

# **Market Position Statement Adults with Mental Health Needs**

**January 2024**

**Revised July 2024**



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# Introduction

The purpose of this market position statement (MPS) is to outline the supply and demand of Adult Social Care services for people with mental health needs in Surrey. It is designed to signal business opportunities for the care market and to give relevant information to inform market development and commissioning plans from 2024. It is an iterative document, which will be refreshed on a quarterly basis to ensure the inclusion of future plans and developments.

There are a range of services commissioned by Adult Social Care, and in partnership with NHS Surrey Heartlands ICB and NHS Frimley ICB. Quantitative and qualitative data sources have been analysed, including the voice of those who draw on support and their unpaid carers, to inform this statement.

The MPS covers two main areas of support for adults with mental health needs:

- accommodation with care and support, including supported independent living and residential and nursing care; and
- community opportunities, including Community Connections services, outreach support, day opportunities for people with dementia and care within the home

## The Surrey Vision

In the [Community Vision for Surrey in 2030](#), Surrey County Council has outlined its ambition for all residents. The most relevant ambitions for adult mental are that:

- everyone benefits from education, skills and employment opportunities that help them succeed
- everyone lives healthy, active and fulfilling lives, and makes good choices about their wellbeing
- everyone gets the health and social care support and information they need at the right time and place

In 2019, the Surrey Health and Wellbeing Board (made up of senior managers from health and social care) published a 10 year [Health and Wellbeing Strategy](#), which was subsequently updated in 2022. The priorities from this strategy are:

- priority one: Supporting people to lead healthy lives by preventing physical ill health and promoting physical well-being
- priority two: Supporting people's mental health and emotional well-being by preventing mental ill health and promoting emotional well-being
- priority three: Supporting people to reach their potential by addressing the wider determinants of health

Outcomes identified within those priorities are supported by adult mental health services and service outcomes link either directly or indirectly to them. For example:

- Priority one outcome – “People are supported to live well independently”
- Priority two outcome – “Isolation is prevented and those that feel isolated are supported”

In 2022, the Mental Health System Delivery Board set its priorities for Surrey. The Board's overarching vision is:

“Together we build and nurture good mental health and emotional wellbeing for all. If anyone needs help, they will find services on offer for themselves, their family and carers, which are welcoming, simple to access and timely. No-one is turned away from a service without being given support to get the help they need”.

As of July 2024, a 'one system plan' for mental health is in development.

## Where are we now

### Prevalence of mental health need in Surrey

Surrey's [Joint Strategic Needs Assessment](#) (JSNA) chapter on emotional and mental wellbeing in Surrey adults, published in March 2023, gives a full breakdown of the determinants of mental health for the population. The key messages are:

- national research shows there is considerably higher prevalence of mental health problems among the general population than the number of people receiving treatment – often the stigma around mental health makes it harder for people to seek help
- overall, Common Mental Health needs in Surrey are relatively lower than across England as a whole
- levels of Severe Mental Illness are lower in Surrey as compared with England as a whole
- given the low comparative prevalence of common mental disorders in Surrey, it is surprising that the suicide rate is only marginally lower than that observed nationally.
- Surrey has a similar rate of emergency admission for neurosis as England as a whole, but higher rates of admission for schizophrenia and bipolar disorder
- there is national research to suggest that deprivation has a negative impact on mental health and that is also the case in Surrey. The most deprived 10% of the population of Surrey have a 28% higher average prevalence of Serious Mental Illness than the most affluent 10%

### Number of people with mental health conditions in Surrey

NHS Surrey Heartlands ICB and NHS Frimley ICB produce data on mental health in their Population Health Management dashboards using Surrey Care Record data which is based on patients registered with a GP within Surrey Heartlands CCG/ICS with an NHS number. This data suggests that, as at the time of writing (May 2024) there were:

- Over 138,000 people with a known mental health condition in Surrey.
- Over 8,000 of those with a 'Severe Mental Illness' (SMI)\*
- 130,000 with a 'general' mental health condition\*\*

\* SMI Cohort: Patients with a diagnosis of psychosis, schizophrenia, or bipolar affective disease.

\*\* General MH Cohort: Patients with one or more of the following: anxiety, neuroses, attention deficit disorder, depression. (Excludes SMI patients).

Demand for social care services continues to rise year on year. In June 2024 there were 3,283 open cases with a primary client category of mental health, up from 3,104 in July 2023.

## Health inequalities

The Centre for Mental Health has a [factsheet](#) explaining health inequalities. It states that:

“Some groups of people have far poorer mental health than others, often reflecting social disadvantage. In many cases, those same groups of people have less access to effective and relevant support for their mental health. And when they do get support, their experiences and outcomes are often poorer, in some circumstances causing harm. This ‘triple barrier’ of mental health inequality affects large numbers of people from different sections of the population.”

