



## Work Stream 2 – tracer short report: Dementia Services (Understanding the new commissioning system in England: contexts, mechanisms and outcomes)

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### **Citation for published version (APA):**

Hammond, J., Hall, A., & Checkland, K. (2017). Work Stream 2 – tracer short report: Dementia Services (Understanding the new commissioning system in England: contexts, mechanisms and outcomes).

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## Understanding the new commissioning system in England: contexts, mechanisms and outcomes

### Work Stream 2 – tracer short report: *Dementia Services*

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#### Introduction

The aim of this project is to understand the development of the commissioning system in England following implementation of the Health and Social Care Act 2012 (hereafter ‘HSCA12’). An initial phase of data collection (March – December 2015) used interviews and observation to develop an overview of the functioning of the new commissioning system. The second phase of the project (November 2015 – March 2017) built upon these findings, focusing in upon five different service area (‘tracers’) in order to explore in more depth the issues arising in different contexts. This report summarises the findings of our exploration of the commissioning of dementia services. This ‘tracer’ was chosen because of its potential to shed light on the development of integrated services between health and social care since the needs of people living with dementia and their informal carers typically span both sectors, and their care requires effective coordination of health and care services.

Dementia is a general term for a number of diseases of the brain that have common symptoms, including problems with thinking, memory, language, and co-ordination. The most common cause is Alzheimer’s disease, accounting for around two-thirds of all cases. Although it is not an inevitable part of ageing, age is a risk factor: dementia affects around one in 14 people over 65, and one in six people over 85. It is progressive, and in the later stages people are highly dependent upon health and social care support as their care needs become increasingly complex. Pharmacological treatments may help lessen some symptoms in the early stages, but there is no effective cure. There is increasing focus upon non-pharmacological intervention (e.g. cognitive therapies; assistive technologies; social support) to help people to live as well as possible for as long as possible. For a detailed overview, see the Alzheimer’s Society dementia guide (Alzheimer’s Society, 2017).

In the last decade there has been increased global and national policy focus upon dementia, underpinned by widespread acknowledgement that there are dramatically increasing numbers of people with dementia. For the UK, figures commonly cited in recent years have suggested that there are around 800,000 people with dementia, projected to double by 2040, with overall costs to the economy of around £23bn expected to triple within the same timeframe (Parker & Baker, 2016).<sup>1</sup> The complex and diverse care needs of rising numbers of people with

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<sup>1</sup> This picture has been challenged by recent work highlighting that such projections have been based on 1980s epidemiological data, and that more recent data suggest prevalence rates (the proportion of the population with dementia) may be stabilising because of overall improvements to people’s health in early and middle life. This alternative position may be difficult to reconcile with the prevailing narrative: “Catastrophic estimates of dementia in future ageing societies serve present political and charity campaigns, and encourage investment into pharmaceutical and health-care industries, maintained by sustained attention of social and general media. Scientific evidence needs to match this excitement to continue to secure research funding and resources” (Wu, et al., 2016).

dementia place increasing demand upon health and social care organisations, as well as unpaid carers (usually relatives). The NHS provides diagnostic services, ongoing assessment, and may fund post-diagnostic social care; otherwise social care is provided by local authorities (LAs) or is self-funded (NHS Choices, 2015); there is also a key role for the third sector in providing information and additional support services. Increasingly, these organisations are encouraged to work in an integrated manner.

In order to understand the impacts of the HSCA12 upon the commissioning of dementia services, it is necessary to consider the Act as part of a broader array of policy initiatives relating to dementia services and to the integration of health and social care. In the following section, we provide a brief summary of major policy initiatives relating to these two areas. For more detail, see the House of Commons Library briefing papers on dementia policy (Parker & Baker, 2016) and health and social care integration (Bate, 2017) respectively.

