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Going for Gold: the Gold Standards Framework programme and accreditation in primary care

Collette Clifford,[1] Keri Thomas,[2] Julie Armstrong-Wilson[3]

[1]Emeritus Professor, School of Nursing, University of Birmingham, Birmingham, UK
[2]GSF National Clinical Lead and Honorary Professor End of Life Care, GSF Centre CIC for End of Life Care, Shrewsbury, UK
[3]GSF Nurse Lead for Hospitals and Primary Care, GSF Centre CIC for End of Life Care, Shrewsbury, UK

Correspondence to
Professor Collette Clifford, c.m.clifford@bham.ac.uk

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ABSTRACT

Primary care teams are pivotal in caring for patients in the final year of life, enabling more to live well and die where they choose. They face increasing pressures from an ageing population, rising mortality and limited resources. Therefore, proactive approaches are required to support people nearing the end of life. The Gold Standards Framework (GSF) Quality Improvement Programmes have been influential in end-of-life care (EOLC) since 2000. The first 10 general practitioner (GP) practices completing the updated 'GSF Gold' Programme and associated Accreditation are demonstrating enhanced EOLC including earlier identification of patients, more advance care planning discussions and improved outcomes for more patients. Use of this proactive approach demonstrates what is possible to achieve in general practices. Progress to date is encouraging, with evidence of significant change, exemplifying a possible model for 21st century primary care to meet the needs of those nearing the end of life.

INTRODUCTION

Primary care teams in the UK include general practitioners (GPs), nurses, allied health professionals and administrative support staff, working in GP-led practice teams. These teams are commonly the first point of contact and key coordinators of care with patients nearing the end of life. It is important that they offer the best end-of-life care (EOLC) as there is only one chance to get it right.

For many years primary care teams have used the Gold Standards Framework (GSF) as a means of enhancing EOLC. The aim of this paper is to report on more recent developments and outline the potential of the updated GSF Gold Programme, associated Accreditation system and Quality Hallmark Award. Uptake of this will be illustrated by reference to the achievements of the first 10 GP practices to gain accreditation.

EOLC in the National Health Service (NHS)

EOLC may be defined as care for people who may be in their last year, months and weeks of life, rather than those in the final days (General Medical Council 2010). When the GSF was introduced in 2000 the need to develop systems to support EOLC for all regardless of diagnosis and location, was just being recognised. Prior to that the excellent hospice and palliative care movement in the UK had led the way in supporting patients and families at the time of death, showing that it was possible to provide optimal care and support at this stage of life. However, this support had become associated with those dying from cancer, a major health concern for many yet the cause of only about 25% of deaths (Thomas 2003, Department of Health 2008).

The need to improve EOLC for all in England, led to the first National End of Life Care Programme 2004–2009 and later the NHS EOLC Strategy (Department of Health 2008). With demographical changes and medical advances leading to increased longevity, the ageing population includes more people surviving cancer and with long-term conditions, multimorbidity, and frailty associated with ageing (Farmer *et al* 2016). The associated predicted rise in death brings more challenges for health planners as there is a need to ensure that all are supported equitably at the end of life. Enhanced community care at the end of life, rather than more costly and limited resource of hospital-based care, remains a key preference for patients and policymakers. Most people would prefer to die at home but still

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almost half die in hospital. Thus, reducing hospitalisation reflects people's choice as well as supporting economic imperatives to make the best use of scarce resources (NHS England 2014a, 2014b, 2015 Public Health England 2016).

The GSF programme

The NHS EOLC Strategy supported the uptake of programmes designed to help staff enhance EOLC planning in a range of sectors and key to this in primary care was the GSF. The GSF was the first coordinated programme for EOLC management in primary care, and was endorsed alongside other programmes designed to give choice and control to patients nearing the end of life and their families (Thomas 2003, King *et al* 2005, Department of Health 2008, Gold Standards Framework 2016a).

The GSF is a Quality Improvement Programme that aims to enhance proactive person-centred EOLC by a three-step process enabling earlier identification of people nearing the end of life, better assessment of clinical and personal needs and preferences, and focused planning and coordination of care to meet these needs and preferences. The first step, identifying those patients considered to be in their final year of life, was seen as important from the inception of the programme, especially to support earlier identification of those with life-limiting conditions other than cancer.

