takes I need to get through this I have a young family that are dependent on me' (patient's words)

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below (clinician signature) — Focus on symptom control as per guidance below (clinician signature)

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

For hospital admission if becomes unwell.

Should be for all interventions to sustain life:- for all active treatment, for full escalation to intensive care setting if required. For full resuscitation attempts.

CPR attempts recommended Adult or child	For modified CPR Child only, as detailed above	CPR attempts **NOT** recommended Adult or child
clinician signature	clinician signature	clinician signature

Version 2.0 © Resuscitation Council UK, 2017

Integrated GSF Cross-boundary pro-active care makes a big difference !

	Number of patients on EPaCCS	total ed attendance	Average number of attendances per person
19/20	2,551	5,304	2.08
20/21	2,653	4,240	1.60
21/22	2,843	3,433	1.21

Reduced hospital transfers

	Number of patients on EPaCCS	Total admissions	Average number of admissions per person
19/20	2,551	3,467	1.36
20/21	2,653	2,822	1.06
21/22	2,843	2,032	0.71

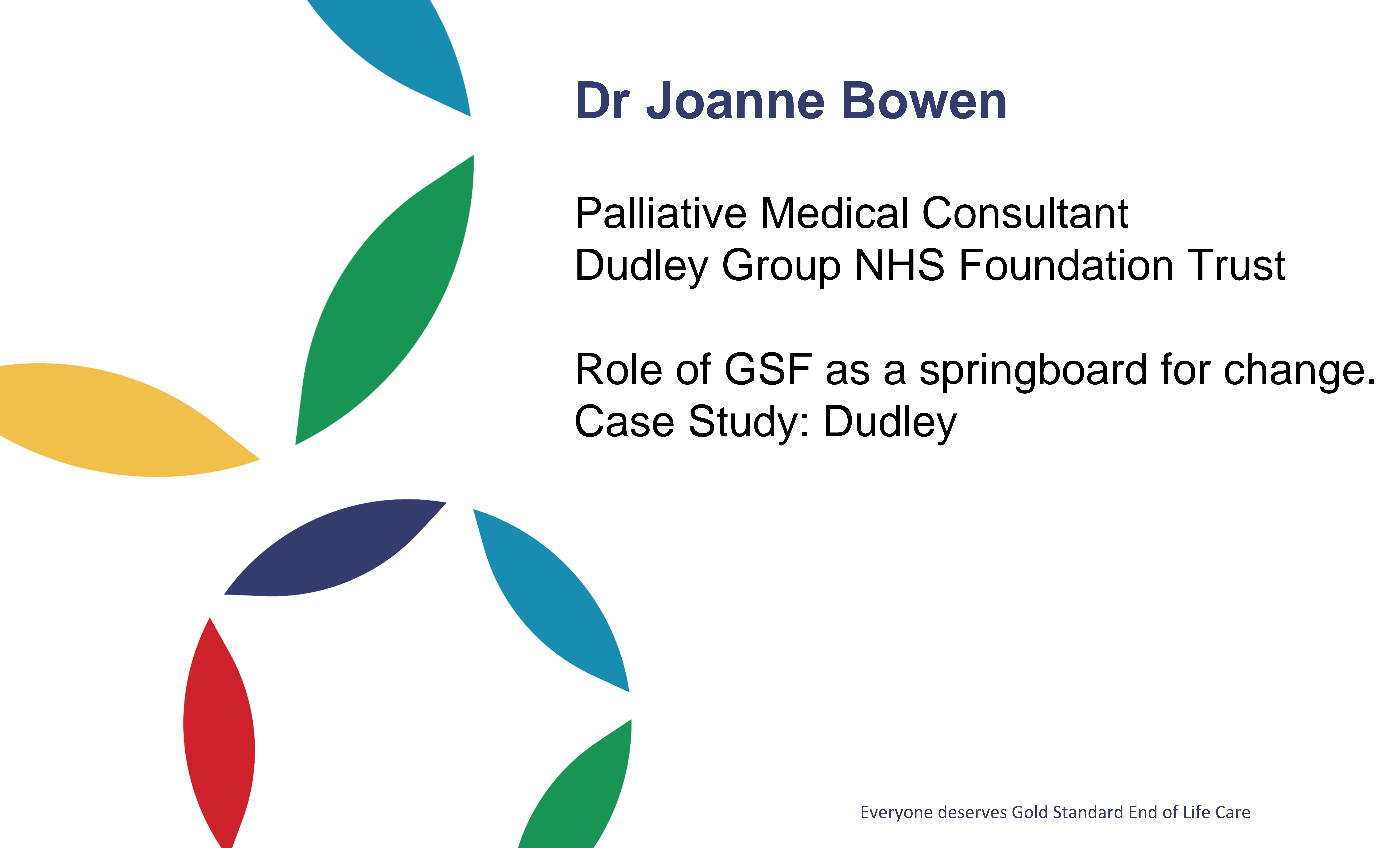
Reduced emergency admissions

Brave conversations, brave decisions

Just because we can, doesn't mean we have to: a holistic approach is needed

Limited resources : prioritisation is needed more than ever - benefit more people for less expenditure; avoid unnecessary interventions having identified what matters most to our patients.

Questions?


Dr Joanne Bowen
Palliative Medical Consultant
Dudley Group NHS Foundation Trust
Role of GSF as a springboard for change.
Case Study: Dudley
Everyone deserves Gold Standard End of Life Care

Gold standards
Framework
Dr Joanne Bowen
NHS
The Dudley Group
NHS Foundation Trust
THANK YOU
NHS
CARE
RESPECT
RESPONSIBILITY

Ambition in 2018

Date:
Date of Birth:
NHS Number:

