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Title

Commissioning social care for people with dementia living at home: findings from a national survey

Short running title

Commissioning dementia home care: a national survey

Authors and institutional affiliations

Sue Davies[1], Jane Hughes[2], Saima Ahmed[1], Paul Clarkson[1], David Challis[2] and Members of the HoSt-D (Home Support in Dementia) Programme Management Group

1. The University of Manchester, Personal Social Services Research Unit (PSSRU), Manchester, UK,

2. University of Nottingham Innovation Park, Institute of Mental Health

Corresponding author details

Sue Davies. Personal Social Services Research Unit (PSSRU) at The University of Manchester, Fourth Floor, Ellen Wilkinson Building, Oxford Rd, Manchester, M13 9PL. Telephone: 0161 305 5680 Email: susan.l.davies@manchester.ac.uk

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Abstract

Objective: To explore the complexities, circumstances, and range of services commissioned for people with dementia living at home.

Methods: A national survey was used to collect data from English local authorities in 2015. Commissioners of services for older adults were invited to complete a questionnaire. An exploratory cluster analysis of nominal data was conducted using a TwoStep procedure to identify distinct groups.

Results: 122 authorities (83%) responded to the request. Four approaches to commissioning were identified, reflecting commissioning practices at the organisational, strategic and individual service user levels. Commissioning at the service user level was most apparent. Bivariate analysis found that these configurations were not associated with the types of dementia specific services provided but were related to the number available. Authorities delivered a greater range of specialist services when joint commissioning between social care and health partners was undertaken. However, the joint commissioning of services was less observed in services specifically for people with dementia than in generic services for all older people. There was limited evidence that local circumstances (population configuration and deprivation levels) were associated with this approach to commissioning.

Conclusions: The significant role of health partners in the delivery of social care services to support older people living with dementia in their own homes is evident. As the population with dementia ages and physical health needs increase, how dementia specific services differ from and complement those services available to all older people, warrants further investigation.

Key words

Dementia, Home Care, Commissioning, Adult Social Care, Survey

Key Points

Little is known about the specialist support available for people with dementia living at home or how it is commissioned.

There is more evidence of commissioning social care at the level of the individual compared with the commissioning of services to meet their specific needs at a strategic level within localities.

However, the range of services available specifically for people with dementia increases when joint commissioning between social care and health partners is undertaken.

Introduction

With the population ageing globally, dementia presents a significant health and social care challenge [1]. This is apparent in primary (preventing development), secondary (offering early-stage treatment) and tertiary prevention - ameliorating difficulties and enhancing well-being. With regard to the latter, the need for appropriate care for those close to the end of life, in the context of comorbidity and frailty, has been emphasised [2]. Internationally, the tertiary care of people with dementia is often portrayed as a clinical pathway [3, 4, 5, 6]. However, people with dementia in the oldest age groups have needs characterised by complexity which are often inadequately addressed in existing disease based models of tertiary care [7]. Meeting the needs of people with dementia and their carers often requires substantial social care provision: specialist services available to people with dementia or those provided for all older people, including those with dementia.

In England, health and social care have historically been commissioned separately with the former undertaken by clinically-led CCGs (Clinical Commissioning Groups), and their forerunners and social care by local authorities. The latter have primary responsibility for the planning and organisation of services to support people with dementia at home and their carers, although these functions are increasingly discharged through joint health and social care arrangements. Local authorities are diverse in terms of their size (from 2,200 to 1.4 million people) and in the composition of the population they serve (proportion aged over 65 ranges from 6% to 25% and proportion of a minority ethnic group ranges from 1% to 71%) (ONS, 2017). Many local authorities have coterminous geographical boundaries with CCGs but some have to negotiate with two or more.

Whilst commissioning has been described as 'the process of planning and buying health and social care services to meet the needs of the local population' [8, pg. 60], little is known about these arrangements for people with dementia living at home. This study is designed to fill this knowledge gap through a case study, using England as the unit of analysis [9], to explore the complexities, circumstances, and range of services commissioned in localities. Its aim was to explore the provision of social care for people with dementia living at home. The research questions were:

To what extent do health and social care agencies jointly commission services for people with dementia?

Can different approaches to commissioning social care for people with dementia be identified?

Do identified differences in commissioning arrangements influence service provision?

Are commissioning arrangements linked to local area characteristics?

