

the gold standards  
framework  
in primary care



Omega  
The National Association  
for End of Life Care

the gold standards  
framework

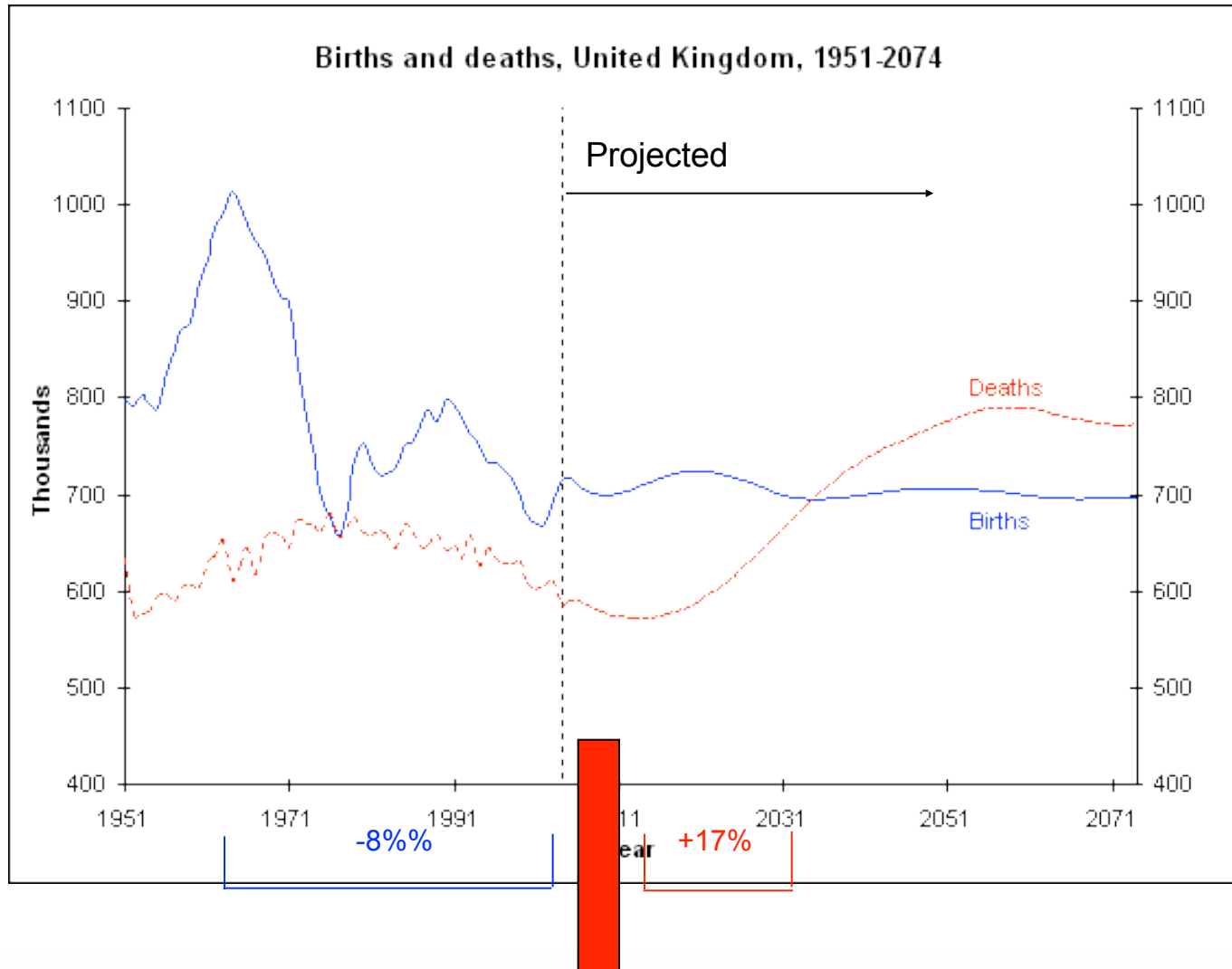
# Plan

1. Context of end of life care
2. Overview - home care for people nearing the end of life
3. Our response- update from National GSF Centre and Omega
5. Ways forward + Take home messages

# 1. Context- The Changing Scene

- **Changing Population - Imperative of 'demographic time-bomb'**
  - Baby Boomers generation
  - Recognition of health economics
- **Changing to care for all**
  - All diagnoses- non cancer – co-morbidities, frailty dementia COPD, HF
  - All settings- hospitals, care homes, homes
  - All times - care in final year/s/ month of life as well as final days / weeks
- **Changing to care provided by all**
  - Generalists provide most end of life care
  - All are involved- specialists provide expert support
- **Care closer to home**
  - Decrease avoidable hospitalisation
  - More dying where they choose- often at home / care home
- **Taking control**
  - Emphasis on Patient Choice + self determination + self care
  - Advance care planning, Mental Capacity Act

# The Future, UK Projections 1951-2071



## THE DEMOGRAPHIC TIME BOMB

Source: Government Actuary Department 2004-based Projections for the UK

# Policy developments

1. DH End of Life Care Strategy in England
2. DH Quality Markers
3. Darzi groups- new impetus in end of life care
4. RCGP End of Life Care Strategy
5. Funding for EOLC Training
6. Skills for Care and Skills for Health minimal competencies

# End of Life Care in Numbers

1. 1% of the population dies each year
3. 17% increase in deaths from 2012
5. 60-70% people do not die where they choose
7. 35% home death rate – 18% home, 17% care home
9. 40% of deaths in hospital could have occurred elsewhere
11. 75% deaths are from non-cancer conditions
12. 85% of deaths occur in people over 65
13. £19k non cancer ,£14k cancer - av.cost/pt/final year
15. 2.5 million generalist workforce-5,500 Pall.Care specialists.

# What if ....Bill

## Current

- In care home – condition worsening
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits -no future plan discussed
- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone
- Family given little support in grief - staff feel let family down
- No reflection by teams- no improvement
- Expensive for NHS - inappropriate use of hospital