NHS

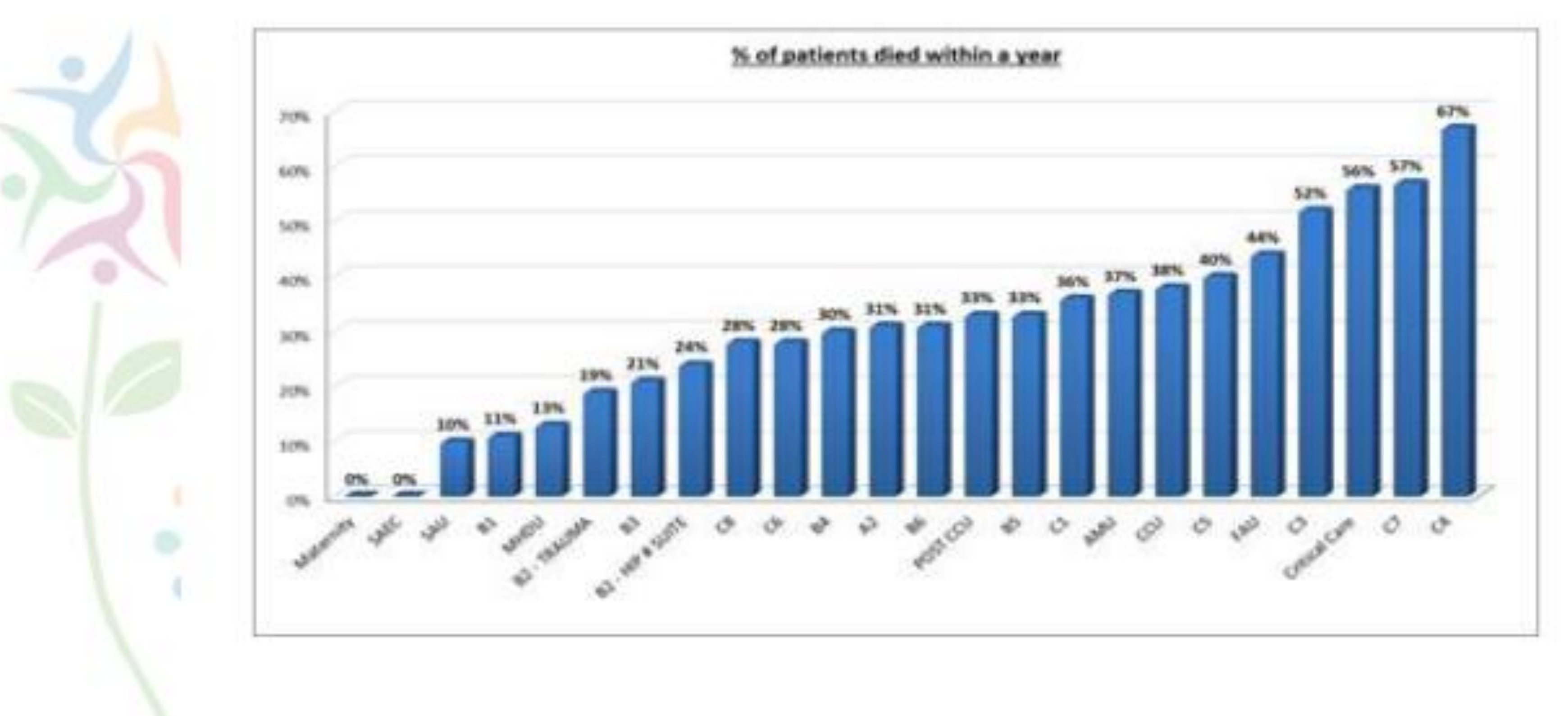
Planning for your future care

Patient's own property
Hand-held record of preferences for care

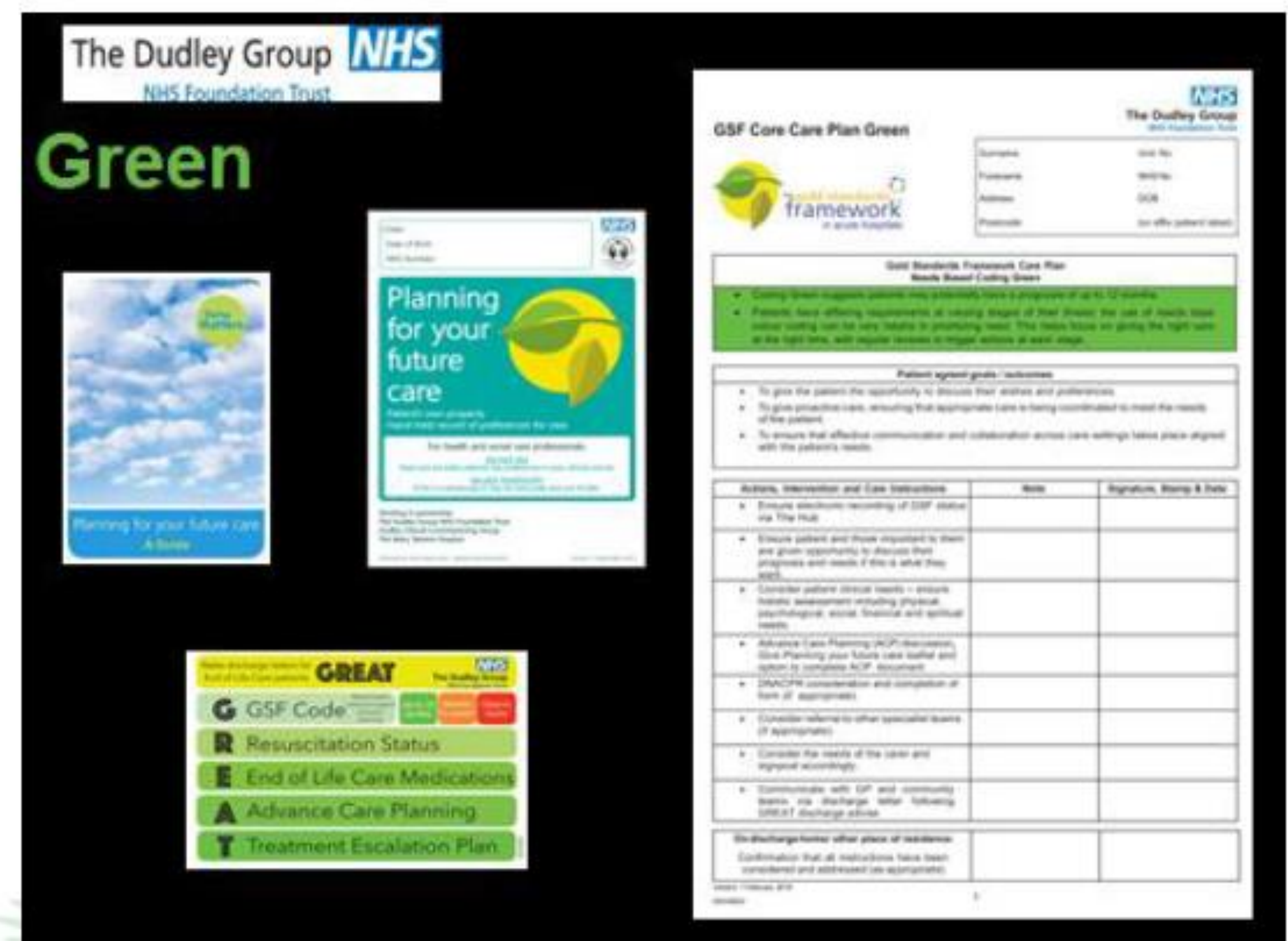
For health and social care professionals:
DO NOT FILE
Read and annotate patient's key preferences in your clinical records
DO NOT PHOTOCOPY
If this is a photocopy it may be inaccurate and out of date.