Early identification in primary care enables inclusion on a register, referred to variously as the GSF, Supportive Care, or Quality Outcomes Framework (QOF) palliative care register. Registration triggers better coordinated EOLC as it means that primary care staff are better able to *assess care needs* and *plan* and *implement* relevant proactive support (Gold Standards Framework 2016a, Public Health England 2014). Involving patients and their carers in the planning process enables shared decision-making and patient choices as all patients identified on EOLC registers are offered advance care planning (ACP) discussion (Thomas and Lobo 2011).

The GSF offers a practical clinician-led step-by-step framework (box 1) to attain a shared high standard of EOLC including:

- Training programmes that may be face-to-face or online;
- Tools and resources developed by the GSF team to support EOLC management;
- Measures by which to judge progress and attainment;
- Support and coaching for local implementation as needed.

The basic GSF Foundation Level required general practices to identify and register patients considered to be in the last year of life and to discuss regularly these patients in multidisciplinary team planning meetings. The aim is to ensure care was planned proactively and appropriately for these patients.

In addition to inclusion in the NHS EOLC Strategy, the GSF was acknowledged as 'good practice' for all GPs and was recommended by the Royal College of General Practitioners (RCGP) (RCGP 2013) and as part of good practice in national policy by the National Institute for Health and Care Excellence (NICE 2011). It was built into contractual requirements for primary care provision in the General Medical Services contracts QOF for primary care from 2004 to 2005 (NHS England 2014c). With growing evidence of its effectiveness (Shaw *et al* 2010) and increased uptake (98% GPs claiming QOF palliative care points by 2014) the potential for greater patient support within primary care was being realised. In sum, this approach, supported by contractual requirements and associated implementation, demonstrated enhanced EOLC provision.

Building on this, the GSF programme has evolved in line with contemporary healthcare policy to ensure that it is as relevant in primary care today as it was at inception. Furthermore, the programme has been rolled out to support EOLC management in a range of settings including care homes, hospitals, domiciliary care and hospices (Badger *et al* 2007, Hughes *et al* 2010, Walshe *et al* 2008, Gold Standards Framework 2016a). This has increased the scope for integrated population-based cross-boundary working as demonstrated in the wider cross-boundary care sites on the GSF website (Gold Standards Framework 2016a).

Box 1 The Gold Standards Framework (GSF) overview

Overall aims of the GSF in primary care:

1. To improve the *quality* of care provided for all patients approaching the end of life by demonstrating organisational change.
2. To improve the *coordination and collaboration* of care within and between teams and across boundaries to ensure seamless care.
3. To *reduce hospitalisation* in the final stages of life and enable more to live well and die well in the home, if this is their wish.

The *three steps* of GSF programme:

Identify, Assess and Plan both 'living well' and 'dying well'.

GSF Good Practice Guide: five core standards

1. Right patient—Identification of patients nearing end of life
2. Right care—Assessing their needs, clinical and personal
3. Right place—Planning coordinated cross boundary care
4. Right time—Planning care at home in the final days
5. Every time—Embedding consistent good practice and identifying areas to improve further

Further information can be found on: www.goldstandardsframework.com

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GSF in primary care: evidence of impact

Evaluation processes are built into the GSF enabling GP practices to benchmark their progress both against their own local targets and national trends with the support of the GSF Centre (Gold Standards Framework 2016b). Alongside this there has been steady increase in the evidence base of aspects of using the GSF in Primary Care that has been useful in informing developments (Munday *et al* 2007, Thomas and Noble 2007, Mahmood-Yousuf *et al* 2008, Dale *et al* 2009).

A systematic review of the literature noting the uptake of the GSF in Primary Care demonstrated effectiveness of the GSF Foundation Level (Shaw *et al* 2010). Issues identified as impacting on GSF uptake suggested GP practice motivation and the role of facilitators was key with evidence to suggest that GP facilitators were more likely to promote change than if the facilitator was a clinical nurse specialist (Petrova *et al* 2010). This was more important than the size and location of the GP team or even funding. Given that the QOF points system referred to above carried some financial reward for GP practices adopting the GSF Foundation Programme, it was interesting to note that uptake was not obviously influenced by this as the rapid uptake of the GSF in the early days was not funded (Shaw *et al* 2010).

