

End of Life Care – delivering excellence in practice in care homes

Oct 10th 2019
The Care Show , Birmingham

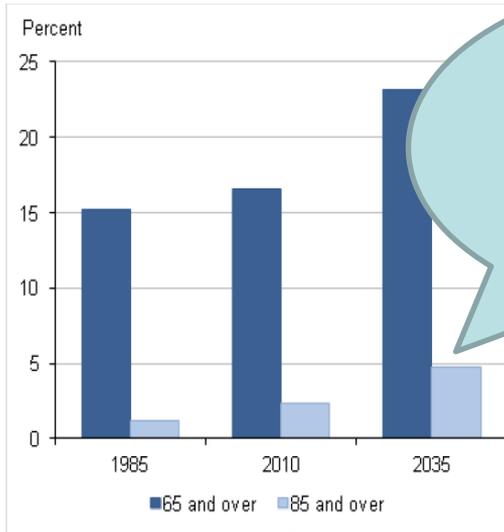
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Learning outcomes

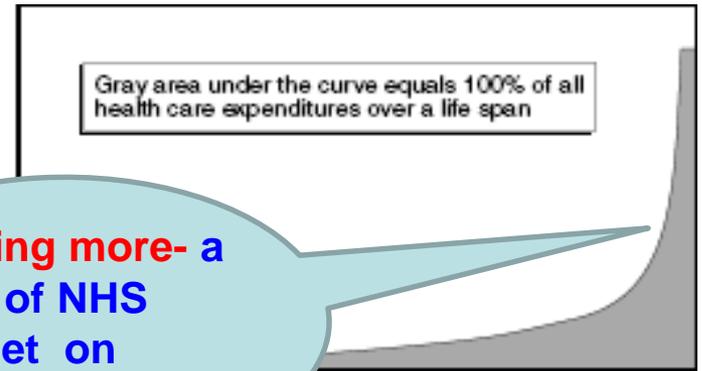
1. Understand recent national policy updates and the increasing recognition of importance of quality care in care homes.
2. Learn of the work of The GSF Centre improving end of life care in care homes and other settings
3. Learn of the experience and examples of good practice from GSF Accredited care homes
4. Discuss key areas for improvement and next steps

Challenges of the Ageing population-

more older people , more dying, more in institutions, costing more in 20 years



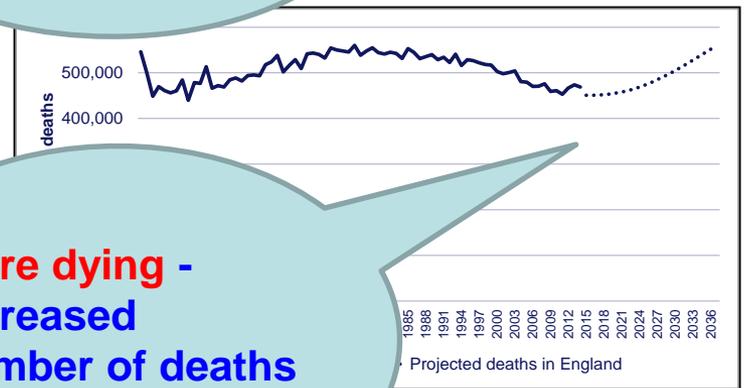
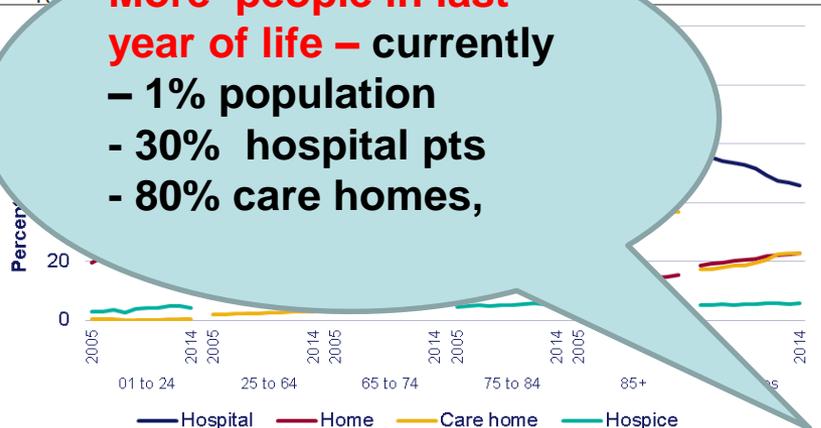
More ageing Over 85 yr olds double , over 100 quadruple



Costing more- a third of NHS budget on EOLC

Source: Office for National Statistics, Northern Ireland Statistics and Research Agency

More people in last year of life – currently – 1% population
 - 30% hospital pts
 - 80% care homes,



More dying - Increased number of deaths by 25% by 2040

Context- National policy in EOLC

- EOLC higher on the agenda
- DH EOLC Strategy+ GMC guidance 2008
- Ambitions 2015
- Government Choice Agenda
- 2019 Long Term Plan 2019
- 2019 Universal Personalised care

- NICE Guidance on EOLC Service Delivery Oct 2019

Long Term Plan Sect 1.42

...., the NHS will personalise care, to improve end of life care. By rolling out training to help staff identify and support relevant patients, we will introduce **proactive and personalised care planning** for everyone identified as being in their last year of life.