Working in partnership
The Dudley Group NHS Foundation Trust
Dudley Clinical Commissioning Group
The Mary Stevens Hospice

585 Inpatients on 03/06/2018, 197 (34%) patients died within 12 months.



Involvement



End of Life Care - Gold Standards Framework

☐ **Click here to access the Gold Standards Framework guidance on the intranet**

GSF Code
- ○ GREEN (up to12 months)
- ○ AMBER (months / weeks)
- ○ RED (days / hours)
- ○ NOT APPLICABLE

Advance Care Plan offered ○ Yes ○ No

Priorities for Care of the Dying Person communication document commenced ○ Yes ○ No

Preferred place of care
- ☐ Own home
- ☐ Care home
- ☐ Hospital
- ☐ Hospice
- ☐ Other (please specify)

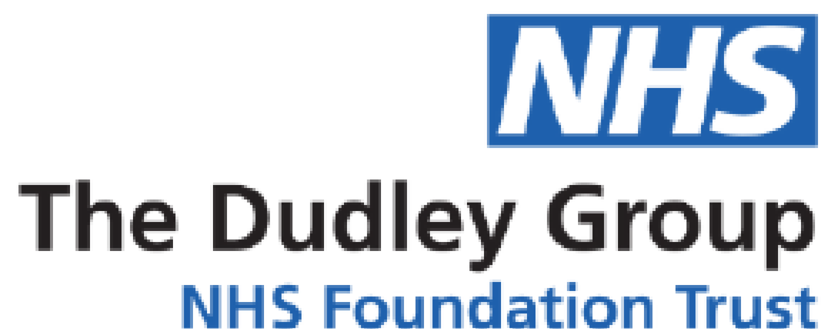
*The preferred place of care options will be displayed in the output in the order they are selected from the list (order of preference) - **Ensure only a maximum of two options are selected.***

Comments

EPR June 2021

EWS	Sepsis Screen	Vital Signs	Vital Signs Due	Escalation	Cap Glucose	VTE Due	Antibiotic Review	Pharmacy Intervention	GSF
					target	07 Oct, 23:32	09 Oct!!		
			00:02	CPR CRIT MET CP/NIV LVL2	11.3 - Borderline	Review: Sun 02 Oct, 13:54			
			-06:13		6 - In target	Review: Wed 05 Oct, 23:38			
			03:59	CPR CRIT MET CP/NIV	5.7 - In target	Review: Wed 28 Sep, 18:51		Complete ✓	
			03:05	CPR CRIT	7.3 - In target	Completed			
			00:00			Completed	Levofloxacin: Wed 12 Oct		

Vital Signs Due	Cap Glucose	VTE Due	Antibiotic Review	Pharmacy Intervention	Escalation	GSF
08:54	4.3 - In target	Review: Sun 09 Oct, 13:03				
01:07	5.9 - In target	Review: Thu 06 Oct, 15:12				
02:42	5.8 - In target	Review: Sun 09 Oct, 14:20	Amoxicillin: Wed 12 Oct		CPR CRIT MET	
06:57	7.3 - In target	Review: Sat 08 Oct, 19:20				
02:43		Review: Sun 09 Oct, 19:11	Benzylpenicillin injection: Wed 12 Oct			



Gold Standard Framework Key Performance Indicators

Metric	Target	% Achieved November 23	% Achieved December 23	% Achieved January 24
% GSF identified	30%	15.6%	16.2%	15.8%
% Hospital deaths with GSF Amber or red	60%	61%	68%	62%
% GSF red or amber achieve preferred place of care on discharge/death	60%	57%	49%	57%

Snapshot of inpatients in last year of life on 01/04/2022			
Adult Ward	**No of inpatients on ward on 01/04/2022**	**No of those patients who died over 12 months from 01/04/22 (died in any setting)**	**% of patients who died over 12 months from 01/04/22 (died in any setting)**
1	18	11	61%
2	23	14	61%
3	39	23	59%
4	24	14	58%
5	7	4	57%
6	20	11	55%
7	24	10	42%
8	50	19	38%
9	16	6	38%
10	38	14	37%
11	42	15	36%
12	52	18	35%
13	25	7	28%
14	47	13	28%
15	23	6	26%
16	15	3	20%
17	31	6	19%
18	29	4	14%
19	35	4	11%
20	37	4	11%
21	19	1	5%
Total across adult inpatient wards	**614**	**207**	**34%**