### **Dementia and integrated care: siting the HSCA12 within a broader policy landscape**

Specific focus upon dementia began in earnest in 2006 with the first **national clinical guideline** on the care and support of people with dementia and their carers (NICE, 2006). This included emphasis upon integrated working amongst diverse health and social care organisations. In 2007, the Labour government announced its intention to make dementia a national priority via the development of the first ever **National Dementia Strategy** (Department of Health, 2009), which contained three broad aims: (i) to increase awareness and reduce stigma; (ii) to increase diagnosis rates; and (iii) to enhance post-diagnostic services. Following the 2010 general election, the Coalition government demonstrated continuing commitment to these aims through the **Prime Minister's Challenge** (Department of Health, 2012). With the Alzheimer's Society, the government also launched the **Dementia Friends** initiative in 2012, to help develop dementia-friendly communities through mass roll-out of dementia awareness training within workforces of community organisations. Dementia has also informed the remit of Public Health England (PHE), the executive agency of the Department of Health created by the HSCA12 to oversee national health and wellbeing. PHE lent its support to the Dementia Friends initiative and has made **dementia risk reduction** one of its seven priorities (Public Health England, 2014).

These dementia-specific initiatives form part of a broader context of initiatives to support the integration of health and social care, beginning with the Health Act 1999 which enabled the NHS and LAs to pool budgets. The HSCA12 introduced statutory Health and Wellbeing Boards, subcommittees of LAs, to act as key co-ordinating mechanisms or stewards for local health and social care systems. The HSCA12 was introduced in the midst of a number of spending reviews which all announced **initiatives to integrate budgets**, most notably the £5.3bn Better Care Fund (implemented from 2015/16) to create pooled budgets between LAs and NHS Clinical Commissioning Groups (CCGs), signed off by Health and Wellbeing Boards.<sup>2</sup> The Care Act 2014 created the legislative basis for the Better Care Fund (Department of Health, 2016), and pronounced statutory requirements for LAs regarding social care, including an obligation to support carers. There have also been **initiatives for organisational integration**. The Five Year Forward View (FYFV) (NHS England, 2014) included emphasis upon the integration of health and social care services through 'new care models.' These include 'integrated care pioneers' primarily aimed at improving user and carer experiences of services, and 'vanguards' in 50 local sites testing a number of different models to improve co-ordination of community and/or

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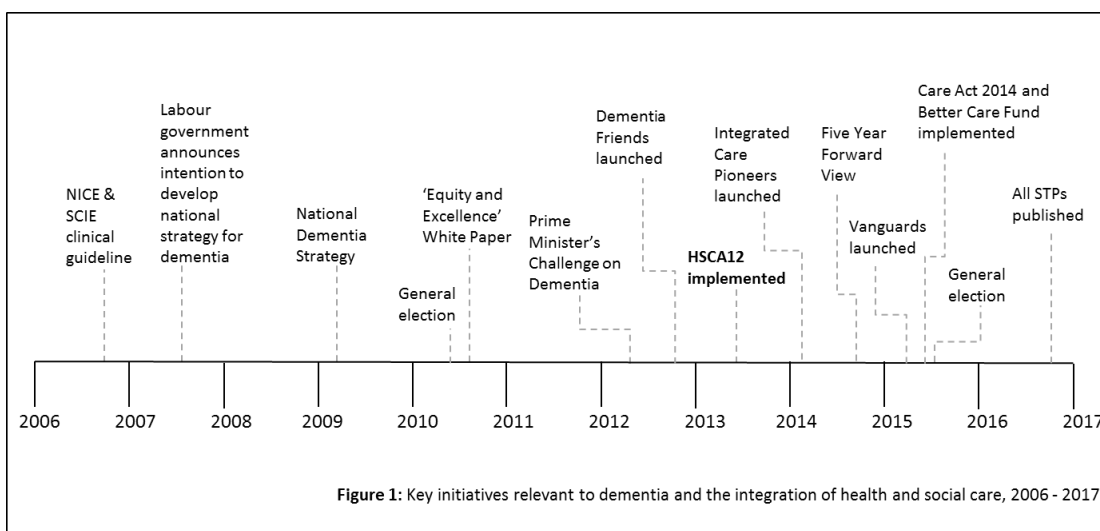
<sup>2</sup> Figures cited for the total value of the Better Care Fund are either £3.8bn or £5.3bn: the initial policy framework published in 2014 stated that the total would be at least £3.8bn, which then rose to £5.3bn as CCGs and LAs pledged increased contributions at the local level (Department of Health, 2016).

hospital services. Implementation of the FYFV is to be supported by Sustainability and Transformation Plans (STPs) covering 44 areas across England (NHS England, 2017). Each STP outlines a vision for integrating health and social care within its footprint from April 2017 to March 2021, with funding to be allocated from a £2.1bn Sustainability and Transformation Fund. STPs have no statutory basis and require a willingness from multiple stakeholders to cooperate.

