

B3: Reshaping Access to Emergency Care Pathways by Implementing Meaningful Upstream Interventions

The Remote Emergency Access Coordination Hub (R.E.A.C.H.)

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Tiffany Wishart
London Ambulance Service
 @TiffanyWishart1

Joanna Moore
Barts Health
 @JoM0oRe

Northeast London



- Concept and overview of the REACH model
- Barriers to change & learning from the BEACH pilot
- Review of impact and experience data
- Key learning
- Discussion

What often prevents us 'Getting it Right First Time' for urgent and emergency care patients?

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Menti code: 1249 9234



Questions posed by Don Berwick in 1991:



Where does suboptimization occur within health care organizations?



Is it among health care organizations?

Is it between health care and non-health care organizations?



How can we better manage health care as a system, optimizing total performance?

Don Berwick (1991)

The REACH model:

Operational hours:

- 0800-2000: 365d/year

REACH Team:

- Consultant
- Nurse Shift Leader
- Receptionist
- 2 x junior clinician (1xSpR and either SHO, ACP, PA)

Key Enablers:

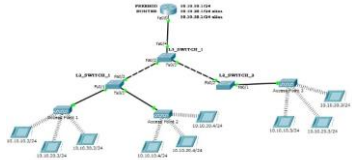
- Direct, cloud stored telephony system
- Directory of services
- Access to clinical systems

Patient Cohort:

- Patients aged >2
- Formal referral pathway for LAS



Concept of the REACH model



Virtual single point of access for emergency care patients



Coordinated systems approach to patient flow



Shared approach to risk across the system

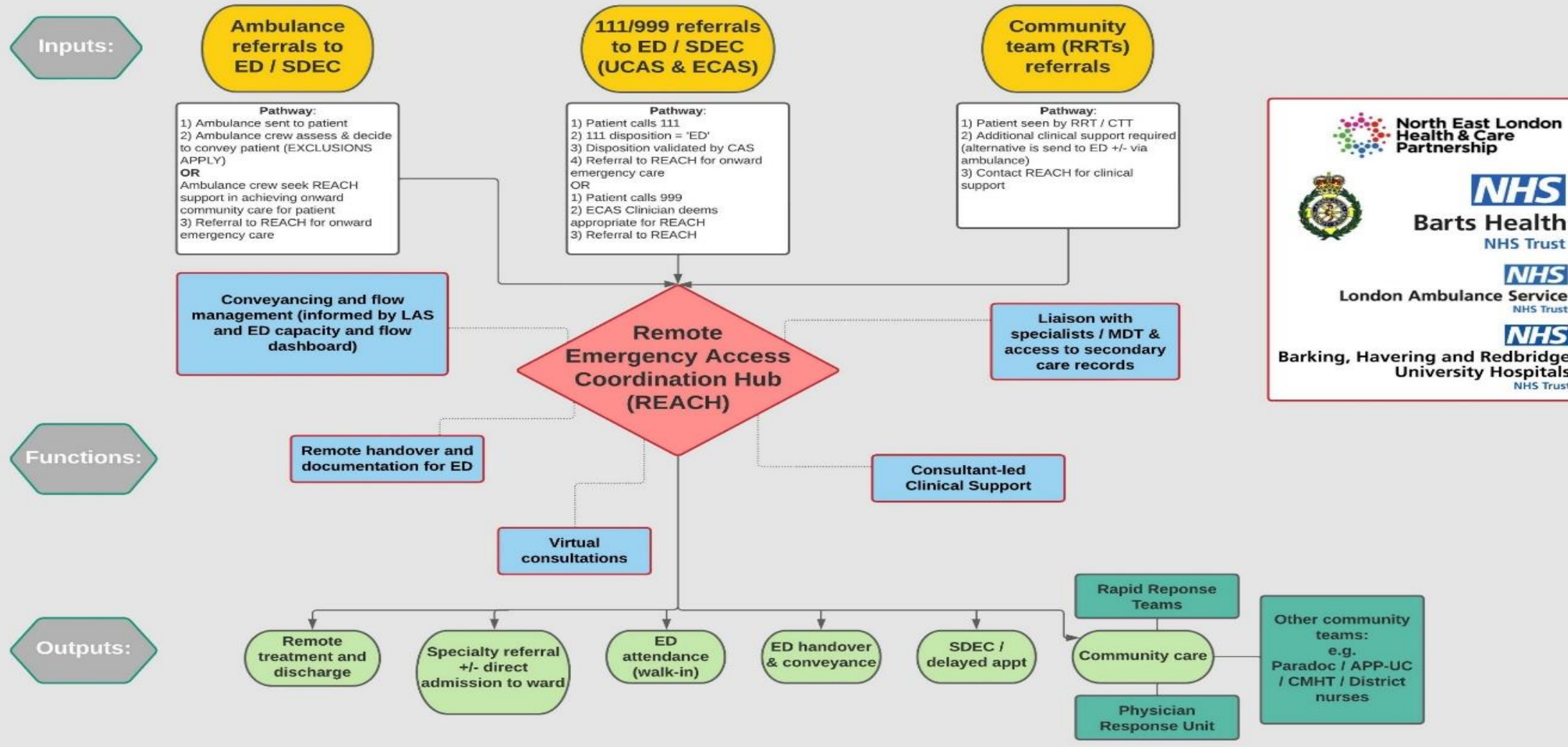


Increased systems knowledge

'The right care, in the right place, first time'

REACH Schematic

Northeast London Clinical Pathways via the Remote Emergency Access Coordination Hub (REACH)



Alignment with National Policy

National policy for Integrated Emergency Care

GIRFT in Emergency Care

Same Day Emergency Care

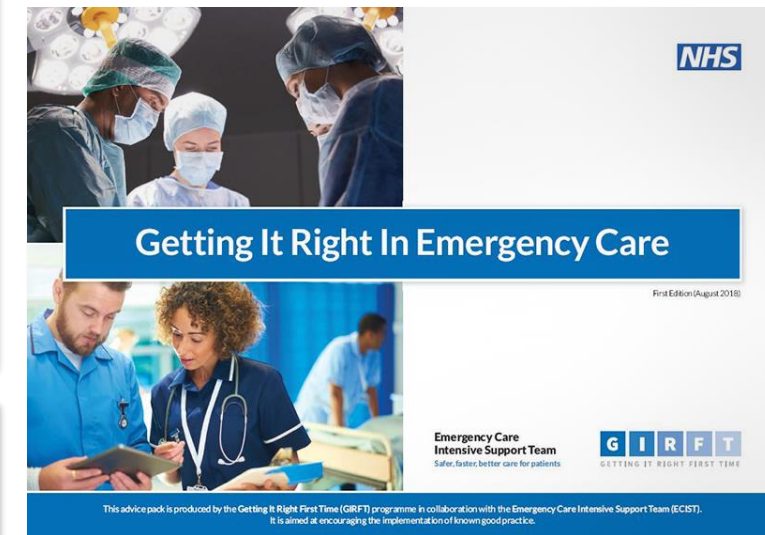
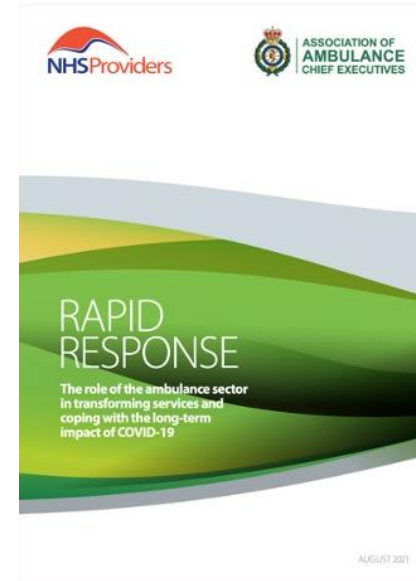
Ambulance Rapid Response Strategy

Transformation of UEC – NHSE 2020

NHS Long Term Plan

CQC recommendations for systems

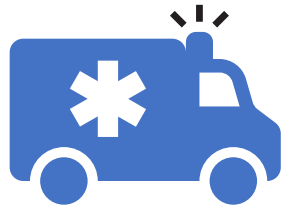
Emerging CEM specialism



- Improves patient experience
- Reduces unnecessary hospital admissions
- Avoids unplanned, longer than necessary stays in hospital

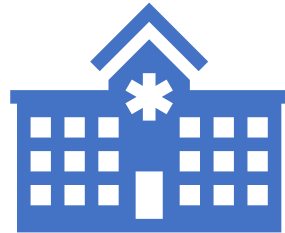
The REACH Journey

2014 -> PRESENT



Physician
Response
Unit (PRU)

OCT 2020



Barts Emergency
Access
Coordination Hub
(BEACH)

SEPT 2021



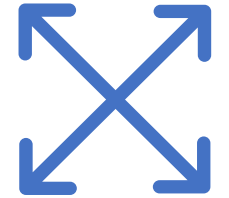
BEACH Paused

NOV 2021



Remote Emergency
Access Coordination
Hub (REACH)

JAN – MAR 2023



REACH Pilot
expansion

BEACH Service Paused... why?

The middle of every successful
project looks like a disaster.