A consequence of better quality care will be a **reduction in avoidable emergency admissions and more people being able to die in a place they have chosen**

GPs' QOF EOLC (37 points)

1. Early identification
2. Personalised ,coordinated care
3. Support families and carers

And next year increased working with care homes

NEW GSF Primary

FREE Bronze- foundation

- Step by step guidance
- Proactive Identification Guidance (PIG),
- Guidance on Advance Care Planning (ACP),
- Public facing 3 minute ACP video
- Brief easy-view videos raising awareness – v
- Templates - templates SCR1-6 used in QOF
- Guidance on how to run a GSF/ palliative care



Silver

- Organisational (RDA) audits demonstrating change
- QI workbook and guidance
- Animated summary to aid teaching



Gold

- QI training programme , Resources, Attaining QOF
- Audit evaluation at organisational and patient level



Enhance Health in Care Homes (EHCH) since Vanguards + Anticipatory Care

The Ageing Well Programme

Enhanced Health in Care Homes

- National rollout of the **Enhanced Health in Care Homes (EHCH)** model and supporting full roll out of NHS Mail for Care Home Providers by 2023/24
- Support the full roll out of all the clinical domains of the model being delivered in full in 2020/21 jointly with Primary Care Networks in all residential and nursing homes.
- Creation of a national standard specification for community health providers and Primary Care Networks will be developed to start implementation in April 2020.
- Upgrade NHS support to all care home residents who would benefit by 2023/24

Improvements in community health service provision

- Full usage of the mandatory Community Services Data Set (CSDS)
- Getting data sharing agreements and information governance arrangements signed and implemented between community health providers and Primary Care (and wider partners such as voluntary sectors and Councils).
- Ensuring provider and commissioning arrangements include regular review and update of local Directory of Services (DoS)
- Deliver the core recommendations in Lord Carter's review into the productivity of community health services, focusing on:
 - All community services are recording onto a clinical system that has full interoperability with GP systems
 - Introduction of e-rostering and e-scheduling for all clinic and home visiting staff
 - Developing workforce plans for Community Nursing staff

Working in partnership to deliver Ageing Well



Anticipatory Care

for people living with moderate and severe frailty

What is Anticipatory Care?

- to help people live with health and functional problems as long as possible
- Initially, people with severe frailty and support can be offered to ensure independence and improve well-being as people age.

**Identify
Assess
Plan +
Support**

What is the Anticipatory Care Model?



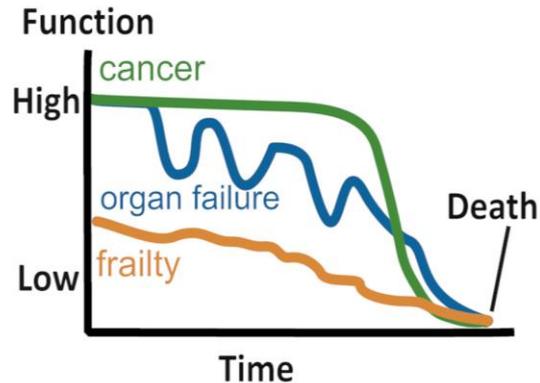
Anticipatory Care: for people living with moderate and severe frailty



Increasing recognition of Importance of care homes

- Currently over **20%** die in CH– most are elderly with dementia
- By 2040 **40%** people likely to die in care homes,
- 3x more CH beds than hospital beds
- Care Homes are ***‘the hospices of the future’***
- NHSE Vanguards/Enhanced Health in Care Homes EHCH
- Recognition of mild moderate and severe **frailty**

dementia + hospital = deterioration



This is about the people you care for ...



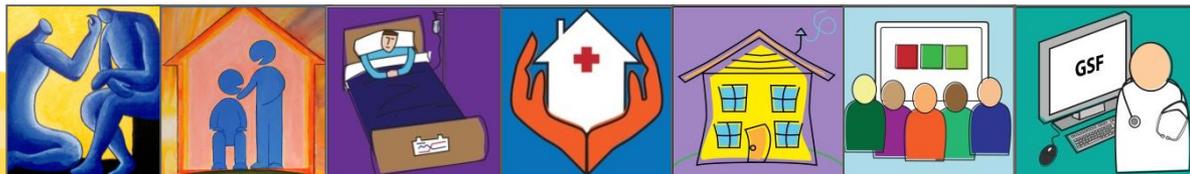
2. Overview and Update from the GSF Centre



**GSF is the leading Training Provider
in End of Life Care in the UK**

enabling generalist frontline care providers to
give a **'gold standard'** of care
for all people nearing the end of life

Prof Keri Thomas OBE



National Spread over 20 years

developing a national momentum of best practice



1. Spread



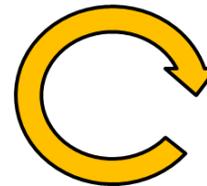
12 Quality Improvement training programmes in all settings,

