

Mental Health Commissioning Delivery Plan

**Adults, Wellbeing and Health Partnership's
strategy for Commissioning Mental Health
Services in Surrey**

2025 to 2030



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Foreword

In the Adults, Wellbeing and Health Partnerships directorate at Surrey County Council (SCC), our ambition is to support our residents to 'live their best lives'. We know that people live their best life by connecting to their communities, embracing supportive technology and accessing joined-up support and care when needed, which delivers what matters to them. We will achieve this by:

- delivering operational excellence in all that we do whilst keeping our residents and communities safe
- promoting independence and wellbeing to prevent, reduce and delay reliance on long-term care
- managing demand and focussing resources on those most in need, to ensure an effective and financially sustainable system
- providing strategic leadership to reduce health inequalities and enable thriving communities

Our Mental Health Commissioning Delivery Plan supports this ambition and has been developed alongside people with lived experience of mental ill health and unpaid carers. We will make sure that services commissioned for people with mental ill health, and their carers, are grounded in a co-production ethos. Co-production is an approach we use in commissioning where people, family members, carers, organisations and commissioners work together in an equal way, sharing influence, skills and experience to design, deliver and monitor services and projects.

Jane Bremner, Head of Commissioning: Mental Health

The vision

Good mental health is the foundation upon which individuals build their capacity to live full, meaningful and flourishing lives. In Surrey, as across the nation, mental health is not a peripheral concern but a central pillar of overall wellbeing. It shapes our ability to form relationships, pursue aspirations and navigate life's challenges. Access to the right kind of mental health support when it is needed is essential for maintaining overall health, independence and dignity. For those who draw on services, it can be the difference between prolonged distress and the possibility of recovery, stability and renewed hope. The need for a whole-person, empathetic and collaborative approach to mental health has never been more urgent.

This five-year Mental Health Commissioning Delivery Plan for Surrey is designed to outline a set of principles, aspirations and commitments to ensure that mental health services are not only accessible and effective, but also more deeply integrated into the fabric of our community. The group who co-produced this strategy agreed on the importance of adopting a holistic approach which recognises that mental health is intrinsically interconnected with physical health, education, early-life experiences, housing, employment, relationships, family structures and social inclusion. We cannot offer mental health services that truly respond to people's needs if we do not recognise how these factors inter-relate and have an overall impact on mental and emotional health.

At the heart of this plan is a commitment to empower individuals in our community to achieve their potential and live healthy, fulfilling lives. Over the next five years, we will work closely with our collaborative partners, including NHS and ICB colleagues, charity/third sector organisations and lived experience experts (including those who have experienced mental ill health and unpaid carers) to build mental health services that are responsive, compassionate and effective for the people who draw on them for care and support. It is essential that we take a whole-family approach, considering not just the needs of the individual but also how a person's mental health needs impact, and are impacted by, those in their support network.

This Commissioning Delivery Plan has been designed to align with other relevant strategies and ambitions, including the Community Vision for Surrey in 2030 and 'The Surrey Way'. Key objectives such as tackling inequality, ensuring that 'everyone gets the health and social care support and information they need at the right time and place' and making sure that 'no-one is left behind' are central to our approach. This plan will draw on local insights from Surrey's most recent Joint Strategic Needs Assessment and align with priorities of other relevant strategies from across Adult Social Care and the NHS, such as the One System Transformation Plan, the [All Age Autism Strategy](#) and the most recent [Surrey Carers Strategy 2021 to 2024](#) (extended to 2026). This alignment is necessary for several reasons:

- To ensure that our Mental Health Commissioning Delivery Plan moves in the same direction as other strategies from across Surrey County Council, creating consistency and a 'one-council approach' to planning and delivering Adult Social Care services.
- To draw on the knowledge and insights of our colleagues, whose co-produced strategies were designed in partnership with people with lived experience of drawing on relevant services, adding richness and depth to this Mental Health delivery plan.

To support an integrated approach to mental health support in Surrey, recognising that, just as our needs and experiences inter-relate and overlap, the services designed to meet those needs should be similarly responsive and capable of taking a whole-person approach to mental health.

Surrey 2030 vision

In 2018, Surrey County Council (SCC) worked with residents, communities and partners across Surrey to develop a vision for what Surrey would look like by 2030. Informed by these conversations, SCC created a Community Vision for Surrey in 2030, which includes the following commitment to health and social care:

'By 2030, we aspire for Surrey to be a uniquely special place where everyone has a great start to life, people live healthy and fulfilling lives, are enabled to achieve their full potential and contribute to their community, and no-one is left behind'.

Our five-year commissioning strategy is committed to supporting this vision and making it a reality for people living with mental health needs and unpaid carers in Surrey. This Delivery Plan will draw out the details of our current commissioning activities and how they support SCC's over-arching vision, while building upon these with 'commissioning intentions', which will detail how we plan to go forward and develop on these priorities over the next five years.

Local Government Re-organisation

This Mental Health Commissioning Delivery Plan has been created during a time of significant transformation within Surrey County Council, as we prepare for devolution and the establishment of new Mayoral Strategic Authorities. While the current Mental Health Commissioning Team at SCC will not continue in its present form following local government re-organisation, the need for a clear, forward-looking strategy is more important than ever.

Our aim is to ensure that the commissioning of mental health services over the next five years is informed by the deep institutional knowledge and experience built within Surrey County Council's adult mental health commissioning function. This expertise – developed over many years in collaboration with local organisations and people with lived experience – needs to be preserved and embedded into future approaches. As we transition towards the formation of new unitary councils by 2027, we hope that this plan will serve as a guide for how services are commissioned in the future, ensuring continuity, coherence and a strong platform from which each new unitary authority can build and evolve.

Introduction to Mental Health Adult Social Care (ASC) in Surrey

Mental health is an increasingly vital area of focus within Adult Social Care (ASC) and recent trends in Surrey highlight this urgency. It might appear, at first glance, that mental health expenditure is not the most pressing concern for a system under significant financial pressure, with mental health care packages making up only 4% per year of overall ASC spending and 7% of new packages of care in Surrey between 2023-24.

However, on closer inspection, the particular challenges that the mental health system faces in meeting the rapidly growing needs of our communities become apparent. In Surrey, the number of referrals for mental health services has more than doubled since 2020, with an 87% increase in residents receiving Adult Social Care support for mental health related needs. Spending has increased by over 118% and, if this continues to grow at the same rate, Mental Health is on track to make up 16% of overall ASC spending by 2030. This growth is greater than any other area of Adult Social Care and sets an important and unavoidable challenge in ensuring that we have the financial stability, resources and foresight needed to continue meeting our duties under the Care Act 2014.

The purpose of this Commissioning Delivery Plan is to set out how Adult Social Care will support people with mental health needs over the next 5 years in a way which emphasises independence, autonomy and empowerment. As the demand for mental health services continues to grow, the importance of commissioning intelligently and responsively within SCC's resources becomes increasingly important. This strategy will secure our commitment to the following:

- ensure that people with mental health needs and their unpaid carers get the care and support they need at the right time and place, with a focus on choice, dignity and independence
- actively engage with voluntary and private sector partners to shape and diversify the care and support market

- explore, learn and act upon the direct experiences of individuals and unpaid carers who have drawn on care and support services to inform commissioning decisions and processes
- prioritise individual and community outcomes when looking to commission high-quality, cost-effective services

This Mental Health Commissioning Delivery Plan will provide an overview of the services currently commissioned across Surrey, including support for individuals with both eligible and non-eligible social care needs. It will briefly summarise the services, offering insight and local context to current commissioning activity, before moving on to our commissioning intentions over the next five years.

