3. Evidence that GSF helps reduce hospitalisation in all settings (admissions, hospital deaths, hospital bed days, rapid discharges home, re-admissions etc).

Thomas K, Armstrong Wilson J A. Foulger, Tom Tanner National GSF Centre. Sept 2016

GSF helps reduce hospitalisation, enabling more to live and die in their preferred place of care. By taking a more proactive approach, with earlier identification and assessment of needs, teams undertaking GSF find that hospitals admissions, deaths and lengths of stay are significantly reduced. This has been a consistent finding in all GSF Evaluations in all settings, particularly in care homes and primary care, where some homes and practice show a halving of hospital deaths and crisis admissions.

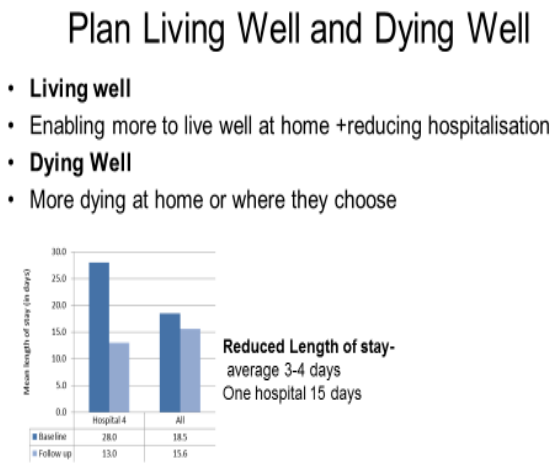
Reducing hospitalisation however is a very complex area and requires consistent change across a wide range of areas: including for example in a care home it requires effective training and communication to all staff including bank and night staff , effective documentation of ACP discussions an preferred place of care for all residents, development of care homes policies, implementation of preventative measures , communication with GPs and out of hours providers and regular reflection and audit to review progress. In hospitals reduced hospitalisation is incorporated into means of reducing length of stay, rapid discharge and transition home and reducing read-missions, many of which require complex interventions, improved communication and good community support.

1. Evidence from Intrinsic GSF Evaluation Audit

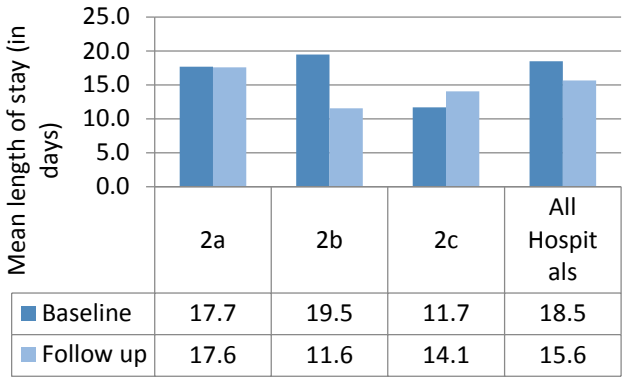
Acute hospital data

There is strong evidence of reduced length of stay across all early phases of the GSF Acute Hospital Programme. Data is taken from the GHK independent Evaluation using Before and After GSF After Death Analysis for 15 deaths and 15 discharges (ref see GHK phase 3 and phase 4 report on GSF evidence section website).
http://www.goldstandardsframework.org.uk/evidence.

There is also anecdotal evidence from some hospitals of reduced readmissions- pending further data. On completion of the Phase 3 AH training programme – Average Length of Stay (LOS) for all the hospitals was reduced by 3 days (from 18 to 15 days).

