THE ROYAL BOROUGH OF KINGSTON UPON THAMES

Royal Borough of Kingston

Adult Social Care

Market Position Statement

2016-2017

Contents

Introduction

This Market Position Statement (MPS) is designed to share information and analysis of interest and benefit to providers of care and support in the Royal Borough of Kingston upon Thames (RBK).

The aim is for this MPS to be used to continue the dialogue with providers about the direction of travel for care and support which will meet the needs and aspirations of local people now and in the future, and how together, we can create a vibrant market that promotes independence, dignity and choice.

Kingston Council and Kingston Clinical Commissioning Group (CCG) recognise that care and support providers are an important source of intelligence about the size, capacity and characteristics of the local market. We want service providers to utilise their knowledge and experience to think creatively about future business models and develop new and innovative solutions which can best respond to changes in the market. This MPS also offers an opportunity for commissioners to build a constructive and enabling relationship with care and support providers, and sets out our intention to encourage the development of a diverse range of flexible and sustainable service options which deliver quality value for money solutions.
This MPS therefore contains key information about:

- **Population demand**
- **The current configuration of care and support services**
- **The envisaged direction of future procurement and consideration as to how the market will need to develop to provide the range and level of support that will be required**

Kingston population

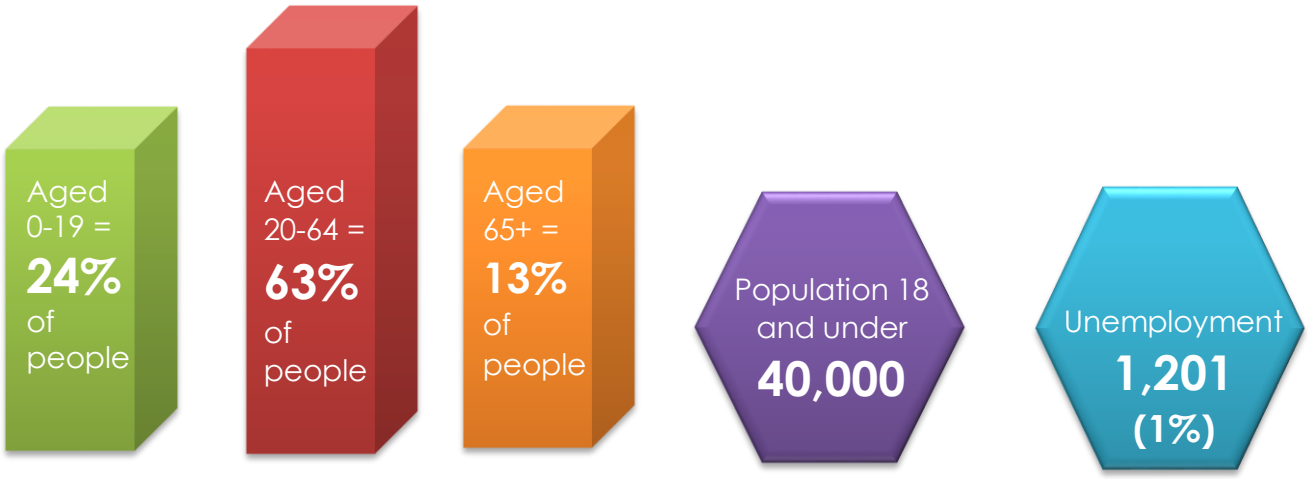
The Royal Borough of Kingston upon Thames is located in South West London and shares borders with Wandsworth, Richmond, Sutton, Merton and Surrey. It has the third smallest population of any borough in London (apart from the City of London and Kensington and Chelsea) and is the seventh smallest borough in terms of geographical area.

Since 2001, Kingston's population has grown from a starting point of 149,000 by over 13% and is predicted to grow by a further 7% to 181,000 by 2025, and by a further 3% to 186,200 by 2035. Furthermore, with the post-war baby boom of the 1940s to 1960s combined with the fact that life expectancy in Kingston is above the national average, the number of people aged over 75 in the borough is set to rise 44% by 2035.

Key Facts about Kingston

Kingston Population estimated 173,525 (2015)

Age Profile



Life expectancy in Kingston upon Thames

81 years for men

84 years for women

Average House Price **£461,587**

http//data/London.gov.uk/dataset/average-house price

Housing and Household estimated **63,639** (households in the borough in 2011 Census)

71% of dwellings were owned in 2001

64% of dwellings were owned in 2011

DEPRIVATION

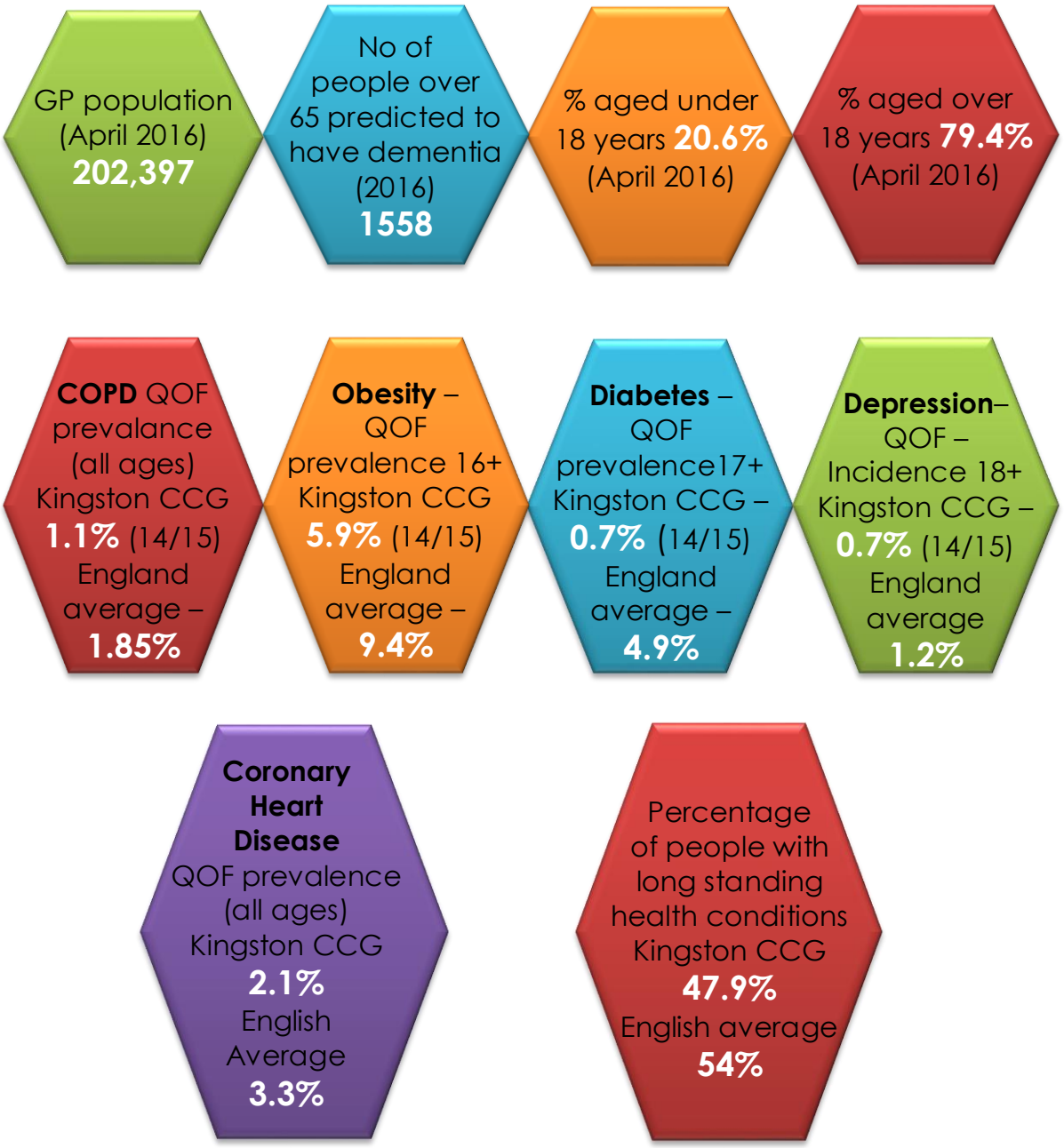
2015 Indices of Deprivation ranks Kingston **278** out of **326** Local Authorities in England (where 1 = more deprived, making Kingston the second least deprived Authority in London)

Ethnicity	**Persons as %of Total**
All ethnicities	**160,060 -100.0%**
White	74.5%
Black, Asian & minority Ethnic	25.5%
Asian/Asian British	16.3%
Mixed/multiple ethnic group	3.9%
Other ethnic group	2.8%
Black/African/Caribbean/Black British	2.5%

Disability

8,605 people have a long term health condition or disability that limits their day to day activities a lot

Health Profile in Kingston



COPD – ***Chronic Obstructive Pulmonary Disease***
QOF – ***Quality Outcome Framework***
Data – ***2014/2015 (fingertips.phs.org.uk)***

National policy context

National policy is a significant driver for local health and social care commissioning intentions. For a number of years public policy has encouraged greater personalisation and the integration of health and social care support for adults and carers in need.

The Care Act (2014) also represents the most significant reform to the care and support system for a generation. The new duty for local authorities to facilitate and shape a diverse, sustainable and quality market has implications for everyone involved: people with care and support needs, carers, providers and commissioners. The Act:

Local policy context

This MPS also complements and underpins a number of local strategic and multi-agency plans, including:

Our Vision for 2020: The Kingston Plan –

This sets out the strategic direction and long term vision for the economic, social and environmental wellbeing of the borough.

https://www.kingston.gov.uk/info/200279/performance_and_improvement/719/our_vision_for_2020_the_kingston_plan/2

Kingston's Health and Wellbeing Strategy –

Identifies the areas that health and social care need to work on together to make Kingston a healthy and successful place. These are the things that cannot be achieved by the NHS, Social Care or Public Health working alone.

https://www.kingston.gov.uk/downloads/download/485/joint_health_and_wellbeing_strategy

Kingston's Joint Strategic Needs Assessment (JSNA) –

The JSNA informs the development of Kingston's Health and Wellbeing Strategy in that it determines and analyses local population data to guide future prioritisation and investment. The demographic evidence presents a picture of the changing population and needs profile of the borough.

https://www.kingston.gov.uk/info/200365/joint_strategic_needs_asses

THE ROYAL BOROUGH OF KINGSTON UPON THAMES

Commissioning standards

This MPS incorporates recently published commissioning standards developed by the University of Birmingham, Think Local Act Personal (TLAP) and the Department of Health. These twelve standards underpin effective commissioning and set out what good commissioning looks like. These standards will in turn underpin Kingston's future health and social care commissioning and procurement practice.

Person-centred and focuses on outcomes

Good commissioning is person-centred and focuses on what people say matters most to them. It empowers people to have choice and control in their lives and over their care and support.

Co-produced with people and their communities

Good commissioning starts from an understanding that people using services, and their carers and communities, are experts in their own lives and are therefore essential partners in the design and development of services.

Well led by local authorities

Good commissioning is well led within local authorities through the leadership, values and behaviour of elected members, senior leaders and commissioners of services and is underpinned by the principles of coproduction, personalisation, integration and the promotion of health and wellbeing.

Delivers social value

Good commissioning provides value for the community not just the individual, commissioner or the provider.

Demonstrates a whole system approach

Good commissioning convenes and leads a whole system approach to ensure the best use of all resources in the local area through joint approach to ensure the best use of all resources in a local area through joint approaches between the public, voluntary and private sectors.

Uses evidence about what works

Good commissioning uses evidence about what works; it uses a wide range of information to promote quality outcomes for people and communities, and to support innovation.

Ensure diversity, sustainability and quality of the market

Good commissioning ensures a vibrant, diverse and sustainable market to deliver positive outcomes for local people and communities. It is concerned with sustainability including the financial stability of providers.

Provide value for money

Good commissioning provides value for the community not just the individual, commissioner or the provider. Good commissioning provides value for money by identifying solutions that ensure a good balance of quality and cost to make the best use of resources and achieve positive outcomes for people and their communities.

Develops commissioning and provider workforce

Good commissioning requires competent and effective commissioners and facilitates the development of an effective, sufficient, trained and motivated social care workforce. It is concerned with sustainability, including the financial stability of providers and the coordination of health and care workforce planning.

Promotes positive engagement with providers

Good commissioning promotes positive engagements with all providers of care and support. This means market shaping and commissioning should be collective endeavours, with commissioners working alongside providers and people with care and support needs, carers, family members and the public to find shared and agreed solutions.

Promotes equality

Good commissioning promotes equality of opportunity and is focused on reducing inequalities in health and wellbeing between different people and communities.

Develops commissioning and provider workforce

Good commissioning requires competent and effective commissioners and facilitates the development of an effective, sufficient, trained and motivated social care workforce. It is concerned with sustainability, including the financial stability of providers and the coordination of health and care workforce planning.

Key Messages for care and support providers

Key Message 1:

Market shaping and oversight role for local authorities

(a) Market Development – Kingston commissioners plan to support care market development in the following ways:

- Working with care and support providers to ensure they offer continually improving, high-quality and innovative service provision supported by a highly trained workforce.
- Ensuring that local commissioning practices and services delivered comply with the requirements of the Equality Act 2010.
- Working with providers and other stakeholders to develop a sustainable market for care and support.
- Encouraging a diversity of providers and different types of services.
- Having due regard to the sufficiency of provision, in terms of capacity and capability, to meet anticipated needs for people requiring care and support regardless of how they are funded.
- Understanding the market and developing greater knowledge and awareness of providers' businesses.
- Running and facilitating commercial supplier events to support local care and support providers.

(b) Quality assurance - The provision of high quality social care and support is a key outcome for people in need, carers, service providers and commissioners alike, and it is important, particularly at a time when financial pressures are increasing, that the issue of quality is not overlooked.

The Council will work with providers through our established Provider Forums to promote these quality standards; and will work with Kingston CCG and the Care Quality Commission (CQC) through jointly established Quality Groups to share market intelligence and better develop a co-ordinated response to quality matters as they arise.

