**Gold Care Application Form** June 2025

**Please complete in word with as much information as you are able to provide, and add signatures at the end . Please send by July 4th to** **keri.thomas@gsfcentre.co.uk** **and** **admin@gsfinternational.org.uk** **. Any queries or more info needed, let us know.**

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| --- | --- |
| **General**  |  |
| **Why do you want to undertake this pilot?** And what do you hope to get out of it?  |  |
| Any particular **strengths** of your team or hospital?   |  |
| Any particular areas of **challenge**?  |  |
| **Commitment** Are you able to undertake the things described in the criteria , including local facilitation/project lead, training , workshops and evaluations ?  |  |
| Any areas of **concern**? |  |
| What would **success** look like to you ?  |  |
| **Your Hospital** or Health Centre Level 4  |  |
| **Name** of Hospital or Health Centre Level 4  |  |
| **Location** and countryUrban/rural?  |  |
| **General email** and telephone no  |  |
| **Details of hospital** eg how many wards, how many beds, areas of speciality, serving what size of population etc  |  |
| **Hospital funding**eg Government, charity etc.  |  |
| **Which wards** are you including in this pilot ( suggested 2 wards initially)  |  |
| **Ward 1** - How many beds? How many staff ?What conditions or areas of speciality do they cover? |  |
| **Ward 2** - How many beds? How many staff ?What conditions or areas of speciality do they cover? |  |
| Other wards/areas?  |  |
| **Additional information** eg research at university WHO link , or other ? |  |
| **Mortality or Palliative care Data** **if you have it.** Do you know how many die in your hospital each /year/month/ week  or what proportion of patients this represents?  |  |
| Or any other useful information related to palliative and end of life care from your hospital or area? |  |
| **Your Team and support**  |  |
| **Clinical Lead** for Gold Care Pilot - name, role  |  |
| Contact details – email and phone for what’s app  |  |
| **Lead Facilitator** – name, role (may be same as above )  |  |
| Contact details – email and phone for what’s app |  |
| **Second Facilitator** as back up -name, role  |  |
| Contact details – email and phone for what’s app |  |
| **Medical Support / Lead Doctor**  Support from lead medical clinician (if different from Clinical Lead) – please name and describe role . |  |
| Contact details – email and phone for what’s app |  |
| **Palliative Care** Please describe any Palliative care/specialist support you may have  |  |
| **Board Support** Do you have confirmation of support from senior Hospital Authority / Board to undertake this pilot? Name and Role  |  |
| **Others** eg social workers, chaplain **?**  |  |
| Any areas of **difficulty** you can foresee?  |  |
|  **Your area**  |  |
| **Needs** Describe the key needs for palliative care in your area  |  |
| **Challenges** What are the greatest challenges for you in providing palliative and end of life care in your area? |  |
| **Conditions** What do most patients you see die from? Or what are the most common conditions you are seeing requiring palliative or end of life care? |  |
| **Community** What support do patients have in the community in your area?  |  |
|  Do you have a link with the Palliative Care Association in your country or with APCA? If so with whom?  |  |
| **Any other** useful additional information? |  |
| **Any other comments?**  |  |

**Confirmation** that you agree to undertake the pilot Gold Care programme, share learning and innovations and complete evaluations

Signed by Date……………………

Gold Care Pilot Lead / Facilitator ……………………………………………………………………………………..

 Lead Clinical / Medical Support ………………………………………………………………………………………

Palliative Care support …………………………………………………………………………………………………

Hospital Board/ Authority representative ..................................................................................

Many thanks

We look forward to hearing from you. Any queries do contact us.

Keri Thomas