By 2010 there was evidence to suggest that circa 61% of practices in a survey with a 60% response rate were using the GSF (Hughes *et al* 2010). To investigate this further the Department of Health commissioned the GSF to facilitate an audit of primary care EOLC provision. Records were provided for 4487 people in a survey of 502, of the 874, general practices invited in 9 of the 10 Strategic Health Authorities in England in February and March 2009. Data were collected reporting care management for about half of the deaths that had occurred nationally at that period of time. The audit showed that only 27% patients in the audit who died were identified on an EOLC register and, of these, only 23% were non-cancer patients, contrasting with the fact that circa 75% died from 'non cancer' conditions. The audit highlighted local and national inconsistencies in care management. It was noted that those on the register received better coordinated EOLC once identified than those not identified, emphasising the impact and importance of the Foundation Level GSF but also showing the need for further improvement (National Primary Care Snapshot Audit 2009).

This evidence stimulated a review of the GSF programme, and resulted in a 'next stage' of development leading to the GSF Gold Programme (Gold Standards Framework 1916b). As shown in table 1 the new programme is offered at three levels. The 'Bronze' level reflects the original GSF Foundation Programme outlined above. The 'Silver' programme offers enhanced educational support to practices and some evaluation activities to nurture uptake. The 'Gold' programme requires greater commitment from the whole GP team and a willingness to develop and audit uptake of local Action Plans. To support this at 'Gold' level, practice teams have access to more training and local development opportunities, GSF tools

Table 1 Synopsis of GSF Programmes for Primary 2016

GSF level	Involves	Outputs	Shortcomings
Bronze*	Builds on basic uptake of GSF since 2004	▶ Palliative care register ▶ Team meeting at least every quarter to discuss patients and plan proactive care	Tend to focus on mainly patients with cancer and most only in the final weeks or days of life
Silver	Two interactive half day workshops for a group of practices. Short training DVD Access to tools to help care management Access to audit evaluation tools to monitor progress	Increased numbers of patients identified on the register including patients without cancer and care homes residents Enhanced communication skills, supported increase in advance care planning discussions Progress in care support	Some good initial changes demonstrated regarding equity of access on the register Mainly led by GPs —but not involving whole team
Gold GSF	Opportunity to attend national 'launch' workshops. Practice-based distance learning programme. 6 modules DVD/online Team interaction leading to development of local Action Plans. Tools to help care management Access to evaluation audit tools Support to apply for GSF/RCGP Accreditation and Quality Hallmark Award	Whole team ownership (Clinical and administrative support). Local Action Plans for EOLC. Practice protocol Increased identification of EOLC needs for patient population. Framework for monitoring development and measuring achievement. Demonstration of achievement through audit enhances team motivation. Accreditation and award increases sense of achievement and underpins further developments.	Practice commitment is key Time investment in staff programme (1 hour per month for at least 6 months)

*Reflects GSF Foundation.
EOLC, end-of-life care; GPs, general practitioners; GSF, Gold Standards Framework; RCGP, Royal College of General Practitioners.

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and increased local evaluation of progress and the potential to apply for accreditation to demonstrate success in this regard. This is described in more detail below.

The GSF Gold Programme in primary care

The GSF Gold Programme is based on the principle of 'whole team' ownership involving all primary care staff who may have contact with patients. This includes all professional clinical staff, doctors, practice nurses, district nurses and allied health professionals. An added strength of this level is that the administrative staff are fully involved as they are commonly the first point of contact with patients and families in primary care.

All staff complete six learning modules, available on a DVD or online via the GSF 'Virtual Learning Zone'. Additional information is provided by good practice guides and workbooks. There is also an option to attend national workshops used to launch the programme. The modules are commonly completed during 1-hour team meetings at 1–2 month intervals. The modules cover the three main steps of the GSF shown in box 1, and help staff *identify* the 'right' patients, *assess* their clinical and personal needs and *plan* both 'living well' and 'dying well' in their preferred place of care, and how to help support family and carers into bereavement. At each step staff are introduced to tools that may help that process available on the GSF website (Gold Standards Framework 2016c).

Between meetings, practice teams develop a local Action Plan leading to their own EOLC Protocol that stimulates gradual and cumulative changes in practice. The first step remains the need to identify patients likely to be in the final year, months, weeks or days of life. These are recorded on the register and coded according to their likely needs and expected disease trajectory. This triggers staff to implement key activities for proactive support for that patient and their family ensuring more patients are identified earlier in their illness trajectory. The local Action Plans and EOLC Protocol helps teams target key areas of EOLC development and use of GSF Audit measures gives them the opportunity to demonstrate measureable progress.

