A. Service Specifications

<table>
<thead>
<tr>
<th>Service Specification No.</th>
<th>OSMHLD/0001</th>
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</thead>
<tbody>
<tr>
<td>Service</td>
<td>Recovery House – Support Provision</td>
</tr>
<tr>
<td>Commissioner Lead</td>
<td>CCP for Mental Health &amp; Learning Disabilities</td>
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<tr>
<td>Provider Lead</td>
<td>Rethink Mental Illness</td>
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<tr>
<td>Period</td>
<td>April 2013 – March 2018</td>
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<tr>
<td>Date of Review</td>
<td>Annual with a formal review prior to April 2016</td>
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1. Population Needs

The Provider will review the need for CQC registration as required.

1.1 National/local context and evidence base

This service specification application is inviting bidders for the support provision within the Recovery House. The Crisis Response Home Treatment (CRHT) elements of the Mental Health Urgent Care Services (MHUCS), is already provided by the local NHS Mental Health provider.

Vision of this service

The Recovery House will provide a high quality support service for people experiencing an acute mental health crisis. It will be an alternative to inpatient care. The “Recovery” principles will be the basis for the service, alongside the philosophy of compassion and respect.

This service specification outlines the principles and values upon which the Recovery House service for the west of Dorset is based. It draws upon the following strategy and policy documents, research, and legislation, to inform the development of the service model:

Links to Local and National Strategies

The Service will achieve objectives in local and national strategies including those detailed below. Additional strategies can be added with the agreement of both parties.

National Strategies:

- No Health without Mental Health (DH 2011)
- Mental Health and the Productivity Challenge – Improving quality and value for money Kings fund 2011
- The Economic Case for Improving Efficiency and Quality in Mental Health (DH2011)
- Audit Commission report Crisis Response Home Treatment (CRHT) Services
- Recovery focussed model
- The White Paper ‘Our Health our care our say’
- A stronger local voice: a framework for creating a stronger local voice in the development of health and social care
- Nice guidelines
Local Strategies:

- 1 in 4 Joint pan Dorset Mental Health Commissioning Strategy 2010
- Dorset Mental Health Improvement Plan 2011 -2014
- Suicide and Self harm in the South West 2011 -2014
- Safeguarding - Children and Adults
- Mental Health Urgent Care Pathway ‘Recovery Pathway’ – See Appendix one
- Dorset MH Quality, Innovation, Productivity and Performance (QIPP) agenda
- Service Specification for NHS Dorset west of Mental Health Urgent Care Service (MHUCS) 2011
- Dorset Mental Health Housing Strategy

The introduction of the Recovery House is part of Dorset PCT/CCG plans to redesign the mental health services in the west of Dorset within the MH QIPP agenda. It also fulfils a long standing aspiration of mental health service users from the Dorset Mental Health Forum.

- ‘Support Provider’ means the person, firm, company or organisation appointed by the Purchaser and includes its employees, volunteers and agents, which is responsible for providing the Services in accordance with this Agreement and the Specification.
- Dorset PCT/CCG (working in partnership with Dorset County Council’s Adult & Community Services Directorate) and including its employees and agents, which is responsible for the purchase of the Services detailed in this Agreement and the Specification. Commissioner and purchaser are interchangeable descriptions in this specification.
- ‘Service User’ means person placed in the service by Crisis Response Home Treatment (CRHT) Services
- ‘Recovery’ means – focusing care on supporting recovery and building the resilience of people with mental health problems, not just on managing their symptoms.
- The ‘Mental Health Urgent Care Services’ (MHUCS) – Recovery House forms part of the ‘Recovery Pathway’

‘Recovery House’ support is provided for up to two weeks to prevent the need for people who are in a mental health crisis going into acute mental health inpatient hospitals. It is an alternative to hospital admission.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Preventing people from dying prematurely</th>
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</thead>
<tbody>
<tr>
<td>Domain 2</td>
<td>Enhancing quality of life for people with long-term conditions</td>
</tr>
<tr>
<td>Domain 3</td>
<td>Helping people to recover from episodes of ill-health or following injury</td>
</tr>
<tr>
<td>Domain 4</td>
<td>Ensuring people have a positive experience of care</td>
</tr>
<tr>
<td>Domain 5</td>
<td>Treating and caring for people in safe environment and protecting them from avoidable harm</td>
</tr>
</tbody>
</table>
2.2 Local defined outcomes

Key Service Outcomes

Service Users shall be supported to exercise the maximum levels of choice and control over the support they receive.