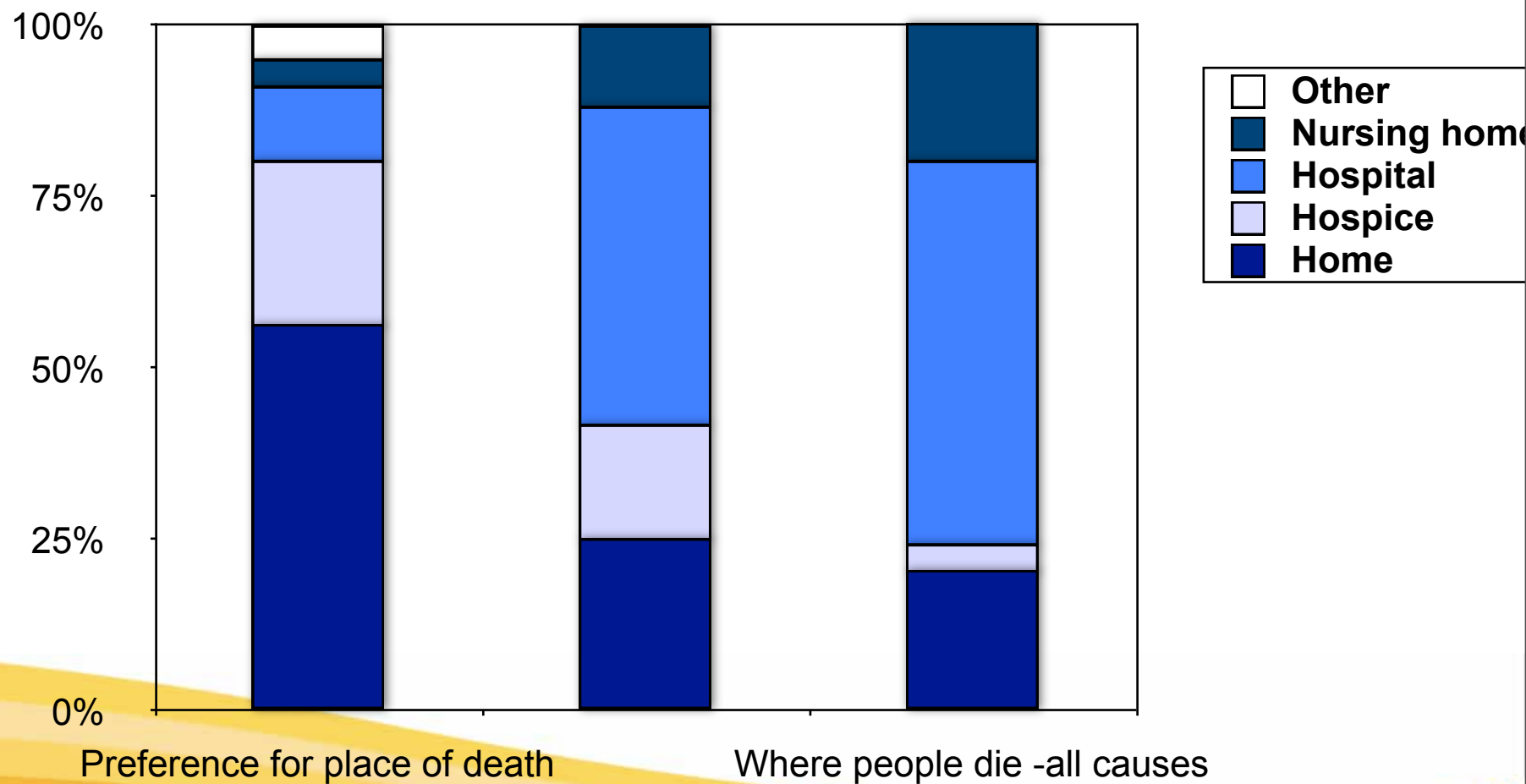
# What if ....Bill

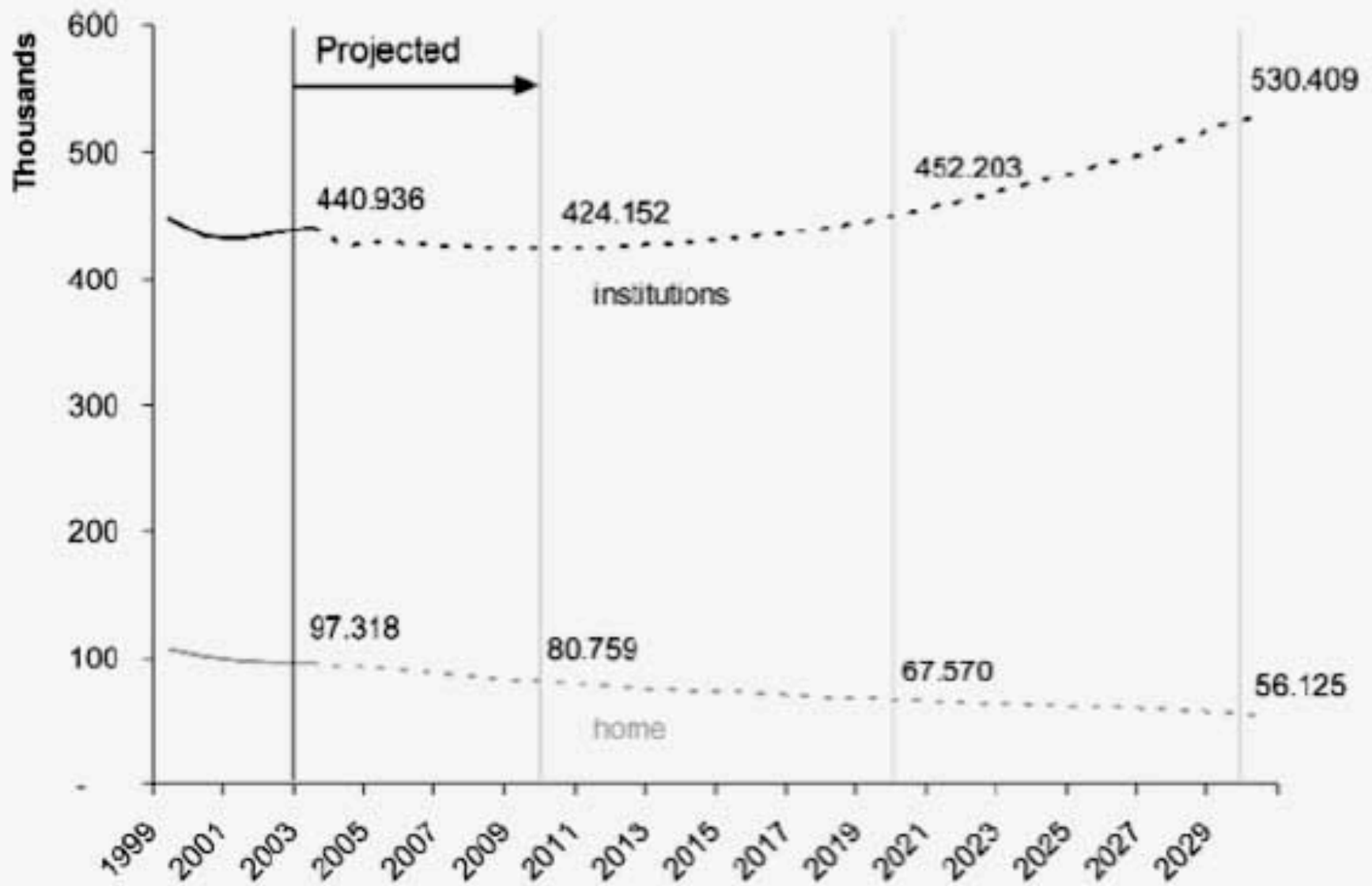
## Current



- In care home – condition worsening
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits -no future plan discussed
- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone
- Family given little support in grief - staff feel let family down
- No reflection by teams- no improvement
- Expensive for NHS - inappropriate use of hospital

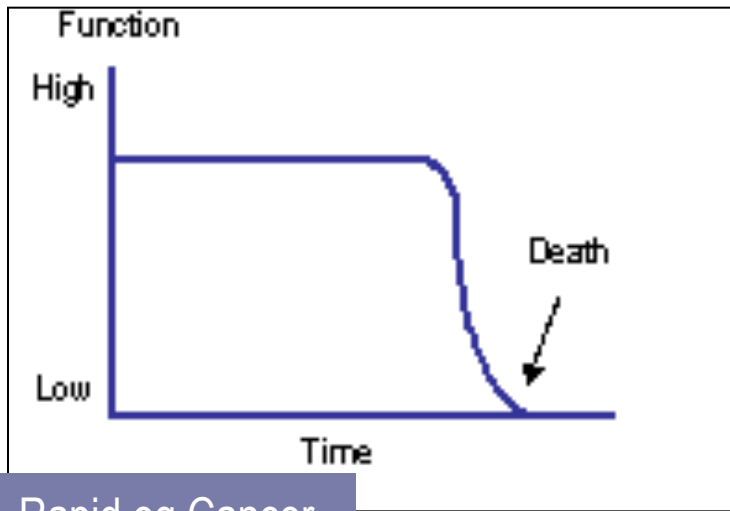
# Choice- preferred and actual place of death