Auditing the impact of the GSF

Audit tools are used by GSF Gold practices to measure the impact of uptake of the GSF. The first set of measures is described as Key Outcome Ratios (KORs) and the second, the After Death Analysis (ADA) tool. These tools use straightforward outcome measures found to be useful in monitoring the progress of GSF uptake. Teams taking up the GSF Gold Programme agree to monitor progress using these audit tools at the start of the programme (baseline) and follow-up at accreditation as described below.

Key Outcome Ratios

The measures used in the KOR audit are listed in box 2. The first measure at baseline is to record the number of people on the register nearing the end of life. This indicates scope for improvement by noting the number of patients who died in the practice over the previous year and identifying what percentage of this group had been recorded on the register against the overall deaths during that time span. It has been estimated that 1% of population die in each year indicating 1% of the population of each practice will be in the last year of life (Dying Matters 2016) and could be included on the register. Thus, for example, a practice with a population size of 10000 may anticipate 100 deaths in a year. If, at baseline, the practice team noted only 20 patients (20% of the predicted total) who died in the year had been identified on the register, they may then take measures to increase the number identified to, for example 50%, over the next year. Such measures would include seeking more non-cancer patients, those from care homes, and those with repeated hospital admissions. Once identified they would determine how best to plan and implement care provision following the GSF framework (see box 1). Subsequently if, at follow-up for accreditation, 60% of those who died were identified on the register this shows a change in practice and suggests increased awareness of patients' EOLC needs.

Further audit data is then collected from the patients' identified on the register. It is then recorded whether ACP discussions had taken place enabling patients to discuss and clarify care preferences such as preferred place of care, where they prefer to die and views on 'do not attempt resuscitation' (DNAR) orders. Finally, consideration is given to identifying carers. This enables them to be registered for support and, later, to receive bereavement care.

In sum, use of the KORs give the practice 'global' measures as to the extent they are identifying care

Box 2 Gold Standards Framework (GSF) Key Outcome Ratios (KORs)

- Number of people on the register
- Number and proportion of patients with cancer/without cancer on end of life register
- Number and proportion of care home patients on end of life register
- Number of patients offered advance care planning (ACP) discussion
- Number of patients who died in usual place/residence
- Number of patients on the DNAR on register
- Carers assessment—the number of carers registered
- Bereavement care—number of bereaved carers on register

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Box 3 Staff comments about the impact of the Gold Standards Framework (GSF) Gold Programme

The GSF Gold Programme:

- *"Encouraged a greater engagement with palliative care among the doctors. Prior to doing the programme, there was a fair amount of cynicism and a feeling of 'heartsink' when palliative care was mentioned…by discussing learning points in a safe environment, clinicians have become more enthusiastic and have developed their skills in identifying palliative patients (particularly non-cancer patients) and developing care plans…."*
- *"On addition to our palliative list, patients are given contact details of our palliative secretary as first point of contact, and she is able to signpost appropriately and for example get supplies of emergency medications in a timely fashion. (Nurse, practice 7)"*
- *"Our meetings continue to provide a useful tool for exchange of information and we have recently been joined by staff from social services which will soon prove to have significant benefits to patients and their carers. We have also set up a "drop-in" surgery on alternate weeks with family carers service: carers are able to call in for advice or arrange for an assessment locally. (GP, practice 4)"*
- *"It has allowed the practice to advance its working relationship with the district nursing team far beyond that of other local practices…we have supported the team in setting up and using electronic advances such as tasks, electronic referrals and visit books within the clinical system to improve communication and effectiveness."*
- *"The development and use of the advance care planning documents has aided clinicians to raise awareness to all patients that this a subject that can and should be discussed with family and friends well in advance of it being required. (Nurse, practice 1)"*
- *"The GSF training has helped to move us to a completely different place. Now patients have a genuine choice about where they would like to be cared for. People are now confident not just that they'll be asked what they want at the end of life, but that it will happen, so they can die peacefully at home with their families, if that's what they want." (GP, practice 1)*
- *"What GSF has helped us do is actually deliver better more coordinated care, not just well intentioned care. We're more skilled at symptom management and while delivering better end of life care can take more time, the rewards are great." (GP, practice 5)*
- *"It helped us direct to those most in need. Our register now better reflects the ethnicity and need of our population." (GP, practice 16)*
- *"We look after the whole population of our elderly patients much better now- much more proactively. And when we look back, we can really see the difference." (GP practice 2)*
- *"GSF has really helped us to have a good structure in place and given everyone in the practice the confidence to initiate what can be difficult conversations with people about where and how they want to be cared for and that means everyone feels more in control." (GP practice 12).*

needs and helps in planning care to enhance uptake year on year.