2. Depth

7 GSF Accreditation Quality Hallmark Awards

3. Joined-up

Population-based Integrated Cross-Boundary care



- 17 Regional Training Centres,
- 10 Cross Boundary Care Sites,
- 40 GSF projects at any one time



GSF Principles have been embedded in national NHS strategy and policy

Accredited Programmes

- Primary Care
- Care Homes
- Hospitals
- Domiciliary Care
- Hospices
- Prisons
- Retirement Villages



GSF international GSF used in over 12 countries and now new charity Andrew Rodger Trust working in end of life care in Africa



'Gold Patients'

Name: <input type="text"/>
NHS number: <input type="text"/>
GP: <input type="text"/>



Scale -Thousands using GSF

Trained about 3,500 teams, 20,000 staff across the UK ,
GSF improves the care of about half a million people/ year



GSF Primary Care-

All 8500 GP practices doing basic bronze
Over 700 doing silver/ gold



GSF Care Homes -
3200 trained – 25% N homes



GSF Acute Hospitals –
477 wards in 49 hospitals



GSF Community Hospitals –
62 wards in 50 hospitals



GSF Domiciliary care –
1200 care workers



GSF Hospice Support
8 hospices – 3 accredited



GSF Prisons.
3 prisons



GSF Retirement Village
19 RVs



GSF Integrated Cross Boundary Care
Sites – 10 sites

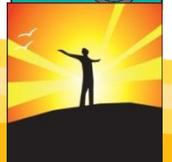


Plus Subjects

Dementia Care

Clinical Skills

Spiritual Care/Compassion





GSF Care Homes Training and Accreditation



“the biggest, most comprehensive end of life care training programme in the UK”

Over 3200 trained (25% NHs)

About 800 accredited

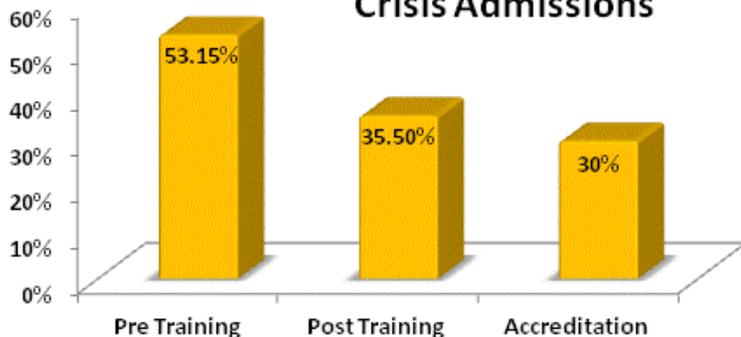
Many now 1/2/3/4th accredited

Now updated new GSF Care Home programme

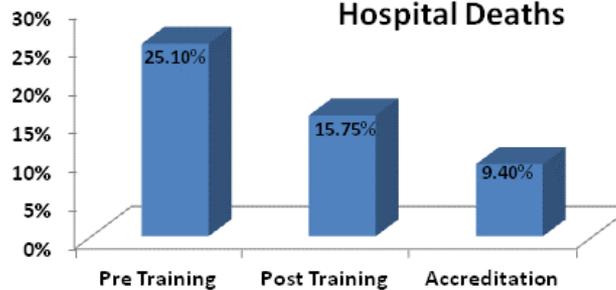
- shorter more affordable
- Outcomes focussed
- Linked to Vanguards



Crisis Admissions



Hospital Deaths



GSF Care Homes

Summary

- Began 2004- first accreditation 2008
- 2 phases / year for 15 years
- Over **3200** care homes trained across UK (*GSFwebsite map*)
Many thousands staff trained , hundreds of Ambassadors
- 18 GSF Regional Training Centres
- Many emulators eg 6 Steps but none accredited
- **2018 GSF CH programme revised** , updated and shortened

- Strong **evidence of impact and sustainability**
- Over 800 accredited , now 29 accredited for 4th time (12 years on) + 6 Care home of the Year Award



What do we hope to achieve with GSF?

1. Better quality of care experienced by all people nearing the end of life



2. Better communication, + coordination, systems, teamwork



3. Better outcomes

–for people-
living well and dying well where they choose



+ health systems-
better use of limited resources, reducing over- hospitalisation.



GSF 1357 Summary

GSF Summary



Aim: To enable a gold standard of care for all people in the last years of life, supporting them to live well until they die.



