Summary Evaluation of Effectiveness for Gold Standards Framework Primary Care

Reduced Summary November 2016 v1

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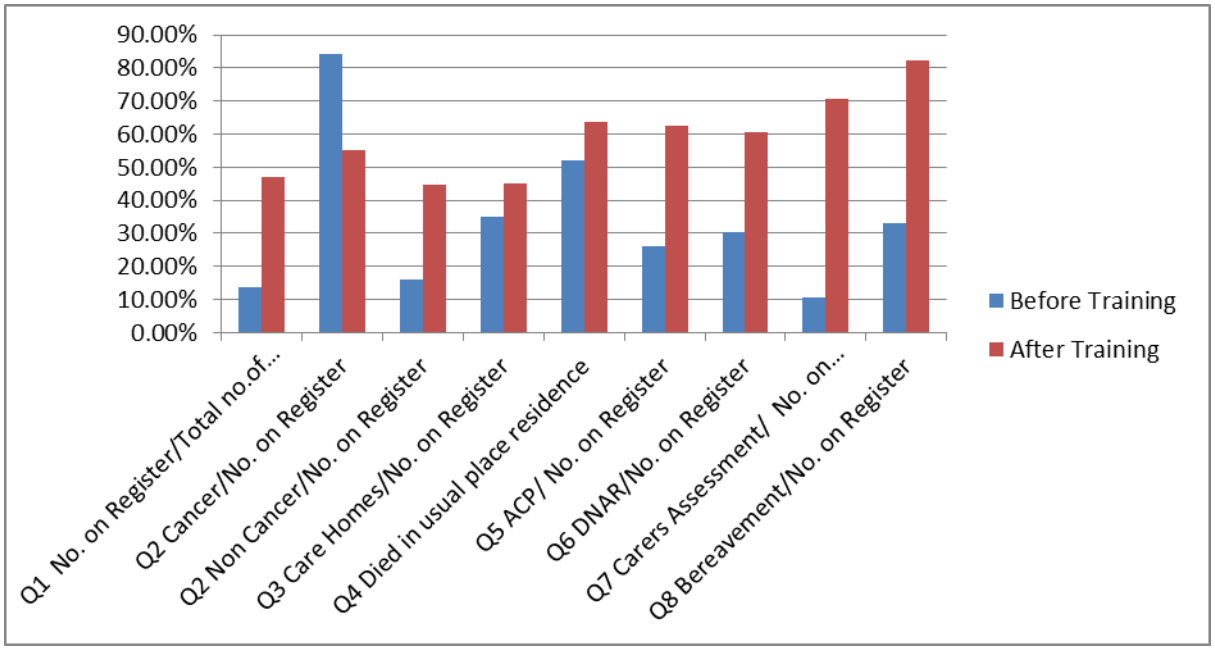
1. Summary

Uptake of GSF Going for Gold – Since 2009 GSF Going for Gold has been available for primary care to enhance end of life care within general practice. Over three hundred practices have purchased the going for gold programme and in 2012 the very first 7 practices were able to apply for accreditation and receive the quality hallmark award.

The graph below demonstrates what was achievable from the first 7 accredited practices in 2012