Informed by the expertise of professionals and individuals with lived experience who have co-produced this strategy, as well as evidence-based resources such as the Surrey JSNA, this plan will identify key gaps in current service provision and put forward a plan for how these needs could be addressed in the years ahead. While Local Government Reorganisation may change the structures of commissioning, we hope that our strong, evidence-based proposals will provide a valuable foundation for the new unitary councils to build upon.

Health inequalities

The long-term effects of health inequalities on individuals and communities, particularly in their ability to sustain good mental health and recover from periods of poor wellbeing, are well known. These inequalities are shaped by a range of social factors including demographic, socioeconomic and geographical conditions, which collectively influence our overall quality of life.

People living with serious mental illness (SMI) face some of the strongest disparities, with life expectancy estimated to be up to 20 years shorter than the general population. Differences in physical and mental health outcomes are deeply rooted in social determinants such as education, housing, employment and access to healthcare. These challenges can be intergenerational, stemming from adverse childhood events (such as experiencing abuse), poor housing, poverty, trauma, social isolation and unstable employment.

The report 'Long-term Conditions and Mental Health: The Cost of Co-morbidities' highlights that:

- 30% of people with a long-term physical health condition also experience a mental health problem
- 46% of those with a mental health condition also have a long-term physical health issue

Depression and anxiety are particularly prevalent among people with conditions such as cardiovascular disease, diabetes, COPD, arthritis and asthma. Those most affected include individuals with multiple long-term conditions, people living in deprived areas, women and older adults. Co-morbid mental health issues are associated with reduced ability for self-management, poorer health outcomes and diminished quality of life.

Health disparities can be further exacerbated by 'diagnostic overshadowing', where physical symptoms are misattributed to mental illness. Additional contributing factors include high rates of substance use and suicide; both of which remain leading causes of death for people experiencing poor mental health. People with SMI often miss out on preventative care, such as

screenings and health checks, with older adults and minoritised communities facing additional barriers to accessing mental health services.

Our commitment to tackling inequalities

Across all the services that we commission, we are committed to addressing the social determinants of poor mental health and the inequalities that contribute to a reduced quality of life.

Housing

We support people facing homelessness through our Housing Related Support services, including Floating Support to prevent eviction and funding for homeless hostels to support recovery in those who are facing a housing crisis. Our Supported Living settings work collaboratively with individuals, their families and District & Borough Housing teams to ensure that each person's housing pathway, or 'move-on plan', is agreed from the outset and that individuals are offered mental health support during their stay. Through quarterly KPIs, we track the number of people who are supported with housing.

Poverty

All services we commission need to show how they support individuals towards financial stability. We encourage providers to work closely with local, trusted organisations such as Citizen's Advice to do this effectively. Providers of supported living services within our 'Dynamic Purchasing System' (DPS) must evidence their ability to support someone's financial wellbeing as part of a holistic mental health approach. Floating support services, similarly, are trained to support people to address debt and manage other financial risks. Our quarterly KPIs monitor the number of people who are supported with their financial wellbeing each quarter.

Adverse childhood experiences, violence and trauma

Our specifications for Supported Independent Living and Community Connections include requirements for trauma-informed approaches across all elements of service delivery. This is vital as we know that people with lived experience of trauma will be present across all the services that we commission, making it essential that staff are trained to provide sensitive, informed and effective care and support. KPIs for monitoring this include staff training records and case studies to evidence how people with trauma histories are supported in the service.

Social isolation

Supporting a person's sense of belonging is central to every service that we commission. Community Connections exemplify this by offering free, local wellbeing groups and activities that promote social support and integration. However, all of the services that we commission are required to address social isolation, with KPIs tracking support for leisure activities, community group participation and relationships.

Stigma and discrimination

Co-production is a cornerstone of how we commission services in Adult Social Care. By challenging traditional power dynamics, we can promote equal partnerships and elevate the voices of those with direct, lived experience of drawing on adult social care services. This helps to challenge the marginalisation of disabled people and those from underrepresented communities, whose voices often go unheard in the planning, delivery and reviewing of services. We monitor service demographics to ensure accessibility across Surrey and

commission targeted services to work directly with communities that struggle to access mainstream services, such as the Gypsy, Roma, Traveller floating support service.

Healthcare access

We recognise that nearly half of the people who draw on the services that we commission live with both long term physical and mental health conditions. It is essential that the providers that we work with can demonstrate how they support people’s physical health as part of a holistic approach to wellbeing - including support with attending health appointments, managing medication and maintaining healthy lifestyles. This is a requirement before joining our Supported Independent Living DPS and is monitored through KPIs such as uptake of annual health checks and support with GP/Health appointments.

Education and employment

Supporting access to education and employment is integral to many of the services that we commission. Supported Independent Living services and Housing Related Support providers must show how they help people to engage and sustain education or employment. Providers are also encouraged to run educational sessions themselves to help with skill-building and independence in key areas such as cooking or managing finances. Community Connections providers are encouraged to run psycho-educational sessions to enhance understanding and insight into various aspects of mental health. KPIs track the number of individuals supported into education, volunteering and employment.



Figure 1: An image showing current Mental Health services commissioned by Adult Social Care at Surrey County Council

Carers

Insight and local context

Current wellbeing and prevention services available for all unpaid carers

The [Surrey Carers Strategy 2021 to 2024](#) (extended to 2026) shared the vision: ‘Surrey should be a place where carers are recognised, valued and supported in both their caring role and as an individual. Carers will be respected as partners in care, will have a strong voice that influences improvement, and will be able to access the support they need, when they need it, and in the way that works best for them. This support will be available equally to all carers’.

Surrey County Council commissions a wide range of prevention and wellbeing services to ensure that carers are supported in their caring role and to have a life outside of caring. Carers have told us that a priority must be ensuring that services address their needs, and that the pathways between services are as easy as possible to navigate. The services available for carers are outlined in the [Market Position Statement for support of carers of all ages](#).

As part of the process to commission services, from April 2022 onwards, we reviewed and revised the service specifications (which detail exactly what each service needs to provide) to ensure that the new set of services are well placed to meet carers' needs over the coming years. The specifications are informed by carer feedback and the commitments in this strategy. Services are monitored and reviewed throughout their lifetime, to ensure they are meeting the needs of carers.

Specific services for carers of people with mental health needs

Surrey County Council are testing out approaches to support carers for people with mental health needs and/or substance misuse needs. The three overarching aims of this approach are:

1. to support the health and wellbeing of individual carers of people with mental health needs, using a whole family approach
2. to ensure unpaid carers have the skills they need to continue their caring role
3. ensure that Mental Health Services (both acute and in the community) operate using Carer Friendly practice

These services are being evaluated to determine if they are effective and to inform our longer-term approach.