Each Service User will be offered the level of support indicated and agreed through the Risk Management Plan and Wellness Recovery Action Plan (WRAP).

The service will aim to instil the hope of personal recovery and increased self worth through the use of tools such as the Mental Health Recovery outcomes framework.

This tool can be used to work with an individual towards their personal aspirations which might include support in the following areas:

- Work on self esteem and confidence
- Re framing their experiences to enable them to manage future experiences
- Developing meaningful roles in the community
- Work on individuals strengths and experiences
- Improving self care
- Increasing sense of personal responsibility
- Increasing skills to avoid or manage future crises

General benefits of the service will be:

- A reduction in the number of people requiring an inpatient admission
- A reduction in the number of emergencies amongst people in acute mental health crisis that would currently result in the need for intensive services

Download information on Mental Health Recovery Star at http://tiny.cc/mmr53

Individual Service User Outcomes

The provider shall establish procedures that identify outcomes and enable them to evaluate the effectiveness of their support.

The Provider will engage positively with Service Users in a recovery focused way in order to achieve the following outcomes.

- Service Users able to evaluate their progress whilst in the recovery house
- Service Users able to take back control and adapt
- Service Users able to access the roles, relationships and activities that are important to them
- foster hope and hope-inspiring relationships

Individual Service User outcomes must be reported in accordance with the Recovery Star

Service Users shall be enabled to achieve as much as possible within the 14 days and the achievements might include any of the following outcomes:

- participation in leisure /cultural / faith and /or informal learning activities
• contact with external services /groups /friends /family
• improved health in mind and body
• improved ability to manage their acute mental health crisis
• improved abilities to manage their physical and mental health
• improved ability to manage their substance misuse issues
• feel able to stay safe, feel safe and secure
• able to manage any self harming behaviour
• avoid causing harm to others
• Increased confidence to make a positive contribution
• Increased ability to have greater choice and/or control and/or involvement within their wider community

In addition, Service Users should:
• Feel free from discrimination
• Be socially integrated not isolated

3. Scope

3.1 Aims and objectives of service

People experiencing acute and severe mental health crisis should be treated in the least restrictive environment with the minimum of disruption to their lives. The MHUCS seek to provide an integrated approach to the delivery of care for people experiencing an acute mental health crisis in a range of settings, including home treatment, day treatment, the Recovery House and inpatient care. The Recovery House is a key part of this recovery pathway which will aim to:

• Deliver high quality care which is known to be effective and acceptable
• Promote the safety of Service Users, their family/carers, all staff and the wider public
• Offer choices to promote independence and Recovery
• Offer a well coordinated service between all staff and agencies
• Provide stable recovery accommodation for up to two weeks
• Support to Service Users to maintain their permanent residence
• Deliver continuity of care including “moving on”
• Give prompt and effective help to Service Users and their families/carers
• Be accessible so that help can be obtained when and where it is needed through local communities

The above aims will be achieved through the following objectives:

• Establishment of services based on the principles of “Recovery”
• Provide safe, effective and high quality short term (14 days maximum) alternative to an inpatient admission for men and women in the west of Dorset who are receiving treatment from the MHUCS
• Responding to individuals who are experiencing an acute mental crisis, providing help and support to Service Users with an emphasis on building up their individual resilience
• To provide person-centred short term, help and support including brief solution focussed approaches to crisis resolution.
• Service Users supported in the least restrictive environment, returning to their home setting within the 14 days.
- Support staff in the Recovery House will be actively involved in planning for the Service Users departure and return to their home with ongoing treatment from the CRHT services if needed
- Support staff will work in partnership with Service Users, family/carers and CRHT staff in order to help resolve and re-establish a sense of control and wellbeing, enabling the departure of the Service User to their home environment within the 14 day timescale.
- Services will be delivered to clear and high standards, that are safe and sustainable.