This brief exploration of the policy landscape shows that there is **no specific, novel programme theory (Weiss, 1998) within the HSCA12 that underpins any explicit changes to the commissioning of dementia services. The HSCA12 also did not give much specific attention to the integration of health and social care.** Figure 1 below shows a timeline illustrating key relevant initiatives since 2006, highlighting where the HSCA12 sits in relation to other initiatives. It shows that the commissioning of dementia services is influenced by longer-standing initiatives around dementia and integration that span at least a decade. These two strands of policy initiatives contain their own programme theories, which may be summarised at a broad level as:

- The programme theory underpinning dementia-specific initiatives is founded upon the main aims of the National Dementia Strategy, and may be thought of as one of linear logicity: a clear and widespread conception of ‘dementia’ as a discrete condition, and a better understanding of its challenges, will result in more appropriate and effective preventive and supportive interventions because of increased attention, knowledge and information-sharing.
- The programme theory underpinning integration initiatives holds that integrating NHS and local authority services will result in the patient being placed at the heart of care, enhancing clinical outcomes, patient experience and value for money, because of a range of mechanisms to integrate budgets and ways of working.

The relevance of the HSCA12 to dementia services commissioning has been to place primary care clinicians at the heart of commissioning through the creation of CCGs, and to introduce (either directly or indirectly) of a number of mechanisms (such as Health and Wellbeing Boards and the Better Care Fund, which added democratic oversight) to support integration of care.



## **Dementia ‘tracer’: approach and findings**

In order to explore the impact of the HSCA12 upon dementia services commissioning, we undertook extensive reading of relevant policy and other documents, and conducted interviews with a range of commissioners and service providers. These comprised the 78 interviews in Work Stream 1 (involving individuals from CCGs, NHSE, and LAs), and subsequent, more detailed Work Stream 2 interviews with nine individuals from LAs, CCGs, and third sector organisations, in two English Areas, which correspond to NHSE Area Team footprints (as originally conceived).<sup>3</sup> Data analysis was iterative, with the findings from the emerging analysis informing later interviews.

- **Area 1** is a socio-economically diverse metropolitan county with a population of over 2.5 million and a large city at its core.
- **Area 2** is a highly ethnically and socio-economically diverse metropolitan county with a population of over 1.25 million and a large central city.

This report presents findings organised into two overarching themes: (1) The impact of CCGs upon dementia services, and (2) Mechanisms for integrated working.

### **Theme 1: The impact of CCGs upon dementia services**

One joint commissioner of dementia services in an Area 2 locality felt that the **creation of CCGs as discrete organisations had led to fragmentation** and variability in service provision:

“before where you could talk to one PCT and they would broker arrangements with other PCTs, now you have to speak to each CCG separately... so I’ve had to [develop] business cases by CCGs... it means that it can be a postcode lottery”  
[16450, CCG, Area 2, Oct 2016]

One senior CCG member in Area 1 reflected that joint working between CCGs and LAs around dementia commissioning was more influenced by a **local history of joint working** than the creation of CCGs directly, highlighting the absence of specific attention in the Act to integrated working:

“there’s a history of working like that together and I don’t think the Act has particularly catalysed it or impeded it... you could argue that the Act has helped because now we’ve got clinicians driving more of that commissioning... [who] see the unintended consequences of reductions in local government expenditure... but frankly my view is that that’s just a pragmatic response to where we are anyway” [18967, CCG, Area 1, Jan 2017]

Participants offered **reflections about opinions of primary care clinicians on national targets for diagnosis rates, and the impact these opinions had on commissioning**. Work stream 1 data suggested that in one locality within Area 2, there was reluctance amongst some clinicians to diagnose because of a perceived lack of post-diagnostic social care services [6814, CCG, Area 2, Sept 2015]. However, data from work stream 2 suggested that historic attitudes to dementia amongst clinicians in this CCG appeared to be changing over time:

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<sup>3</sup> Area Teams were absorbed into the four existing regional teams when NHS England was reorganised in April 2015.