Commissioning intentions

The all-age carers joint strategic needs assessment (JSNA) chapter is in development. This will capture the current needs and identify any gaps for carers in Surrey which we will use to guide our practice and commissioning.

In 2025/26 we also plan to tender for income maximisation services for carers. The financial burden of caring is recognised as a priority for unpaid Carers and has been widely reported nationally and locally.

The specialist service for carers of people with mental health needs will be evaluated and this evidence base used to inform our commissioning intentions.

Prevention services

Surrey County Council's Housing Related Support and Community Connections services are designed as part of a preventative offer, closely aligned to the NHS 10 Year Health Plan, with its focus on Neighbourhood approaches and its emphasis on a key shift from treatment to prevention. These services reflect key recommendations from the Lord Darzi review of the NHS in England, which advocates for the integration of primary and community health and social care services. They also support the vision outlined in Skills for Care's Long-Term Strategy, which warns that, 'unless Government focuses on prevention, the care workforce will need to grow even further as more people draw on care and independence reduces'.

The Local Government Association defines preventative services as those which:

- 'Enable access to earlier support to people in anticipation of needs that may otherwise escalate'
- 'Support individuals with reason to draw on care and support, in their context – with support for those who offer care unpaid and for wider families and communities'
- 'Are often provided within and by communities, often with minimal or no input from registered professionals'
- 'Often work alongside people, helping them to feel more able to do things for themselves, rather than providing things to people'

The Local Government Association highlights that increased investment in preventative services not only empowers people to live with dignity and independence but also delivers substantial financial benefits to a system under extreme financial pressure, with an estimated saving of £3.17 saved for every £1 spent.

Surrey's Joint Strategic Needs Analysis (JSNA), which examines the overall health of the county's population, offers vital insights into local mental health needs, which our Housing Related Support and Community Connections services are specifically designed to address. National research demonstrates a notable gap between the prevalence of mental health issues in the general population and the number of people receiving treatment. Local data from NHS Surrey Heartlands ICB and NHS Frimley ICB indicates that, in September 2025, there were:

- over 166,000 people with a known mental health condition in Surrey
- over 9,000 of those with a 'severe mental illness' (SMI)*
- over 157,000 people with a 'general mental health condition'

*SMI cohort – patients with a diagnosis of psychosis, schizophrenia or bipolar affective disorder

** General MH cohort – patients with one or more of the following: anxiety, neuroses, attention deficit disorder, depression (excludes SMI patients).

Our Community Connections and Housing Related Support services are carefully designed to address this unmet need and support people within their communities in ways which are both nurturing and empowering. These services foster resilience, promote independence and help people thrive in familiar, community-based settings.

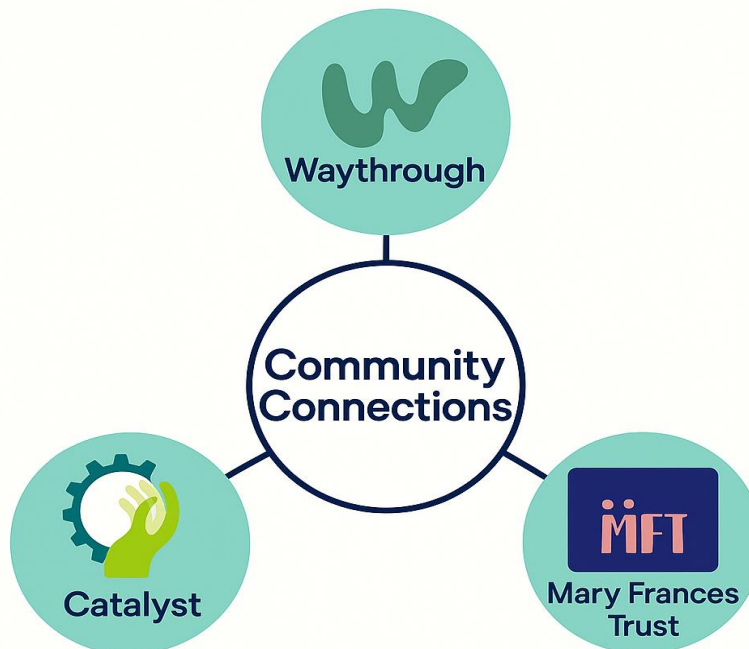
Community Connections

'Mental health is a basic human right for all people. Everyone, whoever and wherever they are, has a deserving and inherent right to the highest attainable standard of mental health. This

includes: the right to available, accessible and good quality care and the right to liberty, independence and inclusion in the community.’ **World Health Organisation.**

Community Connections services are built on the shared agreement that, to create equity around access to mental health support in the community, we need to offer an effective preventative service that is free at the point of contact and accessible to anyone who may need it. These services are a key part of our preventative mental health offer for adults in Surrey, supporting people to stay well in their communities through participation in social, leisure, sports, art and educational activities. Often bridging the gap between primary mental health care and secondary mental health care, Community Connections services help those with self-defined mental health conditions avoid the need for statutory mental health services. Instead, they support people in less clinical (and, for many, less daunting) community spaces. Community Connections services can also help those with long-term mental health needs to manage their condition holistically, avoiding crises that may require more lengthy or intrusive intervention. This, in turn, lessens the pressure on acute services and reduces the likelihood of needing treatment in a medical setting, which can be distressing for both the individual and their family.

Community Connections services work in partnership with people who draw on support, unpaid carers and other local organisations to provide opportunities for people with mental health needs to improve their overall wellbeing in different areas. This includes, but is not limited to, improving physical health, managing relationships and building self-esteem. Support is flexible, delivered in both group and 1:1 settings, and is adapted to the emerging needs of individuals and the wider community. The three lead providers of Community Connections (Catalyst Support, Mary Frances Trust and Waythrough) offer support to the whole population of Surrey Heartlands Integrated Care System (ICS), as well as to the population of Surrey Heath, Farnham and the western wards of Guildford, part of the NHS Frimley ICS.



The Community Connections service aims to address the disparity between the number of people living with mental health conditions and the number of people seeking treatment by offering free, accessible mental health groups and activities within communities, while addressing the wider stigma around mental ill-health that can prevent the seeking of support. To

achieve this, and to support long term wellbeing, it is essential that our providers deliver a highly personalised service using experienced, high-quality staff, volunteers and peer workers to support individuals in a way that works for them. Additionally, these services need to connect to the community and amplify the voices of people with lived experience of mental ill-health. This can be achieved through their commitment to co-production approaches and participation in wider community initiatives.

A renewed contract for the Community Connections services came into effect in April 2024. The effectiveness of Community Connections is measured by whether individuals feel that the service helped them to achieve their personal outcomes and either improve or sustain their emotional wellbeing. Our data shows that these services continue to be effective, with most areas of Surrey exceeding targets for successful interventions and improved/maintained measures using the Recovery Star. Throughout this contract, there is an expectation that our providers will continue to improve equity of access to the service. This includes identifying geographical inequalities and under-representation of certain groups and evidencing that they are addressing these imbalances through a planned, targeted response.