Rosabeth Moss Kanter

London Ambulance Service
NHS Trust

[illegible]

Associating
Positive and
Negative baseline

LAS-BEACH crew - Benefits of the BEACH

Category	Percentage
100% BEACH	21
100% BEACH	13
100% BEACH	14
100% BEACH	12
100% BEACH	12
100% BEACH	10
100% BEACH	9
100% BEACH	9
100% BEACH	7
100% BEACH	6
100% BEACH	2
100% BEACH	1
100% BEACH	1
100% BEACH	1

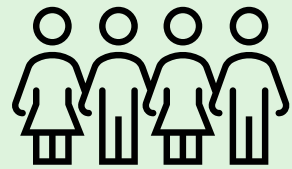
Avg Job cycle duration trend by Pathway

Month	BEACH Convicted	BEACH Non-convicted	BEACH Pathway	Control convicted
Oct	01:45	01:35	01:40	01:40
Nov	01:50	01:40	01:45	01:45
Dec	02:00	01:50	01:55	01:55
Jan	01:55	01:45	01:50	01:50
Feb	01:55	01:35	01:50	01:50
Mar	01:55	01:45	01:50	01:50
Apr	01:55	01:45	01:50	01:50
May	01:55	01:45	01:50	01:50
Jun	01:55	01:45	01:50	01:50
Jul	01:55	01:45	01:50	01:50
Aug	01:55	01:45	01:50	01:50
Sep	01:55	01:45	01:50	01:50

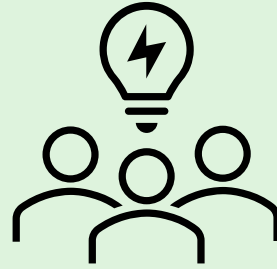
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EACH Ambulance - Project Plan and Gantt Chart					
#	Project Milestone / Action	Action Owner	Start Date	End Date	POSA
1	Collaboration and partnership working				
1.1	Harvesting the learning from REACH pilot - L&S staff	JM/TW/NK	30/09/2021	24/10/2021	n
1.2	Create EACH (NE) ambulance pathway steering group	JM	14/10/2021	14/10/2021	n
1.3	Create ACP criteria and take through CAG	TW/TJ	14/10/2021	26/10/2021	n
1.4	SOP ratified for ambulance pathway model	TW/TJ	14/10/2021	26/10/2021	n
1.5	Clear feedback loop and shared learning/clinical spaces identified and agreed in SOP	JW/TW	14/10/2021	01/11/2021	y
1.6	Inclusion / exclusion criteria clearly agreed in SOP	TJ/TW	13/10/2021	26/10/2021	n
1.7	Agreement on name of programme	AM	14/10/2021	26/10/2021	n
1.8					
A	Shared data and reporting				
A.1	EACH (NE) Pilot data analysed to identify true performance	TW/JSA/JT/TW	14/10/2021	01/11/2021	n
A.2	Data analysed in post to synthesise real time data	AM	13/10/2021	14/10/2021	n
A.3	Data analysed to analyse EACH baseline data from Oct 2020-August 2021 and Oct/Sept 2021	TM/TW/JSA	23		
A.4	Measurement plan agreed	AM	12/10/2021	01/11/2021	y
A.5	Measurement plan escalated to CAG/sign board for sign off	MY/TJ/TW/JW	26/10/2021	01/11/2021	n
A.6	Measurement plan data sharing agreement drawn up by A&E partners - L&S and B&M	AM	26/10/2021	01/11/2021	n

Key Learning #1



**Stakeholder
engagement**



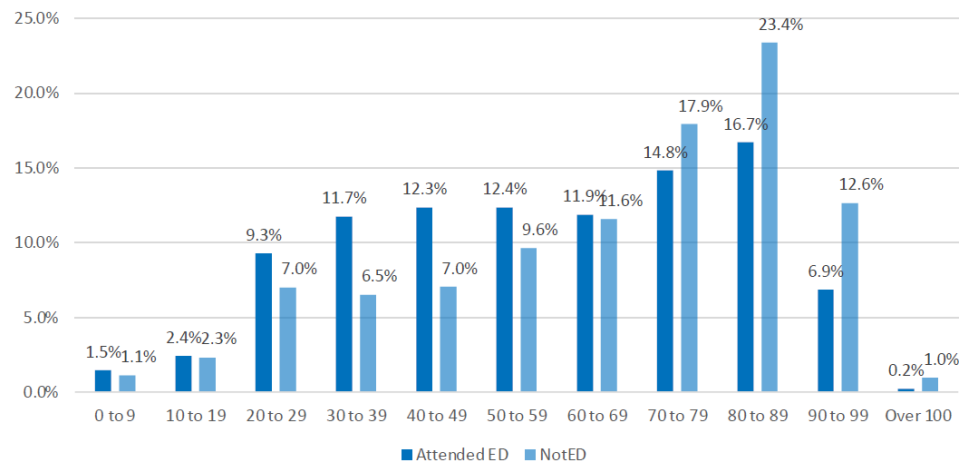
**Shared vision &
co-design**

Impact

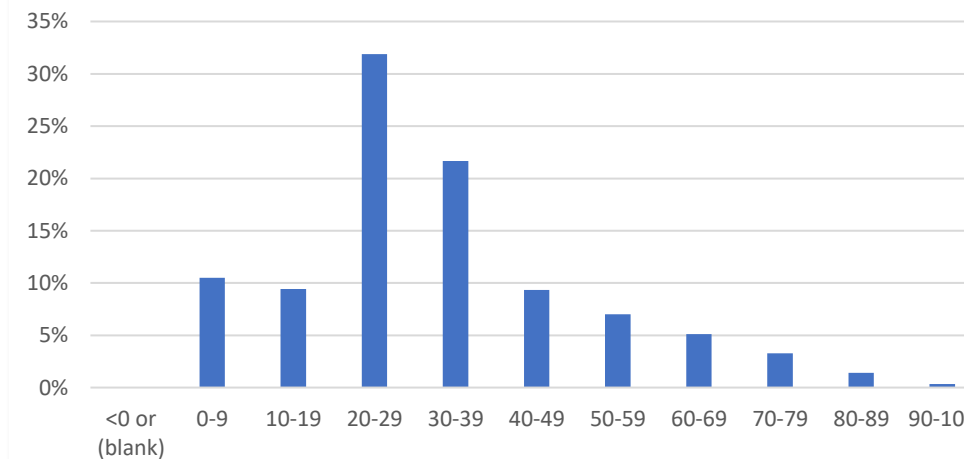


AMBULANCE REFERRALS

Figure A6: Proportion REACH-999 patients in each age decile comparing those attending vs not attending ED

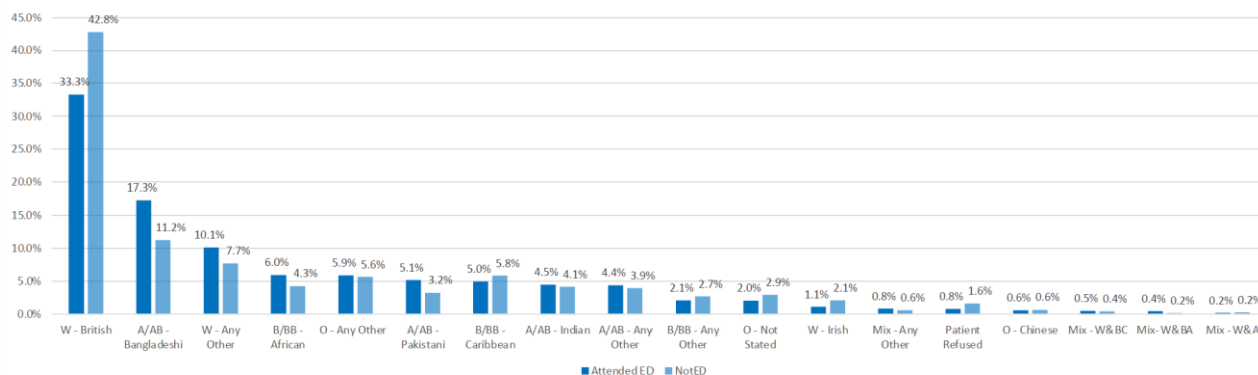


111 REFERRALS

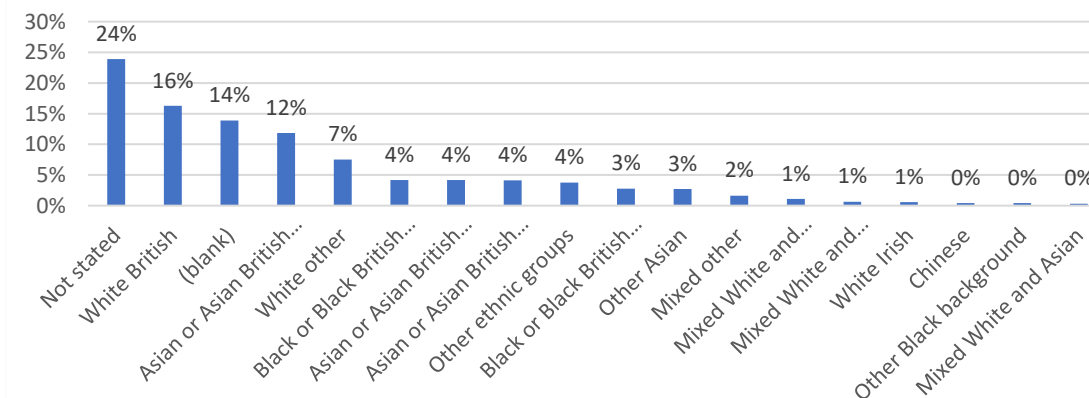


REACH 999 PATIENTS ETHNICITY

Figure E2: Ethnicity distribution of REACH-999 patients comparing those attending vs not attending ED



REACH 111 PATIENTS ETHNICITY

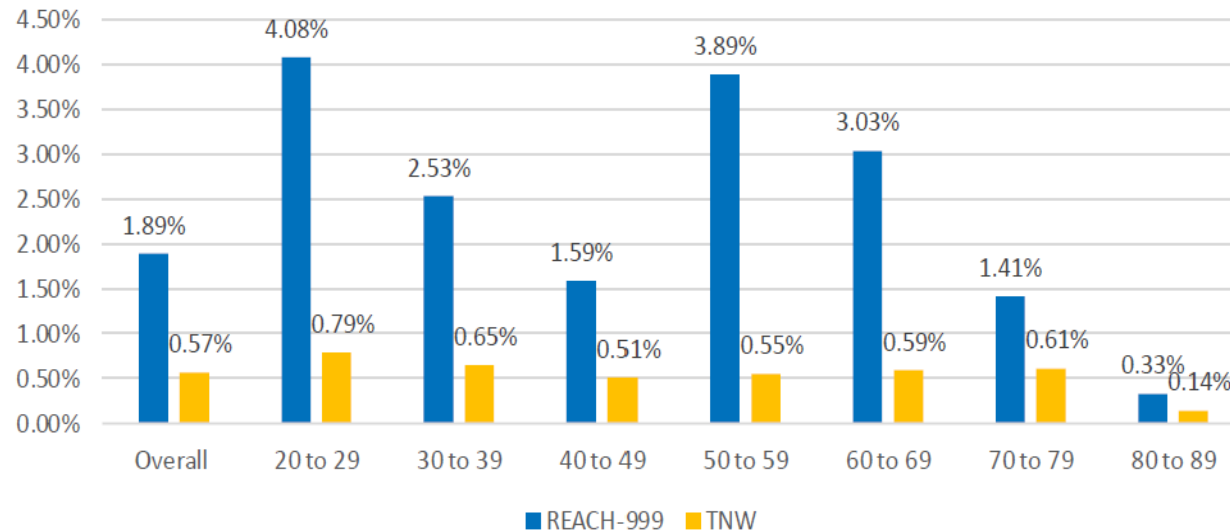


Equity Deep Dive: Learning Disability and Index of Multiple Deprivation Score (IMD): +ve impact

KEY FINDING

3x more people with a recorded learning disability accessed care through the REACH-999 service overall, and at each hospital site, than would be expected based on the prevalence of people with LD attending Barts Health E.Ds.