(c) Training and workforce development

– The Council recognises that the quality of care and support that people receive is dependent upon the skills and commitment of the people providing the care and thus we are committed to supporting the care workforce. Providers have outlined the difficulties in recruiting and retaining a skilled care workforce mainly due to the high area cost and increased job complexities. The Council will set out its expectations toward the care workforce in its contracts and expects its contracted providers to demonstrate that they value their workforce by offering appropriate remuneration, training and career opportunities. We are also fully committed to providing professional development opportunities for social care staff from our partner agencies in the private, voluntary and independent sectors. A significant number of external organisations are currently registered with our online training system. These include care homes, care agencies and voluntary and community sector organisations. Our criteria for registration is that organisations must be either based in the borough or, if based outside the borough, have a contract with the Council to provide care and support services. The workforce training programme can be accessed by contacting the Council's Learning and Development Team on 020 8547 6091 or 6082 or by evolve@kingston.gov.uk. Care providers can access online training at www.evolve.learning.pool. Training resources are also offered by SCIE and Skills for Care:

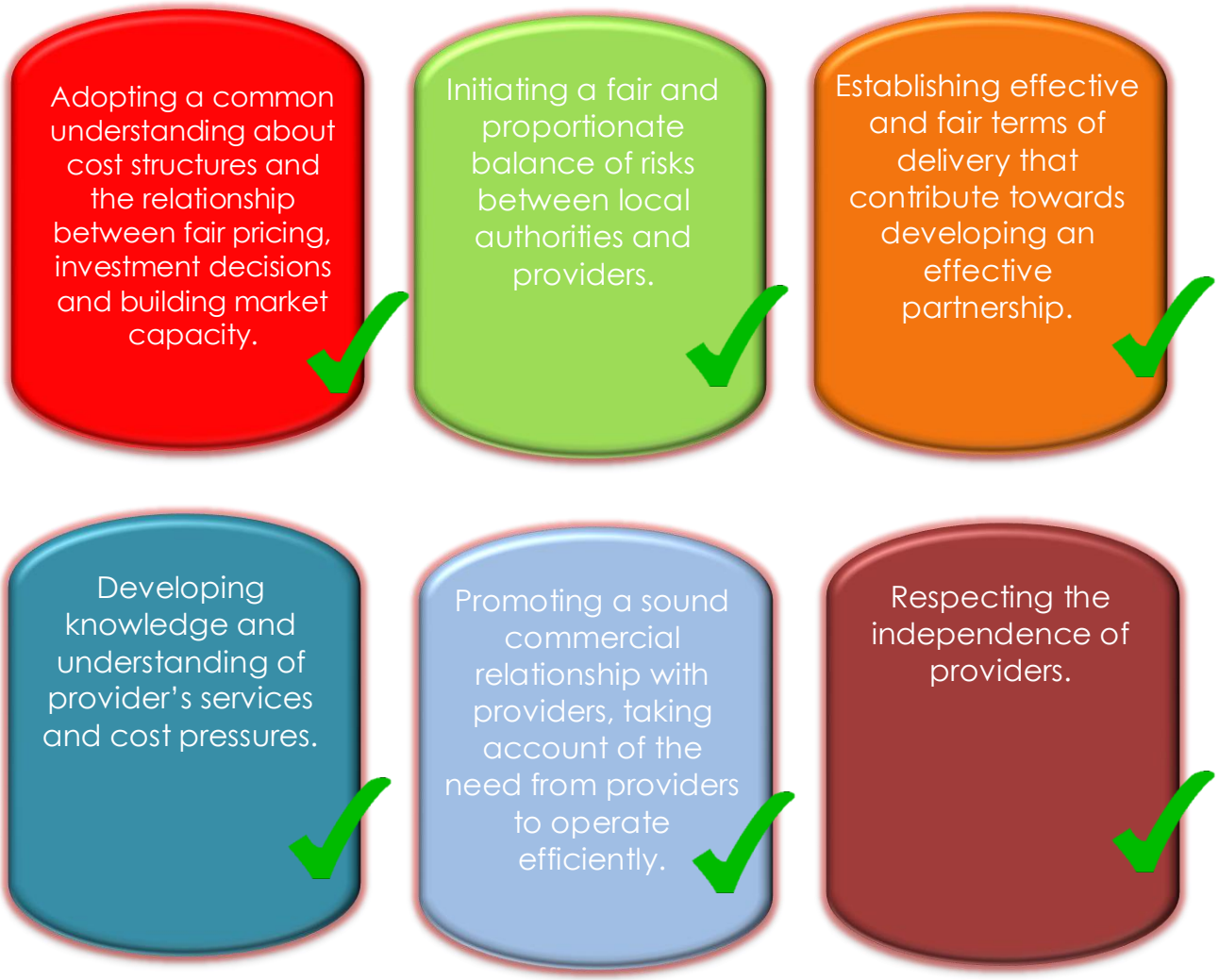
http://www.scie.org.uk/
http://www.skillsforcare.org.uk/Home.aspx
https://www.nmds-sc-online.org.uk/Default.aspx

(d) Contingency planning for provider business failure - The Care Act 2014 sets out duties that require Councils to act should a regulated care provider business fail. Under the Act, Councils have a temporary duty to meet people's needs where a care provider is unable to continue to operate. The duty applies to all people receiving care from registered care providers providing regulated care activities who are registered as operating in the borough, whether or not the local authority organises or pays for that care.
The duty aims to ensure people's needs are met where a business has failed and services can no longer be provided. However, in most cases where a business fails administrators will be in place and continue to run the business until it can either close in a planned way or a buyer is found, in these planned cases the duty would not be triggered.

In cases where there is an imminent failure Councils have a duty to act. The Act outlines that Councils must meet the needs for care and support which were being

met immediately before the business failure for 'as long as it considers necessary' and 'as soon as they become aware of the failure'. The temporary duty also extends to where the person is self-funding their care and support. Kingston has a Provider Failure Policy that is available to all provider organisations on the Council's website.

(e) Developing a co-productive relationship: Implementation of the following actions will assist the Council and providers in developing a co-productive relationship:



Key Message 2:

Health and social care integration

In the past, health and social care have often separately procured services from the same organisations using different specifications, and requiring a different set of outputs and performance measures.
In line with the Better Care Fund (BCF) national requirements and Kingston's vision for health and social care integration, the Council and CCG are taking practical / progressive steps away from this approach.

(a) Joint commissioning - Our ambition of creating a joint health and social care commissioning service for Kingston, which brings together the commissioning functions of the Council's Adult Social Care and Public Health departments and Kingston CCG is making good progress. Working together as one by sharing our resources and know-how makes sense if we are to achieve the best quality and most effective outcomes for local people.

The service is now being mobilised and we have set up the Commissioning Executive Management Team to oversee the development of the service. As the service develops the following commissioning priorities have been agreed.

1. Home Care transformation
2. Residential and nursing care
3. All-age learning disability service
4. Mental health service transformation
5. Kingston Coordinated Care
   - Customer Journey project
   - Active and supportive Communities project

Detail of priorities 1-4 will be shared in the client group specific appendices, but given that health and social care integration is at the very heart of priority number 5: Kingston Coordinated Care, it is important to highlight the particulars here.

(b) Kingston Coordinated Care (KCC) - The KCC Programme is all about making sure local people:

Stay independent, healthy and well for longer, with good community support to enjoy their lives to the full and: . . .

. . . have easy access to top quality, person centred care and support when they need it

KCC is a partnership production between the Council, Kingston Clinical Commissioning Group, Your Healthcare Community Interest Company (CIC), Kingston Hospital NHS Foundation Trust, South West London and St Georges Mental Health NHS Trust, the local voluntary and community sector, Home Care agencies and GP Chambers (the federation of Kingston GPs). We are working together to improve how residents receive the help they need. Before starting this joint programme we asked people for their views through an exercise called 'Voice of the Customer' (2015).

People reported that they wanted to be listened to and understood better, they wanted more choice and control in their lives, and better joined-up, coordinated and consistent quality care and support.

Staff also said similar things to the people using our services, they too were frustrated with the way we provide our services and the barriers they face to delivering the best care and support for people.

What people say they need from Services

Health & Social Care

One team, one budget, one easy, joined up health and social care pathway

Care Exchange

No more 'assault courses' for people using services or for staff supporting them

Care Exchange

One team, one budget, one easy, joined up health and social care pathway

Care Exchange

Direct access to information about the person, to the right people and support, right away

We are using these responses to build our programme on what people told us is working well and not so well in the current system. Through the use of that information, the joint programme will:

- Deliver a simple customer journey - currently our service users need to go through too many processes with too many different organisations to get the support they need.

- Use the experience of people at the first point of contact to help people connect with support available in their community - people should only need a full assessment if their needs cannot be met through community or one off support such as equipment.

- Develop an integrated model of care where providers work closer together as one system.

- Bring social care, public health and clinical commissioning functions together (as described above) to work jointly to our local needs - commissioning health and care services together will reduce duplication of effort. As part of this programme, the Council and the CCG are combining their resources to deliver the Active and Supportive Communities Strategy; and are jointly commissioning support for adults from the voluntary and community sector that will support people early to stay independent and well for longer and so not need statutory services so soon. The delivery plan for the strategy is closely linked to the Customer Journey project and will be designed to deliver a coordinated approach to the community-focused preventative activities in Kingston. This will optimise resources and help build the resilience people need to enable them to stay happy, healthy, socially active and able to cope in their day to day lives.

Key Message 3:

Outcome based commissioning and contracts

Increasingly commissioners are being asked to put together outcome based specifications that focus in on 'added value' as opposed to a fixed number of outputs and activity.

These specifications are more complex in style involving taking a more holistic approach to a population type or condition rather than focusing on a specific service.

These specifications look to allow providers to establish the best solutions for how to manage and achieve the best outcomes for a client group. They involve more sophisticated risk sharing and partnership arrangements through lead providers / contractors.

They also encourage service users to express the outcomes they want for themselves and therefore provide scope for service user empowerment and choice.

Outcomes refers to the impacts and end results of services on service users. This may be general e.g. improve the health of older people, or individualised and person-centred, where they are based on the priorities and aspirations of individuals.

This type of commissioning is challenging but also presents opportunities to improve outcomes and achieve better value.

Key Message 4:

The impact of self-funders

The services directly funded by the Council only represent a percentage of the overall care market across Kingston. Self-funders are the majority consumers of local care and support and potentially have a very significant impact on what the local market provides by way of services.

The self-funding market is a significant part of the overall care market, with an estimated £4.9 billion being spent in care homes and a further 168,000 places being 'topped' up with individuals private funds. (IPC (2011) Op Cit)

A self-funder is someone who "pays for all their social care or support from their own private resources" (including welfare benefits such as state pension or attendance allowance) or top up their local authority residential or domiciliary care funding with additional private spending. The Institute for Public Care estimates that 44.9% of registered care home places in England are self-funded. The proportion of self-funded places in residential care homes is 39.6% and 47.6% in nursing homes. In Kingston self-funders make up a considerable proportion of the residential and nursing care populations. Our best estimate is that approximately 60% of these beds are occupied by people funding their own care.

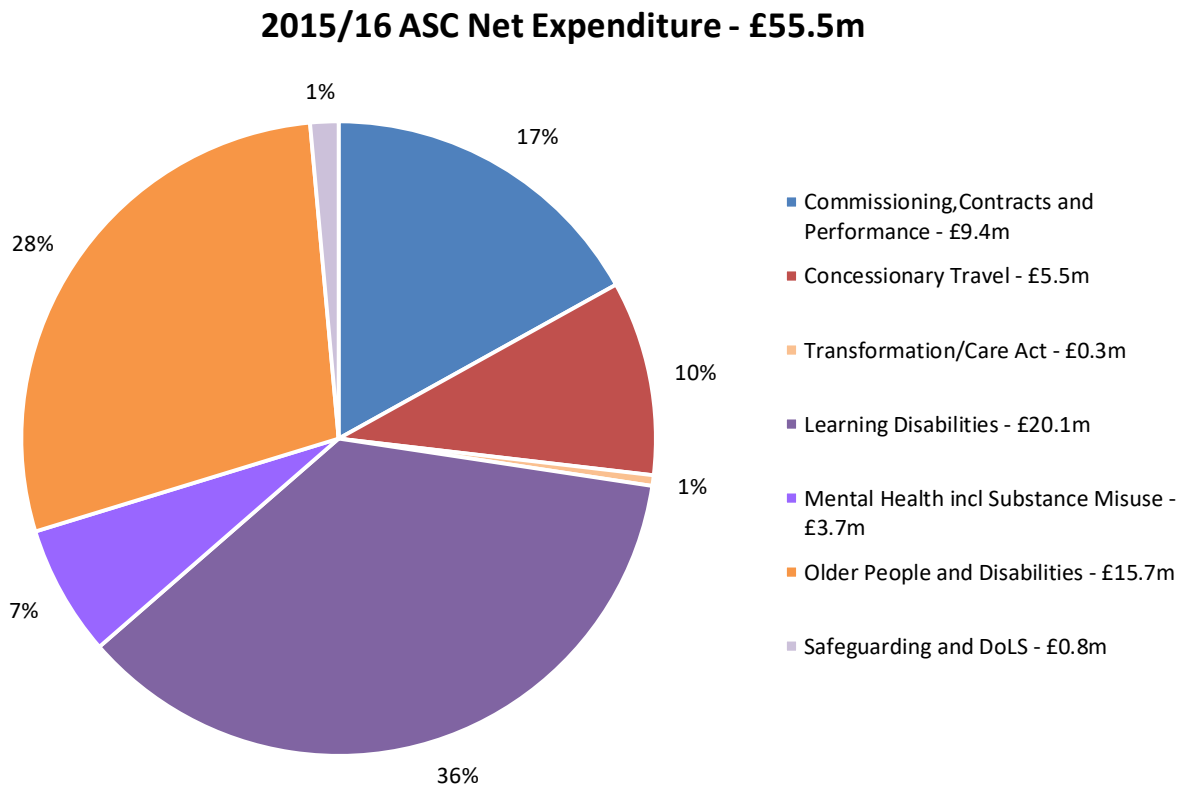
Understanding the needs of self-funders and making sure that there is appropriate provision for them is an increasingly important part of securing a sustainable and diverse market place across the borough. Over the next few years the Council has identified that continuing to improve its understanding of self-funders and how the market best meets their needs is a priority.

Key Message 5:

Funding and demand

The 2015/16 budget for Adult Social Care was £55.5.m

Figure 1: Council budget for Adult Social Care



Local authorities have faced and continue to face significant funding reductions as part of the government's austerity drive to deal with the national deficit. This is programmed to continue up to 2019/20. At the same time as financial resources are constricting, demand for services are rising due to population growth and increases in life expectancy. To meet this challenge the Council has refocused the way it works and commissions. This has been underpinned by a strong commitment to support the most vulnerable and deliver the outcomes that matter most to our communities. This means that difficult decisions have had to be taken to deliver the necessary savings. £8.6M (6%) was taken out as savings to balance the 2015/16 Council budget. In total since 2010, more than £30M (23%) has been taken as savings and greater savings will continue to be required to set a balanced budget annually.

