Gold Standards Framework (GSF) IMPACT assessment

Prof Keri Thomas OBE Founder and Chair

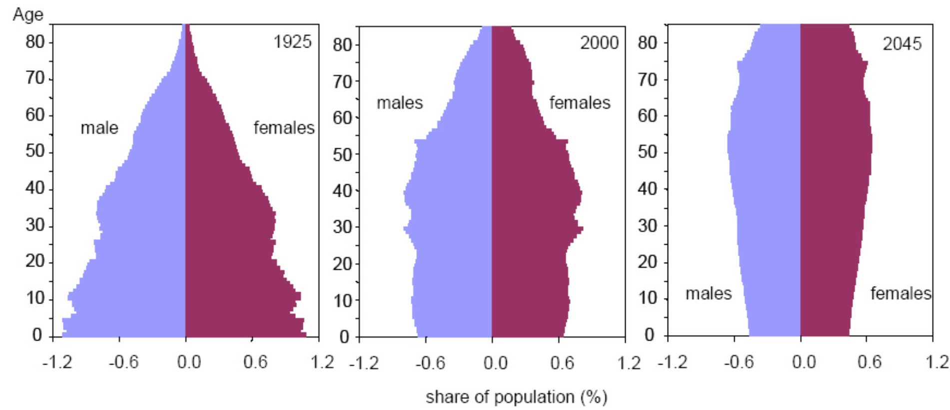
Everybody deserves Gold Standard care at the end of their life.

Context *'A Perfect Storm could shipwreck the NHS'* Health Minister

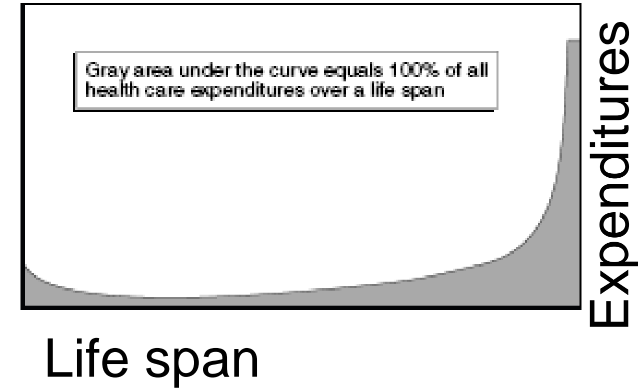
-The aging population , increasing multi-morbidities & complexity + costs

The Ageing Population

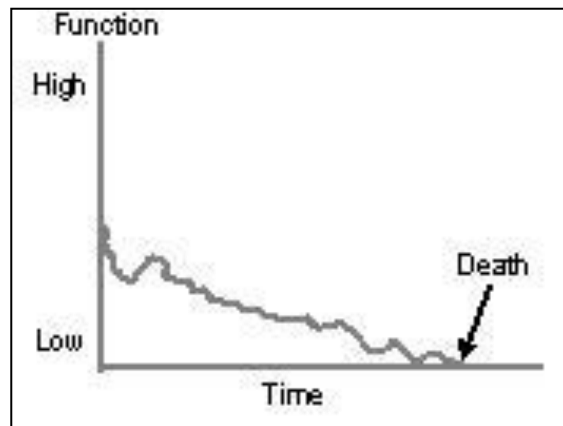
1% population die/ year- increasing in future

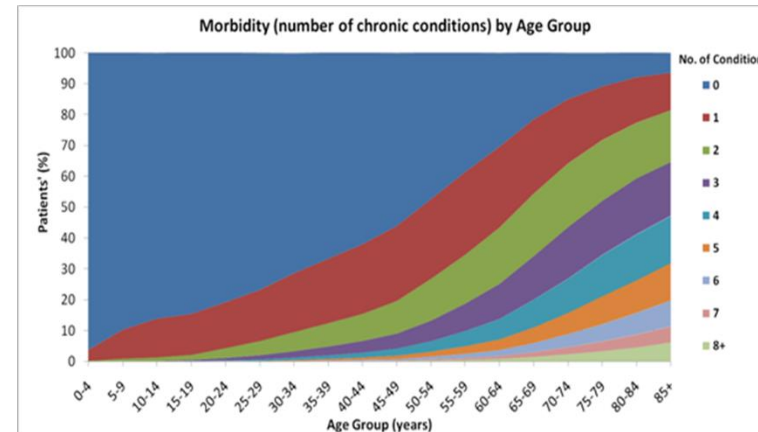


Increasing costs



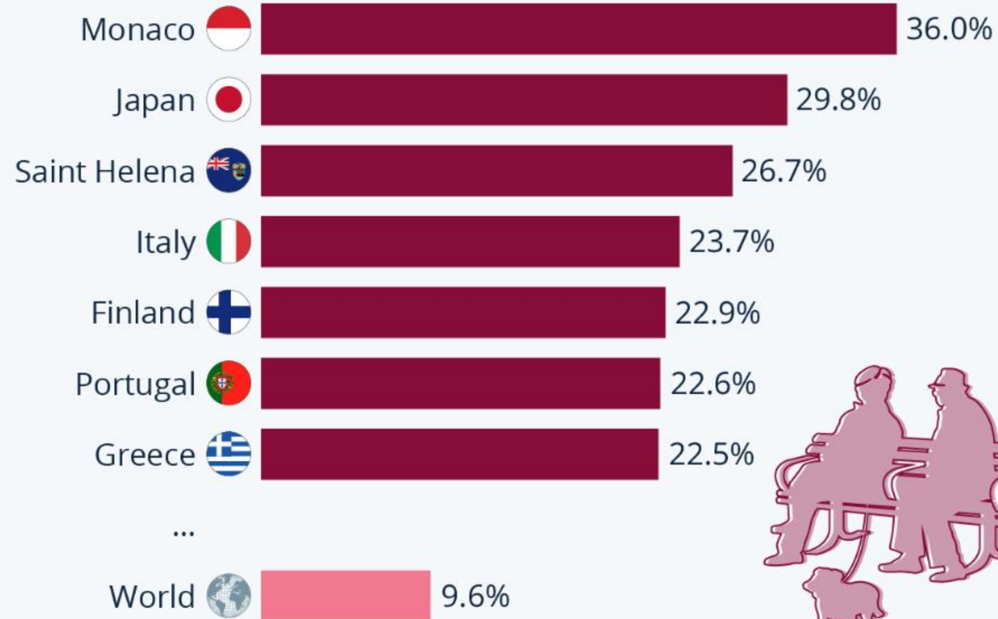
Dementia, Frailty and increasing multi-morbidities are the biggest killers