After Death Analysis

To determine the extent to which care given impacted directly on the outcomes of patient and carers at the end of life, the ADA tool is used to audit whether care was given as planned after the death had occurred (Thomas 2009, Thomas and Clifford 2010). At baseline, before starting the GSF Gold Programme, patient-level data are collected by the GP teams using the online ADA audit tool on a sample of the last 10 deaths (five who were on the register and five who were not registered).

Cases are audited to identify if patients died in the place of their choice; whether relevant information was shared with all caring personnel, especially the 'out-of-hours' healthcare team; whether relevant anticipatory drugs were available if needed; and whether the carer was assessed and supported? In addition, within this, a 'Significant Event Analysis' reflection is encouraged for each patient to help determine organisational factors that may have impacted on care given.

The KORs and ADA audits are repeated at follow-up for accreditation giving benchmarked data to assess progress.

Using the audit data

The audit data helps practice teams reflect on care given and devise their own Action Plans and EOLC Protocol towards to the standards to which they aspire. These plans help teams to focus and provide a means of monitoring changes in practice and thus stimulate organisational action. For example, if the proportion of 'non-cancer' patients on the register is low, too few are from care homes, the ethnic mix not representative, or too few are offered ACP discussions, ways to increase this are discussed and plans to address this implemented by the team. As indicated above, early identification is seen as key to EOLC planning, as inclusion on the register alerts staff to the

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needs of the patient, regardless of the underlying condition or setting, thereby reducing inequity (Public Health England 2014). It also triggers some proactive additional supportive measures from the whole team, such as ensuring access to a named GP, quick response if prescriptions are needed and out of hour teams alerted to patient needs. These taken together help deliver earlier proactive supportive care with fewer unanticipated crises.

The model adopted is one of encouraging local growth which allows EOLC to be enhanced at a realistic rate for practitioners. There is an aspiration within the GSF Gold Programme to increase early identification, but key targets are set locally. This ensures that efforts to enhance service provision are realistic for the local situation. This is more likely to support sustainability than setting national benchmarks that may not be attainable.

Staff perspective

An organisational survey is completed as the primary care team starts the GSF Gold Programme giving baseline data to note the nature of the practice such as location, population and staffing ratios to help inform the evaluation process. A 'before' and 'after' staff survey is administered to all members of the team (clinical and administrative) to determine staff confidence and the impact of the training and skill development in supporting EOLC. In addition the GSF team gather data through staff discussions and interviews during the accreditation process when the staff are encouraged to reflect on what has changed within the whole practice team. This is useful in recording both positive and negative experiences of using the GSF Gold approach.

GSF Gold Accreditation and Quality Hallmark Award

The GSF Gold Accreditation Programme was introduced in 2012. This is based on the well-used and quality-assured GSF accreditation process already in use for GSF care homes. GSF accredited care homes have shown enhanced EOLC provision that has supported more to die in the homes with an associated reduction in acute hospital admissions and deaths (Badger *et al* 2007, Gold Standards Framework 2016a).

Primary care accreditation is aligned with a Quality Hallmark Award co-badged by the RCGP bringing independent peer review into the process. Most practices complete the training and implement the GSF over 6–18 months before seeking accreditation. An important feature of this programme is that practices set their own pace of development to reflect organisational needs, an approach that is preferred by participants.

To be eligible to apply for Accreditation and the Quality Hallmark Award, practice teams need to have completed the GSF 'Gold' training programme, have developed and implemented their own EOLC management local Action Plans, submitting a local EOLC portfolio and providing evidence of improvement using the evaluation tools mentioned, plus assessment at a telephone interview with the team. The self-assessment checklist and portfolio are summarised under five headings against the GSF standards of the '*right care*, for the *right person*, in the *right place*, at the *right time*, *every time*' as listed in box 1.