“you still get people at a strategic level that think what is the point of commissioning services for people with dementia [because there is no cure]... [however] we are building up a generation of newer GPs that are coming on board with it” [16450, CCG, Area 2, Oct 2016]

Similarly, work stream 2 data from an Area 1 CCG revealed that the drive to increase diagnosis was seen as an essential first step in supporting people with dementia:

“we have very high diagnosis rates, and that’s because I think the majority of our clinicians recognise that the only way to start to deal with some of these issues is to know that they exist... there’s a whole range of different support [services] available” [18967, CCG, Area 1, Jan 2017]

One commissioner in Area 2 expressed frustration with an apparently high level of influence that GPs held within the CCG (“the one thing the CCG will listen to is clinicians”), and feared that this influence was unquestioned by members of an older generation:

“people with dementia and their carers, they’re old people that won’t ask for anything, they’re grateful for whatever they get, so if the GP says there’s no services for you, they will believe the GP” [16450, CCG, Area 2, Oct 2016]

The prominent role for clinicians in shaping the commissioning and awareness of dementia services may have resulted in these services being viewed through the lens of a **medical model rather than a social model of care**. This was exemplified by one dementia services joint commissioner in Area 2, reflecting on an information event she had arranged for GPs:

“[a family carer speaking at the event] was telling these GPs that how going to a carers’ group for two hours every two weeks kept her going for four years looking after her dad with dementia, and around the room there was this sharp intake of breath... she didn’t want anything else, she just wanted to be able to talk to somebody, but how do you get that across when all they’re interested in is measurables?” [16450, CCG, Area 2, Oct 2016]

This quote suggests that the medical model may hold influence because it is more **amenable to discrete measurements** required by **national CCG Improvement and Assessment Framework indicators** (NHS England, 2016). One of these indicators is the proportion of people with dementia whose care plans have received an annual review. One commissioner in Area 2 was sceptical of the appropriateness of this indicator for service improvement, suggesting that it did not capture more holistic aspects of social support:

“the government rate CCGs based on a 12 month annual review that GPs have to do with a care plan... we have these workers that spend all their time with people in the first diagnosis but that’s not included... there’s a lot of tick-box stuff... they’re looking in the wrong place for signs of improvement.” [19314a, CCG & LA, Area 2, Feb 2017]

One CCG participant in Area 2 highlighted how the need to commission dementia support services at a broad social level was felt to be a very different type of commissioning than the traditional commissioning of medical services:

“There’s a massive amount of anxiety [about dementia] but there’s nothing we can do about it. So that’s about organising society at a system level to cope with the impacts of cognitive impairment in old people. How the hell do we support people and carers to deal with that phenomenon in society? That’s a completely different type of commissioning, that’s involving engaging and talking to people, partnership working” [6010, CCG, Area 2, Aug 2015]

There were questions about the amount of resources commissioners would be able to allocate to dementia services in a milieu of competing performance management priorities, although in December 2016 in Area 1 it seemed that there had been improvements in recognition of dementia services:

“the CCG as commissioners have obviously only got a finite amount of money... if you’ve got another condition that they’re really not performing well with, why would they put the money against dementia... that was quite noticeable when there was a review done of [all Area 1] locality plans, albeit it was very early days and I think locality plans have become much more sophisticated now” [18216, Service provider, Area 1, Dec 2016]

The impact of primary care clinicians as influential agents seemed to have been recognised by a prominent **third sector** organisation, which sought to **present its offers of service in ways that might appeal to GPs**:

“we’ve worked very much in selling the service to GPs as a treatment, part of your treatment plan, so speaking their language” [17945, Third Sector, Area 2, Dec 2016]

Another third sector participant from Area 1 pointed to some confusion about **how far the third sector was seen to be a viable option**:

“because of the awareness of dementia there’s much more open door... [but] there’s still a little bit of that ‘we can’t work with the voluntary sector because we’d be recommending your services and we can’t do that’” [17946, Third Sector, Area 1, Dec 2016]

