National Dementia Care Improvement Programme

Improvement Plan – Testing “8 Pillars” model of community support

Supporting Commitment 3 of Scotland’s National Dementia Strategy (2013-2016)

This paper sets out the improvement approach being adopted by the National Dementia Care Improvement Programme (NDCIP) to support test sites in Scotland to test models of integrated care and support based on the “8 Pillars” model of community support.

Context

In June 2013, Scottish Government and COSLA published Scotland’s second 3-year National Dementia Strategy. A major part of implementing the strategy will be supporting better community-based, integrated health and social care (including housing) support for those people whose dementia has advanced to the extent that they need intensive interventions to stay living at home for as long as possible. This will increasingly take place within the context of local partnership work to develop joint commissioning plans that seek to shift the balance of care towards community-based supports, as part of service re-design to provide better integrated care and support.

Commitment 3 of the new dementia strategy is intended to complement this partnership activity and states that the Scottish Government will, in partnership with JIT, COSLA, ADSW and Alzheimer Scotland, test and evaluate a range of approaches to providing better integrated care and support, on the basis of Alzheimer Scotland’s “8 Pillars” model of community support http://www.alzscot.org/campaigning/eight_pillars_model_of_community_support. (See Appendix 1.)

As part of the new dementia strategy, a National Dementia Care Improvement Programme will support service improvement across Scotland and, as a major part of that remit, it will provide support to identified test sites for this work.

Test Site Aims and Improvement Support

Through a nomination and selection process, 4 test sites teams will be identified to work with the National Dementia Care Improvement Programme to test models of integrated care and support based on the “8 Pillars” model of community support. Successful sites will be selected in October 2013 and will be supported through to January 2016. It is anticipated that the test sites will cover urban, rural and island environments.

The aim of the test site work is to:
• Test different models and approaches to delivering the key role of the Dementia Practice Coordinator within the "8 Pillars" model. As part of this work, ideally the testing will be in different hosting models for the Dementia Practice Coordinator in different areas: for example in primary care, local government and integrated services.

• Assess the costs and benefits of implementing the “8 Pillars” model including the Dementia Practice Co-ordinator role. This analysis will consider costs and benefits across the local health and social care system and will look at both qualitative and quantitative data. In particular it will test the assumption that, by implementing this approach, local services will be able to deliver better outcomes for more people with the same or less resource.

• Better understand which groups of individuals might benefit from a Dementia Practice Co-ordinator and demonstrate those benefits in practice in test sites.

• Assess the helpfulness of the other 7 pillars in directing the development of integrated care and support and, where appropriate, develop a better understanding of the distribution of need/demand across each of the pillars.

• Engage wider community planning partners in testing how their services can contribute to the other 7 pillars through responding better to the needs of people with dementia.

This project sits squarely in the context of community planning and health and social care integration. Test sites may derive from either health and social care partnership level or from a locality level, whichever is considered most relevant and applicable in terms of local needs and current service configuration.

**Improvement Support**

Through a series of learning sessions, webex calls, peer support and improvement expertise; test sites teams will be supported to:

• build capacity and capability for improvement in order to facilitate local testing and spreading of improvements
• source, develop and share change packages and measures in order to build on existing improvement work at a national and local level
• test change packages, measures and associated prototypes in order to inform the key elements of an integrated package of care
• share learning and examples of good practice
• share test site data to demonstrate progress against measures
• plan for spread and sustainability including the development of a spread plan, and
• evaluate the work throughout the project, from both a qualitative and quantitative perspective.

An introductory event will be held in January 2014, to enable test site teams to meet each other and to learn from other related dementia workstreams, including dementia demonstrator sites and post diagnostic support test sites. Thereafter, test site teams will attend 5 national learning sessions over the course of the 2 year programme. Teleconference and video conference facilities will be available where possible. Webex calls will be arranged between learning sessions. (A high level timeline is outlined in Appendix 2.) Test site visits, telephone support calls and tailored educational sessions will
be available to support test sites. JIT Associates will also provide ‘critical friend’ support to the test sites and attend and contribute to local steering groups.

It is recognised that some test sites may have different levels of knowledge and expertise to take this work forward (particularly around improvement) and therefore, in advance of the first learning session, a Knowledge and Skills Needs Analysis will be carried out to identify individual requirements in order to design effective support for individuals and teams. This Knowledge and Skills Needs Analysis will be repeated during the 2 year programme to demonstrate how knowledge and skills have been enhanced.

Access to existing change package material including the Post Diagnostic Services test sites toolkit will be available for test site teams to use and adapt to fit with their local context. Encouragement and support will be offered in the generation of new ideas and thinking, creating opportunities for innovation and peer support in testing the models of integrated care and support based on the “8 Pillars” model of community support. JIT can also facilitate access to learning from other partnerships across Scotland. We will invite feedback on the toolkit and related material to further develop and refine the change package, taking account of learning from test site activities. (A high level driver diagram is outlined in Appendix 3.)