Commissioning intentions

Rising pressures on mental health services in the context of continued health inequalities, increasingly complex/co-occurring needs and ever-more pressured funding streams, make it vital that the services that we commission are reviewed and refined to meet current needs. To recommission this service, we worked alongside the Independent Mental Health Network and individuals with experience of drawing on Community Connections services to create a specification for the service that reflects current needs across Surrey. These conversations, together with the relevant data, informed our commissioning intentions and service delivery plan for Community Connections from April 2024. Some key priorities for development include:

- making support available during evenings and weekends for those who need it, including people who may have caring or work commitments
- making support available on an individual basis for those who are anxious or lack confidence to join groups
- increasing awareness and availability of services in more isolated, less well-served parts of Surrey
- ensuring that in-person and virtual support is available, to meet varying needs, including appropriate support to access online groups for those who would like to join virtually but struggle with technology
- introducing a minimum staff training requirement which includes, for example, carer awareness, neurodiversity training and trauma-informed care
- introducing specialist workshops and support for more complex or co-occurring conditions such as eating disorders, addictions and autism
- introducing a new tool to monitor outcomes for those focused on maintaining their wellbeing rather than recovery



Making support available during evenings and weekends



Making support available on an individual basis



Increasing awareness and availability of services in more isolated parts of Surrey



Ensuring that in-person and virtual support is available



Introducing a minimum staff training requirement



Introducing specialist workshops and support for more complex or co-occurring conditions



Introducing a new non-recovery based outcome monitoring tool

We continue to monitor these services through quarterly contract meetings, drawing on performance data and reviewing progress against the service development plan. In addition, we have recruited Lived Experience Facilitators to carry out site visits to Community Connections services alongside the mental health commissioning team. This collaborative approach offers valuable, first-hand insight into how consistent and equitable the service offers are across the county. The ‘friendliness’ and ‘approachableness’ of Community Connections services was paramount to the group who co-produced this MH Delivery Plan, echoing feedback that we get from people who draw on these services. One member expressed that services should feel like they are ‘walking alongside you’ in recovery and be delivered by staff who are warm, compassionate and supportive. These essential qualities of the service will be monitored through regular client feedback, which is routinely shared with commissioners to inform ongoing service improvement.

Community Connections services will continue to provide support at a primary care level, sitting within GPIMHS to help prevent people from reaching crisis and to provide carer’s support. During the co-production of this strategy, a gap in support for specific groups was identified – particularly people leaving prison and veterans. It was felt that Community Connections could play a bigger part in helping individuals with an offending history who have a lower-level mental health need to access the right support within their communities. Those with expertise in this area stressed the importance of a multi-agency approach, with services ideally delivered through a ‘hub’ or ‘one-stop shop’ model, to ensure coordinated and accessible support.

A joined-up approach is key here, to achieve some of the priorities identified by the working group for this strategy. Community Connections providers are already collaborating with local organisations that specialise in supporting groups at higher risk of mental ill-health, such as the LGBTQ community, unpaid carers and those affected by domestic abuse. Activities are delivered in partnership with organisations such as the East Surrey Domestic Abuse Service

(ESDAS) and jointly run drop-in services are co-ordinated at local venues. Building on this approach to include veterans and those with an offending history could bring similar benefits to these communities. This approach could be further strengthened by integrating Community Connections services into the new Neighbourhood Health Centres, as envisioned in the NHS 10-year Health Plan.

Additional gaps were identified that relate more specifically to health-funded services, such as a lack of night-time support for individuals experiencing mental health crises, which can be a particularly difficult time for those living with a mental health condition. While decisions around Safe Havens rest with health partners, we recognise the close link with our Community Connections providers, who operate and resource these services. Concerns also remain around the level of mental health support available in Accident and Emergency hospital departments and more broadly during out-of-hours periods. Addressing these issues requires a co-ordinated, system-wide approach and we are hopeful that the increased investment of £120 million into mental health emergency departments (as outlined in the NHS 10-year Health Plan) will enhance crisis support and ensure that people are able to receive the help they need – when they need it most.

Housing Related Support

Insight and local context

The Mental Health Commissioning Team currently commissions 27 Housing Related Support (HRS) services throughout Surrey to support those with a mental health and housing need and those experiencing multiple disadvantage. These services include homeless accommodation, low-level mental health supported living (move-on) and floating support services. They are delivered in partnership with local district and boroughs, housing associations and the Voluntary Community and Faith Sector (VCFS) and are commissioned to offer an early-intervention service to Surrey residents. They support people to avoid homelessness and the escalation of mental health needs which can occur as the result, or alongside, worsening life circumstances.

These services embrace the ‘whole-person’ approach which is a key priority in the One System Plan, attending to ‘housing, employment, benefits, health and care in an integrated way’. There is a focus on ‘need’, rather than eligibility, which eases referral pathways and allows people to get the support they need at an earlier stage. To prevent, reduce and delay the need for more intensive care and support, these services are available to individuals regardless of whether they are eligible for statutory social care support or not. By preventing and addressing homelessness in Surrey, we hope to prevent some of the key risk factors that affect homeless people in England:

- around 80% of homeless individuals experience some form of mental health problem, including depression, anxiety, PTSD or psychosis
- studies indicate that 45-50% of homeless people have a severe mental illness (SMI) like schizophrenia or bipolar disorder. Rates of dual diagnosis (mental health plus substance use) are high, estimated at 50-60%
- approximately 38% of homeless people report problematic drug use and alcohol dependency affects around 25-30%. Overdose risk is significantly higher than the general population, with homeless people 17 times more likely to die of drug-related causes

- the average age of death is 42-47 years for homeless men (vs 76 nationally)
- around 35-40% of homeless people report having experienced physical violence or assault in the last year. Sexual violence is disproportionately high, especially among homeless women, with estimates of 20-30% having experienced sexual assault.
- suicide rates among homeless people are 6-10 times higher than in the general population
- homeless individuals are 3-6 times more likely to be hospitalised for preventable conditions

During the period of 2023-2024, approximately 3,851 people in Surrey accessed Housing Related Support services. 49% of people had a mental health need and 17% had needs associated with substance use. The costings equate to £22 per week, per person, which is significantly less than an average of £844 per week in a supported living setting or £187 per person receiving home-based care. Continuing to invest in Housing Related Support services contributes towards our focus on prevention and supports people to live with dignity and independence, whilst improving the overall financial stability of the health and social care system.

We continue to commission several floating support services for those experiencing housing, financial and health-based challenges; with some services (such as the Gypsy, Roma, Traveller floating service) designed specifically to support communities who experience greater health and socio-economic inequalities in Surrey. By offering these preventative services, we can support people with issues that, if not addressed, could escalate to the point of needing more significant, statutory care and intervention. We want to support people in our communities to live their lives in the way that they choose, for as long as possible.

Commissioning intentions

Our recommendation is that Housing Related Support services continue to be commissioned and re-commissioned until Local Government Re-organisation is complete, after which time, each unitary council may re-shape the offer according to assessed need across their newly defined areas.

The commissioning team is currently reviewing the service specifications and relevant schedules for HRS services. This will ensure that they are fully up to date and accurately capture what each HRS service should be delivering. This will also put the services and the commissioning function in the best position, ready for LGR.

As the Mental Health Commissioning Team, we continue to strongly advocate for these services and their part in the wider focus on prevention and early intervention. We hope that, post-devolution, preventative services will continue to receive the funding and investment that they need to support some of the most marginalised people in our communities.