Detailed Market Position Statements

What follows are specific Market Position Statements setting out our commissioning intentions and priorities for the following five groups:

Adults accessing local community support

Older people and adults with physical disabilities or sensory impairments

Adults with a learning disability (including autism)

Adults with mental health conditions

Adults with substance misuse needs

Market Position Statement for adults accessing local community support

Help us to develop the right care and support for adults to access from their local communities

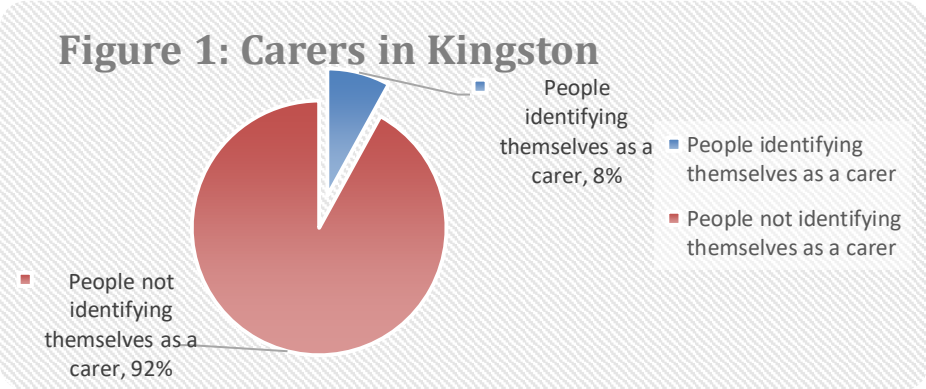
As part of the Kingston Coordinated Care Programme, the Council and Kingston CCG are combining their resources to deliver the Active and Supportive Communities Strategy, with the vision that "*Adults in the Royal Borough of Kingston upon Thames are assisted to build and maintain the resilience that enables them to stay happy, healthy, socially active and able to cope in adversity*".

The Active and Supportive Communities Strategy aims to deliver a coordinated approach to the community-focused preventative activities in Kingston. The intention is to optimise resources and help build the resilience people need to enable them to stay happy, healthy, socially active and able to cope in their day to day lives.

The Care Act 2014 highlights the importance of preventing, reducing and delaying individuals need for statutory sources of support and of assisting them to access the help they need from their local community. Key groups identified include carers (where the local authority has specific duties related to care and support) and those who are at risk of social isolation or disadvantage.

Population figures and need related to carers

- A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support[1].



[1] www.carers.org/whats-a-carer

- 13,288 people in Kingston (8% of the Kingston population) identified themselves as a carer in the 2011 Census, which was an overall increase of 8.6% since 2001.
- Within Kingston 5.9% of the population provide at least one hour of unpaid care a week. This is less than England (6.5%) but similar to London. Over 1,600 people provide 20-49 hours on unpaid care per week and over 2,300 people in Kingston provided 50 hours or more.
- The majority of carers in Kingston are aged 35 to 64 (see Figure 2). There were 990 young carers (under 24) and 2,518 older people providing care at the time of the 2011 census[2].
- It is estimated that 25% of carers nationally care for people with mental health problems[3].
- One in six carers nationally, or around a million people, have already given up work or cut back on their workings hours to care[4].
- 74% of carers surveyed struggled to pay essential bills and 52% said they were cutting back on food just to make ends meet[5].
- Carers are at increased risk of social isolation.
- Carers are more likely to have reduced life experiences, including employment and learning opportunities[5]. It is estimated that carers save the economy £119 billion per year[5].
- In Kingston, as with the rest of the UK, more young people with disabilities are surviving to live a full life and in addition people are living longer, many with long-term conditions or complex health needs. Coupled with this, the shift towards independent living and care at home means that a greater emphasis is put on informal carers who need assistance so that they can support the person they care for.
- The majority of people who need care and support are over 65 with the majority cared for by their children.
- Many people do not recognise themselves as carers and do not know that support is available or may be reluctant to ask for help. In Kingston there are 1,500 carers (11.3% of people who identified themselves as a carer) who are in touch with either social care services or Kingston Carers Network.

[2] RBK. Kingston Core Dataset 2013/14.

[3] RBK. Mental Health and Wellbeing in Kingston. Annual Public Health Report 2014.

[4] Ipsos MORI, Carers UK and Department of Work and Pensions (2009) One million give up work to care.

[5] Carers UK (2001) It Could Be You – A report on the chances of becoming a carer.

Interviews and questionnaires with 73 working age carers supporting someone living in the Borough of Kingston showed that:[6]

- The age of the person being cared for ranged from under 5 to over 85 with 18-24 being the most common age followed by over 85.
- The most common needs of the person being cared for were physical disability, dementia/memory loss and mental health problems.
- 38% had given up employment to be a carer and 24% had reduced their working hours. 38% stated they would like to work part time.
- 44% stated that they were significantly worse off financially since caring and 32% stated that they were worse off financially since caring.
- 7% rated their mental and emotional health as very poor and 31% as poor.
- The most common symptoms experienced by carers since caring were poor sleep quality (85%), feeling low (81%), excessive tiredness (80%) and feeling overwhelmed or very emotional (71%). 67% of carers said that they felt anxious and 51% reported feeling depressed. 7% of carers they had experienced feelings of harming themselves or other people.
- Over two thirds felt their health had slightly or significantly declined since caring.
- 76% felt listening to and respected by their GP and 63% felt involved in health care planning with their GP.
- 36% of carers felt that their caring role was getting more difficult over time, 27% said that diagnosis had been the most difficult time and 8% said that hospital discharge was the most difficult time in their caring journey.
- 94% stated a carer support worker in hospital would have helped with the hospital discharge planning process.
- Over half (58%) of carers said that they feel they need more help to continue caring and only 27% carers felt they had enough support.
- 45% of carers said that more support from health and care professionals would help them to cope better.
- Over two thirds (39%) said that more support from friends and family would help them to cope.

[6] RBK. JSNA Carers Survey. 2015.

- 40% of carers said they had not had a Carer's Assessment and only 30% had either a joint needs assessment or a separate carer's assessment in the last 12 months.

Population figures and need related to the risk of social isolation

- Nationally 17% of older people are in contact with friends, family or neighbours less than once a week.
- 13% of people over 65 in the UK say that they always or often feel lonely.
- "Social relationships, or the relative lack thereof, constitute a major risk factor for health – rivalling the effect of well-established risk factors such as smoking" (Science magazine).
- Nationally about 3.8 million older people live alone; 70% of these are women over 65[7].
- Over 2 million people over 75 live alone; 1.5 million of these are women[7].
- Older people in Kingston occupy 21% (13,344) of Kingston's households.
- It is estimated that there were 7,946 people living alone in 2012 and this will rise to 9,201 by 2020; a 15.8% increase[8].
- Women aged 75 and over made up 48% of older people living alone in 2012. However the greatest percentage increase in older people living alone between 2012 and 2020 is estimated to be in men aged 75 and over (24.4%) followed by women aged 65-74 (22.8%)[8,9].

Table 1: Number of older people living alone in Kingston and London 2011-2013

Period		Kingston	London
2011	Single person households, over 65	7,114	332,337
2012		7,237	337,937
2013		7,336	342,167
2011	Total estimated households	63,798	3,278,345
2012		64,239	3,317,744
2013		64,680	3,357,144
2011	Single person households, over 65 as a % of total estimated households	11.2	10.1
2012		11.3	10.2
2013		11.3	10.2

- In Kingston 76% of older people are owner-occupiers[8].

[7] Age Concern.
[8] RBK. Older People in Kingston Living Well in Later Life. Annual Public Health Report for Kingston 2013.

- 25% of people aged 65-74 years in Kingston live alone rising to 50% among those aged 75 and above[8,9].
- The number of older people living alone is projected to have increased year-on-year between 2011 and 2013 both in absolute terms and as a proportion of total households[10].
- 37.8% of Adult Social Care users in Kingston report having as much social contact as they would like[11].

Current service provision

The Active and Supportive Communities Strategy has 6 key commissioning outcomes:

1. People can improve their health and well-being and are supported to be active and independent for as long as possible to live longer, healthier lives. *All organisations involved in delivering our Active and Supportive strategy will be expected to show how their work contributes to making this outcome happen.*

2. People are socially connected and resilient and can access the practical support they need to maintain their independence. *Supported by Kingston Voluntary Action, a collaborative 'network' of 12 voluntary sector organisations led by Staywell have come together to identify what they can contribute to achieving some important areas of support.*

3. People can access support that helps them to use their 'Personal Budget' effectively to promote their independence. *Kingston Council and Kingston CCG are exploring a joint commissioning approach leading to a competitive tender.*

4. People caring for others are valued and recognised and are supported to maintain a balance between their caring responsibilities and a life outside caring. *Our recently updated Carers' Strategy, together with the National Carer's Strategy, was used to develop a new service specification. The Carer Support contract has been awarded to Kingston Carers' Network as the lead agency and they will work in partnership with the Alzheimer's Society to provide services.*

5. People can access information and advice that supports them to live as independently as possible and/or support others. *We have commissioned targeted and group specific information and advice (e.g. for carers, for older*

[9] General Household Survey.
[10] RBK. Kingston Core Dataset 2013/14.
[11] Public Health Outcomes Framework.

people and for refugees and asylum seekers) within specific contracts.

6 People can access specialist advocacy support when they need it to maintain their choice, control and independence. *Following a competitive tender, the Specialist Advocacy contract has now been awarded to a partnership of Kingston Advocacy Group, Advocacy for All and Balance Community Interest Company. More detail can be found below.*

The Council and Kingston CCG are therefore jointly commissioning support for adults from the voluntary and community sector that will help empower people to stay happy, healthy, socially active and resilient.

Carers

- The typical support accessed by carers in Kingston can be defined by three broad categories:
    - Universal preventative services – predominantly information and advice
    - Targeted preventative services delivered to the cared-for person following a carers assessment e.g. respite or assistive technology
    - Targeted preventative services delivered to carers and accessed directly by carers following a carer's assessment e.g. carers one-off direct payments
- In 2015/16:
    - 572 carers were referred for face-to-face advice and advocacy, a further 250 received information and advice at Kingston Hospital.
    - 300 carers had increased income following advice/advocacy (approx. £1M).

Housing related support

- The Council currently funds the housing advice and support costs for a range of different clients groups: adults with mental health conditions, adults with substance misuse needs, adults who are homeless, adults who have experienced domestic abuse, older and vulnerable adults and ex-offenders.
- The Council recognises that the focus of future commissioning will be to relieve pressure on high-level and high-cost support services by increasing the level of support provided in the community and increasing throughput to independent living with floating support.

Direct Payments

- Direct payments are cash payments to people who need care and support services, giving them the opportunity to organise the help they need directly. Direct payments offer people greater choice and control over their lives, and put them in control of the decisions about how their care and support is delivered.
- Direct payments will continue to be offered to all eligible Adult Social Care users who are eligible to receive them.
- Kingston currently has over 300 direct payment users. The majority opt to employ their own personal assistants.
- It is anticipated that there will be an increased demand for direct payments from carers.
- Direct payment support services such as assistance to recruit staff and manage payments are provided by a local voluntary sector provider organisation.

Social resilience

The social resilience network of voluntary and community sector organisations deliver a wide range of services designed to maximise people's independence, help them to make a positive contribution to their local community, reduce social isolation and improve their wellbeing either through delaying deterioration and dependency or aiding recovery. Services are designed to deliver a network of informal support services across the borough. The service is provided by Staywell and their eleven 'network' partners. It is intended that it will:

- Increase the levels of new people accessing activities which will ultimately impact on the long term health goals for the population: befriending, peer and group sustainable activities that help reduce social isolation
- Provide advice and information
- Enable access to a wide range of locally available services across the borough that work in partnership and offer a seamless customer journey.

Specialist advocacy

The following specialist advocacy services are available in Kingston provided by a range of voluntary sector provider organisations:

- Independent Mental Capacity Advocacy (IMCA) for adults who lack the capacity to make a particular decision and who do not have anyone to help them speak up.
- Care Act advocacy for people who have difficulty being involved in their care assessment and planning.

- Appropriate Adult advocacy for vulnerable adults being interviewed by the Police.
- Advocacy for people with complex mental health or learning disability needs who have difficulty speaking up for themselves
- Independent Mental Health Act advocacy.

Future commissioning intentions and development opportunities

- It is acknowledged that the Royal Borough of Kingston has a vibrant and diverse voluntary and community sector (VCS) that provides a wide range of care and support related services and activities to residents.
- The Council and Kingston CCG are exploring the opportunity to shift resources towards improved levels of prevention, as well as short term interventions in community settings. The aim is to improve user experience and prevent people reaching crisis through the early provision of targeted information, support and guidance.
- As per the evidence highlighted above loneliness and isolation can impact significantly on a person's wellbeing. As a result we are working with partner organisations to identify the current scale and impact of this issue and will work with stakeholders to develop local prevention support and meaningful community activities for older and vulnerable people through continued investment in the voluntary sector and housing related support. This includes day opportunities for both those with low/moderate or high/complex needs.
- We are planning to promote the newly commissioned preventative services across the borough and to other service providers and the wider community. This will be done using multi-media/digital methods to capture stories, in particular to demonstrate collaborations that result in better outcomes for people.

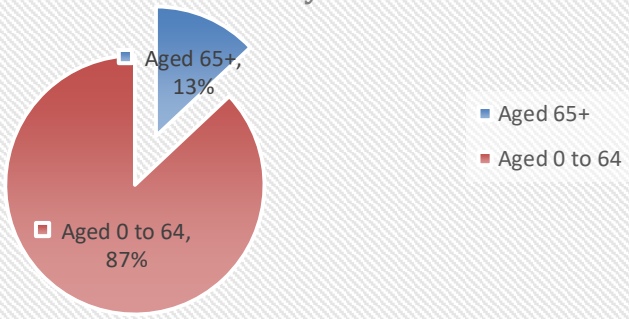
Market Position Statement for older people and adults with physical disabilities or sensory impairments

Help us to develop the right care and support for older people or adults with physical disabilities or sensory impairments living in the Royal Borough of Kingston

Older people population figures and need

The ageing of the population has important implications for the health and social care system in Kingston. Depending on the health of an individual, an older person can spend a number of years in poor health and it is during this period that they can require extensive health and social care interventions.