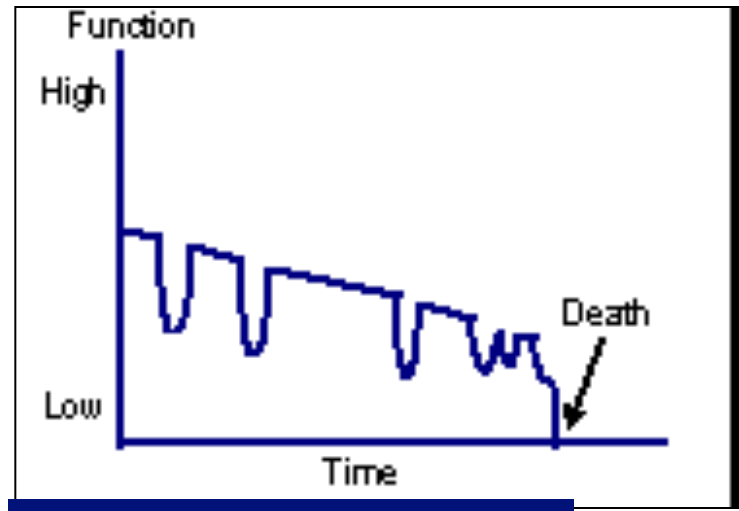


## Number of deaths by place of occurrence 1999-2030

Gomes & Higginson 2008



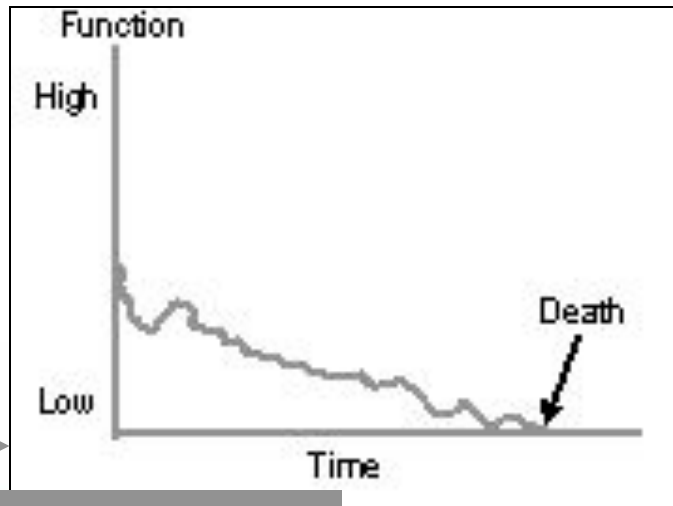
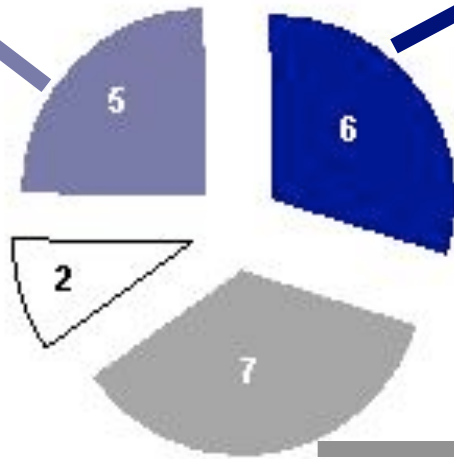
Rapid eg Cancer



Erratic eg Organ Failure

GP has about 20 deaths / year

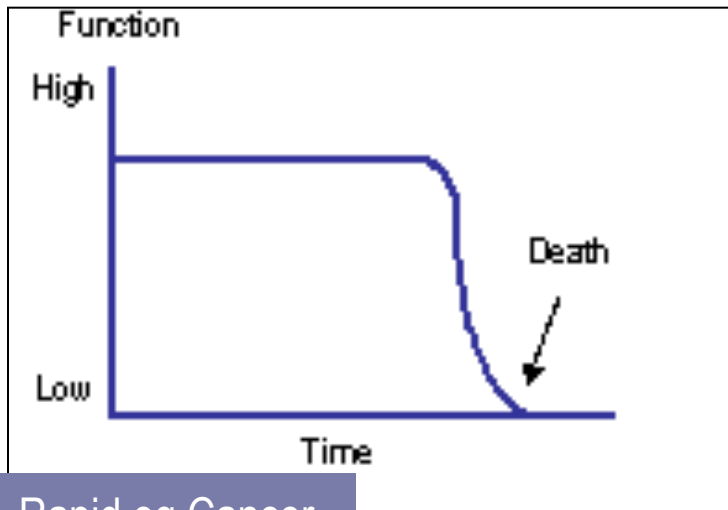
Sudden death / Other



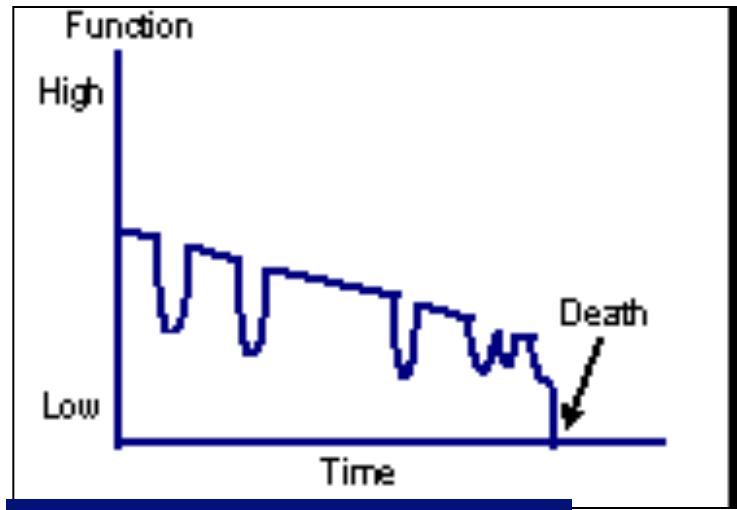
Slow eg Dementia, frailty

# Three ways of dying

## Rapid, erratic and slow dying trajectories- After Lynn



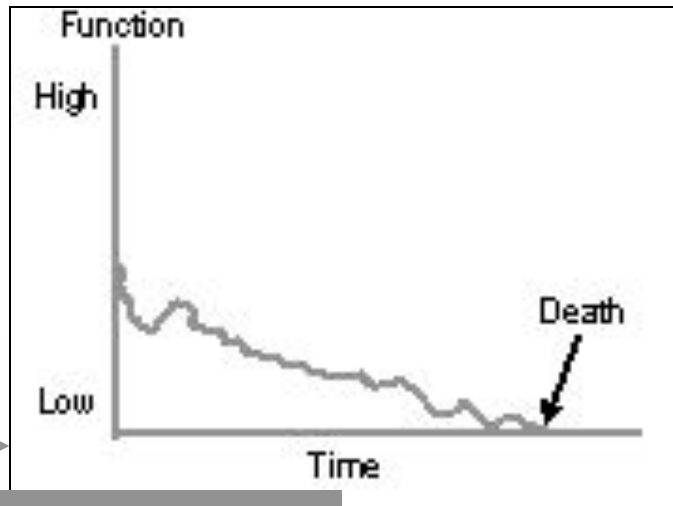
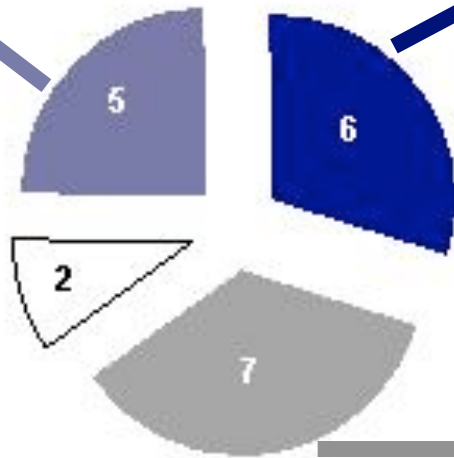
Rapid eg Cancer



Erratic eg Organ Failure

GP has about 20 deaths / year

Sudden death / Other



Slow eg Dementia, frailty

# A different approach...the 1% Rule.

1% population die each year -530,000/yr/England

Every GP has about  
20 patients who are in the  
last year of life..

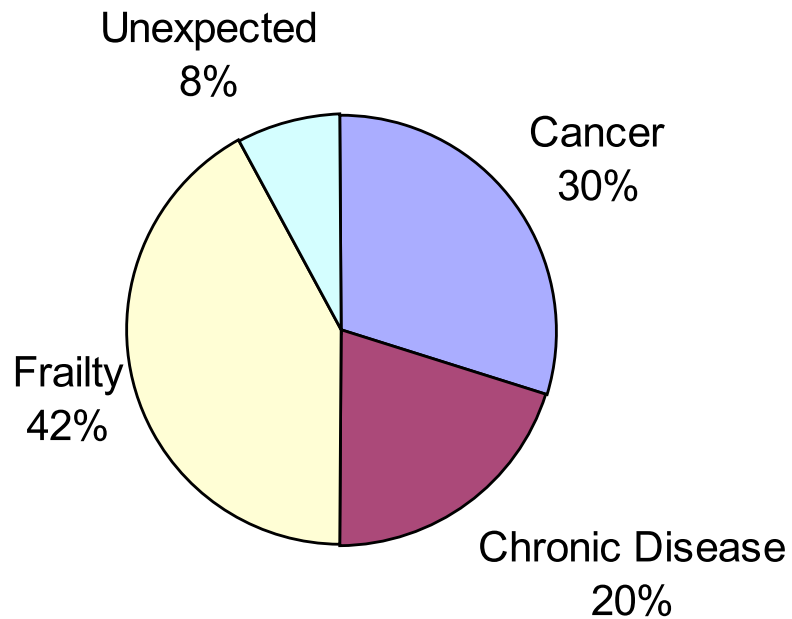
....how can we make  
the best of this last year ?