Care within the Home and Outreach

Insight and local context

Adult social care services for individuals and carers with eligible care needs must be offered as early as possible and in the most appropriate place for each person. Often, this will be in a

person's home through an Outreach or 'Care within the Home' service. An independent review of SCC's Adult Social Care services in 2024 identified approximately 73 residents open to mental health social care teams in Surrey each year who would benefit from receiving initial support in a more independent, non-accommodation-based setting. Additionally, 49 people in Supported Living accommodation and 24 people in residential (general and dementia) care each year might be better supported by Care within the Home services.

It is essential to support people with eligible care needs and their families in a way which maintains their independence as much as possible. Avoiding accommodation-based services, where appropriate, not only results in significant system-wide savings but, more importantly, supports independence, prevents institutionalisation and keeps people closely connected with their families, friends and communities. An asset-based approach, which considers each person's individual and community strengths, is often best sustained within a person's own home. For many individuals and their carers, remaining at home for as long as possible is a key priority. Facilitating this, where appropriate, is essential in honouring principles of the Care Act 2014 around choice and control.

The independent review also revealed that approximately 60% of people contacting Adult Social Care for mental health support were already at crisis point - often triggered by, or resulting in, a breakdown in their home environment. At this stage, the rupture can be so severe that options such as Care within the Home or Outreach services are no longer viable. There are clear links here with the preventative ASC community support offer and wider One System Plan priorities. These include:

- developing an all-age community mental health offer
- developing an all-age crisis pathway offer
- improving access to health and social care services for neurodiverse people
- more equitable support for underserved and 'complex' mental health groups
- a community-wide prevention approach

All workstreams, and the agencies involved with making them a reality, have a significant part to play in supporting people to stay well at home.

A key part of the One System Plan that is particularly relevant here is the 'whole-person' approach, which recognises that mental health is shaped by a complex interplay of personal, social and environmental factors. By designing interventions that bring agencies together to support individuals and their families in a collaborative and flexible way, we can help prevent crises that can lead to the breakdown of the home environment. These challenges are often compounded by factors which run alongside a person's deteriorating mental health, such as housing instability, financial pressures, relationship or carer breakdown, or the emergence of personal care needs. Many personal and circumstantial factors that lead someone to require accommodation-based support could be mitigated by effective Care within the Home or Outreach services.

This includes ensuring that people leave hospital with the right home-based care package in place. Current data shows that 31% of people discharged from mental health inpatient care move into supported living services, compared to just 26% who return home with support. This highlights the need to strengthen community-based options that enable people to remain in their own homes.

The current picture

Care within the Home

In September 2025, there were 198 approved providers of home-based care operating in Surrey, of which 53 specialise in people with additional needs including mental health, autism and learning disabilities. As of 1 September 2025, 231 people with mental health needs were being supported by Care within the Home providers. These services focus on supporting daily living tasks and providing practical assistance, which often includes personal care.

Key development opportunities were identified by those with lived experience who co-produced this strategy. These include:

- enhanced support for the whole family from Care within the Home services, recognising that individuals live within complex relational networks. The needs of carers, especially young carers, should be identified at the point of assessment. Providers commissioned to deliver care should adopt a whole-family approach to supporting people at home
- stronger collaboration with experienced providers in mental health care is essential. Concerns were raised about some agencies offering only brief visits or lacking the skills to support individuals with mental health needs. There is a need for greater training opportunities in areas such as trauma-informed care, neurodiversity and co-occurring conditions
- greater availability and choice of home care providers who are equipped and willing to support people with mental ill health. Currently, freedom of choice is perceived to be limited, particularly for working-age adults with mental health needs

Practitioners also identified key areas for development:

- closer collaboration with health colleagues to ensure a clear understanding of Adult Social Care's role in supporting people who are leaving hospital. Managing expectations around supported living provision is crucial, as it can influence referrals to accommodation-based services when home-based care might be more appropriate.
- improving the current home-based care offer to ensure it meets the needs of individuals with multiple or complex mental health needs. Current interventions are often described as too 'rigid' and 'action-focused', rather than recovery-orientated. Expanding Assertive Outreach services and increasing access to Personal Assistants (PAs) could significantly enhance support for people within their own homes

Outreach services

Outreach services are being developed which have a focus on supporting individuals in areas beyond daily living tasks. These services aim to promote emotional wellbeing, social inclusion, relationship management and improved independence. We are currently exploring options for expanding Outreach in Surrey, including engaging the provider market and assessing the feasibility of an in-house service. The goal is to establish Outreach as a distinct and specialist offer, separate from Care within the Home and to ensure access to highly trained professionals with expertise in delivering recovery-focused support in people's homes. This development aims to address key gaps and create an offer that better facilitates community inclusion and personal recovery. The group co-producing this strategy noted some key adaptations needed to enhance the more traditional 'Care within the Home' model, to make this Outreach offer more effective at meeting a range of different needs, including:

- enhanced **skills and experience** to support early intervention, prevent hospital admissions and reduce the risk of relapse. This includes supporting individuals to 'take small steps back into the world again', access acute health and crisis services and participate in community activities to stay well, including creative groups and sensory regulation spaces.
- a strong **recovery focus** when supporting people with their MH care needs at home is essential to help people to feel empowered and avoid the risk of de-skilling people when managing their daily living tasks.

Additional note:

Everyone involved with co-producing this strategy acknowledges that staying at home (or returning home after a hospital stay for mental ill-health) is not always the most appropriate option. It is essential to consider each individual's unique circumstances and the impact that staying at home, or returning home after hospital, will have on the whole family. As such, we will continue to commission supported living and residential care services for those people where this is the 'ideal care' offer, while continuing to develop 'Care within the Home' and 'Outreach' options for when this is more appropriate.

Technology to support Care within the Home and Outreach services

Surrey County Council offers a growing range of technology solutions to support individuals to continue to live independently at home, while also enhancing 'Care within the Home' and 'Outreach' care packages. These tools include apps that help people to manage daily routines by providing tailored instructional videos or connecting users to support networks for managing emotional regulation and mental health crises. Smart home technology, such as motion sensors, can offer reassurance to carers, particularly overnight, and help reduce the need for additional staffing when someone's needs fluctuate.