This accumulated evidence is presented in a Review Report that goes with the Practice EOLC Portfolio to an independent panel comprising of an independent GP, a RCGP representative, a primary care nurse, and a quality assurance lead (Gold Standards Framework 2016b). This panel determines if the overall evidence demonstrates sustainability of enhanced EOLC provision. If so, the practice is Accredited and presented with the Quality Hallmark Award; if not guidance is given as to requirements to meet this goal.

The IMPACT on the first GSF Gold Accreditation Practices

The first 10 GP practices to receive the Quality Hallmark Award are representative of GP practices in England spanning both rural and inner city locations and population size as shown in table 2. This table also shows the average number of deaths that may be expected for the population size in a given year and demonstrates the numbers identified for the register at accreditation as a percentage of the whole in each practice.

Drawing on the KORs data provided by participating practices, at accreditation quantifiable and tangible changes in practice can be seen. Overall, practices noted a big increase in the number of patients who were placed on the EOLC register and associated support identified. For example, as can be seen in figure 1 there is:

- Earlier identification of patients on the EOLC register (range 14–51%);
- More patients with non-cancer conditions registered (range 18–48%);
- More ACP discussions recorded (range 28–62%) and within this,
- An increase in resuscitation discussions (range 26–62%.),
- More people dying in usual place of care (ie, where they chose) (range 42–58%),
- Improved carers' assessment (range 18–72%),
- Improved formalised bereavement support (range 32–82%).

As practices begin the process of reaccreditation longitudinal progress can be seen. For example, a steady increase of patients identified on the register in the early practices seeking reaccreditation is shown in figure 2. Cumulated data from work ongoing in GSF trained or accredited practices shows this at about 60% (Gold Standards Framework 2016d).

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Table 2 Gold Standards Framework (GSF) Gold Programme—summary of 10 participating general practices showing location, population size, estimated number of deaths and patients identified on GSF register at accreditation

Practice number	Estimated practice population	Area location of practice	Estimated patient deaths per year at 1% population	Number of patients on register at accreditation and indicative percentage of estimated deaths, n (%)
1	15 000	North East (urban)	150	47 (31)
2	8200	South East (urban)	82	33 (40)
3	9750	North (rural)	98	52 (53)
4	10 000	South East (rural)	100	41 (41)
5	6000	North West (urban)	60	42 (70)
6	14 790	South (coastal town)	148	47 (32)
7	22 000	North (inner city)	220	139 (63)
8	33 000	North East (urban)	330	149 (45)
9	13 000	East (coastal town)	130	46 (35)
10	2400	South (rural)	24	26 (107)

Staff feedback

Post accreditation, participating practices were asked to consider the organisational impact of adopting the GSF Gold Programme. Indicative feedback with the GSF team reported 'qualitative' changes as a result of learning and action planning including:

- Inclusion of more patients with all conditions in all settings, including those with frailty, long-term conditions and dementia and from care homes;
- More patient-focused care offering routine ACP discussions to determine needs and wishes;
- Culture change and greater team working of all team members, especially non-clinical staff with greater team satisfaction;
- Greater coordination involving the wider health and social care teams, with improved use of electronic registers;
- Improved active support for carers.

This feedback also indicates how the whole team, from administrative to clinical staff, can be involved in supporting patients and families. Some examples from practices are shown in box 3.

DISCUSSION: ADDED VALUE, LESSONS LEARNT AND IMPLICATIONS FOR PRACTICE

The improvements demonstrated in the first 10 GSF accredited practices show excellent standards of EOLC in primary care. A key question is how might this be extended to a wider number of practices where Foundation Level GSF is already embedded when primary care is buckling under the strains of meeting the high demands and needs of the changing population, including an ageing population with multiple healthcare needs (The King's Fund 2016). It is noted

