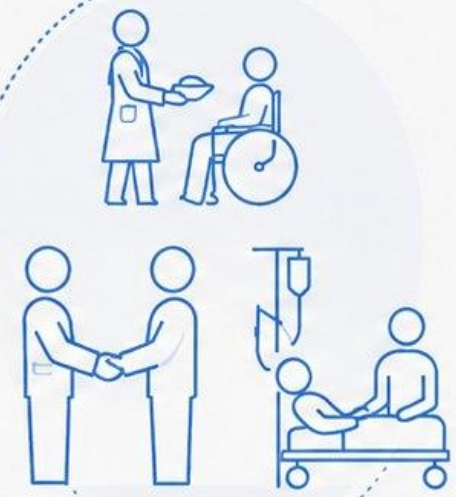
Gold Care Africa

P.C.E.A. CHOGORIA HOSPITAL • SINCE 1922 • Caring With Love

Adapting the Gold Standard Framework for Proactive End-of-Life Care in Africa:

Lessons from the Gold Care Africa Pilot at PCEA Chogoria Hospital



Dr Ian Kibet
Senior Family Medicine Resident,
PCEA Chogoria Hospital

BOTSWANA

Wonca 9th Africa Region Conference 2026
10 - 11 September, Gaborone

Maius Inkindi, MD | Marrie Kendi, RCO | Bildad Mwenda, RCO | Lilian Kamita, MD | Grace Macharia, MD | Raul Ncuti, MD
Bramwel Otieno, MD | Dickson Fundi | Jackline Chepkirui | Charity Koki | Mathew Loftus, MD | Prof Keri Thomas OBE

This presentation aims to:

01

Describe
how the Gold Standard Framework was adapted and implemented at PCEA Chogoria Hospital.

02

Demonstrate
its role in improving early identification and care planning for patients with palliative and end-of-life care needs.

03

Share
early outcomes, lessons learned, and opportunities for wider integration.

PCEA Chogoria Hospital, Kenya

Serves a catchment of **500,000** in **Central** and Eastern Kenya.

The region has a high burden of **NCDs** and **malignancies**.

Has **350** bed capacity with an **oncology unit.**

Background & Rationale

- Because of the rising prevalence of non-communicable diseases (NCDs) and life-limiting conditions in Africa, around **800,000** Kenyans are in need of palliative care annually. However, less than **<4%** of Kenyans needing palliative care receive it (**Cheboi et al., 2024**).

- In studies done in the United Kingdom, **28.8%** of hospital inpatients **(approximately 1 in 3)** are in their last year of life (**Clark et al., 2014**).

- 2023 SPICT survey at PCEA Chogoria Hospital: **33%** had palliative care needs; **<10%** were identified and documented (**Kamita et al., 2023**).

- SPICT survey in medical and surgical wards: **55%** of cancer patients received palliative care, but only **12%** of non-cancer patients received holistic end-of-life care (**Kamita et al., 2023**).

The SPICT-LIS Tool

SPICT-LIS™ helps identify people in low-income settings with advanced, progressive illnesses.
Offer the best available appropriate treatment. Assess unmet supportive and palliative care needs. Plan care.

Look for general indicators of poor or deteriorating health. May have one or more of these indicators.

- **Performance status is poor or deteriorating.** (e.g., person stays in bed or a chair more than half the day).
- **Depends on others** for care needs due to increasing physical and/or mental health problems.
  Person's carer needs more help and support
- Progressive **weight loss;** remains underweight; weight gain from persistent fluid retention.
- **Persistent symptoms** despite the best available appropriate treatment;
  cannot access treatment due to costs or distance to travel.
- Person wishes to focus on **quality of life;** chooses to reduce, stop or not have treatment
  asks for palliative care.
- **Unplanned hospital admissions;** increased visits to hospital, clinic or health facility
  with progressive illness or complications.

Problem Statement

There are too many patients with palliative care needs relying on overstretched palliative care teams

Difficulty for frontline clinicians to identify patients in the final year of life

Reactive rather than proactive care in the final year of life

Poor coordination of care between the hospitals and the community

Unnecessary admissions, hospital stays, and futile treatments for end-of-life patients.