Several risks have been identified when commissioning technology to support care at home include, along with proposed mitigations:

Risk 1: overdose from medication dispensers:

- **Mitigation:** dispensers can be fitted with alarms that alert an individual's support network if additional compartments are opened

Risk 2: infringement of privacy:

- **Mitigation:** SCC's technology offer is underpinned by a consent-driven approach, ensuring individual's agreement is sought at all times

Risk 3: increased paranoia symptoms:

- **Mitigation:** technology is only used where appropriate, guided by individual risk assessments

Risk 4: technology failures:

- **Mitigation:** smart systems are designed to alert an individual's support network immediately if issues arise

Risk 5: increased isolation and its impact on mental health:

- **Mitigation:** emphasis is placed on choice and control, using technology to enhance (not replace) human interaction. For example, technology may be used to avoid unnecessary disruptions at night rather than reduce meaningful contact

Commissioning intentions

Over the next five years, we will be focusing on developing a Care within the Home and Outreach offer that meets the needs of people with eligible mental health needs in Surrey. For this offer to be an appropriate and appealing alternative to more intensive options, such as residential and supported living settings, there are some key areas of development for Adult Social Care. Some of these developments will be practice based, involving better collaborative working between ASC staff and our health partners. However, there are crucial commissioning responsibilities here, which we are committed to working towards over the next five years:

- **Market development:** we will work with our provider market to develop a clear understanding of what is needed to support someone with mental health needs to live a fulfilling life in their own home, particularly in the context of Outreach services
- **Specification and standards:** we will ensure that the needs of people with mental ill health are considered within any commissioning process, clearly outlining expectations around recovery-focused practice, trauma-informed approaches and whole family support
- **Workforce development:** we will support our providers to invest in their workforce by mandating, and supporting access to, training in areas such as neurodiversity, co-occurring conditions and emotional regulation. This will help build a confident, skilled workforce to deliver personalised and responsive care
- **Technology-enabled care:** we will continue to explore and commission technology solutions that enhance independence and safety at home, while ensuring these tools are used ethically, appropriately, and in ways that promote—not replace—human connection
- **Monitoring and evaluation:** we will establish robust mechanisms to monitor the impact of commissioned services, using feedback from people with lived experience, carers, and practitioners to continuously improve the offer. This will include tracking outcomes related to independence, wellbeing, crisis prevention, and community inclusion

By embedding these commissioning intentions into our strategic planning, we aim to create a sustainable, person-centred system that supports people to live well at home, wherever possible, and ensures that more intensive forms of care are available when needed.

Care and Support with Accommodation

Insight and local context

Care and support with accommodation - often referred to as supported independent living - is an essential offer for adults with severe and enduring mental health and/or substance use needs who do not have access to, or are unable to maintain, their own housing. Individuals in Supported Living require tailored support to avoid prolonged hospital stays and to achieve the stability necessary to live with as much independence and self-determination as possible.

In supported independent living settings, care providers work in partnership with landlords - typically not-for-profit housing organisations - to help individuals to maintain their tenancies, manage their finances and build life skills. Surrey County Council commissions the care providers, who identify suitable housing partners to deliver this integrated support model.

Residents in supported independent living typically pay rent directly to landlords using either Housing Benefit or the housing element of Universal Credit. Housing Benefits are managed by Surrey's eleven borough and district councils, who each determine eligibility independently.

To secure Housing Benefit, both landlords and residents must meet specific criteria. Landlords are also required to operate within relevant housing legislation, such as the Housing Act 1988, which governs Assured Shorthold Tenancies (ASTs). This is the most common tenancy type for private rentals, including those used in supported independent living. Additionally, social landlords will soon be required to comply with the [Social Housing \(Regulation\) Act 2023](#), which came into force in April 2024. This legislation strengthens the powers of the [Regulator of Social Housing](#) (RSH) to hold social housing landlords accountable for the safety and quality of their housing.

As of August 2025, Surrey County Council's mental health teams support over 350 people in supported independent living settings. These placements may be in shared or single-occupancy settings, located either within Surrey or in neighbouring areas.

Commissioning intentions

In April 2024, a new dynamic purchasing system was launched to enhance mental health provision across Surrey. The system is structured into four distinct lots, each tailored to an individual's level of assessed need and the nature of the service – whether it is recovery-focused or intended as longer-term support (a 'place to call home') This framework ensures that the care and support delivered in any given setting is at the right level for each person and provided by staff with an appropriate level of skill and training.

When applying to join our DPS, it is essential that providers evidence how they reflect our values, in areas such as promoting independence and wellbeing, personalisation, inclusiveness, dignity and integrity. They must also be able to show how they can deliver against our key criteria in areas such as:

- supporting community inclusion
- supporting choice and control
- supporting strength-based approaches
- providing personalised care and support
- offering affordability

Identified Priority Areas

Commissioners have also identified specific areas of need, both geographically and in terms of the needs of people who require support. These priorities include:

Self-contained properties

There is a need for self-contained properties supported by a single staff team, ideally with access to communal spaces.

Complex needs

Feedback from stakeholders indicates a rise in complexity among people requiring support. This includes co-occurring conditions, neurodiversity, forensic needs under part 3 of the Mental Health Act, behaviours that challenge, substance use and/or self-harm. SCC seeks applications from services with evidence of experience and recognised training in these areas.

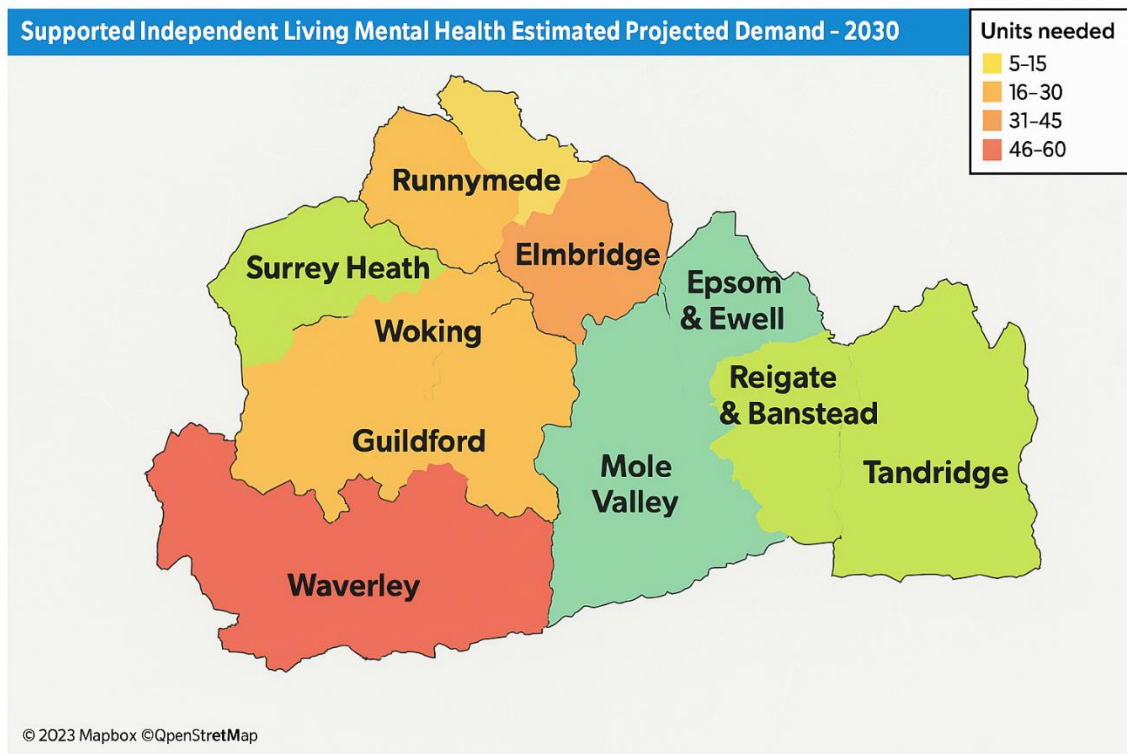
Low need / 'Move on' services

There is a current shortage of services for individuals with lower support needs, particularly those transitioning from higher-need settings. These services typically do not require overnight staffing but should offer out-of-hours on-call support and/or technology to enable independence.