In addition to support from NDCIP and JIT associates, the test sites will also have access to:

- additional funding for improvement capacity locally (up to £50k per site per year for 2 years) and
- an external evaluation team, which will work closely with the test sites throughout the project to support the evaluation of the different models.

**Outputs**

The outputs for this work will be:

- An evaluation report summarising the lessons learned from the test site work, including a cost benefit assessment of the 8 Pillars model.
- If appropriate, revisions to the “8 Pillars” model.
- A decision nationally on whether to adopt the “8 Pillars” model for inclusion in the next Dementia Strategy.
- Implementation guidance and tools which will be available to support the practical roll out of integrated care and support for individuals with dementia. These will be developed in partnership with the test sites and based on the practical experience of implementing integrated services with the aim of providing supportive guidance for consideration by local areas.
- A change package which reflects the learning from the test sites and the change concepts tested.
- Case studies and flash reports from each test site to share progress, challenges, learning and improvement data.
• Summary of the needs analysis tool to show how knowledge and skills have been enhanced during the course of the programme.

For the avoidance of doubt, this work is not primarily designed to support delivery of the new dementia post-diagnostic HEAT target, which is designed to support people in the earlier stage of the illness. We do, however, recognise that many people being diagnosed from 1 April 2013 and entitled to receive the post-diagnostic HEAT commitment will be in more advanced stages of the illness and will require more intensive support, such as that outlined in the “8 Pillars” model. Work is already being progressed nationally to look at the appropriate application of the post-diagnostic HEAT target with individuals in the more advanced stages of their illness and the Scottish Government will issue additional guidance on this as appropriate. Further, national data collected as part of the HEAT process will, over time, include information on the proportion of individuals being diagnosed and receiving post-diagnostic support at each stage of the illness. Further advice and support will be provided to the test sites as appropriate on the relationship between the 5 and 8 pillars models.

Accountability and reporting arrangements

This programme is led and coordinated through a partnership between Scottish Government, JIT, COSLA, Alzheimer Scotland and ADSW. Progress is reported to the National Steering Group for the 8 pillars workstream, and to the Dementia Strategy Implementation and Monitoring Group and the JIT Board.

The Chief Nursing Officer Directorate at Scottish Government, and other key stakeholders such as Chief Executive, Medical Director and Nurse Director groups (in line with the communication strategy and plan) will be provided with progress reports via existing governance groups and through regular flash reports.

Each test site should have a clear governance structure. This could be through a new steering group or a pre-existing group. A JIT Associate will provide support to this group through attending these meetings and providing a ‘critical friend’ support role.

It is recommended that an Executive Sponsor from each test site area be identified to provide local leadership and strategic support for this work.

Reporting mechanisms:

Incoming:
• Progress reporting from other national programmes and workstreams (eg dementia strategy commitments, Post Diagnostic Support Test Sites, Dementia Demonstrator Test Site work and evaluation, 5 pillars, OPAH Inspections, Improving Care for Older People in Acute Care workstream, Person Centred Health and Care Collaborative)

Outgoing:
• A community website/shared space will be developed to facilitate the sharing of test site activity and good practice.
• Test sites will provide regular flash reports in advance of each Learning Session to show progress, highlight challenges and improvement results. Test sites will present on their flash
report at each learning session and these will be published on the community website. These can be used to share good practice and progress within test site locality and with other stakeholders.

- Case studies to showcase test site improvement will be developed to share learning and good practice.
- Test site members are responsible for reporting on progress as agreed within their own locality.

A communication strategy will be developed for this workstream to ensure appropriate and timely engagement with all key stakeholders.
Appendix 1: 8 Pillars Model

This “8 Pillars” model focuses specifically on that stage of the illness where more intensive community services are needed to enable people to stay living well and as independently as possible at home for as long as possible. The model is based on a coordinated, holistic approach which also aims to provide continuity of care in the form of that key contact point for people with dementia and their carers.

![Diagram of the 8 Pillars Model]

- Dementia Practice Coordinator – a named, skilled practitioner who will lead the care, treatment and support for the person and their carer on an ongoing basis, coordinating access to all the pillars of support and ensuring effective intervention across health and social care.
- Support for carers – a proactive approach to supporting people in the caring role and maintain the carer’s own health and wellbeing.
- Personalised support – flexible and person-centred services to promote participation and independence.
- Community connections – support to maintain and develop social networks and to benefit from peer support for both the person with dementia and the carer.
- Environment – adaptations, aids, design changes and assistive technology to maintain the independence of the person and assist the carer.
- Mental health care and treatment – access to psychiatric and psychological services to maintain mental health and wellbeing.
- General health care and treatment – regular and thorough review to maintain general wellbeing and physical health.
- Therapeutic interventions to tackle symptoms of the illness – dementia-specific therapies to delay deterioration, enhance coping, maximise independence and improve quality of life.
Appendix 2 – Timeline

This initial high level timeline provides key milestones for the programme. A more detailed timeline with confirmed dates will be provided for test site teams.

