QI Case Study: Reducing Waiting Times within Dementia and Frailty

By Dr Ravinder Kaur Hayer and Dr Nibha Hegde

For our first QI case study, we recently spoke to Dr Ravinder Hayer about her project within Dementia and Frailty. It's one of the very first of our projects that is showing a project score above 4.0, which means that expected results have been achieved for major subsystems, the project is being actively implemented and that goals for the project are 50% or more complete.

This is fantastic, so we were very excited to talk with Ravinder about the project to hear about the changes they implemented that lead to improvement, especially when COVID has been affecting us all in rather unpredictable ways.

Thanks for taking the time to speak with us Ravinder. QI is a relatively new approach within the Trust. How did you come to be involved in QI and this project?

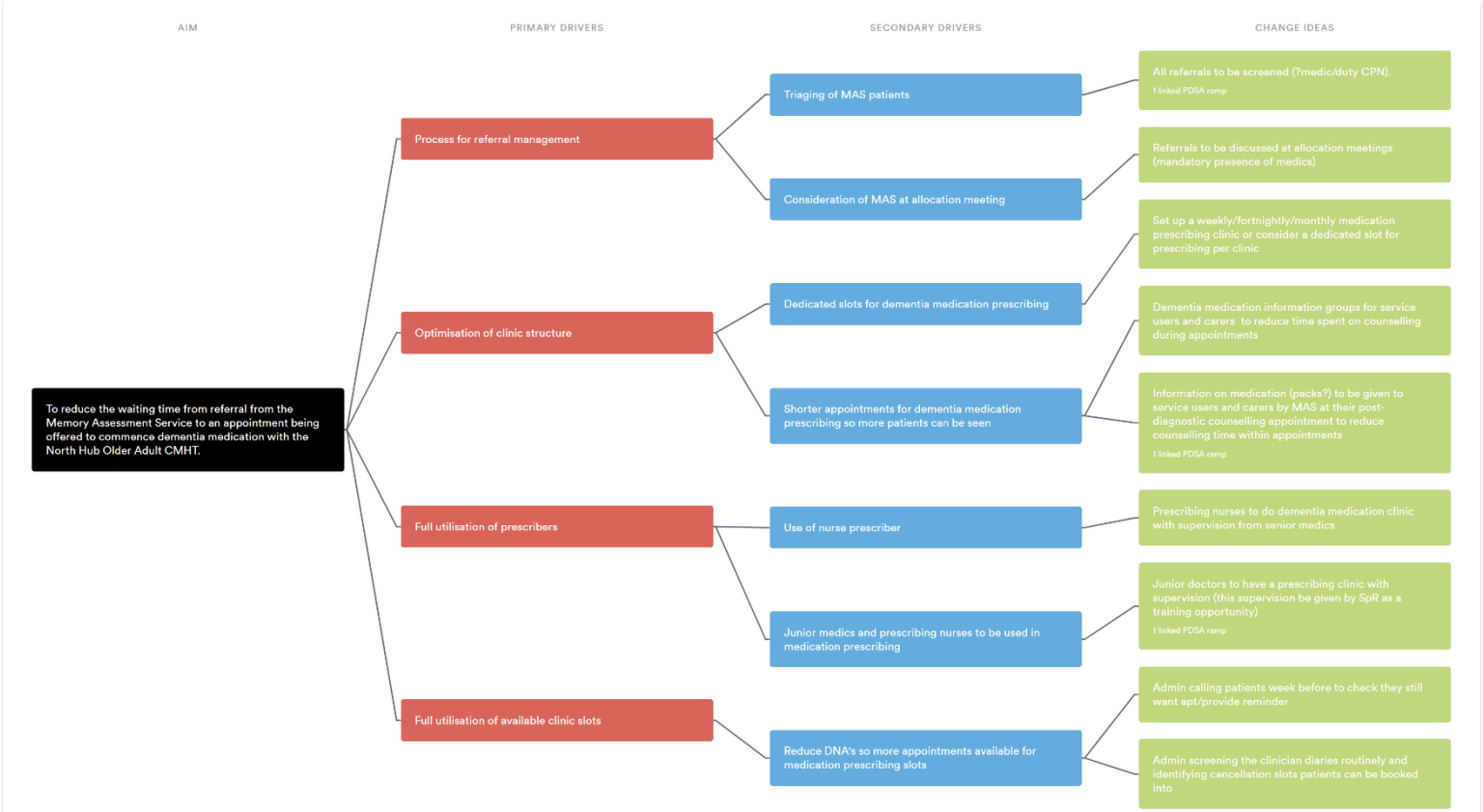
We had the opportunity to attend the Institute for Healthcare Improvement*, 'Improvement Science in Action'* Training Course in September last year. As part of this, we were asked to submit an idea for a QI project to the QI team. We both thought of an audit we had completed recently, which highlighted that there were considerable waiting times for dementia medication to be commenced by the Community Mental Health Team (CMHT) once a diagnosis of dementia was made by the Memory Assessment Service (MAS). A multitude of factors were identified in contributing towards this delay. Although there were some factors which were due to resourcing within the team, others were attributable to patient factors or circumstances beyond both MAS and the CMHT's control, such as delays in imaging and reporting of scans at the general hospitals where these were contracted to be carried out. Arguably, the most significant factor leading to delays was the fact that within the two services, there were *two* sets of waiting times; one for an assessment of memory and then another to be seen by a medic for consideration of treatment.