What is Gold Standard Framework?

It is a structured approach to **identify and care for patients** in the last year of life that has been endorsed by the **UK Department of Health** and adopted at a basic level by all UK GP practices (**Sandhu et al., 2018**).

Patients in the last year of life are identified as **"GOLD"** patients and given a traffic light code based on the disease trajectory.

Many studies in the UK reveal that GSF improves **early recognition**, **staff confidence**, and **multidisciplinary collaboration and communication** in offering palliative care, and coordination (Shaw et al., 2010; Badger et al., 2011; ICU Accreditation Study 2026).

The Gold Care Africa Project

Based on GSF- UK to equip **frontline generalists.** to identify needs and offer **personalized** and **proactive** end-of-life care.

Phase 1 was conducted in **PCEA Chogoria Hospital** in Kenya, **St Francis Nagalamme Hospital** in Uganda, and **Kitovu Mobile Clinic** in Uganda, in conjunction with **APCA.**

The program entails training **frontline generalists** through **monthly online workshops,** **annual symposiums**, and seed funding from the Andrew Rodger Trust.

GSF COLOUR-CODING SYSTEM

RED
Dying
(Last days of life)

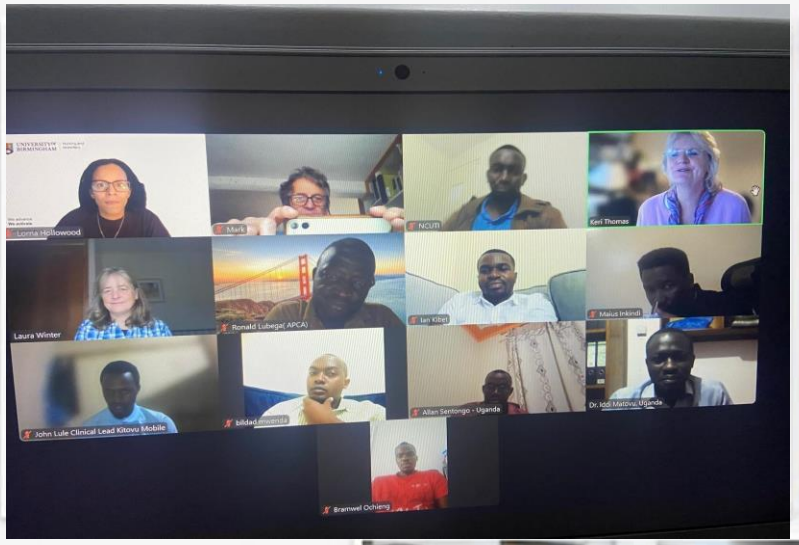
AMBER
Deteriorating
(Last weeks of life)

GREEN
Unstable
(Last months of life)

BLUE
Stable
life limiting conditions

WHITE
No current evidence
of life-limiting illness

Workshops and symposiums



Objectives

IDENTIFY

- Locally developed indicators
- SPICT/ SPICT LIS/ PIG
- Surprise Question
- Organ-specific indicators of deterioration

ASSESS

Assign needs-based colour code and develop a proactive care plan

GREEN AMBER RED

PLAN

- Initiate family discussions
- Offer Advance Care Planning at different levels (Levels 1–3)
- Link up with community team for home based care
- Care aligned to needs and preferences

The Quality Improvement project aimed to;

a. **Adapt** the UK Gold Standard Framework to develop sustainable, **locally appropriate models** of proactive end-of-life care that reflect African healthcare systems and cultural contexts.

b. Build the **confidence and skills** of frontline generalist teams through structured training, mentorship, and practical tools.

c. Improve **early identification** of palliative care needs, **advance care plans**, and **community linkages** using needs-based colour coding (RAG) and proactive care planning.

Methodology

An ongoing 12-month Quality Improvement (QI) project using mixed methods from November 2025- November 2026, with quantitative pre- and post-intervention comparisons and monthly evaluation of weekly needs-based coding data.