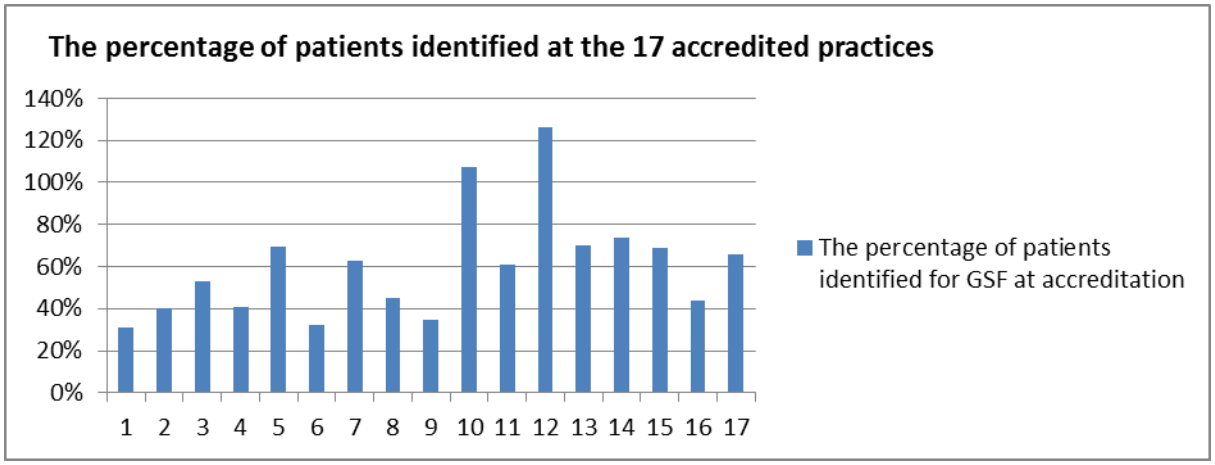


Effect and impact of GSF - GSF is able to demonstrate impact at accreditation:-

There is good evidence that use of the GSF Prognostic Indicator Guidance improves early recognition or identification of patients considered to be in their last year of life. However, this is only the first key step in the full GSF Quality Improvement Programme used in primary care. Intrinsic comparative evaluations of teams progressing with the GSF programme demonstrates significant change towards current population-based estimated 1% and that high levels of early identification in line with can be achieved. The further steps of GSF, including use of Needs-based Coding, MDT discussions ,assessment and planning, all then work together to ensure more proactive care for patients in line with preferences.

Early identification is GSF's first key step. The GSF training and coaching enables staff to increase their identification rate over time, supported by use of the GSF Prognostic Indicator Guidance and abbreviated forms of it (eg Mini-PIG, PIGLET) through teaching, coaching , use of run-charts, workshop feedback ,peer-support etc. Over the course of the full GSF Programme (6-24 months), teams demonstrate increased identification rates for all patients, assessed regularly in a variety of ways. Before and after evaluations are assessed, plus Accreditation portfolio submissions includes clarification of consistency and sustainability, examined further at the Visit.

In 2016 there is cumulated data from 17 GSF Accredited GP Practices (more details available).
Conclusion for these GSF GP Practices – an average identification rate of 60% of all patients that died were identified for their practices register (in line with population figures of estimate 1% population dying/ year) .



The graph above demonstrates that some GP practices, following GSF Going for Gold training and Accreditation, are attaining high rates of identification of patients for their GSF/Palliative Care register, averaging 60%. This demonstrates what is possible to achieve by a few and could be an encouragement for others.

GSF Bronze level – Approximately 95% of GP practice teams in England have adopted GSF in some form at least at Bronze Level to meet Quality Outcome Framework (QOF) requirements.

1. **Awareness of and attitudes** of staff towards dying patients**.** Affirming the importance of good delivery of home based palliative care for all patients nearing the end of their lives.

2. **Patterns of working** - structures, processes and patterns- systems, means of team-working etc. The main particular benefits appear to be:-
   - 2.1 Improving communication within and between teams and with patients and their carers.
   - 2.2 Improving the consistency and reliability of care - so fewer patients 'slip through the net'
   - 2.3 Improving anticipatory care and proactive planning
   - 2.4 Some specific benefits such as anticipatory prescribing of drugs left in the home, handover forms, greater team involvement in care of dying patients eg with a white board

3 **Tangible Patient outcomes -** eg more home deaths, more asking and recording of patients' preferences, better provision of information, better discussion and recording of advance care planning, etc

c) Effect of GSF on Strategic planning.

Use of the Gold Standards Framework (GSF) in community palliative care for Primary care teams is supported by a strong and growing evidence base, by UK national policy developments and by Parliamentary support and recommendation.

The aim of this paper is to provide a summary of GSF evaluations, audit reports and research studies that we are currently aware of, to inform ongoing spread, development and further research of the Gold Standards Framework In the light of the current changes within the NHS, further issues are arising related to the increasing ageing population , end of life care, community palliative care, GSF can be part of the solution.

2 Research evidence and external evaluations so far

There has been evaluation and measurement of the effects of using GSF at every stage, both nationally and in many local areas. It is hard to describe exactly what the benefits of GSF have been for those who have used it, both those who have adopted it with great enthusiasm, or those who have taken it up only minimally. Some benefits appear to be less tangible, more attitudinal and may have an impact on the team's approach to all patients with serious illness in a very significant way. Clear benefits in terms of patient outcomes are famously difficult to measure and to compare, but there are some tangible measurables which are possible to quantify.

