

Summary of Evidence

Gold Standards Framework Care Homes (GSFCH) Training programme

National GSF Centre Updated September 2016

This summary of evidence describes the value and impact of use of the GSF Care Homes programme since it began in 2004 in about 3000 care homes in over 40 project areas/CCGs. It includes evidence related to three areas – **(1) improving the quality of care, (2) the coordination and collaboration and (3) patient outcomes**, specifically reducing hospitalisation and enabling more to live and die where they choose.

This underpinning evidence for effectiveness of GSF in Care Homes includes use of

- The intrinsic GSF CH evaluations for local audits of groups of homes (using GSF metrics such as After Death Analysis, Key Outcomes Measures, organisational questionnaires etc.),
- Larger scale area-wide reports for commissioned projects (e.g. Barking Havering Redbridge, Airedale etc.),
- Published grey literature, testimonies and qualitative feedback and published peer review papers evaluating GSF CH.

Key message: GSF enables the right care for the right person in the right place and at the right time, every time.

The GSF Care Homes Programme improves:

1. Quality:

- a) **Culture** - Through transforming the culture and quality of care with sustainable long term improvements. Encouraging an open, realistic approach to discussing dying and quality of care for dying.
- b) **Workforce** - Improving job satisfaction, staff recruitment and retention. Developing staff confidence, morale and motivation giving care. Encourage an open, culture and approach to discussing dying and quality of care for dying.
- c) **Patient Centred Care** - Helping residents live well until they die, and die well where they choose. Promoting more personalised care in line with person centred approach.
- d) **Proactive & Anticipatory** - Facilitating proactive care and anticipatory care planning
- e) **Standards & Governance** - Improving documentation (including ACP and DNAR forms) , recording, and communication with all care homes staff. Promoting more personalised care and person centred approach through advance care planning discussions. Improving standards of care through governance. Earlier identification of patient needs

2. Coordination:

- a) **Proactive early identification of patients**
- b) **Team work and collaborate with team**
- c) **Enable team-working and information sharing with external teams; promoting collaborative working with GPs, District Nurses, Palliative Care and other specialists.**
- d) **Carer Support**

3. Outcomes:

- a) **Improve patient centre care** - Enabling more to live and die in the place of their choosing. Significant reduction in numbers of hospital deaths (e.g. halved) and crisis hospital admissions. Reduced length of stay in hospital. Fewer crises calls out of hour.
- b) **Symptom control** - Improving effective assessment and management of symptoms, including anticipatory planning and management.
- c) **Cost effectiveness** - Enabling cost effectiveness and cost savings for the NHS
- d) **Sustainability**

End of Life Care and GSF – why is this important?

Key message: Care Homes play a vital role in caring for large numbers of the population nearing the end of life, though there is limited training and resources to support them.

About a fifth of the population die in care homes, over half die in hospitals, and about 80% of care homes residents are considered to be in their last year of life. Many hospital admissions could be avoided enabling more to live and die where they choose with better community care and with better trained staff - estimated at 40-50% hospital deaths in the NAO Report ¹³.

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 our ageing population, taking an earlier more proactive population based approach will enable better care for more people and fewer avoidable admissions and deaths in hospitals, allowing better integrated cross boundary care for a greater population of people. With hospital admissions and prolonged lengths of stay causing significant expenditure and backlogs in the system, this also leads to better use of limited resources at a time of decreasing funding.

Improving End of Life Care is a priority and an ambition of the Department of Health ¹², NHS England and Health Education England. But how can such transformation happen on the ground and what evidence is there that systematic proactive care can improve patient experience of care, coordination and patient flow across boundaries of care, cost-effectiveness and outcomes?

How does GSF help?

Key message: GSF is a proven, cost effective quality improvement programme, with sustainable proven outcomes and impact across the whole system of care in local areas and significant patient benefits.

The Gold Standards Framework (GSF) Centre is the leading provider of EOLC training for frontline health and social care staff in the UK. GSF provides, evidenced based service improvement programmes (quality improvement) with compliant high standards of care and ongoing support (quality assurance) and Accreditation (quality recognition) that can be used to enhance the commissioning of services for all quality outcomes.

The role of GSF since 2000 and GSFCH since 2004 in improving this care is clearly identified within The End of Life Care strategy in 2008¹⁷ *“Every organisation involved in providing end of life care will be expected to adopt a coordination process such as the GSF”*¹⁷, NICE Guidance and many national policy health and social care documents. Thus, GSF can play a key part in transforming end of life care, providing a flexible, empowering model, which can adapted to local need.

Developing from grass-roots experience into a ‘national momentum of best practice’ within care homes, primary care, hospitals, prisons and hospices, GSF now involves almost 3000 homes, and is recognised as a marker of excellence in end of life care by CQC and others. GSF enable frontline teams to improve the quality and organisation of care, through early identification of those who are in the last year of life, improved listening and assessment of need and planning of cross boundary care. The GSFCH programme optimises quality of care and is well respected clinically. Through implementation of GSF there has been a step-change in the quality of care for many thousands of people, and significant NHS cost-savings through reduced hospitalisation. The GSF Centre provides training programmes to the NHS, Local Authorities and social care across the UK and internationally.

Outcome measurement

Key message: GSF has an established set of outcome ratios and evaluation, which demonstrates improvement in Quality of Care; Coordination and Collaboration; and Reduced avoidable hospitalisation

Measurement of EOL quality of care is challenging, but essential. Over time, GSF has established a unique set of key outcome ratios, audit and feedback for evaluation, which fit around the NHS Outcomes Framework¹⁴, NHS England Actions for EOL Care (2014)¹⁵, Social Care Policy and NICE Quality Standard for End of Life Care Standards (2011)¹⁶. Quality improvements, such as staff confidence, patient and carer experience are further evaluated through case studies based on feedback from participants. These give insight into the qualitative outcomes of participation in a GSF programme. These established metrics of measurement enable GSF programmes to collate cumulated evidence demonstrating the achievements and benefits of participation and to continue to evolve.

1. Quality

a. Culture

Key message: GSF transforms the culture of end of life care for patients, for families and staff.

Finding	Evidence
<ul style="list-style-type: none"> • GSFCH programme changes the culture of care from reactive to proactive planning, increasing patient centred care. Residents are involved in decision making, and facilitating improved communication, team-working and collaboration. • Residents, relatives and staff benefit from cultural changes in perception of roles and responsibilities, a sense of working together and pride in giving quality care. • The GSFCH programme enables staff to confidently raise discussions regarding individual needs, wishes and preferences, not just as a one off event, but more effectively as part of the culture of care they provide. • Staff are enabled to support implementation of choices and communicate these preferences. 	<p><i>“GSF provided a vision of what end of life care can look like and the mechanism to deliver it. It is changing culture and practice in a really significant way. It’s been transformational”</i> (Dr Peter Nightingale Former RCGP EOL lead)</p> <p><i>“GSF has really pulled us all together as a team, both in the home and with our health and social care colleagues”</i> (Care Home staff member)</p> <p><i>“It’s been life-changing for us, improving all aspects of care, not just towards the end of life.”</i> (Manager of GSF accredited care home)</p>

b. Workforce

Key message: GSF improves staff confidence to manage the challenges in end of life care.

Delivery of high quality end of life care is dependent upon an effective, skilled and knowledgeable workforce, working within a pro-active culture of care. Research has demonstrated that GSF increases knowledge, empowerment and confidence⁴, enabling staff to confidently assess, monitor and meet the needs of dying residents¹.

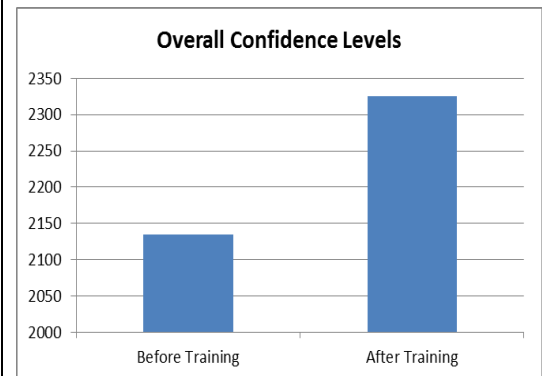
GSFCH programmes measure confidence across 10 areas, pre and post-participation in the GSF programme. The largest increases in confidence have been evident in the areas of planning cross boundary care, having and recording ACP discussions with residents, and assessing their clinical needs.

GSF has been shown to increase confidence levels by 24% - 28% (GSF data 2014).

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

(Care Home GSF Lead Nurse)

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).



c. Patient centred Care

Key message: GSF facilitates ACP such that patients and carers receive care, support, information and symptom management in a timely and coordinated fashion.

