

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

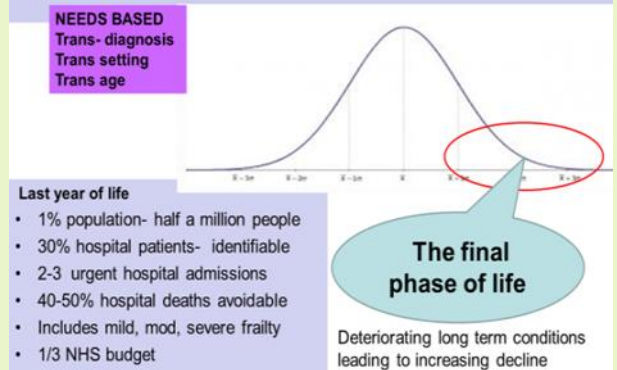
## Context - why improve end of life care?

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**

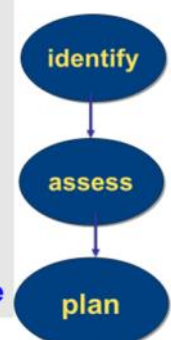
## How GSF can help

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](mailto:info@gsfcentre.co.uk)  
or see: [www.goldstandardsframework.org.uk](http://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

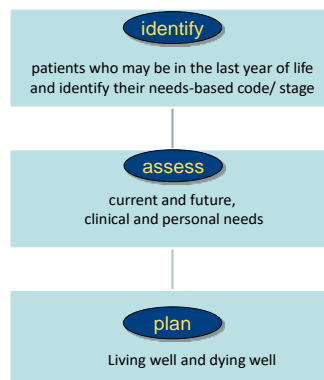
## How GSF can help you improve EOLC and implement the Long Term Plan

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 –

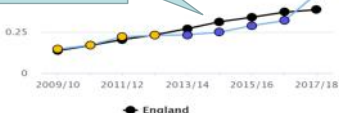
**PERSON CENTRED**  
‘Every appropriate person should  
be offered ACP discussions’,  
mainly Advance Statements,  
by their usual/ chosen care provider,  
which then becomes an action plan  
for quality of care’.



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

### Proactive Care – early identification

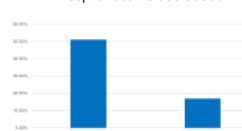
GPs' Identification  
rates increased 0.18%  
to 0.5% after GSF



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](mailto:info@gsfcentre.co.uk) or see: [www.goldstandardsframework.org.uk](http://www.goldstandardsframework.org.uk)