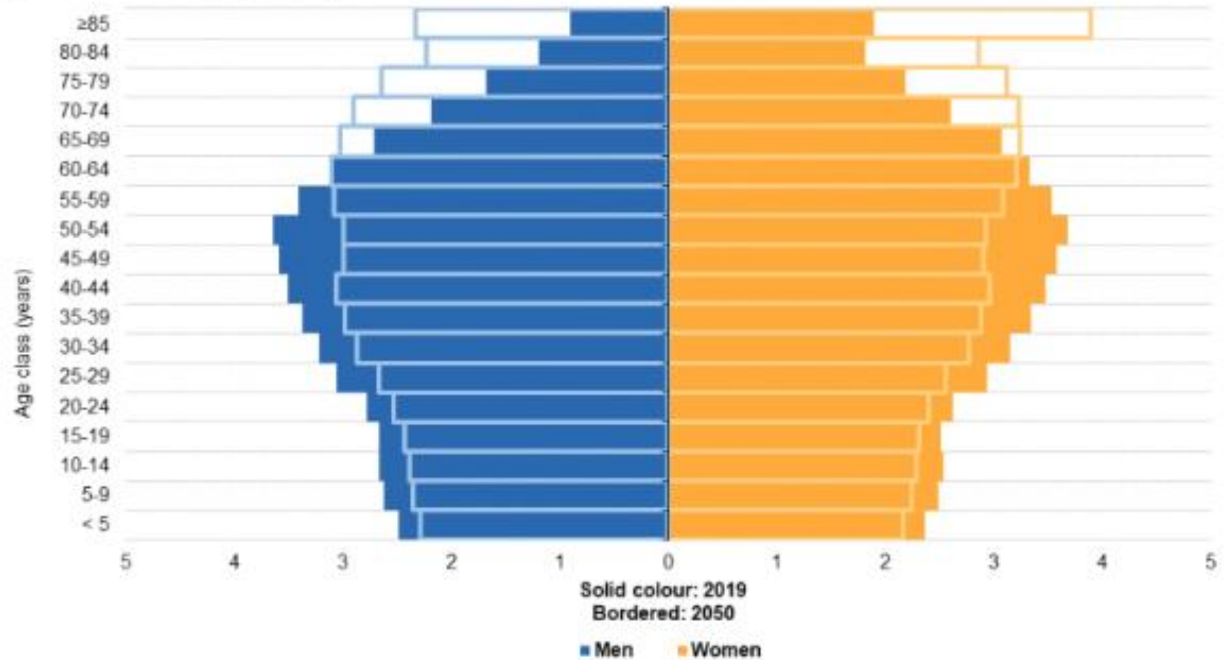




Super Aged Society

with over a fifth are 65 or over





Health in Ageing Society

UK's Chief Medical Officer Report 2023

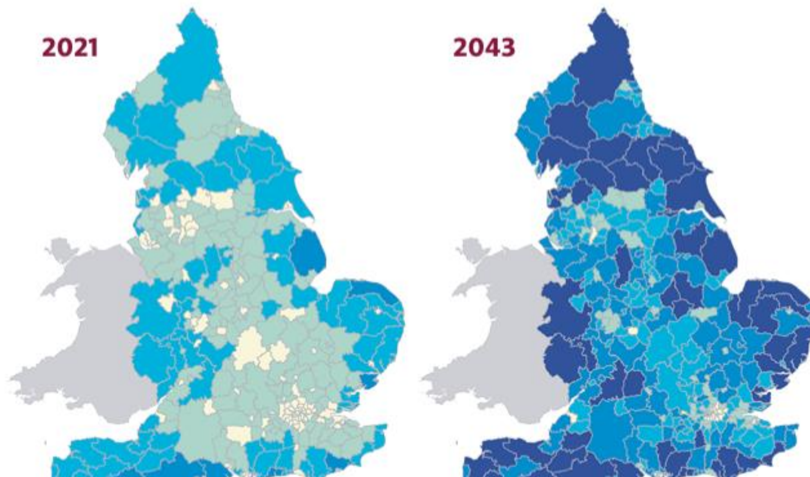
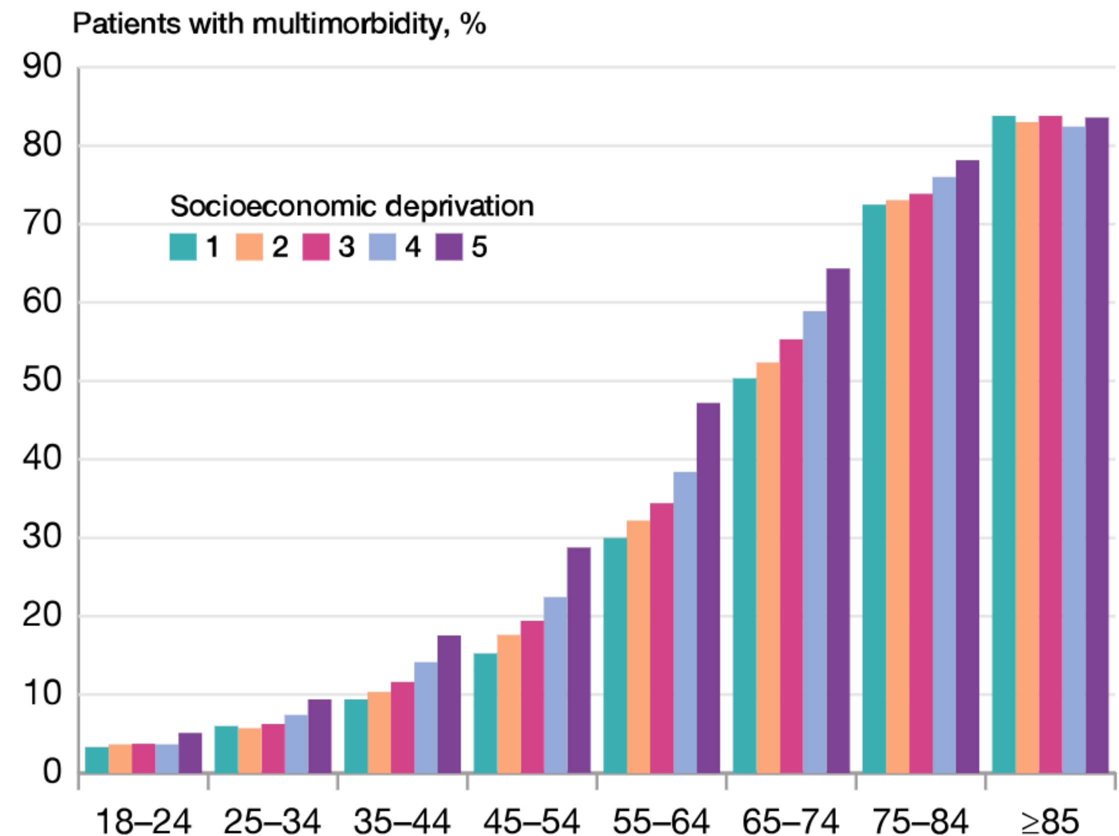


Figure 4: prevalence of multimorbidity (2 or more conditions) by age and deprivation

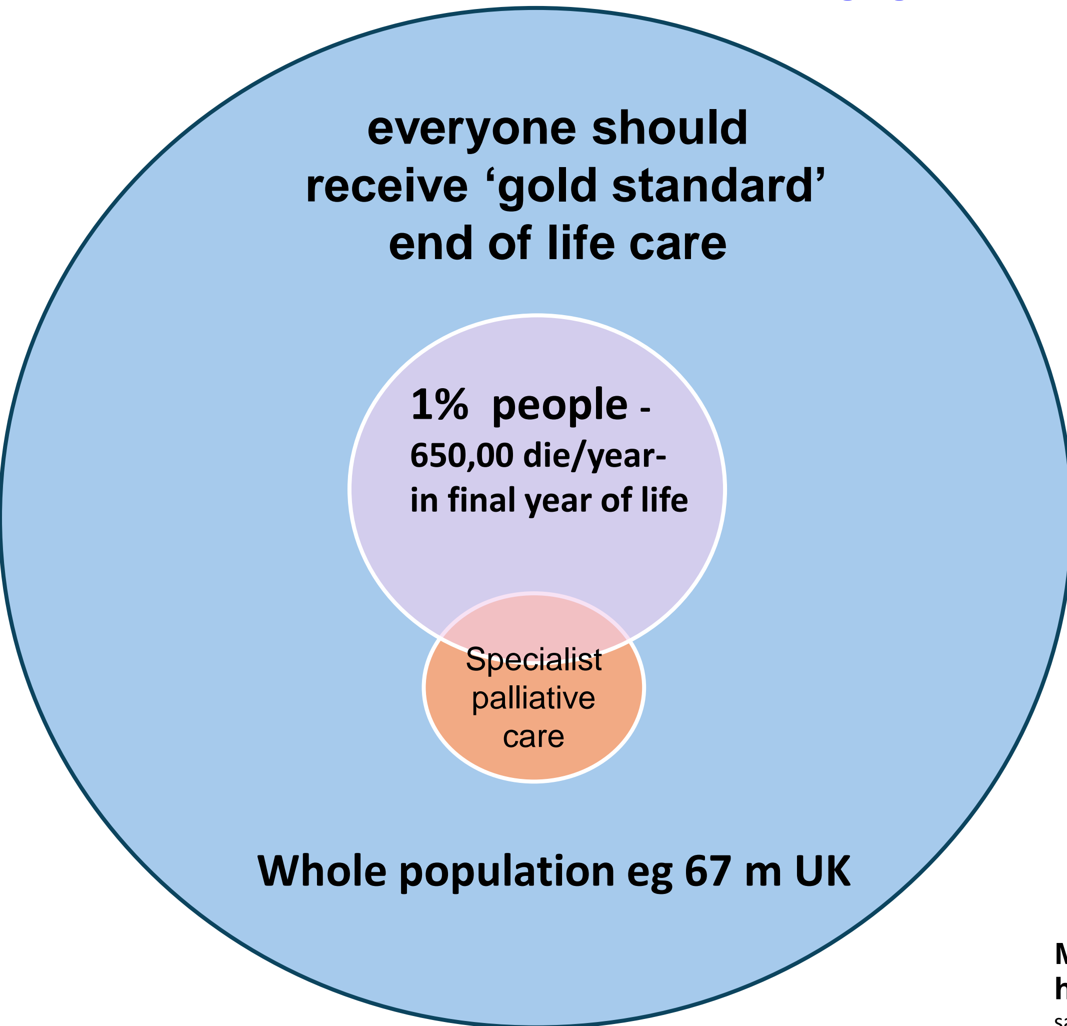


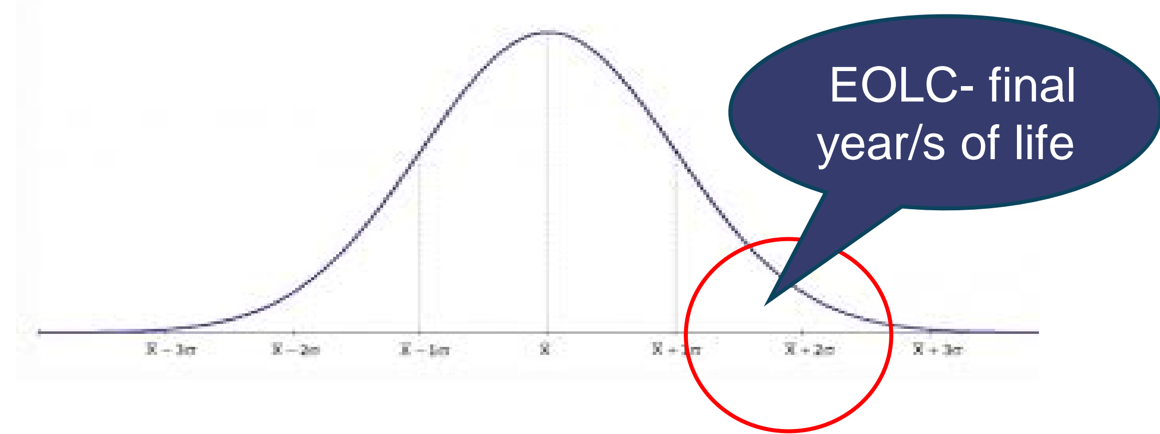
End of Life care in Numbers (UK)