One of the building blocks for enabling patient centred care understands their preferences and choices. Advance Care Planning (ACP) can provide a communication process for articulating preferences in anticipation of possible decline in health.

Such advance care planning discussions establish patients' sometimes unvoiced preferences, empowers staff to communicate and advocate wishes, enabling more people to live as they choose. However, these discussions can be emotive and difficult, and require communication skills and confidence across the workforce.

Following training, homes have reported offering 100% of residents an advance care plan discussion (GSF data 2014 n = 45 care homes).

"It is so fantastic to see good theoretical policies put into practice and I want you to know that your framework really has made a difference....Dad died with dignity, pain free, able to stay in his "home", surrounded by his things and looked after by people that cared and who knew him well." (Relative of a resident who died in a GSF accredited care home)

"At GP appointments and meetings with social workers we raise GSF with them and are able to implement it. For example we had a terminally ill lady and she stayed at the home because everybody involved knew and agreed this and the family wanted them to stay there too. Before we would not have had the ability to negotiate this" (Care home staff member)

d. Proactive, Anticipatory

GSF increases the use of recognised symptom assessment tools by 28.5% following the programme (n = 30 care homes). Assessment of clinical needs have also been shown to increase, with GSF facilitation, by 27% from 65% to 92% (n = 45 care homes). Thus, GSF facilitates timely, individualised assessment, and is pivotal in providing individualised, patient-centred care with anticipation of crises. This leads to proactive care planning and management.

- Early recognition and decline
- Use of PIG
- Needs based coding (including blue) for all residents.
- Anticipate needs with Advanced Care Planning.
- Anticipate crisis – Medication, Out of Hours.
- Prevent hospitalisation

Anticipatory prescribing is an important element of the ability for teams to provide timely symptom management. Following implementation of a GSFCH programme 80.55% of residents had anticipatory drugs in place as opposed to 60% pre-GSF.

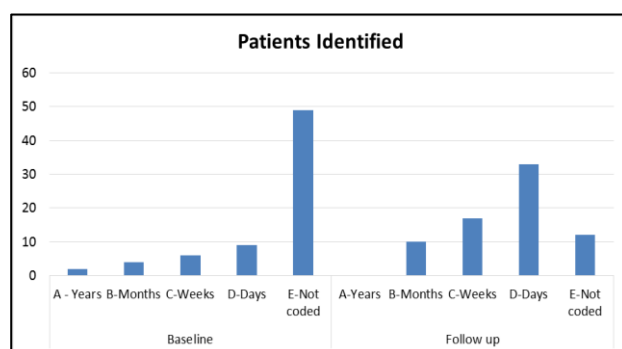
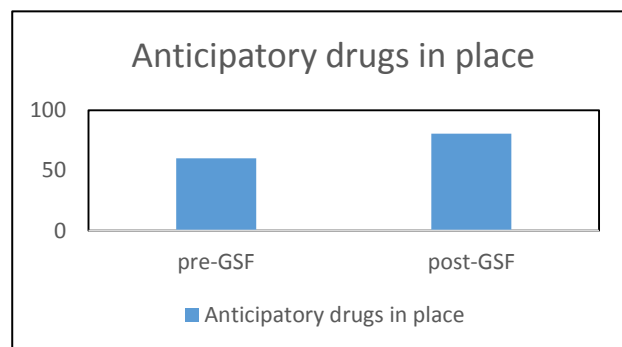
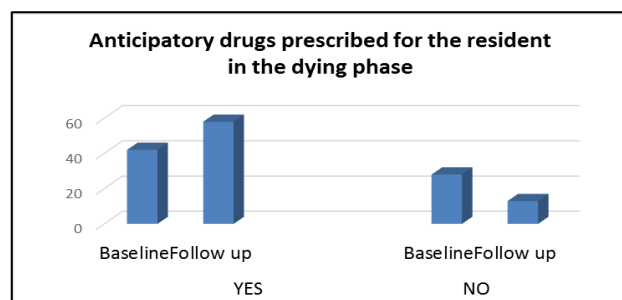


Figure 6: Impact of GSF on Anticipatory Drugs in Place (2015)

e. Standards and Governance

Key message: GSF reinforces robust governance through improving standards and accreditation.

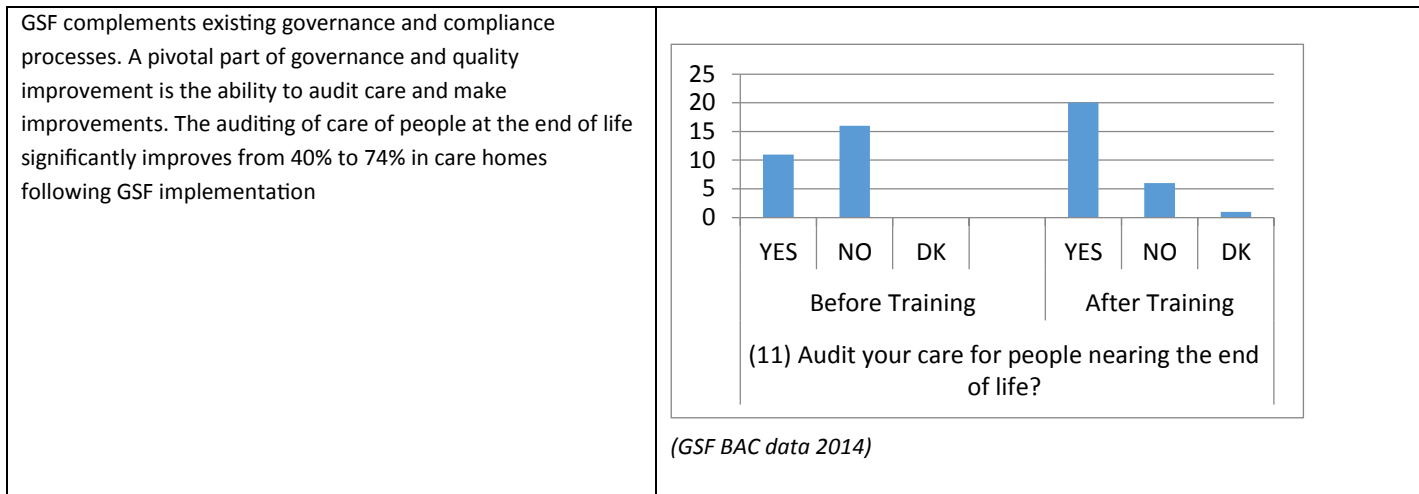


Figure 1: Auditing of patient care before and after GSF training programme

<p>The GSF Quality Hallmark Awards are endorsed by the Royal College of General Practitioners, National Skills Academy and the Care Quality Commission.</p> <p>GSF programmes are recognised by the CQC as a marker of excellence and provide a quality assured approach to end of life care across health & social care, with many GSF accredited homes identified as ‘Excellent or good’. GSF fulfils the essence of the Care Act (2014) and has principles embedded in governance, promoting ongoing development of practice through the use of after death analysis audit tools, ‘key outcome ratios’ and reflective feedback from participants, patients and carers.</p>	<p><i>“GSF is constantly seeking to make the end of life experience a good one”</i></p> <p>(Professor Martin Green, Chief Executive Care England).</p>
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2. Coordination

Key message: GSF improves coordination across care sectors and communication with patients and carers.

GSF enables teams to work cohesively through earlier identification of patient needs, enhancing collaboration with and between teams, whilst facilitating carer assessment.

a. Proactive care and early identification of patients needs

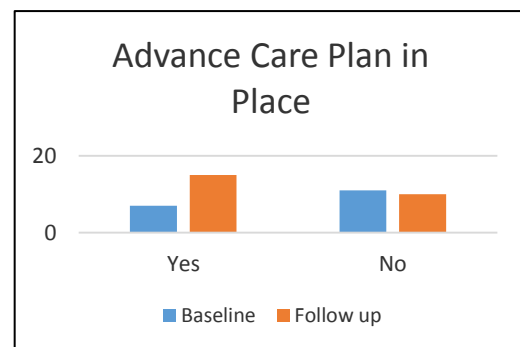
Key message: GSF enables people to live well until they die through proactive care planning and support

GSF builds knowledge to identify those who may be nearing the end of life. With the help of GSF tools, such as the prognostic indicator guidance (supported by the RCGP), triggers and a colour coded system, staff are enabled to identify patients who may deteriorate more effectively. Once identified, this can trigger support, clarify their needs, give opportunity for advance care planning discussions, and enable more patient and carer involvement in decision making to ensure they 'live well until they die'. This is based on consideration of people's needs, rather than predicting exact timescales, acknowledging that people need different things at different times. As many care homes residents are frail or have co-morbidities (both of which are poor prognostic factors) **all** care homes residents are assessed for end of life needs.