Number of deaths in ward area over year from 01/04/22-31/03/23		
Adult Ward	**Total Deaths over 12 months**	**% Identified AMBER/RED by ward area**
12	256	68%
16	182	53%
8	126	68%
10	125	85%
17	113	35%
3	110	65%
11	98	62%
2	88	39%
14	83	72%
4	74	77%
6	56	82%
18	55	47%
5	49	45%
20	47	47%
9	47	81%
1	44	73%
13	33	61%
15	30	47%
19	22	50%
7	20	40%
21	11	73%
	1669	Total % of hospital deaths identified GSF Red or Amber 61%

9 wards/areas GSF accredited:

- C3
- FMNU
- C8
- C1a
- B6
- C4
- C7

First accredited in the country:

- CCU
- Critical care
- Rapid response team

Working toward accreditation in 2024:

- C5
- C6

Discharge

GSF SOP

Gold Standard Framework

GSF Code: AMBER

Resuscitation Status: For CPR - pt strongly prefers this option. For further discussion with GP

Medications: Prescribed anticipatory medication

Advanced Care Plan: Wife looks after him.
Has 4 young children under 10. Has been provided fire fly leaflet, children with parents with cancer and preparing children for loss. Memory box and letter writing discussed.

Treatment Escalation Plan: KB would wish presently to trial SC anticipatory medications were the Ryles tube to come out at home before considering re-insertion if medications are insufficient.

National Audit of Care at the End of Life 2022/23
Key findings at a glance

NC064 - The Dudley Group NHS Foundation Trust

*UK refers to the findings for England and Wales

(CNR – Cat 1)

84%
UK 87%
Case notes recorded that the patient might die within hours or days

(CNR– Cat 1)

92%
UK 95%
Case notes, with an individualised plan of care, recorded a discussion (or reason why not) with the patient regarding the plan of care

(CNR – Cat 1)

100%
UK 98%
Case notes recorded a discussion (or reason why not) with families/carers regarding the possibility the patient may die

(QS)

48%
UK 54%
Families/carers were asked about their needs

(QS)

64%
UK 71%
Families/carers felt the quality of care provided to the patient was good, excellent or outstanding

(H/S)

Yes
UK 60%
Hospitals have face-to-face specialist palliative care service available 8 hours a day, 7 days a week

(CNR – Cat 1)

86%
UK 87%
Case notes recorded extent patient wished to be involved in care decisions, or a reason why not

(CNR – Cat 1)

90%
UK 76%
Case notes recorded an individualised plan of care

(CNR – Cat 1)

90%
UK 79%
Case notes recorded patient's hydration status assessed daily once dying phase recognised

(SRM)

88%
UK 85%
Staff feel confident they can recognise when a patient might be dying imminently

90%
UK 82%
Staff feel supported by their specialist palliative care team

89%
UK 83%
Staff feel they work in a culture that prioritises care, compassion, respect and dignity

Impact of Gold Standards Framework Accreditation on Specialist Palliative Care Referrals; addressing inequalities in access.

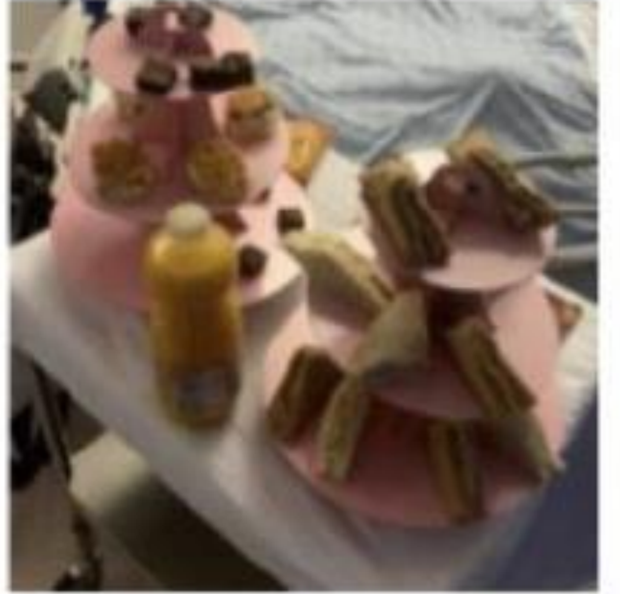
Graph 1: The proportion of referrals to Hospital Specialist Palliative Care by disease group over 16 month period