Figure 1: Kingston population aged 65+ and under 65 years



- There are 22,600 people aged 65 and above living in Kingston; 13% of the total population[12].
- 32% of these are aged 65-69, 22% aged 70-74, 17% aged 75-79, 14% aged 80-84, 9% aged 85-89 and 6% aged 90+[15].
- It is estimated that the population aged 65 and over will increase to 28,900 by 2025 and to 32,900 by 2030.
- The resident population of RBK aged 90 and above will see the greatest percentage increase by 14% by 2020 and by 71% by 2030.[15]

[12] Projecting Older People Population Information System. Population Figures. Kingston upon Thames.

- In Kingston 12.9% of the 65+ population is from a BME community. This proportion will increase as the population ages.[13]
- Age is not always a useful determinant of health and social care needs. It is more helpful to categorise older people into the three following groups to assess their differing needs:
    - Frail Older People - with more complex needs, often requiring specialised services.
    - Transitional Phase - transition between a health active life and frailty requiring targeted services.
    - Active and Independent - entering old age requiring universal services.
- The number of older people living alone continues to increase. The percentage of households which consist of someone aged over 65 living alone in Kingston in 2013 was 11.3% which is slightly above the London average (10.2%)[14].
- Over half (51.9%, 5,000 people) of the population aged 75 and over live alone in Kingston[15]; almost two thirds of these are women[16]. The numbers of people aged 75 and over living alone is projected to rise to 8,128 by 2030[17].

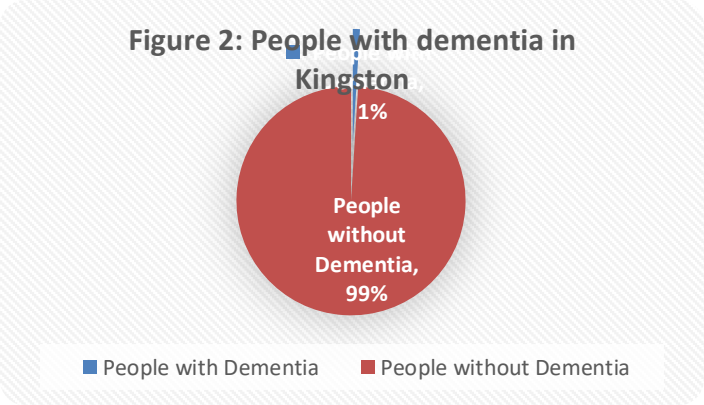
Health of older people

- The number of older people with learning disability is expected to increase between 2014 and 2030 across all age bands. The highest prevalence is amongst people aged 65-74.
- The number of older people with moderate or severe hearing loss and visual loss is expected to increase between 2014 and 2030 across all age bands.
- The number of older people with severe depression is expected to increase between 2014 and 2030 across all age bands[20].
- Depression is very common in older people and it is estimated that 1,942 people in Kingston aged 65 and over will suffer from this condition in 2014[17]. This will include two in five people living in care homes[18]. In many cases the depression is not diagnosed and even when diagnosed may not be treated appropriately.

[13] GLA 2012 Round Ethnic Group Projections - SHLAA Interim. © Greater London Authority, 2013.
[14] RBK. Core Dataset 2013/14.
[15] Projecting Adult Needs and Service Information. Population Figures. Kingston upon Thames.
[16] ONS. Nomis.
[17] Projecting Older People Population Information System. Population Figures. Kingston upon Thames.
[18] RBK. Older People in Kingston Living Well in Later Life. Annual Public Health Report for Kingston 2013.

Dementia population figures and need

- Dementia is a progressive condition that predominantly affects older people. It causes a decline in mental ability which affects memory, thinking, concentration, problem solving and perception.
- Kingston has one of the highest life expectancies in England and, as a result, nearly half of patients over 75 have dementia which is double the national average[19].



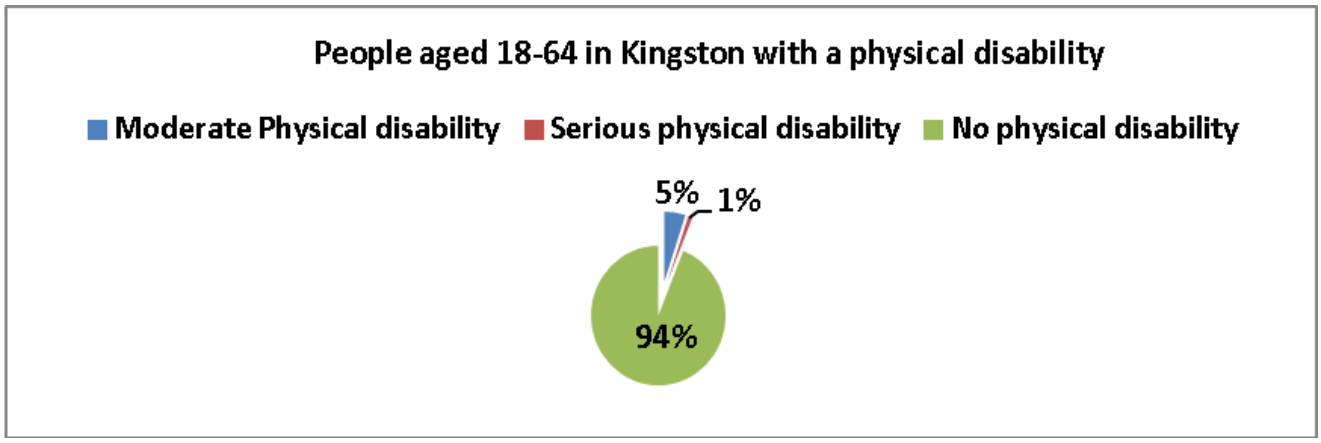
- The number of people with dementia in Kingston in 2014 was estimated at 1,600 and this is expected to increase to 1,800 by 2020[20].
- Many people suffering dementia are undiagnosed - fewer than half of older people with dementia ever receive a diagnosis[21]. This may be due to individuals and families failing to recognise the symptoms or protecting themselves from the perceived stigma of dementia. Even among people who are in regular contact with health services the symptoms may go undetected due to a focus on physical illness, or a perception that nothing can be done[15].
- The advantages of early diagnosis and intervention include reducing or delaying care home placement, and improved quality of life for both individuals and carers[15].
- The prevalence of dementia among older people with learning disabilities is much higher (21.6%) than the general older population[22].
- An estimated 12% of people over 65 in Kingston are from black and minority ethnic groups. Access to services may be challenging due to language barriers, knowledge of services availability, attitudes and practices of service providers and cultural factors[22].
- A small number of younger people in Kingston have early-onset dementia. This group is recognised to have specific differences in their health, care, and social needs[22].

[19] Kingston Hospital.
[20] RBK. Mental Health and Wellbeing in Kingston. Annual Public Health Report 2014.
[21] Alzheimer's Society (2013). Mapping the dementia gap. London: Alzheimer's Society.
[22] RBK. Dementia Strategy 2015-2020. Kingston Clinical Commissioning Group. July 2015

- Most people with dementia have at least one other co-existing illness and 59% of patients with dementia have two or more co-existing illnesses, both physical and mental[22].

- People with dementia tell us that they wish to live in the home of their choice, near to family and carers, and to receive the best quality care at the right time and in the right place. We have heard that holistic support should be available and that it must be extended to carers, for whom the caring role can be extremely demanding and stressful. We aim to change the culture in Kingston to one that is truly supportive of people with dementia.

Physical disabilities and sensory impairment population figures and need



- There are 7,947 people with moderate physical disability aged 18 to 64 in Kingston in 2014.[23]

- 2,242 people aged 18 to 64 in Kingston in 2014 have a serious physical disability. [11]

- The majority of younger people with a physical disability are supported by means other than social care services.

- People with physical disabilities should have the same access to services and opportunities as non-disabled people.

- There were 1,980 people aged 65 and over in Kingston with a moderate or severe visual impairment in 2014 and this is expected to rise to 2,249 by 2020.[24]

[23] Greater London Authority.
[24] Projecting Adult Needs and Service Information. Population Figures. Kingston upon Thames.

- There were 9,537 people aged 65 and over in Kingston with a moderate or severe hearing impairment in 2014 and this is expected to rise to 10,916 by 2020.[23]
- There were 264 people aged 65 and over in Kingston with a profound hearing impairment in 2014 and this is expected to rise to 301 by 2020.[23]
- Sight loss affects two million people in the UK with the vast majority being older people.[25]
- 50% of sight loss is due to preventable or treatable causes although it can be up to 70% in older people.[26]
- The following groups are at higher risk of suffering sight loss:[27] people aged 60 and over, people with a learning disability, people with a family with a history of eye disease and people from certain ethnic groups e.g. African-Caribbean communities are at greater risk of developing glaucoma and diabetes and people from South Asian communities are at greater risk of developing diabetes.

Current Service Provision

It is acknowledged that currently the primary focus of this specific MPS is on social care provision. It is intended that when it is updated this MPS will also include enhanced information on health focused provision.

Home care

Homecare Packages in Kingston (1st April 2015 – 31st March 2016):

No.	%	
483		new home care packages started
109	22%	15 hours or over per week
375	78%	under 15 hours per week
66	14%	Required 2 or more care workers to deliver package of care (complexity)
162	33%	required 14 calls or more per week

[25] RBK. Older People in Kingston Living Well in Later Life. Annual Public Health Report for Kingston 2013.
[26] Tate, R., Smeeth, L., Evans, J., Feltcher, A., (2005) The prevalence of visual impairment in the UK; A review of the literature.
[27] Association of the British Pharmaceutical Industry. Better vision for all. Pharmaceutical Ophthalmology Initiative (POPI).

- The Council currently contracts with two home care providers to provide home care provision in Kingston and commissions further providers through spot purchase arrangements.
- A Support for Living at Home project is currently being mobilised to build confidence in, and enhance the capability of, home care providers to deliver the care and support that people need. In particular how home care providers can develop a workforce capable of taking a reabling approach to home care; coordinate support with other health and social care professionals; and build good community links to avoid people becoming dependent on their home care worker and being drawn into the health and care system.
- Moving to a more reablement and outcomes focused approach means skilling up the whole workforce and putting in place a career structure and progression for home carers, with the commensurate rewards.
- Traditional ways of procuring home care all lead to a largely time and task delivery of care. The project will look to establish a commissioning mode that incentivises providers to focus on how they can influence wider system outcomes by supporting the wellbeing of individual people.

Care home provision

- There are currently 64 care homes registered with the CQC located in the borough (14 of which provide nursing care) and there are currently 756 people aged 65 or over living in a care home in Kingston with or without nursing.[28]
- The Care Quality Commission registration data indicate a maximum 5391 residential and nursing care homes beds in CQC registered establishments within a ten mile radius of the KT1 postcode.
- From the activity data recorded, the need for residential placements for frail older people is likely to reduce as more people are supported in their own homes or take-up sheltered housing options. The demand for general need nursing placements remains stable in terms of current demand and supply. We do though expect that discharge and rehabilitation initiatives with the NHS will increase the proportion of short-stay nursing placements needed as more people recover from a period of ill-health in a nursing home setting prior to returning home.
- The need for both residential and nursing dementia beds remains high, particularly for respite and short-stay purposes. There is also a particular need for dementia care placements that can support residents with needs that challenge services.

[28] ONS. Nomis.

Community services

- Evidence suggests that loneliness and isolation impact significantly on a person's wellbeing. As a result we are working with partner organisations to identify the current scale and impact of this issue and will work with stakeholders to develop local prevention support and meaningful community activities for older and vulnerable people through continued investment in the voluntary sector and housing related support. This includes day opportunities for both those with low/moderate or high/complex needs.

- It is important to note that Floating Support services are available in borough for older and vulnerable people and this provision has recently been extended beyond council housing tenants only to all tenures.

Community equipment and telecare

- Equipment and adaptations can have a significant impact in enabling people to live independently. We will continue to invest in this area in a targeted way because we are aware that these solutions are vital in supporting the independence, dignity and wellbeing of many people living in the borough. During 2015-16 871 residents were supported by Telecare equipment to live at home. The most common telecare equipment is the basic lifeline unit and pendant, falls detector and smoke detector.

Sight and hearing equipment and support

The following interventions are available:

- Information, support and advice about a range of equipment and local support groups.

- Useful equipment such as flashing light systems, door entry systems and text phones for a hearing impairment, or talking clocks and task lighting for a sight impairment.

- Teaching of Braille, Moon and touch typing.

- Rehabilitation and mobility training on all aspects of mobility from the safest place to cross a road to full mobility training with a long cane to maximise independent living skills.

Direct Payments

- Direct payments are cash payments to people who need care and support services, giving them the opportunity to organise the help they need directly. Direct payments offer people greater choice and control over their lives, and put them in control of the decisions about how their care and support is delivered.

- Direct payments will continue to be offered to all eligible adult social care users who are eligible to receive them.
- Kingston currently has over 300 direct payment users. The majority opt to employ their own personal assistants.
- It is anticipated that there will be an increased demand for direct payments from carers.

The market that we wish to facilitate

We want to encourage and engage with providers to consider ways in which they can help older people, adults with physical disabilities or adults with sensory impairments to stay living in their own homes for as long they wish.

Future commissioning intentions and development opportunities

- In the future we anticipate more complex packages of support will be required, so that older people or adults with physical disabilities or sensory impairment can continue to live at home for as long as possible rather than move into residential or nursing care.
- There is a need for more trained staff who are better skilled and more flexible to meet the diverse needs of service users.
- Ensuring value for money for nursing and residential care support for Kingston residents whose placements are funded by the Council or CCG or self-funded.
- For carers to be supported through the provision of respite services that support them to continue in their caring role. These services could be provided by a personal budget.
- For an increase in the use of the Shared Lived Scheme for respite as well as longer term placements.
- Better quality assurance through a programme of monitoring for residential and nursing care homes (using the Quality Assessment Framework) and support through our established provider forums. In addition the Council, Kingston CCG and CQC will work in partnership through the existing Quality Groups to share market intelligence and better develop a coordinated response to quality matters as they arise.
- An increase in the number of people purchasing services via direct payments, therefore giving them greater choice and control.
- The provision of high quality support to people with dementia and their carers.

- Home care providers will be commissioned to take a reabling approach to home care; coordinate support with other health and social care professionals; and build good community links to avoid people becoming dependent on their home care worker and being drawn into the health and care system.

