Butterfly Advance Care Planning & Co-ordination Team (ACCT)

- On Monday 09 November 2020, a new service will be initiated to support people who have deteriorating health and require supportive palliative care, being discharged from Pilgrim Hospital in Boston. The service will be delivered by the Butterfly Advance Care Planning & Co-ordination Team (ACCT), supported by the Butterfly Hospice. It will operate Monday to Friday, 1000-1800 hrs.

- This service has been developed in response to feedback from people, including patients, their families and carers and health professionals. It aims to give time and space for the difficult and compassionate conversations that are needed when discussing future wishes and choices about their end of life care. . It will also put in place plans which are shared with their GP and other community teams to make sure that the palliative care provided meets their needs as closely as possible.

- The service will operate as follows:

    - Before discharge from Pilgrim Hospital, people with irreversible deteriorating health will be identified as benefiting from an Advance Care Planning conversation.

    - The teams involved in identifying people who would benefit from planning for their future are: the Specialist Palliative Care Team (SPCT), the Assertive In-Reach Team (AIR); the Community Care Nurse Specialist (CCNS) and the Acute Medical Short Stay (AMSS) ward staff.

    - At the point that the person is discharged, the relevant team will send either a “task” on SystmOne or will use the Palliative Care Co-ordination Centre SPA form to make a referral to the Butterfly ACCT

    - On receipt of the referral, a daily co-ordinator from the Butterfly ACCT will contact the person and make an appointment for an Advanced Care Planning conversation. This conversation can be by telephone, e-consultation or face to face in the person’s own home. It can also include any other people that the person chooses to support them.

    - The Butterfly ACT will have a compassionate conversation with the person. Each conversation will be scheduled for around 2 hours and will document the outcomes using a range of tools and templates on SystmOne. These templates include: the Advance Care Plan (ACP), Electronic Palliative Care Co-ordination System template (EPACCs), Recommended Summary of Emergency Care and Treatment (ReSPECT), Advance Decision to Refuse Treatment (ADRT) and Comprehensive Geriatric Assessment (CGA)

    - After the conversation, EPaCCS will be initiated and records updatedThe person’s GP will be updated via SystemOne - and include a recommended review date and request to open the share to the person’s record. Should the conversation identify any other referrals to support services, they will be initiated too.

    - The local Neighbourhood Team will be updated of the conversation. Where necessary, the Neighbourhood Team will forward details of the referral to GP practices who use EMIS rather than SystmOne.

    - The personand their care can then be discussed at the GP Practice GSF meeting and/ or the Neighbourhood palliative care “huddle”as needed

    - The county-wide Palliative Care Tracker will be updated by tasking SystmOne support at St Barnabas stating “Butterfly Referral”.

- This service is a Proof of Concept and will run for 8 weeks. Delivery will be measured using a suite of measures that will look at:
    - Increased recognition of people deteriorating from a life limiting condition (measured by the number of patients identified as being in last year of life on the Lincs EOLC register)
    - Increased number of people deteriorating from a life limiting condition who have had high quality and timely conversations about dying, death and bereavement (measured by people who have completed ACP & ReSPECT forms when they are first placed onto the EOL register.)
    - Increased number of people who have had robust care assessments (measured by the offer, completion, and review of EPaCCS care plans)
    - Confidence of staff in delivering palliative care (measured by accessing the outcomes of staff self- assessments)
- Delivery will be monitored weekly by the Butterfly ACCT Project Group and will be reviewed after 3 and 8 weeks. This Project Group reports into the Palliative & End of Life Care Programme via the weekly PEOL Delivery Group meeting.
- Enquiries on this Proof of Concept should be directed to the Operational Lead - Louise Price