*“Its all about  
how you live”*



# National Audit Office report on End of life Care (Nov 08 [www.nao.org.uk](http://www.nao.org.uk))

**Survey Population by Patient Group (N=348)**



# Frailty is the future !

- Frailty/multi morbidity is **biggest killer**
- Multi-morbidity defined as the co-existence of two or more long term conditions in an individual (Mercer et al, 2009).
- **level of multi-morbidity was an independent predictor** of prognosis amongst patients with established cardiovascular disease (Payne et al)
- RCGP doing specific work in multi morbidity as inherent part of GP workload



# Outcomes and Cost

# Outcomes and Cost



# Outcomes and Cost



**OUTCOMES**

# Outcomes and Cost



## **OUTCOMES**

- NOW- about 50% not dying where they choose

# Outcomes and Cost



## **OUTCOMES**

- NOW- about 50% not dying where they choose
- Many die poorly



# Outcomes and Cost

## **OUTCOMES**

- NOW- about 50% not dying where they choose
- Many die poorly
- Weighted towards cancer patients- more die of HF+COPD



# Outcomes and Cost

## **OUTCOMES**

- NOW- about 50% not dying where they choose
- Many die poorly
- Weighted towards cancer patients- more die of HF+COPD



# Outcomes and Cost

## **OUTCOMES**

- NOW- about 50% not dying where they choose
- Many die poorly
- Weighted towards cancer patients- more die of HF+COPD

## **COST**



# Outcomes and Cost

## **OUTCOMES**

- NOW- about 50% not dying where they choose
- Many die poorly
- Weighted towards cancer patients- more die of HF+COPD

## **COST**

- Overspending on hospitals and unwanted treatments



# Outcomes and Cost

## **OUTCOMES**

- NOW- about 50% not dying where they choose
- Many die poorly
- Weighted towards cancer patients- more die of HF+COPD

## **COST**

- Overspending on hospitals and unwanted treatments
- 30% rise in costs if stay same



# Outcomes and Cost

## **OUTCOMES**

- NOW- about 50% not dying where they choose
- Many die poorly
- Weighted towards cancer patients- more die of HF+COPD

## **COST**

- Overspending on hospitals and unwanted treatments
- 30% rise in costs if stay same



# Outcomes and Cost

## **OUTCOMES**

- NOW- about 50% not dying where they choose
- Many die poorly
- Weighted towards cancer patients- more die of HF+COPD

## **COST**

- Overspending on hospitals and unwanted treatments
- 30% rise in costs if stay same

## **CONCLUSION**



# Outcomes and Cost

## **OUTCOMES**

- NOW- about 50% not dying where they choose
- Many die poorly
- Weighted towards cancer patients- more die of HF+COPD

## **COST**

- Overspending on hospitals and unwanted treatments
- 30% rise in costs if stay same

## **CONCLUSION**

- With better planning and prevention of crises more could be expected to die at home/ where they choose



# Outcomes and Cost

## OUTCOMES

- NOW- about 50% not dying where they choose
- Many die poorly
- Weighted towards cancer patients- more die of HF+COPD

## COST

- Overspending on hospitals and unwanted treatments
- 30% rise in costs if stay same

## CONCLUSION

- With better planning and prevention of crises more could be expected to die at home/ where they choose
- Focus on community care and reduction of hospital admissions



# Outcomes and Cost

## OUTCOMES

- NOW- about 50% not dying where they choose
- Many die poorly
- Weighted towards cancer patients- more die of HF+COPD

## COST

- Overspending on hospitals and unwanted treatments
- 30% rise in costs if stay same

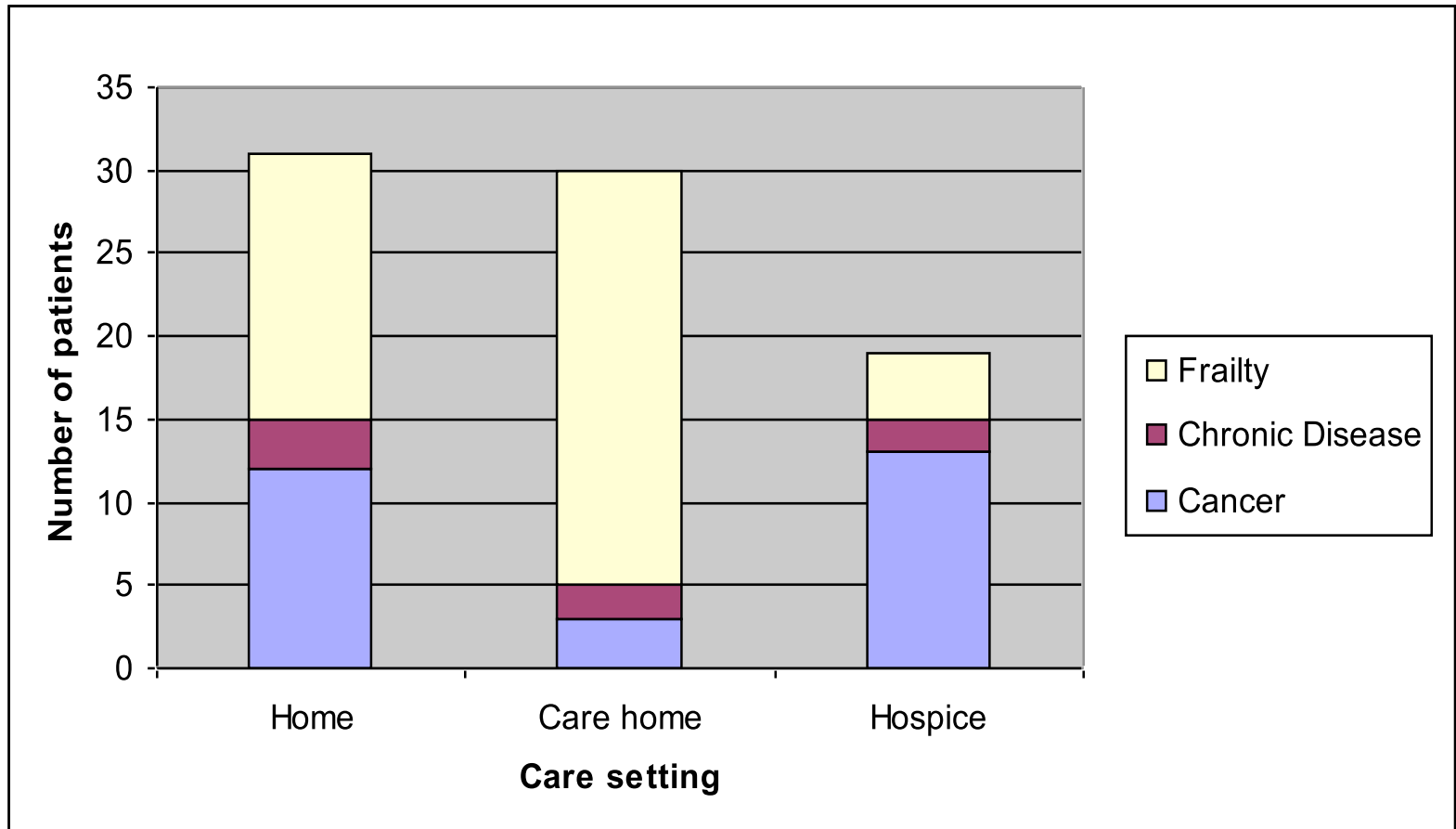
## CONCLUSION

- With better planning and prevention of crises more could be expected to die at home/ where they choose
- Focus on community care and reduction of hospital admissions

Doing nothing is not an option

# Alternative place of care by condition

## NAO report Nov 08



## 2. Overview – ‘Home care....’

1. Home is a state of mind as well as a place
2. Home reminds you of life and living
3. At home you are a ‘person’ not a ‘patient’
4. Reminders of the person you are / once were /others
5. Leaving home – losing hope
6. Home can be care home
7. Home can be your country of origin
8. Salmon instinct ?