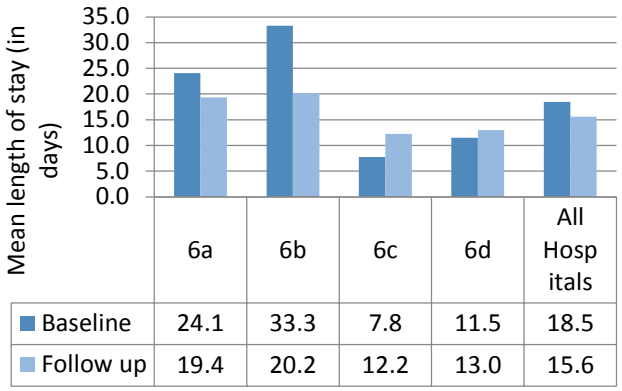


Phase 3 Data - LOS on 2b ward was reduced by 8 days



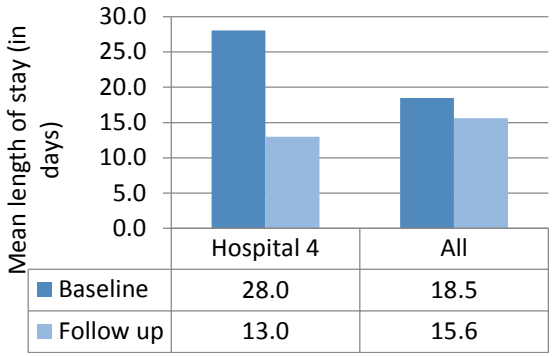
	2a	2b	2c	All Hospitals
Baseline	17.7	19.5	11.7	18.5
Follow up	17.6	11.6	14.1	15.6

Phase 3 LOS on 6a, 6b was reduced by 4.5 and 13 days



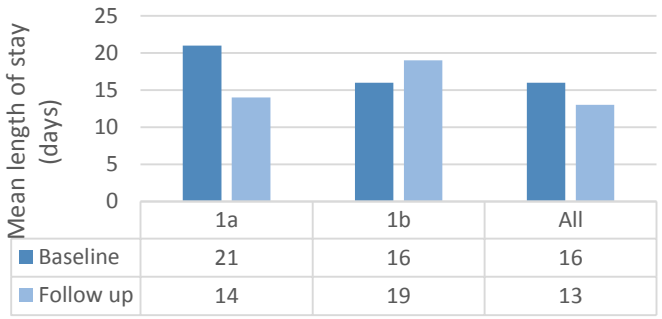
	6a	6b	6c	6d	All Hospitals
Baseline	24.1	33.3	7.8	11.5	18.5
Follow up	19.4	20.2	12.2	13.0	15.6

Phase 3 LOS on ward 4 was reduced by 15days



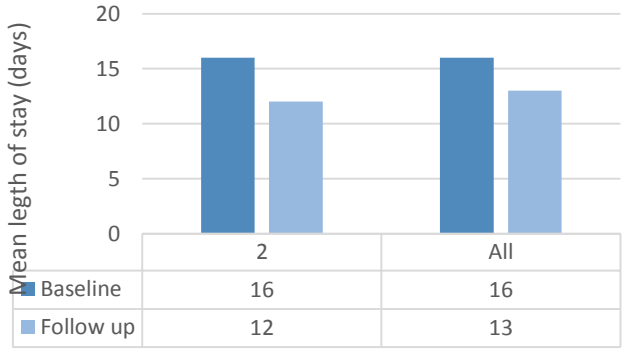
	Hospital 4	All
Baseline	28.0	18.5
Follow up	13.0	15.6

Phase 4 LOS on ward 1a was reduced by 7 days



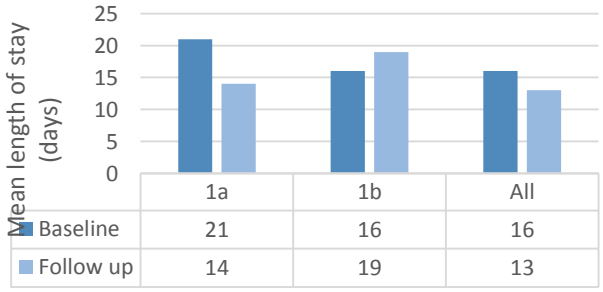
	1a	1b	All
Baseline	21	16	16
Follow up	14	19	13