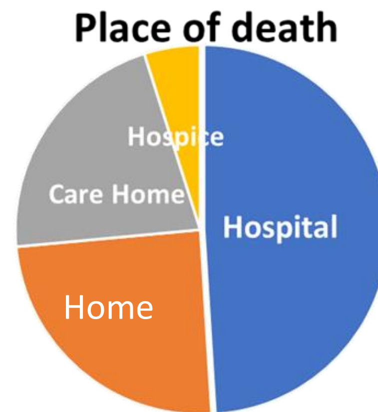
1. **About 650,000 die/ year - estimated 25%** more deaths in the next 20 years.
2. **85%** of deaths occur in people over 65
3. **Most die** from age-related conditions - dementia , frailty, multi-morbidities ,cancer IHD etc **75%** non-cancer
4. **44%** people die in hospital ,29% home,20% care home 4%hospice (2021)
5. **Most people (60-70%**) do not die where they choose
6. **A third** of the NHS budget is used by people in their last year of life (*how well spent is it? Estimated £1bn wastage due to crises/ inappropriate?)*
7. People in their last year of life? Can we identify them?
   - **1%** of population (650,000), **30%** hospital patients, **80%** care home residents
8. **10%** admissions almost 1/3 rd emergency admissions **and 25% hospital bed days** are for people in last year of life- most have 3 unplanned admissions
9. **40%** hospital admissions care homes residents could be avoided – eg by upskilling workforce
10. **Workforce** – Most care is given by generalist frontline staff -(**3** million generalists) **10,000** specialists

How often do your patients die? Once!

Whole-system Population-based approaches to EOLC







Most people dying in care homes and homes by 2040. – needs more support
sagepub.com/doi/10.1177/0269216317734435

Quality end of life care for all

- **any condition**
- **in any setting**
- **given by any care provider**
- **1% population**
- **30% hospital patients**
- **80% care homes residents**

NEEDS-BASED Starting with the person's needs – not the service provided ?

Key Messages 1

The number of people requiring end of life care is rising	In England the number of deaths each year has been increasing over the decade prior to the COVID-19 pandemic[1], and are projected to rise over the coming years.[2]
	In 2021 over 51% of deaths were people 80 years and older. 82% of deaths were people aged 65 years and over, this is projected to increase to 91% in 2040.[3]
	By 2050, it is projected that one in four people in the UK will be aged 65 years and over - an increase from approximately one in five in 2019.[3]
Early identification and planning improves end of life care	Enhanced primary care and compassionate community models can be associated with reductions in unplanned admissions to hospital, with a decrease in healthcare costs.[4]
	Early palliative care can lead to improvements in both quality of life and mood, less aggressive care at the end of life and longer survival.[5]
	Effective identification of frail patients in or approaching the last 12 month of life can improve care.[6, 7]
Good end of life care needs to be provided across all settings	Good care needs to be in every setting – in 2021 the setting for deaths in England was hospital 44%, home 29%, care home 20%, hospice 4%, other places 3%.[8]
	26% of people rated the care and support provided to the person who died in hospital as only fair or poor.[9]
	Home deaths are increasing[10], so more quality care and support must be provided in the community.

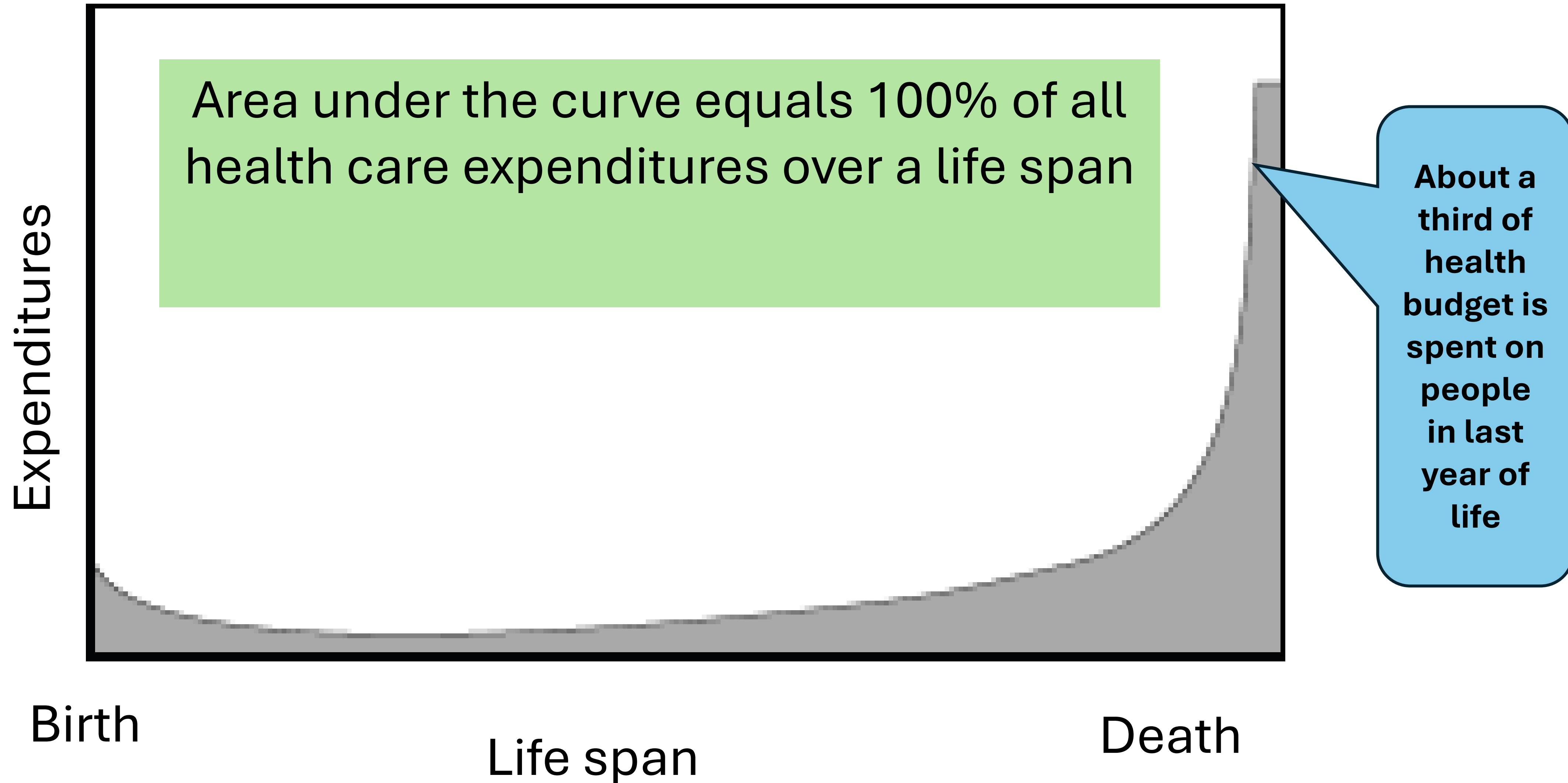
Key to references

Key Messages 2

Geographical variations in end of life care	Out-of-hours palliative and end of life care is currently inadequate and fragmented, and must be better valued, prioritised and strengthened. Services must be developed and provided equitably, irrespective of diagnosis, socio-demographic characteristics (e.g. age, ethnicity) and geographical area.[11]
	Place of death varied between counties and unitary authorities (2021): hospital (35% to 58%), home (23% to 35%), care home (5% to 30%), hospice (1% to 12%), other places (1% to 11%).[8]
	The percentage of people aged 85 years and older who were cared for in a care home when they died ranged from 12.8% to 51.6% across counties and unitary authorities in England.[12]
Inequalities in end of life care services	The NHS Core20PLUS5 approach recognises the need to reduce healthcare inequalities and identifies key actions.[13]
	People living in more deprived communities have: higher hospital versus home deaths; increased use of acute care services in the last 3 months of life; reduced odds of using specialist palliative care services in the last year of life, and are consequently more likely to experience worse care.[14]
	CQC identified a "lack of awareness of people's individual [end of life care] needs is a barrier to good care" mentioning in particular people with a learning disability, the homeless, Gypsies and Travellers.[15]
Workforce	Over recent years insufficient palliative care consultants have been trained to fill vacant consultant posts.[16,17]
	The vacancy rate for community nurses is 12% in England.[18]
	The vacancy rate in adult social care in 2021/22 was the highest since records began in 2012/13 with 65,000 vacant posts, a vacancy rate of 10.7%.[19]