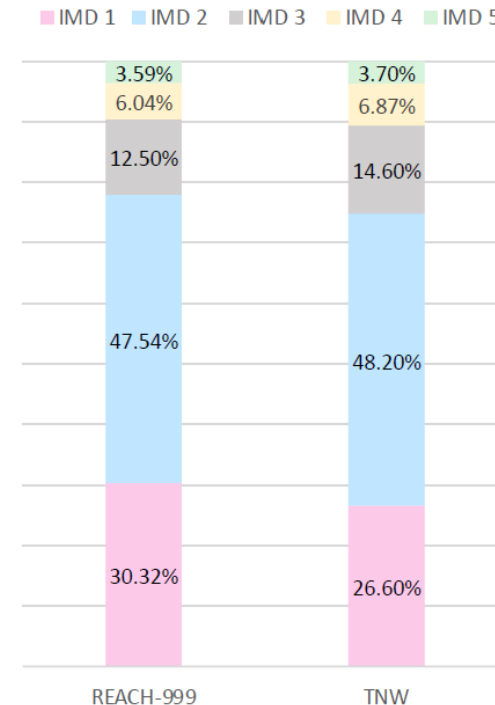
Figure L4: Prevalence of people with a recorded learning disability, by age decile, comparing REACH-999 to TNW



KEY FINDING

REACH-999 has a **3.7%** higher proportion of patients in IMD 1 overall against Barts Health control data.

Figure I5: IMD distribution for REACH-999 vs TNW



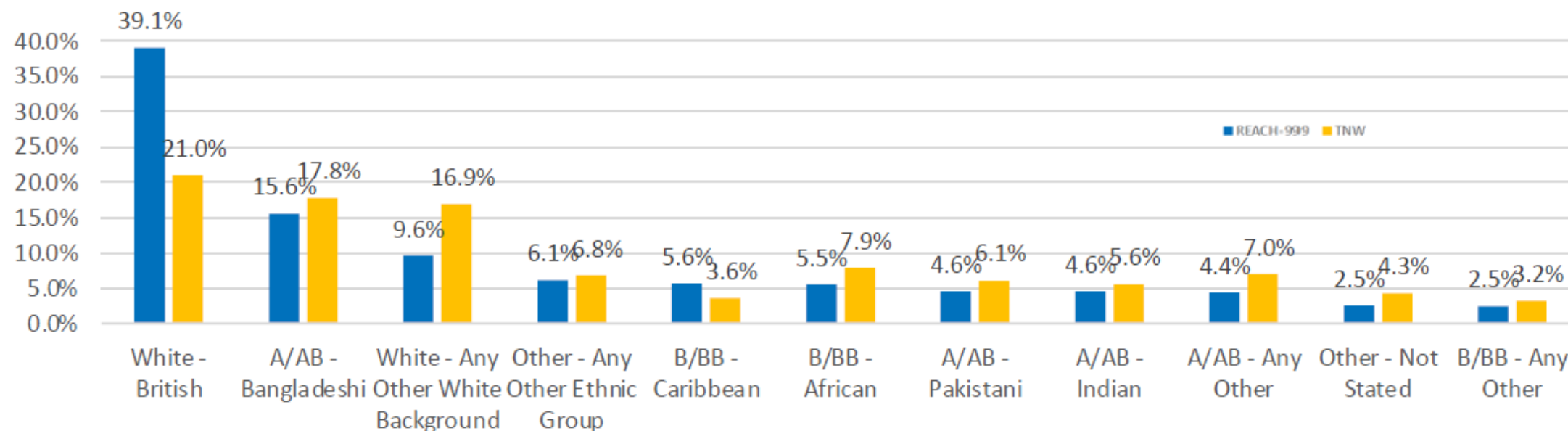
KEY FINDING

REACH-999 is accessed by a significantly higher proportion of White – British patients than would be expected considering the proportion of White – British patients accessing Barts Health E.Ds.

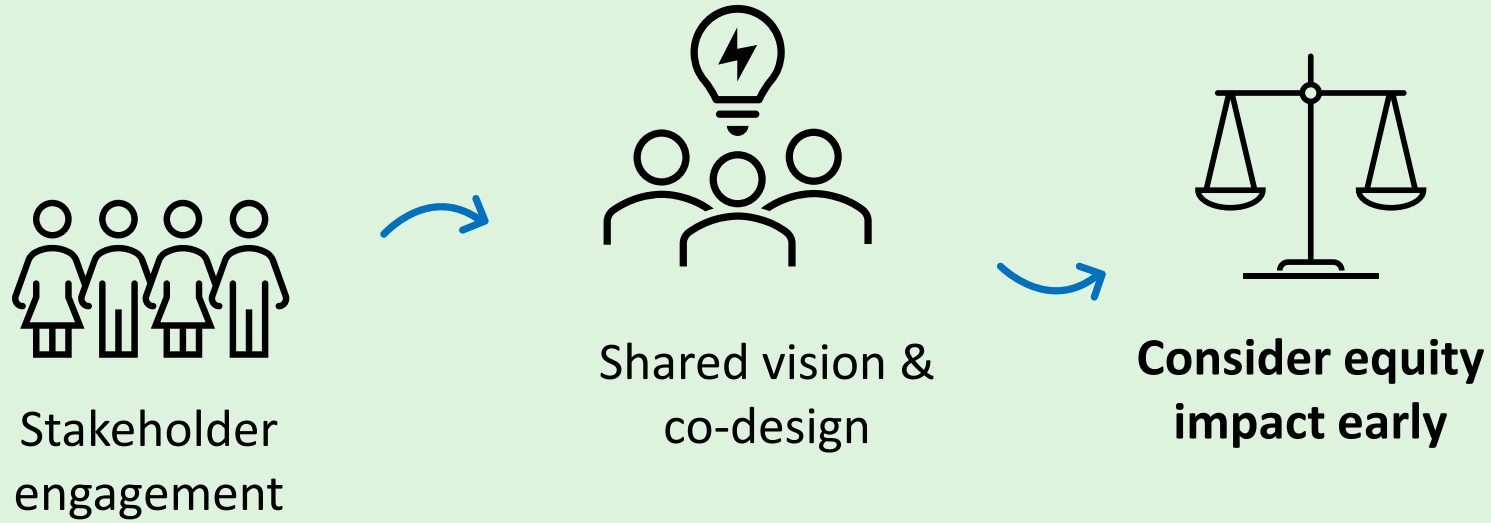
CONTINUING INVESTIGATION:

Work is underway to improve access to interpreting services via virtual consultation to reduce his risk.

Figure E3: Ethnicity distribution of REACH-999 compared to TNW ED patients over 75 years



Key Learning #2



Activity and Impact- REACH TNW 999 pathway



>11,300 calls since November 2021



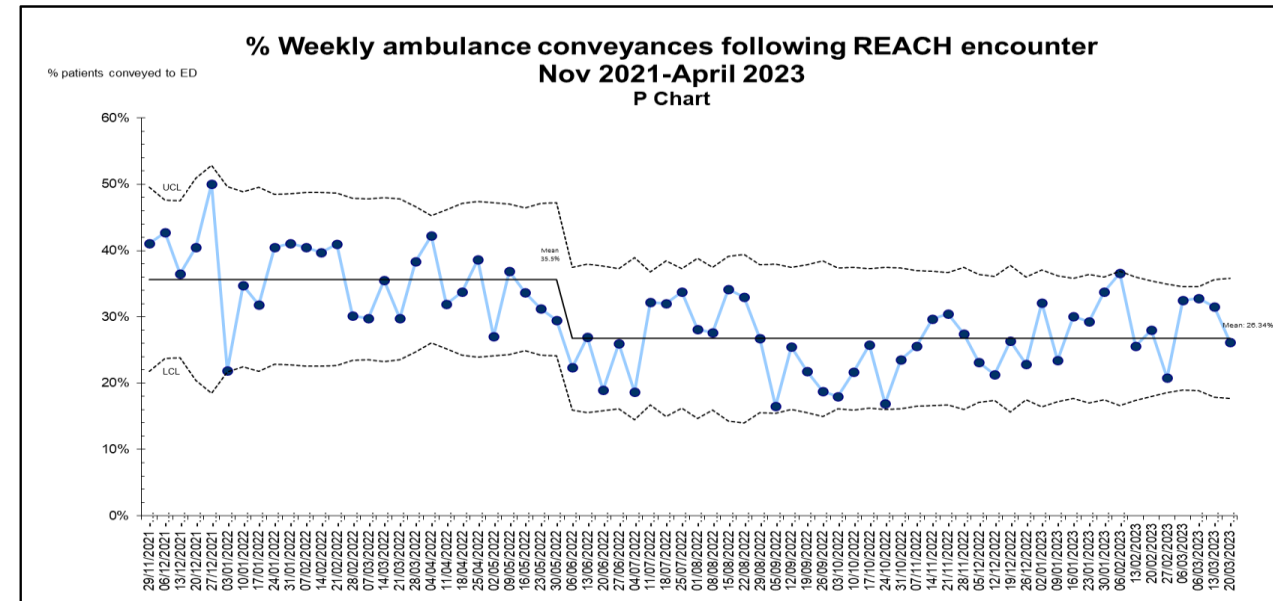
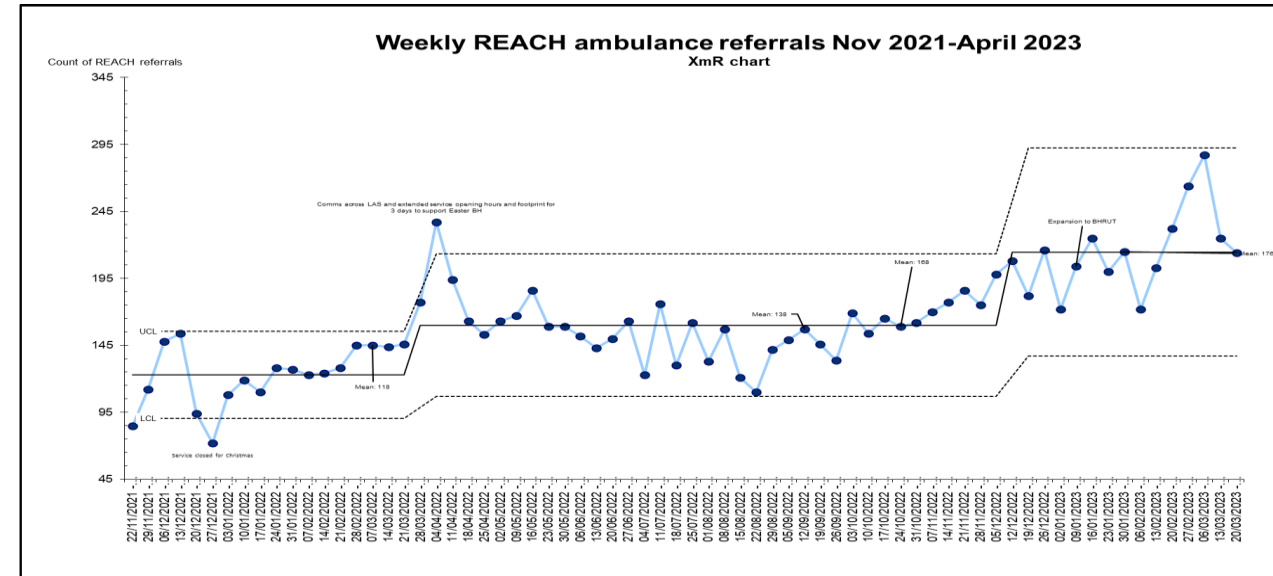
26% conveyance rate and falling