Method

Data collection

A national survey of local authorities was undertaken in 2014/15. Directors of Social Services were initially approached and they identified the most relevant respondent to complete the survey. Copies of the questionnaire were despatched by post and email and included the contact details of the research team for enquires. Authorities were approached up to three times and in three regions staff of the regional offices of the Association of Directors of Adult Social Services facilitated data collection. The questionnaire covered the domains of commissioning (defined as the process of needs analysis and strategic planning) and contracting arrangements (defined as the process of contract setting (procurement), market management and contract monitoring) of the services to support people with dementia living at home. Responses from commissioners of services for older adults within 122 of the 150 local authorities were received (83%). Complete responses permitted a cluster analysis of 100 authorities (67%), encompassing 70% of the total English population. Individual local authorities are not identified in the findings. Data within this study relied on the self-reporting of *specialism* by respondents. S*pecialist* services were defined as those offered only to people with dementia whereas *generic* services were available to all older people, including those with dementia.

Measures and data analysis

Measures of commissioning were used to evaluate the joint arrangements between health and social care agencies. Three of the five measures relate to the process - joint plans and planning, joint specification and overseeing of contracts and a single lead commissioner. Two measures relate to the management of finances - the pooling of both ring-fenced monies and total agency budgets. Joint commissioning arrangements of services provided to all older people and those dedicated to older people with dementia are included with Pearson's chi-squared test conducted to assess differences.

Four measures were used to cluster the commissioning arrangements of local authorities, contributing to the infrastructure available within a locality to support people with dementia living at home. Commissioning of services at both the level of the individual service user (care planning and support) and at the strategic level (joint commissioning, non-statutory sector contribution and dementia service premiums) are included.

1) *Care planning and support* - At the level of the individual, commissioning arrangements for older people, including those with dementia, involve (1) negotiating the most appropriate means to achieve the goals identified in the assessment and (2) securing the necessary services to meet them [10].

2) *Jointly commissioned services* - Joint commissioning between health and social care agencies is a means to promote integrated care and support with the aim of joining up services for the benefit of users and carers [10]. Evidence of joint commissioning in five dementia specific services (care at home, overnight respite, day care, telecare and occupational therapy) at the strategic authority level was measured.

3) *Non-statutory sector contribution* - Services (mainly respite services, day care and care at home) provided by the non-statutory sector (e.g. voluntary sector) to support people with dementia living at home, reflecting the policy guidance of the 2014 Care Act, to promote a *mixed economy of care*

[11]. The term ‘non-statutory sector’ refers to both voluntary and other independent sector providers. The voluntary sector has a tradition of providing specialist services (particularly respite for carers) to enable people with dementia to live at home.

4) *Premium for dementia specific services* – A premium is paid for home care and respite care (day or overnight). This premium takes account of the specialist care, supervision and support required to meet the needs of people with dementia and their carers.

Exploratory cluster analysis was performed to identify groups of authorities whose local commissioning practices shared similarities, compared to other authorities whose commissioning practices formed other distinct groups. There were three steps in this process. (1) Cluster variables were independent of each other with statistical associations (phi coefficient) not exceeding the 0.2% significance level. Due to the binary nature of the variables, the SPSS TwoStep Cluster procedure was applied as an alternative to hierarchical clustering methods. The procedure used a log-likelihood-based distance measure to model distances between variables that are categorical in nature. (2) To determine the optimal number of clusters the Bayesian Information Criterion (BIC) fit statistic was applied. Individual, anonymised, authorities were selected from each cluster grouping to provide exemplars and convey the dominant characteristics of each group. Cluster assignment was then compared with the range of services delivered in localities dedicated to support older living at home with dementia. Differences in the dementia specific services delivered between cluster groupings were tested with Pearson’s chi-square. (3) Differences between clusters were assessed in terms of local area characteristics (demographic, geographical and deprivation measures). Cluster assignment was compared with interval measures via one way analysis of variance tests (ANOVA) to compare group means, where the assumption of homogeneity was not met, the Brown-Forsythe test was applied. The categorical variable of political control was examined via Pearson’s chi-square. IBM SPSS Statistics (version 22.0; SPSS Inc., Chicago, USA) software was used in these analyses.