Market Position Statement for adults with learning disabilities (including autism)

Help us to develop the right care and support for adults with learning disability (including autism) in the Royal Borough of Kingston

Learning Disability population figures and need

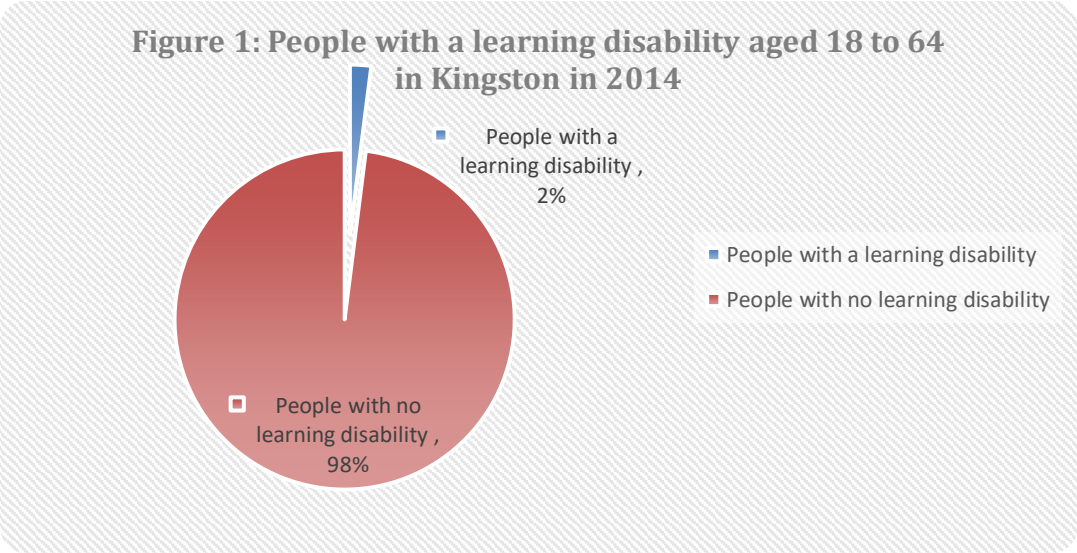


Table 1: Population of Kingston-Upon-Thames aged 18-64 and aged 65 and over predicted to have a learning disability, by age	2014	2015	2020	2025	2030
Population of Kingston-Upon-Thames aged 18-64 over predicted to have a learning disability					
People aged 18-24 predicted to have a learning disability	503	506	505	517	586
People aged 25-34 predicted to have a learning disability	680	682	697	697	680
People aged 35-44 predicted to have a learning disability	655	670	717	751	763
People aged 45-54 predicted to have a learning disability	515	527	570	608	649
People aged 55-64 predicted to have a learning disability	366	370	421	469	503
Total population aged 18-64 predicted to have a learning disability	**2,719**	**2,756**	**2,910**	**3,043**	**3,182**
Population of Kingston-Upon-Thames aged 65 and over predicted to have a learning disability					
People aged 65-74 predicted to have a learning disability	259	268	300	309	350
People aged 75-84 predicted to have a learning disability	140	142	161	205	227
People aged 85 and over predicted to have a learning disability	65	67	75	88	108
Total population aged 65 and over predicted to have a learning disability	**464**	**477**	**536**	**602**	**685**

Source: Projecting adults needs and Service information. Population Figures. Kingston upon Thames and Projecting Older People Population

- There were estimated to be 2,719 people with a learning disability in the 18 to 64 age range in Kingston in 2014[29,30].
- 0.3% of people aged 18 years and over of the GP registered population have a learning disability[31].

[29] Projecting Older People Population Information System. Population Figures. Kingston upon Thames.
[30] Greater London Authority.
[31] RBK. Kingston Core Dataset 2013/14.

- Extrapolating from national prevalence data it would be expected that there would be approximately 600 adults with severe learning disabilities (about 730 using the GP registered population) and around 3,000 with mild to moderate learning disabilities resident in Kingston (3,660 using the GP registered population)[32].

- Local data sources suggest that just over 400 adults with learning disabilities are known to services (JSNA).[32]

- There is a 62% gap in the employment rate between those with a learning disability and the overall employment rate in Kingston (which compares to 60.9% in London and 65% in England)[33]. At the end of June 2016, 12% of people with a Learning Disability are in paid employment. This is above the national average which was 6.6% in 2010-2011 data from the Foundation of people with Learning Disability[34].

- People with a learning disability, like the rest of the population, are living longer. However, they generally have more complex health needs.

- There is little evidence of any closing of the gap in life expectancy between people with learning disability and the general population. Consequently there is a drive to increase access to local health services via annual health checks, health action plans and improved health screening programmes. The number of people with the most complex needs is also increasing.

- There has been an increase in the number of young people with a severe learning disability and the number with profound or multiples disabilities has also doubled This cohort include young people with profound or multiple disabilities, complex autism, mental health needs, and people with behaviours that services find challenging.

- The increase in the number of people with more complex needs has implications for the types and levels of support required, and further reinforces the need for an integrated approach to meeting people's health and social care needs. We also need to ensure that the workforce has the right skills, knowledge and experience to work alongside people with complex needs as part of any planned future models of care and support.

[32] RBK. Joint Strategic Needs Assessment for Kingston 2010-11: People with a Learning Disability.
[33] Public Health Outcomes Framework.
34 http://www.learningdisabilities.org.uk/help-information/Learning-Disability-Statistics-/187693/

Table 2: Total Population in Kingston aged 18-64 and over predicted to have a moderate or severe learning disability, and hence likely to be in receipt of services	**2014**	**2015**	**2020**	**2025**	**2030**
Total population aged 18-64 predicted to have a moderate or severe learning disability	622	631	668	700	734
Total population aged 65 and over predicted to have a moderate to severe learning disability	63	65	72	80	90
Total population aged 18-64 predicted to have a severe learning disability	168	170	179	188	197

Table 3: Population of Kingston aged 18-64 with a Learning Disability, predicted to display challenging behaviour	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 18-24 with a learning disability, predicted to display challenging behaviour	8	8	8	9	10
People aged 25-34 with a learning disability, predicted to display challenging behaviour	12	12	13	13	12
People aged 35-44 with a learning disability, predicted to display challenging behaviour	12	12	13	14	14
People aged 45-54 with a learning disability, predicted to display challenging behaviour	10	10	11	12	12
People aged 55-64 with a learning disability, predicted to display challenging behaviour	7	7	8	9	10
Total population aged 18-64 with a learning disability, predicted to display challenging behaviour	**50**	**51**	**53**	**56**	**58**

Table 4: Population of Kingston-Upon-Thames aged 18-64 predicted to have a moderate or severe learning disability and be living with a parent, by age, projected to 2030	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 18-24 predicted to be living with a parent	76	76	77	80	91

People aged 25-34 predicted to be living with a parent	75	75	77	77	75
People aged 35-44 predicted to be living with a parent	64	66	70	74	75
People aged 45-54 predicted to be living with a parent	27	27	30	32	34
People aged 55-64 predicted to be living with a parent	7	7	9	9	10
Total population aged 18-64 predicted to be living with a parent	**249**	**252**	**262**	**272**	**285**

Source: Projecting Adult Needs and Service Information. Population Figures. Kingston upon Thames.

Making a Difference - Kingston Learning Disability Service Strategy 2012-2017

Underpinning this strategy is the principle that support and services:

- Promote choice, control and independence and are inclusive of all people with learning disabilities, their families and carers.
- Are planned with people with learning disabilities and their families.
- Will be provided in the most cost effective way with an emphasis on service quality.

All-Age Learning Disability Service

Kingston can also improve outcomes for disabled people and their families by creating an 'all age' service for disabled people and children with learning disabilities that provides a streamlined and integrated pathway for children, young people and adults at key transition points in their life. Through this project we aim to reduce the need for and cost of funding long term placements out of borough and to ensure that high quality local provision and community support is available.

Feedback from Engagement Consultation

Five main themes have emerged:

1	To live a fulfilling life and be part of the community with friends and positive relationships.
2	To have a job and to have opportunities to learn new skills and support to take an active part in their community.
3	To be healthy and lead a healthy life which includes support around mental health to reduce anxiety and support to gain more confidence.
4	To feel safe in Kingston, at home and out in the community.
5	To have a home that is appropriate for the individual's needs, which is close to their support network and local connections.

Co-production

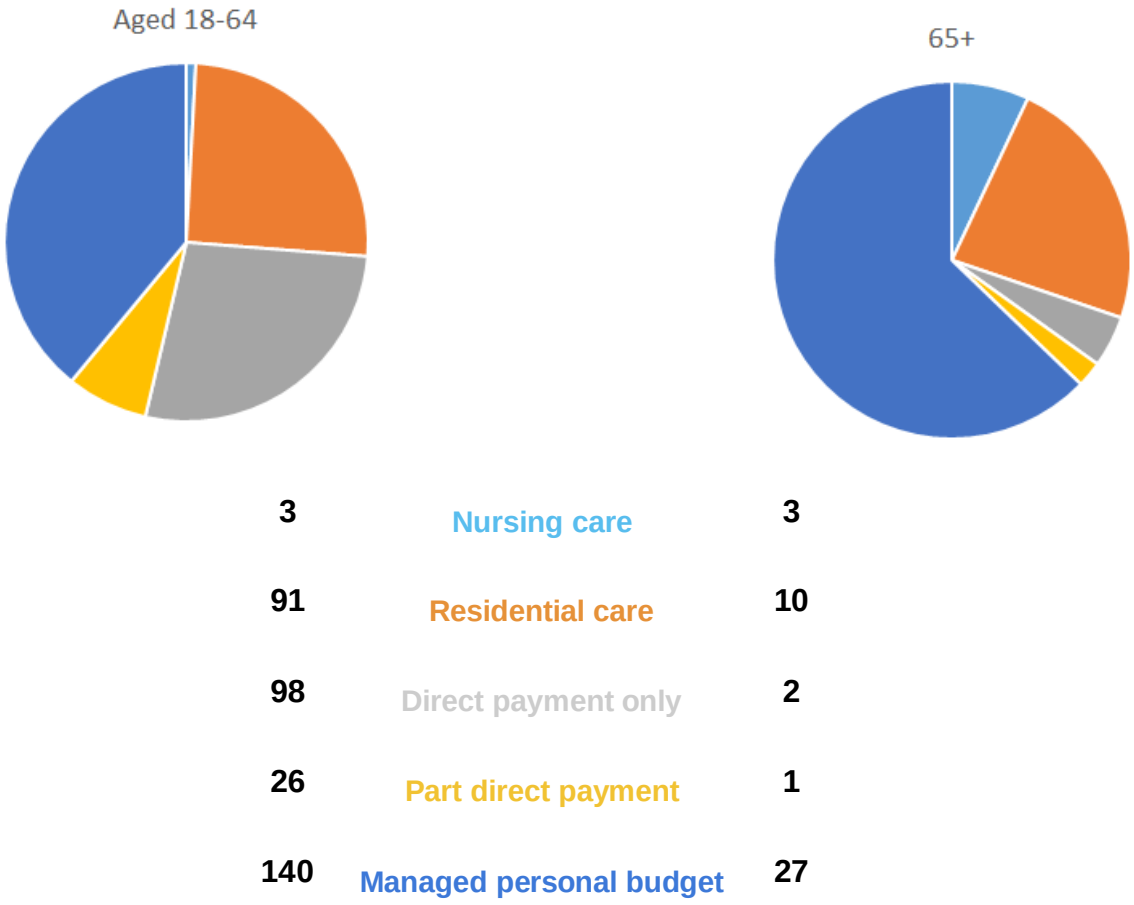
This MPS commits us as commissioners to helping adults with learning disability to get involved in their care and support, set the outcomes they wish to achieve and realise their full potential as citizens. We are committed to giving people with learning disabilities choice and control about where they live, who they want to live with and the support they receive. People with learning disabilities want to lead lives that are fully integrated with the communities they live in.

Current service provision for adults with learning disability

It is acknowledged that currently the primary focus of this specific MPS is on social care provision. It is intended that when it is updated this MPS will also include enhanced information on health focused provision.

Current service provision for adults with learning disability includes: day care, supported living, respite, residential care, nursing care, work activities, employment support, social activities, sport and leisure activities

Figure 2: The services people with learning disabilities received in 2015/16



In 2015/16 34% of service users under 65 and 7% aged 65 and over received direct payments. Nursing care was a very uncommon provision used by only 1.5% of service users overall although this was 7% of those aged 65 and over. 42% of service users had a managed personal budget making this the most commonly used service; and this figure rose to 63% for over 65s.

Carers (parents and family members)

- A high proportion of adults with a learning disability in Kingston live with their parents or family members - hence supporting family carers is a key priority. People living with their families will continue to have access to a range of support, including day opportunities, outreach, support at home, and short-breaks (respite).

Connecting with the community

- There is an expectation that providers will enable greater access to universal services and offer innovative family and community based support. Our focus will

be on services that reduce people's dependence on formal support by helping them build independence and self-care skills, connect with their communities, and access mainstream services. We will also work with providers to ensure more adults with a learning disability are supported to access training, work experience, and voluntary or paid employment.

Direct Payments

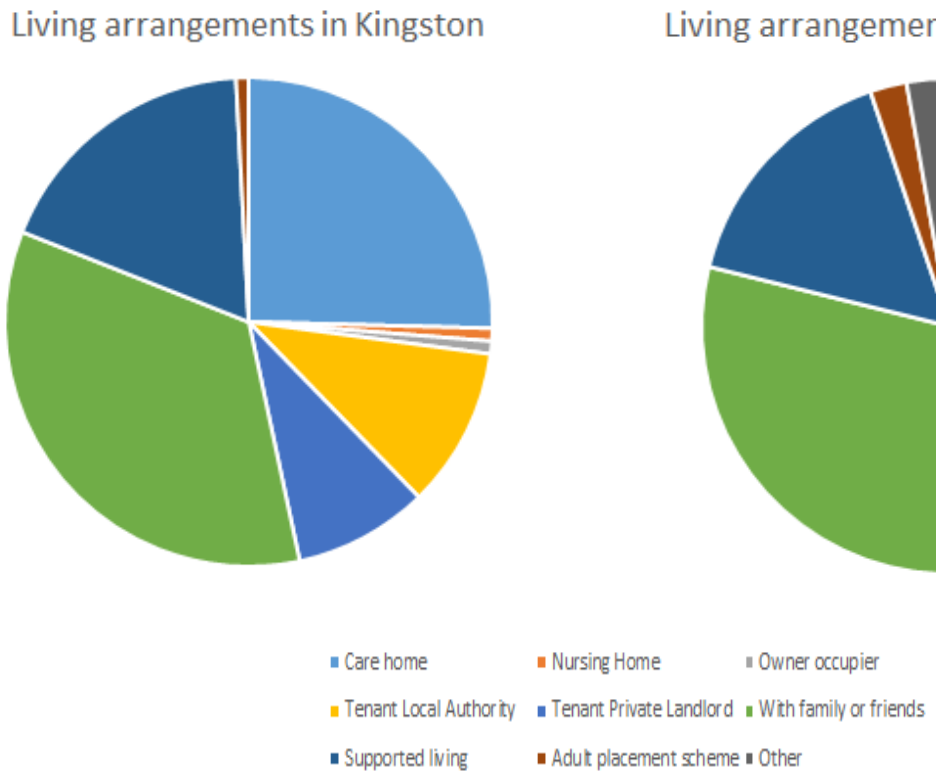
- Direct payments are cash payments to people who need care and support services, giving them the opportunity to organise the help they need directly. Direct payments offer people greater choice and control over their lives, and put them in control of the decisions about how their care and support is delivered.
- Direct payments will continue to be offered to all eligible adult social care users who are eligible to receive them.
- Kingston currently has over 300 direct payment users. The majority opt to employ their own personal assistants.
- It is anticipated that there will be an increased demand for direct payments from carers.