3.2 Service description/care pathway

Description of Service

The Recovery House is intended for Service Users who require support during times of mental health crisis. This support will be community based in the recovery house and for no longer than 14 days. The service will support people who are experiencing an acute mental health crisis to:

- recover from mental health crisis
- become less chaotic, reduce vulnerability to crisis and maximise resilience, through crisis management techniques
- access support to reduce distress and maximise their chances of personal recovery
- access support and advice (this service shall be provided to Service Users, concerned family, relatives and carers)
- stabilise and improve their social functioning, including abilities to maintain employment/training
- establish a detailed understanding of relevant local resources in the community
- reduce the need for other services by increasing resilience and self sufficiency
- use their Wellness Recovery Action Plan (WRAP), to reducing their dependency on MH services
- maintain their medication regime under the direction/supervision of the CRHT staff
- move back to their own accommodation within two weeks

The service will support Service Users to maintain life skills such as cooking, cleaning, laundry, budgeting and paperwork. Individual Support Plans will include a comprehensive needs and risk assessment, forming part of the Service Users overall Recovery Plan which will be subject to daily review, with the Service User, support staff in recovery house and the CRHT staff.

The support provider and a nominated manager from the CRHT service will have monthly Service Review meetings and at the request of the commissioners, evidence from these meetings will provide information on progress and outcomes achieved. Service outcomes will also be reported to the Contract Review Meetings.

A license agreement shall be signed by the Service User on entry to the recovery house. It will include an agreed departure date, the Service User will be given a copy of this and where agreed the family/carer will also have a copy.
**Staffing**

The service shall be staffed by one- two support workers, including peer specialists, 24 hours a day.

Service Users will receive structured support from CRHT staff.

Peer Specialist groups and one to one work will be available in the Recovery house

An appropriate emergency response protocol will be put in place and will be a partnership between the support provider and the CRHT.

The provider shall have staff development and training strategy including training on brief solution focus and problem solving interventions and ‘Recovery’ principles.

Before working unsupervised staff will have an awareness of:

- The needs of Service Users
- The scope of recovery housing support
- The importance of multi-agency working, especially with the CRHT teams

**Referral Routes and Service User Eligibility Criteria**

Service Users shall be referred to Recovery House through a single point of entry, from the west of Dorset Crisis Response Home Treatment Teams (CRHT).

Service Users shall be eligible for this service if they:

- Are on the active caseload of the CRHT services in west of Dorset
- Want an alternative to hospital admission and want to have support in a less institutional setting
- In mental health crisis and are unable at the time to manage the crisis in their current environment
- A person in acute mental health crisis requiring support to develop skills of self–resilience and develop their ability to carry out basic activities of daily living skills

The support provider will admit Service Users who have a range of risk indicators, including suicide; The support provider will need to demonstrate a duty of care to all Service Users. Where suicide risk is identified there will be a clear risk plan and contract with the Service User. In these cases the CRHT staff will oversee this assessment and contract, communicating this to the support provider.

Where the support provider is unable to meet the needs of the Service User, or if acceptance of a referral would be seriously detrimental to the service and/or other Service Users accommodated in the service, they may reject the referral. Although the support provider will have the final say on referral acceptance, the expectation is that the partnership with the CRHT will be so strong that these cases will hardly ever occur.

If a Service User is refused, upon request the support provider will give them and the CRHT written reasons for this decision along with a copy of the Appeals Procedure.

If CRHT and support provider cannot reach agreement on any referral, both parties can escalate the case to the commissioners who will act as arbitrators – (Dorset PCT/CCG.) The commissioners will seek a mutually acceptable resolution with all parties.
Monthly reports on the numbers of Service Users refused by the service must be provided to the commissioner on a bi-monthly basis.