What was the issue you were trying to address? How did this inform your aim?

The aim of this project was to reduce the waiting time from the point of referral from the Memory Assessment Service following a dementia diagnosis, to initiation of dementia medication at North Hub older adult CMHT, to a median of 50 days. This was considered by all those involved to be an achievable target given that at baseline, the median of the mean weekly wait time was measured at 81 days.

How did you go about using the Model for Improvement to plan and move the project forward?

We started by clearly identifying our aim, and then tried to expand our project team. We were fortunate enough to receive input from Tom Cleverley, Information Manager at the Trust, Graeme Brown, Chief Pharmacist and Lead Pharmacist for Older Peoples in the community and Ella Tumelty, a fantastic medical student from the University of Birmingham. Dr Pravir Sharma and the whole team at Reservoir Court CMHT were also heavily involved from the outset. Shelley Wreford and Heather Hurst from the Trust QI team, and Dr Farooq Khan, our project sponsor, provided advice and support throughout, but especially in the very early stages when we were developing a driver diagram to help



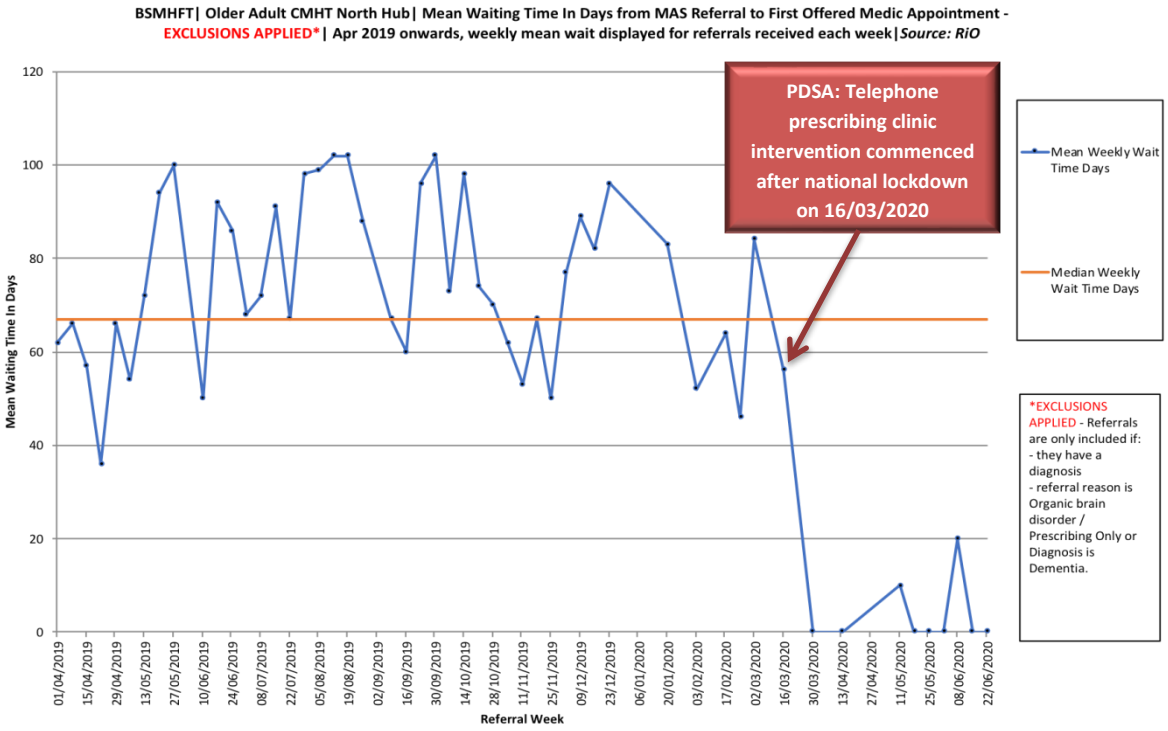
plan our change ideas and weren't very sure where to start. With their guidance, we then set about devising PDSA cycles, which are small tests of change.