Qualitative

- Each hospital's key challenge descriptions (before and after interventions)
- Significant Event Analysis
- Gold Patient Benefits and Stories
- Assessment and Feedback during and after every session

Quantitative Assessments

Baseline Measures and Outcome Measures

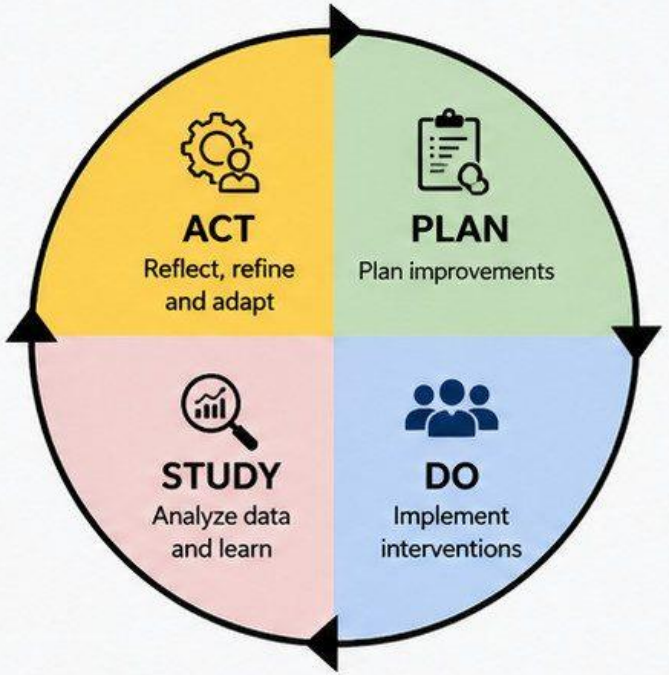
- Ward identification rate.
- Staff confidence.
- Organizational readiness.

Process Measures

- Weekly needs-based coding.
- Advance Care Planning uptake.
- Monthly implementation reviews.

Balance Measure

- Qualitative feedback on staff workload.



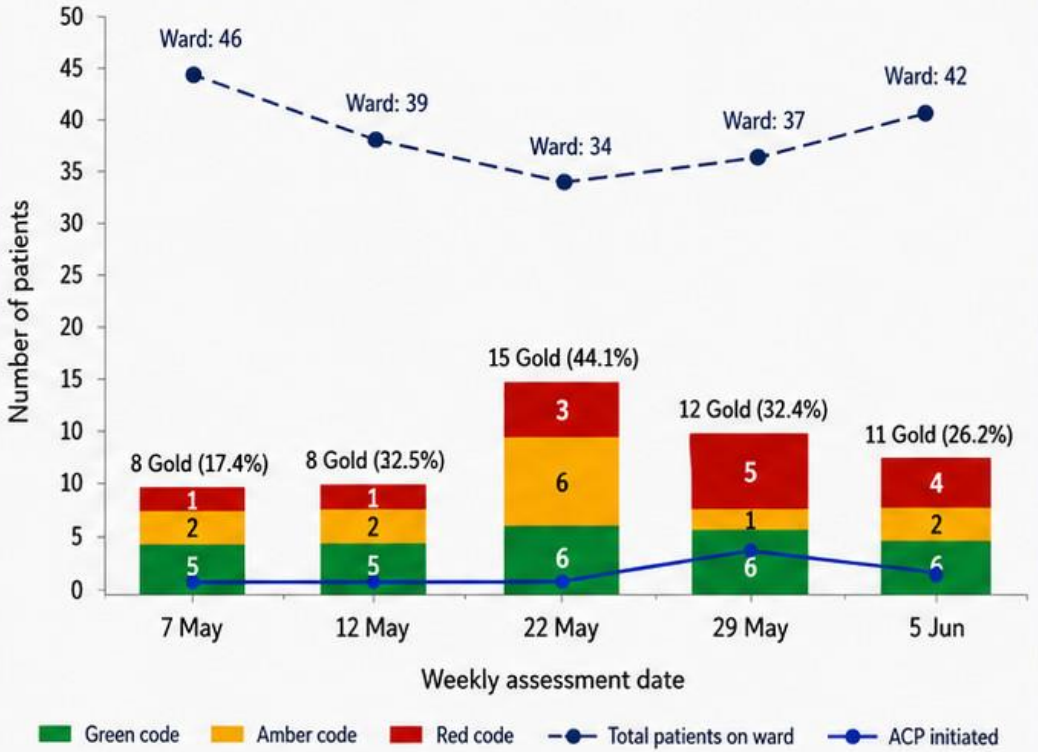
Weekly Coding Track trends and inform decisions