48% conveyance to admission rate



> 8,700 potential ED conveyances saved



Activity and Impact- REACH TNW 111 pathway



> 5,500 active referrals since relaunch



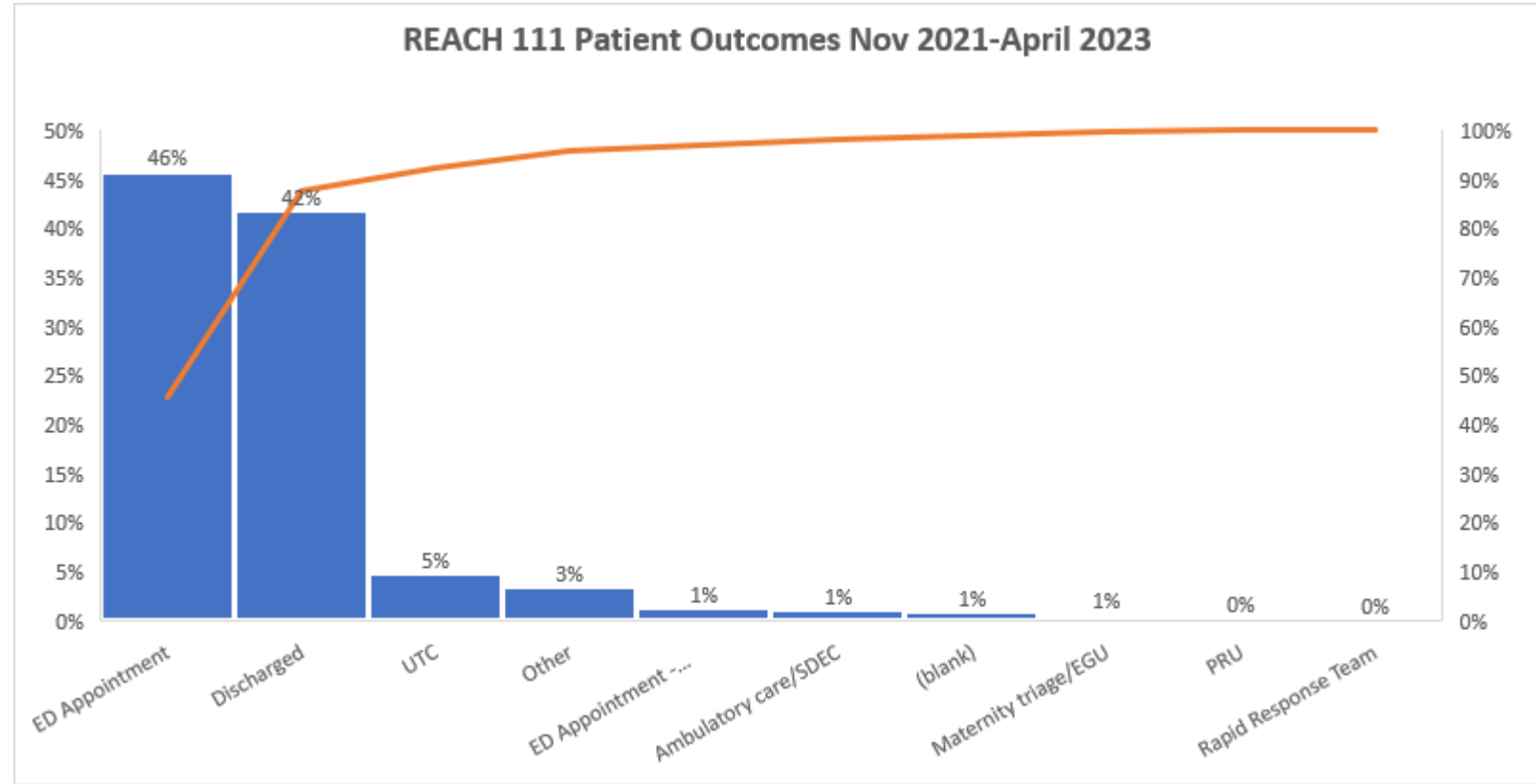
42% discharged following REACH intervention



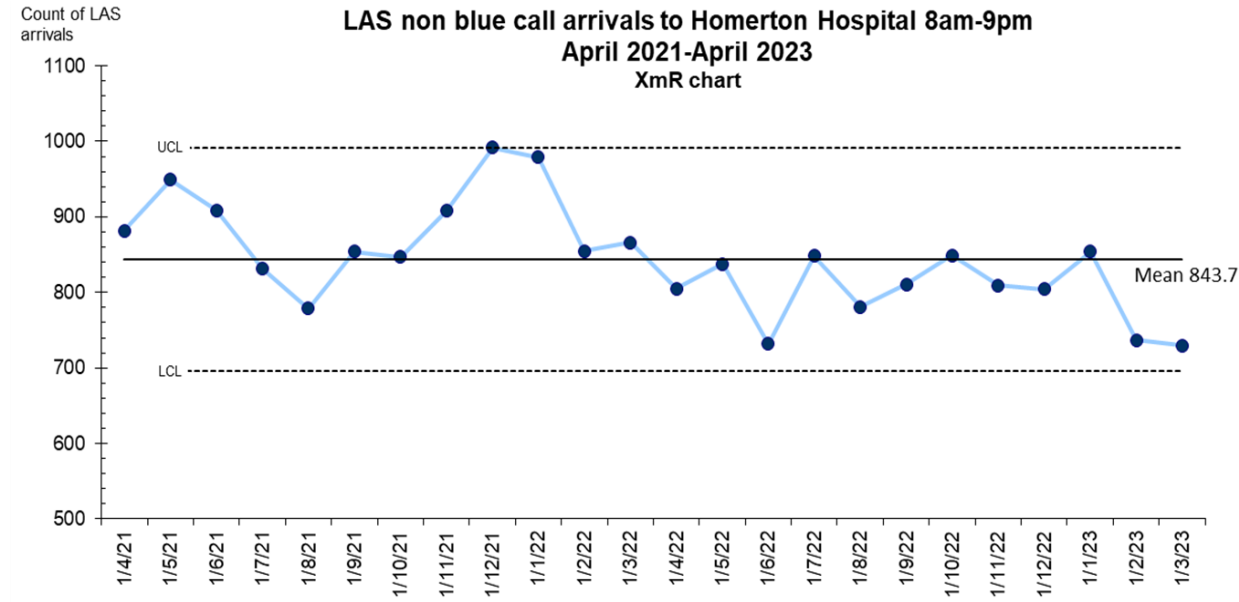
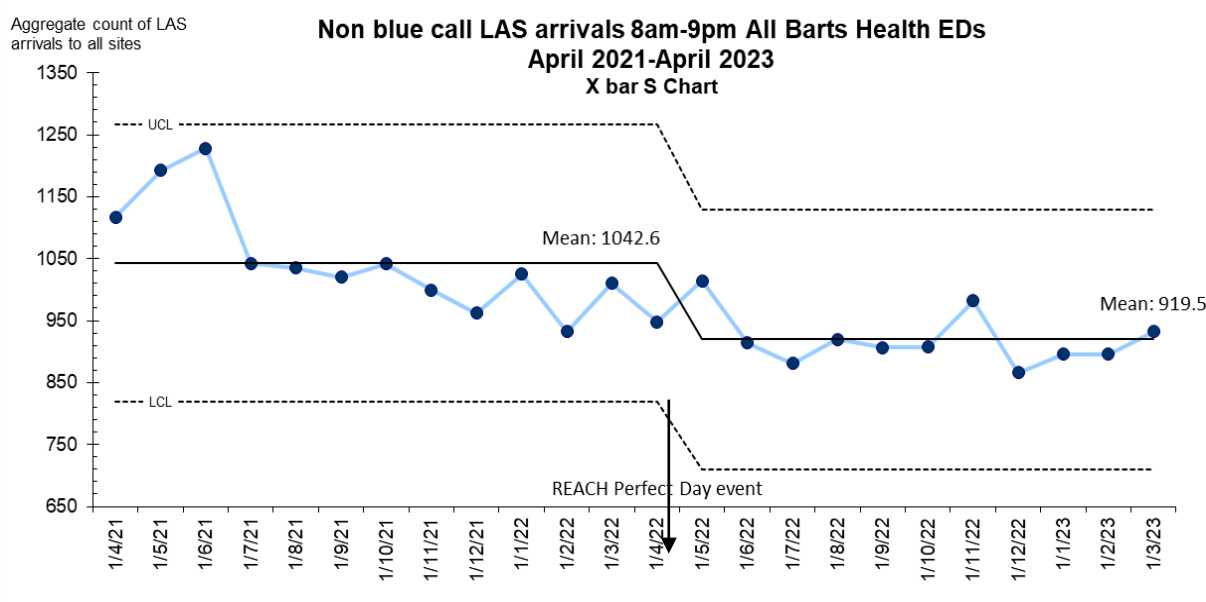
46% advised immediate ED attendance