Reasons why CCGs may show some reluctance to engage with the third sector were unclear, but CCG participants in both Areas highlighted some challenges in working with the sector. Some felt that a prominent national organisation may have **lacked flexibility in a financially competitive environment** and that **its service offers may not have been tailored to local needs**:

“[National dementia organisation] are very much stuck in ‘we want to provide you with these two roles... because it’s our national branding’... a lot of CCGs and commissioners just give them money because it’s [name of organisation]... they couldn’t understand why they weren’t winning any of our contracts and it’s because they don’t compete anywhere else” [19314a, CCG & LA, Area 2, Feb 2017]

“let’s take the concept of the dementia support worker but let’s understand is that a concept that has been sold by [national dementia organisation] or does it have viability in a world where we’ve got lots of competing layers of resource?... [we came to] a view that there would be some things that we could do collectively across [Area 1], but that did not include the concept of the dementia support worker” [18967, CCG, Area 1, Jan 2017]

Other challenges included a **lack of cross-sector cohesion**:

“the voluntary sector needs to better connect together to have a standard offer that it puts to commissioners... that requires a maturity of leadership that often isn’t there in these organisations because they’re run by volunteers a lot of the time, and understandably they’re thinking about their own back garden as opposed to thinking about how can we work with that [other third sector] organisation next door” [18967, CCG, Area 1, Jan 2017]

In Area 2, one participant from a LA highlighted a mechanism to encourage recognition of the third sector through synchronising operating procedures:

“the standard operating procedures [the third sector use] aligns to what the health service would use... because we want to ensure that when we’re referring or encouraging the sector to be used that we are confident what they’re delivering will meet NHS requirements” [19314b, LA, Area 2, Feb 2017]

In summary, this theme highlights a number of issues arising from the creation of CCGs. CCG participants offered mixed reflections about the value of national targets for diagnosis rates. The influence of primary care clinician opinion appeared to lean towards viewing dementia through a more medical model, which was amenable to discrete measurement demanded by performance indicators. There was uncertainty about how far the third sector was integrated into the dementia care system.

### **Theme 2: Mechanisms for integrated working**

**Health and Wellbeing Boards** became fully operational in April 2013, but in work stream 1 interviews, around two years after the introduction of the Boards, some participants seemed **uncertain about their functionality**. One Area 2 CCG member suggested that its Board was “a bit fluffy and overly strategic without real clarity as to how it’s going to achieve what it wants” [6165, CCG, Area 2, Aug 2015], and a member of an Area 1 LA was uncertain how their Board might fulfil a different role from existing LA structures of governance [6167, LA, Area 1, Aug 2015]. However, one participant from a different Area 1 LA identified how they took turns biennially with their CCG in chairing the Health and Wellbeing Board, in order to create a shared endeavour [7033, LA, Area 1, Sep 2015].

There appeared to be established mechanisms for integrated working between CCGs and LAs around dementia services. One CCG member cited a joint “dementia steering group” but highlighted challenges arising from differences in ways of working between the CCG and the LA:

“we talk about the dementia steering group where the local authority is represented... but there’s a lot of distrust between the two organisations from a financial perspective and I think also from a, kind of, understanding of the different ways we commission... even the language is different in terms of what



things mean... we've had services disinvested from the local authority with short notice... the CCG has picked up the tab a few times... working with colleagues in the CCG, if I say something and they disagree with it, they'll be quite honest... with the local authority, that doesn't come through... they'll have to talk to their boss and their boss will have to talk to their boss... it's just a very different way of working" [3391, CCG, Area 1, May 2015]

Another CCG member referred to a "fully integrated commissioning team":

"The team under which dementia is commissioned is a fully integrated commissioning team between the city council and the CCG... managed by a director of integrated commissioning who reports both to me and to the director of adult and child social services in the city council" [18967, CCG, Area 1, Jan 2017]

However, in work stream 1 interviews many participants referred to Section 75 of the NHS Act 2006, which permitted pooled budgets between LAs and the NHS, as a facilitator of integrated working (e.g. 3665, CCG, Area 1, May 2015; 10071, LA, Area 2, Nov 2015). Others reflected that similar arrangements to Health and Wellbeing Boards had been in place prior to the HSCA12 (e.g. 6775, CCG, Area 2, Sept 2015). Therefore, **it was unclear how far integrated working regarding dementia services was influenced by the Health and Wellbeing Boards created by the HSCA12.**