The indications are that the GSF offers an overall sense of improved care provision, better 'patterns' of care management, with 'fewer patients slipping through the net' (see 1.2). Trends indicate that use of the tool can help improve communication, assessment of quality of care provision, noting of patient preferences, advanced care planning, out of hours support, and collaboration within and between teams (see 1.3)

This paper includes references to further information, audits and published articles. Further information will be added as it becomes available.

2. University based Evaluations of GSF Primary Care Programme

	Phase	Investigators	Methodology of study	Key lessons	Publications
2.1	Phase 1 2001	K Thomas Cardiff University MSc. dissertation	Before and after questionnaires, focus groups etc for pilot 12 practices	Pilot study –acceptability to practices, effect of changes, transferability to other practices	Thomas K, Noble B, *"Improving the delivery of palliative care in general practice: an evaluation pf the first phase of the Gold Standards Framework."* Palliative Medicine 2007;21:49-53
2.2	Phase 2 2002	Huddersfield University King et al.	Qualitative comparison of 8 GSF and non GSF practices	Increases consistency of practice Guidance for facilitation	King N, Thomas K, Martin N, Bell D, Farrell S, & *"Now nobody falls through the net Practitioners perspectives on the Gold Standards Framework for community palliative care"* Palliative Medicine 2005: 19:619-627 King N, Bell D, Martin N, Farrell S. *Gold Standards Framework, phase 2: qualitative case study evaluation /final report.* Primary Care Research Group, School of Human and Health Sciences, University of Huddersfield, 2003.
2.3	Phases 3,4,5,6 2003-4	Warwick University Dale, Munday etc.	Before and after questionnaires for 955 (73%) practices	GSF improves structure and processes or patterns especially in certain areas e.g. register, handover form, meetings, etc. For phases 3-6, 955 of 1305 practices (73%) completed both a baseline and a final questionnaire, generally 12 months after starting the GSF programme. In the final questionnaire, 89% of practices report using a register of palliative care patients, 91% have a practice co-ordinator for palliative care, 80% meet regularly to discuss and plan care for palliative patients, and 82% regularly inform out-of-hours providers of patients. Confidence in delivery, quality, and co-	Practice audit reports sent Report written Dale J, Koistinen J, Mahmood K, Munday D, Petrova M, Thomas K. *Evaluation of the Gold Standards Framework for Palliative Care, Macmillan Phases 3-6 (2003-2005).* Report to Macmillan Cancer Support. Warwick Medical School, 2007. Kelt S, Munday D, Dale J. *Patients' experience of receiving GSF-led primary palliative care.* End of life

			As above	ordination of palliative care and communication with specialist palliative care all increase from baseline. Conversely, increased administrative burden was cited as problematic (perhaps the converse of better co-ordination of care). The number of practices reporting that they routinely record patients' preferred place of death rose, but there is not sufficient data to determine whether more patients died in their preferred place. Full analysis of the cumulative audit data for phases 3-6 is continuing, and the report on this work will be available later	Care 2008:2;47-53. Dale J, Petrova M, Munday D et al. *A national facilitation project to improve primary palliative care: the impact of the Gold Standards Framework on process and self-ratings of quality.* Quality and Safety in Health Care 2009;18;174-80. Munday D, Mahmood K, Dale J, King N. *Facilitating good processes in primary palliative care: does the Gold Standards Framework enable quality performance?* Fam Pract 2007:1-9. Mahmood-Yousuf K, Munday D, King N, Dale J. *Interprofessional relationships and communication in primary care: impact of the Gold Standards Framework.* Br J Gen Pract 2008;58:256-63.
			As above		
			Qualitative study using semi-structured interviews with staff of 15 practices in 3 Primary Care Trusts.	Better performance associated with practices that have clear-shared purpose, with effective communication and efficient formal processes. Adoption of framework associated with earlier referral of palliative care patients to district nurses. Best functioning teams used range of meeting styles, with relatively non-hierarchical working style.	
			As above		
2.4	Phases 7,8,9,10 2005-7	Birmingham University – Clifford, Shaw etc	Before and after questionnaires for 401 (30%) practices.	GSF effective in improving care- improves quality, choice, reduces inequity and improves cost effectiveness. BUT variability in usage by practices	Practice audit reports sent Summary reports for each phase available Shaw KL, Clifford CC. *Gold Standards framework. Evaluation of Phase 7 in Primary Care*. School of Health Sciences, University of Birmingham. June 2006. Shaw KL, Clifford CC. Gold Standards framework. Evaluation of Phase 8 in Primary Care. School of Health Sciences, University of Birmingham. November 2006.