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
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<tbody>
<tr>
<td>July 2013</td>
<td>Invitation and criteria sent to Chief Executives of NHS Boards and Chief Executives Local Authorities to seek nominations for test sites. Closing date: 22 August 2013</td>
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<tr>
<td>23-24 October 2013</td>
<td>Interviews to select test sites</td>
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<tr>
<td>End October 2013</td>
<td>Test sites confirmed</td>
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<tr>
<td>Early January 2014</td>
<td>Test site teams in place</td>
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<td>January 2014</td>
<td>Knowledge and Skills needs analysis completed by test site teams</td>
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<tr>
<td>January 2014</td>
<td>Introductory Event</td>
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<tr>
<td>February/March 2014</td>
<td>Learning Session 1</td>
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<td>April 2014</td>
<td>Webex</td>
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<tr>
<td>June 2014</td>
<td>Learning Session 2</td>
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<tr>
<td>September 2014</td>
<td>Learning Session 3</td>
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<tr>
<td>November 2014</td>
<td>Learning Session 4</td>
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<tr>
<td>January 2015</td>
<td>Webex</td>
</tr>
<tr>
<td>April 2015</td>
<td>Learning Session 5</td>
</tr>
<tr>
<td>June 2015</td>
<td>Webex</td>
</tr>
<tr>
<td>September 2015</td>
<td>Learning Session 6</td>
</tr>
<tr>
<td>October 2015</td>
<td>Knowledge and Skills needs analysis repeated by test site teams</td>
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<tr>
<td>Dec 2015/Jan 2016</td>
<td>Final showcase</td>
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<tr>
<td>January 2016</td>
<td>Evaluation Report to inform dementia strategy 3</td>
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Appendix 3: Driver Diagram

The driver diagram below is a tool to help organise our theories and ideas for this improvement programme. It sets out the aim of the programme, the primary drivers and secondary drivers.

The primary drivers represent the 8 pillars and the secondary drivers represent a high level summary of the ‘who and how’ to achieve these 8 pillars.

This driver diagram will form part of a change package which will be developed alongside test sites, to take account of the change concepts being tested and learning from the test sites.

The driver diagram and change package will be updated throughout the programme and used to track progress as we build learning and knowledge in testing the 8 pillars model.

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**National Dementia Care Improvement Programme**

<table>
<thead>
<tr>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
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<tbody>
<tr>
<td><strong>Aim</strong></td>
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<tr>
<td>Dementia Practice Coordinator</td>
<td>Identify and appoint Dementia Practice Co-ordinator (DPC)</td>
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<tr>
<td>Therapeutic Interventions to tackle symptoms of the illness</td>
<td>Ensure appropriate therapeutic interventions are available, determined by individual circumstances, as assessed by DPC in conjunction with specialist colleagues.</td>
</tr>
<tr>
<td>General health care and treatment</td>
<td>Ensure a mandatory 15 month GP check-up for people with dementia is in place with an on-going proactive approach to manage the health and wellbeing of the person.</td>
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<tr>
<td>Mental health care and treatment</td>
<td>Co-ordinated by the DPC, a multidisciplinary approach will be adopted including specialist nursing, GP and psychiatric services. The GP will provide a key component in enabling the DPC to effectively co-ordinate appropriate interventions.</td>
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<tr>
<td>Personalised support</td>
<td>The DPC will liaise with psychiatrists and community mental health team, to facilitate transfer of knowledge, so that health and social care operate as one team in tackling the symptoms of dementia.</td>
</tr>
<tr>
<td>Support for carers</td>
<td>The DPC will assess the person’s requirements and ensure support delivers their key outcomes.</td>
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<tr>
<td>Environment</td>
<td>Evolution towards self-directed support will assist people to make best use of resources. However, personalised support can be delivered now within the existing system by a range of public, private and voluntary sector organisations, for which good assessment and outcome-focused support planning is required. Where support is self-funded, the DPC will continue to have a role to assist the person and their family to design services which support the maintenance of their quality of life.</td>
</tr>
<tr>
<td>Community Connections</td>
<td>Interventions for carers will be delivered across health and social care disciplines. The DPC will identify the individual needs of the carer and link with the appropriate practitioner or service.</td>
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Primary drivers reflect the 8-pillars model and the secondary drivers provide a high-level summary of the ‘who and how’ to achieve these 8 pillars. More detailed information to support the ‘who and how’ will be documented by test site teams through the development of their local change package.