Recognising the Last Year of Life

How to spot patients who are nearing the end of life, estimate prognosis sensibly, and act early — a practical guide for GP trainees.

> Your job is **not** to predict the date. It is to **recognise decline early** and **plan ahead** — so care fits what matters most to the patient.

◎ Why this matters

An average GP sees about **20 deaths a year**. Spotting these patients early means fewer crisis admissions, earlier advance care planning, and more people dying in the place they choose.

◆ The definition to remember

A person is **"approaching the end of life"** when they are likely to die within the **next 12 months** — including the final days.

GMC / NICE definition, used across the NHS

1 Start with one simple question

The single most useful trigger in everyday practice.

THE SURPRISE QUESTION

"Would I be surprised if this patient died in the next year, months, weeks or days?"

If the honest answer is **"No"** — act now. This is an *intuitive* judgement that pulls together everything you know about the patient: their diagnosis, how fast they are changing, their other conditions, and how they are coping at home.

2 Know the three paths to the end of life

Each illness type declines in its own shape. The shape tells you what to expect.

Cancer

Cliff edge. Good function until a fairly rapid, predictable fall over weeks–months.

Organ failure

Staircase down. Slow decline with sudden crises (heart failure, COPD) — each dip can be fatal.

Frailty / dementia

Long dwindle. A slow, shallow slope from an already low baseline over months–years.

Vertical axis = function / ability. Knowing the trajectory helps you anticipate needs and time conversations well.

3 The structured approach: GSF in three steps

The Gold Standards Framework Proactive Identification Guidance (PIG) is the UK's standard tool. Work down the steps.

1. **Ask the Surprise Question.** Would you be surprised if they died within the next year? If **No** → move on.
2. **Look for general indicators of decline** — signs that the whole person is deteriorating (below).
3. **Look for disease-specific indicators** — red flags tied to the patient's main condition (table below).

▶ Step 2 — General indicators (any condition)

- Declining function — in bed or a chair more than **half the day**
- Repeated unplanned admissions or crises at home
- Weight loss **>10%** over the past 6 months
- Persistent symptoms despite optimal treatment
- Less response to treatment; less reversibility
- Patient chooses comfort over active treatment
- A sentinel event (major fall, move to a care home)
- Serum albumin **<25 g/L**

GSF PIG, 7th edition (June 2022)

Step 3 — Disease-specific indicators (the practical short-list)

Condition	Key triggers suggesting the last year of life
Cancer	Spending >50% of time in bed/lying down with metastatic or untreatable disease (prognosis often in months); persistent symptoms despite optimal oncology.
Heart failure	NYHA stage 3–4, breathless at rest or on minimal effort despite best therapy; **3 admissions in 6 months**, or one admission aged over 75.
COPD	Severe disease (FEV_1 <30%), breathless despite treatment; **≥3 admissions a year**; meets long-term oxygen criteria; too unwell for surgery or rehab.
Kidney disease	Stage 4–5 CKD (eGFR <30) that is deteriorating; choosing conservative (no-dialysis) care or stopping dialysis; symptomatic uraemia.
Liver disease	Advanced cirrhosis with complications (use Child–Pugh score); hepatocellular cancer; transplant not an option.
Neurological	Progressive decline despite treatment; recurrent aspiration pneumonia or swallowing failure; can no longer communicate basic needs.
Frailty & dementia	Clinical Frailty Scale **7+**; fully dependent for care; recurrent delirium, aspiration, or pressure ulcers; little meaningful conversation.

Triggers summarised and simplified from GSF PIG 7th edition (2022). Use clinical judgement — one strong indicator can be enough.

✓ The point of all this

You are not labelling someone as "dying". You are saying: **"this person may be in their last year, so let's plan well while there is still time."** Add them to the practice palliative care register and begin the conversations on page 4.

4 Estimating the timescale

Two simple, bedside ways to judge how long someone may have — both beat any complex score in primary care.

◆ The momentum rule — speed of change predicts timescale

Watch how quickly the patient is changing. The *rhythm* of decline usually continues at the same pace:

Month by month	Week by week	Day by day
changes → likely **months** left	changes → likely **weeks** left	changes → likely **days** left

Performance status — how much can the patient still do?