# How well do GPs deliver palliative care: systematic review

## **GPs' contribution pts appreciate**

1. being listened to, allowing ventilation of feelings
2. Being accessible
3. Basic symptom control

## **GPs deliver sound and effective pall care**

4. Best with specialist support
5. Increasing exposure/formalised engagement

# 5 Key factors in enabling home death

Factors influencing death at home in terminally ill patients with cancer: systematic review.

Gomes, B and Higginson, I J. *BMJ* 2006: 515-518

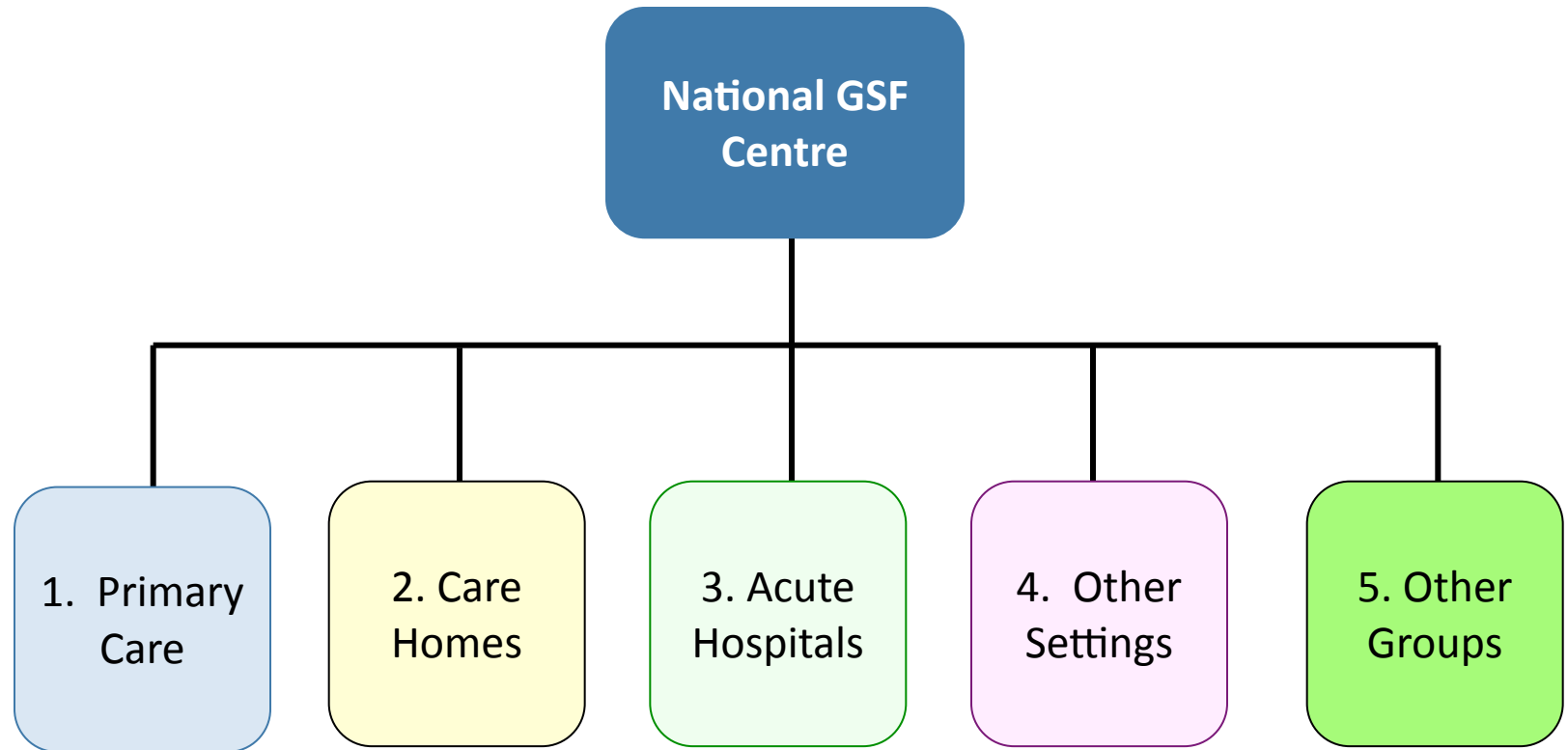
1. Intense sustained reliable home care
  - *Primary care working optimally,*
  - *Supportive care in the home*
2. Self care - public education
3. Support for families and carers
4. Advance Care planning- risk assessment
5. Training practitioners

# But .....

1. **Fewer carers** , carers' views , little support
  
3. **Greater demand**
  - by patients to stay at home
  - plus cost savings by reducing hospitalisation
  
5. **Community care has limits**
  - Hospice at home outreach stretched
  - Domicilliary care, care homes,extra care housing etc
  - Home from home' can be better than real home
  
7. **Changing GP and primary care teams**
  - increasing burden on primary care
  - Support from hospices

# 2. Our response

## National GSF Centre



# What is the Gold Standards Framework ?

A framework to deliver a 'gold standard' of care for all people nearing the end of life

A systematic approach to **optimising** the care delivered by generalist healthcare professionals

The National GSF Centre is hosted within the NHS by Walsall tPCT



# GSF is about ...

- Enabling Generalists - improving confidence of staff
- Organisational system change
- Patient led -focus on meeting patient and carer needs
- Care for all people regardless of diagnoses- non-cancer, frail
- Pre-planning care in the final year of life -proactive care
- Care closer to home – decrease hospitalisation
- Cross boundary care- home ,care home, hospital, hospice,

# Focus on training but also need systems change

## HEAD

- **Evidence based**
- Knowledge
- **'what to do'**

## HANDS

- **systems-minded**
- process/organisation
- **'how to do it'**

## HEART

- **patient- focussed 'why'**
- human compassion
- experience of care

## GSF

Extensive policy support – Dept Health , Quality Markers, RCGP, NICE etc

“GSF is the bedrock of generalist palliative care”

*District Nurse Norfolk*

“ GSF is one of the most significant developments in the improvement of end of life care since Dame Cicely Saunders founded the hospice movement”

*Penny Hansford Director of Nursing*

*St Christopher's Hospice London*



# Different Levels

GSF mainly as organisational change

1. Individual - patients ,carer, staff
2. Organisational – practices, care home
3. Community- area, PCT, LA, ward etc
4. National- population based



# GSF Primary care

• **90%** practices – QOF pall care points basic GSF Level 1 (register and planning meeting) - mainstreaming

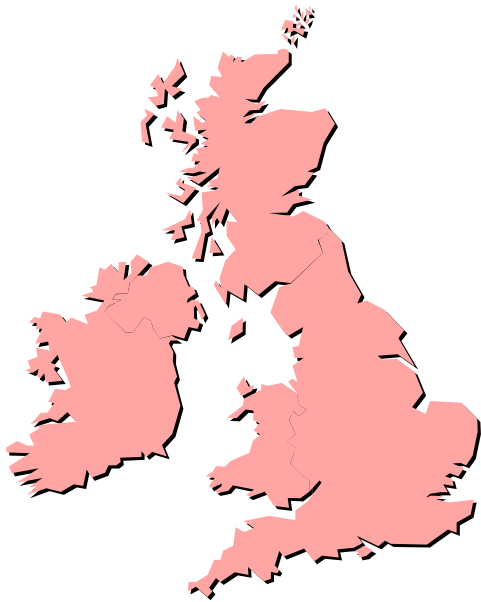
• **60%+** practices using GSF in UK, covering almost 3/4 of the population -(2 surveys)