Common Indicators for Coding

BLUE (Stable patients with uncomplicated chronic diseases)	GREEN (Unstable patients – complications but responsive to care)	AMBER (Deteriorating patients)	RED (Actively dying patients)
• Patients with uncomplicated chronic diseases	• Patients with complications that respond to best available care	• Patients with advanced malignancies	• Multiple advanced organ failure
• Patients responsive to care with outpatient follow up	• Patients requiring unplanned inpatient or outpatient visits for chronic diseases due to complications	• Patient deteriorating on best available care	• Patient desaturating on high flow oxygen or positive pressure ventilating
• Functionally independent and good cognition	• Patient's baseline is still independent and can perform day to day functions	• More than 3 hospital admissions in the last year	• Patients in shock not perfusing on ionotropic support
• Good social support	• Poor social support and non-adherence	• Patient increasingly reliant on caregivers and others for care	• Comatose patients or rapidly declining mental status

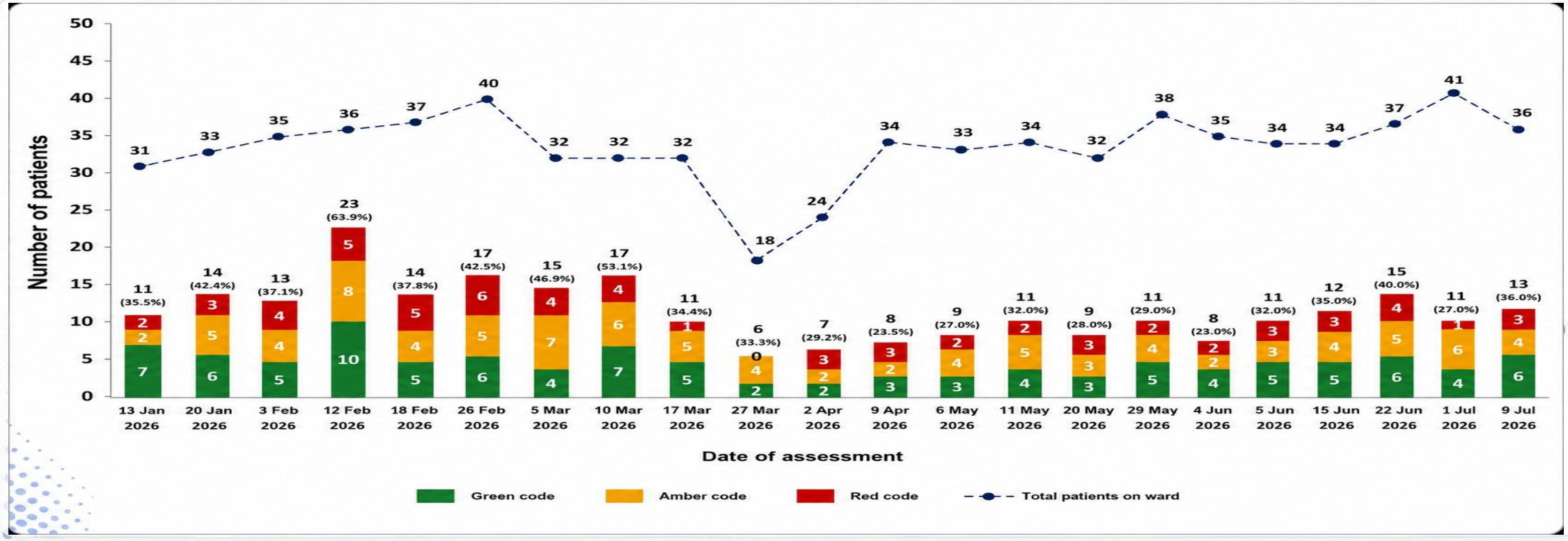
Template for Weekly Tracking Data- May- June 2026

