The Gold Standards Framework Hospital programme: implementation and progress

Keri Thomas, Julie Armstrong-Wilson and Collette Clifford

Abstract

Aim: The implementation and impact of the Gold Standards Framework Hospitals (GSFH) service development programme is described. **Background**: A third of hospital inpatients may be in their last year of life when admitted to hospital. Many will be repeat and unplanned admissions. National policy guidance seeks to change this pattern through implementing patient choice in end-of-life care (EOLC) planning. **Method**: GSFH training and resources help general hospital staff teams develop skills as they identify patients nearing the end of life, rapidly assess their needs and offer advance care planning (ACP). **Findings**: Audit data shows teams that have undergone GSFH training demonstrate earlier identification of patients needing EOLC and offer ACP targeting their individual care needs. **Conclusion**: The model has been taken up by over 350 hospital wards, with a large number seeking accreditation to demonstrate sustainability of good practice in EOLC management.

Key words: ● Gold Standards Framework ● hospitals ● end-of-life care ● palliative care

In our ageing population, people are living longer with persisting conditions such as frailty, dementia and multi-morbidities. Lifespan can exceed 'health span', which leads to increased challenges in end-of-life care (EOLC), defined in national policy as 'care in the last year of life', rather than just a patient's final days (General Medical Council, 2020).

Given the choice, most people would prefer to die at home. However, at present, almost half of all deaths occur in hospital, with a 40% increase in hospital deaths predicted by 2040 (Public Health England (PHE), 2019). This has significant implications for all hospitals, with an estimated third of all hospital inpatients being in their last year of life and many patients having multiple hospital admissions in their final year (Clark et al, 2014; PHE, 2019).

There is increasing pressure on hospitals to improve EOLC provision. Hospital crisis-led interventions may not be appropriate for someone in the final stage of life and repeated admissions may cause additional distress and disruption. The regulator, the Care Quality Commission (CQC), has reported that hospital services have struggled to provide optimal individualised EOLC, while healthcare planners have acknowledged that there is only 'one chance to get it right' (CQC, 2016). Consequently, there has been an increased urgency to reduce unplanned hospital admissions, minimise the length of patient's stay and decrease the number of patients that are dying in hospitals. While efforts have been made to enable more people to live and die in the community, significant challenges remain in finding how to provide optimal care earlier in the EOLC journey and ensure a proactive approach to individual care management (Parliamentary and Health Services Ombudsman, 2015; Koffman et al, 2019). Targets to decrease hospitalisation in the last year of life are key to current health and social care policies in the UK (National Institute for Health and Care Excellence, 2019; NHS and British Medical Association (BMA), 2019).

Aim

This aim of this paper is to give an overview of the Gold Standards Framework Hospital (GSFH) programme, which supports hospital teams in offering patients optimal EOLC in line with their preferences in the final year of life.

Background

The Gold Standards Framework (GSF) is a service improvement programme that aims to

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change clinical practice by supporting the early identification of patients in the last year of life. Through doing so, it hopes to produce a more proactive and personalised approach to care, and enable more to live and die where they choose. The GSF approach was first introduced into primary care in 2000 and was popularised in general practice by GPs (King et al, 2005; NHS and BMA, 2019). It was later introduced into care homes, where it was shown to change practice and enhance EOLC management (King et al, 2005; Badger et al, 2009; Shaw et al, 2010). Early identification of people in the end-of-life stage in the community and care homes enabled more focused EOLC planning and helped reduce hospital admissions, as many opted to die at home (Badger et al, 2009; Shaw et al, 2010).

The introduction of the GSF programme into the hospital sector is the logical next step in the development of a coordinated system for EOLC management and the fulfilment of national policy recommendations (PHE, 2019). The programme also meets the requirements of the NHS's Long Term Plan (2019) which recommends providing more 'proactive, personalised, well-coordinated care'.

All GSF programmes are orientated towards helping generalist frontline teams offer a gold standard of care for all people, irrespective of diagnosis in the last years of life. It is important to distinguish generalist teams from specialist palliative care (SPC) experts in end-of-life care management. While the UK's SPC provision is rated as the best in the world (Line, 2015), frontline NHS health and social care teams, which often deliver more generalised EOLC at a wider level, require additional training to improve their skills and confidence in proactive EOLC management.

At a strategic level, the GSF offers scope for a 'joined-up' cross-boundary EOLC planning system between primary and secondary care. This population-based approach to EOLC supports better integrated care and collaboration within communities and promotes GSF training and principles becoming well-embedded in GP practices and care homes (Thomas and Gray, 2018). Establishing a GSF programme in hospitals is key to this level of development.