GSF therefore enables effective planning and increases the opportunity to have desired conversations regarding choices and advance care planning. This is through patient centred individual assessment and anticipation, delivery, and coordination of care and support at the **right care at the right time and for the right patient.**

"We are now able to provide much more coordinated care and are working even more closely with our colleagues, including the two care homes we work with" (GP Partner)

Staff perceived that the use of the end of life care tools and staff education improved their assessment skills of the physical and cognitive decline and improved the care of the dying resident¹. Using the GSF coding system an average of 81.24% of residents who died across the first, second and third time accredited homes were identified as in their last days or weeks of life. Utilising GSF increases identification of people nearing the end of their lives by 52%, from under 44% to just over 96% (BAC GSF data 2014).



b. Team work collaborate with team

Key message: GSF empowers staff to work better with GPs and other health and social care professionals.

<p>GSF facilitates effective collaboration and communication across services and between teams enabling coordination of care. The GSFCH programme helps</p> <p>‘to improve the quality and quantity of communication and collaboration between nursing home staff and primary care and specialist practitioners’ 4</p> <p>This is vital to achieving people’s wishes and improving experience and safety of care.</p>	<p><i>“GSF has really pulled us all together as a team, both in the home and with our health and social care colleagues” (Care home staff member)</i></p>
<p>Communication can be demonstrated through the use of handover forms with other services and the use of EPaCCs or locally held End of Life Registers, plus the reduction in hospital admissions following the use of GSF. This is partly due to the opportunity for communication through regular review as care home staff gain confidence in participating in discussions.</p> <p>Staff highlight that skills and knowledge developed through participation in GSF and the regular review structure gives opportunity for disseminating learning, and enhancing team-working and integration.</p>	<p><i>‘We are now more aware about what is happening, what we need to do, planning what we are doing’ (Care Home staff member).</i></p> <p><i>“We have regular meetings and talk about GSF and end of life care. There is more structure and more discussion with GPs including talking about GSF. We have had a new GP recently and staff have been adding to his knowledge” (Care Home staff members)</i></p>

c. Collaboration with other teams and GP’s

Key message: Staff feel more confident following GSFCH programme to support and inform carers, so carers feel informed and supported.


<p>Carers’ feedback is collected as qualitative and quantitative evidence of impact of GSFCH. Following GSFH participation carers’ assessment increases, and access to information and support is increased and sustained (including following bereavement where over 90% of relatives have been offered bereavement support).</p>	
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Figure 2 Proportion of carers offered bereavement support following GSFCH programme (2015)

d. Carer support

GSF evidence shows positive Next-of-Kin feedback following the implementation of GSF with a 100% positive feedback for the questions below (GSF BAC data 2014)

- Q1. I felt supported by staff at the nursing home during the last weeks/ days of my loved one's life.
 Q3. I was informed of my loved one's condition in advance and was given the opportunity to be with him/ her
 Q6. Staff made an effort to ensure everything was clearly explained to me
 Q7. Information was explained to me in simple and easy to understand language
 Q8. Staff were professional during the last weeks/ days of my loved one's life
 Q9. Staff were well prepared in delivering end of life care to my loved one
 Q10. The symptoms of my loved one were kept under control
 Q12. I was given the opportunity to spend time with my loved one before they died
 Q13. My loved one was made as comfortable as possible during their end of life care.
 Q15. My loved one died peacefully
 Q17. I felt supported by staff at the nursing home after my loved one passed away

Thus, communicating and working in partnership with carers is improved following the GSFCH programme, promoting more involvement and ensuring all relevant people are informed of plans of care. The GSFCH programme supports carers' assessment and involvement in end of life discussions, building confidence of staff to hold what can be emotive discussions regarding planning and to keep carers informed.

"Before the training staff were not fully aware and involved in end of life care. Now all staff and ancillary staff are aware that they are part of the programme and they are interested and caring, supporting families and asking how they are. The families are more relaxed and are kept informed about conditions and they can ask questions. They are reassured and are less anxious as they are better supported" (Telephone interviews BHR project 2015).

Key message: GSFCH programmes demonstrate positive outcomes in cost effectiveness, reducing hospitalisation and assessment

3. Outcomes

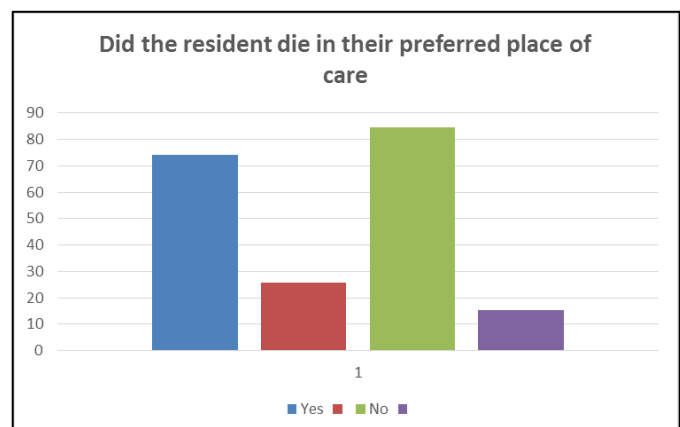
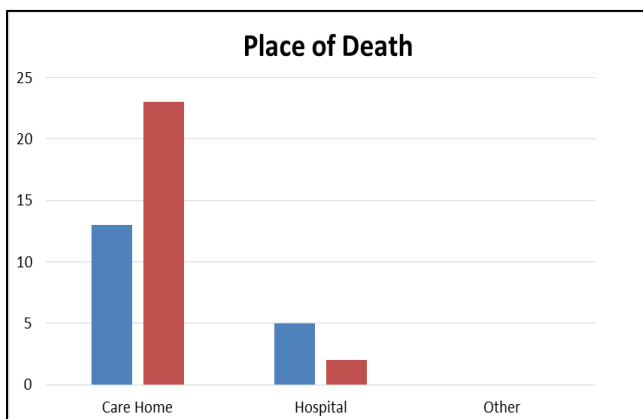
a. Person centred care in line with ACP and DIAPOC

Enabling more to live and die in the place and the manner of their choosing:

Key message: GSFCH training program enables more people to live in the place and manner of their choosing and reduces hospital deaths, crisis admissions and length of stay in hospital.

i. Reducing hospital deaths, inappropriate crisis admissions and length of stay in hospital

The care homes population have particularly high admission rates and care home residents who are hospitalised are more likely to die within 24 hours of admission¹⁰. The National Audit Office Balance of Care report (2008), suggested that 50% of frail care homes residents who died in hospital could have been cared for elsewhere, in line with their preferences and with significant cost savings to the NHS.



Outcomes of GSFCH are aligned to national social and health care policy and include reducing admissions, preferences and choice, reducing length of hospital stay and timely symptom assessment and care planning

b. Cost effectiveness

Key message: GSF improves cost effectiveness and reduces cost to the NHS

- **Halving admissions from care homes**
- **Halving hospital deaths**
- **Reducing length of stay in hospital; Improved discharge times**

Potential Cost savings for NHS:

It is well documented that inappropriate admissions have significant cost for the NHS, with varying valuations on the savings which reducing hospitalisation can incur per admission saved. Figures of between £2-300 per day and a comparative nursing home bed costing of approximately £100 per day^{18,19} are indicative of a saving of £100-£200 per day per patient. GSF evidence supports the drive to reduce inappropriate admissions with hospital deaths in GSF care homes being more than halved (13% in GSF Care Homes compared to 28.1% in the Non-GSF homes – (Somerset GSFCH programme 2012).

Examples of cost savings are shown below, based on these figures.

Furthermore, emergency admissions in the last year of their life are significantly higher than many perceive, with one study demonstrating that 28.8% of inpatients die during the year following admission⁵. The care home population are 40-50% more likely to have crisis admission than for the general population aged 75 or over. This saving may therefore be an underestimation.

For an example CCG with 50 care homes

- Admissions from care homes halved from average 40% to 20% per year
- Length of stay 10 days¹³

Potential saving for the NHS: £1-2 million per year

For an example Care Home with 30 beds

- Admissions halved

Potential saving: £40-80,000 per year

Key message: GSF has halved hospital admissions from Care Homes

These sometimes inappropriate, crisis admissions can be distressing for patients, carers and staff, causing increased demands on health and social care services, but can be prevented by early identification of needs, robust communication and coordination of care. Furthermore, once admitted, patients can experience an ensuing protracted length of stay in hospital.

One of the primary aims of GSF is to reduce hospitalisation of residents. Our aim is to make this a reality by halving hospital deaths and crisis admissions, and current figures show that this is achieved by many homes utilising GSF as evidenced below.