Re-entry to the Recovery House will not occur within 3 months of leaving unless there are exceptional circumstances, for example agreed as part of the WRAP in negotiation with the CRHT and Support provider.

Support

Support services are provided for the purpose of enhancing recovery and reducing dependency and developing a person’s capacity to live independently. The service will be provided by appropriately trained and skilled staff using Recovery principles. The service will support Service Users using coaching and mentoring techniques and dependent upon the assessed need the areas of support might include help with:

- maintaining their accommodation outside the recovery house
- maintaining or regaining life skills, including shopping and cooking
- managing their finances, pay bills and claim benefits
- maintaining contact with families, carers and employers and others in their social network
- maintaining the safety and security of the recovery house
- cleaning their own room and general housework in the recovery house
- avoiding or minimising harm, including risk to self, based on a risk assessment and treatment plans provided by the CRHT
- emotional support and advice
- developing social skills and communication skills with others
- participation in their WRAP including attendance at day treatment services
- accessing local community organisations and social activities
- gaining access to other services
- gaining and/or maintain employment/work experience opportunities or training
- liaising with other agencies, organisations or services on the Service User’s behalf
- advice and advocacy
- peer support and befriending
- accessing relevant mental health and social care services to meet assessed individuals needs

Psychiatrist and GP

To ensure that Psychiatrists and GP are fully aware of a placement at the recovery house the CRHT will:

- inform them about the Service Users’ arrival at the Recovery house
- inform the psychiatrist of their departure date
- inform the GP about the arrival and departure date

The psychiatrist can visit the Service User in the Recovery house as arranged with the Recovery House staff and/or Service User.

In principle the medical responsibility of the Service User remains the responsibility of their GP. If an urgent medical need rises while in the Recovery house the support provider will
arrange of the Service User to register as Temporary Resident (TR) with a local GP practice or attend the “Walk in” centre in Weymouth. The support staff will also inform the CRHT service.

Medication

All Service Users will be required to bring their prescribed medication into the recovery house under the agreement of the CRHT. The Service User and the CRHT staff will inform the support service about the drug regime.

Where appropriate and as part of the support plan, the support staff will encourage the Service User to take their prescribed medication. The support provider will ensure that each Service User has a lockable place to store their medication. Please note that medication will not be administered by the support service staff.

Medication can play a major part of the individual’s recovery plan and non-concordance with this might affect how well they manage their crisis and their stay, in the recovery house. Where a Service User is taking prescribed medication, it will be reported on their WRAP Plan.

The CRHT will inform the support service if the Service User requires encouragement to take their medication. This will be recorded in the Service User’s WRAP.

Where there are concerns about the effects of medication or where there the Service User is reluctant to take their medication, these concerns will be referred to the CRHT key worker by support provider.

Where there is a concern that a Service User requires medical advice or help with medication, the Service User will be actively encouraged to talk with the CRHT team, if the Service User feels unable to discuss with the CRHT the support provider will discuss with the CRHT team. Under no circumstances can force or coercion be used to make a Service User take medication in the recovery house.

Where a Service User does not agree to take their medication, their support/recovery plan will be reviewed. The review will include questions about why the Service User does not want to take medication and will ask whether or not the service is able to work differently to support them.

Where the Service User remains unable to agree to take their medication, the review will focus on whether or not the recovery house is right for them at this time.

If the review indicates that the service can offer support in a different way, this will be written in to the WRAP in agreement with the Service User and the CRHT.

Where the review indicates that the recovery house is not right for the Service User at this time the CRHT will work with the support provider and Service User to move them to appropriate accommodation.
**Support Plans**

An initial needs and risk assessment will be completed, in partnership with CRHT staff, for all prospective Service Users before or on the day the Service User enters this service. This will include a risk treatment plan for each Service User.

The support provider will work with Service Users to develop an easy to understand, mutually agreed, outcome focussed, person centred, recovery plans. These should set clear and achievable goals for the stay of up to 14 days. Each goal will have a date by which it will be achieved. A plan should be in place within one day of the Service User entering the service.