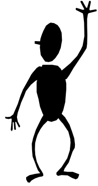
Key to references

Significant Economic Implications



Evaluations and impact measures,

IMPACT Assessment - 4 different levels of change/outcome measures



1. **Individual-** person, family, staff

- **Person-centred care**

2. **Teams/Organisation**

   practice, ward, hospital

- **Proactive care**

3. **Community-** ICBs locality, population area

- **Coordination,**

4. **National-** strategy, policy, regulation,

- **Influence policy and strategy,**

NOTE

Different impact and outcome measures for each level

GSF IMPACT Summary - What difference have we made ?

Impact on staff training

- Over **5,000** teams trained
- About **half a million** staff members trained
- About **2,000 teams** accredited / reaccredited

  - many 5-6th time accredited

Impact on care for people

- **Improved quality of care for millions of people& families**
- **More identified early so *proactive personalised* care**
- **More discussions - advance care planning**
- **more living well and dying where they choose**
- **reduced hospitalisation, fewer crises**
- **Fantastic examplars and frontrunners in all sectors**

Impact nationally & internationally

- UK- part of a national momentum in palliative/end of life care
- **GSF principles** used in all settings, all parts of UK **in policy** eg NHS ,NICE, RCGP and mainstreamed in **primary care**
- Affirming generalists and specialists working together
- Support integration of health and social care , and part of the Coalition of Frontline Care
- UK recognised as world leader in Palliative & EOLC
- The work of **the Andrew Rodger Trust charity** in Africa and **GSF International**– see https://www.gsfinternational.org.uk/

4. IMPACT National

Strategic ,policy, government influence and research-GSF.

- *GSF Centre has so far helped nationally …….*

- **Supported the GPs' Palliative care QOF in 2004 - every GP practice has a proactive GSF/SC register and team meeting (the only country in the world to do so). Each of the 4 nations adopts GSF eg GSF Scotland and covers all GP practices by 2009 (public health data)**
- **Influenced NHS EOLC Strategy 2008 and a key part of the 3 tools proposed by the NHS EOLC Programme**
- **Included in all 3 main parties party manifestos at some stage**
- **NICE Guidance in End of Life Care /Service provision –includes identify, assess (ACP),plan**
- **Academic Research – published papers, evidence pages GSF UK and GSF I websites etc**
- **Continuation of national and local strategic policies**
- **Continued recognition, influence and support by regulator CQC**
- **Integrated / helped influence in NHSE Long Term Plan (sect 1.42)**
- **Recognised by DH, NHSE , Skills for care ,social care UK and internationally**

4. National IMPACT Spread of GSF over 25 years - training generalist frontline staff

- about **5000 teams**/ organisations/ wards trained across all health and social care settings ,
- about **half a million staff** trained ,
- about **2000 accredited** or reaccredited teams (3 yearly)
- **All (8500) UK GP practices** using GSF principles used in QOF since 2004
- 1000s more using GSF principles , many ‘offspring’
- Influence national policy

Coalition of Frontline Care for People Nearing the End of Life

Coalition of Frontline Care for People Nearing the End of Life

Prof Keri Thomas OBE
Founder & Chair GSF Centre UK
& Director GSF International

Prof Martin Green OBE
Chief Executive
Care England

Sarah Mistry
Chief Executive
British Geriatrics Society

British Geriatrics Society
Improving healthcare for older people

Prof Vic Rayner OBE
Chief Executive
National Care Forum

Dr Jane Townson OBE
Chief Executive
Homecare Association

Dr Kirsty Protherough
Director and Chair
Community Hospitals Association

Michael Voges
Chief Executive
Association of Retirement
Communities Operators

The Coalition 3 calls to action-

We, as a coalition of leading health and care frontline organisations, urge you to improve EOLC:

1. **At workforce service level** - to support all frontline generalist staff in health and social care to receive **enhanced training** to provide quality, proactive, compassionate care for people nearing the end of life;
2. **ICB System level** - scale this up in ICBs for **whole-system approaches** to integrated joined-up care; and
3. **Nationally** - policy and CQC **regulation** to support better care for older people nearing the end of life

Keri is co-founder and current Chair of Coalition – sent original Letters to Ministers Sept 23, revised to new Government Aug 24 and preparing draft Coalition Guide ready Oct to include examples of best practice

Other national measures – examples

- ICB dashboards
- PHE fingertips
- Identification rates in GP practices
- Hospital deaths etc
- Dementia leading cause of death
- Care homes admissions from temporary or long term residents
- A third of emergency admissions are for people in last year of life
- CQC ratings outstanding of GSF teams etc
- Social care measures
- Other research

4. GSF EOLC National Survey

the gold standards framework®

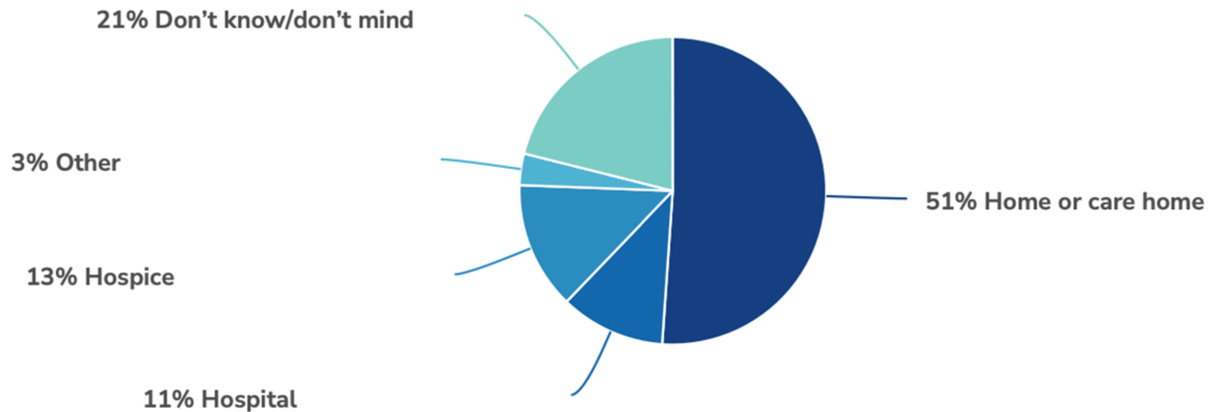
End of Life Care Survey Results

1000 people , all ages, genders, nations June 2023

Place of death

If you were able to choose, where would you prefer to die?

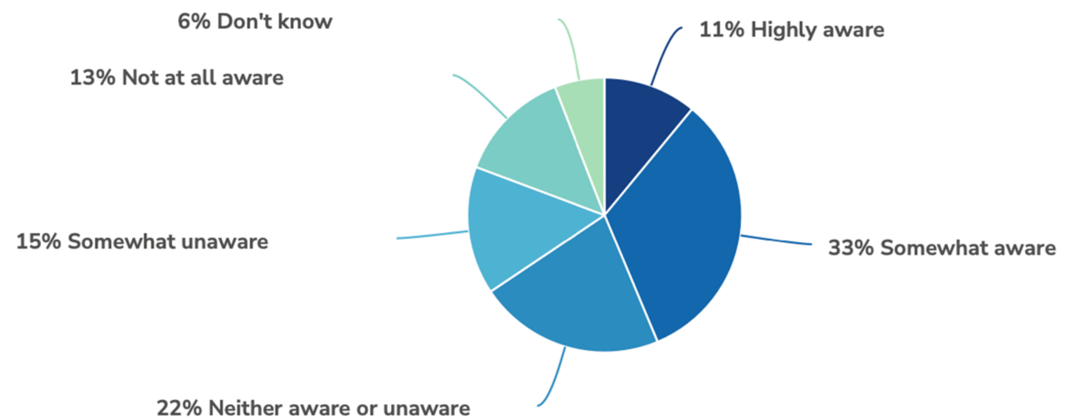
- most prefer home/ care home



Awareness of care and support

Are you aware of care and support available to you when nearing end of life ?