**10-15%** Estimated using deeper GSF Level

**BUT**....need to build on current GSF to meet 4 challenges

- **Consistency,**
- **Effectiveness,**
- **Equity for non-cancer pts,**
- **Quality provision**

**Launch of Next Stage GSF Primary Care June 09**



# Three key bottlenecks



- **Identification of all patients** particularly those with organ failure and frailty
- **Difficult conversations with patients** and families, advance care planning discussions
- **Effective team pre-planning-** predicting needs- change to more proactive earlier team response

# 3 simple Steps

## Identify

Which patients maybe in the last year of life and what stage are they? Use of register .  
(surprise question + PIG+ needs based coding)

## Assess

Current and Future Clinical needs and Personal needs  
(using assessment tools, passport information, ACP etc)

## Plan

Planning meeting- anticipate needs -Use of 7 Cs  
Use Needs Support Matrix and action plans

# Needs Based Coding

Surprise question

Used of Needs based coding

Use of Needs Support Matrices



- C1 Communication**  
SC Register, PHCT Meetings, PHR /care plan  
[Advanced care planning \(ACP\)](#) eg PPC
- C2 Coordination**  
Identified coordinator for GSF, keyworker for patient
- C3 Control of Symptoms**  
Assessment tools, body chart, SPC, ACP
- C4 Continuity Out of Hours**  
Handover form + OOH protocol
- C5 Continued Learning**  
Learning about conditions on patients seen, SEA / reflective practice
- C6 Carer Support**  
Practical, emotional, bereavement, National Carer's Strategy
- C7 Care in dying phase**  
Protocol [LCP / ICP](#)

# Gold Patients

- People know they are 'gold'
- Aspires to best care
- Alignment with advance care plans
- Supportive and encouraging if feel no more can be done



# The Gold Standards Framework in Care Homes

## Goals

- To improve the **quality** of end of life care
- 2. To improve **collaboration** with primary care and palliative care specialists
- 3. To **reduce hospitalisation-** and enable more to live and die at home



# GSFCH Training and Accreditation

## ‘Going for Gold’

### Training

Almost 1000 care homes trained

Phased programme

- Structured curriculum + workshops
- Learning outcomes linked to standards
- Work based changes – action plans



### Accreditation

Up to 100/year accredited

- Rigorous process
- Consistency of practice
- Findings go to independent panel
- Awards Presentation twice a year



# Using GSF Care Homes Training Programme

- Open attitude to death and dying
- All residents have advance care plans
- Improved confidence of staff
- Better working with GPs
- Halving hospital death rates
- Reducing crisis admissions
- Use for residential care homes
- Pilot in domiciliary care

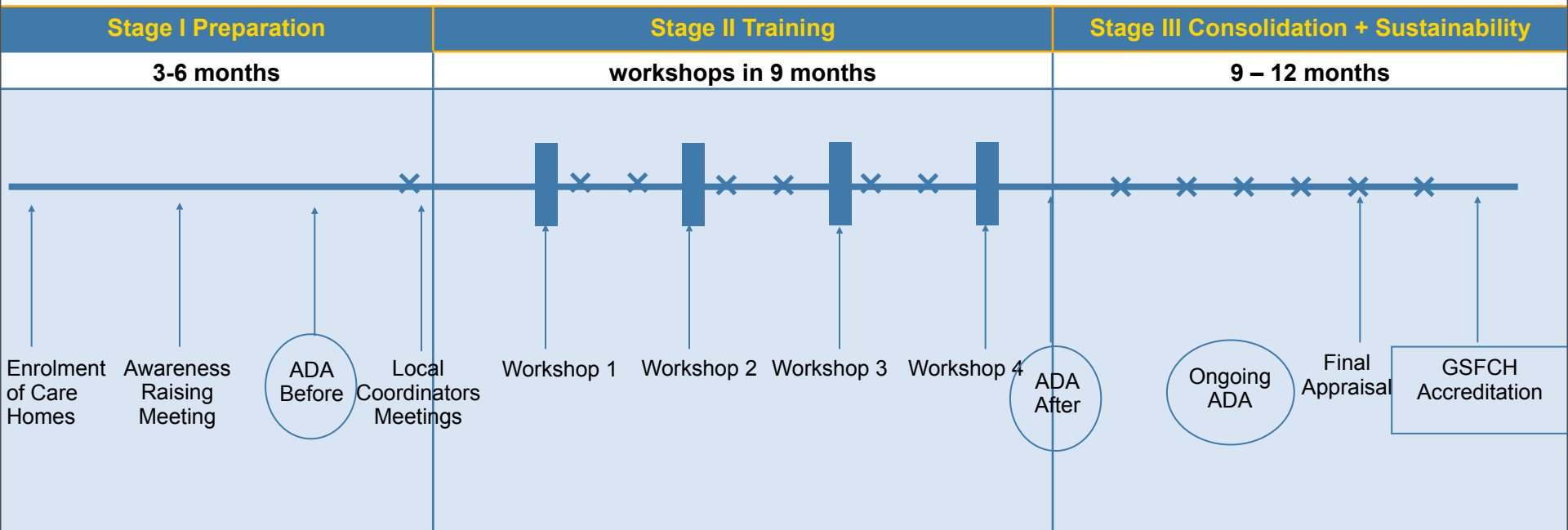


*“GSF has made my work **simple** to care for my residents. It has drawn me **closer** to my residents and relatives, given me **confidence** in discussing end of life care.”*

*(Nursing Home RN Accreditation Round 3 )*

# 3 stage training programme

## Preparation, training,



# 20 Key standards- Accreditation checklist

- Leadership + support
- Team-working
- Documentation
- Planning meetings
- **GP Collaboration**
- **Advance Care Planning**
- Symptom control
- **Reduce hospitalisation**
- DNAR +VoD policies
- Out of hours continuity
- 11. Anticipatory prescribing
- 12. Reflective practice+ audit
- 13. Education + training
- 14. Relatives
- 15. **Care in final days**
- 16. Bereavement
- 17. Dignity
- 18. Dementia
- 19. Spiritual care
- 20. Sustainability

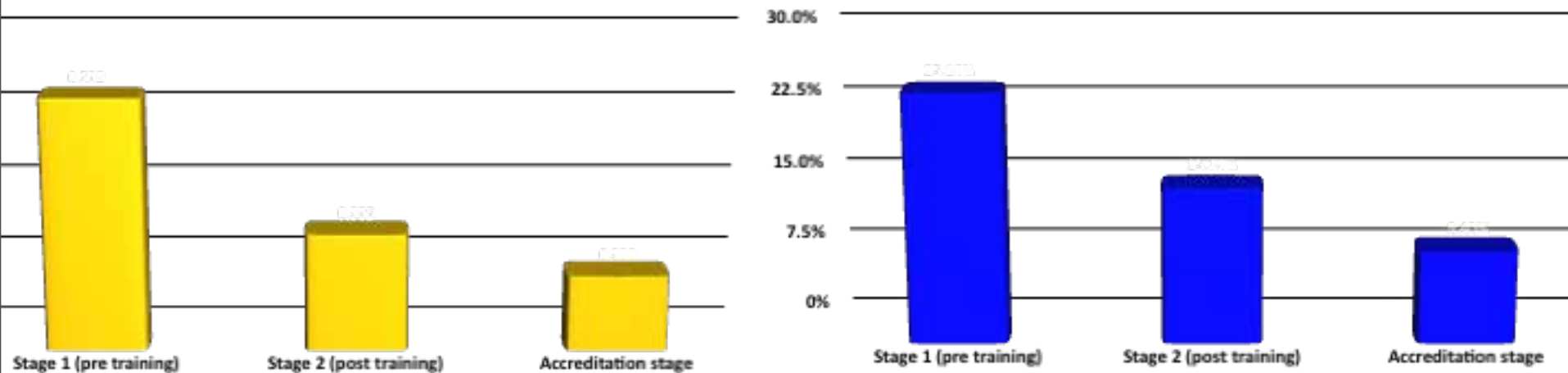
# Reducing hospitalisation

- Advance care planning discussions
- Needs Based Coding
- Needs Support Matrices
- Planning meetings
- Team collaboration
- DNaR/ AND discussions
- Training and education for all staff (including night staff and temp/ bank)
- Policy +guidance on reducing avoidable admissions
- Stop Think policy
- Anticipatory prescribing
- OOH handover form
- Audit/ SEA
- LCP for dying
- Communication with family re ACP