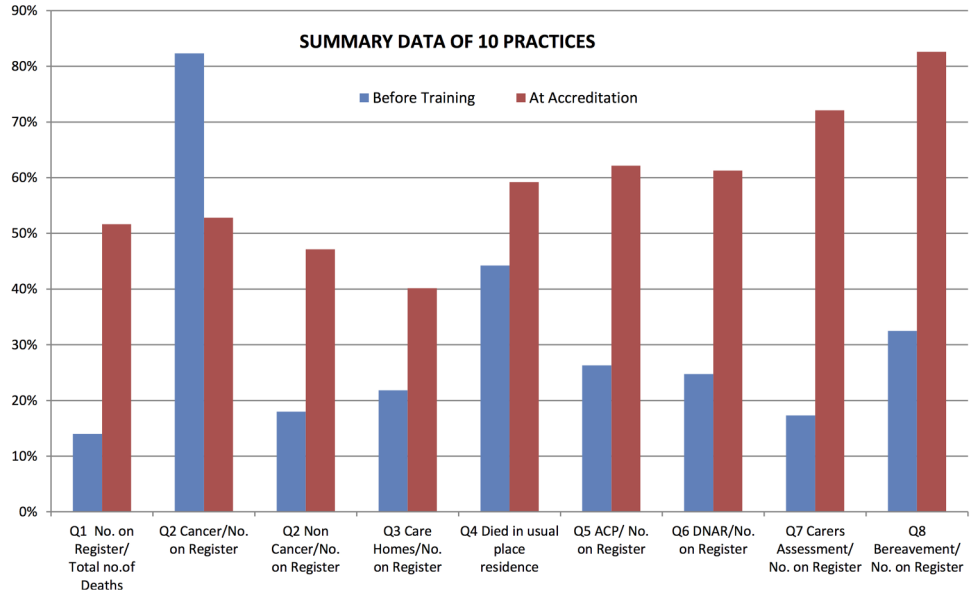

Figure 1 Summary of KORs in 10 GP practice before training for GSF and at accreditation. ACP, advance care planning; DNAR, do not attempt resuscitation; GP, general practitioner; GSF, Gold Standards Framework; KORs, Key Outcome Ratios.

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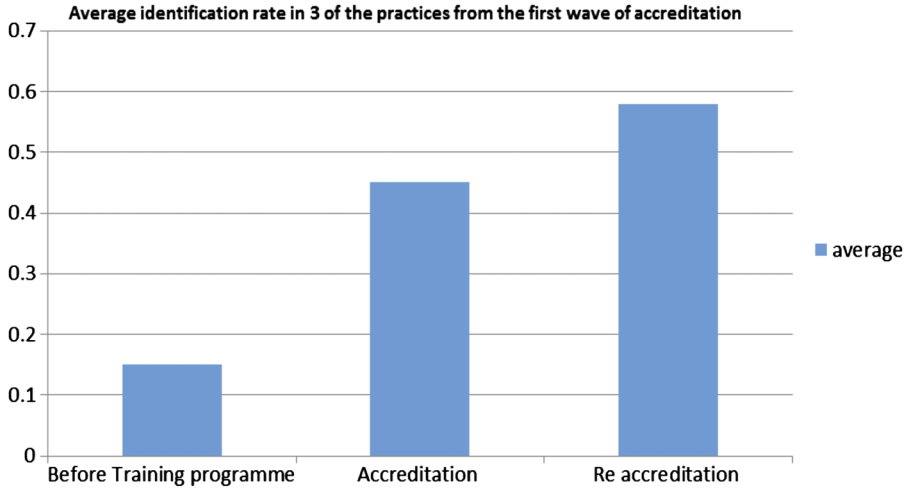

Figure 2 Identification rates for patients in the last year of life in first three practices seeking reaccreditation.

by accredited teams following the GSF Gold Programme that care for all the elderly patients is improving in a more proactive, all inclusive way. This may help practices cope with increased demands and pressures on staff and raises a question as to whether the GSF Gold Programme could become part of a possible solution in managing 21st century healthcare provision. To consider this it is worth noting what lessons have been learnt as the programme has evolved.

The first, noted above, was that while the Foundation Level GSF had been taken up by the majority of GP practices, the National Snapshot Audit (2009) showed that the extent this was done was patchy leaving many people nearing the end of life without optimal support. The indications from work in progress outlined here is that the GSF Gold Programme supported by the accreditation process may support sustainability of good practice by encouraging GP teams to embed changes into everyday practice. It is recognised that not all can reach the standards of accredited teams but some progress towards this would be possible. Changing practice for the better is to be commended, changing practice for the better for longer term sustainability, can only bring added value.