This results in:

- men and women from African-Caribbean communities in the UK have higher rates of post-traumatic stress disorder and suicide risk and are more likely to be diagnosed with schizophrenia. (Khan et al, 2017)
- people who identify as LGBT+ have higher rates of common mental health problems and lower wellbeing than heterosexual people, and the gap is greater for older adults (over 55 years) and those under 35 than during middle age (Semlyen et al, 2016)
- young people with a learning disability are three times more likely than average to have a mental health problem (Lavis et al, 2019)
- 80% of adults with autism (Lever and Geurts, 2016) have at least one mental health condition (Autistica evidence to the Commission)

## Access

The factsheet also highlights that access to services is a problem for these same groups:

“As with the determinants of mental health, access to mental health support is not equally distributed across the population. Groups facing particularly high levels of poor mental health also, paradoxically, often experience the greatest difficulty in accessing services.”

## Domestic Abuse

Women experiencing domestic abuse are more likely to experience a mental health problem, while women with mental health problems are more likely to be domestically abused, with 30-60% of women with a mental health problem having experienced domestic violence<sup>1</sup>.

Domestic violence is associated with depression, anxiety, PTSD and substance abuse in the general population<sup>2</sup>.

In Surrey, 13,390 domestic abuse-related incidents and crimes were recorded in 2020/21 (Surrey JSNA). This is equivalent to 14 incidences and crimes per 1,000 people aged 16 years and over. This rate is lower than the South-East and England, at 21 and 24 per 1,000 population respectively. The rate of domestic abuse crimes and the proportion of all crimes that are domestic abuse related in Surrey are also low compared to other police areas across the country.

## Deprivation

NHS Surrey Heartlands’ population health management dashboard for mental health shows that 45% of those in the total mental health cohort living in Surrey fall within the government’s 5<sup>th</sup> quintile on the index of multiple deprivation (1<sup>st</sup> is most deprived, 5<sup>th</sup> is least) compared to 51% for the whole population. 11% of the total mental health cohort fall within Quintile 1 and 2 (most deprived) versus 9% for the whole population.

# Chapter 1: Accommodation with care and support, including supported independent living and residential and nursing care

## What is supported independent living?

Supported independent living (SIL) can be appropriate for people with a learning disability, physical disability or mental health need who want to live as independently as possible and need some support to do so.

Tenants of supported independent living are provided with accommodation and support. This can include support to develop daily living skills and can sometimes include personal care. Examples of daily living skills include but are not limited to planning and completing meal preparation and accessing the community.

## Supported independent living in Surrey

Surrey County Council has calculated that under the current trajectory, there will be an estimated projected deficit of between 185-210 units of supported independent living (SIL) for people with mental health needs by 2030.