- most unaware of care (56%)



GSF EOLC National Survey

the gold standards framework®

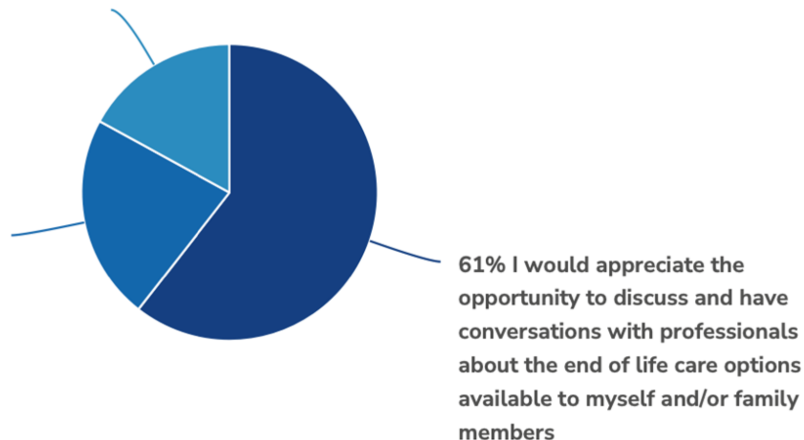
End of Life Care Survey Results

1000 people , all ages, genders, nations June 2023

Discussions / advance care plan

Would you appreciate the opportunity to have conversations with professionals about the end of life options available?

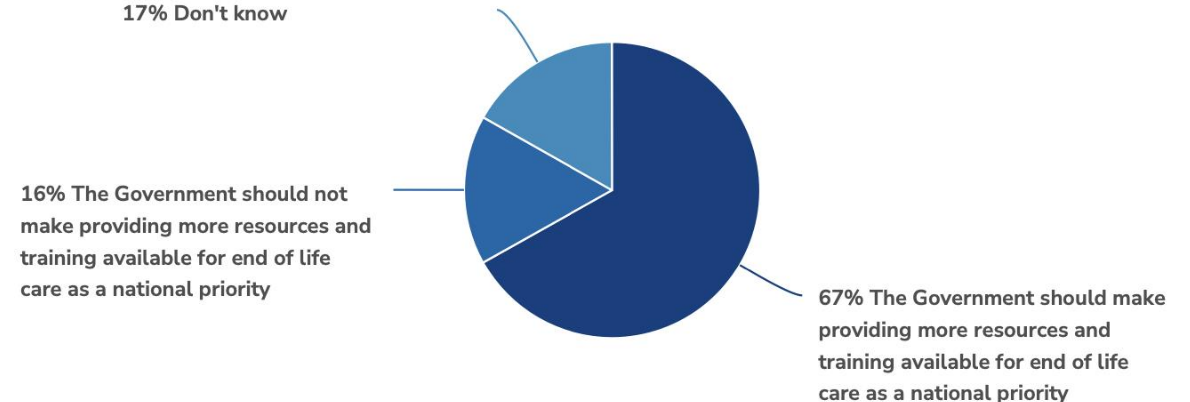
- most would want discussion (61%)



Government prioritise EOLC

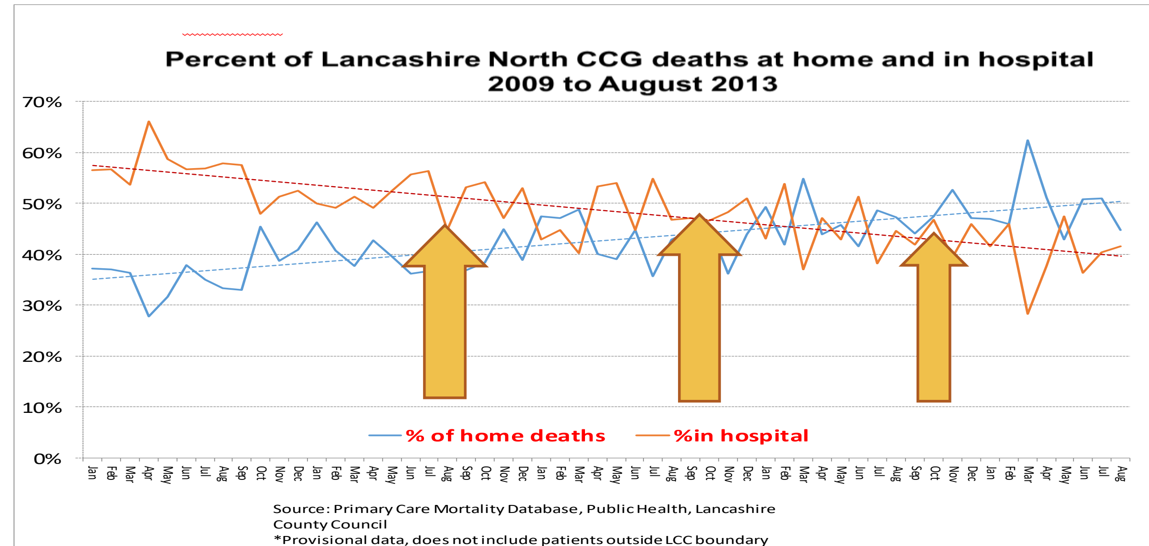
The Government should make providing more resources and training available for end of life care as national priority

- most agree (67%)



3. Systems IMPACT Cross Boundary Care Sites

Morecambe Bay – home deaths overtakes hospital deaths



Morecambe Bay area

Arrows for GSF introduced in care homes, primary care, then hospitals

(**reduced hospital deaths**)

IMPACT ICB/systems level

Whole system with GSF Sites & Gold Patients

GSF Cross Boundary Sites over 15 years

Dorset ,Nottinghamshire, Jersey, Barking, Havering Redbridge, Morecambe Bay, Southport , Airedale, Wolverhampton , NE Essex, Doncaster, Dudley

Airedale Gold Line

Gold /GSF Patients access Gold Line

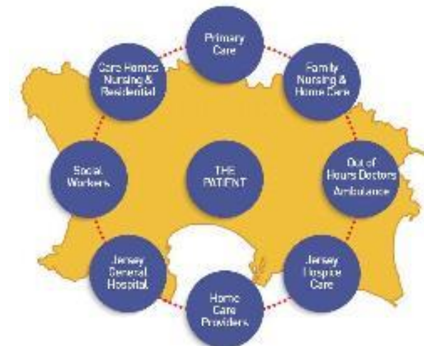
Jersey – whole island culture change

"GSF has changed the culture of care"
"The whole system has become more robust- its joined up and communication is better – its empowered patients to feel part of their care more"

Gold /GSF Patients

GSF registered or 'Gold patients'

- **Pts identified from different settings ,included on register, given Gold card, information sheet**
- **treated as special- added benefits eg 'Gold Line' to coordinate their care**



Everybody deserves Gold Standard care at the end of their life.

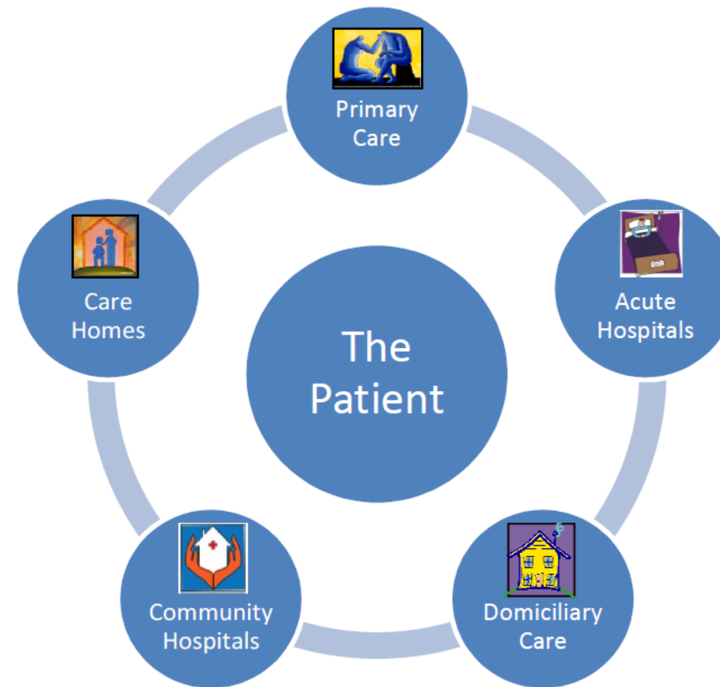
Integrated Cross Boundary Care

the gold standards framework®

HOME

GSF Primary Care

Domiciliary Care Retirement Villages



CARE HOME

GSF Care Homes

HOSPITAL

GSF Acute & Community Hospitals

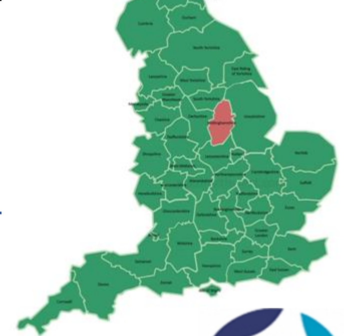
Hospice

the gold standards framework®

IMPACT Nottinghamshire ICS

Key Performance Indicators

Mid-Nottinghamshire
Place-Based Partnership



KPI	Trend
IDENTIFY- Increase no of patients identified on register	- 0.7% - Aim for 2% population ↑
ASSESS-OFFER ACP no of patients with ACP recorded or offered	- Approx 60% - aim 90% ↑
PLAN % of deaths in preferred place of care	-almost 80% -5% increase/ year - ↑
Reduced unnecessary ED attendance and hospital admissions for patients last year of life	-almost halved - ED attendance 2.08- 1.21 /pp -Hosp admissions 1.4-0.7 pp ↓

Everybody deserves Gold Standard care at the end of their life.