> 3,000 ED walk-ins saved since relaunch



System Impact: LAS arrivals by site across Northeast London

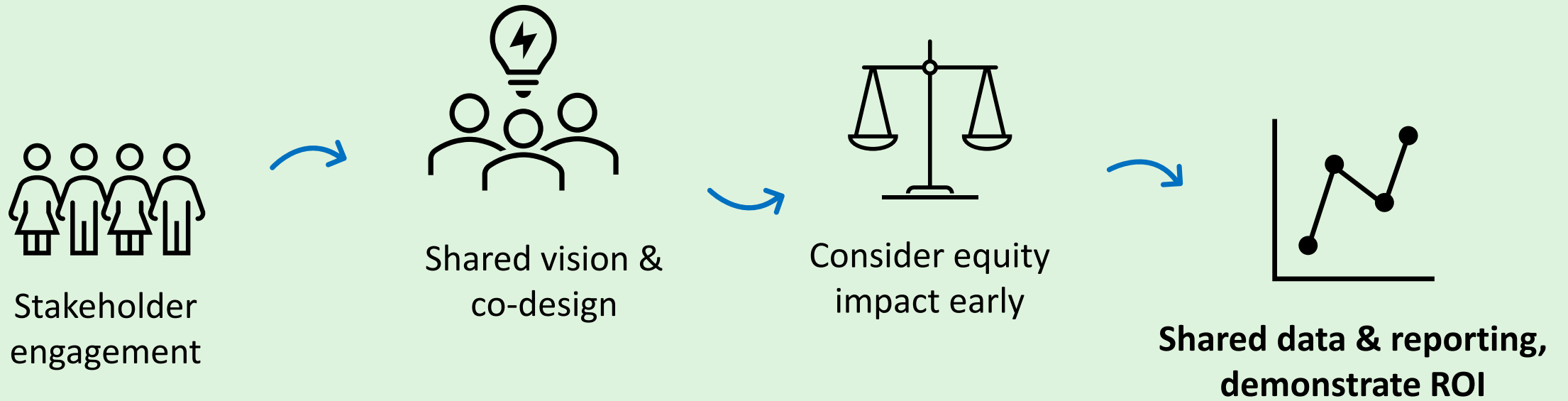


The blue 'X Bar' SPC demonstrates special cause variation in aggregated LAS arrivals between 8am and 9pm across all TNW ED sites. There is a sustained reduction of over 100 ambulances per month since the REACH Perfect Day event in April 2022.

Homerton University Hospital (HUH) LAS arrivals data has been used as a control dataset due to similar patient demographics within NEL and few issues with ambulance flow reducing the risk of confounding variables e.g. LAS step measures.

No special cause variation is noted in HUH LAS arrivals data from April 2021 and April 2023, indicating that the change in Barts Health LAS activity is likely due to REACH intervention at those sites.

Key Learning #3

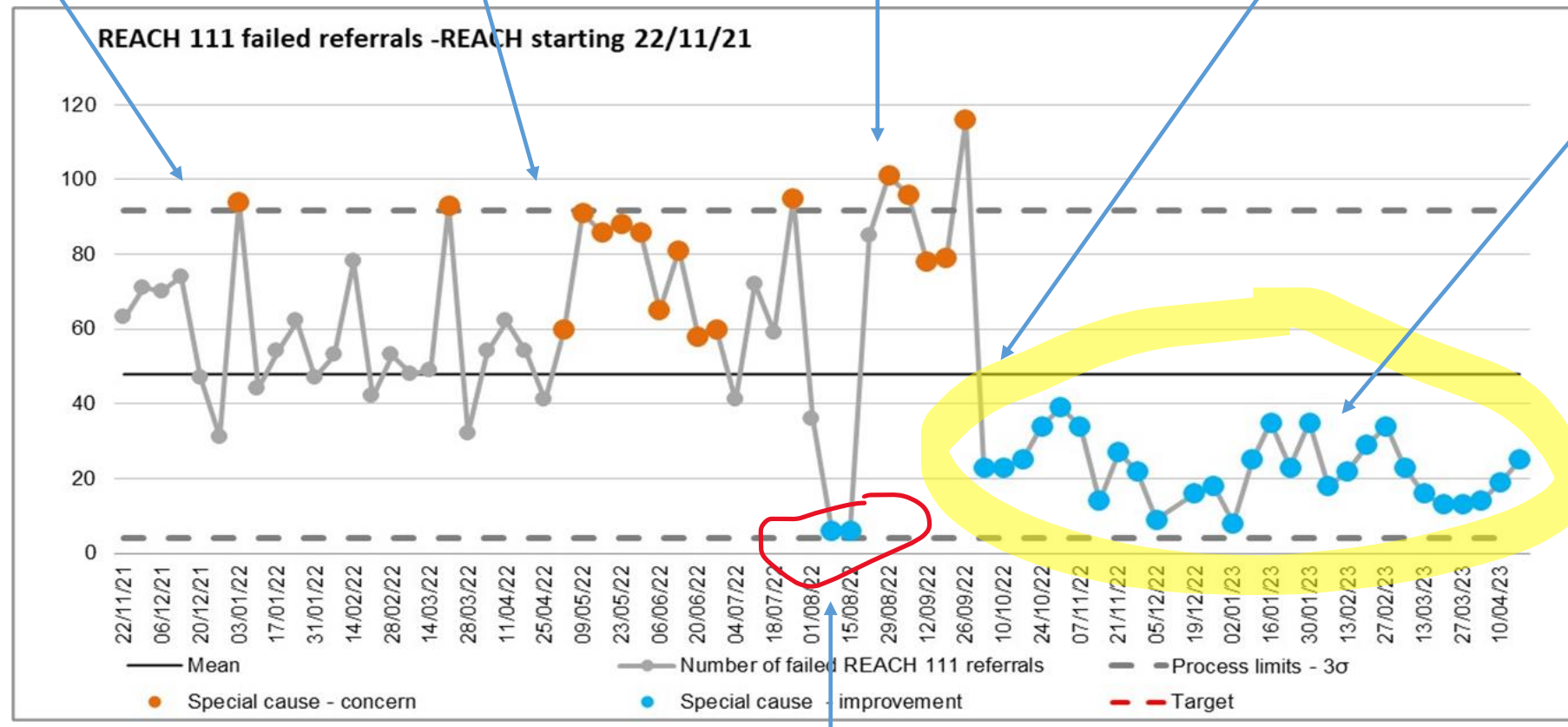


REACH 111 Failed referrals Nov 21 -> April 23:

The Beauty of PDSA

Teaching IUC team on REACH criteria and referral pathways every 3 months in line with CPD rota

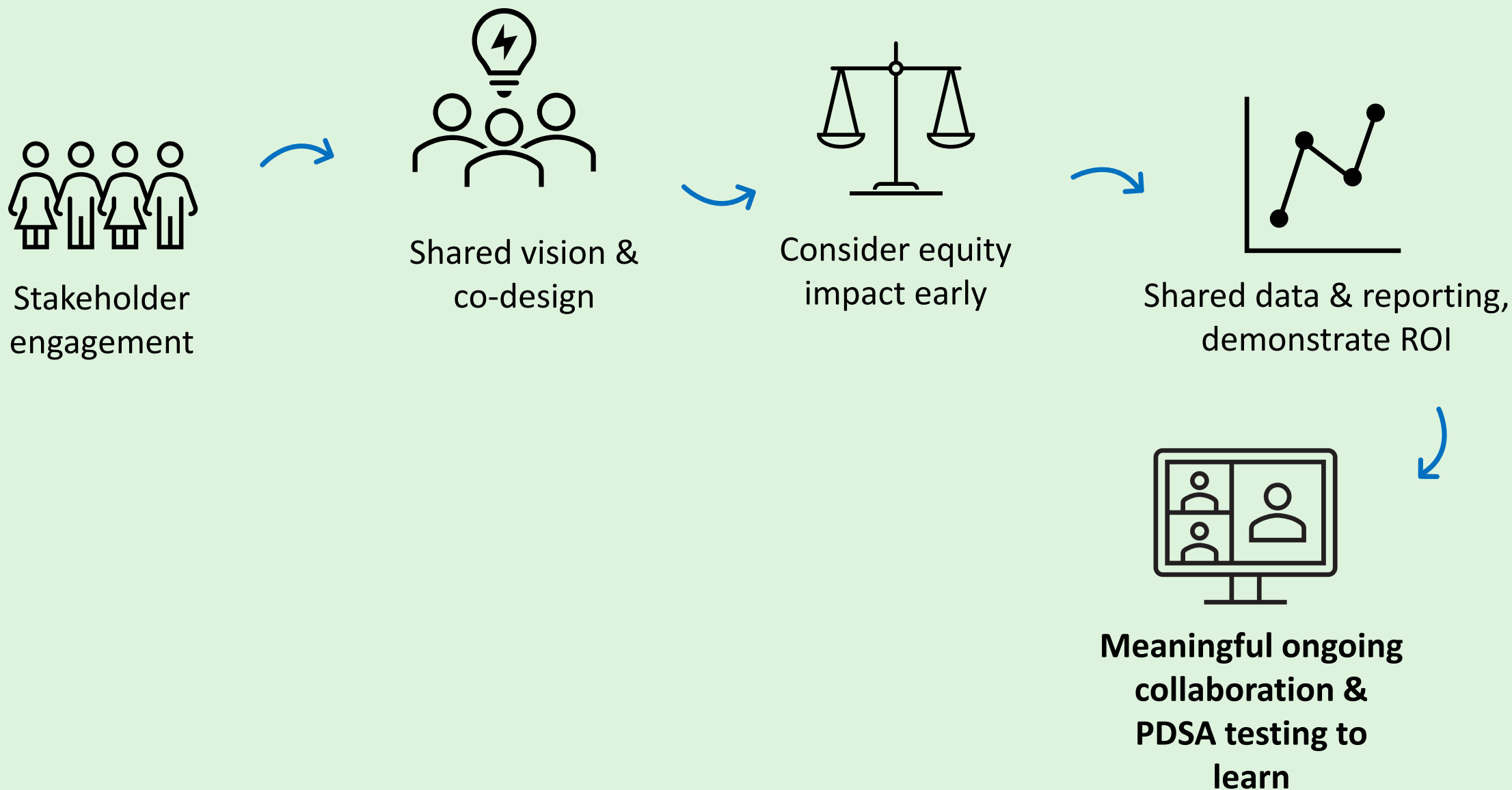
- #1 Reviewing DOS with team leads for easier referral
- #2 DOS deep dive with NEL lead to understand referral routing for UTC/paeds
- #3 Testing with new email address for UTC and paed
- #4 In person testing at 111- deleted one email pathway to IA entirely
- #5 Holding the gains: Expansion to BHRUT: pathway successful