Figure 1: Trends in mental health service demand

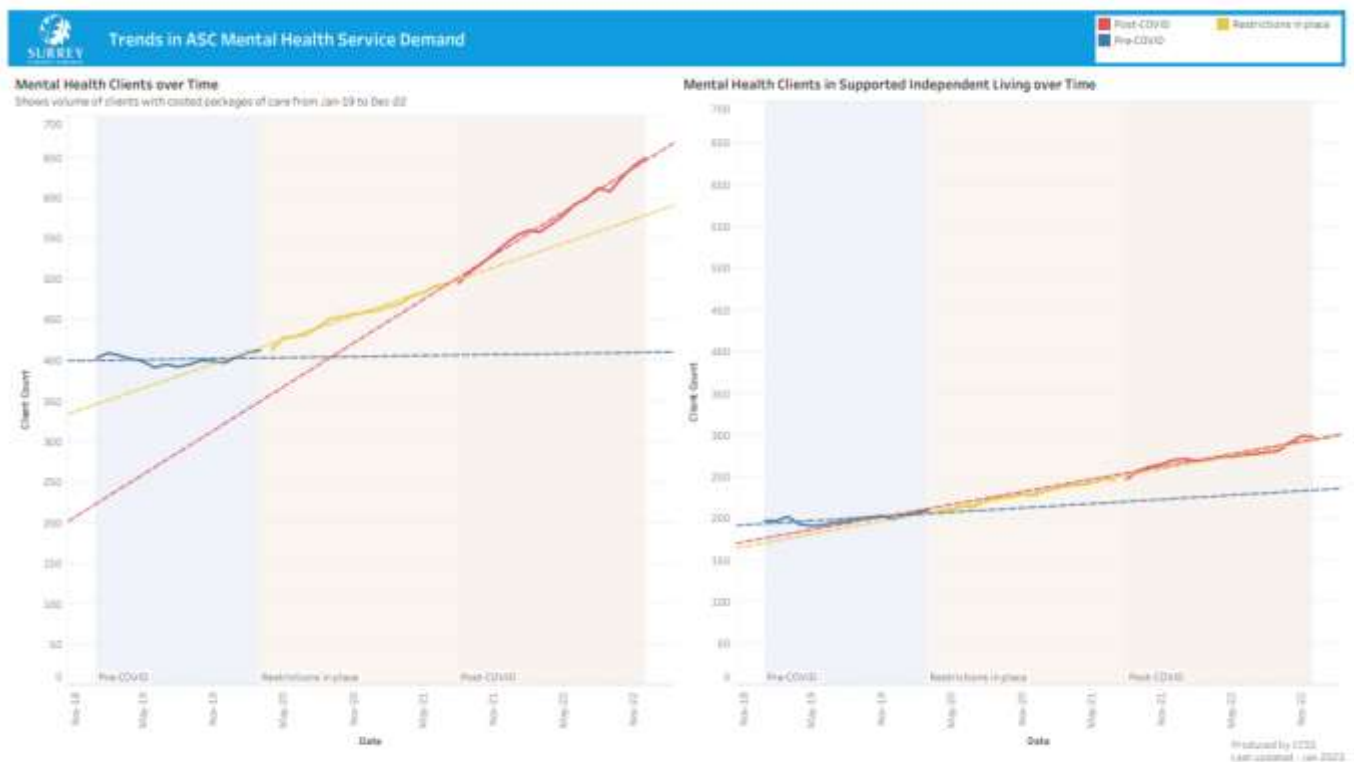


Figure 2: Projected demand model



Mental Health SIL available on the Council’s Dynamic Purchasing System (“DPS”) is classified as either ‘a place to call home’ or ‘support to recover: in other words long or medium term. Our ambition is that everyone in Surrey has appropriate housing, including those with care and support needs.

Residents with care and support needs have said they want to:

- retain their independence for longer
- feel well and have a good quality of life
- feel supported by their communities
- have accommodation choices available to them to meet their range of health and care needs flexibly and responsibly
- have accessible accommodation choices available to them
- receive specialised placements at settings within the county if they have more complex needs
- get the right level of support at the right time and in the right way

The service specification was developed based on engagement with people with lived experience of SIL, ensuring that what was important to people about SIL was specified.

The number of providers and SIL settings in Surrey has grown significantly, by approximately 200 additional units, since the inception of the previous DPS in 2020. However, 185-210 SIL

MH units are still required, including the Council’s target of 70% of these to be self-contained accommodation and shared accommodation that has ensuite facilities.

We know that people are staying in SIL settings for longer than two years. Analysis shows that 149 people have been in their MH SIL setting for more than 3 years. ASC has a new team in place called the Supporting Independence Team, who will help identify the reasons why people have remained in these settings for more than 3 years. The new DPS differentiates between ‘Support to Recover’ and ‘A Place to Call Home’ settings for this reason.

## Residential and nursing care

For some individuals, whose primary need relates to their mental health, residential or nursing care will be an appropriate accommodation with care and support setting to meet their needs. Whilst remaining relatively small absolute numbers compared to residential and nursing care for other client groups, the volume of both residential and nursing care has increased between since May 2019 by 58% and 193% respectively.

Figure 4: Mental health residential care volumes 2019/20-2023/24

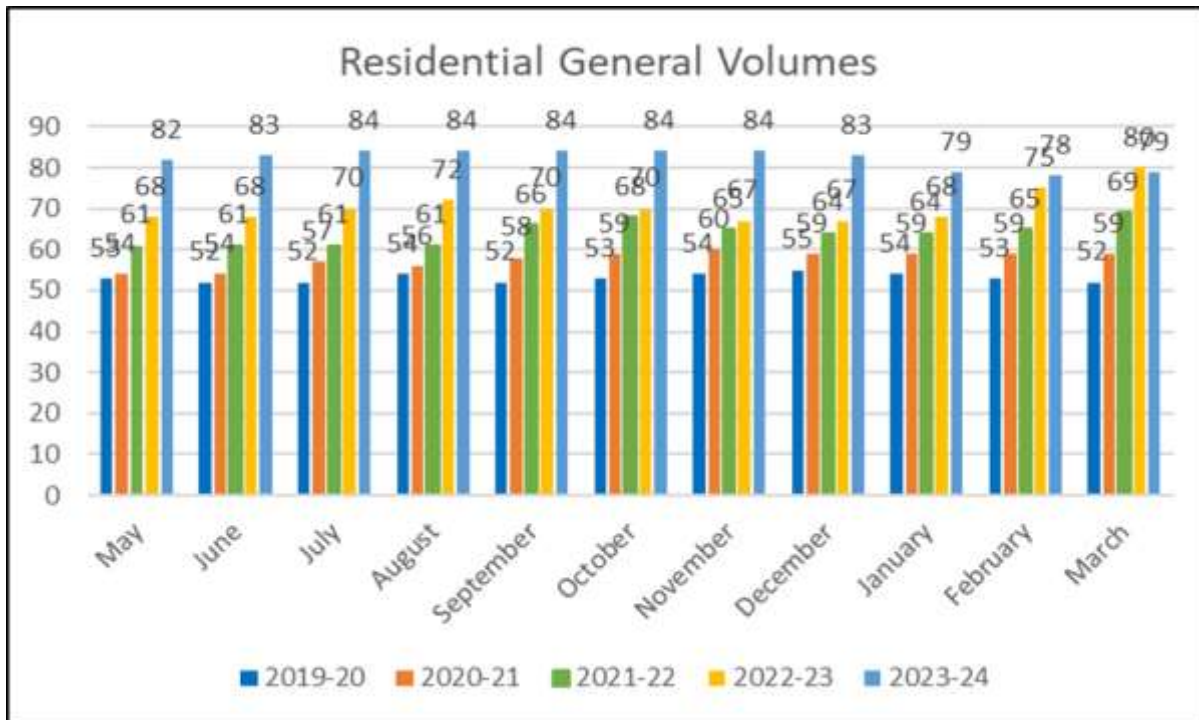
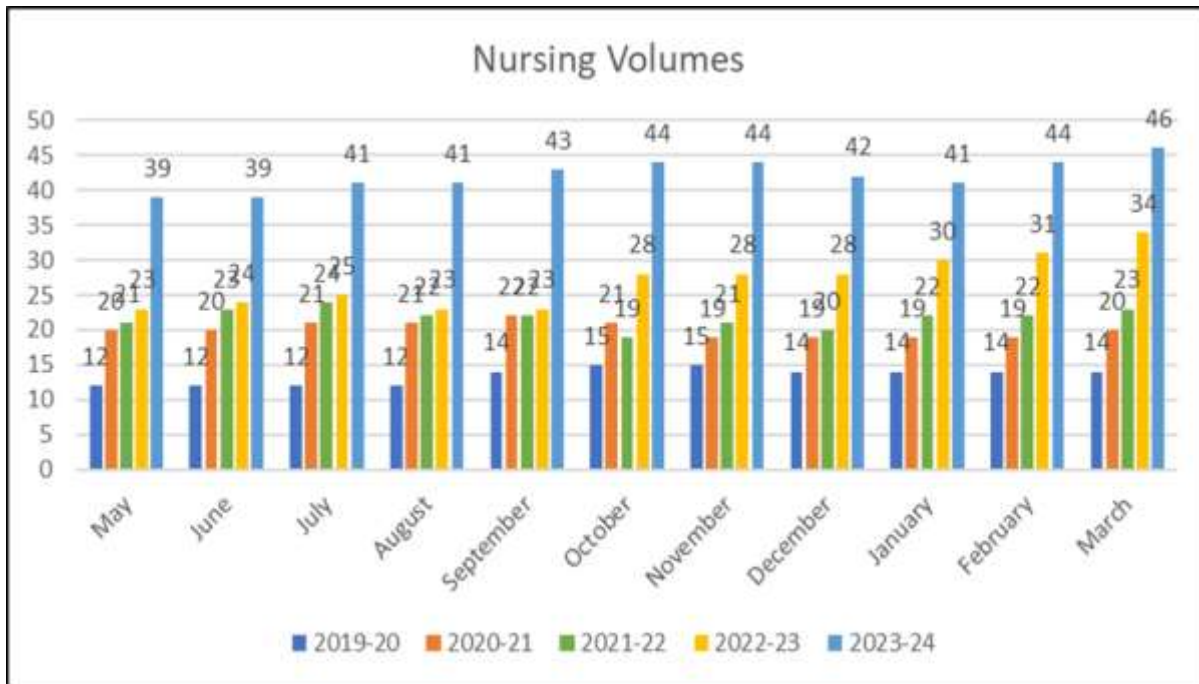