Living arrangements

- Table 6 below outlines the living arrangements for adults with learning disabilities in Kingston known to services compared to national data.

Table 5: Living arrangements of people with learning disabilities in Kingston (%)

	Care home	Nursing Home	Owner occupier	Tenant Local Authority	Tenant Private Landlord	With family or friends	Supported living	Adult placement scheme	Other
Kingston 15/16	25.5	0.8	0.8	10.6	8.9	34.4	18.2	0.8	0
National [7] 2011	22	1.6	2.5	12	3	38	16	2.4	2.8



In 2015-16 the total Adult Social Care spend for Learning Disability services in Kingston was in the region of £20 million. This amounts to 36% of the total Adult Social Care budget. The table below illustrates how this is spent and on what types of services.

Table 6: Type of Learning Disability service and proportion of budget	
Residential Care	32%
Day Care	22%
Supported Living	16%
Direct Payments	12%
Respite	8%
Independent Specialist provision	4%
Other Services	4%
Nursing Care	2%

The market that we wish to facilitate

The market we wish to facilitate is one where people with a learning disability have access to a range of appropriate, high quality support services that enable them to achieve their individual goals and outcomes.

This market should offer sufficient capacity to meet individual choice and changing demand, with a workforce that is skilled and valued through remuneration, training and continued personal development.
http://www.skillsforhealth.org.uk/images//resource-section/projects/learning-disabilities/Learning-Disabilities-

Support must be provided in a way that achieves the best value for money for individuals, commissioners and stakeholders alike and in keeping with Kingston's published "Community Outcomes"
https://www.kingston.gov.uk/downloads/file/240/kingston_plan_

We want to engage with new and existing health, housing, care and support providers to deliver high quality services for people with learning disabilities which:

Offer services that	▪ improve the quantity, quality and suitability of services ▪ help family carers to enjoy a good quality of life ▪ increase employment and volunteer opportunities
Promote personalisation through	▪ personal budgets ▪ increased choice and diversity ▪ providing services that cater for cultural and religious differences

Supporting people with learning disabilities to	▪ plan for their future with their families and carers ▪ have successful transitions into adulthood ▪ prevent admission into hospital ▪ stay healthy and independent ▪ live a fulfilling life ▪ have a job and have opportunities to learn new skills ▪ lead a healthy life and support to reduce anxiety ▪ feel safe in the community and at home ▪ have a home that is close to support networks
Support providers to	▪ promote community integration, progression and independence in services ▪ take a co-production approach in designing and delivering services ▪ understand your business and financial imperatives better to prevent provider failure and support your services ▪ complete the Quality Assessment Framework (QAF) on your services with support from the Commissioning team

Autistic Spectrum Condition (ASC) population figures and need

- Autism is a lifelong, developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them. It is a spectrum condition with some people able to live relatively independently, whereas as others may have accompanying learning disabilities and need lifelong specialist support.
- High functioning autism and Asperger's syndrome are forms of autism in which people may have average or above average intelligence. They tend to have fewer problems with speech but may still have difficulties with understanding and processing language.
- It is believed that 700,000 people in England have autism which is equivalent to greater than 1% and similar to the prevalence of dementia[34].
- It is estimated that approximately 1803 individuals in Kingston have autism[35].

[34] National Autism Strategy 2014.
[35] RBK. Autism JSNA. 2015.

- For every three known cases, there are two undiagnosed individuals who might need a diagnosis at some point in their lives[36].
- Research studies show the prevalence of autism is higher in men (2%) than women (0.3%)[37,38].
- The prevalence of autism increases with the greater severity of learning disability / lower verbal IQ[37].
- Around a third of people who have learning disabilities (IQ less than 70) also have autism[39].
- People with autism are at high risk of bullying or harassment; over half of adults with autism who were surveyed by the National Autistic Society in 2008 reported that they had been bullied or harassed as adults[40].
- 83% of individuals with Asperger's Syndrome surveyed felt strongly that many of the problems they faced were as a direct result of others not understanding them[41].
- Autism could also render someone highly vulnerable if they come into contact with the criminal justice system[37] e.g. police officers, probation services and courts may all be unaware of communication challenges - leading to overly heavy-handed responses to incidents[42].
- Many adults with autism cite employment as the single biggest issue or barrier facing them[43].
- About two thirds of adults with autism do not have enough support to meet their needs and one in three is experiencing severe mental health difficulties due to this. It has been reported that approximately 15% of adults with autism attempt suicide, due to experiences of feeling socially isolated, sexual and financial exploitation, bullying, depression and anxiety[7]. Family and peer support has been shown to improve levels of wellbeing and optimism amongst adults with ASC[7].

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[36] Baron-Cohen S, Scott F J, Allison C, et al. Prevalence of autism-spectrum conditions: UK school-based population study. The British Journal of Psychiatry May 2009, 194 (6) 500-509

[37] Brugha et al. Estimating the Prevalence of Autism Spectrum Condition in Adults, The Health and Social Care Information Centre. 2012.

[38] HS Information Centre. 2009. Autism Spectrum Disorders in adults living in households throughout England: Report from the Adult Psychiatric Morbidity Survey 2007, NHS.

[39] Turk, J. (2010) Autism Spectrum Conditions across the Lifespan, St. Georges University of London, Kings College London and South London, and Maudsley NHS Trust.

[40] Fombonne et al. 2001. Prevalence of Developmental Disorders in the British Nationwide Survey of Child Mental Health. Journal of the American Academy of Child and Adolescent Psychiatry.

[41] Simons, L. (2007) Think Differently, Act Positively – Public Perceptions of Autism, National Autistic Society.

[42] Adult Psychiatric Morbidity Survey. 2007.

[43] Barnard, J. et al. 2001. Ignored or Ineligible: the Reality for Adults with Autistic Spectrum Disorders, The National Autistic Society.

- A survey in 2013 noted that 70% of respondents with ASC were still not getting the help they needed[7].

Table 7: **Total expected number of people with autism spectrum condition (ASC) in Kingston**	**All ages**	
ASC population with IQ>70	897 - 1047	732 - 854
ASC population with IQ<70	823 - 972	671 - 793
Total ASC population	1870	1524

Source: Based on 1.1% national prevalence on the 2014 mid-year population estimates of all ages, males & females 169,958 people. Based on 44% - 52% of people with autism having a learning disability and 48% - 56% of people with autism not having a learning disability.

Table 8: **Age breakdown of people with autism in Kingston**

Age range	**0-9 years**	**10-14 years**	**15-19 years**	**20 -64 years**	**65+ years**
Total	248	97	103	1173	247

Source: RBK. Autism JSNA. 2015.
Notes: Based on 1.1% national prevalence on the 2014 mid-year population estimates of all ages, males & females 169,958 people

- Given the limitations of the data collected locally it is clearly seen that statutory services are only reaching a small proportion of the population of people with autism. Adults with autism known to the specialist services provided by Your Healthcare are only 14% of the estimated population of people with autism in Kingston.

Table 9: **Numbers of people with autism known to services in Kingston**	
Adults with autism without a learning disability (IQ>70) known to Your Healthcare	105
Adults with autism and a learning disability (IQ<70) known to Your Healthcare	97
Number of adults on diagnostic pathway with Your Healthcare	14 without a Learning Disability (LD) on wait list for assessment 5 with a LD on wait list for assessment 7 with LD assessments in progress
Adults with autism known to mental health services	Data not available as recorded as consultation episodes
Adults with autism known to voluntary sector	Data not available as not routinely collected centrally
Under 19's with autism known to AFC	345 Children with Disabilities on the Kingston Register. Children with ASD 240 with autism as primary category. 301 on the SEN Database listed as having ASD of that 301 Children 188 with ASD and additionally listed as having social communication difficulties. 394 with autism as primary need. 61 with autism as secondary need as recorded in the Summer School Census.

Source: Your Healthcare on 1.3.15 (Data collection started in 2012) Achieving For Children, Autism Strategy 2014 including the Disabled Children's Database, SEN Database & Summer School Database 2016

- Prevalence data also suggests that between 25-33% of all adults with autistic spectrum conditions will also develop mental health problems; and 85% will be dependent on state and / or family support. There currently appears to be a gap in support for parents and carers of adults with autistic spectrum conditions who fall below the threshold of specialist services.

- The recent Autism Act highlighted the increasing number of adults with autistic spectrum conditions who have neither a learning disability nor a mental illness.

Consequently, there is a need to improve understanding of autism in Kingston and how to design environments, services and skills to support people with autism more effectively.

Current service provision for adults with autism

Existing service provision for adults with high functioning autism (without a learning disability) include:

- 1-1 support sessions
- Group programmes:
    - Understanding Asperger Syndrome course
    - Communication Skills
    - Preparing For Work (including job club sessions)
    - Anxiety Management
    - Building Relationships
    - Independence skills
    - Social Group
    - Drop In Group

Future commissioning intentions and opportunities for development for adults with learning disability and adults with autism

The following needs and opportunities for development have been identified:

- Accessible respite beds and ground floor accommodation, because there are a number of young people with complex medical needs.
- Respite for young adults with autism and challenging behaviour, this includes activities during the day as well as overnight breaks.
- Supportive living services that can work with adults with learning disability and additional complex needs i.e. mental health conditions.

- Flexible respite because adults can stay on at school until 19 years of age and can then attend local specialist colleges. Flexible respite provision would support these young people to stay living at home with their parents. This could include an after school/college club or service from 3.00-6.00pm weekdays and at weekends to support young adults to attend activities.
- For young adults to have a Continuing Healthcare assessment if they have ongoing medical or complex needs. And for the health needs of adults with complex health needs to be monitored regularly by a health care professional. This needs to be done when the young person is 17 years old so that the provision to meet their assessed health needs can transfer to appropriate adult services.
- Robust housing and tenancy agreements and access to more permanent housing/affordable housing options.
- For dementia services, training and dementia friendly environments in people's homes.
- An increase in the capacity of local specialist college's due to the reduction in the use of specialist residential placements.
- An increase in employment opportunities for adults with learning disabilities.
- Equitable access to services and support for adults with autistic spectrum conditions that enable and empower them.

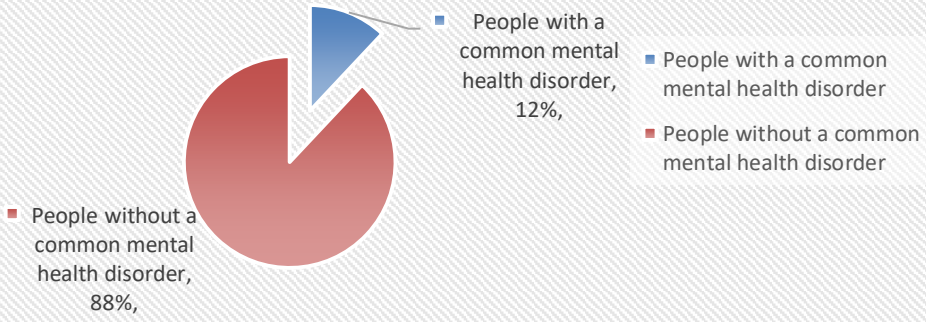
Market Position Statement for adults with mental health conditions

Help us to develop the right care and support for adults with mental health conditions in the Royal Borough of Kingston

Mental health is an essential component of a persons' health and has an impact on every aspect of life, including how people feel, think and communicate. It impacts on physical health, lifestyle choices, and behaviour. Mental ill-health is the largest single source of ill-health in the UK. No other health condition matches mental illness in terms of prevalence, persistence and breadth of impact. It is estimated that 21,000 (12% of the population) borough residents aged 16 and over have a common mental health disorder[44] (including anxiety, depression, panic disorder and obsessive compulsive disorder). In many cases the most appropriate treatment for these conditions will be talking therapies, and this has been recognised by the Improving Access to Psychological Therapies programme. A new mental health strategy for Kingston is also currently being co-produced facilitated by Healthwatch Kingston upon Thames.

Mental health condition population figures and need

Figure 1: Kingston residents aged 16 and over with or without a common mental health disorder



[44] RBK. Mental Health and Wellbeing in Kingston. Annual Public Health Report 2014.

Table 1: Predicted number of people aged 16 and above affected by common mental health disorders in Kingston by age in 2014

	Age band							
	16-24	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**	**All 16+**
Mixed anxiety & depressive disorder	2,221	2,841	2,218	2,377	1,270	704	605	**11,928 (9.0%)**
Generalised anxiety disorder	784	1,105	1,383	1,295	651	363	267	**5,831 (4.4%)**
Depressive episodes	479	579	757	785	302	110	154	**3,048 (2.3%)**
All Phobias	327	500	548	318	222	33	10	**1,855 (1.4%)**
Obsessive Compulsive Disorder	501	395	287	233	79	33	41	**1,458 (1.1%)**
Panic disorder	240	421	339	191	159	55	51	**1,458 (1.1%)**
Any common mental health condition	**3,811**	**4,946**	**4,514**	**4,224**	**2,238**	**1,166**	**1,016**	**21,470 (16.2%)**

Source: ONS 2007 Adult Psychiatric Morbidity Survey among adults in England and ONS 2012 mid-year estimates.