1. IDENTIFY
Proactive

2. ASSESS
Person Centred

3. PLAN
Systematic



1. Right Person

2. Right Care

3. Right Place

4. Right Time

5. Every Time



1. Identify Residents Early

2. Offer ACP Discussions

3. Plan Living Well

4. Plan Care of the Dying

5. Support Families and Carers

6. With Compassion

7. With a Systematic approach

Proactive Personalised Systematic care - GSF helps meet new LTP+ QOF requirements

identify

patients who may be in the last year of life and identify their needs-based code/ stage

assess

current and future, clinical and personal needs

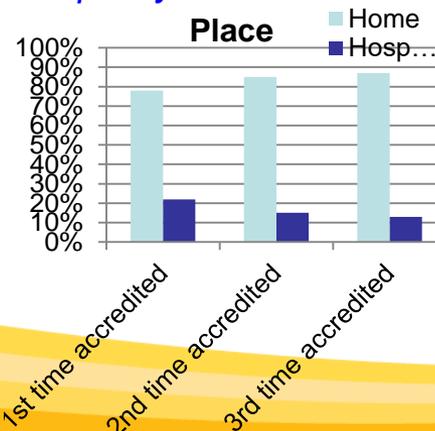
Living well and dying well

GSF helps you meet requirements of Long Term Plan



PROACTIVE
 Guidance
 for patients with
 progressive
 decline/ disease who may be
 in the final year of life –

PATIENT CENTRED
 '... appropriate person should
 be offered ACP discussions',
 '... Early Advance Statements,
 by their usual/chosen care provider,
 which then becomes an action plan
 for quality of care'.



SYSTEMATIC
 Reducing crises and
 hospital admissions.
 Living and dying well in
 preferred place of care

Enhanced Health in Care Homes (EHCH) care model

Care element	Sub-element <i>(further detail on each sub-element in annex)</i>	How GSF helps
1. Enhanced primary care support for care home residents	Access to consistent, named GP	Working with GPs
	Medicines reviews	
	Hydration and nutrition support	
	Out of hours/emergency support	
2. MDT in-reach support	Specialist clinical advice for those	MDT team meetings
	Navigating the system (signposting advice)	
3. Re-ablement and rehabilitation to promote independence	Rehabilitation	(Access to community rehab)
	Community	
4. High quality end of life care and dementia care		Quality care for all residents including the final days And those with dementia
5. Joined up care between health and social care	...mechanisms	Reduced hospitalisation helps joint commissioning
	...with providers and networked care	
6. Workforce	Access to appropriate housing	Staff empowered , confidence boosted , retention rate increased
	Training and development for care staff	
7. Data, IT and technology	Co-ordinated workforce planning	Digital ready with IT/ EPaccs links
	Linked health & social care data	
	Access to care record and secure email	
	Better use of technology	

GSF helps you achieve Enhanced Health in Care Homes (EHCH)

New Updated Care Homes Programme

- Updated in line with NHSE EHCH and new resources
- Shorter
- More affordable
- Simpler
- Outcomes focussed
- Digital ready
- Delivered locally

*“The new updated GSF programme represents **incredibly good value**, **builds on 15 years of success** involving thousands of care homes, where it has been shown to be transformational, not only for staff, but for relatives and residents. **GSF helps demystify dying** and encourages everyone to play their part, so staff morale improves and turnover decreases, enabling better quality care, with better outcomes recognised by CQC, this helps differentiate quality homes from others, making them stand out in this vital area of care.”*

Martin Green OBE, Chief Executive, Care England



NEW GSF Care Homes 2019 Plan

Day 1

Day 2

Day 3

Day 4 Accreditation

**Intro-
duction +
Preparation**

2. Assess
Advance Care
Planning

4. Plan
Dying well

**7 Systematic
care and
Progressing
to
Accreditation**

Pre
Accreditation
webinar

1. Identify

3. Plan
Living well

**5. Family
support**
**6. Compassionate
care**

Homework
Preparation
tasks +
Baseline
evaluations

Homework
+ collecting
evidence for
portfolio

Homework +
collecting
evidence for
portfolio

Homework
and follow up
evaluations ,
embedding and
portfolio
completion

New updated resources

- **Resources**

- DVD - Animated summary/ Keri intro/ reflection/ACP/Nutshell
- Updated PIG, Needs based coding, NS Matrices,
- ACP leaflet+ poster,
- Posters and Care Home Folders



- **Teaching Guidance**

- Updated Good Practice Guide
- + access to VLZ



- **Evaluations**

- Evaluation tools, KOR Trackers/ App,



Is it Cost effective?

- Costs approx. 1-2 weeks of 1 resident in care home
- Reduction of training 30% av care home about £995
- Reduced total if booked accreditation at same time
- Externally supported as good value to care home

- Reduction in average number hospital admissions pays for 3 care homes training

GSF Domiciliary Care Programme



Over 1300 care workers trained

GSF Dom Care Programme delivered in 3 ways

- 1. Certificate** -3 workshops full day + VLZ on line course Open Prog London or at RTC – certificate
- 2. Accreditation** 4 workshops full day + VLZ on line course + accreditation visit
- 3. Bespoke** programme as requested for larger numbers + support webinars

See GSFDC Flyer and section on website with video animation

The NEW GSF Retirement Village Programme

Golden Years 



19 Extra Care Retirement Villages trained
4 GSF accredited so far
Co-badged by ARCO

The
ExtraCare
Charitable Trust

Better lives for older people

The
ExtraCare
Charitable Trust

Better lives for older people 
ards
work

3. Frontrunning GSF Accredited teams



Frontrunners in Hospitals

Showcasing examples of best practice in end of life care with findings from recent GSF Accredited Acute and Community Hospital wards, demonstrating earlier identification of more patients, more clarifying their wishes and more dying where they choose.