Phase 4 LOS for ward 2 was reduced by 4 days



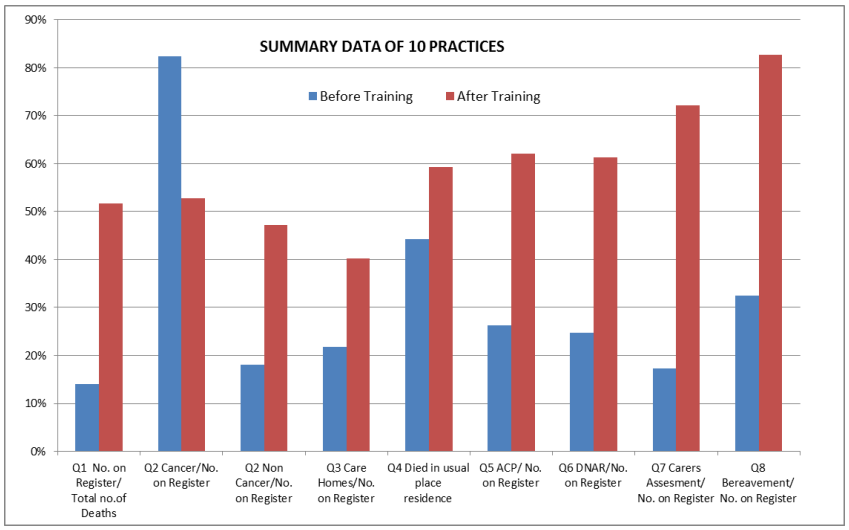
	2	All
Baseline	16	16
Follow up	12	13

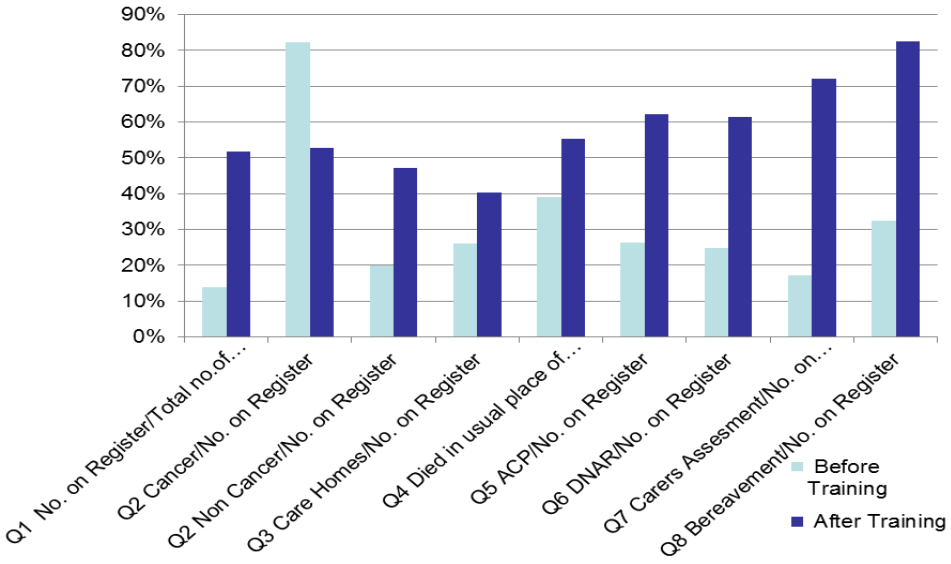
Phase 4 LOS on ward 1a was reduced by 7 days



	1a	1b	All
Baseline	21	16	16
Follow up	14	19	13

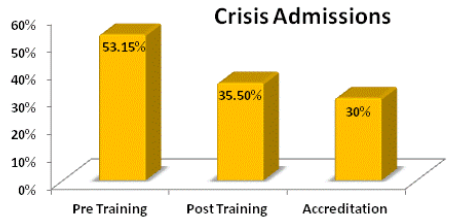
Primary care Data – Summary from the first 10 GSF Accredited practices 2015

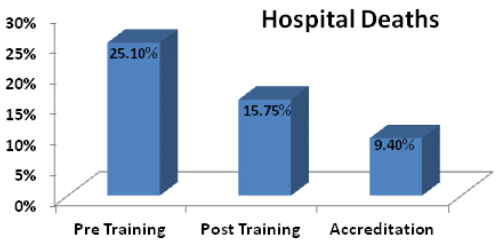


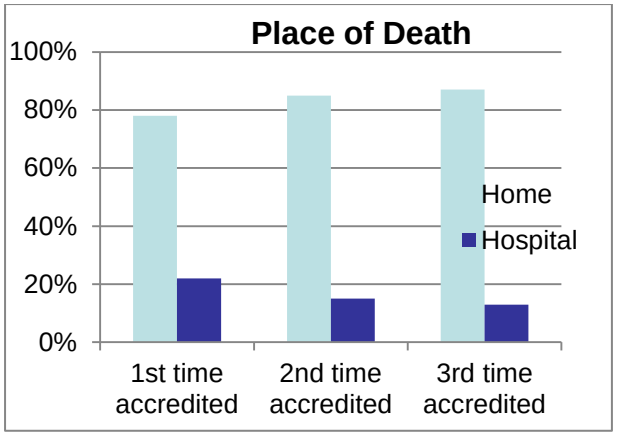


Care Homes

Following GSF care Homes training and accreditation, cumulative before and after ADA analysis for care homes shows reduction on hospital deaths and admissions- see Summary of Evidence and project based audits for further details. Cumulated Care Homes results Phases 7-12.