Figure 5: Mental health nursing care volumes 2019/20-2023/24





# Market opportunities

## Supported independent living

A new community accommodation with care and support DPS was launched in September 2023. This can be accessed by signing up to [proactis](#), then searching for:

- **Project Name:** SCC IC Care and Support with Community Accommodation DPS
- **Project Reference:** RFX1000432

Providers can bid for a range of lots for people with mental health needs; there are also lots relating to people whose primary needs relate to learning disability and/or autism and for people whose primary needs relate to physical disabilities and/or sensory impairments.

There are 4 lots available related to providing community accommodation with care and support for people with mental health needs, outlined below:

### Lot 5: Level one Mental Health - A Place to Call Home

Care and Support with Community Accommodation for people whose primary need is a long-term and enduring mental health problem. Level one is for people whose needs are less complex.

### Lot 6: Level two Mental Health - A Place to Call Home

Care and Support with Community Accommodation for people whose primary need is a long-term and enduring mental health problem. Level two is for people who have a high level of need/complexity. Examples of high complexity could include (but is not exhaustive) people with multiple health needs, neurodiversity, self-harm, forensic needs under part 3 of the Mental Health Act, and/or substance use.

### Lot 7: Level one Mental Health - Support to Recover

Care and Support with Community Accommodation for people whose primary need relates to their mental health. These services are medium-term to help people recover and to become more independent with support. The indicative timescale for length of stay would be 18-24 months unless stated otherwise as part of the assessment and review process with budget holder and supporting agencies. Level one is for people whose needs are less complex.

#### **Lot 8: Level two Mental Health - Support to Recover**

Care and Support with Community Accommodation for people whose primary need relates to their mental health. These services are medium-term to help people recover and to become more independent with support. The indicative timescale for length of stay would be 18-24 months unless stated otherwise as part of the assessment and review process with budget holder and supporting agencies. Level two is for people who have a high level of need/complexity. Examples of high complexity could include (but is not exhaustive) people with multiple health needs, neurodiversity, self-harm, forensic needs under part 3 of the Mental Health Act, and/or substance use.