These leading GSF Accredited hospital wards are examples of the best practice in end of life care. These frontrunners demonstrate what is currently being achieved by such patients, following their completion of the GSF Going for Gold Programme at the British Geriatric Society and the Community Hospital Association. They are all others in giving the very best end of life care to their patients – if they can do it, they can do it better.

These are grass-roots practical examples of how some wards are able to provide patient-centred care for their patients on the quality of their end of life care, enabling more to die at home, more to them to the GP for their care, more to meet the NHS Ambitions, more to GSF Cross Boundaries, more to improve End of Life Care.

Key areas include:

1. Proactive identification of more patients
2. Person-centred care
3. Place of care and dying in
4. Reducing hospitalisation
5. Providing quality of care



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 their wishes and more dying where they choose.

These leading GSF Accredited practices are examples of the best that GPs can do for their patients in their last years of life. These frontrunners demonstrate what is currently being achieved by some primary care teams in their care for patients in their last years of life, following their completion of the GSF Going for Gold Programme and GSF Accreditation, as led by GPs. They are an encouragement and inspiration to others in giving the very best end of life care to their patients – if they can do it, they can do it better.

- 1. Proactive care: early identification of more patients and more patients
- 2. Person-centred care: more patients offered advance care planning discussions about preferences
- 3. Place of death: more dying in preferred places of care or usual places of residence
- 4. Reducing hospitalisation: reduced hospital deaths, hospital bed days, out-of-hours visits
- 5. Providing the quality care: enhanced by patient and families, convenience and culture change for staff

Building on the Bronze Foundations level GSF, implemented through GSF, these practices completed the Next Stage GSF 'Going for Gold' programme, with GSF Accreditation, supported and endorsed by RCGP.

Practice	1. Proactive identification rates	2. Person-centred care	3. Place of death	4. Reducing hospitalisation	5. Quality of care
Average for GSF Accredited practices	Avg. 75-80% register identification rates	60% offered ACP discussions	60% die where they choose	20% less hospital bed days	21% scores offered support (0-100%)

Note - these practices identify more patients earlier, achieving register identification rates of about 75-80%, over double current national average of 34% (NICE Fragments) and then use needs-based coding to prioritise. Identification rates are calculated by numbers on the register over practice population to 1%, and additionally the number of patients who died who were identified.

Examples of Frontrunning GP Practices

Practice name	Abbey View Surgery, Dorset
Practice Population	26,747
GP(s)	1 GP

Key Achievements:

- Register identification rate: 84%
- ACP discussions: 80%
- Quality of care: 21%

Homes

Care Homes from GSF Accredited Care Homes, and more dying where they choose. of the best that care can be for people and more dying where they choose.

Care Homes have become one of the person-centred care for a large proportion of those with severe frailty and dementia. With about a fifth of Care Homes residents are considered to be dying from care homes residents, NAO Report staff and community support.

lots examples of how some care homes provide top quality, proactive, personalized care for all of their residents. This has an impact on the quality of life for people in their final years of life and their families, reducing time spent in hospitals and enabling more to die where they choose.

Examples	1. Proactive - Identification	2. Person-centred - ACP discussions	3. Place of death - dying in	4. Reducing hospitalisation,	5. Quality of care -
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GSF and CQC ratings



- GSF Accreditation recognised by CQC
- **About 30% CQC outstanding care homes are GSF accredited**
- Many moved up CQC ratings since GSF
- GSF Accreditation provides evidence

“In 2019 we received for the second time another Outstanding CQC rating and as a team we believe that achieving GSF accreditation contributed to our Outstanding rating.”

Paula du Rand, Kineton Manor manager

“GSF is the foundation of our care which means it is the foundation of our CQC rating.”

Simon Pedzisi, Director of Care and Services from Nightingale House

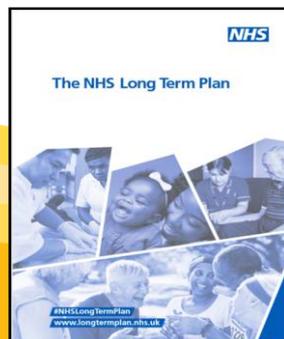
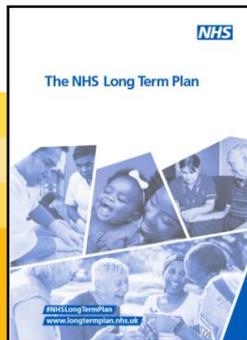
Contribution of GSF - part of the solution

the **gold standards**
framework[®]



**Putting policy
into practice on
the ground to help**

- **Identify- proactive**
- **Assess –person centred**
- **Plan – coordinated care**



3. Experiences of GSF

Quotations from GSF Accredited teams

- **Liz Seymour, Manager of Melrose Nursing Home, Worthing:**

“GSF has **influenced everything we do** and it’s now part of the make-up of who we are. It’s the backdrop of everything.

- **Helen Brewster, The Cedars, Bourne:**

“Implementing GSF in my Home has, for residents, relatives and staff, been one of the **most positive, rewarding experiences** we have had over the past 5 years.”