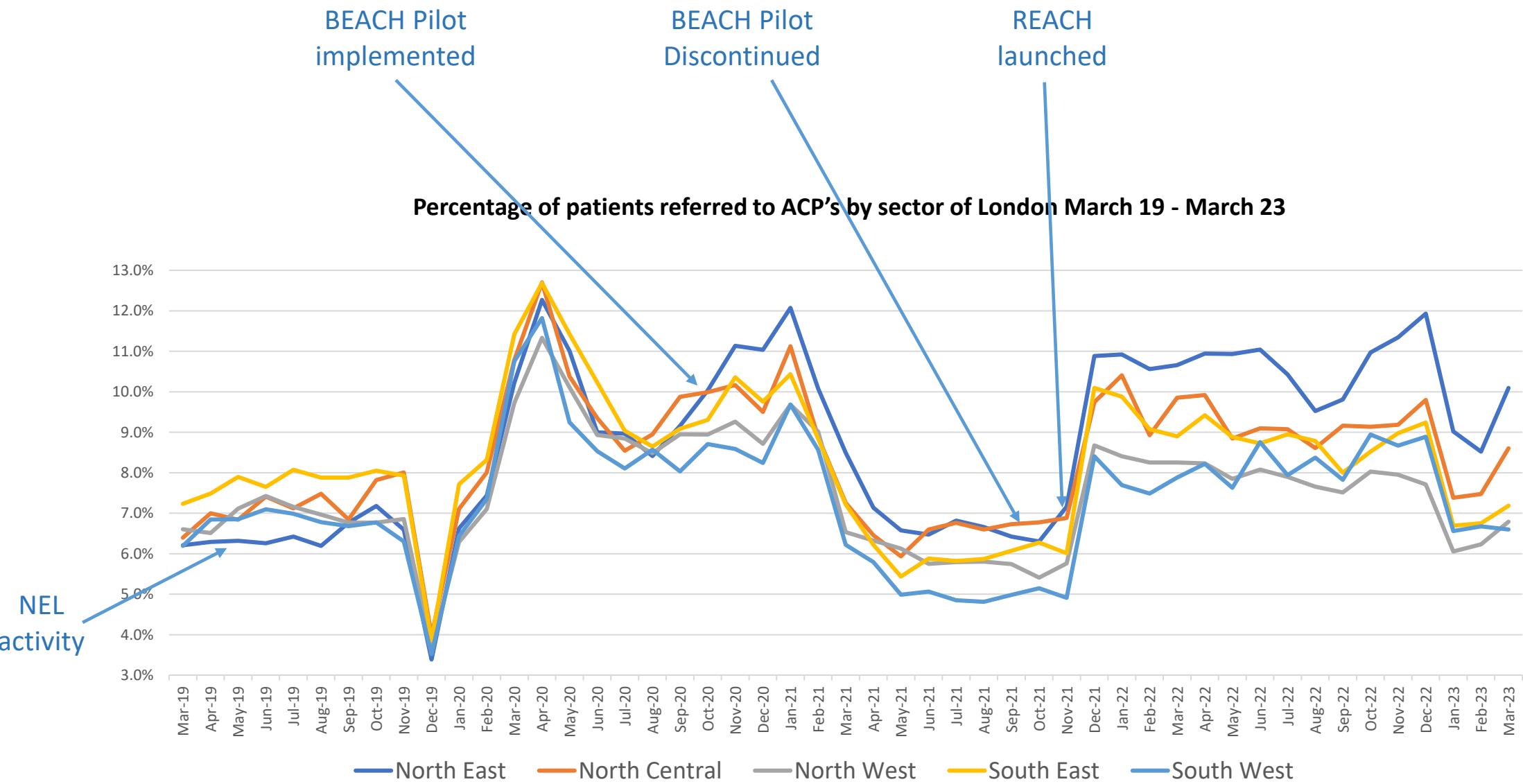
Special cause variation:
Adastra outage Aug 22

...Woohoo!

Key Learning #5



Appropriate Care Pathway (ACP) Utilisation



From Nov 2021- Sept 2022 the REACH service saved **156 metric tonnes of Carbon Dioxide emissions** through non-conveyed patient activity

What does this equate to in reality?

185

acres of U.S. forests in one year ?



2,579

tree seedlings grown for 10 years ?



6,753

trash bags of waste recycled instead of
landfilled ?



30.4

homes' electricity use for one year ?



- The REACH is resource and cost saving from an Integrated Care System perspective.
- REACH results in a system-wide cost saving of £1,582,757 pa, despite the cost of running the service.
- The model is highly scalable with potentially wide-reaching impact.

REACH Evaluation Report

28 April 2023

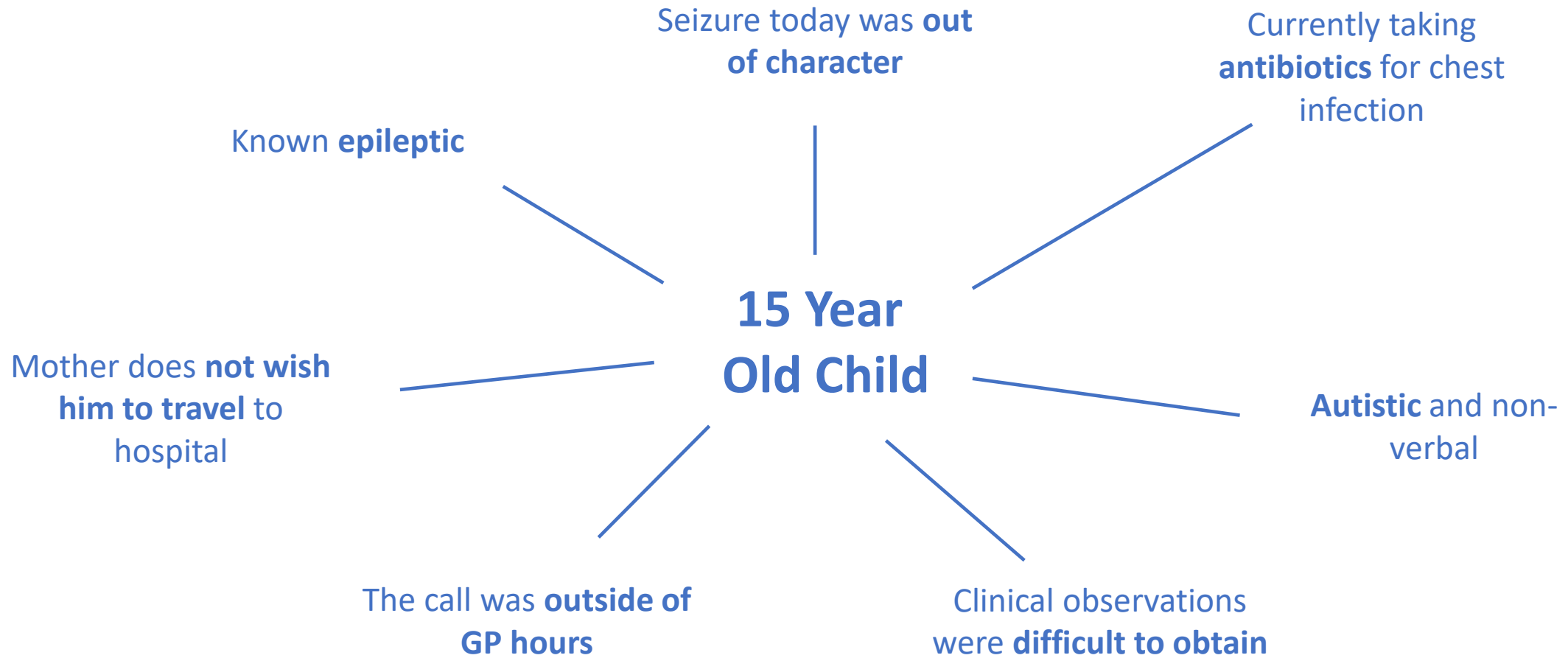


How can we work together as Healthcare system partners to design new services and identify key impact measures that really matter to our communities?