Cumulative GSF Care Homes ADA results for first time, second time and third time accredited care homes 2015

Attainment of GSF Accredited teams in different settings

	1. Identify	2.Assess	3.Plan Living well	4.Plan Dying well
Aims of GSF accredited organisations	Early recognition of patients- aim 1% primary care 30% hospital 80% care homes	Advance Care Planning discussion offered to every person	Decreased hospitalisation + improved carers support	Dying where they choose using personalised care plan in final days
GP practices (Rounds 1-6, 17 practices)	60% average patients identified (range 31-126%)	68% average offered ACP discussion (range 37-100%)	Halving hospital deaths, not sure how you have captured this as there is no data to back it up 71% carers offered support (15-100% -15 practices)	65% die where they choose (15 practices) 64% using 5P plan final days (7 practices)
Acute Hospitals (Round 1-3, 8 wards)	32% average identified early (range 9-58%)	95% average offered ACP discussion (range 62-100%)	Length of stay reduced Carers support improved	More discharged home, 80% 5Ps care final days plan (2 wards)
Community Hospitals (Round 3-5, 8 wards)	59% average identified (range 31-100%)	79% average offered ACP(range 38%-100%)	Carers support improved	More discharged home 100% 5Ps care final days plan (7 wards)
Care Homes accredited	100% identified, 81% identified in dying stages	100% offered 95% uptake	Halving hospital deaths+ admissions 97% carer support	84% dying where choose, 90% using 5Ps care plan

Increasing home deaths, reducing hospital deaths and improving advance care planning in GSF care homes.

a) Reductions in hospital deaths and emergency admissions enabling people to live and die in their care home are sustained long term following use of the GSF Care Homes Training program. 75% of first time GSF accredited homes achieved over 80% home death rate. This level is sustained over time with care homes who have undergone a third round of GSF Accreditation demonstrating continued improvements in home death rate, with 89.63% of residents remaining 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).

b) Crisis admissions and length of stay in hospital Crisis admissions in the last six months of life in 45 care homes were evaluated prior to and following participation in the Gold Standards Framework Care Home Programme. Outcome measurement showed a significant reduction from 44.4% of care home resident admissions to hospital in the last six months of life to 12% admissions. Hospital bed days fell from 87 to 36 (58%).

c) Advance Care Planning Following GSF Accreditation, homes reported offering 100% of residents an advance care plan discussion GSF data shows that 96% (n=441) of those residents who died, had an Advance Care Plan in place (Barking the Havering & Redbridge project, Phase 10 data from 45 care homes. 2014/15). 2014).

Source: Ref http://www.goldstandardsframework.org.uk/accredited-care-homes EAPC May 2015 Conference Copenhagen Reaccredited Care Homes Accepted Abstract – Thomas K Stobbart-Rowlands M et al. **http://tinyurl.com/jlqsa3a**

Positive Response from Care Home Staff undertaking GSF Care Home programme
Qualitative interviews with Nurses, health care assistants and managers regarded the training and support afforded by the GSFCH programme to inform EoLC for older residents positively. The framework has the potential to promote a coordinated approach to EoLC for older people. In the post accreditation period, there is a need for ongoing support and development to help embed the key tenets of the GSFCH in the culture of caring.

Three core themes were identified: (i) a positive regard for the GSF for care homes (GSFCH); (ii) challenges around end of life care for older people; and (iii) difficulties in using the GSFCH.

Int J Palliat Nurs. 2015 Jan;21(1):35-41. doi: 10.12968/ijpn.2015.21.1.35. Views and experiences of nurses and health-care assistants in nursing care homes about the Gold Standards Framework. Nash A[1], Fitzpatrick JM. http://www.ncbi.nlm.nih.gov/pubmed/25615833

3. Other Published literature/ qualitative feedback

See extensive published literature on use of GSF in care Homes and Summary of Evaluations

See http://www.goldstandardsframework.org.uk/evidence.