Dr Julie Barker GP, Notts EOLC Lead
Current state of metrics as new ICS

- *"Getting the GSF culture embedded within all frontline services cant be emphasised enough"*

- *GSF spread to all providers*
- *Early identification up – 0.7% (8000 pts /1.1m)*
- *Offering ACP to all identified patients*
- *Meaningful ACP conversations by GP or trained usual care provider*
- *Family gain confidence in proactive care*
- *More dying where chose (80%)*
- *Almost halved crisis ED emergency attendance*
- *And halved hospital admissions /per pt*

GSF EOLC Metrics at ICS Level

Cross Boundary care / ICS Metrics
– pilot and paper sent to NHSE

Summary Report of Population Based EOLC Metrics Pilot in GSF Cross Boundary Care Sites -a 2 year study involving 12 CCGs and one hospital trust Nov 2015-Dec 2017

Prof Keri Thomas, Julie Armstrong Wilson, Sue Richards GSF Centre Prof Sir Muir Gray Right Care

Context- the need to improvement EOLC measurement across a wider CCG area

- Within the context of end of life care (EOLC) strategic planning for CCGs, STPs or ACS there is a recognised need to measure EOLC at a population level, to benchmark measurables and implement improvements in whole-system care. NICE EOLC Guidance [1]and NHSE Ambitions[2] affirms the direction of travel. The RCGP EOLC Group working with Right Care suggested commissioning metrics[3], CQC's Thematic Review used 4 criteria for 17 CCGs assessments,[4] (none satisfactorily completed) and PHE's EOLC Atlas of Variation examines variations in key areas[5]. Inclusion in CCG IAFs is beginning. But currently there are no piloted population-based EOLC measures.

- The DH response to the Choice Review in EOLC affirmed the use of EOLC Metrics at CCG/ area-wide levels. "**Recommendation 25** That ***indicators be developed for the NHS and Adult Social Care Outcomes Frameworks to hold the health social care system to account for delivering choice and improving experience for all at the end of life. ….NHS England will develop and implement a suite of new metrics to measure progress against the NHS Mandate on both quality and choice in end of life care, with the intention that the new metrics will feature in a new Clinical Priority Area for End of Life Care in the CCG Improvement and Assessment Framework, by June 2018".***[6]

- Measurement of End of Life / palliative care is inherently difficult and the inadequacies of such assessments and evaluations is acknowledged at the outset. However inadequate, an attempt to measure EOLC could ensure that further progress in population-based EOLC is made. The 4 levels of possible outcome measurement, include: -

  1. **Patient level** outcomes (eg OACCS,POS)- much progress has been made, specific to patient level data
  2. **Team or provider**-level measures (eg CQC Inspection of hospitals or GP practices, GSF Accreditation etc
  3. **Area-wide population** level eg CCG/ ACS - CCG IAF but as yet no agreed outcome measures
  4. **National measures** related to NICE Guidance and Ambitions, PHE EOLC Intelligence Network etc

- With localised commissioning there is a need to assess progress at the third area-wide CCG/ACS level. This pilot is an initial attempt to develop and pilot a set of population-based EOLC metrics in a number of CCG areas that are currently involved as GSF Cross Boundary Care Sites or are using GSF in a varied number of settings.

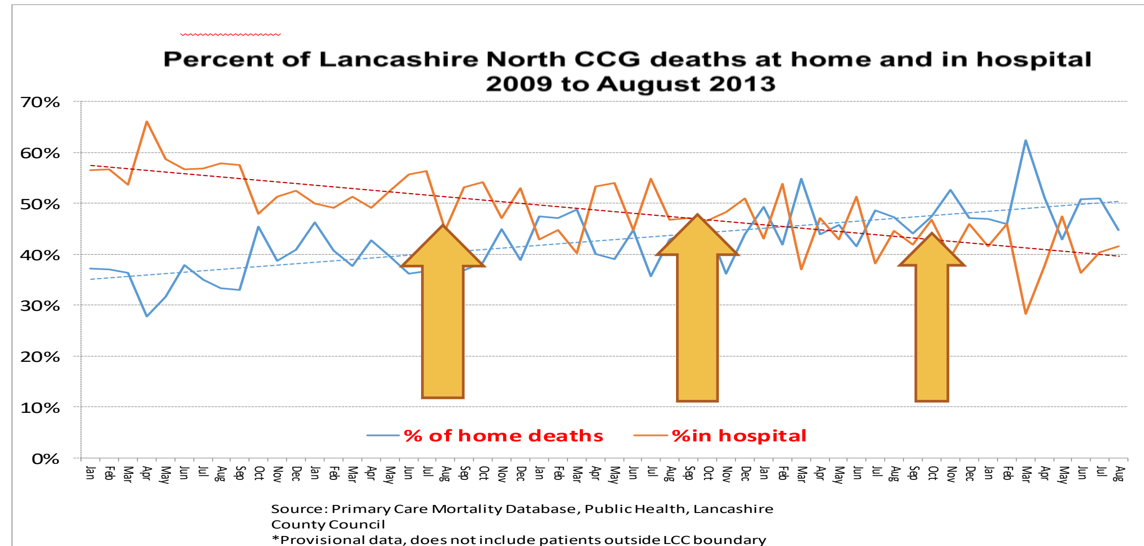
- **Gold Standards Framework (GSF)** programmes [7]offer comprehensive quality improvement training for generalist staff in any setting caring for people with any conditions in the final years of life . The 3 key steps are to **identify** patients earlier in their final yea/s of life (enabling more proactive care) **assess** their needs both clinical and personal (enabling more person-centred care) and **plan** both living well and dying well (enabling systematic consistent care) that ensures reduced hospital admissions and deaths. GSF has been used extensively over the last 20 years in all settings, and the 9 Cross Boundary Care Sites includes areas with GSF used in hospital plus

BOX 1 EOLC Metrics First Level	Objectives	NICE Guidance 2013 /other	Ambitions 2015	Outcome measures	Number of people	Proportion - % of deaths	Read Code used	Additional Notes
1. Proactive care-people are identified early	To proactively **identify** all people considered to be in the last year of life at an early stage to be able to give them proactive person-centred care in line with preferences	**1 Identified early**	2. Each person gets fair access to care (with any diagnosis or setting)	**1. Number and percentage of people identified as being in the last year of life (Red, Amber, Green code only)**				Numbers on register divided by local mortality rate –including health and social care with any diagnosis and setting, from digital locality register eg EPaCCs, SCR or cumulated from GPs registers- including frailty, cancer/non-cancer etc. (if needed subdivided into primary care/)
2. Person-centred care - advance care plans offered	To offer every identified person the chance to have an **advance care planning discussion** (known by some as a personalised care plan) with the person of their choice	**2 ACP offered**	1. Each person is seen as an individual	**2. Number and percentage of the identified people who are offered Advance Care Planning (ACP) discussions** **i. Level 1 – information on ACP and consent for EPaCCS** **ii. Level 2 – Preferred Place of Care, Proxy Spokesperson, DNAR/Resuscitation** **iii. Level 3 - Full ACP/Advance Statement**				Percentage of people offered a person-centred Advance Care Plan that includes proxy spokesperson /LPOA and preferred place of care- largely Advance Statement Includes best interest discussions for people with dementia - recorded and reviewed (as below)
3. Place of care and death Living + dying where choose	To enable every person the opportunity to die in their preferred place/s of choice. State NHS Mandate Choice at the end of life (Gummer)	Choice NHS Mandate	1. Each person is seen as an individual	**3. Preferred place of choice** **i. Number and percentage of people with Preferred Place of Care/Death recorded** **ii. Number and percentage of people who died in their recorded preferred place of choice.** **iii. Number and percentage of people dying in usual place of residence/DIUPR**				Percentage dying in noted preferred place of care or death PPOC/D (this could be a range of choices.) is **indicative proxy measure** assessing trend in improved patient choice but note difficulty and limitations of this metric.
4. Preventing over- hospitali-sation - reduced hospitalisation	To reduce over-use of hospitals, hospital mortality and increase care at home	5 year forward NHS Mandate	3. Maximising comfort and wellbeing	**4. Hospital data** **i. Number and percentage of deaths that are in hospital of the whole population (eg 50%)** **ii. Number and percentage of deaths with 3 or more emergency admissions in the final 90 days of life** **iii. Number and percentage of days people spent in hospital in final 90 days of life**				Hospital data form **indicative proxy outcome measures** (relates to DIUPR), in line with the CCG IAF 2017/18. Assesses trend towards reducing over-hospitalisation and improved community provision. Acknowledged that some hospital deaths are inevitable, good and chosen place.
5. Provis-ion of quality carel	To enable people nearing the end of life to both live well and die well, in line with their needs, wishes and preferences.	NHS Mandate	3. Maximising comfort and wellbeing	**5. Qualitative feedback assessment of wellbeing and living well** - Use of a validated feedback tool measuring experience of care for patients and carers. Please name assessment tool and date of data collection, e.g. monthly, quarterly or annually.				Qualitative feedback options eg survey/ VOICES/POS /PACA/ complaints/ carers feedback, other feedback.