Patient & Staff Experience

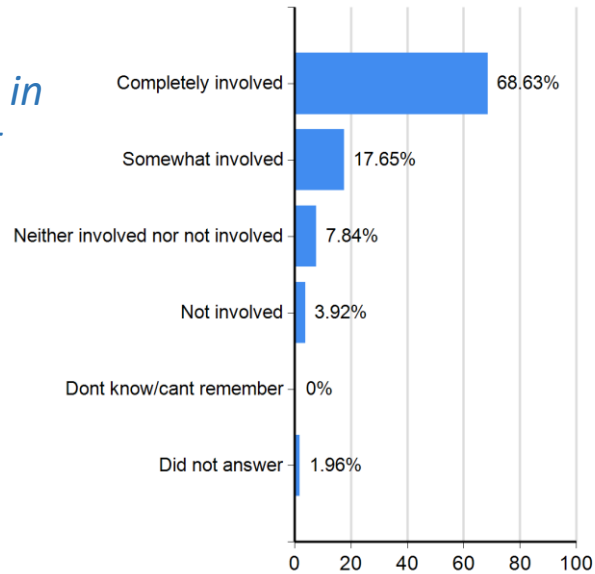


Case example



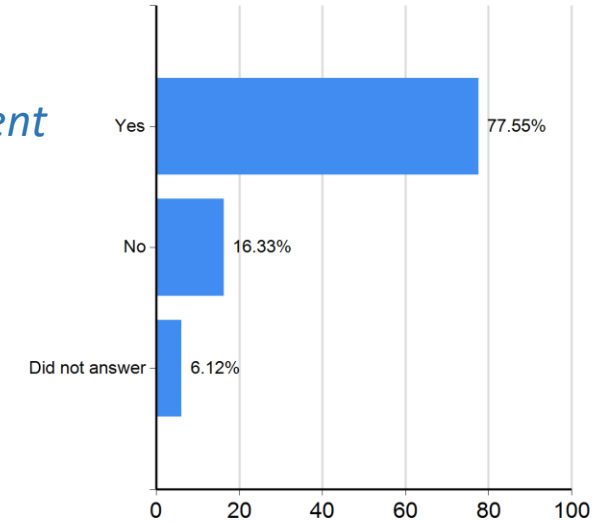
Impact: Patient experience

How involved did you feel in the decisions made about your care?

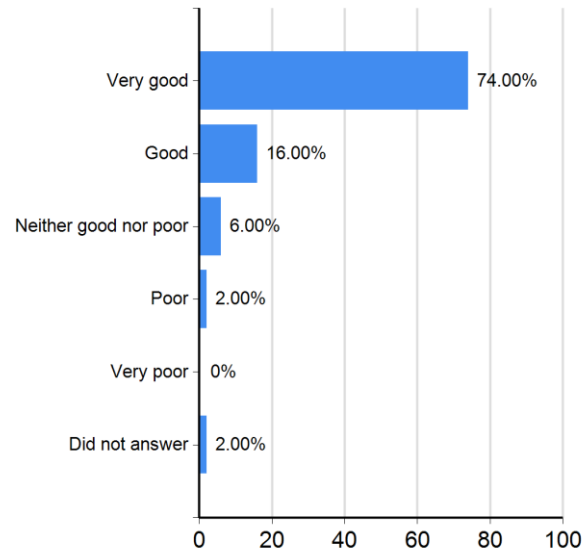


Our way of working is designed to provide you with top quality treatment whilst reducing congestion and infection risk within the A&E department.

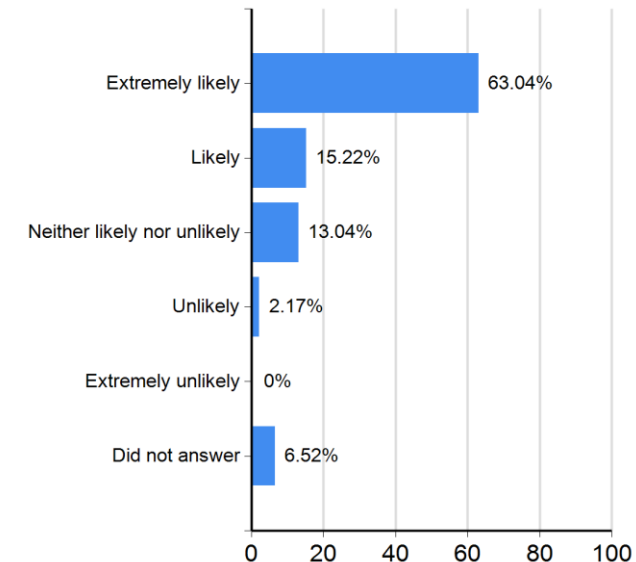
Do you believe it offers this?



How would you rate the experience of care you received throughout the REACH process?



How likely are you to recommend REACH process to others?



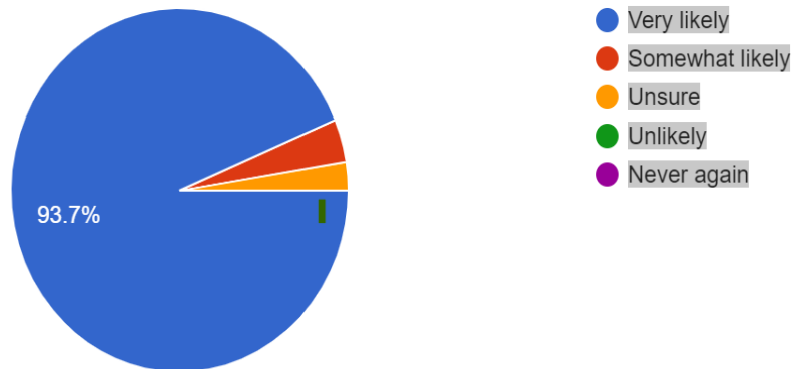
Staff experience: 80 responses

KEY FINDING

93.7% of staff were **very likely** to use REACH again or recommend to others.

How likely are you to use REACH again or recommend the service to other healthcare professionals?

79 responses



KEY FINDING

88% of LAS staff were **likely or very likely** to have conveyed their patient to ED without a REACH encounter

For patients that were **not** conveyed to ED following a REACH referral, please score the likelihood that you **would have** conveyed to ED if REACH were not an option.

59 responses



Staff experience: voices

REACH does an amazing job. It is always a pleasure to discuss a patient, and **collaborate to provide holistic care to patients**, ensuring unnecessary conveyance is minimised.

You improve my clinical understanding of a variety of conditions, and assist in identifying red flags I may have overlooked or not known about on some presentations. Patients feel listened to and validated that there is something happening in the background.

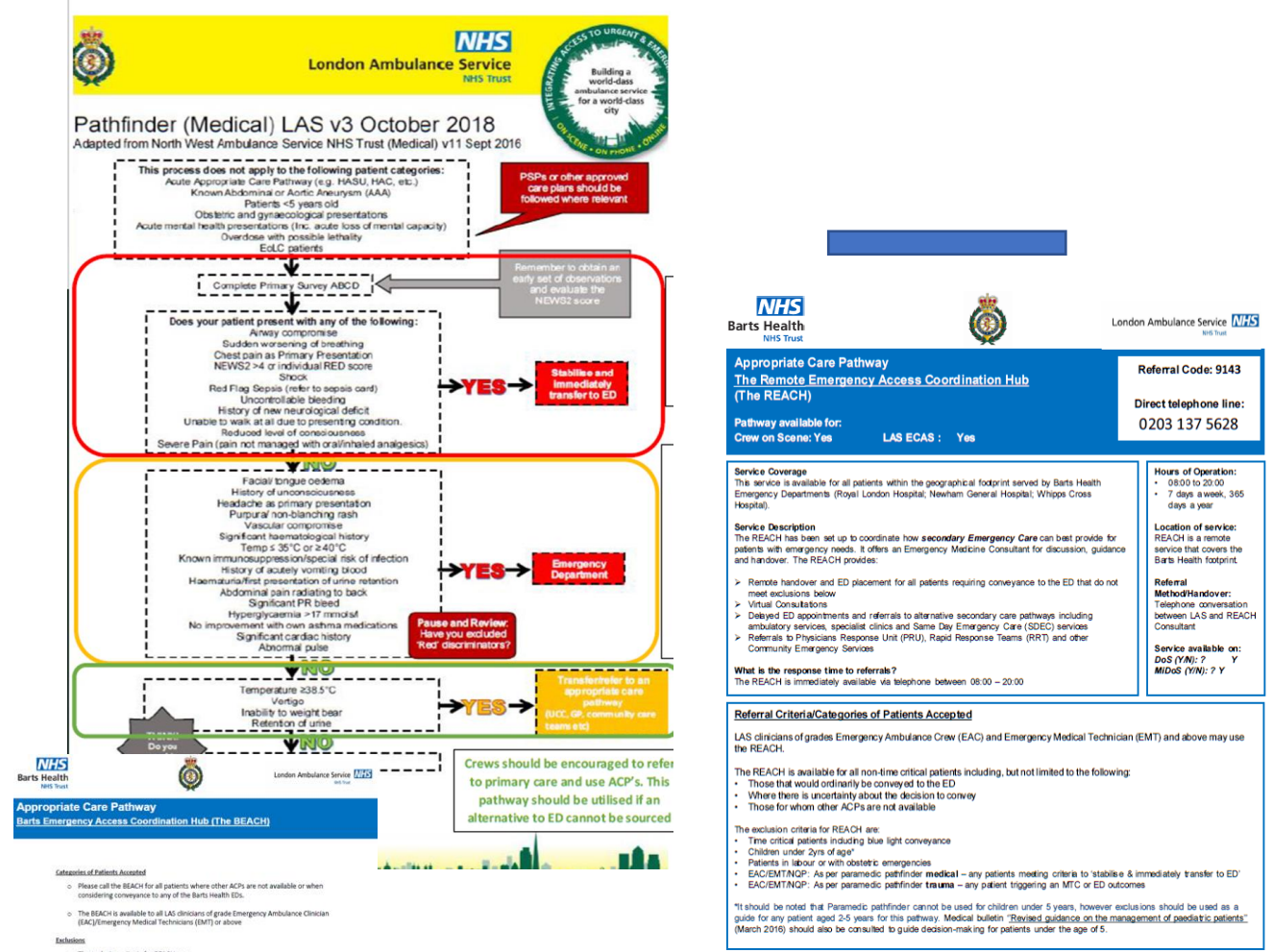
I will continue to use this service, and feel privileged that the NE (Barts) have this option.

Amazing service, an ACP that is worth its weight in gold. **Invaluable and crucial to patient wellbeing and what seems like a harmonious relationship with LAS.** Finally a team of Drs and Nurses that listen to and take understanding from LAS crew.