## **Priorities for mental health supported independent living**

Mental health commissioners have identified several key priorities for supported independent living in Surrey. Bids are being welcomed for providers that can deliver the following:

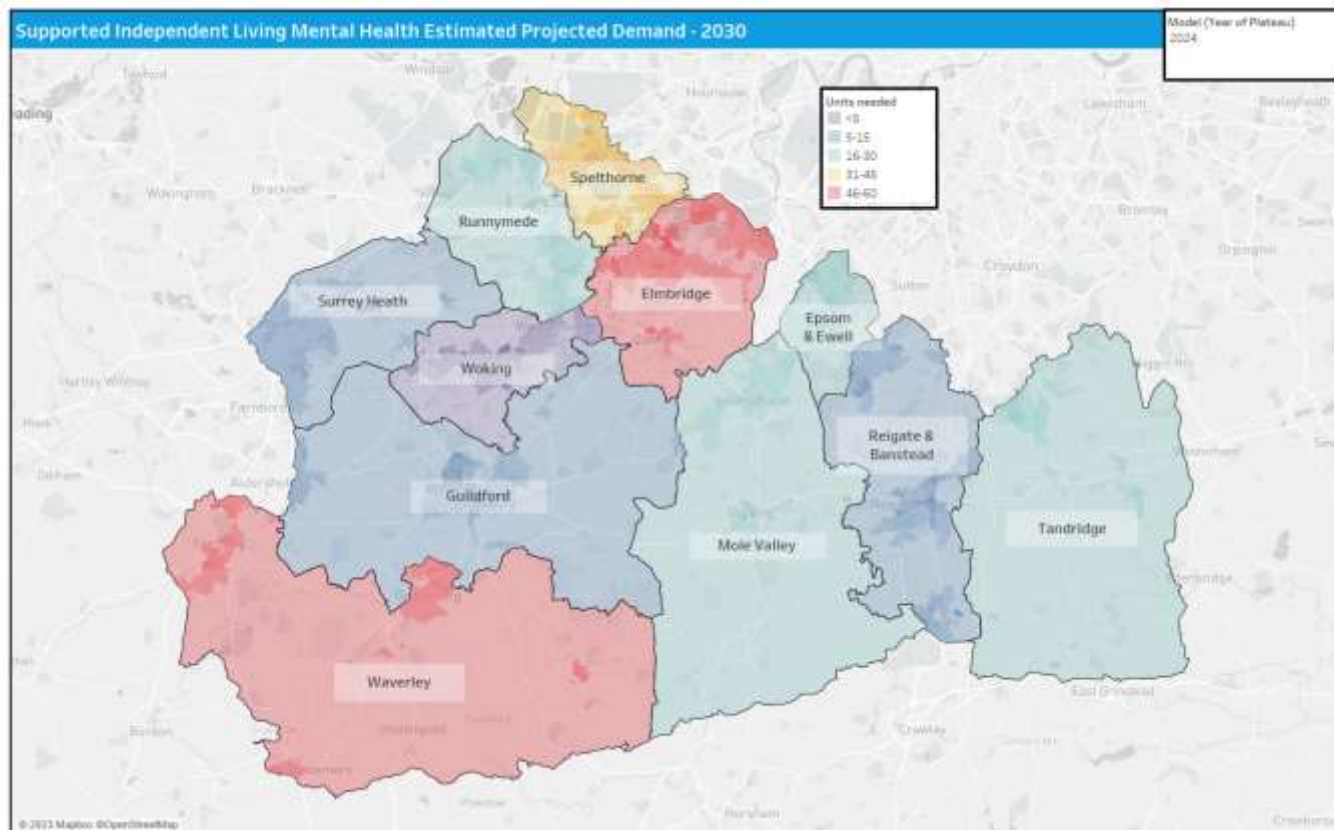
- self-contained properties - there is a need for self-contained properties that can be supported by one staff team, preferably with a communal area
- complex needs - feedback from stakeholders indicates an increase in complexity, particularly where people have multiple health needs, neurodiversity, forensic needs under part 3 of the Mental Health Act, behaviours that challenge, substance use and/or self-harm. SCC will be seeking applications from services with evidence of experience and recognised training in these areas
- low need / 'Move on' - feedback from stakeholders has identified a lack of low needs services to support move-on from higher need services. SCC will be seeking applications from services who can provide a range of support including lower needs. Lower needs services are unlikely to require staff on site overnight and services would instead provide access to on-call out-of-hours support and/or technologies to enable independence when staff are off-site

Commissioners would welcome applications from providers with a range of services within a small geographical area, which can give more confidence to people who want to move on whilst maintaining relationships they have built in the community or with staff. This may also enable a more gradual reduction in staffing when using staff who know the person well. This can be achieved where the service is with the same provider or where there are agreed referral pathways and flexibility within resources.

### **Location**

The DPS ending 31st March 2024 has seen an increase in the number of providers supporting individuals in Surrey, however feedback from stakeholders suggests that there is still a shortage in some locations and to meet some specialist needs.

Figure 6: Number of units/ individual places estimated to be needed over the next 6 years (until 2030).



This DPS will be actively seeking applications from the areas identified as needing more services. As examples priority areas will be Elmbridge, Waverley, Spelthorne, Mole Valley, Runnymede, Epsom and Ewell and Tandridge. Feedback from people with lived experience suggests location within walking distance of public transport and amenities (including shops, leisure opportunities, occupational opportunities, faith needs) must be a priority.

### Female only

Feedback has identified challenges placing females in predominantly male supported independent living services, and current data confirms that females are under-represented in supported independent living settings when compared to the numbers open to Surrey County Council's mental health teams.

### Young adults

Feedback has indicated that it can be hard to place younger people (18-25) in supported independent living if current residents are older and again, data confirms a slight under-representation of under 25's in Surrey's current framework settings.