- **Denise McPhee, Manager, Church View:**

“GSF has improved what we do immensely and we’ve noticed a **major reduction in hospital admissions**. In fact, hospitals and hospices are now referring patients to us to look after at the end of their lives.”



Quotations Sept 2019

- Rekha Govindan, Manager of Chegworth Nursing Homes, said:
 - *“GSF has opened our eyes and those of healthcare practitioners generally to exactly what we should be doing and when, providing a simple step-by-step guide ensuring no one falls through the cracks. It has helped us look at the patient as a whole and assess all of their needs and wishes.”*
- Liz Jones, Policy Director of National Care Forum, said:
 - *“Care home residents and their families want and should be able to receive compassionate, personalised and proactive care. The Gold Standards Framework is a fantastic resource to help the care home workforce provide this.”*



Achievements of GSF Care Homes

Improved team morale and retention

“It’s been life-changing for us, improving all aspects of care, not just towards the end of life.”

CD Manager of GSF accredited care home

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

*GSF CH Lead Nurse
West Yorkshire*



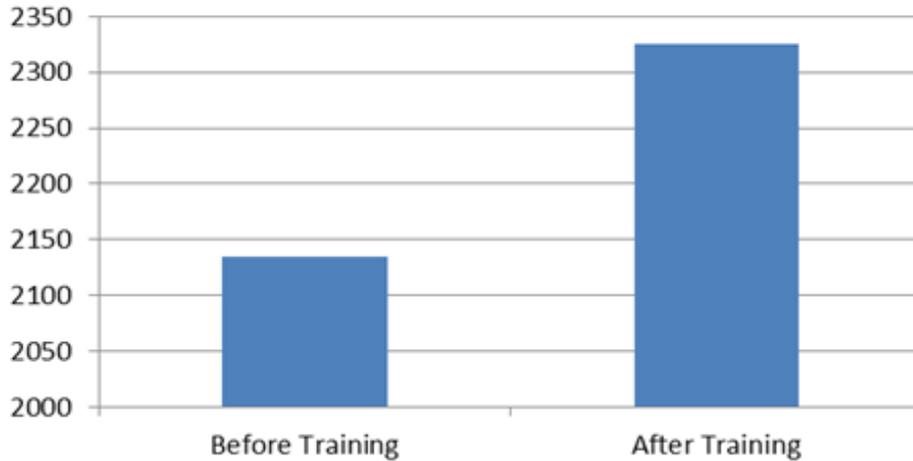
Improved confidence of staff

Qualitative feedback shows staff are more confident in their role, have more job satisfaction, and that the GSF tools enable them to make the most of what they do (GSF Data 2014-2015 across 45 care homes).

Proactive

Improved collaboration with GPs

Overall Confidence Levels



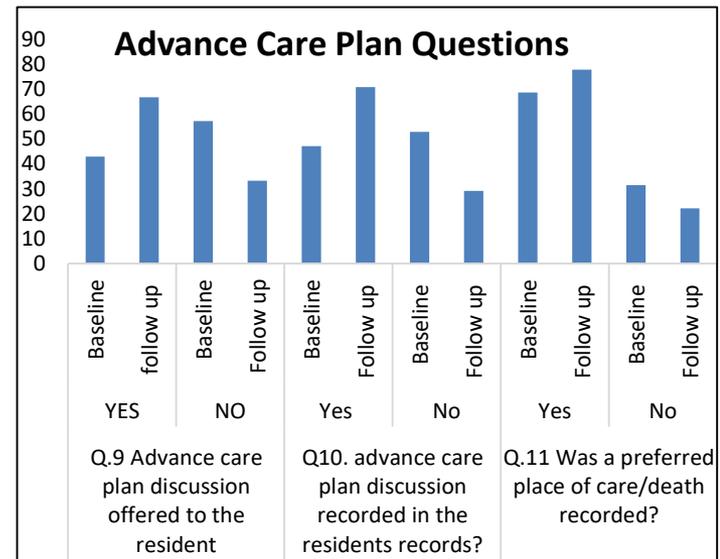
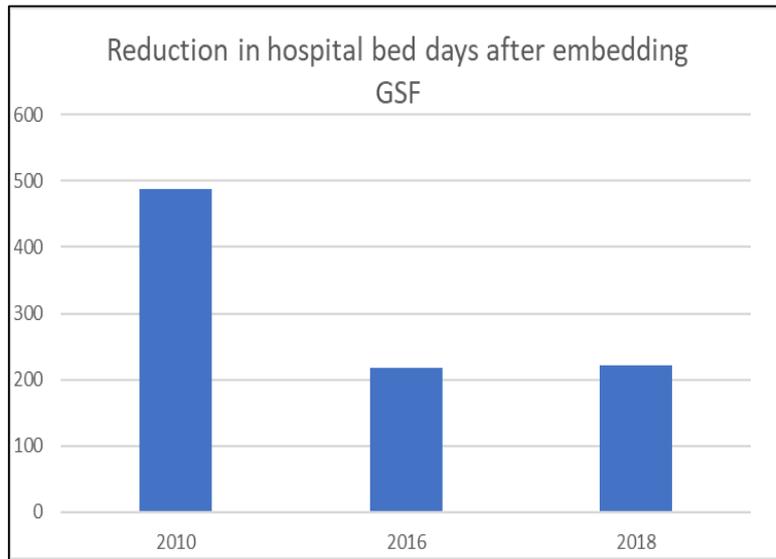
“Now since GSF we have a better relationship with our care homes, include their residents on our register and have reduced our hospital bed days from 488 to 222 – reduction of 266 bed days”