90%
80%
70%
60%
50%
40%
30%
20%
10%

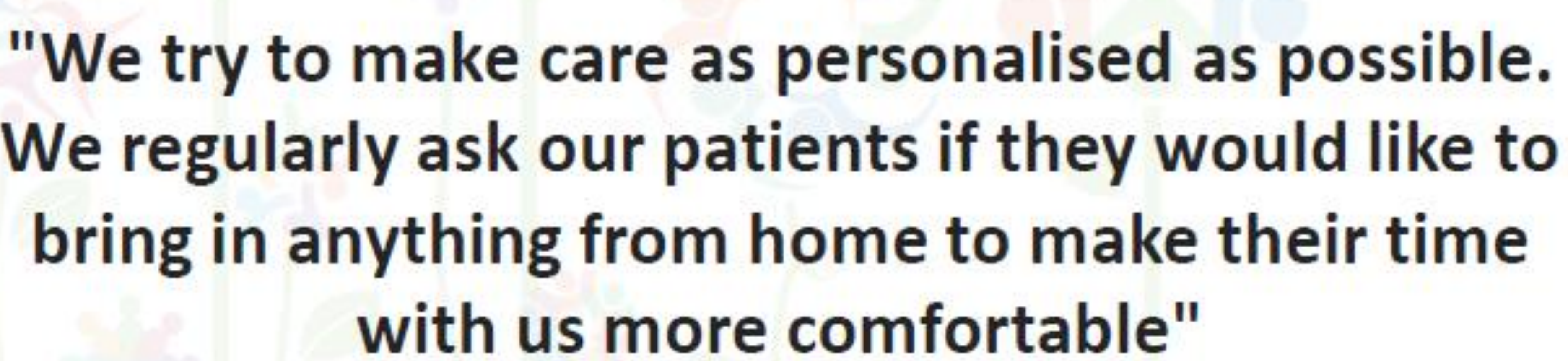
Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23

Cancer Non-Cancer

"A lovely Nurse and Care Support Worker organised a wedding for a terminal patient. We often have priests come on to the ward and pets visit to see their owners for one last time"



"We had a gentleman recently who was end of life, his wish was to see his dog. The dog stayed over night tucked up in the bed under his owner's arm"



"We try to make care as personalised as possible. We regularly ask our patients if they would like to bring in anything from home to make their time with us more comfortable"

"A Doctor recently painted the nails and moisturised the hands of a dying lady as part of her final wishes, so that her family had a lovely hand to hold"

Questions?

Advance Care Plan Day 2024

Home | National Resources | About | National Conference | News | Contact

https://advancecareplanday.org/

@ACPDay2024

The UK's first national day dedicated to Advance Care Planning. 8th May, 2024

Join at Menti.com with code: **71 22 11 3**

Join at https://www.menti.com/alagc7ipjnuf

Mentimeter

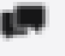
Pose a question for the panel

1/1

Asked on Pose a question for the panel

Do you think Specialist Palliative care teams sometimes de-skill generalist staff? Almost like they don't need to do this as there is another team who will.

✓ Answered



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Please complete our Post-Event Survey:
https://forms.office.com/e/nYGgx7nNN4

To express an interest in GSF Training for your ICS, complete the EOI form:
https://forms.office.com/e/FpX5Z2je7T

Join at Menti.com with code: **71 22 11 3**

Join at https://www.menti.com/alagc7ipjnuf

Mentimeter

And finally - what key thing will I do as a result of today's event?

11 responses

- Forward learning and feedback to team and implement as part of our regular GSF meeting
- Sharing ideas of best practise, helping empower workforce in liverpool
- Start a newsletter
- Share with my team.
- Improve my interventions with patients. Encourage and facilitate development of the team following learning
- Check the key messages against our local strategy
- Ensure our SMT are informed to make the difference and support the clinicians and patients to provide high quality care
- share learnings from today with colleagues
- Look into GSF Accreditation for the
- Feedback to team
- Review our spend on high expense low value care & consider how it can be best reinvested in front line EOL care

ICS Offer

- Commissioning a provider organisation/s to join a GSF programme (Hospitals, PCN, Care Homes, Domiciliary Care Agencies, Retirement Villages or Prisons)

- EOLC roadshow - awareness raising event across the ICS

- Bespoke training tailored to ICS needs and requirements

- ICS Accreditation

the gold standards framework®

Thank you for joining us today.

FOLLOW US:

Everyone deserves Gold Standard End of Life Care