# Decreased hospital admissions and deaths with GSFCH Training programme

Crisis admissions

Hospital deaths



# Vision of a national momentum of best practice

- Raise the standards- carrot not stick
- A gold standard of care for residents and their families
- Job satisfaction, confidence, rewards and enjoyment for staff
- Benefits to the owners, the GP/ primary care teams, the PCT, the NHS and the wider community
  
- Quality Hallmark Award encourages aspiring to the best
- The public, relatives and commissioners expect high standards
- Share and showcase best practice
- Gaps identified and met
- Sustainable change- (re-accredited 3 yearly)





## c) GSF Acute Hospitals

- Using GSF principles adapted for hospitals
- Cross boundary care and in-patient care
- The 'missing link'
- Pilot Nov 09/10
- Assess
  - Hospital admissions, length of stay and deaths
  - Confidence of staff
  - Coordination of care



## c) GSF Acute Hospitals

- Using GSF principles adapted for hospitals
- Cross boundary care and in-patient care
- The 'missing link'
- Pilot Nov 09/10
- Assess
  - Hospital admissions, length of stay and c
  - Confidence of staff
  - Coordination of care



# Cross boundary care

## GSF Primary Care



## GSF Hospitals



## GSF Care Homes



# Other GSF tools



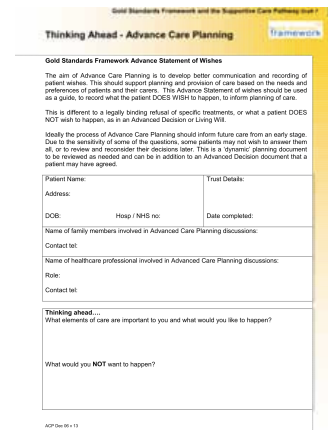
Prognostic Indicator Guidance – PIG + Surprise Questions



Use of templates in Locality Registers



Passport Information



Advance Care Planning – Thinking Ahead



After Death Analysis - ADA

	Pt needs	Support from hospital/GPs	Support from GP
Years			
Months			
Weeks			
Days			

Needs Support Matrix



# GSF - Advance Care Planning

## GSF Thinking ahead includes:

- - open questions
  - what matters to you
  - what you wish to happen and what not to happen
- Proxy - who else involved (LPOA) +Who to call in a crisis
- Preferred place of care & death, options
- Other requests eg special instructions

Gold Standards Framework and the Supportive Care Pathway that ?

Thinking Ahead - Advance Care Planning framework

**Gold Standards Framework Advance Statement of Wishes**

The aim of Advance Care Planning is to develop better communication and recording of patient wishes. This should support planning and provision of care based on the needs and preferences of patients and their carers. This Advance Statement of wishes should be used as a guide, to record what the patient DOES WISH to happen, to inform planning of care.

This is different to a legally binding refusal of specific treatments, or what a patient DOES NOT wish to happen, as in an Advanced Decision or Living Will.

Ideally the process of Advance Care Planning should inform future care from an early stage. Due to the sensitivity of some of the questions, some patients may not wish to answer them all, or to review and reconsider their decisions later. This is a 'dynamic' planning document to be reviewed as needed and can be in addition to an Advanced Decision document that a patient may have agreed.

Patient Name:	Trust Details:
Address:	
DOB:	Hosp / NHS no:
	Date completed:
Name of family members involved in Advanced Care Planning discussions:	
Contact tel:	
Name of healthcare professional involved in Advanced Care Planning discussions:	
Role:	
Contact tel:	

**Thinking ahead...**  
What elements of care are important to you and what would you like to happen?

What would you **NOT** want to happen?

ACP Dec 06 v 13

# Online After Death Analysis Audit Tool

ADA measures patient outcomes eg place of death, preferences, use of services etc