- It is estimated that there are 11,928 people in Kingston aged over 16 with mixed anxiety and depressive disorder, 5,831 with generalised anxiety disorder, 3,048 with depressive episodes, 1,855 with phobia, 1,458 with obsessive compulsive disorder and 1,458 with panic disorder[45].
- Adult safeguarding: The most common social care need of the adult at risk at the point an alert was raised was mental health, followed by dementia[46].
- Depression affects 1 in 5 people over the age of 65 living in the community and 2 in 5 living in care homes[47].
- However depression is often not diagnosed, and even when diagnosed is often not treated appropriately. Depression is often overlooked as it often occurs alongside other illnesses. As few as one in six people with depression ever discuss it with their

[45] RBK. Mental Health and Wellbeing in Kingston. Annual Public Health Report 2014. (Original source: ONS 2007 Survey of Psychiatric Morbidity among adults in Great Britain and ONS 2012 Midyear Estimates.)
[46] RBK. Mental Health and Wellbeing in Kingston. Annual Public Health Report 2014.
[47] Adults in Later Life with Mental Health Problems: A Factsheet, at www.mentalhealth.org.uk, quoting Baldwin R (2002) Depressive Disorders In Jacoby R and Oppenheimer C (9eds) Psychiatry in the Elderly (3rd edition) pp 627-676 Oxford: Oxford University Press, (2002).

GP[48]. Only half of those that do discuss it are diagnosed and treated, primarily with antidepressants. Older people are rarely referred for psychological interventions, despite good evidence that these can reduce their need for GP appointments, hospital stays and outpatient visits.

- 4% of people in Kingston age 18+ are recorded as having depression by GPs in 2012/13[49].
- It is estimated that there were 636 people with severe depression in 2015 in Kingston aged 65 and older.
- A third of people who provide unpaid care for an older person with dementia have depression. Depression is the most common risk factor for suicide. Older men and women, especially those aged over 75, have some of the highest suicide rates of all age groups in the UK[50].
- It is estimated that as many as 70% of new cases of depression in older people are related to poor physical health[51,52]. People with two or more long term conditions are seven times more likely to have depression than those without any long term conditions[53].
- Untreated depression leads to worse health outcomes and increased healthcare spending for people with long term conditions[54,55].

Anxiety

- Between 1,900 and 4,600 of older residents in Kingston have some symptoms of anxiety.

Psychotic disorder

- The data suggests that compared with common mental health disorders far fewer people will have psychotic disorders; 444 people aged 18-64 in Kingston have a psychotic disorder[51] and the number of adults estimated to have schizophrenia in Kingston is 226[50]. The prevalence of psychoses recorded in Kingston general practices (0.8%) is lower that the London average of 1%[50].

[48] Chew-Graham C, Baldwin R, Burns A. (2004) Treating depression in later life; we need to implement the evidence that exists. Editorial. BMJ Jul 24;329(7459):191-2.
[49] Public Health England. Community Mental Health Profiles.
[50] RBK. Kingston Core Dataset 2013/14.
[51] Office of the Deputy Prime Minister (2004) Mental Health and Social Exclusion: Social Exclusion Unit Report.
[52] Dennis M. et al (2005) Self harm in older people with depression, The British Journal of Psychiatry 186:538-539.
[53] RBK. Older People in Kingston Living Well in Later Life. Annual Public Health Report for Kingston 2013.
[54] Simon G, Katon W, Lin E, et al (2005) Diabetes complications and depression as predictors of health service costs. General Hospital Psychiatry 27: 344-51.
[55] Frasure-Smith N et al (1999) Gender, depression, and on-year prognosis after myocardial infarction. Psychosomatic Medicine 61:26-37.

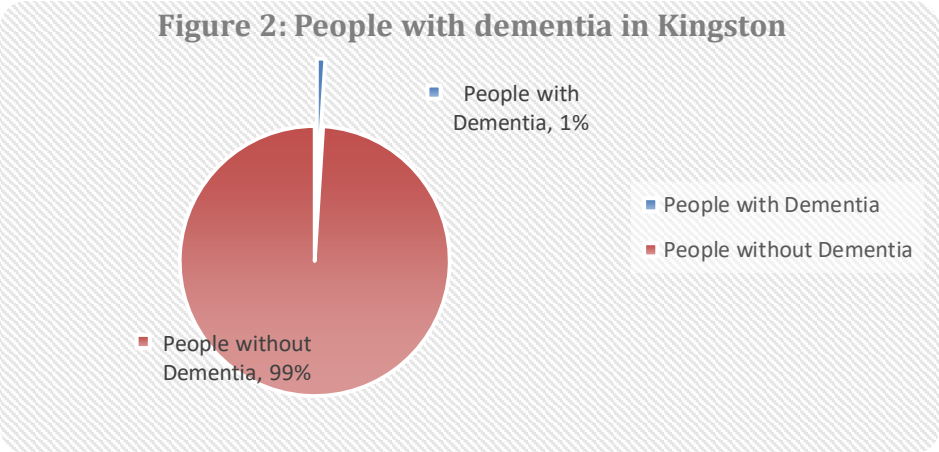
Suicide

- What follows are the current and projected suicide rates for Kingston up to and including 2030:

Table 2: Kingston-upon-Thames mortalities of people aged 18-64 from suicide, by gender, projected to 2030	**2014**	**2015**	**2020**	**2025**	**2030**
Males aged 18-34 predicted to commit suicide	1	1	1	1	2
Males aged 35-64 predicted to commit suicide	3	4	4	4	4
Females aged 18-34 predicted to commit suicide	1	1	1	1	1
Females aged 35-64 predicted to commit suicide	1	1	1	1	1
Total population aged 18-64 predicted to commit suicide	6	7	7	7	8

Source: Projecting Adult Needs and Service Information. Population Figures. Kingston upon Thames.

Dementia population figures and need



- Dementia is a progressive condition that predominantly affects older people. It causes a decline in mental ability which affects memory, thinking, concentration, problem solving and perception.
- Kingston has one of the highest life expectancies in England and, as a result, nearly half of patients over 75 have dementia which is double the national average[56].

[56] Kingston Hospital.

- The number of people with dementia in Kingston in 2014 was estimated at 1,600 and this is expected to increase to 1,800 by 2020[57].
- Many people suffering dementia are undiagnosed - fewer than half of older people with dementia ever receive a diagnosis[58]. This may be due to individuals and families failing to recognise the symptoms or protecting themselves from the perceived stigma of dementia. Even among people who are in regular contact with health services the symptoms may go undetected due to a focus on physical illness, or a perception that nothing can be done[53].
- The advantages of early diagnosis and intervention include reducing or delaying care home placement, and improved quality of life for both individuals and carers[53].
- The prevalence of dementia among older people with learning disabilities is much higher (21.6%) than the general older population[59].
- An estimated 12% of people over 65 in Kingston are from black and minority ethnic groups. Access to services may be challenging due to language barriers, knowledge of services availability, attitudes and practices of service providers and cultural factors[59].
- A small number of younger people in Kingston have early-onset dementia. This group is recognised to have specific differences in their health, care, and social needs[59].
- Most people with dementia have at least one other co-existing illness and 59% of patients with dementia have two or more co-existing illnesses, both physical and mental[59].
- People with dementia tell us that they wish to live in the home of their choice, near to family and carers, and to receive the best quality care at the right time and in the right place. We have heard that holistic support should be available and that it must be extended to carers, for whom the caring role can be extremely demanding and stressful. We aim to change the culture in Kingston to one that is truly supportive of people with dementia.

[57] RBK. Mental Health and Wellbeing in Kingston. Annual Public Health Report 2014.
[58] Alzheimer's Society (2013). Mapping the dementia gap. London: Alzheimer's Society.
[59] RBK. Dementia Strategy 2015-2020. Kingston Clinical Commissioning Group. July 2015

Current service provision

The number of people with mental health problems receiving services from Adult Social Care in Kingston, 2013/14 were:

- Aged 18-64: 26 receiving residential or nursing care and 505 receiving community based services[60].
- Aged 65+: 87 receiving residential or nursing care and 255 receiving community based services[61].

The number of people with mental health conditions receiving community based services from Adult Social Care, 2013/14 were:

- Aged 18-64: 16 receiving home care, 17 receiving day care, 41 using direct payments, and 483 receiving professional support[61].
- Aged 65+: 84 receiving home care, 26 receiving day care, 38 receiving meals, 14 using direct payments, 153 receiving professional support and 32 using equipment and adaptations[61].

Primary Care Services

- The Kingston IAPT (Improving Access to Psychological Therapies) service (known as iCope) aims to support people suffering from common mental health problems such as depression, anxiety disorders, obsessive compulsive and panic disorders. It provides a first-line treatment solution for people with mental health needs such as talking therapies, combined with medication for people experiencing one of these conditions.

Secondary mental health services

- Figure 1 details the current number of people accessing community based secondary mental health services in Kingston.

[60] RBK. Mental Health and Wellbeing in Kingston. Annual Public Health Report 2014.
[61] RBK. Mental Health and Wellbeing in Kingston. Annual Public Health Report 2014.

Figure 1: Current cases open to Mental Health Services	
Early Intervention Service	**78**
Crisis and Home treatment Team	**22**
North Kingston CMHT	**458**
South Kingston CMHT	**413**
Older Peoples CMHT	**209**

Supported accommodation and housing related support

- There is a persistent demand for accessible supported accommodation based services following hospital discharge. The number of permanent care home placements commissioned has reduced over recent years. This is in the main due to the recovery model in mental health and the resulting increased numbers of people placed in supported living services. The market for mental health residential and nursing care remains relatively small and as such we do not currently envisage any significant change in demand.

Future commissioning intentions and development opportunities

- The transformation of mental health services in Kingston is one of the top priority areas for 2016/17. We are working closely with the Kingston Public Health team to promote resilience and to reduce self-harm and suicide.
- We have an ambition to embed mental health - promoting it, maintaining it, supporting and treating those with problems - within the community.
- We are up-skilling existing primary care, commissioning new primary mental health services both for functional and organic mental health and working with existing mental health providers to integrate their services in the community with primary care.

Progress on the 2015/16 Commissioning Intentions and Operating Plan key items:

2015/16 Commissioning intentions	Progress
Personality Disorders - carried forward from 2014/15: agree plans for personality disorder services for implementation in 2016/17;	▪ This is work in progress with South West London and St Georges Mental Health Trust (SWLStG) delivering its community transformation programme.
Capacity - strengthen community focus for adult mental health provision, including: ▪ Enhance primary care provision ▪ Expand the home treatment service ▪ Introduce a single point of access to more specialist services ▪ Increase IAPT capacity and linkages with primary care ▪ Ensure focus for Community Mental Health Teams (CMHTs) is on those with more severe illness ▪ Strengthen hospital - community liaison, including crisis intervention ▪ Reserve hospital referral for those with high level / acute needs ▪ Ensure IAPT services have the capacity for veterans of the armed forces	▪ Enhanced primary care mental health provision has been commissioned for both functional and organic mental health ▪ The home treatment service in Kingston has been expanded to meet the original Department of Health guidance over numbers of staff required for our population. ▪ The IAPT (Improving Access to Psychological Therapies) service capacity has been recurrently increased. Kingston is currently meeting all the national targets for this service. ▪ We are working closely with the Metropolitan Police to agree a mental health model that works aligned with them. The police are often the first point of contact with people who are experiencing a mental health crisis.
Community wellbeing services – continued development to enable shift of emphasis and provision, reducing specialist, often hospital-based services, increasing generalist community provision, especially in primary care and involving voluntary and community sector provision	This work is established through Kingston's delivery of the Crisis Care Concordat. Kingston has developed a five year action plan against this national directive.

Seek to consolidate provision of community wellbeing and substance misuse services from a single base and derive benefits from this realignment	▪ Following public consultation the transfer of substance misuse services to Hollyfield House in Surbiton was not implemented. The CCG will look at other ways of treating people who may have co-morbidities within one service.
Redesigned services for older adults, shifting some resource from inpatient and specialist services to enhanced generic, community services (likely requirement for short-term pump-priming to enable transition): (i) implementation of community-based Dementia services, key components being: ▪ primary care focus, practice lead GPs / mental health champions ▪ additional Dementia Adviser posts working with primary care ▪ Kingston community-based memory service (including clinics) ▪ strengthen links with / capacity in voluntary and community sector (ii) strengthen community services and support to allow revised model of inpatient provision (towards assessment and short term treatment), reduce inpatient beds, reduce average lengths of stay	▪ Following consultation a dementia strategy for Kingston was agreed in July 2015. ▪ Negotiation for long term funding of Dementia Advisor and Dementia Development Worker post with CCG and RBK. ▪ Commissioning of a new community based memory clinic which will review and support people with dementia who have been diagnosed by SWLStG but who do not require ongoing secondary mental health care. ▪ Building capacity in Kingston Dementia Alliance to establish a Dementia Friendly Kingston and requesting that the Dementia Development Worker takes a strategic overview to determine what is required in terms of local support and services. ▪ Review the role of Social Workers within SWLStG and potentially realign into generic health and social care services which are community based.

Market Position Statement for adults with substance misuse needs

Help us to develop the right care and support for adults with substance misuse needs in the Royal Borough of Kingston

There are a variety of reasons why people use drugs and alcohol. Many people use drugs and alcohol in a recreational way that causes no problem to them or the people around them and most people are able to stop using them without help and support. However drug and alcohol misuse[62] (harmful use and dependence) negatively impacts on the lives of people using these substances and can also have a significant impact on the people around them, including their families, friends, communities and wider society. It is estimated that alcohol misuse costs society £21 billion each year and the cost of drug misuse to society is £15.4 billion each year in healthcare, crime and loss of productivity.

Substance misuse population figures and need

Table 1: Population of Kingston aged 18-64 predicted to have a drug or alcohol problem, by gender, projected to 2030

	2014	2015	2020	2025	2030
Males aged 18-64 predicted to have alcohol dependence	4,785	4,855	5,150	5,420	5,664
Females aged 18-64 predicted to have alcohol dependence	1,838	1,864	1,960	2,039	2,115
Total population aged 18-64 predicted to have alcohol dependence					
	6,623	**6,719**	**7,111**	**7,459**	**7,779**
Males aged 18-64 predicted to be dependent on drugs	2,475	2,511	2,664	2,804	2,930
Females aged 18-64 predicted to be dependent on drugs	1,281	1,299	1,366	1,421	1,474
Total population aged 18-64 predicted to be dependent on drugs					
	3,756	**3,810**	**4,030**	**4,225**	**4,404**

Source: Projecting Adult Needs and Service Information. Population Figures. Kingston upon Thames.

[62] The National Institute for Health and Clinical Excellence (NICE) defines drug misuse disorders as intoxication by, dependence on, or regular, excessive consumption of psychoactive substances leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs (including alcohol when used in combination with other substances).

- Table 1 shows an expected 16% increase in people aged 18-64 predicted to have alcohol dependence in Kingston from 2015 to 2030. In 2014/15 227 adults accessed alcohol treatment in Kingston. A 15% increase in people aged 18-64 predicted to have drug dependence is also predicted in Kingston from 2015 to 2030. In 2014/15 342 adults accessed drug treatment in Kingston.