‘The most impressive outcome was the reduction in hospital admissions and deaths’. (Somerset staff member 2009)

The GSFCH programme has been shown to reduce hospital admissions and length of stay in hospital in the last year of life, with a reduction in avoidable hospital deaths (Hockley et al 2010).

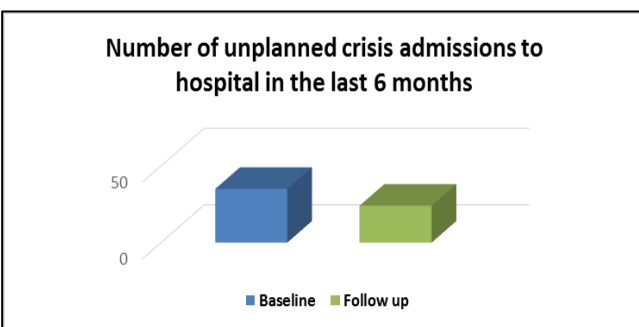
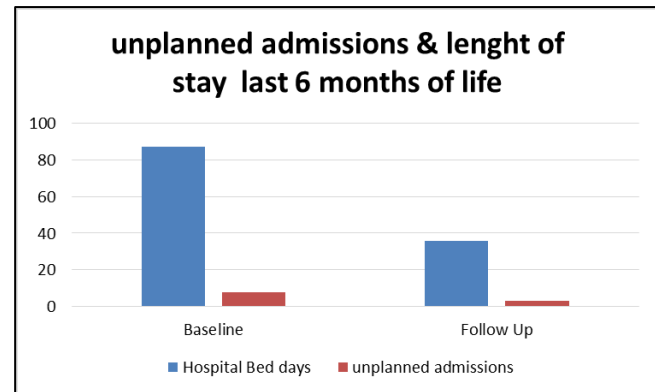
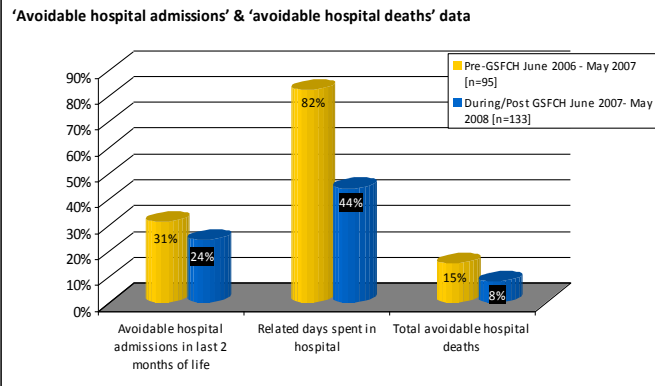


Figure 3: Reduction in avoidable hospital admissions and avoidable hospital deaths data before and after GSF Training (Hockley et al 2010)

Comparison pre and post programme has shown reduced crisis events and crisis admissions to hospital from 37.8% to 26.3%² and GSF Outcome data has shown a significant reduction from 44.4% of care home resident admissions to hospital in the last 6 months of life to 12% admissions.

Further GSF comparative data for care homes using GSF and care homes not using GSF, has been shown to reduce hospital admissions in GSF Homes by 20.6% (GSF), compared to 7.4% (in non-GSF). This aligns to the decrease in hospital deaths of residents in GSF-participatory care homes than care homes without GSF: 13% compared to 28.1% (Somerset GSF data 2009).

Following the GSFCH programme there is also evidence for a reduction in length of stay in hospital, with length of stay falling by 58% for those patients who were admitted from care homes participating in GSFCH (GSF data 2015) and an average of 6 days reduction in stay (GSF data 2012). This is achieved through the improved communication of people's preferences and coordination following participation in the GSFCH programme.

The GSFCH programme reduces hospitalisation by reducing the need for crisis decision making through identification of deterioration, and anticipatory care planning and prescribing.

"It's very helpful to know what people want, making it easier for patients, staff and families and helping to avoid crises"
(Lancashire Care Home Staff Member).

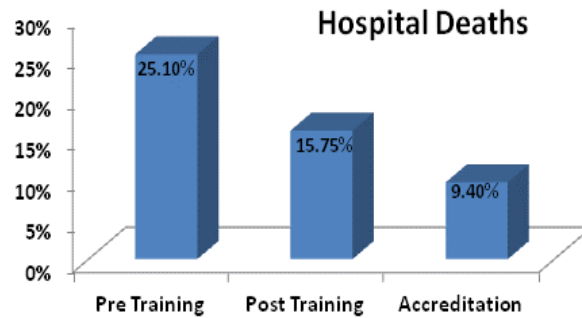


Figure 4: Hospital deaths before, after and at accreditation

Thus, a substantial value of accreditation is a continued improvement on reducing hospitalisation

GSF data shows that these benefits of GSF are sustained. Cumulated GSF 'after death analysis audit' results continue to show decreased hospital deaths and admissions following implementation of GSFCH Training programme and an even further decrease in hospital deaths following accreditation (GSF cumulated data 2015).

"He died peacefully in his bed surrounded by his family a few minutes later. Before we did GSF we probably wouldn't have had the confidence to do that and the patient would have died in the ambulance." (Lancashire Care Home)

c. Symptom Control

Effective assessment and management of clinical needs and symptoms

Key message: GSF facilitates clinically effective assessment, ensuring patients have assessment of symptomology and appropriate anticipatory medications in place.

Management of symptoms is an important element in high quality end of life care and impacts upon patient experience. Good symptom assessment and management can avert potential crisis admissions. GSF enables staff to be more proactive in their assessment, management and anticipation of symptoms, such that assessment of clinical needs supports decision making, effective planning and delivery of end of life care. Documentation and communication of this assessment is essential to promote coordination. GSF evidence shows that recording the stage of life and needs of residents on a register increased by 62.1% from 25.9% to 88% following implementation of GSF (GSF BAC Data 2014).

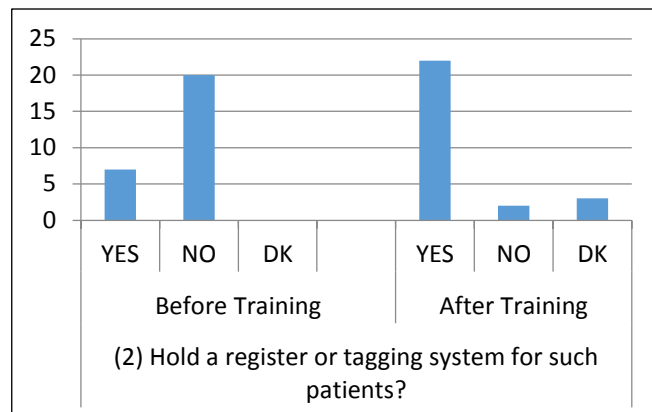


Figure 5: impact of GSFCH on recording the stage of life and needs of residents on a register or tagging system

d) Sustainability of improvements

Key message: Care homes can sustain real and tangible, ongoing good practice and development through the GSF reaccreditation process

Since 2009, when care homes were first GSF accredited, there has been evidenced, sustained and improved practice with continued use of GSF, with GSF Key outcomes ratios demonstrating sustained 80% achievement of standards

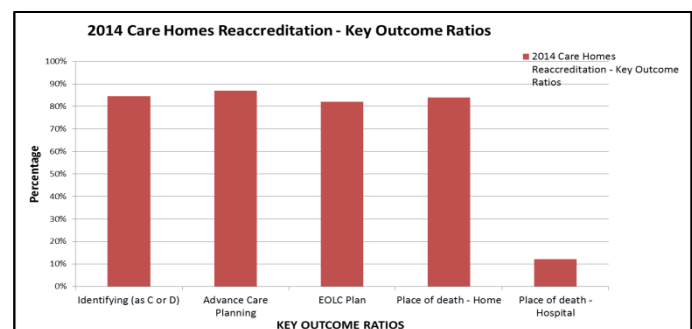


Figure 7: Care homes reaccreditation key outcome ratios (2014)

NB: Identification of patients as c or d suggests advancing disease or frailty/functional decline with continued deterioration and it is recognised there could be only months to weeks (c) or weeks to days (d) remaining; Appropriate decisions relating to care and support are in place, documented and communicated.

75% of first time GSF accredited homes achieve over 80% home death rate. This is sustained over time with care homes who have undergone a third round of accreditation with GSF demonstrating continued improvements in home death rate. 89.63% of residents remain in their care home until the end of their life, and 100% of residents in these care homes being offered ACP discussion. On the third round GSF accreditation 64.28% (n=14) of these care homes achieved between 90 and 100% home death rate and 21% of those had a 100% home death rate. (Data from Round 15 GSF accreditation & reaccreditation report August 2015).