Scales such as the **Palliative Performance Scale (PPS)** and **Karnofsky** grade physical ability from 100% (normal) down to 0% (death). The single most useful threshold:

PPS	What the patient can do
100–80	Up and about; near-normal activity
70–60	Reduced activity; some help needed
50	**Mainly sitting / lying** — in bed ≥50% of day
40–30	Mainly or totally bed-bound; needs most/all care
20–10	Fully bed-bound; minimal intake; drowsy/comatose

▲ Key pearl

Once a patient spends **50% or more of the day in bed or lying down (PPS ≤50%)**, prognosis is often measured in months — only about **1 in 10** live beyond 6 months.

*In oncology the quick version is **ECOG (0–4)**: ECOG 3–4 (in bed/chair >50% of the day) signals the same significant decline.*

▲ Be honest about uncertainty — and lean towards planning sooner

Estimating survival is like a **weather forecast, not a train timetable**: give a direction and a range, never a fixed date.

Even experts get it wrong (more than double or less than half the true time) about **1 in 3** times — and most errors are **over-optimistic**. So when unsure, plan earlier rather than later. Share the uncertainty openly: estimates are not promises.

Chow et al., systematic review of clinical prediction of survival

◎ Three clinical signs that sharpen a short-term estimate

In advanced cancer, the combination of **weight loss ≥10 kg**, **confusion / cognitive decline**, and **difficulty swallowing** together predicted survival of under 4 weeks with about 74% accuracy — as good as two doctors' estimates.

Bruera et al., prospective palliative care unit study

5 Recognising the last *days* of life

A different question from the last year. NICE NG31 lists the changes that suggest death is close.

▲ Signs death may be near (days–hours)

- More sleep, drowsiness, reduced consciousness
- Eating and drinking little; swallowing failing
- Increasing weakness; bed-bound
- **Mottled skin**; cool peripheries
- Noisy chest secretions ("death rattle")
- Irregular (Cheyne–Stokes) breathing
- Restlessness or agitation; social withdrawal

✓ Two safety points

Improvement may mean recovery. If signs ease, the person may be stabilising — review rather than assume.

If you are genuinely uncertain, **seek senior or specialist palliative advice**. Do not order tests that will not change care.

◎ Specialist scores exist

Tools like the **PPI**, **PaP** and UK-developed **PiPS** combine signs (intake, oedema, breathlessness, delirium, bloods) to estimate weeks. They are mainly specialist/research tools — NICE notes they are **not used routinely** in practice.

6 Once you would not be surprised — act

Recognition is only useful if it triggers action. Five things to put in place.

- ✓ Add to the practice **palliative / EOL register**
- ✓ Start **advance care planning** — what matters most, preferred place of care
- ✓ Complete **ReSPECT / DNACPR** where appropriate
- ✓ Arrange **anticipatory medicines** and community support (per local palliative guidance)
- ✓ Consider an **SR1 form** for fast-tracked benefits
- ✓ Review regularly and coordinate the team

▲ What's changed from older teaching

- The focus has shifted from **"predict the survival time"** to **"identify early and plan"** (GSF PIG; NICE QS13 & NG142).
- The **Liverpool Care Pathway was withdrawn (2014)** and replaced by individualised care in the last days (NICE NG31).
- The **DS1500 is now the SR1 form**, and the benefit "Special Rules" timescale extended from 6 to **12 months**.
- Karnofsky and PPS remain valid, but now sit alongside **frailty scales** (Clinical Frailty Scale / Rockwood) for non-cancer decline.

Key sources: Gold Standards Framework Proactive Identification Guidance (PIG), 7th ed., 2022 · NICE NG31 Care of dying adults in the last days of life · NICE QS13 / NG142 End of life care for adults · GMC Treatment and care towards the end of life · DWP Special Rules (SR1), gov.uk 2025 · Chow et al. (2001); Bruera et al. (1992); Morita et al. (1999). Adapted and modernised from Woelk & Harlos, *Guideline for Estimating Length of Survival in Palliative Patients*.