Results

Table 1 compares local joint commissioning arrangements for generic older peoples' services with those for specialist dementia services. Joint commissioning across four of the five practices was most evident in generic services; though, the pooling of total agency budgets was slightly more prevalent in dementia specific services. The p-values in this table indicated that neither generic nor dementia specific services were associated with any of the five approaches to joint commissioning. Across all services, processes related to joint commissioning activities were more frequently implemented than those activities relating to joint management of finances. The proportion of authorities employing joint plans and planning processes in both generic and dementia specific services was just under half (46%) whereas just over one quarter (28%) employed these in neither service. With regard to joint specification and overseeing of contracts, just over one quarter (27%) of authorities employed these in both generic and dementia specific services, just under half (47%) employed these in neither. About a third (36%) of authorities had a single lead commissioner for health and social care in both generic and dementia specific services. With regard to financial arrangements, 30% of respondents pooled ring-fenced monies and 10% pooled total agency budgets in both generic and specialist services.

[Table 1]

The exploratory cluster analysis, of 100 local authorities, identified four distinct groups (Table 2). Cluster B was the largest group (n=34) with Cluster C the smallest (n=16) providing a ratio of size of 2.12. A confirmatory silhouette analysis, to examine the separation and cohesion between the clusters, produced an average coefficient of 0.5, indicating that authorities within a cluster are at an acceptable distance from the boundaries of other clusters. Cluster A included those authorities providing the full range of five jointly commissioned dementia specific services, those authorities within Clusters B, C and D had, on average, fewer than two services. The average for the sample was 2.3 services. Clusters A and B included those authorities providing care planning and support. Cluster D comprised those in which specialist support provided by the non-statutory sector was absent. The payment of a premium for dementia specific services showed the least variation across clusters with a low of 13% of authorities in Cluster C and high of 38% in Cluster B. Providing additional information to Table 2, the dominant characteristics of clusters are presented in Box 1, illustrated with anonymous exemplar authority descriptions.

[Table 2]

[Box 1]

The associations between cluster membership and other measures, reflecting the services delivered to those living with dementia at home, are shown in Table 3. Levels of dementia care planning and support services were highest in Cluster A, as was the provision of dementia specific telecare and assisted living technologies and hospital discharge services. Cluster B had the highest levels of authorities providing respite care (through family placement opportunities) for those living with dementia. Due to relatively small cluster sizes it was anticipated that Chi-square tests would reveal that specific services delivered were independent of cluster membership. However, the total number of these specialist services provided was related to cluster membership ($p<0.05$), Cluster A authorities provided significantly more.

[Table 3]

Table 4 shows the characteristics of the cluster groups and local area characteristics. These exogenous factors reflect the potentially influencing circumstances beyond the control of service commissioners. Cluster D authorities had the highest mean values across deprivation measures and population measures (size and aged over 65). Cluster B authorities were those classified as more rural in geographical terms. These findings however, failed to reach significance.

[Table 4]

Discussion

This paper has presented data from a national survey of local authorities pertaining to local arrangements of commissioning services to support people with dementia living at home. Means/mechanisms of joint commissioning between social care and health were less likely to be used for services for people with dementia than in generic services for older people. Four approaches to commissioning social care for older people with dementia were identified through a cluster analysis derived from four measures spanning both strategic commissioning and that at the level of the individual. The findings indicated that commissioning configurations did not influence the types of dementia specific services provided but are were related to the number of them available. No significant exogenous factors were associated with the different approaches to commissioning identified.

This study was subject to limitations which must be considered in the interpretation of these findings. Firstly, the data relied on the self-reported activities of commissioning officers within local authorities. Dementia services and their associated commissioning procedures, as described within the survey, were not observed independently or verified by other means, consequently social desirability could lead to the over reporting of perceived 'good practice'. Secondly, the study did not identify how specialist services for people with dementia differ from generic services, offered to all older people, including those with dementia. Thirdly, the analysis is considered descriptive in nature, identifying likeness across authorities with modest differences between cluster groups evident. Although statistical criteria were used to assess cluster membership, errors in classification can occur in such explorative analysis. Fourthly, the data were collected in 2015 and potential modifications in commissioning practice in subsequent years must be considered, and this, along with the relatively small number of measures used in the classification, influences the robustness of cluster memberships. Despite this, the study has established distinct and various approaches to the commissioning of services to support those with dementia living at home. Effective home support requires that the needs of people with dementia are reflected at both the strategic and individual levels of commissioning so that activities at the level of practice are undertaken in relation to broader resources and agency level activities [12]. In this study, local authorities exhibited modest differences in terms of the configuration of their commissioning arrangements both at the organisational strategic and individual service user levels of commissioning, highlighted in the cluster analysis. These are explored in more detail below.