## Residential and nursing care

As outlined previously, demand for residential and nursing care for people whose primary need relates to their mental health is also increasing.

Analysis work is currently being undertaken to ascertain levels of need for residential care, with or without nursing, for working age adults open to the mental health locality teams. This analysis

will inform future options of working with the market to ensure that quality and affordable provision can be delivered that meets the identified demand to this type of care.

A service specification for the provision of residential care, with or without nursing care, is being developed for working age adults. This is an existing 'ghost' lot on the residential and nursing care home DPS that can be activated.

## **Working together**

The Council is keen to work together with community accommodation with care and support providers to develop new SIL accommodation. Market engagement via a Request for Information (RFI) in May 2024 confirmed high level deliverability of SIL MH alongside general needs housing. Further discussions will take place with the responders to the RFI and a detailed commercial delivery strategy will be developed to enable this to progress.

The Council also works closely with the Integrated Care Boards in Surrey with regards to people whose care and support is jointly funded. Work is also progressing with Surrey and Borders Mental Health Partnership Foundation Trust to develop a system wide view of need and future demand. This work includes people who may or may not have eligible social care needs, but who require intermediate care options to facilitate discharge into the community or to prevent admission. We are also working together to explore options for rehabilitation-based accommodation options to ensure people can continue their recovery safely in the community.

The Joint Mental Health Housing Protocol was launched in March 2023. It was developed by all 11 District and Borough Councils, Surrey and Borders Partnership Trust and SCC. It has three key overarching aims:

- set out joint working arrangements for Housing, Mental Health services, Adult Social Care, Clinicians and supported housing providers to improve the experience of clients with mental health issues who need help and support with accommodation
- prevent where possible clients being discharged from mental health wards without appropriate accommodation and support planning
- prevent homelessness

Over 220 people attended the launch events from a diverse range of organisations including all Housing Needs Managers, Housing Association staff, supported living providers, SABP hospital discharge coordinators, Adult Social Care mental health teams, and SABP CMHRS. A review of the Joint Mental Health Housing Protocol is being carried out to:

- assess the extent to which the protocol has been embedded across the system
- explore whether the protocol remains relevant and proportionate, conveying accurate and consistent information about the processes
- make recommendations to remove any barriers to implementation and improve provision gaps
- identify opportunities for improvement and enhanced partnership

# Chapter 2 Community opportunities, including: Community Connections services; care within the home and outreach support

## Community Connections

In Surrey, the voluntary sector plays a key role in delivering community opportunities via the universally accessed, preventative service 'Community Connections'. The broad aim of Community Connections is to work in partnership to reduce health inequalities by expanding opportunities for individuals with self-defined mental health needs to live well and achieve their full potential, through participation in social, leisure, sports, art and education, within their local community. It will be preventative in two ways: helping people stay well and avoid the need for secondary care services and for those with existing mental health conditions, to help them avoid a mental health crisis.

### Where we are now

Providers support around 6,000 people – based on Q4 2023-24 performance data. There is 46% more demand versus Q4 2017-18 (after 12 months 'bedding in' of current contract).

### Health inequalities

Service users are largely representative of the Surrey population, and in some cases more diverse e.g. certain ethnic groups, disability, sexual orientation. Due to health inequalities, we'd hope that this was the case. Services are flexible in responding to the needs of service users. For example, one provider has set up an ASD specific peer support group and another an LGBTQ+ group.

### Outcomes

Currently around 88% of outcome measures for those supported with the Recovery Star are maintained or improved – based on Q4 2023-24 performance data. Approximately 68% of people left the service in 2023-24.. This is currently just below the comparator Talking Therapies outcome target for "reliable improvement" (71%) - Outcomes - NHS Digital (Please note: NHS have set this target to be achieved *by* 2028/29. The providers connect between 150 and 300 people that they've supported successfully to other services each quarter.

### Value for money

Cost per person supported ranges from £47.33 per person in East Surrey to £136.80 per person in North-West Surrey – based on Q3 2022-23 performance data. On average, cost per person across Surrey is £79.52 per person, which compares favourably with other MH services like IAPT (£427 per referral) and community crisis referrals (£3,448 per referral). Comparator data comes from Carnall Farrar report to MH Delivery Board, December 2021 – based on Q3 2022-23 performance data.

The 2024/25 budget for community connections services is £2.5 million.

## Areas for development

Engagement with people with lived experience and other stakeholders was conducted in the summer of 2022 and informed the new contracts which started in 2024. The most important aspects of Community Connections that people with mental health needs and carers wanted to see maintained were the quality of the staff and activities, the ability to meet in groups and socialise (plus peer support) whilst also having access to support one to one and the reliability of the service. Knowing the support is there, even if they don't go that week, was key for many people.

When it comes to improvements to the service, based on the needs analysis provided by the providers, the Surrey context and feedback gathered from all stakeholders, the following recommendations were included in the new contracts from April 2024:

**Supporting people in the community and at home** – The pandemic forced many services to move online. This allowed people to access support from home whilst avoiding the risk of catching Covid and reducing related anxieties, with many people still suffering from these anxieties. The engagement process clearly highlighted that people benefit from both virtual and in-person support depending on their needs at the time, therefore the recommendation is that the specification should require providers to support people in the community and at home.