Week Number	Date	Number of patients on the ward	Number of patients Identified for Gold Care	The Percentage of patients identified / week	How many patients are Green code	How many patients are Amber code	How many patients are Red code	ACP progress # started	ACP Level 1 No of people offered initial opening discussion DNAR and ACP information	ACP Level 2 No of patients offered ACP discussion includes PP, PROXY etc	ACP Level 3 No of patients with ACP completed document	No of Gold Care pts discharged
1	7th May 2026	46	8	17.39%	5	2	1	2	2	2	-	2
2	12th May 2026	39	8	20.51%	5	2	1	2	2	-	-	-
3	22nd May 2026	34	15	44.11%	6	6	3	2	2	-	-	-
4	29th May 2026	37	12	32.43%	6	1	5	5	5	-	-	6
5	5th June 2026	42	11	26.19%	5	2	4	4	4	-	-	-



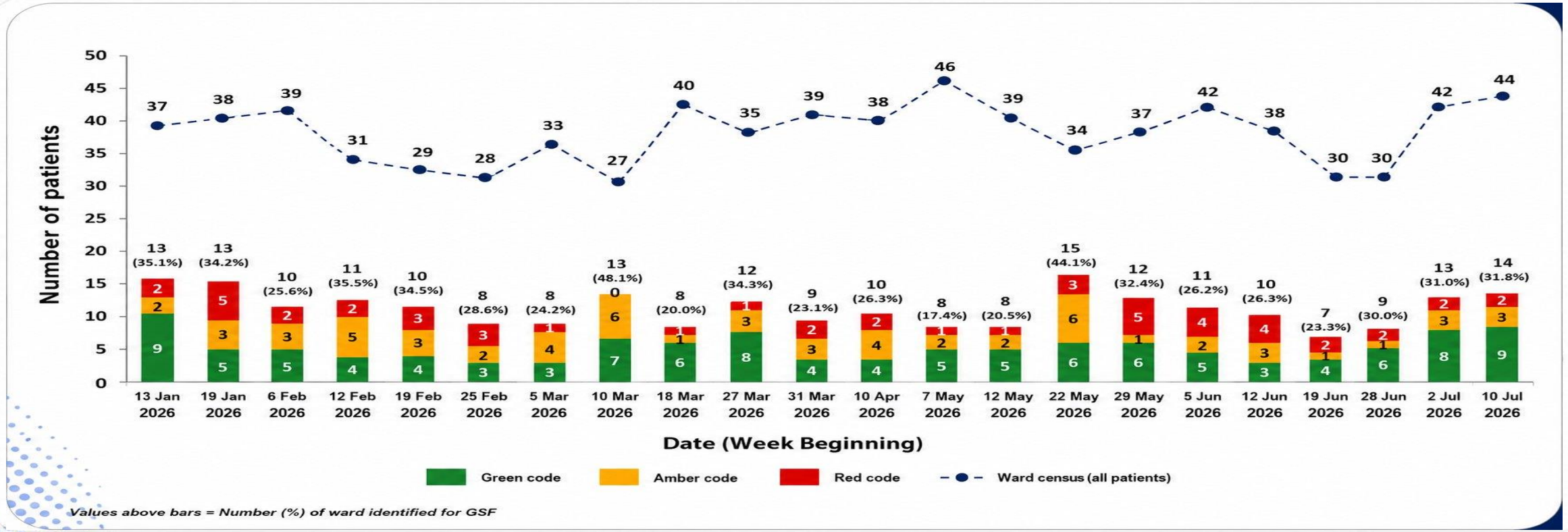
The proportion of Gold patients who received Advance Care Planning each week in the male medical ward during May–June 2026 ranged from **33.3%** to **53.1%**.

January to July 2026 Male Medical Ward



On average, **12** Gold patients were identified each week in male medical ward.
The proportion of ward patients identified as Gold ranged from **22.9%** to **63.9%**,
with an overall identification rate of approximately **36%**.

January to July 2026 Female Medical Ward



On average, **10** Gold patients were identified each week in the Female Medical Ward.

Average weekly proportion of Gold patients: **29.7%**.

The proportion of ward patients identified in the Female Medical Ward ranged from **48.1%** to **17.4%**.