The Gold Standards Framework Hospital programme

The GSFH programme was first introduced as a pilot scheme in 2008 (Phase 1). The service improvement model was used in the programme and offered a comprehensive step-by-step quality improvement (QI) approach to planning and managing EOLC in hospitals (GSF, 2019a). Participating hospitals and wards were self-selecting, which indicated their interest in improved EOLC management and its role in their local service development. Given their role in clinical care, nurses play a key role in adopting the GSFH, although commitment and collaboration from all members of the healthcare team is crucial for its overall success (ICF GHK, 2012; ICF GHK, 2014; Shaw et al, 2010).

Method

The GSFH programme follows a systematic and pragmatic approach. The process begins with three key steps: the identification of patients as early as possible, the assessment of needs and wishes to enable more personalised care, and the planning of subsequent well-coordinated care in line with noted preferences. The stated aim is to give 'the right care to the right person, in the right place at the right time, every time' (GSF,, 2019a). Seven key tasks help frame activities, which are underpinned by a compassionate approach. Advance care planning (ACP) is key to help people in their end-of-life live well and die in a place of their choosing (NHS and BMA, 2019; Thomas, 2017). The consideration of family and/or carer support is fundamental in care planning (*Figure 1*).

Staff training is delivered by interactive workshops over 18–24 months, either as an open external programme to teams from varied wards, or on-site for 'whole hospital' programmes. These programmes are followed by ongoing coaching and support delivered in person, by telephone and the intranet. Hospital teams are given access to guidance tools for assessing care needs, such as GSF Proactive Identification Guidance (PIG), which helps staff identify patient's end-of-life status and triggers the GSF process if appropriate (GSF PIG, 2017). National and international data suggests that more patients in the end-of-life period can be identified using the GSF PIG tool (O'Callaghan et al, 2014; Milnes et al, 2019; Chong et al, 2020).

Offering ACP discussions to each patient identified has helped to develop individual personalised care plans that are aligned with patient preferences. ACP discussions have been tailored to individual need and may involve several sessions. The ACP includes, among other factors, consideration of place of care preferences, resuscitation wishes, and designated power of attorney/proxy spokesperson(s). ACP has been shown to reduce the length of time in hospital and, when possible, help patients avoid further hospitalisation and the disruption and

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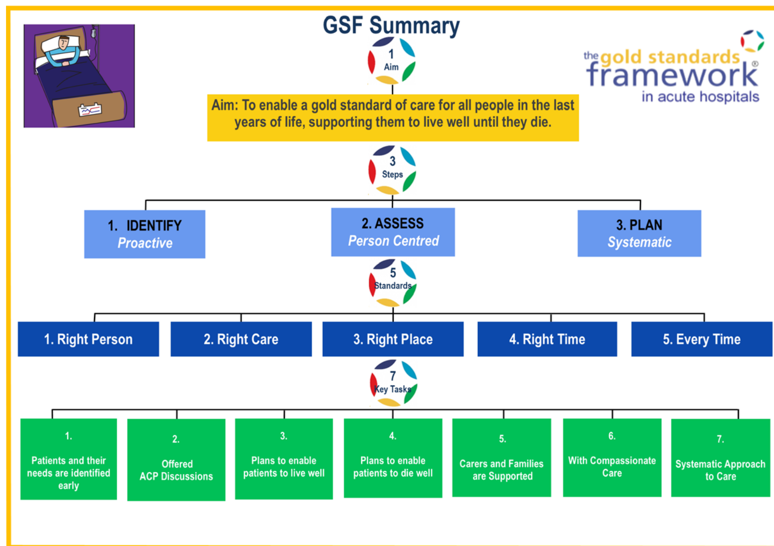

Figure 1.The Gold Standards Framework Overview

distress that is associated with it. Patient consent is sought to enable healthcare professionals to share ACP discussions and plans with GPs and community providers. Such discussions allow information gleaned from discussions in hospitals to be shared for follow-ups with primary and secondary care providers. Digital technologies, such as electronic care record (EPaCCS), are used where possible (National Palliative and End of Life Care Partnership, 2015).

Gold Standards Framework Hospital Evaluation

Service development programmes should demonstrate quality improvement (QI) has occurred in care delivery (Health Foundation, 2015). Consequently, evaluation systems have been embedded in the GSFH programme through a range of audit measures, to monitor tangible progress and demonstrate its impact on care provision.