The second key lesson reinforced the value of local ownership of programme developments. While the GSF Gold Programme provides the framework and the impetus to develop EOLC locally in GP practices, the requirement for practice staff to develop their own Action Plans, EOLC Protocols and mode of implementation at a pace that suits local needs is important. Practices undertaking the GSF Gold Programme are supported to do this at their own pace, with flexible timelines and using various adaptations to enable strong uptake and embedding into practice. Rather than a rigid timetable for implementation, enabling practices to set their own goals for progress supports motivation to continue to improve EOLC.

Another lesson is the importance of local champions and motivated local leaders to launch the programme and that whole team commitment is required for success, a common finding in most quality improvement programmes. As indicated in table 1 the first GP accredited practices represent a typical range of those in England today, varied population sizes, spread across the country in both rural and inner city locations. They have the same pressures and demands on primary care delivery as others but, moving beyond aspiration, have demonstrated it is possible to enhance EOLC management. Importantly, they have bought equity in EOLC provision for people with cancer as well as other life-limiting conditions, including frail elderly people. They have also demonstrated better working relationships with other relevant agencies, such as care homes and hospitals as well as working well with their specialist palliative care teams. This is underpinning clear developments in cross-boundary working in EOLC as shown on the GSF website (2016a).

In addition to direct-care issues, accredited practices have learnt that following the GSF Gold framework does not mean duplication of effort meeting other policy demands, but that they can focus their attention more specifically on those most in need. They also have a broader remit to include all patients from any setting with any condition, and not just those with cancer known to the palliative care team. This helps somewhat to meet the needs of the ageing population that is challenging primary care provision in many areas. Hence, as suggested above, integrating better organised care with more proactive identification and more ACP discussions to ensure care is tailored to their needs, could be part of the way that primary care in future could meet the challenge of 21st century demands for better EOLC.

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Work in progress

At the time of writing a number of other GP practices have followed the GSF programme to accreditation and data illustrating their progress is shared on the GSF website (Gold Standards Framework 2016a). There remains much to be done and the GSF team are working with other partners to develop ways in which these achievements can be implemented more widely. Acknowledging the successes reported here, it is noted that work needs to be done to evaluate why GPs may adopt the GSF and also why others cannot and how to spread it further by overcoming other barriers such as time constrained GPs under pressure in many ways. Such work is necessary to inform EOLC planning for as many people as possible, not just a select few.

There is also scope to determine the extent to which a framework such as GSF can impact on wider cross-boundary care provision (noted above). For example, what is the impact in a locality if primary care teams, GP practices and hospitals were all using the GSF to identify and plan EOLC provision? Data accruing with the GSF programme gives insights but it is acknowledged that there is a need for large-scale independent evaluation to help inform this information.

CONCLUSION

In a world of finite resources, health leaders are interested in simple solutions that are locally 'owned' and driven but with significant impact on outcomes for patients and for the health system as a whole. More proactive, person-centred care through earlier identification, offering every identified person a chance to have ACP discussion to clarify their preferences and tailoring care to meet these needs, including reducing hospital admissions and deaths, might be crucial parts of the jigsaw in the future.

The GSF Gold Programme is an example of this process. The ideas are not complex; they simply reflect what should be done to support patients at the end of life. The associated accreditation system enables practices to demonstrate more widely what they have achieved and how they are striving to enhance services further.

Back in 2004 the unlikely prospect of the roll out of Foundation (now Bronze) GSF leading a step change in care across the country did not seem possible. The significant achievements of these early GSF Gold accredited practices demonstrates what is possible to achieve and that with further support and encouragement there is the possibility that more might attain such high level of EOLC in primary care, a further step change to an even greater level of care. The GSF teams continue to develop this programme and are monitoring progress to determine how to overcome factors inhibiting uptake of the GSF. However, if primary care were able to deliver such high consistent standards of care, the impact on the population nearing the end of life could be considerable, with fewer hospital admissions and deaths, more care tailored to patient wishes and greater satisfaction from bereaved relatives. If it is possible in these few practices it might just be possible for more.

The work reported here shows that with motivation and commitment primary care staff can develop and sustain enhanced EOLC in their own community. As frontrunners in this area, GSF accredited practices demonstrate what is possible to achieve and therefore act as an encouragement and inspiration to other practices keen to improve indicating 'if they can do it, we can too!'.

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