What were the initial PDSA's you planned? And did they change at all due to COVID?

Various PDSA's were carried out between August 2019 and January 2020 to try and reduce the waiting time for initiation of dementia medication, all with limited success. These included medics screening the MAS referrals to identify where additional investigations were needed and arranging these prior to the outpatient appointment. However a trial of this revealed none of the service users during the PDSA period required additional investigations and therefore this PDSA did not have an impact on waiting times. A proposed PDSA of shortening appointment slots for dementia medication prescribing, in order for more patients to be seen in any given clinic, caused some concern amongst clinicians who worried about having inadequate time to assess the service users and complete the necessary 'new patient' documentation on Rio. As such, this was not pursued. Then struck the Covid-19 pandemic. The next PDSA which planned for junior doctors to run prescribing clinics under supervision was stopped with immediate effect as the juniors were redeployed from the community onto the wards. It was at this point that the project seemed to have been stopped in its tracks.

How has COVID affected the project? What difficulties have you had to work around? Did it present any opportunities?

Quite unexpectedly emerged another PDSA; one that had previously seemed impossible due to MAS being commissioned to run as a purely diagnostic service. This arose as Dr Pete Bentham very kindly offered to ease pressure on the Trust during these unprecedented times by organising telephone reviews to initiate medication after service users were diagnosed by MAS and prior to referral to the CMHT. This new telephone clinic commenced in March 2020, after the national lockdown was announced, with a view to continue until the worst of the pandemic had passed. Dr Bentham would counsel the service users on medication, and assess their suitability for it, before referring formally to the CMHT and requesting they generate the initial prescription. The CMHT would then be responsible for continuation of the prescribing and follow-up. This had a dramatic effect on the waiting time for diagnosis to initiation of medication, as the run chart below demonstrates.



How did you feel when you first realised you were actually seeing evidence of an improvement which you had been directly responsible for?

We were hugely surprised when we saw the data, as we hadn't anticipated seeing such a positive change to the results so quickly!

What was the outcome of the project compared to your aim, did you achieve what you set out to?

As a result of the unplanned PDSA cycle, and the introduction of Dr Bentham's telephone prescribing clinic, the wait went from a median (of the mean weekly waiting times) of 81 days (between 01/04/19 up to, and including, 09/03/2020) to **0 days** (between 16/03/2020 up to, and including, 22/06/2020). The overall median of the mean weekly wait across the project, taking into account both the waiting times from the baseline data and that during the PDSAs, was 67 days, and is represented on the run chart by the red horizontal line.

How important has it been to involve service users in the project? Did you work with anyone to go about getting the insight and support you needed?

Involvement of service users and carers in this project was key and their input was sought from the outset. With the help of Alex Rawlings, Lead See Me Worker from the See Me Service User Engagement Team, we attended a Dementia Council meeting and met with service users and their carers to obtain their experiences of dementia medication prescribing and their views on some of our change ideas. For example, a suggestion of creating a specialist-led medication information group was met with the feedback that, *"It feels like an obvious filler, and that it is trying to compensate for the long wait, but not actually useful."* They did agree that written information, in the form of an A4 leaflet, about medication for dementia would have been useful *prior* to their appointment with a psychiatrist. The group also unanimously felt that sending appointment reminders to service users and an identified carer would be beneficial.

What's next for the project?

As a result of the success demonstrated by the PDSA above, Dr Khan, as Clinical Director for Dementia, Frailty and Clinical Specialties is using the above data to try and secure funding to model this way of working going forwards. Whilst it is acknowledged that a telephone prescribing clinic has its limitations and may not be appropriate for all of our service users, this PDSA has demonstrated that it could be utilised by many. It may also help to reduce face to face contact during the difficult times we find ourselves in currently, where the aim remains to reduce this where it is possible and safe to do so. Furthermore, a draft dementia medication information leaflet, to be sent out with the letter for the prescribing outpatient appointment, is in development by Graeme Brown as a direct result of feedback from service users and carers. This highlights that although there is no denying the absolute devastation this virus has caused across the world and in every aspect of our lives, it has also brought with it the opportunity, and in many cases, the necessity to work differently.