Quality improvements, such as reducing emergency admissions, so people are enabled to stay in a care home at end of life, are evidently sustained longer term following use of the GSFCH programme. This is because the GSFCH programme empowers staff to continue to strive to maintain improvements, but to also continue to drive improvements in the quality of care.

“We hold [GSF] in really great esteem as a framework to drive continuous improvement. One of the things we find impressive is the reaccreditation program which....is always seeking to push boundaries further to make sure quality and safety ...is always being pushed on to new boundaries”

(Alan Rosenbach Special Policy Lead , Care Quality Commission)

Appendix 1:

Supporting Regional and Local Evidence: Audits and Reviews

Bradford, Airedale and Craven

31 care homes across Bradford, Airedale and Craven signed up to the project. Two of these homes merged leaving 30 homes undertaking the GSF training.

Summary of Outcomes

a. .Improvement in quality of care

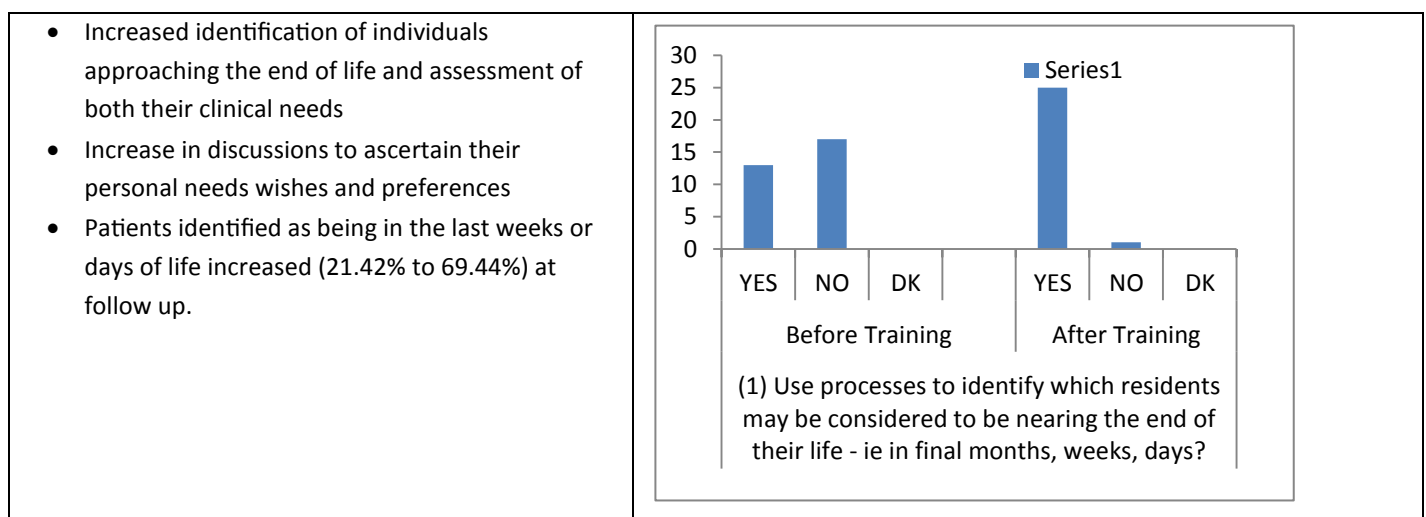


Figure 8: Impact of GSF on use of processes to identify residents considered to be nearing end of life

- Identifying the stage of life for each resident in the home showed a marked improvement; from 22.22% to 96.29% across the homes.
- The largest increases were seen in response to questions about coding. Routine coding of residents and informing GPs of residents' codes both increased by over 300%.

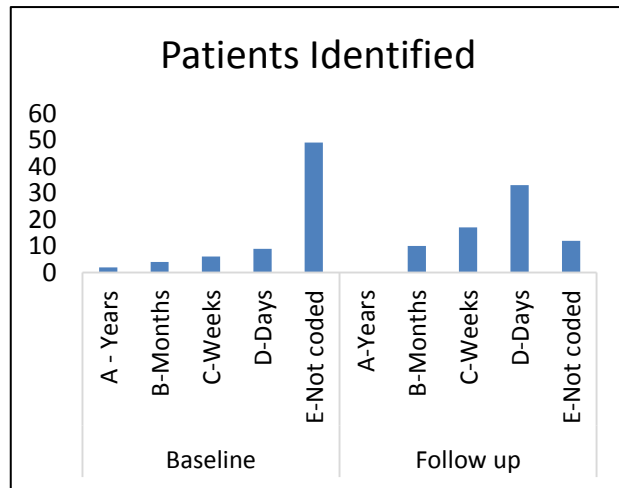


Figure 9: Impact of GSFCH on Coding

- 100% positive feedback for 11 of the 15 questions on the next of kin/bereavement questionnaire returns
- Increases in confidence were seen across all 10 areas measured. Comments included: "It has already helped me by giving me confidence to speak up for others who lack the ability to speak up for themselves" and GSF will "enhance communication skills and advocacy skills"
- Symptom assessment and anticipatory prescribing improved with 80.55% of the residents having anticipatory drugs in place at follow up as opposed to 60% at baseline. Use of recognised symptom assessment tools increased by around 28.5% at follow up. Reported assessment of clinical needs showed an increase of 24.63% from 62.96% to 92.59%
- Auditing care of people at the end of life has also shown a significant improvement from 40.74% to 74%

b. Staff confidence

- The largest increases in confidence were seen in the areas of having and recording ACP discussions with residents (16%), recognising residents who may be in the last year of life (18%) and planning cross boundary care (12%).
Improved Advance Care Planning

- There was an increase in homes stating that they routinely have Advance Care Planning discussions (11%), increases in homes routinely discussing preferred place of care with their residents and increases in staff confidence in having and recording Advance Care Planning discussions following the training programme.
- Residents not dying in their preferred place of care fell from around 26% to just over 15%

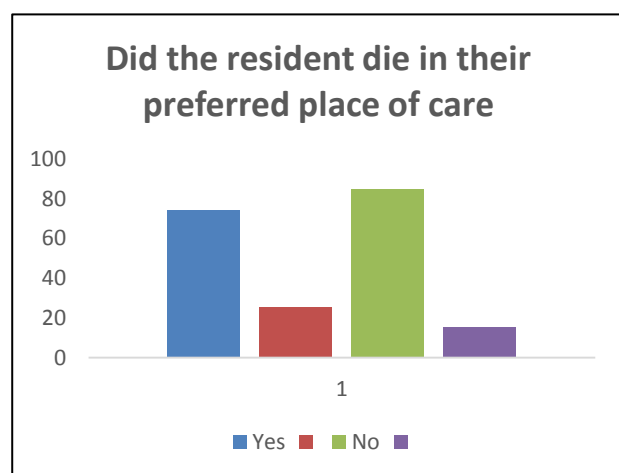


Figure 10: Impact of GSFCH on achieving death in preferred place of care

<ul style="list-style-type: none"> • At follow up stage the question “(Do you routinely) Discuss their preferred place of care?” Was answered “Yes” by 100% of respondents. • In the After death analyses there was an increase of 23.7% of residents having a documented advance care plan. Advance care planning discussions recorded for those residents that died increased from around 47% to 71% and those with a preferred place of care recorded increased by around 10% to 78%. At baseline the homes reported a good level of advance care planning discussions of 65% this increased to homes reporting that 92% of residents were being offered an ACP discussion. 	
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- Qualitative reflections on the after death analyses show a reduction in the number of issues caused by lack of identifying, planning and communication.

c. Reduction in crisis hospital admissions and length of stay for care home residents

- At baseline the ADAs recorded 26 admissions for 17 of the residents and a total of 250 hospital bed days. At follow up there were 33 admissions for 14 residents with a total of 210 bed days. However at follow up 10 of the admissions did not result in a hospital stay, whereas at baseline only one of the recorded admissions resulted in a same day discharge.
- Crisis admissions in the last 6 months of life, from the 16 homes that completed both base line and follow up ADAs showed a significant reduction of around one third from 33 admissions for 70 resident deaths to 24 admissions for 72 deaths. Reduction in hospital deaths of care home residents
- Although there was only a small increase of 11% in residents dying in their preferred place of care, the baseline data for these homes showed a higher than average home death rate, compared to national data, 74% of residents at baseline died in their preferred place of care. One of the homes registered for the current round of accreditation achieved 90% home death rate at baseline and 100% at follow up and accreditation submission.