Notable PDSA Changes

December 2025 – We started weekly codes for patients in the male and female medical wards.

January 2026 – Started offering subsidized ripple mattresses for bed-bound GOLD patients in the medical wards.

January 2026 – We started linking discharged GOLD patients to the community team for home-based care.

March 2026 – We started providing free ripple mattresses for bed-bound patients in the community.

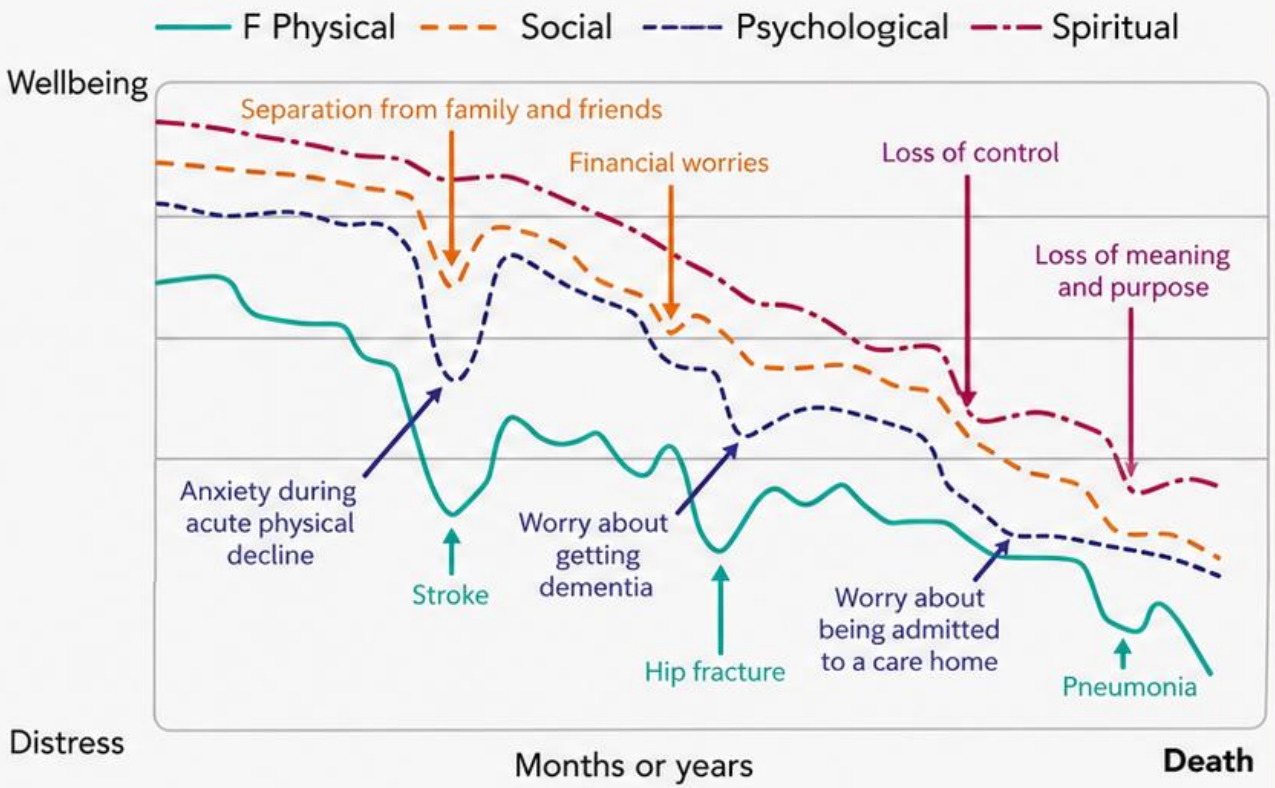
May 2026 – Included a hospital chaplain on the Gold Care team to offer spiritual support for Red and Amber patients.

July 2026 – Initiated the process of incorporating the 5 color codes into the EMR for universal coding for all patients in the hospital.

Assessing Needs

All Dimensions of Dying

Wellbeing–Distress Trajectory in the Last Year of Life



Adapted from Murray et al. (2024).