Commissioning to meet individual needs

In this study, the commissioning of services to meet the specific needs of older people, including those with dementia, at the individual level is apparent. Most authorities include care planning and support activities within their overall commissioning arrangements, however, the cluster analysis reveals a group that this is absent (Table 2, Cluster C). These care planning and support activities, core tasks within care management for older people, involve the negotiation of services between service users, carer and provider agencies. More recently, with the intention to provide a more personalised service with a more flexible response to need, service users and their carers have the opportunity to take more control in the planning and organisation of their own [10] via self-direct support and personal budgets. This has the potential to increase the complexity of commissioning at the operational level [13]. However, it has been suggested that, particularly for older people with dementia, there will be a preference to minimise their responsibility in decisions regarding the purchasing of services and equipment and the creation of complex care packages [14]. In this context, the responsibility for care planning and support activities for individuals with dementia will continue to lie with care managers [12].

Strategic commissioning arrangements

Some evidence of strategic commissioning of dementia specific services was evident. However, the cluster analysis highlighted variation in extent to which to which this was undertaken, particularly in terms of the joint commissioning of services with health partners. This was illustrated in Table 2 (Cluster A compared to Cluster D). The importance of involving health organisations to improve the commissioning of social care services has long been recognised [15]. Successive legislation and guidance [16; 17; 10] has required NHS organisations and local authorities to increase their partnership working and it is now a statutory duty, facilitated by the introduction of flexibilities to promote joint working. Joint commissioning has been identified as a means to ensure better outcomes for populations in an area [10]. The importance of this for people with dementia has been articulated previously [18]. Historically it has been noted that despite the volume of policy and guidance attempting to increase and improve joint working only limited progress has been made [19]. However, this survey provides more recent evidence of joint commissioning in respect of services for people with dementia (see Table 1). Furthermore, potential links between joint commissioning and the provision of a higher number of specialist services was suggested (Table 3, Cluster A). Nevertheless, organisational arrangements such as joint lead commissioners or the pooling of budgets was less apparent, confirming previous research relating to services for people with dementia [20].

Specialist services for people with dementia

There is little evidence of a shared understanding of the form and content of specialist services for people with dementia. Within this survey *specialist* services were defined as those offered only to people with dementia, *generic* services were available to all older people. However, the nature in which these two service types differed, other than service user group targeted, was not specified. In terms of specialist services, care delivered within the home was the least reported with respite care and day care, services provided outside the home, were the most frequently reported (Table 3). In other research, specialist day care has been identified also by activities (sensory activities, such as ball games) and diet (high calorie food, soft in texture) [21]. Similarly, care delivered within the home has been characterised as available only to those in the later stages of dementia and providing care reflecting care specific to the condition (e.g. in support of therapeutic goals, such as the reduction of problem behaviours) around the clock as required [12]

It has been suggested that commissioning arrangements should promote such diversity in service provision [22]. In this study there was also no evidence of a link between the availability of specialist services and different approaches to commissioning (Table 3). It may be that how services are commissioned is less important than the manner in which they are delivered. An appropriately skilled and trained workforce is vital in the delivery of specialist care for people with dementia living at home with their carers. In residential settings training has been shown to improve a carer's knowledge of the disease and increase their confidence to manage the challenging behaviours associated with the condition [23]. However, it has been reported about half of people affected by dementia thought that home carers were not adequately trained to understand their specific needs and that a third have not received appropriate training [24].

Conclusion

This typology suggests that joint working between health and social care organisations results in a greater range of services specifically for people with dementia, complementing services available to all older people. However, the joint commissioning of services is not widely reported in this study.

Nevertheless, as the population with dementia ages and physical health needs increase joint commissioning of services for people with dementia and their carers will become increasingly important, informed by the experience of existing service users and their support planners. This will be important in the provision of tertiary prevention, ameliorating difficulties and enhancing well-being, for people with dementia in achieving the goal of living well [24]. Given the study has identified different approaches to commissioning, future work could examine the extent to which this affects outcomes for patients and their carers.