[Barking, Havering, Redbridge \(BHR\) & Dagenham: Review of a quality improvement programme \(n= 45 care homes\)](#)

BHR CCG commissioned GSF to deliver the Care Homes Quality Improvement Training Programme to care homes. This was delivered at Saint Francis Hospice, a GSF Regional Training Centre, and supported by the National GSF team.

Summary of outcomes

i. Quality of care

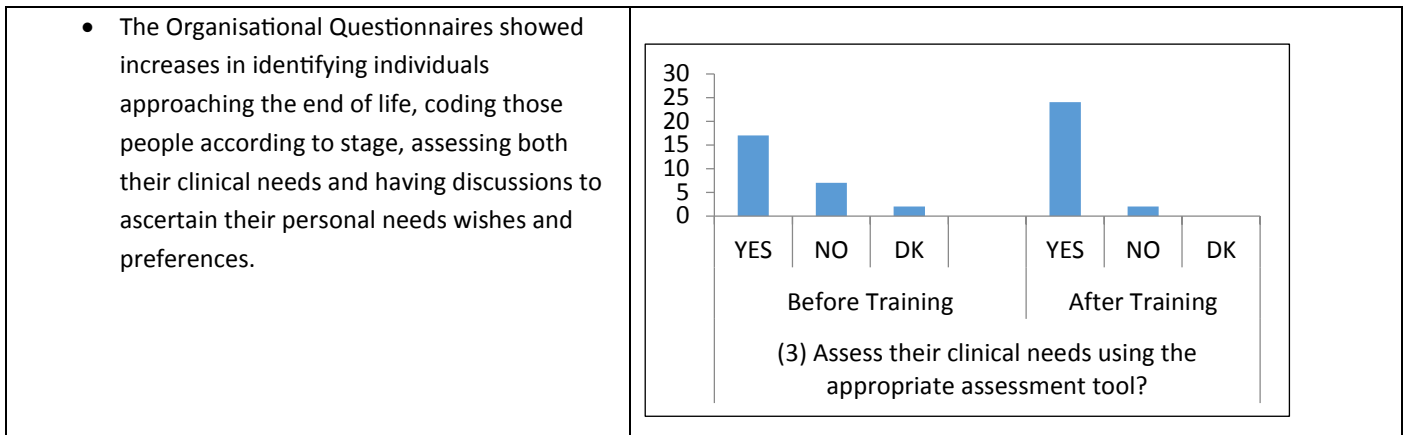
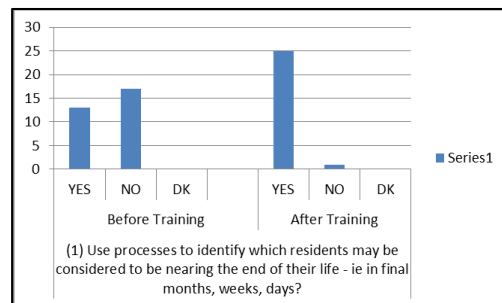


Figure 12: Use of Assessment Tool for Assessment of Clinical Need

- At follow up stage the question (6D) 'do you routinely) discuss their preferred place of care?' was answered 'Yes' by 100% of respondents.



ii. Staff confidence

- Increases in confidence were seen across all 10 areas measured with increases in overall confidence levels of between 24% and 28%; average confidence rating increased by between 24% and 90% across the three cohorts.

	Cohort A	B (n=25)	C (n=29)
Increased in average confidence rating	90%	24%	48%
Increase in overall confidence levels	25%	24%	28%

Table 1: Confidence increases in multi-cohort study.

- In addition qualitative feedback was provided by Coordinators attending the programme on the Overall Feedback Forms. Staff report being more confident in their role and that the tools enable them to make the most of what they do.

iii. Increase in advance care planning and recorded Preferred Place of Care

- There was an increase in homes stating that they now routinely have Advance Care Planning discussions with their residents following the training programme. There was also an increase in homes routinely discussing preferred place of care with their residents.
- There was also an increase in reported staff confidence in having and recording Advance Care Planning discussions. In the After death analyses there was an increase of 57% of residents having a documented advance care plan

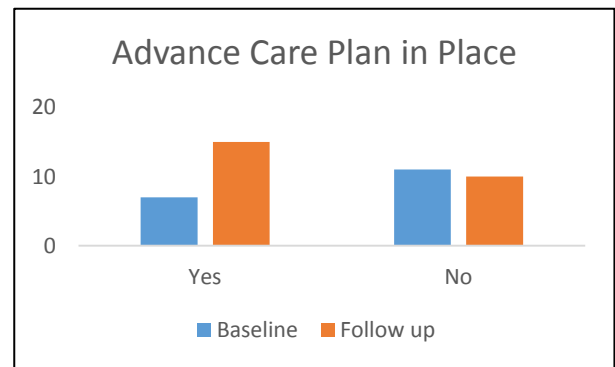


Figure 13: Advance Care Plan in Place

- Advance care planning discussions recorded for those residents that died increased from 39% to 96% .

iv. Reduction in crisis hospital admissions and length of stay for care home residents

- At baseline the ADAs recorded 87 hospital bed days and 8 unplanned admissions across 18 residents. At follow up there were 36 hospital bed days and 3 unplanned admissions for 15 residents, representing a 50% reduction in hospital bed days per resident and over 41% reduction in hospital admissions across the 6 homes. The homes After Death Analysis already showed a home death rate of 72% pre training, and this increased by 20% immediately following training.

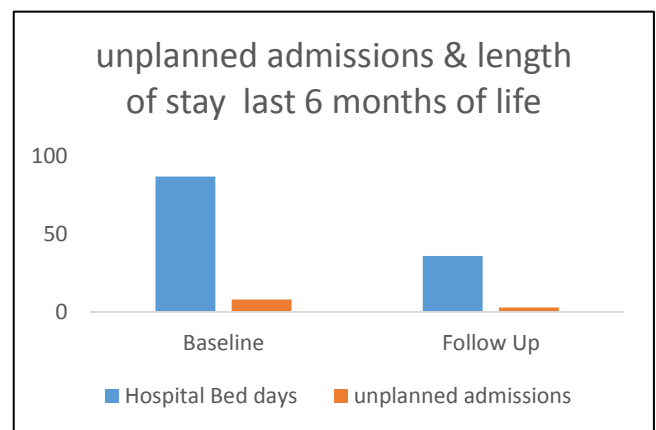


Figure 14: Unplanned admissions and Length of Stay

- Crisis admissions in the last 6 months of life, showed a significant reduction of around one third from 8 admissions for 18 resident deaths to 3 admissions for 25 deaths (n= 6 care homes). Hospital bed days fell by around one third from 87 to 36.

1. St Christopher’s Hospice: A longitudinal review of deaths occurring across 4 London Boroughs

Evaluation of the impact on admissions in a 3 year period during implementation of GSFCH across 53 nursing care homes, 5 primary care trusts and influencing the care of over 1,000 residents.

Summary of Outcomes

Table 3: Comparison of Place of Death.

The percentage of residents dying in nursing care homes increased by 15%

2. Somerset:

Comparison of hospital admissions, deaths and emergency admissions in GSF trained care homes (n= 67 Care Homes over a 2 year programme).

Planned outcomes

1. Improve the quality of care for all residents during their stay in the care home.
2. Improve collaboration with GPs, PHCTs and specialists
3. Reduce avoidable hospital admissions
4. Enable every care home with nursing in Somerset to use GSFCH
5. Improve the quality of end of life care in care homes
6. Enable more people to die with dignity in their care home
7. Reduce the number of acute hospital admissions from care homes
8. Reduce the number of people dying in acute hospitals following admission from a care home.

Summary of outcomes

Outcomes achieved:

Improvement in quality of care

- Improved quality of care demonstrated through the qualitative satisfaction survey.

Coordination and collaboration

- Anecdotal evidence of improved collaboration with GPs, PHCTs and specialists

Reducing hospitalisation

- Reduced avoidable hospital admissions: reduction in acute hospital admissions in GSF homes of 20.6% compared to before the project started. In the non GSF homes there has been a reduction in acute hospital admissions of 7.4% over the same time.