One CCG member felt that the **Better Care Fund was a potent mechanism for integrating care** [5732, CCG, Area 2, Aug 2015]. National Audit Office analysis published at the time of writing this tracer report stated that the Better Care Fund has not yet achieved its potential, but has been successful in incentivising local areas to work together (National Audit Office, 2017). The Fund appeared to result in commissioners **parcelling dementia services up within broader social care programmes for older adults, and there were mixed perceptions about whether or not this would help or hinder the availability of dementia services.** In Area 2, one joint commissioner suggested that it might help to increase dementia services [16450, CCG, Area 2, Oct 2016], but a third sector participant expressed a preference for dementia services to be commissioned discretely [17753, Third Sector, Area 2, Dec 2016].

Participants from two CCGs in Area 1 highlighted how the Fund seemed to have helped **develop relationships between CCGs and LAs**, and navigate reciprocal impacts of financial decisions [4785, CCG, Area 1, Jul 2015; 4721a, CCG, Area 1, Jun 2016]. Similarly, a participant from an LA in Area 1 suggested that it helped the LA consider its joint working with the local CCG [8247, LA, Area 1, Nov 2015]. However, one CCG member in Area 1 expressed some **uncertainty around governance** because the Fund was primarily an LA responsibility that seemed to be "working slightly without the CCG in practice" [3391, CCG, Area 1, May 2015]. Another participant from an Area 2 CCG felt **that the Fund had not been able to ease tensions between the CCG and the LA:**

"there's an uneasy relationship between the CCG and some elected members because they politically disagree with the way the government has restructured the NHS... we've really committed resource to [the Better Care Fund], so we've put £[X] million into [name of locality] alone to directly cross-subsidise adult social care this year... [but] that relationship, despite that, actually still feels uneasy" [6010, CCG, Area 1, Aug 2015]

Work stream 2 interviews suggested that financial disparity inherent to Better Care Fund contributions led to persistent friction which might threaten joint working:

“I feel there’s an increasing divide between the council and the CCG because of the Better Care Fund contributions... traditionally the CCG has put in quite a lot and not seen an awful lot for it and I think the CCG kind of wants that back now... there’s a lot of unpleasantness... I’m not even sure that joint commissioning will continue” [19314a, CCG & LA, Area 2, Feb 2017]

From the outset, one locality in Area 1 had used its Fund allocation as a **contribution to a greater pooled budget for elderly care**, which was believed to be a rare innovation compared to most of the country [3772, CCG, Area 1, May 2015]. This possibly challenges the status of the Better Care Fund as the principal mechanism for integrating care, as the contribution specific BCF funding had made to this pooled budget was relatively small. Around a year after the introduction of the Fund, a member of another Area 1 CCG reflected that its locality should also have pooled budgets to a greater extent, but also seemed to suggest that the public might find the increased level of risk to be unpalatable:

“I think the Better Care Fund is a bit of a distraction because it was a small amount of money and we spent loads of time on it and actually what we probably need to start really thinking of is, just pool our budgets and that will come with the risks that it comes with, but there’s then a story to the population about how we really allocate and manage our budgets.” [4519, CCG, Area 1, Jun 2016]

Two participants reflected that **the Fund was a nebulous concept**, describing it as a “cash shunting process” [19313, LA, Area 2, Feb 2017] with some “smoke and mirrors” [18967, CCG, Area 1, Jan 2017] creating a disingenuous image of a completely new resource.

At the time of writing this tracer report, the leading mechanisms identified for integrated working are **Sustainability and Transformation Plans (STP)**. The relationship between STPs and the Better Care Fund was unclear; one participant from an Area 2 CCG expressed strong opinions that a focus on **dementia and the Better Care Fund had not been integral to STP development**:

“we thought [the STP] was going to be built on the BCF [Better Care Fund] and things like dementia would be in there, but they’ve done all their planning and it’s only in the last couple of weeks that we’ve been saying hang on a minute, you’ve got to include the BCF stuff [16450, CCG, Area 2, Oct 2016]

This lack of focus likely reflects the fact that STPs have been driven by the FYFV and the NHS, whereas the Better Care Fund is a joint venture between LAs and the NHS. This participant also expanded on her frustrations at the perceived primary care clinician influence highlighted earlier, suggesting that “if [name of clinician] gets a role [in the STP] then dementia will be important... if it’s not him, there are no other clinicians in the city that are interested” [16450, CCG, Area 2, Oct 2016]. This highlights the important influence that interested individuals can have on areas of service.

