8 Pillars Model: Improving Co-ordinated Care for People with dementia and cares in the community

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Dementia in Scotland

5.4 million population

93,000 People living with Dementia
16,000 People newly diagnosed each year (incidence data, 2017)

Scottish Government priority since 2007
Third Dementia strategy due to be published Summer 2017
Focus on Dementia: National Improvement Portfolio

- **Diagnosis and Post Diagnostic Support**
- **Integrated Care Co-ordination**
- **Advanced Care**

Primary Care, Community, Acute Hospitals, Specialist Dementia Units
Dementia Local Delivery Plan Standard

To deliver expected rates of dementia diagnosis, all people newly diagnosed with dementia will have a minimum of a year’s worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.

*(Scottish Government Target, introduced 2013)*
8 Pillars Model

Supporting people with moderate to severe dementia

By tackling the full range of factors that influence the experience of dementia in a co-ordinated way, this work takes a therapeutic approach to enhancing the resilience of people with dementia and their families and carers.
Testing the 8 Pillars Model

5 Health and Social Care Partnership Areas
Data set summary (109 people with dementia)

56% of people had post diagnostic support

42% of people aged 76-85
Improvement approach: Breakthrough Series Collaborative

• X5 Test Sites
• X11 Learning Sessions
• Webinars
• Peer Support/Action learning sets
• Bespoke on-site support
• Building capacity and capability
• Data for improvement
• Carer and Staff focus groups & interviews
• Sharing learning and good practice
Evaluation

- an assessment on the overall effectiveness of the 8 Pillars model in enabling people with dementia to stay living well and as independently as possible at home for as long as possible;

- the importance of the role of the Dementia Practice Coordinator (DPC) in that process; and,

- an evaluation of the applicability and relevance of the proposed service model in the context of wider policy landscape in Scotland, for example in the areas of the integration of health and social care, the reduction in unplanned hospital care.
Dementia Practice Coordinator identifies the individual needs of the person with dementia and their carer, supporting them on an on-going basis throughout their journey, coordinating access to each of the pillars and linking with the relevant practitioners and services to provide effective support and intervention across health and social care.
Crisis prevention and intervention
• Reducing Falls
• Avoiding hospital admission
• Supporting earlier discharge from hospital
Summary of Evaluation Findings

People with dementia and cares valued single point of contact. This role is key (Dementia Practice Co-ordinator) to crisis prevention and intervention.

Specialist Dementia Team Approach providing Dementia Practice Co-ordination enabled more flexible approach to providing support for people at different stages.

Communication and data sharing – understanding and appreciating different roles, role shadowing

Leadership and national improvement and educational support – transformational change

8 Pillars is a useful framework for supporting people with dementia at moderate to severe stage of their dementia. DPC comment: Examines all aspects of a person’s life, not just the aspect most directly concerned with their own professional practice.
Supporting Implementation

- Role recognition: Autonomy to act
- Responsiveness: Right Support at Right Time
- Readiness for Change & Re-design to meet changing demands
- Right level of knowledge and Skills

Person with dementia and carer

Personal Outcomes
Unintended Consequences

• Dementia Friendly Community Developments
• Improved diagnosis rates
• Catalyst for transformational change
Next Steps

• Publication of evaluation findings
• Spreading learning and supporting transformation
• Links with Act on Dementia
Thank you

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The Improvement Hub (ihub) is a part of Healthcare Improvement Scotland
Personalised Outcome Plan

75% People with Dementia have a Personalised Plan

30% Carers have Personalised Plan