Commissioners are looking to work with providers offering a range of services within defined local areas. This approach helps to reassure individuals who are ready to move on, allowing them to maintain the relationships they've built, whether with staff or the community. It also supports a more gradual and person-centred transition, particularly when familiar staff are involved, enabling continuity of care and a gradual reduction in support levels.

This model can be effective when services are delivered by the same provider or where there are well established referral pathways and a flexible use of resources across organisations.

- **Location:** while the previous DPS (ending in March 2024) increased the number of providers in Surrey, gaps remain in certain areas and for specific specialist needs. The map below outlines the estimated number of units/ individual places required from 2024 to 2030.



This DPS actively seeks applications from providers operating in the following areas: Elmbridge, Waverley, Spelthorne, Mole Valley, Runnymede, Epsom and Ewell and Tandridge.

Feedback from people with lived experience highlights the importance of service locations within walking distance of public transport and amenities such as shops, leisure opportunities, employment opportunities and religious buildings.

- **Female only services:** feedback has also identified challenges in placing females in predominantly male supported independent living services. Data confirms that women are

under-represented in supported independent living compared to the number open to Surrey County Council's mental health teams

- **Young adults (18-25):** feedback has also indicated that it can be difficult to place younger adults in settings where most residents are significantly older. Data confirms a slight under-representation of under 25s in Surrey's current settings and welcomes applications from providers who can offer age-appropriate environments for this group

Direct Payments

Insight and local context

The advantages of receiving Direct Payments (DPs) for people living with long term mental health conditions are well-recognised. Mental illness can have a profound impact on a person's confidence and self-esteem, so the ability to commission personalised support using an agreed budget can be a powerful and empowering option.

DPs align closely with person-centred, strength-based approaches. They enable individuals to tailor their support by, for example, hiring Personal Assistants (PAs) with specific skills, experience and values that resonate with them. Care packages can be more creatively designed to include a mix of PAs, care agencies, education classes, community groups, gym memberships or social activities. This flexibility offers more autonomy than traditional care arrangements and can help individuals and their carers feel more in control of their support.

Challenges in Mental Health contexts

Despite their benefits, DPs continue to prove challenging to use by people with mental health needs in Surrey, with uptake significantly lower than among those with learning or physical disabilities. Several factors are likely to contribute to this low uptake:

- **administrative complexity:** the process involved with managing direct payments can feel overwhelming and inaccessible
- **culture resistance:** practitioners may feel less confident in promoting DPs, often favouring traditional care packages perceived as easier to implement and lower risk
- **limited market development:** a shortage of available community-based services (particularly trained PAs) can deter people from considering direct payments.
- **perceived rigidity:** mental health needs often fluctuate, and DPs may be seen as too inflexible to accommodate this
- **lack of awareness:** many individuals and carers are unaware of the scope and potential of DPs, which can limit uptake

Strategic developments

To address these challenges, Adults Wellbeing and Health Partnerships have established a dedicated Direct Payment Team to implement the 2023 Direct Payment Strategy. This team is focused on addressing the challenges outlined above, focusing on the following areas that are relevant to MH Commissioning:

Specialist training

The Direct Payment Team will explore the training needs of PAs supporting people with mental health conditions, including emotional support, motivational coaching and crisis management. They aim to expand the current training offer for PAs and raise awareness of existing resources and training currently available through Skills for Care.

Expanding the PA Market

The Direct Payment Team are looking to grow the PA workforce by addressing barriers that discourage individuals from choosing PA roles over agency work. This includes developing peer support networks to reduce isolation and promote connectivity, as well as sharing positive stories to challenge stigma and highlight the rewarding nature of the role.

Promoting Person-Centred Assessments

To ensure that direct payments are considered as a viable option, assessments need to take place that fully understand the needs and aspirations of the individual. Comprehensive, open-minded assessments that use flexible, creative approaches will ensure that each person is at the centre of their own care from the outset, including how that care is commissioned and delivered.

Increased flexibility

The group who co-produced this strategy identified the potential for one-off DPs to be used preventatively – particularly for those whose mental health needs fluctuate. This could include support during periods of crisis or transition, aligned with work around the Adult Social Care 'Front Door'. There is also scope to integrate technology such as the 'Brain in Hand' app, which offers flexible, responsive support and could be funded through DPs.

Supporting people with DPs

While organisations like SILC (Surrey Independent Living Charity) offer valuable support, becoming an employer of a PA can be really daunting, especially for those with mental health needs or caring responsibilities. A simple, accessible guide to supporting someone in a self-employed PA role would help individuals navigate responsibilities such as insurance, tax and annual leave.

Improving systems

Work is ongoing to improve the accessibility and usability of the DP system, making it easier for individuals to manage their payments and engage with the process confidently.

Transitions

Insight and local context

Many of the challenges faced by Transitions services within Adults, Wellbeing and Health Partnerships arise from the difficulty of supporting individuals and their families as they move between two very different systems. These challenges largely stem from differences in legislative frameworks, service models and eligibility criteria across the two systems. As a

result, individuals and families can experience uncertainty, disruption and a lack of continuity of care during this critical period.

Children's services typically operate with a family-centred approach, while adult services focus more on individual needs and independence. This shift can be difficult to navigate, particularly when assessment processes differ and the nature of available support changes significantly. These challenges can lead to delays in care, unmet needs and increased pressure on families and professionals.

Ensuring that transitions are well supported can have a lasting impact on health, wellbeing and independence. A more co-ordinated, person-centred approach is being developed to bridge the gap between systems and to ensure that young people are not left behind.

Commissioning intentions

Over the next five years, our Transitions commissioning colleagues within Adults, Wellbeing and Health Partnerships will focus on improving transitions by:

Strengthening data and intelligence

- working with children's services to improve the quality and timeliness of data about young people who may require support as they approach adulthood
- using this intelligence to proactively plan services and ensure appropriate provision is in place

Embedding lived experience

- working closely with people who have lived experience of transitioning from children's services, as well as their families and carers, to understand their journey and inform service design

Shaping the market

- collaborating with providers to develop the right kinds of support for young adults, including flexible and inclusive services that can adapt to changing needs

Building provider capacity

- ensuring providers have the right skills, values and training – including trauma-informed approaches, and a focus on continuity and independence

Promoting early planning and integrated pathways

- embedding transition planning from age 14 onwards to ensure smoother handovers between children's and adult's services
- developing integrated pathways that reduce service gaps and promote continuity

Exploring innovative models of support

- co-producing new models of care with young people, including supported-living, peer-led services and community-based interventions
- ensuring these models reflect aspirations for independence, inclusion and meaningful lives

Suicide prevention

Insight and local context

Surrey has a Suicide Prevention Strategy 2025-2030, which was formed collaboratively between health, local government, people with lived experience and the voluntary and community sector (VCS). It highlights our commitment to reducing the number of lives lost to suicide and sets out key actions that we need to take to achieve this. Surrey's strategy aligns with the National Suicide Prevention Framework, whilst reflecting extensive local engagement and data analysis. There is a key focus across the strategy on learning from lived experience, the importance of cross-sector collaboration and embedding suicide prevention approaches across all services and communities in Surrey.