Measuring EOLC is intrinsically difficult due to the sensitivity of asking patients or families to comment on care delivery during such a difficult time. Consequently, the GSF programme uses 'proxy' audit measures to indicate progress and provide tangible measures of change in the organisation of patient care. Audit data measures outcomes to illustrate how practice has changed. For example, weekly 'run charts' record the number of patients who have been identified with EOLC needs, ie in a single ward. Prior to the GSFH programme, this would not have been a routine assessment in most hospital wards, so this insight provides a proxy measure regarding the extent to which the EOLC needs of patients have been addressed following the implementation of the GSF.

The second audit measure is a discussion regarding the implementation of the GSFH with the patient and family. Each patient's needs can be 'coded' in a way that correlates roughly with their health status at the time. This needs-based coding highlights the level of need using the red, amber, green (RAG) colour coding system. Red colour coding signifies last days of life, amber signifies a deteriorating state and green signifies a patient decline or that the patient is in an advanced stage of the disease (GSF, 2017). Care plans will reflect this, showing whether the patient is seen as being in the final days, weeks, months or years of life. These audit measures provide comparative data for ward teams to monitor GSFH uptake over time.

These audit data do not directly reflect individual patient care, although more detailed information about individual patient management can be gathered retrospectively from the 'after death' or 'after discharge' audit analysis (ADAs). This online tool enables some assessment of the impact of care at patient level, whether it was concordant with GSF principles and patient wishes, and the extent to which proactive personalised care was given prior to death or discharge from hospital. The GSF ADA tool has been tested and utilised for this purpose in other settings (Thomas and Clifford, 2010). At ward level, staff complete organisational questionnaires. This helps them monitor progress, review key tasks within the GSFH programme and provides data to inform programme developments, such as promotional factors and wider GSFH uptake.

Gold Standards Framework Hospital accreditation

Hospital teams can apply for GSFH accreditation once new EOLC systems have been embedded and sustained in practice, which is commonly 2–3 years after training has begun. The accreditation process follows strict internationally recognised guidance and protocol, and successful teams are presented with the well-recognised GSF Quality Hallmark Award, supported and co-badged by independent professional organisations: the British Geriatric Society (BGS) for acute hospitals and the Community Hospitals Association (CHA) for community hospitals (GSF, 2019b). Teams can apply for a re-accreditation every 3years. The accreditation process requires evidence of GSF implementation in the GSF seven key tasks noted in *Figure 1*. Evaluations, audit data and further evidence are included in a portfolio that

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demonstrates how GSF has been implemented, embedded and sustained in practice on the ward.

An assessment visit from a GSF team, usually a nurse, doctor and layperson, provides an opportunity to review the portfolio of evidence and interview staff to explore use of the GSFH on the ward and review progress made in practice. Reports are presented to an independent panel, including BGS/CHA representatives, who make the final decision about the award.

The accreditation programme is one means of enabling participating wards to show tangible evidence that EOLC improvements have been successfully adopted and sustained. Such improvements have been identifed when regulatory assessments have been undertaken by the CQC.

Findings

The early phases (2-4) of the GSFH programme were seen as pilot work and assessed through an independent evaluation that included staff interviews regarding their experience of the process, reflections on barriers and facilitators of implementation, and a review of GSFH tools, key outputs and outcomes. The findings from these reports were used to refine and further develop the GSFH teaching programme, and the varied environmental needs of acute and community hospital wards were considered and integrated (ICF GHK, 2012; ICF GHK 2014).

Now in its tenth year (phase 10), the GSFH programme has been taken up by 298 wards across 49 acute hospitals and 62 wards across 51 community hospitals. There are currently 15 projects involving a 'whole hospital' approach, where GSFH has been integrated into EOLC planning across the whole organisation. To date, 60 wards have received the GSF accreditation and 11 wards have been accredited for the second time.

The accreditation portfolios demonstrate that tangible progress has been sustained in participating hospitals over a 3-year period. They further demonstrate that the GSFH approach has worked in a variety of environments, including geriatrics, oncology, medical, surgical, and other speciality and community wards.

Accredited wards have demonstrated earlier identification of patients in their final year of life, with an average of 47% of patients identified in acute hospital wards and 65% identified across community wards. Such wards have shown that healthcare professionals can develop needs-based coding (GSF 2017), create proactive supportive care plans and hold initial ACP discussions with most identified patients.

The findings from the eight most recent GSF accredited wards (2018-2019) demonstrate significant progress has been made, and that key outcomes aligned with recommended national policy regarding early identification and personalised care have been achieved. This further demonstrates that the standards aspired to were attainable and sustainable in practice. The success pattern was consistent across a varied mix of speciality hospital wards across three different hospital trusts. These 'frontrunner' hospital teams are cited as examples of best practice and promoted as encouragement to others (GSF, 2018).