- Alcohol is one of the three biggest lifestyle risk factors for disease and premature death in the UK, after smoking and obesity. Alcohol is a causal factor in more than 60 medical conditions, including: mouth, throat, stomach, liver and breast cancers; high blood pressure, cirrhosis of the liver; and depression[63]. It is likely to be a factor in poor disease management increasing the risk of long term disability and accounts for 10% of disability-adjusted life years (DALYs)[64]. 85% of Kingston residents drink alcohol and 28% drink at increasing and higher risk levels[65]. Drinking at higher risk levels increases the risk of alcohol-related disease; the risk of liver disease is increased by 13 times and risk of coronary heart disease is increased by 1.7 times for men and 1.3 times for women[66].

- It is estimated that there are 522 opiate and crack users (OCU's) in Kingston and that 28% are injecting drug users[67]. This figure does not include people injecting novel psychoactive substances such as mephedrone or image and performance enhancing drugs which include steroids and tanning substances. Providing opiate substitute prescribing and sterile injecting equipment helps to protect individuals from the transmission of blood borne viruses and provides long term health savings.

Mental health

- Research[68] has shown that the majority of people accessing substance misuse services (75% drug users and 85% of alcohol users) were experiencing mental health problems and 44% of mental health service users either reported drug use or were assessed to have used alcohol at increasing risk or higher risk levels in the past year.

- Between the 1st April 2015 and 31st December 2015 29% of people starting drug treatment and 25% starting alcohol treatment were also receiving care from mental health services for reasons other than substance misuse. This reflects the number of

[63] World Health Organisation (2012) The impact of Alcohol on Health. Available from : http://www.euro.who.int/__data/assets/pdf_file/0003/160680/e96457.pdf [accessed 10th March 2016]
[64] Lundbeck Ltd (2015) Under Pressure Tackling two of the most common preventable health harms in the UK; high blood pressure and excessive alcohol consumption. A Treat 15 Expert Group Report [online]. Available from: http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2015/09/MF_underpressure_v10_online.pdf [accessed on the 10th March 2016]
[65] North West Public Health Observatory (2012) Topography of Drinking Behaviours in England [online] Available from: http://www.lape.org.uk/downloads/alcoholestimates2011.pdf [accessed on the 10th March 2016]
[66] NHS Choices The risks of drinking too much [online]. Available from: http://www.nhs.uk/Livewell/alcohol/Pages/Effectsofalcohol.aspx [accessed on the 10th March 2016]
[67] Public Health England (2015) Drugs Data: JSNA Support Pack Key data to support planning for effective drugs prevention, treatment and recovery in 2016-17. Unpublished report.
[68] Weaver, T. (2003). Comorbidity of substance misuse and mental health in community mental health and substance misuse services. British Journal of Psychiatry, 183, 304-313.

people whose co-morbidity met the criteria for access to community mental health services but does not include those people with common mental health problems such as anxiety or depression. Individuals with coexisting mental health and substance misuse issues experience worse physical health, higher levels of personality disorder, greater levels of disability and lower quality of life than those who do not. Successful outcomes require early intervention and effective collaboration across alcohol, drug and mental health services.

Parents

- The impact of a parent's/carer's substance misuse on children will vary from family to family, and children living with parental substance misuse will respond and cope differently. Experiencing substance misuse does not necessarily preclude loving and effective parenting[69]. There is a strong stigma attached to substance misuse, which means that the issue can remain hidden, further exacerbating the problem. Parents/carers themselves require and deserve support and asking for help should be seen as a sign of responsibility rather than as a parenting failure.

- In 2014-15 Kingston Wellbeing Service supported 255 parents who lived with their children, representing 42% of the overall caseload compared to 29% nationally. For children of substance misusing parents/carers, parental engagement with treatment services is a protective factor and it is vital that substance misuse services are in place in Kingston to support them.

Investing in treatment

- Drug and alcohol dependency leads to significant harm and places a financial burden on communities. It increases the demand for health, social care and criminal justice services and associated costs. Investment in prevention, treatment and recovery interventions reduce this demand and the associated costs and improve outcomes for individuals, their families and the community. When engaged in treatment, people use less illegal drugs, commit less crime, improve their health, and manage their lives better. Preventing drug and alcohol related deaths is also an important function of a recovery orientated drug and alcohol treatment system.

- Investing in drug and alcohol treatment saves money; Public Health England estimates that every £1 spent on drug treatment saves £2.50 in costs to society. Over the last decade Kingston has invested approximately £1.2 million annually in

[69] Department of Education (2014) Assessing Parental Capacity to Change when Children are on the Edge of Care: an overview of current research evidence. Research report available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/330332/RR369_Assessing_parental_capacity_to_change_Final.pdf [accessed on the 10th March 2016].

drug and alcohol prevention, treatment and recovery services. This investment has resulted in favourable outcomes with:

- 48% of alcohol users successfully completing treatment compared to 39% nationally.
- 51% of non-opiate users successfully completing treatment compared to the national top quartile of 47%.
- 44% of alcohol and non opiate users successfully completing treatment compared to the national top quartile of 42%.
- 9% of opiate users successfully completed treatment; this was in line with the national top quartile[70].

Current service provision

Community based treatment

- In Kingston a range of interventions are provided within a stepped care approach where people are initially offered the least intensive, most cost effective intervention and they are able to move up and down the system depending on their needs and treatment outcomes. Drug and alcohol treatment services are available for people who require support or clinical interventions to enable them to reduce drug and alcohol related harm and help them overcome their dependence. The service is provided at Kingston Wellbeing Service and the current delivery model is based around a fixed site service at Surbiton Health Centre. The service is also available through a small number of satellite services in GP practices, criminal justice and community settings.

- There are cohorts of people who are reluctant or unable to access a fixed site service and might be more likely to engage if services were available from a greater range of venues. In order to reduce access inequalities Kingston plans to explore opportunities for co-location and joint working arrangements with other health, social care and criminal justice services to make the service more geographically available. Options to extend opening hours and provide care at home or in a preferred location will also be explored to meet the changing needs of the drug and alcohol using population.

[70] Public Health England (2016) 2015-16 Quarter 3 Diagnostic Outcomes Monitoring Executive Summary report (DOMES). Unpublished report.

Locally commissioned services in Primary Care

- Alcohol Identification and Brief Advice (IBA) is an evidence based intervention directed at people drinking at increasing and higher risk levels who are not typically seeking help for an alcohol problem. It is an opportunistic and cost effective intervention that can be delivered in a wide range of settings. Twenty four out of twenty seven GP practices provide alcohol IBA in Kingston.

- People registered with two GP practices are able to receive opiate substitute prescribing treatment and support for a community alcohol detoxification directly from their GP. Care is delivered in partnership with the drug and alcohol treatment provider.

Locally commissioned services in Pharmacies

Kingston commissions three services through community pharmacies.

- Eight pharmacies provide alcohol IBA.

- Ten pharmacies provide Supervised Self-Administration (SSA) of methadone or buprenorphine (opioid substitute medication). This is available for people who are new to treatment, at risk of misusing prescribed medication or who lack safe storage facilities.

- Eleven pharmacies provide needle and syringe exchange services in Kingston. These services reduce the transmission of Blood Borne Viruses (BBV) and other infections caused by sharing and re-using injecting equipment, through the distribution of sterile injecting equipment. Bins are also provided so that people can safely store and return used injecting equipment and this also benefits the community by reducing the risks presented by inappropriately discarded injecting equipment.

Locally commissioned online services

- Kingston's e-drink-check website (e-drink-check.kingston.gov.uk) is designed to help local residents think about how much they are drinking and provides information about alcohol and its effects, as well as tools and tips for people wishing to moderate or stop their drinking. It also provides information about local alcohol treatment services.

Residential Rehabilitation

- Drug and alcohol treatment mostly takes place in the community, near to people's families and social networks, however a stay in residential treatment may be required for some people. These services are funded by adult social care.

- Residential treatment is accessible to Kingston residents who require high level intensive support to become abstinent from drugs or alcohol and who meet the Care Act eligibility criteria. In Kingston 3% of the treatment population accessed residential rehabilitation services in 2014-15 and this is the same as the national figure.

- Although residential rehab currently accounts for a small proportion of adults in alcohol and drug treatment it accounts for 12% of the total funding. On average a period in rehab costs £700 a week, making it much more expensive than non-residential treatment services.

Recovery support

- Mutual aid groups are a source of structure and continuing support for people seeking recovery from dependence, and for those directly or indirectly affected, such as partners, close friends, children and other family members. Peer support has long been recognised as a valuable resource for people leaving treatment in order to prevent a relapse. This is a critical time for those wanting to remain abstinent or to achieve a level of stability.

Future commissioning intentions and development opportunities

- In line with national trends the numbers of people accessing treatment for opiate addiction is reducing. It is predicted that more people will require support for non opiate drug use including cannabis, cocaine and Novel Psychoactive Substances (NPS) such as mephedrone and synthetic cannabinoids. People using these drugs are likely to be younger and are not likely to present to treatment services for help. They have different needs to opiate users and will require shorter, intensive interventions focused on preventing further harm and recovery. There are also growing numbers of people requiring support to reduce or stop their use of over the counter and prescribed medication.

- Although fewer opiate users are presenting to treatment, Kingston has a high proportion of opiate users who have been in treatment for 4 years or more and many of them have high levels of complexity. There are a growing number of older drug users, many of whom have serious health related problems as well as substance misuse issues which will need an effective local response.

- There is a growing concern about the recent increase in the number of people injecting a range of stimulants, particularly the recently emerging psychoactive drugs such as mephedrone. Injecting of these drugs is associated with increased risk behaviours (such as increased injecting frequency and sharing of injecting equipment), due to the effects of the drugs leading to compulsive use. This increases the risks of transmission of blood borne viruses, as well as injection site

infections, abscesses and deep vein thrombosis[71]. The provision of effective interventions, such as needle and syringe programmes and other treatments for drug use will need to be available and will need to respond to any changes in patterns of drug use and associated risk.

- There is a perceived rise in the use of drugs during sex which has prompted concern about high-risk sexual behaviour. The relationship is complex and while it is not possible to say that using drugs cause's sexual risk-taking behaviour it is possible to say that there is an association between the two. Those who inject drugs are at an increased risk of contracting blood borne viruses (BBV) and sexually transmitted disease. The provision of effective interventions, such as needle and syringe programmes and other treatments for drug use will need to be available and drug and alcohol treatment services will need to work with sexual health services to respond to any changes in patterns of drug use and associated risk.

- There is a group of people whose chronic substance misuse is a contributory factor in more frequent or very frequent contact with health and social care services. These individuals are a highly cost intensive, complex and challenging group, and are more likely to experience the poorest outcomes including debilitating illness and premature death. This is a group defined as much by the presence of chronic physical and mental illness and unmet social needs as they are by their substance misuse. An effective local response needs to be developed which includes non-site based contact and which supports behavioural change, including reduction in risk behaviours and improved management of chronic disease.

- Treatment access and outcomes for drug and alcohol misusing offenders needs to be improved as they are comparatively worse than for other substance misusers, and relapse rates are higher.

- There is a need to develop the range, availability and geographical locations of treatment and recovery support to ensure this is widely available, including for parents and those with caring responsibilities, people with mobility issues and those in employment or education.

- There is a need to improve the range and access to recovery focused support to assist treatment completion and long term recovery in the community. This could include interventions to support people to get back into education, training and

[71] Public Health England (2015) Shooting Up: infections among people who inject drugs in the UK. Available from: https://www.gov.uk/government/publications/shooting-up-infections-among-people-who-inject-drugs-in-the-uk [accessed on the 10th March 2016].

employment as well as opportunities to provide facilitated access to mutual aid groups where required.

- There are limited accommodation options for people with substance misuse issues in Kingston and with housing at a premium this continues to present the borough with a challenge on how best to support those people who wish to make meaningful changes in their lives. Access to supported housing for people leaving residential treatment services is also required to support people to sustain their treatment gains and recovery in the community.

- Substance misuse and homelessness do not exist in isolation and housing options for homeless people who are dependent on drugs and alcohol need to be available to enable them to access treatment services to stabilise their drug or alcohol use. People experiencing both are likely to have a range of needs cutting across physical and mental health, social care and criminal justice.

Future funding

- The current funding for drug and alcohol prevention, treatment and recovery services is approximately £1.2 million per annum. Kingston Council will continue to develop the drug and alcohol treatment pathways and services to meet the recovery needs of individuals and reduce inequality in access and outcomes. However the reduction in the Public Health Grant will have a major impact in Kingston as in other local authorities.

- Efficiencies will need to be made over the next three years and the Council will need to ensure that services and spend are matched to the needs of local residents, the outcomes sought and deliver best value for money. These efficiencies will be delivered as part of the Council's Outcome Based Budgeting (OBB) approach. This approach aims to focus the Council's resources on organisational priorities set out in the Kingston Plan. The plans for substance misuse services will be shaped by stakeholder feedback and engagement with people who use the service and those who deliver it.

Glossary

- Benchmarking – collecting data from one service area or Council and comparing them against others to ascertain how something is performing on price and quality.

- Kingston Clinical Commissioning Group – is the local health commissioner (formerly the Primary Care Trust) responsible for commissioning acute and community health services.

- Care Act in 2014 - the latest national directive setting out in legal terms the statutory duties of care placed upon local authorities Care Ladder – a term used by health and social care to refer to the level of service starting with self-help and moving right the way through to bed based care in a nursing home .

- Commissioning – is the process of researching, planning, buying and reviewing services being delivered by providers.

- Commissioning Strategy – is a plan for how a particular set of services will be commissioned over the next few years and the outcomes desired.

- Community Sector – is the not for profit community providers.

- Community Services – is a catch all term for any service delivered in a community setting.

- Direct payment- are a payment made to you by the Council; this can be used to meet your identified social care needs.

- Health and Wellbeing Board – is a statutory body created under the Health and Care Act 2012 that has oversight of the health a research document put together by health and care officers setting out the population profiles and associated needs of the local population.

- Market Intelligence – the building of information about the levels, type and quality of services being provided by the market across a local area used to inform commissioning strategies.

- Marketisation of care – when increasingly care services are delivered by the market and no longer provided directly by the public sector.

- Personalisation – services that are tailored to the needs of the individual taking into account their personal objectives and outcomes.

- Self-management – enabling residents with long term conditions to manage those conditions through training, education, telehealth or general information, advice and guidance services.