- Dr Laura Pugh GP Smethwick
- GSF Practice of the Year 2019

Person-centred

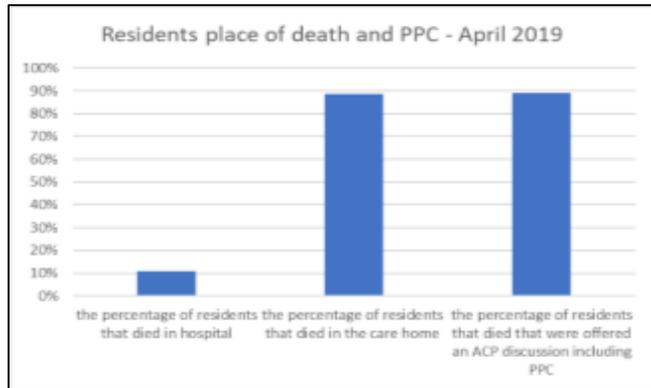
Offering advance care planning discussions

- Increased offering ACP discussions

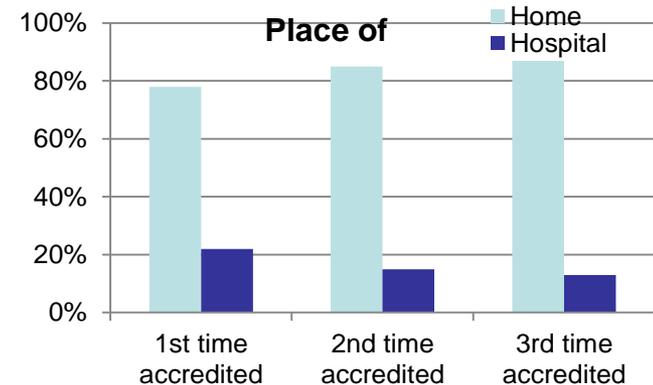
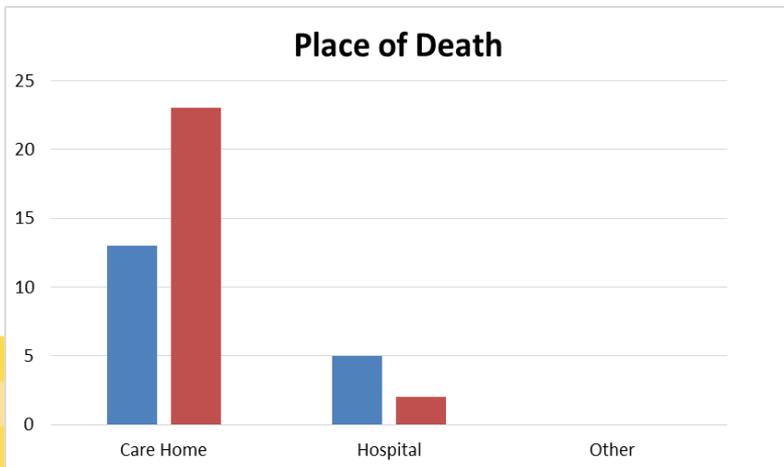
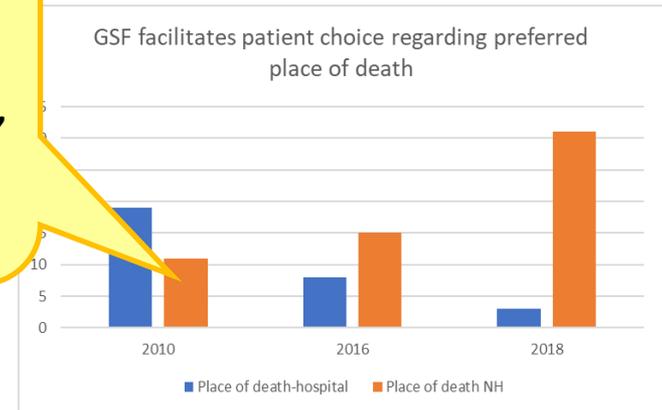