					Shaw KL, Clifford CC. Gold Standards framework. Evaluation of Phase 9 in Primary Care. School of Health Sciences, University of Birmingham. March 2007. Shaw KL, Clifford CC. Gold Standards framework. *Evaluation of Phase 10 in Primary Care.* School of Health Sciences, University of Birmingham. Sept 2007. Publication pending

3. Independent Research Studies – Publications in Peer Review Journals

See in addition Karen Shaw article 2009 Palliative Medicine for systematic review of GSF in Primary Care

	Phase	Investigators	Methodology of study	Key lessons	Publications
3.1		Warwick University Munday etc	In depth qualitative study	GSF improves practice but variability GSF helps processes	Petrova M, Dale J, Munday D, Koistinen J, Agarwal, Lall R. *The role and impact of facilitators in primary care: findings from the implementation of the Gold Standards Framework for palliative care*. Family Practice Advance Access published 29 October 2009.
3.2		Manchester Todd etc Walshe et al.	Qualitative study involving 47 interviews of multidisciplinary staff from 3 Primary Care Trusts in the North West England. Trusts varied in extent to which GSF was in use. Conclusion The GSF was principally described as beneficial in terms of process aspects eg the way professionals particularly district nurses, could control previously difficult aspects of their work with others, particularly GPs.		Walshe C, Caress A, Chew-Graham C, Todd C. *Implementation and impact of the Gold Standards Framework in community palliative care: a qualitative study of three primary care trusts.* Palliat Med 2008;22:736-43.
3.3		Hughes et al. 2008. University of Sheffield	Postal questionnaire to 2096 (60%) general practices.	61% of practices reported involvement with the GSF and reported activity consistent with	Hughes P, Bath P, Ahmed N, Noble B. *Improving supportive and palliative care for adults with cancer in primary care: A national survey of general practices.* University of Sheffield. April 2008.

				framework.	
2.6		Huddersfield University King et al.	Qualitative study using semi-structured interviews with district nurses (n=24) community matrons (n=15) and key stakeholders from other professional/managerial groups (n=7) recruited from 3 purposively selected geographical areas.	GSF improves felt to systemize care, and raise awareness, but variations in the utilisation reported. GP support considered a crucial factor in uptake of the GSF.	King N, Melvin J, Ashby J. *Community Nursing Roles and The Gold Standards Framework For Community Palliative Care: Final Report.* Centre for Applied Psychological Research, School of Human and Health Sciences, University of Huddersfield, 2008.

- **Full literature search** on community palliative care- as described in Chapter 5 of the GSF text book.
- **Phase 1 2001-2** - **Cardiff University** MSC dissertation and forthcoming paper by Keri Thomas and Bill Noble (of Sheffield University) on the original 12 pilot practice, looking at whether GSF was acceptable to practices, whether it changed practice and what were the effects of the change.
- **Phase 2 2002-3 Huddersfield University** - Qualitative research study led by Dr Nigel King. Paper pending and recommendations made for best implementation. Matching GSF practices with non- GSF practices in 4 areas, with semi structured interviews and themed analysis
- **Phase 2 2002 -** Cancer Services Collaborative Information Analysis Team - presentations at BMJ Quality/ IHI congresses 2004,5
- **Phases 7 - 12 2005-7 Birmingham University.** Led by Prof Collette Clifford, using the same before and after questionnaires, with audit feedback for practices and PCT areas to demonstrate changes and identify areas for future development.
- **Other measurement of uptake -** by SHA End of Life care Leads
- **Other independent research studies** - several currently underway.

5. Audits

5. References

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