Where a Service User and a support worker disagree over a particular issue both perspectives will be recorded and fed back to the CRHT. The Service User will be advised of appeal procedures.

The support provider will continuously review the support provided to meet the Service Users changing needs. A support plan review can be carried out:

- upon a request by the Service User, their immediate family, the CRHT service or the service purchaser
- following any significant incident or major change in need

Any changes to the support plan will be agreed with the CRHT and shared with relevant agencies

The support provider’s forms and procedures will be validated by the purchaser and reported to the Contract review meeting.

The support provider will allocate a named Support Worker to every Service User.

**Carers**

The principal carer of a Service User will be identified and will be offered a meeting with the named support worker. This will occur within three working days of arrival of their relative to the recovery house. The support worker if needed will link with the CRHT team if a re-assessment of their needs is required.

**3.3 Any acceptance and exclusion criteria and thresholds**

**Acceptance**

The Recovery House will accept people who are experiencing an acute mental health crisis and are diagnosed with a functional mental illness; this may be accompanied by substance misuse. A history of substance misuse, violence and aggression will NOT be sufficient grounds for automatic refusal and/or exclusion from the recovery house.

Where an individual is in contact with criminal justice services, e.g. on probation, tagged or under a curfew, referrals will be discussed on a case by case basis to agree how the individual can be managed. Where a placement is agreed, the appropriate measures from the criminal justice service need to be in place.
It will not be practical for the recovery house to be used as a bail address because it is a service that is time limited to 14 days and not a temporary accommodation option.

**Exclusion**

The support provider may operate an exclusion procedure for a number of hours or in rare instances for the purposes of safety overnight. The support provider will investigate all other options before excluding a Service User overnight. The support provider, will work with the CRHT to arrange alternative safe accommodation for the duration of the exclusion, this may need to be an inpatient stay. The risk to the individual must be weighed against the risk to other Service Users in the recovery house by the support provider.

The exclusions procedure must be governed by an exclusions policy and will make reference to the initial needs and risk assessment undertaken by the support provider with the Service User prior to the Service User entering the recovery house. Any decision to exclude must take into account the risk to both the potentially excluded individual and the community. At all times the CRHT teams will be included and informed of any exclusions. All associated support provider records would be updated and must be held on the Service User file.

Where a Service User no longer requires the level of support offered at the Recovery House or the scheme can no longer meet the needs of the Service User, a meeting will be held with them, CRHT and where appropriate, other agencies to discuss alternative options. The Service User should be supported to move to appropriate accommodation within 14 days. A move on procedure must be in place by the support provider.

The use of the exclusions procedure must be reported to the purchaser as soon as practicable. Monthly reports on the numbers of Service Users excluded from the service must be provided at the contract review meeting with the purchaser. The support provider will endeavour to ensure that the Service User moves on to a safe environment and ensures that the Service User is given information on alternative services.

**3.4 Interdependence with other services/providers**

The recovery house will be located in Weymouth and provide 7 single bedrooms, kitchen/dining and bathroom facilities. There will also be a shared lounge for Service Users. There will be an office/staff room of use by the support provider.

Good communication will be established between the support provider, the commissioner, the CRHT and the housing provider. The communication and partnerships will ensure that the agreed goals of the service will be achieved within the agreed timescales.

The support provider will link with the housing provider to oversee the agreed maintenance arrangements; repair and decoration of the recovery house are kept to a high standard. The recovery house will provide support 24 hours per day, seven days a week for a very short time. The accommodation will be suitable for people in acute mental health crisis. It will be homely, comfortable, safe and relaxing. The recovery house will be safe for visitors and family, including visiting children. The premises will be non-institutional in appearance and afford levels of privacy and dignity both indoor and outside so conducive to a period of reflection and aid recovery.
There will be regular meetings between the housing and support providers arranged by the support providers. The support providers will arrange payment of all the household bills.