Comparison of data on deaths in nursing homes – 2007 to 2010	2007/2008	2008/2009	2009/2010
	% of deaths occurring in Nursing Homes [numbers of deaths]	% of deaths occurring in Nursing Homes [numbers of deaths]	% of deaths occurring in Nursing Homes [number of deaths]
TOTALS	57% [184 / 324 deaths – across 19 NHs]	67% [663 / 989 deaths – across 52 NHs]	72% [769 / 1071 deaths – across 53 NHs]

Total number of emergency admissions, by quarter, for Homes in the GSF project compared to those which are not. 01/04/2007 – 30/09/2010

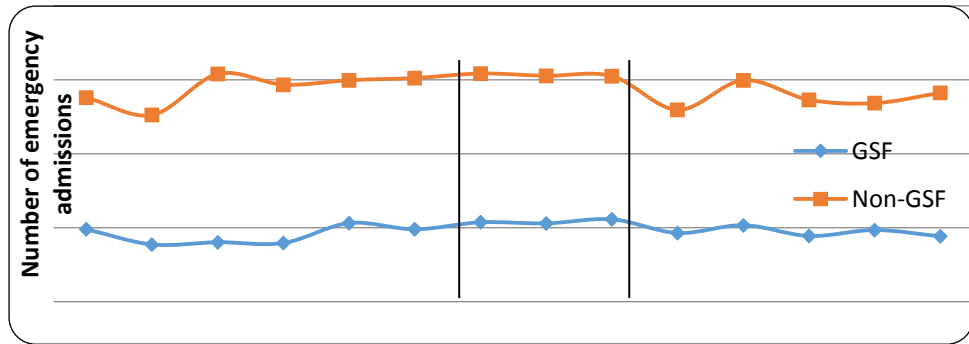


Figure 14: Comparison of admissions for GSF homes and non-GSF homes (The 2 vertical lines indicate workshop 1 and workshop 4).

- There is variation quarter to quarter, but the difference between the two groups does seem to continue as shown in figure 1, and comparing the changes from the start of the programme in April-June 2009 with the final full quarter available, July-September 2010, the GSF group has maintained a reduction in admissions of 20.6%, compared to a reduction of 7.4% in the non GSF group. Assuming that without intervention, admissions in the GSF group would have reduced at the same rate as in the non GSF group, this represents 29 admissions saved by that time.
- Between the start and end of the programme, both groups' admissions reduced. The GSF Care Homes programme has not been the only intervention aimed at Care Homes, but by the time of workshop 4, over the period of the programme, admissions had reduced by 20.2% in the GSF group, and 10.5% in the non GSF group.
- More people were able to die in their care home: The percentage of people dying in their care home rose from 81.1% to 86.9% in the GSF homes, and from 67.4% to 71.9% in non GSF homes.
- From the start of the project to the last quarter available, deaths in acute hospitals from patients from GSF homes reduced by 5.8% from 18.8% to 13.1%, and in the non GSF homes by 3.9% from 32% to 28.1%.
- Reduced number of people dying in acute hospitals following admission from a care: Deaths in acute hospitals for patients from GSF homes reduced by 5.8% from 18.8% to 13.1%, and in those from non GSF homes by 3.9% from 32% to 28.1%

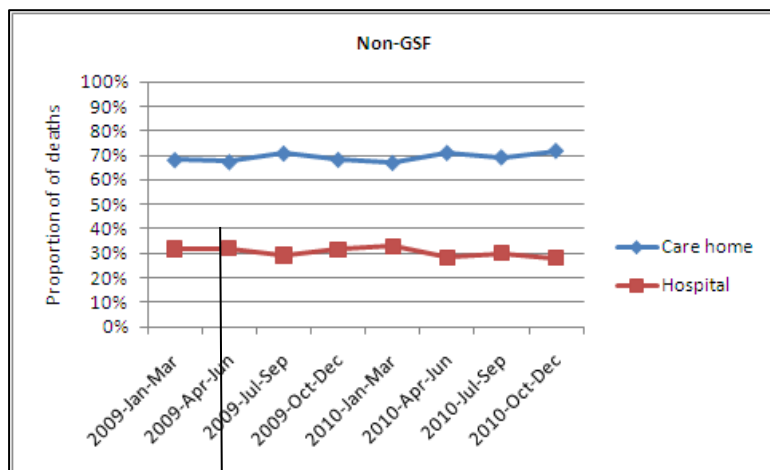
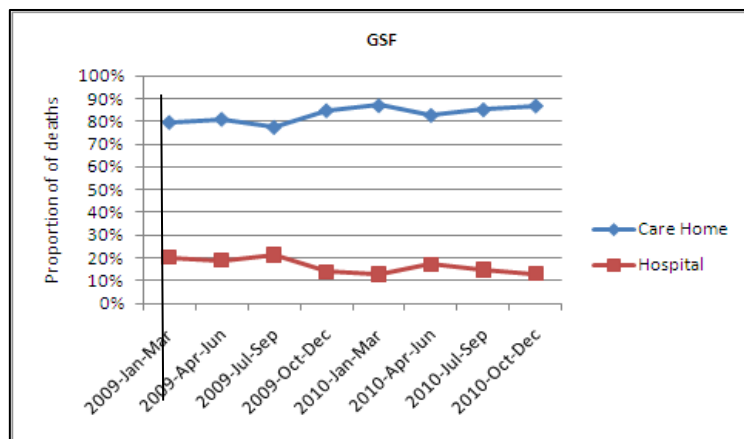


Figure 15: Deaths in GSF homes

Figure 16: Deaths in non GSF homes

- Over the same period of time the percentage of people dying in their care home rose by 5.8% from 81.1% to 86.9% in the GSF homes and by 4.5% from 67.4% to 71.9% in the non GSF homes.
- In the 9 months prior to the 1st workshop, the difference in admission rates between the 2 groups decreased; during, and after the start of the project, the difference in admission rates increased.

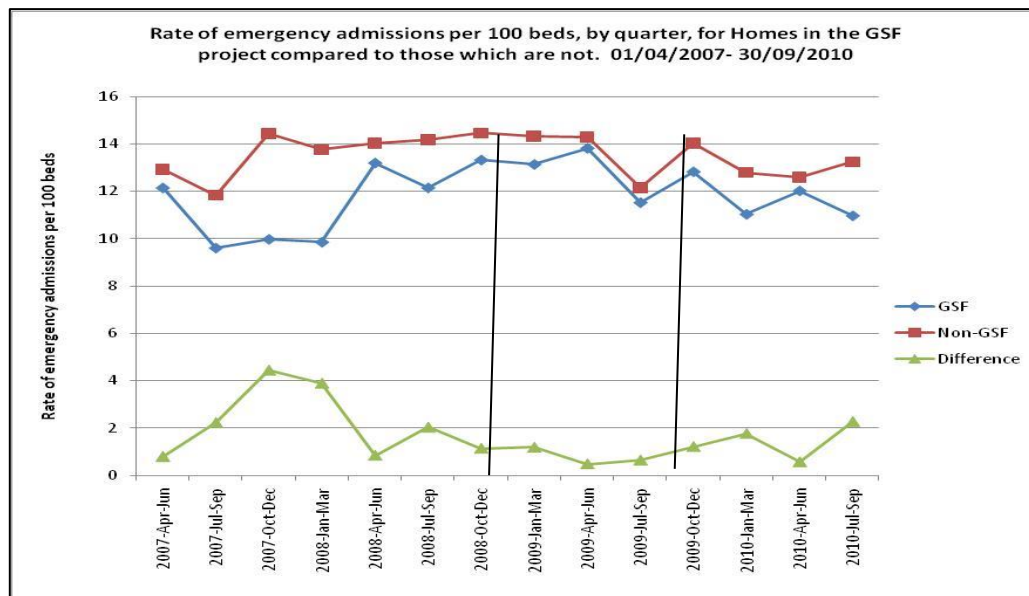


Figure 17: Admission rates per 100 beds with indicators of the 1st and 4th workshops

3. Manchester: GSF Care Homes Training Programme

Analysis using the ADA (After Death Analysis) Audit tool (n = 24 care homes).

Summary of Outcomes

- The number of days in hospital reduced by over 58% once GSF was implemented.
- The number of patients hospitalised reduced by 11% and their average length of stay by 53%.

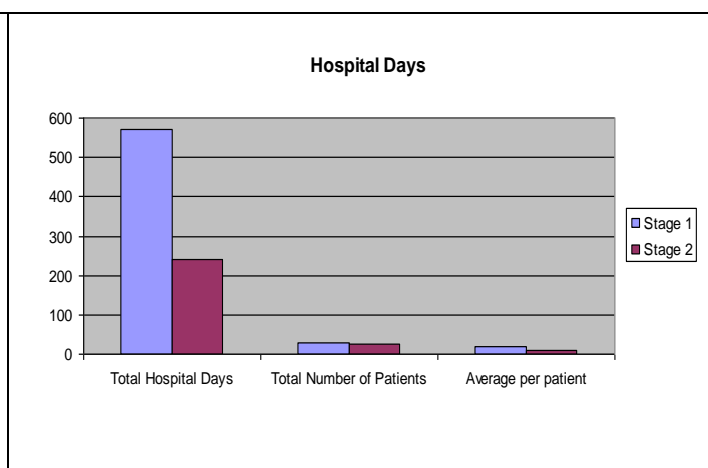


Figure 18: Reduction in hospital bed days

- The recording of a preferred place of care /death showed an increase from 51 to 83%.
- The number people dying in preferred place of choice rose from 47 to 74%.
- The Advance Care Plan discussion rose from 28 to 74% and ACP recording increased from 30 to 70% of cases.
- The use of GSF needs based coding rose from 13% to 81% overall.
- Once implemented in 27% of cases the respondents stated that nothing could be improved upon relating to the patients care.