	1. Proactive - Identification rates	2. Person-centred- ACP discussions offered	3. Place of care and death- Dying in preferred place of care /DIUPR	4. Preventing over-hospitalisation , (admissions, LOS, deaths).	5. Provision of quality care
Average for GSF EOLC Metrics pilot	47% -patients identified	47% offered ACP discussion	53% die where they choose	52% hospital death rate- other measures more difficult to extract in the time available .	Limited assessment here but patient feedback obtainable from some and VOICES available in future

2 Teams
IMPACT
GSF Accredited teams
eg GP practices, care homes, wards - 'micro-systems'

Morecambe Bay – home deaths overtakes hospital deaths



Morecambe Bay area
Arrows for GSF introduced in care homes, primary care, then hospitals
(**reduced hospital deaths**)

2.IMPACT-Teams **Findings from GSF Accredited Teams**

"GSF has helped to take us to a new place" *Dorset GP*

"The GSF training has helped us change the culture of the practice "

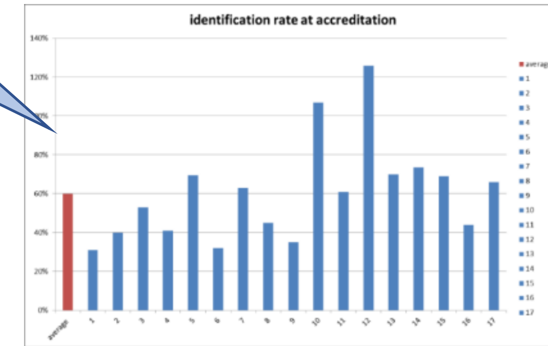
Dr Neil Hunt presenting awards to GSF Accredited practices at the National GSF Conference, 28th November 12, London

It is possible -

- **Identifying more patients**
- **offering most ACPs,**
- **reducing hospital deaths ,**
- **more dying where choose**

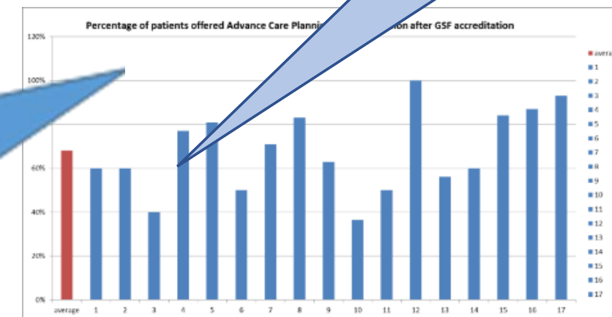
GSF Accredited practices

Identification average 65%



ACP offered *average 68%*

"Since completing the GSF training, we have more than halved the number of days identified patients spent in hospital."



Re-accredited practices show GSF is sustainable long term once embedded.

IMPACT- How GSF Measures Impact at Team Level

Pre and Post training and at Accreditation

- **Organisational level**
  - Key Outcome Ratios
- **Patient level data**
  - ADA (5 deaths / 5 discharges)
- **Staff survey**
  - Confidence level pre and
- post training
- **Monitor progress during training using:**
  - Organisational questionnaire
  - Target Exercise
  - Run charts / Tracker tools to monitor
- identification rates
- offering of ACP
- hospital admissions/ deaths

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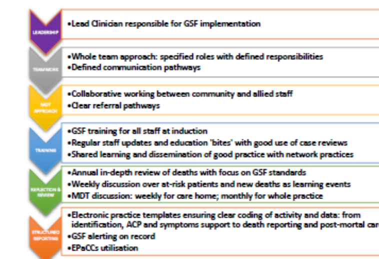
The Impact of GSF Implementation at Chase Meadow Health Centre: A Systematic Approach to Care to Achieve Sustainability

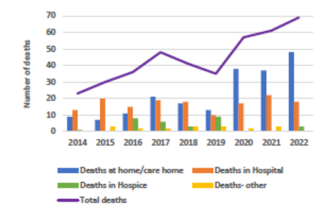
GPs are uniquely suited to caring for patients reaching end of life. We look at the whole person and consider care within the context of the patient's family, carers, and the wider community. Continuity of care and taking responsibility for the many disease episodes over time and coordinating care across organisations provide opportunities for a team approach and collaboration between community-based teams. This is achieved through good pathway development and adopting a culture of audit and monitoring. The robust systems in place through GSF implementation within the practice have helped us accomplish and maintain this.

GSF Implementation: Key Areas



The Impact: Measured Outcomes

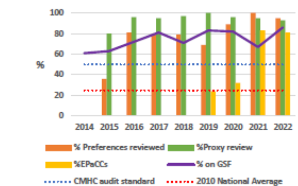
Fig. 1 Place of Death- 8 year Trend



Conclusion

Implementation and adherence to the GSF infrastructure created at Chase Meadow Health Centre has led to a robust and sustained impact on improving the quality of end-of-life care we provide. We have increasingly achieved adherence to patient's preferred place of death wishes (fig.1). In 2014, 43% of deaths occurred in the patient's preferred place of death rising to 74% in 2022. Furthermore, through having a systematic approach to our care for those on our GSF register, this ensures quality measures far exceed national standards and are reproducible year on year (fig.2).

Fig. 2 Achieving a good death- GSF standards



'"GSF has inspired us to create a structured framework ensuring patient preferences are consistently communicated and prioritised. Crisis avoidance and reduced distress has helped us to ensure our patients live and die well."

IMPACT

Note- it is possible!

GSF Accredited teams in different settings

	1. Identify	2.Assess	3.Plan Living well	4.Plan Dying well
Aims of GSF accredited organisations	**Early recognition of patients- aim 1% primary care 30% hospital 80% care homes**	**Advance Care Planning discussion offered to every person**	**Decreased hospitalisation + improved carers support**	**Dying where they choose using personalised care plan in final days**
GP practices (Rounds 1-4)	**70%** patients identified (range 35-90%)	**75%** offered ACP discussion (range 40-1		
Acute Hospitals	**35%** identified early (range 20-58%)	**92%** off discussio 85-100%)		
Community Hospitals	**45%** identified	**98%** offered A		
Care Homes accredited	**100%** identified, **81%** identified in dying stages	**100%** offered 95% uptake	**Halving** hospita deaths+ admissions **97%** carer support	here choose, **90%** using 5Ps care plan

Key Message- It is possible to-

- **identify more people early**
- **offer more people advance care planning (ACP) discussions**
- **enable more to die where they choose**
- **reduce hospital ED attendance, admissions ,and deaths**
- **Across ALL HEALTH and CARE settings**

GSF Frontrunners- real life examples of best practice

the gold standards framework

Frontrunners in Primary care

Showcasing examples of best practice in end of life care with findings from recent GSF Accredited GP Practices, demonstrating earlier identification of more patients, more clarifying wishes and more dying where they choose

These leading GSF Accredited practices, are examples of the best that practices can be in caring for people in their last years of life frontrunners demonstrate what is currently being achieved by some primary care teams in their care for patients in their last years of life, fo their completion of the GSF Going for Gold Programme and GSF Accreditation, co-badged by RCGP. They are an encouragement and inspir others in giving the very best end of life care to their patients – **if they can do it, then you can too!**

These are grass-roots practical examples of how some practices provide top quality, proactive, person-centred care for their whole popul patients, including those with frailty, dementia and non-cancer conditions. This has an impact on the quality of life for patients and their fam their final years of life, reducing time spent in hospitals and enabling more to die where they choose. The practices' palliative care registers no accurately reflect their wider populations (the estimated 1% of their population in the last year of life), and they attain standards in line with policy, NHSE Ambitions, GMC, NICE Guidance and CQC Primary Care Standards. Key areas include providing:

1	Proactive care	*early identification*
2	Person-centred care	*more patients offere*
3	Place of death	*more dying in prefe*
4	Reducing hospitalisation	*reduced hospital de*
5	Providing top quality care	*experienced by pati*

Building on the Bronze Foundations level GSF mainstreamed through QO with GSF Accreditation, supported and endorsed by RCGP.