Discussion

The GSFH approach aspires to be proactive and pre-empt problems through early recognition of decline in health and advance care planning for EOLC. A major factor to its successful spread and uptake has been the enthusiastic approach of hospital teams, commonly led by nurses, who share successes and struggles as part of a community of best practice. They share experience through the GSFH networks and report measurable progress in the way in which they manage EOLC in hospital settings (Quinn and Thomas, 2017; GSF, 2018).

The mode of delivery of the GSFH programme involves the GSF team, which work directly with clinical staff across developing communities of practice, in order to increase understanding of

Key points

- There is an urgent need to reduce unplanned hospital admissions, minimise the length of patients stays and decrease the number of patients that die in hospitals
- The Gold Standards Framework is a service improvement programme that aims to change clinical practice by supporting the early identification of patients in the last year of life. Through doing so, it hopes to produce a more proactive and personalised approach to care
- Participating hospital wards demonstrate tangible improvements, including increased earlier identification of patients in the last year of life, the capacity to anticipate and introduce needs-support plans before they are needed, and the ability to assesses clinical and personal needs and liaise more closely with community teams

CPD reflective questions

- What three strains are being placed on current hospital wards?
- What does the Gold Standards Framework aim to do?
- What, if any, tangible improvements has it demonstrated?

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factors that promote and inhibit uptake of the EOLC programme. The proactive approach in which service developments respond to policy challenges and develop organisational strategic plans and local care delivery systems reflects key components in managing change through service development (Ferlie and Shortell, 2001).

Participating hospital wards demonstrate tangible improvements, including increased earlier identification of patients in the last year of life, the capacity to anticipate and introduce needs-support plans before they are needed, and the ability to assesses clinical and personal needs and liaise more closely with community teams. The increased potential to reduce hospitalisation and enable more patients to die at home reflects a successful adherence to the policy vision of the proactive population-based approach to EOLC (CQC, 2016; CQC, 2017; NICE, 2019).

A strength of the GSFH programme has been that effective implementation of its approach has been adopted by generalist providers. Using simple audit measures, changes in EOLC service delivery have been seen relatively quickly across individual wards; increased identification rates in hospital patients suggests that GSF processes and data have been reliable and effective (Clark et al, 2014).

Overall, further research into the impact of the GSFH programme, factors that both support and inhibit uptake and the impact on care given is needed. Challenges remain and more work is required to determine how to ensure optimal benefit from the GSFH programme. Feedback from staff surveys can be added to the early evidence from the pilot work completed in the early stages noted above. Barriers identified include time pressures, staff turnover and shortages, cultural resistance to discussing EOLC issues and gaps in communication between hospitals and community settings. On the positive side, it is evident from our work that multidisciplinary teamwork and the support and commitment of senior management and, where possible, specialist palliative care teams are key to further successes. Integrating GSFH into everyday practice on the wards as part of smarter working practices can help address these issues. It is also important to note that, while proxy audit measures can indicate that care systems change as a result of GSFH, more insight is needed to explore the impact of this on patients and families.

Conclusion

Looking forward, the GSFH programme can play a key role in the population-based, person-centred EOLC that is seen as important for future care planning (Thomas and Gray, 2018).

The next steps of the overall GSF programme development has the potential to offer joined-up EOLC delivery systems across health and social care, which incorporate cross-boundary working between hospital, community and social care. This model has been developed and trialled, and recent evaluations suggest that the model will positively support the vision of integrated EOLC optimal care (Thomas and Gray, 2018; GSF, 2020). Again, further research to evaluate this broader approach is crucial.

Finally, it should also be noted that, while the work reported here is England-orientated, there is scope for adoption in other healthcare sectors with similar policies driving EOLC management systems. There is evidence that GSF assessment tools have been incorporated internationally, with countries such as Australia, Brunei and South Africa appropriating elements within their public hospitals (Milnes et al 2019; Raubenheimer et al, 2019; Chong et al, 2020).

In conclusion, this paper has given an overview of a service development designed to enhance EOLC in hospital settings. The GSFH programme offers staff training and support and, through integral evaluation systems, enables participating staff teams to audit the extent to which they change EOLC practice. Accreditation of this work enables staff teams to demonstrate sustained quality improvement in EOLC management. Nurses, working with the wider medical and healthcare teams, are crucial to leading implementation of GSFH at the local and strategic level. *IJPN*

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