

# TOP TIPS GUIDE TO

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# SUPPORTIVE AND PALLIATIVE CARE MEETINGS

Patients value care that is high quality and co-ordinated. Efficient meetings in a Primary Care setting are of great importance in ensuring that the physical, social, psychological and spiritual dimensions of care are delivered effectively.

## Top tip 1: Regularly remind your team why they have supportive and palliative care meetings

- On average 1% of your practice population will die each year.
- Most of these deaths can be predicted.
- Identifying patients thought to be in their last years of life enables earlier discussion of their wishes and improved care at the end of life.
- A proactive team approach to the shared care of frail elderly people with multiple co-morbidities, including cancer, becomes more possible.
- Well run meetings support individual clinicians to not only care for their patients better, but to also care for themselves.
- 'Branding' the meetings as supportive and ensuring the name of your register includes the term 'supportive' can make earlier conversations easier.

## Top tip 2: Prepare for the meetings

- Identify, train and nurture a committed lead administrator with IT and organisational skills. If a GP cannot attend the administrator will share important information.
- Involve your team – district nurses, community matrons, GPs, GP trainees, clinical nurse specialists, practice nurses, community specialist palliative care nurses, palliative care consultants, etc.
- Agree to set up a regular team meeting at least monthly, possibly lasting 60 minutes.

## Top tip 3: Identify patients for the supportive and palliative care register

- Aim for early identification of patients in the last years of life – this is especially important for people with dementia.
- Use existing predictor tools eg [GSF Proactive Information Guidance \(PIG 2017\)](#), [Supportive and Palliative Care Indicators Tool \(SPICT\)](#), Primary Care Electronic Frailty Index (eFI).
- Encourage everyone in the team in all settings to ask 'Would I be surprised if this patient died in the next 12 months?' (the surprise question).
- Use other information – eg hospital phone calls or specialist letters, patients own concerns, patient's choice eg patient with advanced chronic kidney disease who chooses not to have dialysis, carer concerns, other staff concerns (care home/nursing home, district nurses, community matrons etc), frequent unplanned admissions to hospital, use of out of hours services (OOHS).
- Discuss with the patient and gain consent to them being added to the supportive and palliative care register, explain the benefits such as the ability to share electronic information.

## Top tip 4: Prioritise patients according to need

Needs based RAG coding helps you to organise your meetings, an option is shown here, but others exist:

- 1 Red – last days of life
- 2 Amber – last weeks of life or increasing decline
- 3 Green – last months of life or advancing disease
- 4 Blue – incurable condition but could live for years, eg dementia or frailty.

- Use your own and other staff's knowledge of the patient and their health status/closeness to death, prioritise the most unwell.
- Use your prioritisation code as a guide to who to discuss first eg patients coded red.
- You will not need to discuss every patient on the list at every meeting eg stable patients coded green and blue.
- Include new additions since the last meeting and anyone else any team member has concerns about.
- Discuss all deaths since the last meeting including deaths of patients who were not on the register and sudden or unexpected deaths – consider bereavement care needs.
- The aim is to do the right thing at the right time – predicting need and provision of care.

## Top tip 5: Run an effective meeting

- Plan the meeting; use the agenda as a tool, eg:
  - 1 Introductions
  - 2 Red patients (15 mins – include discussion of physical, social, psychological and spiritual dimensions)
  - 3 Amber patients (30 mins)
  - 4 Green/Blue 'changing' patients
  - 5 Review of deaths – celebrating good care and identifying areas to improve
  - 6 Review of relevant admissions/discharges
  - 7 New patients to the register
  - 8 AOB – such as educational points or Significant Event Analysis (SEA, see tip 6)
  - 9 Summarise and plan date for next meeting
- Chair and run the meeting in a positive and supportive way, the issues dealt with can be challenging, but keep control of time.
- Invite the lead/administrator to ensure GP notes are up to date and accurate, and highlight key areas – especially actions and accountabilities.
- Follow up agreed actions and responsibilities – plan the next meeting.

## Top tip 6: Significant event analysis

- Review outcomes for patients:
  - Highlight good practice from 'good deaths'
  - Patients who died in hospital – was this the preferred place of death? If not, could the admission have been prevented?
  - Identify any barriers that prevented a 'good death'.
- Patients not on the register who died – could they have been identified?
- Encourage a culture of trust and learning from each other.
- Identify training needs of the team, perhaps formalise SEA every six months to highlight important issues. You can find a guide to performing SEA here [http://www.nes.scot.nhs.uk/media/346578/sea\\_-\\_full\\_guide\\_-\\_2011.pdf](http://www.nes.scot.nhs.uk/media/346578/sea_-_full_guide_-_2011.pdf)

## Top tip 7: Continuity and coordination of care

- Nominate a lead clinician who knows the patient the best – this is the person best placed to have conversations with the patient about Advance Care Plans (ACP), DNACPR, etc, and to coordinate care.
- Identify a 'buddy' or form a 'micro-team' of GPs to provide care in the absence of the lead clinician.
- Record actions from the meeting in a coded manner suitable for sharing:
  - Clinical – eg anticipatory prescribing, care needs assessment, discussions with patient/family.
  - Admin – updating register, alerts, OOHs notifications, maintenance of register.

## Top tip 8: Communicate

- With patient and family/carers – use every opportunity to discuss wishes and preferences for future care and check consent to share information is given.
- Ensure information is effectively shared with 'out of hours' service, ambulance service, secondary care and specialists if appropriate.
- Use agreed local ways of sharing information with team. Ideally use IT Systems such as EPaCCs (Electronic Palliative Care Coordination Systems), or KIS (Key Information Summary) in Scotland.

## Top tip 9: Maintain your register

- This can be done outside of the regular meeting – establish a smaller key team eg administrator, lead GP, practice nurse, district nurse or other key person.
- Add new patients identified as being in last years of life.
- Remove patients (those who have died or moved to another practice).
- Move patients according to their needs/changing health status eg now actively dying (amber to red), increasing decline (green to amber).
- Add new important statements eg now has DNACPR order, change in preferred place of care.

## Top tip 10: Reinforce positivity whenever possible

- Simply recognizing a job well done is a boost to morale, especially to the staff in a service facing hard times and dealing with difficult clinical situations. Share compliments and thank you's.
- Share news about the practice and local developments. Attendees might not know everything about new NHS developments. Highlight good news, address concerns honestly but point out the positives whenever you can.
- Ask team members whether they need help with anything. Even if no-one can directly help, asking colleagues what they need lets them know you want to work with them toward a common goal and value their needs.
- Invite suggestions and opinions about current work challenges and improving meetings and processes. Hear new ideas, colleagues feel more positive when their opinions are valued.

You'll know that someone with cancer still has a life to lead, friends to see, family who need them and people to love. But did you know that Macmillan can help you support your patients to get on with their life no matter how cancer affects them.

We offer practical, emotional and personal support that your patients may need to hold on to who they are and what's important to them.

Together, we can be there for people during treatment, to help with work and money worries and to give them the time they need to talk about their feelings or whatever's troubling them.

From the moment someone is diagnosed, for as long as they need Macmillan can help.

Remind your patients they can call us on **0808 808 00 00** (Monday to Friday, 9am–8pm) or visit **macmillan.org.uk**

Life with cancer is still life – let's help people live it.

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