

How GSF helps improve end of life care, implementation of the NHS Long Term Plan and GPs' QOF

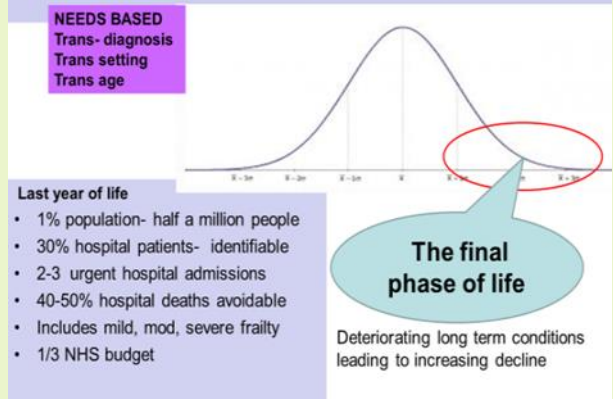
Context - why improve end of life care?

As you consider the future LTP 10-year plans as CCGs, STPs and ICS's, now is the right time to develop strategic, top level, transformational change for better end of life care, improve personal and population outcomes.

It is estimated that:-

- About a **third of the NHS budget** is used by people in last year of life (with an estimated £1bn possibly wasted)
- **1% of the population** are in their last year of life - over half million people - including **30% of all hospital patients** (Clark 2014) and **80% care homes residents**
- There will be **25% more deaths by 2040** (ONS data)
- **Most can be identified early** e.g. using the GSF PIG tool
- **Most do not die where they choose** (Choice in EOLC. Gov.UK 2015)
- **Just under 50% die in hospital** on average (PHE NEOLCIN)
- Most have **2-3 unplanned admissions** in the last year of life
- **40-50% hospital admissions could be avoided** with better anticipatory care (NAO Report EOLC 2008)
- **Proactive measures e.g. GSF programmes** in all settings can reduce hospitalisation and enable more to die where they choose, thereby reducing avoidable costs

The important last phase of life- a 'win win' opportunity to make a difference



The NHSE Long Term Plan affirms the importance of End of Life Care

The NHSE Long Term Plan (Jan 2019) affirms the importance of improving end of life care, including care for all people with any condition in the last year of life. It recommends improving end of life care and integration of frailty with an approach that is:

- proactive
- personalised
- well coordinated

In addition, the new 1-year BMA GP QOF from April 2019 and forthcoming NICE Guidance, also affirm the importance of these key areas.

National Policy- EOLC Long Term Plan Sect 1.42, UPC and QOF

LTP Sect 1.42. With patients, families, local authorities and our voluntary sector partners at both a national and local level, including specialist hospices, 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

Recommends
Proactive
Personalised
Coordinated
Care

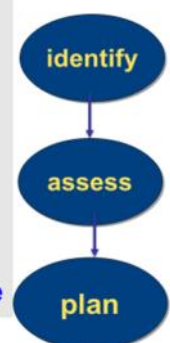
How GSF can help

For 20 years GSF has been teaching this proactive person-centred coordinated approach for all people with any condition, in any setting, using the 3 GSF pillars of identify assess and plan, with transformational fully resourced programmes to enable teams to put policy into practice on the ground. The impact of GSF in its frontrunning teams and integrated cross-boundary care sites is significant.

For more details contact: info@gsfcentre.co.uk
or see: www.goldstandardsframework.org.uk

A practical way forward with GSF

- **Early identification**
 - of people in last phase of life
 - **Proactive**
- **Assessing personal needs**
 - Advance care planning (ACP) discussions
 - **Person centred**
- **Plan**
 - Living well , dying well
 - **Systematic integrated care**
- *Across whole journey , across whole community , enabling all frontline staff*





Gold Standards Framework (GSF)

the leading training provider in End of Life Care for generalist frontline staff for 20 years



Quality Improvement Quality Assurance Quality Recognition

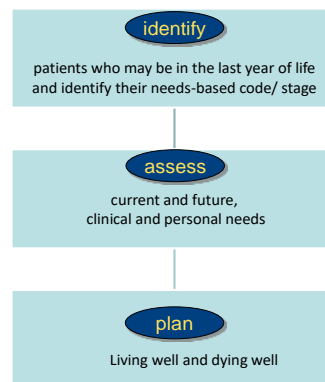
How GSF can help you improve EOLC and implement the Long Term Plan

The LTP and QOF strongly mirrors what we at GSF have been teaching thousands of teams, with the 3 pillars of:-

- **Identify** - increasing early identification for more proactive care and better planning
- **Assess** - offering ACP discussions to all for more person-centred care in line with preferences
- **and plan** - for systematic consistent coordinated care, enabling more living well with fewer hospital admissions and dying at home

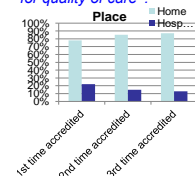
Therefore *GSF helps you attain these goals* in practice on the ground. GSF accredited **frontrunning teams** in primary care, care homes, hospitals, etc., demonstrate what is possible to encourage others.

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



PROACTIVE
GSF Proactive Identification Guidance identifying patients with advanced progressive decline/ disease who may be in the final year of life –

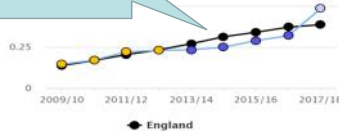
PERSON CENTRED
'Every appropriate person should be offered ACP discussions', mainly Advance Statements, by their usual/chosen care provider, which then becomes an action plan for quality of care.'



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

Proactive Care – early identification

GPs' Identification rates increased 0.18% to 0.5% after GSF



125 Birmingham GP practices doing GSF increased identification above national rates

Coordinated Care – reducing hospitalisation

Hospital deaths decreased



GP Practice Dorset – hospital deaths decreased 51% to 17%



Care homes - Reducing hospital admissions more dying at home

So GSF is one of the tried and tested ways to implement national initiatives and put policy into practice

- **In line with policy**- NHSE Long Term Plan, NICE, Ambitions, Vanguards, QOF and CCG/ ICS policies
- **Improves quality of care**, more proactive, person-centred, more ,advance care planning reduced hospitalisation
- **CCG commissioning** – GSF helps reduce hospital admissions and deaths, improves cost-effectiveness
- **CQC** - Care Homes –35% CQC outstanding homes were GSF accredited, many GSF hospitals improved CQC ratings

NEW GSF QOF Support

FREE Bronze- foundation level

- 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 – why improve end of life care?.
- Templates - templates SCR1-6 used in QOF
- Guidance on how to run a GSF/ palliative care meeting



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
- Working better with care homes



We believe the Long Term Plan presents a real and substantial opportunity to improve EOLC, mainstream this proactive person-centred approach, to enable more to live well until they die. For more details of GSF programmes and our Cross boundary care sites, contact us: info@gsfcentre.co.uk or see: www.goldstandardsframework.org.uk