Well Coordinated / systematic

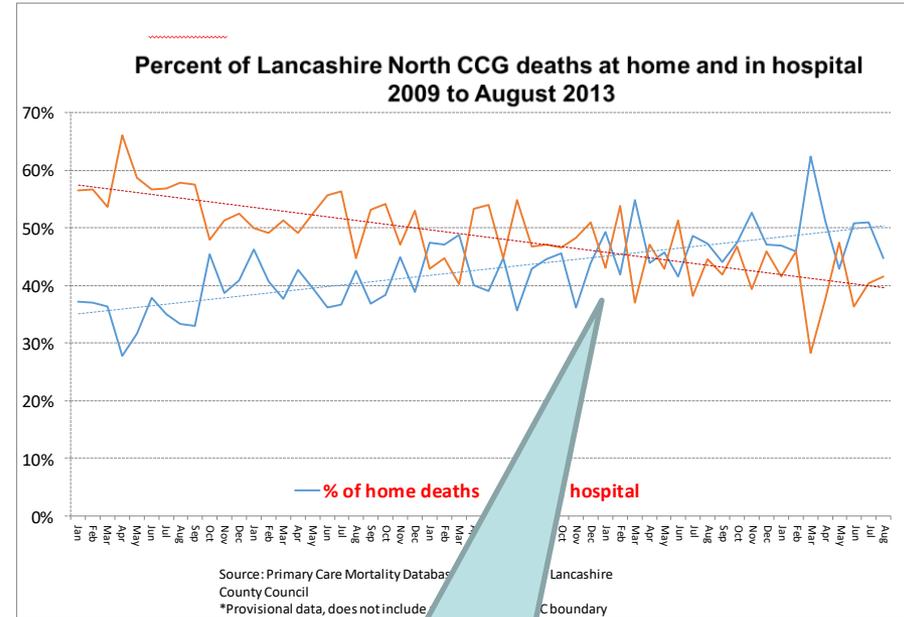
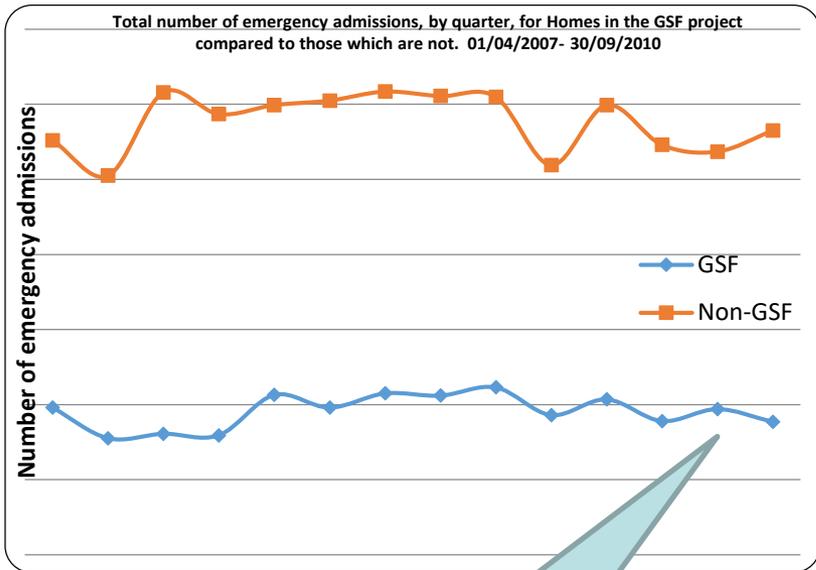
Reducing hospitalisation



In the GSF Accredited Care Homes, 89% residents are dying in their preferred place of care, (care home), and significantly fewer 11% dying in hospital



Reducing hospitalisation



Com
non-
reduc
comp
there
7.4%

Reduced number of emergency admissions in GSF homes compared to non-GSF homes of 20.6% compared to non GSF homes admissions of 7.4%

Tipping point More dying at home than hospital

Everyone has an important role to play

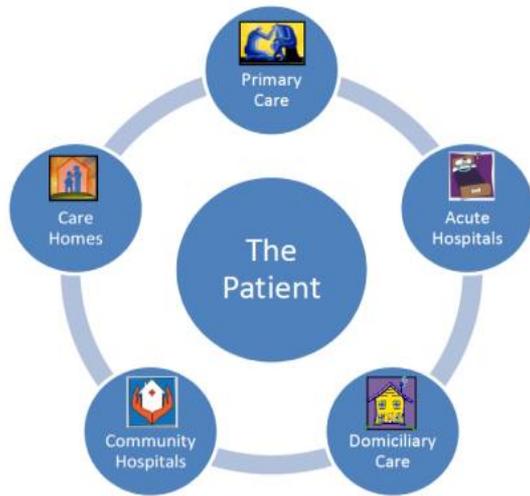
*“End of Life care
is everybody’s
business”*

Sir Bruce Keogh
CMO NHSE



4. Key areas for improvement and Next Steps

Integrated cross boundary care



- **NHS policy recognition of care homes** – Vanguards, EHCH , Ageing Well Programme, Long term Plan, contract GPs , QOF , NICE Guidance , Kings Fund etc
- **GPs improved collaboration** with Care Homes + domiciliary care
- **Proactive** early identification
- **Person-centred-** offering ACP
- **Well-coordinated**, integrated care reduced hospitalisation ,
- **GSF Accreditation** highly regarded as a kitemark for quality 20 years on

Gold Standard End of Life Care

-GSF is part of the solution

the gold standards
framework[®]



Tried and tested for 20 years

Putting policy into practice on the ground to help

- **Identify** - *proactive*
- **Assess** – *personalised*
- **Planning** – *coordinated care*

Contact us for more details www.goldstandardsframework.org.uk
info@gsfcentre.co.uk

– see leaflets at back