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Tables/Box

Table 1: Joint commissioning between social and health care services (N=114)

	Dementia specific services n(%)	Generic services n(%)	*P*-value
Joint plans and planning processes	59 (52)	75 (66)	0.00
Joint specification and overseeing of contracts	37 (33)	54 (47)	0.00
Single lead commissioner for health and social care	23 (20)	33 (29)	0.00
Pooling of ring-fenced monies	15 (13)	28 (25)	0.01
Pooling of total agency budgets	10 (9)	8 (7)	0.00

Table 2: Commissioning arrangements for home support for people with dementia (N=100)

Level	Measure	Total sample (N=100)	Cluster A (n=23)	Cluster B (n=34)	Cluster C (n=16)	Cluster D (n=27)
Individual	Care planning and support	74 (74.0%)	23 (100%)	34 (100%)	0 (0.0%)	17 (62.9%)
Strategic	Jointly commissioning services	27 (27.0%)	23 (100%)	0 (0.0%)	4 (25.0%)	0 (0.0%)
	Non-statutory sector contribution	65 (65.0%)	16 (69.6%)	34 (100%)	15 (93.8%)	0 (0.0%)
	Premium for dementia services	29 (29.0%)	6 (26.1%)	13 (38.2%)	2 (12.5%)	8 (29.6%)

Table 3: Types of dementia services[1] by cluster (N=100)

	Total sample (N=100)	Cluster A (n=23) n(%)	Cluster B (n=34) n(%)	Cluster C (n=16) n(%)	Cluster D (n=27) n(%)	*P*-value
Specialist care planning and support	31(31)	11(50)	9(27)	4(27)	7(26)	0.22
Respite care	83(83)	22(96)	27(82)	14(88)	20(74)	0.21
Day care	81(81)	19(83)	29(89)	14(88)	19(74)	0.31
Family placement	43(43)	9(39)	17(52)	6(38)	11(41)	0.72
Care at home	28(28)	8(35)	4(25)	11(32)	5(19)	0.55
Telecare/assistive technologies	63(63)	18(78)	21(64)	9(56)	15(56)	0.53
Hospital discharge services	51(51)	16(70)	17(52)	5(31)	13(48)	0.12
4 or more services	47(47)	18(78)	11 (34)	7(44)	11(41)	0.04*

[1] either commissioned jointly by health and social care agencies or solely by the latter

*p< 0.05

Table 4: Local area characteristics of clusters (N=100)

	Cluster A (n=23)	Cluster B (n=34)	Cluster C (n=16)	Cluster D (n=27)	*P*-value
Mean population size (0,000)	28.3	39.5	34.1	42.5	0.22†
Mean proportion of rural population (%)	16.07	25.13	10.85	17.99	0.22
Mean proportion of population ages 65 or over (%)	15.47	16.89	16.77	17.44	0.18
Mean IMD rank of average score	72.83	78.59	75.00	87.22	0.65
Mean income deprivation rank of older people score	74.09	83.82	74.75	87.30	0.56
Mean proportion of population BME (%)	16.3	11.8	9.9	11.5	0.30
Political control (%)					
Labour	34.7	55.9	56.3	40.1	
Conservative	26.1	32.4	31.3	37.0	0.39
Liberal Democrat	0.0	0.0	0.0	3.7	
No overall control	39.1	14.7	12.5	18.5	

†Brown-Forsythe test applied as assumption of homogeneity is not met.

Box 1: Dominant cluster characteristics with exemplars

Cluster A–All five of the specified dementia specific services (home care workers, telecare and assistive technologies, occupational therapists, overnight respite care and day care) were commissioned jointly, reflecting the distinguishing feature of this cluster group as a whole. In the exemplar authority, commissioning practices were also linked to individual service plans and a premium price was not paid for the provision of dementia specific home care.

Cluster B- Lower numbers of jointly commissioned services were evident within this cluster group, with an average number of 1.5 services jointly commissioned. In the exemplar authority, the single jointly commissioned service was telecare and assistive technologies for those with dementia. Services from the non-statutory sector (e.g. respite care) were commissioned. Commissioning practices were linked to individual service plans and a dementia premium was not paid for the provision of home care.

Cluster C- Few dementia specific services were jointly commissioned with health partners, the average number was 1.8 within this cluster group as a whole. In the exemplar authority, two dementia specific services were jointly commissioned (overnight respite care and day care). Commissioning practices were not linked to individual service plans and a premium price was not paid for the provision of dementia specific home care.

Cluster D- The distinguishing attribute of this cluster group was the absence of services from the non-statutory sector (e.g. respite) in the provision of dementia specific services. Joint commissioning with health was also least evident within this group with the lowest average of 1.4 dementia specific services. In the exemplar authority, none of the dementia services were jointly commissioned with health partners, commissioning practices were linked to individual service plans and a dementia premium was not paid for the provision of home care.