"I love having REACH, it is the best thing I have seen the LAS do since I have worked here. **They make me feel like I am part of the decision-making process rather than taking over.** My only criticism is it closes at 8pm"

Establishing a stable service:

- SOP and quality standards
- Business case and relocation case
- Process for managing clinical incidents
- Governance structures locally and system wide
- Shared learning arrangements
- Shared data reporting
- Induction and ongoing training
- Risk register



REACH Patient Safety Profile

Re-contact Rate

ED re-contact rate within 7 days:

REACH: **2.77%**

BH: 3.18%

LAS re-contact rate with 24 hours:

REACH: **0.12%**

LAS (all): **0.12%***

Reportable Incidents

15

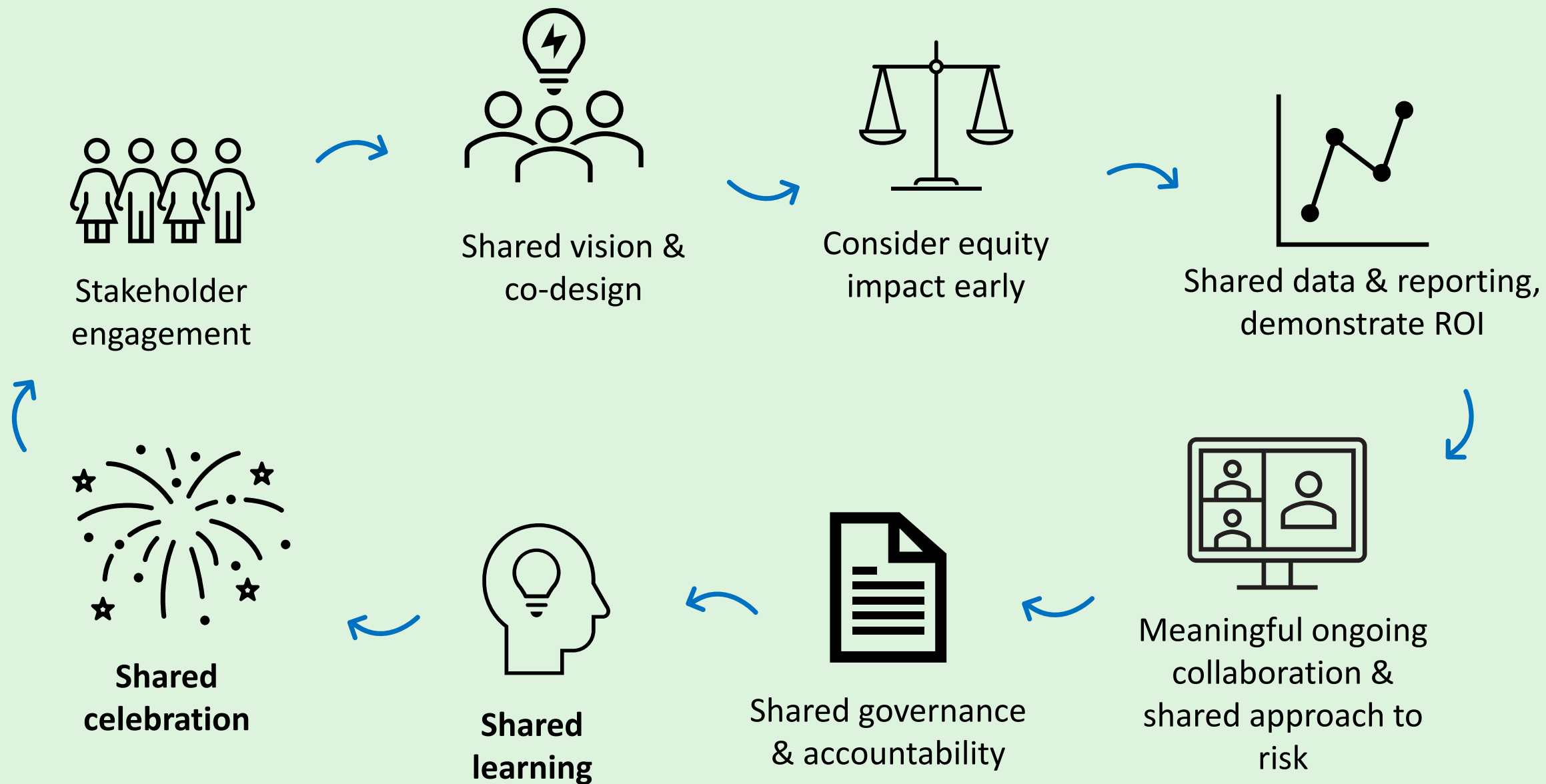
- 3 submitted to SI meeting for review

Serious Incidents

0

*LAS re-contact data taken from LAS Continuous Re-contact Clinical Audit (2021 – 2022) 1st April 2021 – 31st March 2022

Key Learning #6



Key Learning

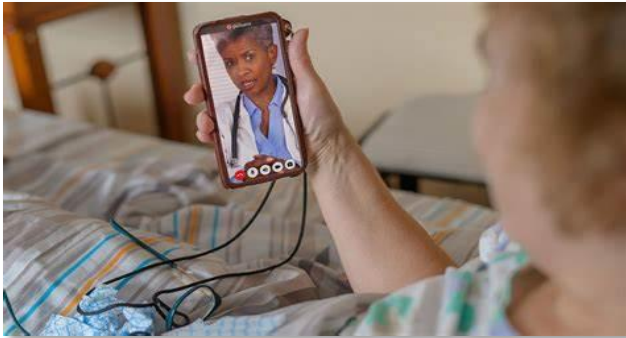


Key Learning: REACH programme



Workforce

- Building trust and insight
- New skills & increased knowledge
- Shared risk



Patients

- Right care in the right place
- Enhanced experience
- Patient involvement



System

- ↑ utilisation of alternative pathways
- Flow & capacity management
- Financial

**What are the key principles
that enable sustainable systems
change and innovation within
health and care?**

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Menti code: 1249 9234



Systems Improvement and Key Learning

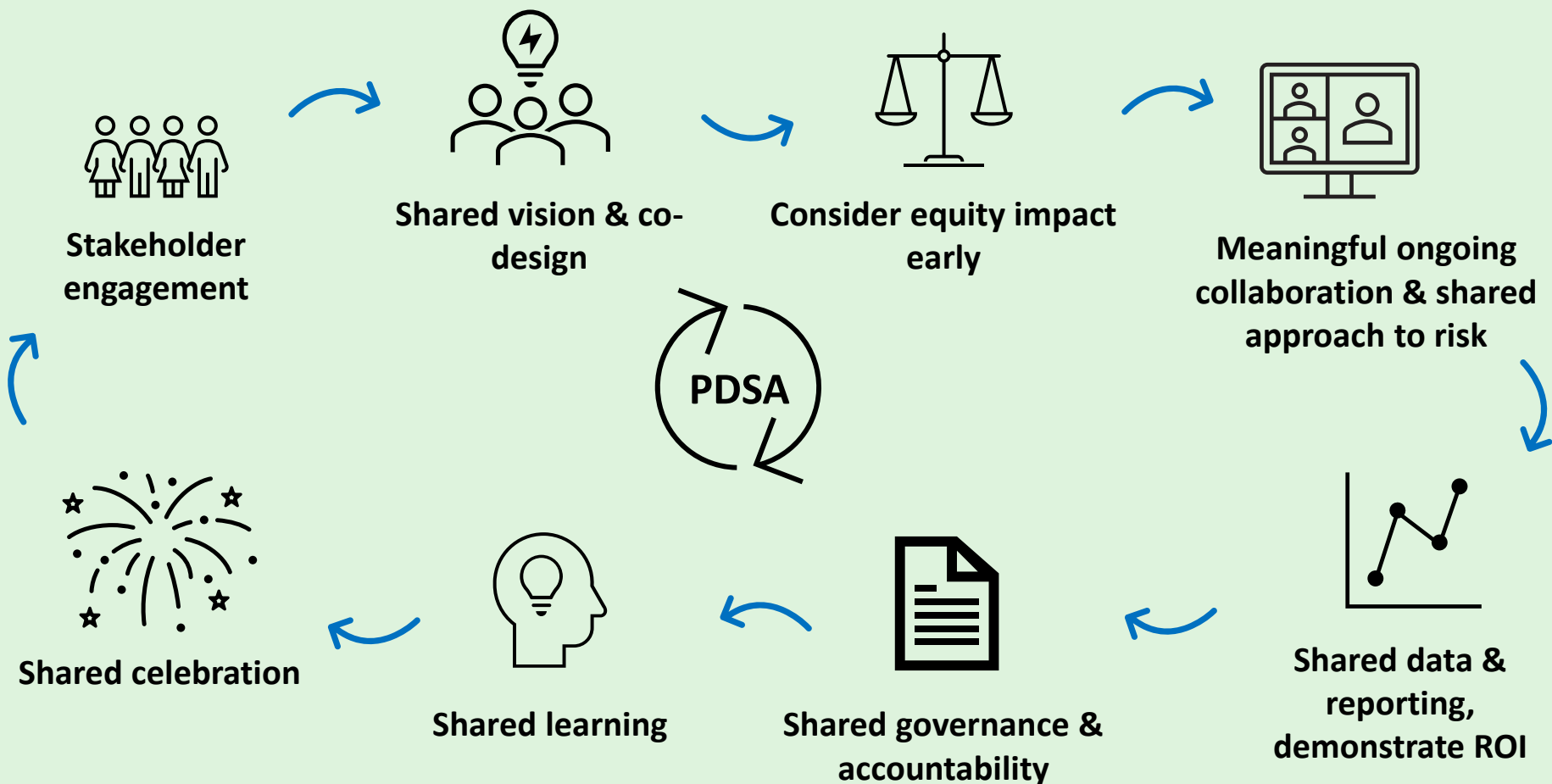
STOP:

SUB-OPTIMISING
PARTS OF THE SYSTEM



START:

OPTIMISING THE SYSTEM AS A WHOLE



Thank you for listening

Tiffany Wishart
London Ambulance Service

✉ Tiffany.wishart@nhs.net

🐦 @TiffanyWishart1

Joanna Moore
Barts Health

✉ Joanna.moore20@nhs.net

🐦 @JoM0oRe