Appendix 2: Supporting peer reviewed literature demonstrating evaluation and impact of GSF.

There are a number of peer reviewed research publications which support the value of GSFCH programme implementation. Some of these are summarised below. Further literature supporting the value and impact of GSF (including peer review literature) is available on the GSF website <http://www.goldstandardsframework.org.uk/evidence>

1. Improving Quality

There are three areas useful for development of End of Life Care (i) care planning, (ii) communication, and (iii) collaboration and coordination⁶. GSFCH programme improves all of these.

a. Transforming culture of care

- GSFCH improves end-of-life care by influencing end-of-life culture, decision-making and practice and changes culture and staff perceptions of care of the dying. Care home staff changed their attitudes about dying following implementation of GSFCH programme. This enabled more informed end-of-life decision-making involving families/friends, staff and GPs¹¹.

b. Workforce

- Agreement by care staff and the wider multi-professional team that the use of GSF tools promoted staff confidence to assess monitor and meet the needs of dying residents¹
- GSF increased knowledge, empowerment and staff reported increased knowledge and confidence in end-of-life care⁴
- Leadership is important in facilitation of GSF for nursing homes completing the Gold Standards Framework for Care Homes programme through to accreditation⁸.

c. Patient centred care and discussion of ACP

- The need for and the positive impact of GSF on development of communication skills to effectively hold ACP discussions⁹
- GSF increased discussion regarding CPR, increased use of a register enabling the identification of end-of-life care needs and increased use of ACP⁷.
- Advanced care plans, showed a statistically significant improvement between baseline and follow up with GSF²
- GSF facilitation has positive benefits on communication skills needed for ACP discussions⁹.

2. Coordination and collaboration

a. Earlier identification of patient needs: Prognostic guidance

- There are complexities facing relatives, residents and nursing home staff in the awareness, diagnosis and prediction of the dying; GSFCH program can enable staff to manage these complexities⁶.

b. Collaboration with teams and between teams

- GSF enhanced collaboration and networking with other services. Improved collaborations between home staff and health service practitioners were identified by 33% of managers as one of the main programme outcomes through increased knowledge and confidence. Reported levels of communication with GP's increased with staff feeling more confident to initiate contact and discuss end-of-life care with GP's and specialist palliative care colleagues⁴.

c. Carer assessment and support

- Written information provided for families, showed a statistically significant improvement between baseline and follow up after GSF².

3. Outcomes including reducing hospitalisation

a. Cost effectiveness

- Literature is scarce regarding cost benefits of interventions and impact value, specifically for care home residents, but the number of emergency admissions in the last year of their life are significantly higher than many perceive, with one study demonstrating that 28.8% of inpatients die during the year following admission⁵. This gives a perspective for potential cost save.

b. Reducing hospitalisation through enabling more to live and die in the place of their choice, reducing inappropriate crisis admissions and hospital deaths and length of stay in hospital

- GSFCH programme positively impacts on care home resident outcomes, with a direct and measurable effect on communication, continuity, reduction in numbers dying in hospital and less crisis admissions and crisis events. GSFCH programme yields a reduction in the number of hospital admissions from 31% at baseline to 24% with a subsequent reduction in inappropriate days spent in hospital in the last two months of life of 38%⁷
- Pre-programme 80.9% of residents died in the care home compared with 88.5% at follow-up. (This was mainly due to a decrease in the percentage of deaths in hospital). GSF decreased crisis events and crisis admissions to hospital. (Of the residents who died in the 6 months before the programme 37.8% had a crisis admission to hospital in the previous 6 months, whereas post-programme the figure was 26.3%). Staff attributed these changes in their approach to end-of-life care to the GSFCH programme².

c. Effective assessment and management of needs and symptoms

- Access to 'as required' medication at the end-of-life showed a statistically significant improvement following GSF implementation².
- Anticipatory prescribing is viewed as a key element in the management of pain and other distressing symptoms¹

Sustainability of improvements

Appropriately funded structured programmes, such as GSF, have the potential to assist nursing homes improve the provision of end-of-life care to older adults, in line with government health policy²

Appendix 3: References

Supporting Research Literature

1. Ashton, S., McClelland, B., Roe, B., Mazhindu, D. And Gandy, R., (2010). End of life care for people with dementia: an evaluation of implementation of the GSF and LCP... Gold Standards Framework...Liverpool care of the Dying Pathway. *Palliative Medicine*, 24(2), pp. 202-202 0
2. Badger, F., Clifford, C., Hewison, A., Thomas K. (2009). An evaluation of the implementation of a programme to improve end of life care in nursing home. *Palliative Medicine* 23; 502. Originally published online 28 May 09; Badger F, Thomas K, Clifford C (2007) Raising Standards for Elderly People Dying in Care Homes *European Journal of Palliative Care* for publication; 14 (6)
3. Badger, F. J., Shaw, K. L., Hewison, A., Clifford, C., and Thomas, K. (2010) *Gold Standards Framework in Care Homes and Advance Care Planning*.
4. Badger, F., Plumridge, G., Hewison, A., Shaw, K. L., Thomas, K., and Clifford, C. (2012) 'An Evaluation of the Impact of the Gold Standards Framework on Collaboration in End-ofLife Care in Nursing Homes. A Qualitative and Quantitative Evaluation'. *International Journal of Nursing Studies* 49 (5), 586-595
5. Clark, D., Armstrong, M., Allan, A., Graham, F., Carnon, A., and Isles, C. (2014) 'Imminence of Death among Hospital Inpatients: Prevalent Cohort Study'. *Palliative Medicine* 28 (6), 474-479
6. Johnson, M., Attree, M., Jones, I., Al Gamal, E., and Garbutt, D. (2014) 'Diagnosis, Prognosis and Awareness of Dying in Nursing Homes: Towards the Gold Standard?'. *International Journal of Older People Nursing* 9 (2), 95
7. Kinley, J., Froggatt, K., and Bennett, M. I. (2013) 'The Effect of Policy on End-of-Life Care Practice within Nursing Care Homes: A Systematic Review'. *Palliative Medicine* 27 (3), 209-220
8. Kinley, J., Stone, L., Dewey, M., Levy, J., Stewart, R., McCrone, P., Sykes, N., Hansford, P., Begum, A., and Hockley, J. (2014) 'The Effect of using High Facilitation when Implementing the Gold Standards Framework in Care Homes Programme: A Cluster Randomised Controlled Trial'. *Palliative Medicine* 28 (9), 1099-1109

9. Stone, L., Kinley, J., and Hockley, J. (2013) 'Advance Care Planning in Care Homes: The Experience of Staff, Residents, and Family Members'. *International Journal of Palliative Nursing* 19 (11), 550
10. Tedford, M., Bancroft, R., and Flannigan, L. (2012) Unnecessary Admission and Death in Hospital of Care Home Residents and the Impact of a Community Geriatric Service. *European Geriatric Medicine* 3, S110-S110
11. Watson, J., Hockley, J. And Murray, S., (2010). Evaluating effectiveness of the GSFCH and LCP in care homes. *End of Life Care Journal*, 4(3), pp. 42-49.

Policy and Strategic documents

12. National Palliative and End of Life Care Partnership (2015) Ambitions for palliative and end of life care: A National Framework for Local Action 2015-2020 <http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf>
13. National Audit Office (2008) End of Life Care <https://www.nao.org.uk/wp-content/uploads/2008/11/07081043.pdf>
14. Department of Health (2015) NHS Outcomes Framework 2015-2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385749/NHS_Outcomes_Framework.pdf
15. NHS England (2014) Actions for EOL Care 2014-2016 <https://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf>
16. NICE (2011) Quality Standard for End of Life Care Standards <https://www.nice.org.uk/guidance/qs13/chapter/using-the-quality-standard>
17. Department of Health (2008) End of Life Care Strategy: promoting high quality care for adults at the end of their life. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf
18. Kings Fund (2011) Emergency bed use: What the numbers tell us. <http://www.kingsfund.org.uk/sites/files/kf/data-briefing-emergency-bed-use-what-the-numbers-tell-us-emmi-poteliakhoff-james-thompson-kings-fund-december-2011.pdf>
19. Department of Health (2014) Reference Costs Guidance 2013-2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380322/01_FCosts_publication_v2.pdf