Examples	1. Proactive – Identification rates	2. Person-centred – ACP discussions offered
Average for GSF Accredited practices	Av. 75-90% register identification rates	68% offered ACP discussion

Note – these practices identify more patients earlier, achieving Registe of 34% (PHE Fingertips) and then use needs-based coding to prioritise. population x1%, and additionally the num

Examples of Frontrunning GP Practices

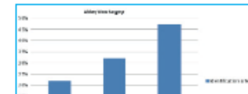
Abbey View Surgery, Dorset

Practice name	Abbey View Surgery Dorset
GP Lead	Dr Damien Patterson
Practice Population	15,319
Accredited 2012 / Re accredited 2016	

"The GSF training has helped to move us to a completely different place."

Key Achievements

- Register Identification rate 54% patients
- 59% offered ACP
- 34% non-cancer and care homes residents



*"Before we started GSF training we noticed that many people were being sent to hospital inappropriately and were not experiencing the care they would have liked. The GSF training **has helped to move us to a completely different place.** Now patients have a genuine choice about where they would like to be cared for. And they are choosing to stay at home, in their care home or in the local hospital unit we run." People are*

the gold standards framework

Frontrunners in Care Homes

Showcasing examples of best practice in end of life care with findings from GSF Accredited Care Homes, demonstrating earlier identification, more clarifying wishes and more dying where they choose.

These leading front-running GSF Accredited Care Homes are examples of the best that care can be for people in their last years of life. These practical examples from front-running teams demonstrate what can be achieved ...if they can do it, you can too!

The needs of older people are at the forefront of NHS and social care transformation. **Care Homes have become one of the mainstays of end of life care** (EOLC) outside hospitals and are key providers of person-centred care for a large proportion of people nearing the end of their lives, particularly the very elderly and those with severe frailty and dementia. With about a fifth of the population dying in care homes and over half dying in hospitals, about **80% of Care Homes residents are considered to be in their last year of life.** Many hospital admissions (estimated 50% of hospital deaths from care homes residents, NAO Report) could be avoided enabling more to live and die where they choose with better trained staff and community support.

These frontrunners demonstrate what is possible to achieve. They are grass-roots examples of how some care homes provide people in their final coordination and taff to work better rass roots.

5. Quality of care - feedback

100% carers offered support

force

Accredited – 2010 Beacon
Re-accredited – 2013 Beacon

GSF has helped us deliver the care our residents want where they want it, in their home!

itchen staff and domestics staff.
Nursing Home:
r wishes right from when s everything from the and how they want their nance hotel and we want e right up until the end of

ndards work

ospitals

care with findings from recent GSF monstrating earlier identification of more dying where they choose.

These leading GSF Accredited hospital wards are examples of the best practice in caring for people in their last

gold standards framework

1. IMPACT

at individual patient/resident and staff members

Hospital patient feedback

Being a gold patient has helped me feel valued and supported in every part of the hospital, everyone should be a gold patient!

Wife of Care Home Resident feedback

Its been wonderful- right to the very end. When my husband came here and was cared for by the staff that are GSF trained and accredited we knew we could be sure we're getting the best kind of care

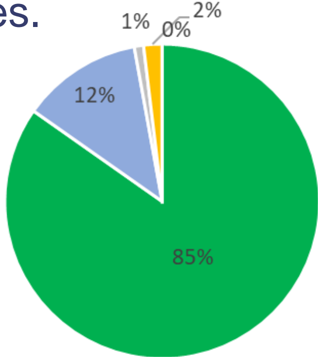
GP Practice Staff member feedback

GSF has helped us to create a structured framework ensuring patient preferences are consistently communicated . Crisis avoidance and reduce distress has helped us to ensure our patients live well and die well

Chase Meadow Health centre

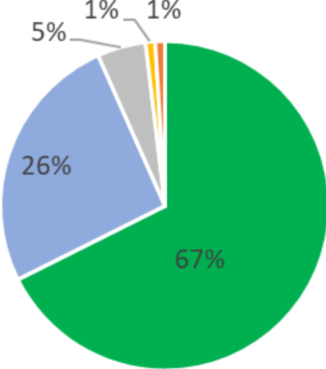
End of Life Care - Accreditation Survey 2023

1. Use of GSF improved the experience of care for people and their families.



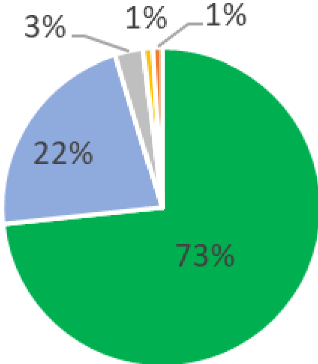
Mildly agree Uncertain / no view Mildly disagree

3. Use of GSF has had a positive impact on staff wellbeing.

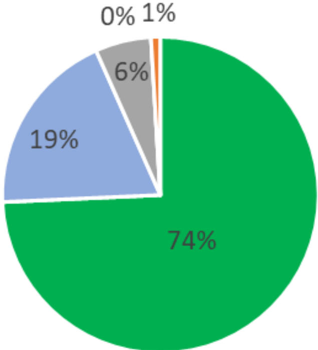


Strongly agree Mildly agree Uncertain / no view Mildly disagree Strongly disagree

2. Use of GSF has improved the morale and teamwork for your staff.



4. Use of GSF has had a positive impact on job satisfaction.



E

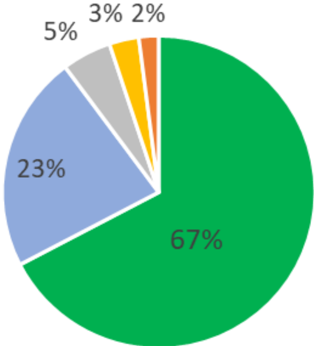
Mildly agree Uncertain / no view Mildly disagree

Strongly agree Mildly agree Uncertain / no view Mildly disagree Strongly disagree

Impact in hospitals - Accreditation Survey 2023

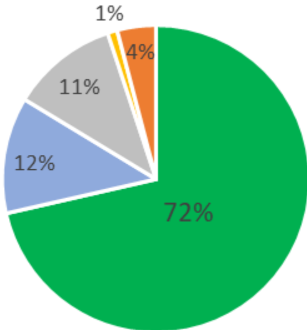
6. Use of GSF has reduced your hospital admissions.

(does not include hospital data)



7. Use of GSF has reduced your hospital death rate.

(does not include hospital data)



Qualitative Feedback

8. Can you share any thoughts or examples of how GSF has impacted on the end-of-life care you provide?

"GSF has given us the confidence and the skills to deliver the best EOL care to residents and our families." Care Home

9. Can you give any figures for reduced emergency hospital admissions, deaths or days in hospital?

"We have had six deaths so far this year and all six deaths happened in the home. We were able to get their preferences documented. Through coding changes, there was early detection of deterioration in needs and the home was able to prepare, involving the individual, preferred family and MDT to ensure a respectful pain free death in the place of their choice." Care Home

"We have been able to reduce hospital admissions by 62% over the last 3 years" Care Home.

10. Can you elaborate on how GSF has impacted on staff morale, job satisfaction or staff retention?

"Staff are more confident in dealing with death and dying matters. They have more job satisfaction in knowing they aided someone to live well and also die well. Staff retention has improved tremendously." Care Home

IMPACT GSF hard and soft

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Hard measures

- **Spread and integration**
- **Proactive** -Increased early identification on registers and proactive care (non-Ca, frailty , care homes residents)
- **Personalised** - Increased advance care planning ,
- **Coordinated** - joined up
- **Decreased hospitalisation** crises, hospital admissions + deaths, more dying where choose

Soft measures

- Changed culture
- Empowered staff – broadened focus
- Improved teamwork
- Improved staff confidence
- Improved pt satisfaction
- Improved continuity, communication
- Springboard for other things – Gold and Silver patients, registers
- Helpful during COVID

d of their life.

Social and economic impact

the gold standards framework®

- Dying where they choose ‘ good death’ measures
- Family distress measures
- Grief- 9 bereaved people for every person that died
- Hidden carers’ costs in lost earnings
- Social care costs funded by houses

- Decreasing over-hospitalisation improving waiting times
- Decreased admissions , decrease hospital bed days, increase rapid discharge
- ROI
  - For the cost of 3 nights in hospital, one team could be GSF trained
  - For the cost of 1 average admission to hospital , 3 teams could be GSF trained