Code-Based Proactive Care Plans

BLUE (Stable patients with chronic diseases)	GREEN (Patients who have chronic diseases but are unstable)	AMBER (Patients who are actively deteriorating)	RED (Patients who are actively dying)
• Offer patient education	• Avoid unnecessary hospital readmissions	• Minimize prolonged hospital stays	• Do a family conference on DNACPR status
• Advice on lifestyle modification	• Social support at home and psychological support	• Family conference with advance care plans	• Offer optimal symptom control- analgesia, feeding, antiemetics etc
• Close out patient follow-up	• Develop advanced care plans	• Home-based care and social support: Link with community health teams	• Spiritual support from chaplains
• Link with appropriate support groups	• Ensure close follow-up, clinic appointments, with follow-up calls if they are missed	• Spiritual support- chaplains	• Reduce unnecessary interventions- NGT, cannulation, surgical debridement etc

Benefits for Gold Patients

- Timely initiation of ACP discussions with the patient and families on DNR/DNI, Proxy, Preferred place of care, and practical specific preferences.
- Provision of full supportive care in the ward.
- Subsidized/ free ripple mattresses and dippers for bed-bound patients.
- Possible home visits with essential medications (morphine and bisacodyl) and basic household shopping.
- Access to a 24-hour telephone line with the community team for basic consultations.

Community Oriented Care.

Key Lessons: What has Gone Well?

With this model, frontline generalists can **assess the palliative care needs** of patients on admission and offer appropriate care.

Has helped **integrate palliative care discussions** into routine ward rounds instead of relying on specialist teams.

The model promotes longitudinal care with **continuity** from the wards into the community.

The model has helped generalists offer better **proactive, holistic, patient-centred care** and improve the **dignity** of patients who were previously overlooked.

Main Challenges faced

Cultural inertia about disclosing terminology diagnoses to patients rather than their families.

Stigma around having ACP discussions with the family.

The community aspects of the model are still heavily reliant on funding grants.

High generalist staff turnover requires frequent CMEs and training.

Key Takeaways

Structured tools enable earlier identification of patients approaching end of life.

Training and mentorship empower frontline teams to provide proactive end-of-life care.

Early identification enables timely advance care planning and better coordination of care.

The Gold Care pilot demonstrates a scalable model for improving equity in end-of-life care across Africa.

Acknowledgement

- **Professor Keri Thomas** — for her vision, mentorship, and leadership of the Gold Care Africa pilot.
- **Gold Care Africa faculty and UK tutors** — for their guidance and support throughout the project.
- **Andrew Rodger Trust** — for funding the implementation and training activities.
- **PCEA Chogoria Hospital management and staff** — for their commitment to improving end-of-life care.

References

1. Badger F, Plumridge G, Hewison A, et al. *Int J Nurs Stud*. 2012;49(5):586–595.
2. Cheboi SK, Ng'ang'a WS, Nyamanga P, Kibet S. *Palliat Care Kenya*. 2024.
3. Clark D, Armstrong M, Allan A, et al. *Palliat Med*. 2014;28(6):474–479.
4. Jacob SL, Nayak MG, George LS, et al. *Palliat Care Soc Pract*. 2025;19:1–-11.
5. Kamita LM, Murray SA, Njiru L, et al. *BMJ Support Palliat Care*. 2024;14(e1):e334–e336.
6. RACGP. *Aged Care Clinical Guide (Silver Book)*. 5th ed. Part A: Palliation and End-of-Life Care. 2019.
7. Reay M, Jennings M, Harpham-Lockyer L, Bowen J. *J Intensive Care Soc*. 2026;27(2).
8. Sandhu P, Allison B, Sleeman KE. *BMJ Support Palliat Care*. 2018;8(1):A28–A29.
9. Scott Murray SA, Boyd K, Moine S, et al. *BMJ*. 2024;384:e067896.
10. Shaw KL, Clifford C, Thomas K, Meehan H. *Palliat Med*. 2010;24(3):317–329.

Visit the website of the **SPICT-LIS** *for information about how it can be used and even translated into different languages https://www.spict.org.uk/spict-lis/ to start care planning for people with serious illnesses in hospitals and in the community.*