The support provider will work in partnership with Dorset HealthCare NHS University Foundation Trust (DHUFT), the Crisis Response Home Treatment Teams (CRHT) to manage Service Users who are experiencing an acute mental health crisis in a proactive and effective way. The support services will maintain an awareness of the services available to Service Users for immediate referral, for example the day treatment service or for speedy departure from the recovery house.

The support provider will agree a discharge plan before the Service User enters the recovery house with their Care Co-ordinator in the CRHT. Other appropriate referrals will take place early in the Service Users stay in the recovery house. Service Users shall be signposted to services as appropriate and as speedily as possible.

The PCT/CCG has an expectation that the support provider will develop positive working partnerships with a wide range of local support agencies.

Particularly:
- Families and Carers
- NHS Dorset / Dorset Clinical Commissioning Group
- Primary Care Teams/GP surgeries
- Dorset Mental Health Forum – Peer Specialists
- Community Mental Health Teams
- Dorset Police
- Dorset County Council – Adult and Community Services Directorate
- Housing Authority Housing Advice Agencies
- Dorset Race Equality Council and other equality groups
- Dorset Advocacy Services
- Substance misuse agencies
- Ex offenders agencies
- Local Advice agencies
- Local voluntary agencies and community resources – e.g. Rethink, MIND, Gateway Clubs, Age Concern.
- Other Dorset Supporting People supported housing and floating support providers
- Dorset Supporting People Provider Forums

The above is not an exhaustive list and does not limit providers to working only with these agencies. The support provider will update the Purchaser with details of the agencies with whom it works at contract review meetings, monthly to start then bi-monthly.

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

This specification for the delivery of the Recovery House is consistent with the standards detailed within Mental Health Urgent Care Services of the west of Dorset:

- NICE Quality Standards
- CQC Essential Standards
4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

Mental Health Recovery Star at http://tiny.cc/mmr53

4.3 Applicable local standards

Quality Standards
The service philosophy is based on the belief that Service Users have the same rights and aspirations as others and share the same basic needs, including where necessary the need for support to achieve their ambitions and aspirations. These include the need to:

- have a secure, safe and supportive home environment
- learn skills that are useful in developing self-confidence, a sense of personal responsibility, the capacity to exercise choice and have greater levels of independence in all aspects of their life
- maintain their personal care skills
- undertake meaningful and rewarding activity
- develop and sustain personal relationships
- understand their rights and responsibilities relating to the recovery house and service

Service Users will:

- be treated with dignity and respect
- be enabled to achieve self-sufficiency appropriate to their choices, abilities and needs
- participate in devising and implementing a Support Plan with a member of the staff team and other relevant professionals
- have the opportunity for physical, emotional, social and intellectual development, to develop social and domestic skills to their maximum potential, and to pursue any individual educational, vocational or recreational interests
- have access to local community facilities and services
- be consulted and fully involved in decisions about current and future services, which shall be designed to meet their needs
- when sharing the communal areas be encouraged to play a full part in all decisions affecting the quality of life in the recovery house
- have the right to adequate support and protection and to be free from emotional, physical, social or intellectual neglect or abuse
- be treated as individuals and consequently the service shall be designed to meet their specific needs while experiencing acute mental health crisis
- be encouraged to develop self-confidence, a sense of personal responsibility and the capacity to exercise choice in all aspects of their life
- have the right to privacy
- have the right to an advocate to pursue matters on their behalf within the CRHT service
- the support provider shall seek to provide an independent advocate when this is requested Service Users must give their permission to the support provider to inform the CRHT staff
- Be given opportunities, assistance and advice to maintain the permanent accommodation
5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

Key Service Outcomes

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• Increased confidence to make a positive contribution
• Increased ability to have greater choice and/or control and/or involvement within their wider community

In addition, Service Users should:
• Feel free from discrimination
• Be socially integrated not isolated

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

None

6. Location of Provider Premises

The Provider’s Premises are located at:

The Support Provider’s Premises are located at:

13 Roundhayes Close
Weymouth
DT4 0RN

Landlord – East Boro Housing Trust

7. Individual Service User Placement

Not applicable