- Comparative- before and after
- Benchmarking

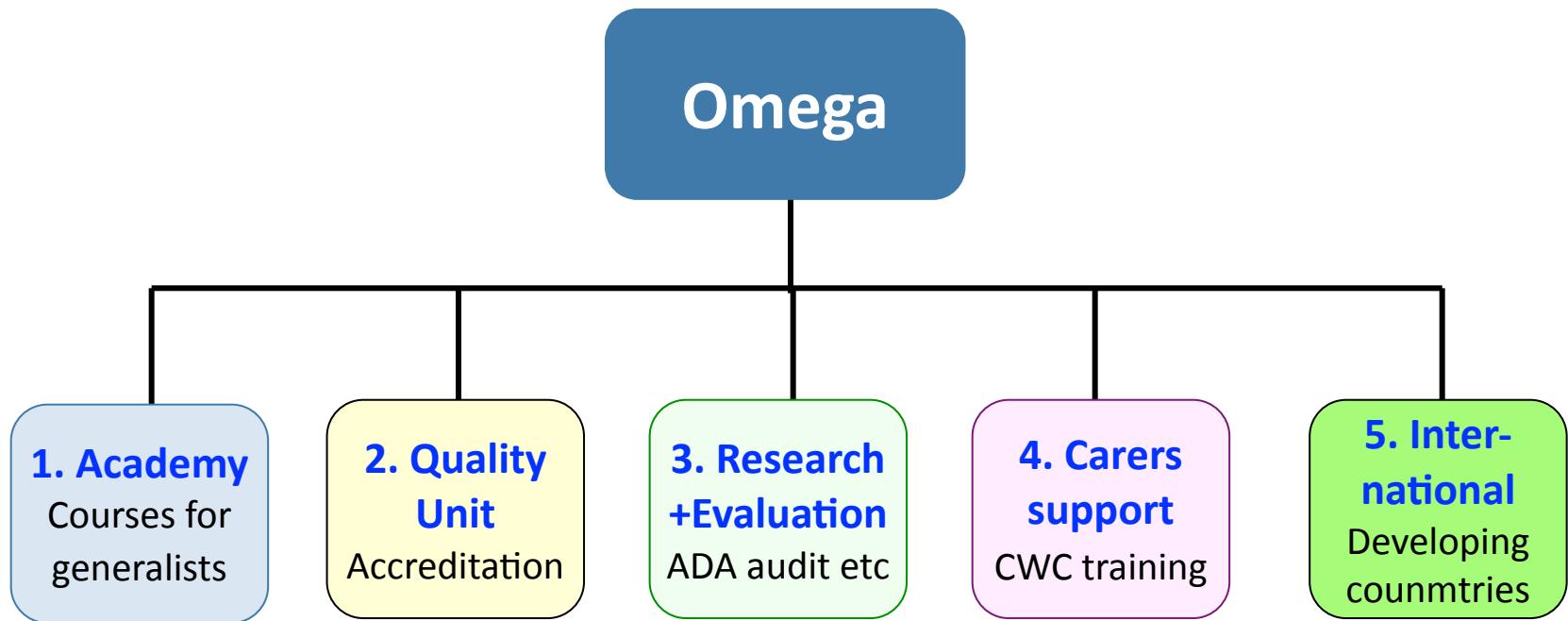




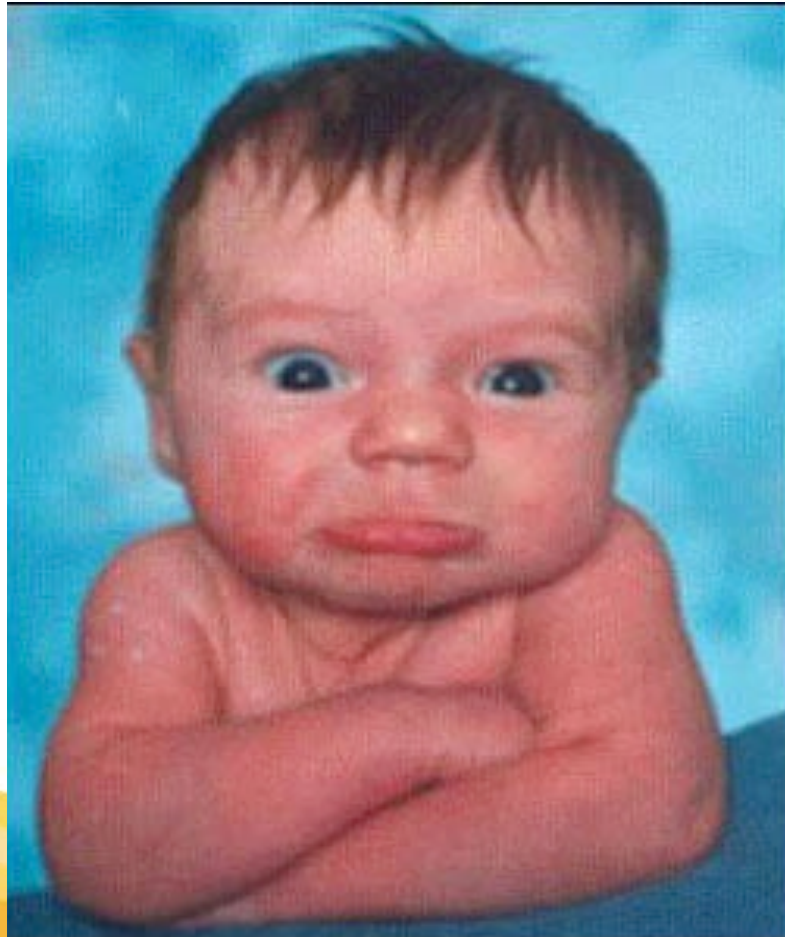
# Omega

## National Association for End of Life Care

“promoting excellence in care for people nearing the end of life”



# 4. What next ?



# Community End of Life Care The Big Challenge



## How

are we going to be able to  
care well

for all people

nearing the end of their lives  
in the future?

# What if ....Bill

## Current

## Ideal

- In care home – condition worsening
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits -no future plan discussed
- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone
- Family given little support in grief - staff feel let family down
- No reflection by teams- no improvement
- Expensive for NHS - inappropriate use of hospital

# What if ....Bill

## Current

## Ideal



- In care home – condition worsening
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits -no future plan discussed
- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone
- Family given little support in grief - staff feel let family down
- No reflection by teams- no improvement
- Expensive for NHS - inappropriate use of hospital

# What if ....Bill

## Current

## Ideal



- In care home – condition worsening
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits -no future plan discussed
- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone
- Family given little support in grief - staff feel let family down
- No reflection by teams- no improvement
- Expensive for NHS - inappropriate use of hospital

# What if ....Bill

## Current

## Ideal



- In care home – condition worsening
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits -no future plan discussed
- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone
- Family given little support in grief - staff feel let family down
- No reflection by teams- no improvement
- Expensive for NHS - inappropriate use of hospital

# What if ....Bill

## Current

## Ideal



### Using GSF

- In care home – condition worsening
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits -no future plan discussed
- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone
- Family given little support in grief - staff feel let family down
- No reflection by teams- no improvement
- Expensive for NHS - inappropriate use of hospital

# What if ....Bill

## Current

## Ideal



- ~~• In care home – condition worsening~~
- ~~• Poor quality of life and crisis admissions to hospital~~
- ~~• Ad hoc visits -no future plan discussed~~
- ~~• Staff and family struggling to cope~~
- ~~• No advance care planning, no life closure discussion~~
- ~~• Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone~~
- ~~• Family given little support in grief - staff feel let family down~~
- ~~• No reflection by teams- no improvement~~
- ~~• Expensive for NHS - inappropriate use of hospital~~

### Using GSF

- **Identify and code stage**

# What if ....Bill

## Current

- In care home – condition worsening
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits -no future plan discussed
- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone
- Family given little support in grief - staff feel let family down
- No reflection by teams- no improvement
- Expensive for NHS - inappropriate use of hospital

## Ideal

### Using GSF

- **Identify and code stage**
- **Assessment of clinical and personal needs**



# What if ....Bill

## Current

- In care home – condition worsening
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits -no future plan discussed
- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone
- Family given little support in grief - staff feel let family down
- No reflection by teams- no improvement
- Expensive for NHS - inappropriate use of hospital

## Ideal

### Using GSF

- **Identify and code stage**
- **Assessment of clinical and personal needs**
- **Advanced care planning**



# What if ....Bill

## Current

- In care home – condition worsening
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits -no future plan discussed
- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone
- Family given little support in grief - staff feel let family down
- No reflection by teams- no improvement
- Expensive for NHS - inappropriate use of hospital

## Ideal

### Using GSF

- **Identify and code stage**
- **Assessment of clinical and personal needs**
- **Advanced care planning**
- **Planning -regular support + coordination within primary care**



# What if ....Bill

## Current

- In care home – condition worsening
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits -no future plan discussed
- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone
- Family given little support in grief - staff feel let family down
- No reflection by teams- no improvement
- Expensive for NHS - inappropriate use of hospital

## Ideal

### Using GSF

- **Identify and code stage**
- **Assessment of clinical and personal needs**
- **Advanced care planning**
- **Planning -regular support + coordination within primary care**
- **Handover form out of hours**



# What if ....Bill

## Current

- In care home – condition worsening
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits -no future plan discussed
- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone
- Family given little support in grief - staff feel let family down
- No reflection by teams- no improvement
- Expensive for NHS - inappropriate use of hospital

## Ideal

### Using GSF

- **Identify and code stage**
- **Assessment of clinical and personal needs**
- **Advanced care planning**
- **Planning -regular support + coordination within primary care**
- **Handover form out of hours**
- **Crisis – discussion with family+ GP**



# What if ....Bill

## Current

- ~~• In care home – condition worsening~~
- ~~• Poor quality of life and crisis admissions to hospital~~
- ~~• Ad hoc visits -no future plan discussed~~
- ~~• Staff and family struggling to cope~~
- ~~• No advance care planning, no life closure discussion~~
- ~~• Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone~~
- ~~• Family given little support in grief - staff feel let family down~~
- ~~• No reflection by teams- no improvement~~
- ~~• Expensive for NHS - inappropriate use of hospital~~

## Ideal

### Using GSF

- **Identify and code stage**
- **Assessment of clinical and personal needs**
- **Advanced care planning**
- **Planning -regular support + coordination within primary care**
- **Handover form out of hours**
- **Crisis – discussion with family+ GP**
- **Admission averted**
- **High quality care provided**
- **Dies in care home**
- **Bereavement care for family**
- **Audit (ADA),reflection**
- **Continuous Quality Improvement**



# What if ....Bill

## Current

- In care home – condition worsening
- Poor quality of life and crisis admissions to hospital
- Ad hoc visits -no future plan discussed
- Staff and family struggling to cope
- No advance care planning, no life closure discussion
- Crisis- worsens at weekend - calls 999 paramedics admit to hospital- A&E- 8 hour wait on trolley-dies on ward alone
- Family given little support in grief - staff feel let family down
- No reflection by teams- no improvement
- Expensive for NHS - inappropriate use of hospital

## Ideal

### Using GSF

- Identify and code stage
- Assessment of clinical and personal needs
- Advanced care planning
- Planning -regular support + coordination within primary care
- Handover form out of hours
- Crisis – discussion with family+ GP
- Admission averted
- High quality care provided
- Dies in care home
- Bereavement care for family
- Audit (ADA),reflection
- Continuous Quality Improvement
- Better outcome for patient, family, staff
- Most cost effective + best use of NHS



# Key Messages

- **End of Life Care is important .It affects us all**
- **Most die of frailty /multi-morbidity/** non-cancer in old age,
- **Too few people die at home** /in their place of choice
- **Hospital deaths often avoidable** and are expensive
- **Everyone has a part to play.** Generalists, specialists, carers
- **GSF helps** improve quality +coordination of generalist care  
use the GSF Training Programmes for care homes, primary care, hospitals

# The 'end' of life points to the 'end' of life



**Life is for living!**

[www.goldstandardsframework.nhs.uk](http://www.goldstandardsframework.nhs.uk)

[www.omega.uk.net](http://www.omega.uk.net)