Strategic priorities

Understanding suicide in Surrey

A focus on improving data collection and analysis to allow for a deeper understanding of risk factors and local patterns. This will allow for more targeted, system-wide interventions.

Tailored wellbeing approaches

A focus on the emotional wellbeing of particular groups who have increased vulnerability to suicide, including children and young people, carers and neurodiverse individuals.

Safer communities

Plan and implement interventions which reduce access to means of suicide and promote environments which are conducive to good mental health.

Youth-focused prevention

Address rising concerns around suicide attempts among children and young people.

Bereavement support

Enhance support for those bereaved by suicide to reduce the risk of further trauma and suicide.

High risk groups

Prioritise interventions for people with known mental health conditions and other identified risk factors.

Suicide prevention in mental health commissioning

Suicide prevention is an integral part of every service that we commission. All our specifications include mandatory training in 'Suicide Awareness and Prevention' and services supporting individuals with complex mental health needs must evidence training in areas such as 'Understanding self-harm in the context of complex emotional needs' and 'Trauma-Informed Care'. Providers of supported living services are required to demonstrate their skills and

experience in safeguarding individuals who are at significantly increased risk of suicide, particularly those with complex needs, addressing both environmental factors and risks linked to specific mental health conditions.

With the establishment of new, unitary authorities, we hope for a stronger emphasis on integrated working with health partners. The group that co-produced this MH Commissioning Delivery Plan identified several key areas for development:

- support for those bereaved by suicide is currently limited, often to a single peer support group serving a wide geographical area. Given that multiple family members will be affected by the suicide of a loved one, this limited service provision can result in complex emotional dynamics within families
- updated NICE guidance from NHS England on [‘Staying Safe from Suicide’](#) needs to be shared and implemented across all ASC commissioned services. This guidance ‘promotes a shift towards a more holistic, person-centred approach’ to suicide prevention, moving away from models that rely heavily on risk prediction
- support for carers must be improved, both in terms of consistency and quality. Carers are frequently overlooked, despite being a group at heightened risk of suicide themselves

Our Action Plan

What will we do?

Community Connections

- work with providers to ensure support is developed across key priority areas as identified in the new specification. This includes evenings and weekend support, individual support to join groups, in-person and virtual support and specialist workshops for co-occurring conditions
- increase awareness and availability of services in more isolated, less well-served parts of Surrey
- introduce a minimum staff training requirement which includes carer awareness, neurodiversity training and trauma-informed care
- introduce a new tool to monitor maintenance goals rather than recovery outcomes
- explore community connections provision for veterans and people with an offending history
- monitor demographic insights around service use to ensure equity across Community Connections
- continue to monitor the implementation of the service delivery plan and service effectiveness, focusing on individual outcomes, case studies and feedback surveys

Housing Related Support

- continue to commission and re-commission until Local Government Re-organisation is complete, after which time each unitary council may re-shape the offer according to assessed need across their newly defined areas
- review HRS service specifications to ensure that they are fully up to date and capture what each HRS service should be delivering
- continue to advocate for HRS services and their part in the wider focus on prevention and early intervention

- continue to monitor the effectiveness of the services we commission, focusing on outcomes and equity of access

Care within the Home and Outreach

- we will ensure that the needs of people with mental ill health are considered within any future commissioning process, clearly outlining expectations around recovery-focused practice, trauma-informed approaches and whole family support
- we will ensure that future commissioning processes involve effective market and workforce development, technology-enabled care and robust mechanisms to monitor the impact of commissioned services

Care and Support with Accommodation

- we will continue to monitor how our DPS providers are delivering against our key criteria in areas such as: supporting community inclusion, supporting choice and control, supporting strength based approaches, providing personalised care and support, offering affordability
- we will work with the market to develop services which meet specific identified areas of need, including: self-contained properties, services for people with complex needs, low-need or 'move-on' services, services in locations that are currently under-served, female-only services and settings for young adults (18-25)

Carers

- we will continue to support the Carer's Commissioning Team to ensure that all commissioning activity considers the needs of carers of people with mental health conditions, including the upcoming tender for income maximisation services and the evaluation of specialist carer's services

Direct Payments

- we will support the Direct Payment team in implementing the 2023 Direct Payment strategy, ensuring the needs of people with mental ill health and their carers are considered in all developments

Transitions

- we will support the Transitions team to improve integrated pathways between children's and adults services for individuals with mental health needs and their carers

Suicide prevention

- we will support SCC's Public Health team in their implementation of the Suicide Prevention strategy 2025-2030
- we will continue to embed suicide prevention approaches across all of the services we commission, with a particular focus on groups who have increased vulnerability to suicide, including young people, carers and neurodiverse individuals

Evaluation and impact

By embedding an ongoing process of evaluation and a clear focus on impact, this Delivery Plan supports the mental health commissioning function in Surrey to remain transparent, accountable and continuously improving. Its success will show through both measurable outcomes and through continuing to listen to the experiences of individuals and carers who draw on mental health support. We hope that this plan offers a helpful framework for the two, new unitary authorities of East and West Surrey to commission effectively to continue to reduce health inequalities, improve independence and quality of life, strengthen families and communities, prevent crises and build a mental health system grounded in partnership, compassion and long-term sustainability.

Led by

This work will be led by the Mental Health Commissioning Team, with oversight from Jane Bremner, the Head of Mental Health Commissioning. The MH Commissioning Team will continue to work with colleagues leading on related priority areas, including Carer's, Transitions and Direct Payments, to ensure a cohesive approach across commissioning activity.

Appendices

Linked strategies

This Mental Health Commissioning Delivery Plan aligns with the following strategies and visions:

- [Community Vision for Surrey 2030](#) – promoting health, inclusion and equity
- [The Surrey Way](#) – a strategic framework to focus on achieving better outcomes for residents
- [One System Transformation Plan](#) – supporting integrated care and whole-person approaches
- [All Age Autism Strategy](#) – ensuring neurodiverse people receive support that meets their needs
- [Surrey Carers Strategy 2021 to 2024](#) (extended to 2026) – recognising and supporting unpaid carers
- [Surrey Suicide Prevention Strategy](#) – reducing suicide rates through collaborative action

Glossary of terms and abbreviations

- **Co-production:** Equal partnership between professionals and people with lived experience in designing and reviewing services
- **Outreach:** Non-accommodation based support delivered in the community
- **Recovery Star:** A tool used to measure progress in mental health recovery

- **ASC:** Adult Social Care
- **DP:** Direct Payment
- **DPS:** Dynamic Purchasing System
- **GPIMHS:** General Practice Integrated Mental Health Service

- **ICB:** Integrated Care Board
- **JSNA:** Joint Strategic Needs Assessment
- **PA:** Personal Assistant
- **SCC:** Surrey County Council
- **SMI:** Severe mental illness

Co-production core Project Group members

We would like to thank Janice Clark and all other Reference Group members, including the Independent Mental Health Network, who helped to co-produce this Delivery Plan. Your insights and guidance were central to this strategy and helped ensure that, at its core, its focus is on individual's lived experiences and improving the lives of people living with mental health needs in Surrey.