One participant in Area 2 who was employed in a joint post between a coterminous LA and CCG highlighted an **inherent tension for STPs comprised of smaller localities that may have incompatible needs**:

“the [#] areas of [name of STP footprint] have got different needs... locally the council is very clear about us having its one CCG to work for the [name of town] population... it’s not in the council’s interest to want its commissioners to suddenly only work for [name of STP footprint] and not just in [name of town]” [19314a, CCG & LA, Area 2, Feb 2017]

This extract highlights the lack of involvement of LAs in the development of STPs, which has been highlighted elsewhere (Local Government Association, 2017). This participant also stated “I’m not employed to work for an STP and I don’t intend to”, foregrounding a potential challenge for STPs arising from their lack of statutory footing compared to LAs and CCGs.

In summary, this theme shows that integrated working around dementia services predated the HSCA12. The relationship between dementia services and Health and Wellbeing Boards was not entirely clear, and the Better Care Fund was generally perceived as a superior mechanism for integration. It was seen to be useful for helping develop relationships between CCGs and LAs, although there could be tensions due to their imbalanced financial contributions. There was some confusion that the name ‘Better Care Fund’ erroneously implied that the Fund was new money. Dementia was not always included within STPs and there could be some tensions for STPs comprised of localities with apparently mutually incompatible needs.

### **Summary**

The HSCA12 was implemented in the midst of a number of initiatives which were focused either specifically upon dementia services or upon integrating health and social care. Across both Areas 1 and 2 there was a broadly similar picture in which:

- CCG participants offered mixed reflections about the value of national targets for dementia diagnosis rates, which appeared to relate to understandings about the availability of post-diagnostic support
- The power of primary care clinician interest in determining resource allocation towards dementia was particularly highlighted in one locality of Area 2
- Dementia may still be viewed through more of a medical model than a social model of care, perhaps in part because of the measurements demanded by national performance indicators
- The third sector appears to have a key role to play but the extent to which it is perceived to be a full member of the dementia care system is variable and unclear
- The influence of Health and Wellbeing Boards on integrated working in dementia services was unclear
- The Better Care Fund has generally been perceived as useful for helping develop relationships and joint working between CCGs and LAs. However, CCGs contributed a greater proportion of the money, and this disparity seemed to be foregrounded in situations where there were existing uneasy relationships between the CCG and the LA
- There is some confusion that the name ‘Better Care Fund’ misleadingly implies that it was an entirely additional resource
- In Area 2 there were concerns that dementia was not included within STPs, and some tension for STPs comprised of smaller localities that may have incompatible needs.

## **Actionable messages**

This tracer report has highlighted that dementia services commissioning is influenced by over a decade of policy initiatives focusing specifically on dementia, and more broadly on integrating health and social care. Specifying the direct impacts of the Health and Social Care Act 2012 from within this broad policy context is difficult. The influence given by the Act to primary care clinicians may result in some tensions between medical and social models of dementia care. There may also be challenges in implementing mechanisms to help join together health and social care. The evidence highlights the need for:

- Simplification and clarification of mechanisms for joint working and commissioning of dementia services between CCGs and Local Authorities
- Further consideration of how to integrate the third sector into the dementia care system as a whole
- Greater focus upon dementia services within STPs, but with recognition of existing work within localities of the STP.

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### **Disclaimer**

This research was funded by the Department of Health via the Policy Research Programme. The opinions expressed represent those of the authors, not the Department of Health

### **Acknowledgements**

We are grateful to our participants, who were generous with their time and who tolerated repeated requests for clarification and elucidation. We would also like to acknowledge the significant contribution of the research team: Dr Anna Coleman, Professor Matt Sutton, Mr Tom Mason, Professor Pauline Allen and Professor Nick Mays.