**Providing both shorter-term (recovery) and long-term support** – Research suggests that there will be people coming out of hospital or secondary care services at a high rate following the Covid-19 pandemic and some of these will be referred to Community Connections. However, the feedback received shows the importance of this service to some people as a 'life' line, which is reliable and always there. Therefore, it is recommended that the service specification and outcome monitoring reflect the need to support both cohorts.

**Extending support on evenings and weekends** – as a system, we want people to be in work and therefore able to live independently and well. To facilitate this, it is recommended that all Community Connections providers cater for people who work by offering support outside normal working hours. Similarly, people that are isolated may not have people to spend time with on the weekend as others might. Therefore, support at the weekends should be made available as well.

**More specialist support to meet increasing needs** – providers report that they are seeing an increased number of people with advanced mental health conditions, likely worsened by the pandemic and their report indicated that they support many people not open to SABP. Likewise, during the engagement people were asking for support beyond things like managing 'anxiety' and 'stress', suggesting there is need in the community being unmet. It is therefore recommended that the specification acknowledge this and propose that providers look at how/if they can work in partnership to identify and bring in specialists on topics like eating disorders, depression, and sexual abuse, where some people are not able to access support from secondary care services.

**Focus on accessibility** – providers, service users, carers and professionals, highlighted various ways that the service could be developed or promoted more to certain groups. The recommendation is that the specification calls for providers to ensure support is offered (delivered directly or in partnership with other organisations) to:

- young (16-25) and older adults (65+)
- people at risk of being digitally excluded
- people without a face-to-face service in easy traveling distance e.g., Spelthorne
- those with disabilities
- people from Black, Asian and Minority Ethnic groups
- carers

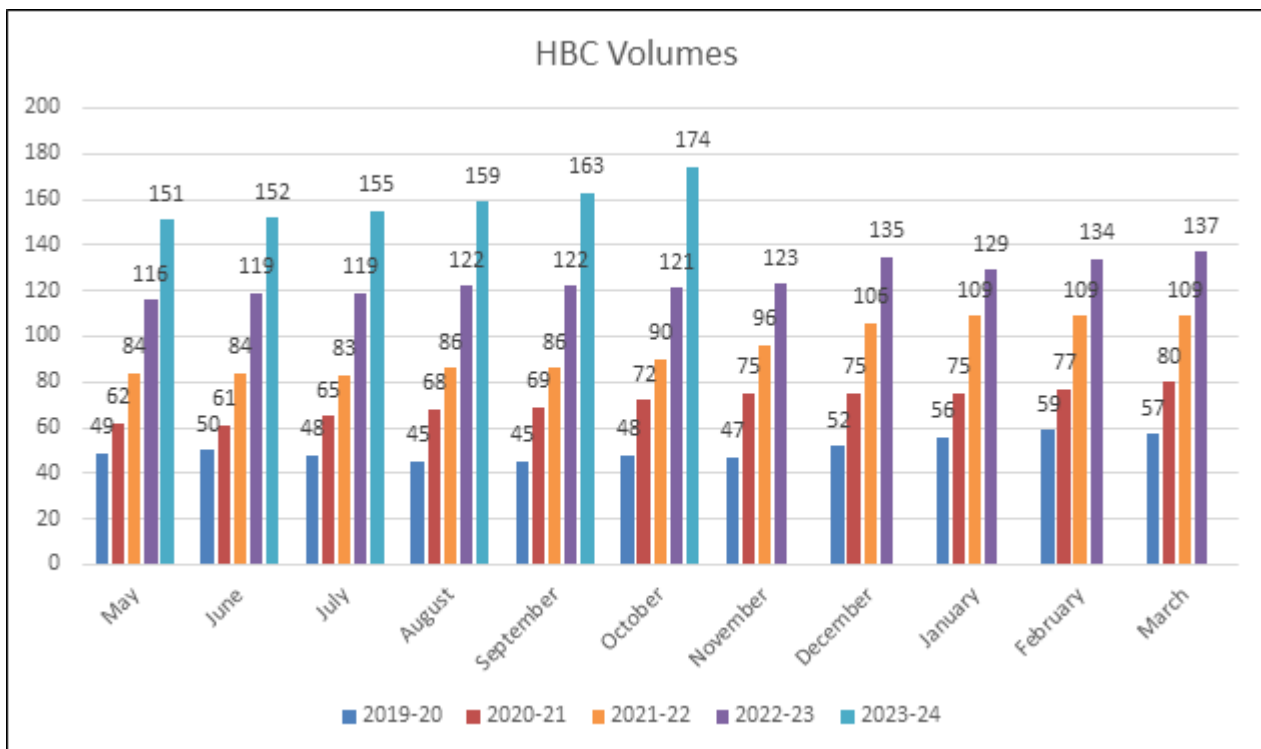
# Care within the home

As part of the Surrey Wide ‘Care within the Home’ contract, which commenced 1<sup>st</sup> October 2020, there is an additional needs ‘lot’ that providers who have successfully qualified for inclusion onto the main contract framework can apply for. The additional needs lot cover care within the home support for the following categories of care: People with Learning Disabilities, People with Autism, Mental Health, Physical Disability, Sensory Impairment and Acquired Brain Injury. A separate set of qualifying questions and evaluation criteria is used to assess the suitability of applicant providers.

As of July 2024, there are 37 care quality commission registered care agencies approved for additional needs, of which 32 are accepted to support people with mental health.

The volume of people being supported by the commissioning of a care within the home care package since October 2019 has increased by 262%.

Figure 7: Mental health care within the home volumes 2019/20-2023/24



Prior to October 2020, finding a suitable ‘care within the home’ agency to provide support for people with mental health had been difficult, primarily because of a lack of capacity in the market. However, as of July 2024, our brokerage team can source suitable providers within a reasonable timescale from the point of referral to the market, usually taking 24 to 48 hours. This has been influenced by the provider market increasing their workforce, using the UK visa sponsorship for employers [scheme](#) and increased pay rates to care staff.

## Market opportunities

Where individuals require support that includes personal care, we have an obligation to commission care quality commission registered care agencies for such activities. This

requirement, by its regulatory nature, stifles the opportunity to explore alternative providers such as community and micro provider organisations.

## Working together

We already have an agreement with Health collages that individuals with a Section 117 categorisation, that the Council's brokerage team commission the placement through our approved providers, and recharge Health for their funding contribution. Were this arrangement not in place, Health would need to approach the same market and contract with them separately.

## Community Outreach Support

Outreach support is provided to individuals in their own home and in the community. It aims to develop or maintain the person's independence, confidence, and self-esteem to achieve their individual outcomes. The level of support an individual receives will vary according to their personal support plan. We are not currently including personal care in our definition of community outreach for people with mental health needs. See below for a list of types of support that would be considered as 'community outreach'.

For adults with mental health needs, there is a high demand for hospital beds, and thus pressure to find support as part of the hospital discharge process. As a result, the aim is to develop a plan to commission community outreach in a more strategic way, to provide an alternative to accommodation-based services.

Community outreach support might include:

- maintaining and developing emotional wellbeing
- maintaining and developing confidence accessing the community
- prompting with health and wellbeing tasks e.g., maintaining hygiene, taking medication
- help with finances, claiming benefits and budgeting
- support to maintain a tenancy
- maintaining and developing life skills, such as food shopping, cooking and household chores
- supporting people to access college, or voluntary or paid work
- supporting people to use public transport
- accessing community-based activities such as attending clubs
- support around hoarding/decluttering
- attendance at appointments
- helping people to maintain and develop relationships
- outreach support does include personal care. This would be considered 'Care at Home'. Please see previous section

## Where we are now

There are fewer than 10 providers delivering this type of service for people with a primary need of mental health. SCC has an in-house reablement and Enabling Independence services (both provide short-term intervention). There are fewer than 50 people receiving this support in their own home, though there may be people receiving support from a Care at Home service when the service they need is more like community outreach e.g. there is no need for personal care or support dressing/washing. Most of these people are supported by just two providers. Most providers only support one or two people. On average, boroughs have access to between 3-5 of the services.



Services work with clients on a short or long-term basis can support people with mental health needs plus a learning disability and/or autism, forensic history, substance use, physical disabilities.

Some of our key challenges are:

- recruitment – Providers report that recruitment is a challenge in this sector, due to recent rises in the cost of living
- financial viability – The current low volume of outreach packages, makes it hard to run an outreach service. Some providers need to have a minimum visit length (longer than Care at Home) to ensure viability. Cost of travel (not covered in package of care) was also highlighted as a financial constraint. Feedback suggested that services could be combined with other services, such as supported living

## Market opportunities

- shared language – language is not consistent in the sector in Surrey, with some referring to ‘Outreach’ and others to ‘floating support’
- agreed model – there is no widely agreed definition of what is and what isn’t community outreach
- availability – from a mental health perspective, there is potential for a wider range of services in all districts and boroughs
- barriers to entry – what are the challenges in this market?
- market expansion - there are a number of organisations delivering other service models in the community who may be interested in developing outreach services
- training - would provision of training encourage more organisations to develop their skill-base while promoting inclusion within our community?

## Working together

We already have an agreement with Health colleagues that individuals with a Section 117 categorisation, that the Council’s brokerage team commission the placement through our approved providers, and recharge Health for their funding contribution. Were this arrangement not in place, Health would need to approach the same market and contract with them separately.

## Community Opportunities for People Living with Dementia

Dementia is most common amongst older people and in Surrey it is estimated that between 2020 and 2030 the overall number of people with dementia is forecast to increase by 28%, from 17,700 to 22,672 older people. The NHS Digital, Health and Care of People with Learning Disabilities, 2020/21 estimates there are around 105 people with a learning disability who have dementia and approximately 232 people with young onset, without a learning disability in Surrey.

Most people with dementia will have at least one other condition and this is being identified as part of the developing work on frailty in the different placed based areas. The growing demand for services by people with dementia and their carers means we need to address this challenge

with integrated and proactive care for all parts of their journey of care. We have mapped out current community opportunities supporting people with dementia in Surrey and have worked closely with the Connect to Support Surrey Team to ensure information is up to date and easy to find.

As part of our work developing a new approach to the market for community opportunities, we will analyse current available support and needs going forward to include a range of services from dementia cafes to lunch clubs, to specialist services for more complex needs. The plan is for a market opportunity for this area of work to be available in early 2025.