Service Specification

Supported Living and Community Enablement and Support Services for People with Mental Health Needs in Norfolk

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Introduction

1.1 Norfolk currently provides support to working age adults with mental health needs through:

1.1.1 Supported living schemes with 24/7 support on site, funded through block contracts, for people with eligible social care outcomes. Each scheme has been commissioned separately.

1.1.2 Floating support in their own homes with accommodation related issues. This has also included support for people in acute mental health hospitals to support discharge. This is delivered through one county wide block contract with health and social care funding.

1.1.3 Outreach support to individuals with eligible social care outcomes in their own homes provided by a range of providers on spot contracts. This service includes community engagement.

1.2. Through re-commissioning and remodelling these services together, the aim is to deliver an integrated service on a locality basis. This Service will:

- Support people to live independently and safely in their own homes through the provision of support in their homes and the community.
- Enable people to recover and develop the capacity to live more independently in their communities.
- Develop the capacity of people to maintain their recovery and their ability to live as independently as possible.

There is a fourth lot covering the Norwich locality for intensive outreach and the successful bidders will be expected to work in partnership with the Provider of this service to provide an integrated service.

1.3 In particular the service will:

1.3.1 Create a pathway for people to move from residential care to supported living and then to independence in the community, where the support at each stage is provided by a team of staff whom the service user is familiar with.

1.3.2 An integrated staff team where support workers are recovery focussed, are operating on the principles of psychologically informed environments and support people to develop their ability to do things for themselves.

1.3.3 Provide flexible levels of support to minimise the risk of crisis, to be able to provide more intensive support when needed and increase the potential for long term recovery.

1.3.4 Where approaches have failed in the past, take a creative approach based on services user’s strengths and wishes to develop hope and resilience.
1.3.5 Know what’s in the local community and be able to link people in with activities and friendship groups which offer sustainable support and use community assets. This will include locality based services for women in the service.

1.3.6 Utilise supported living schemes in the service as a ‘hub’ for support to service users in the community outreach element at evenings and weekends.

1.3.7 Provide support to and engagement with people who have dual diagnosis or who are difficult to engage to prevent them going into crisis and becoming ‘revolving door patients’.

2 Service Values and Principles

2.1 The following values and principles will underpin all activities undertaken in the delivery of the Service:

2.1.1 The Service shall promote and encourage choice and be based on promoting independence through support to achieve desired outcomes
2.1.2 Service users are supported in achieving their full potential
2.1.3 Service users shall be treated with courtesy, dignity and respect and will be at the centre of all decision-making that impacts on their lives
2.1.4 Personalisation, meeting the needs of individuals in ways that work best with them
2.1.5 Incorporation of the Recovery Approach, summarised by the phrase ‘hope, agency (i.e. control) and opportunity for all’
2.1.6 Continuity of support within the service, with trusting relationships with familiar staff, under-pinned by multi-disciplinary working
2.1.7 The Service shall seek to meet and promote the cultural and religious needs of service users from ethnic minority backgrounds. It will be a fundamental principle of all policies and practices that all people are equally valued regardless of their gender, disabilities, race, ethnic origin, language, religion or sexual orientation.
2.1.8 To treat service users and carers as peer partners with expertise in support and care. To work with them using a co-productive approach in the planning, development and monitoring of the Services and in establishing good practice, reviewing policy and procedures and maintaining and continuously improving delivery of the Service
2.1.9 The Service will liaise with other Providers of services to vulnerable people in order to develop effective and efficient practices and partnerships which will optimise the effectiveness of all services in Norfolk. This will include information sharing to avoid service users having to repeat their stories.

1 http://www.rcpsych.ac.uk/pdf/Recovery%20is%20for%20all.pdf
3. **Service Objectives**

3.1 The high level service objectives of the service are:

3.1.1 To provide a outcome based and personalised support service to people with mental health needs
3.1.2 To support people to improve and maintain their own health and well-being, operating on the recovery model
3.1.3 To work collaboratively with partners, and in particular services in other areas commissioned under this specification, social services, housing and support providers, and the Norfolk and Suffolk Foundation NHS Trust (NSFT)
3.1.4 To provide services that reflect best practice and strategic policy direction and are responsive to emerging legislation and structures
3.1.5 To provide services that reflect local needs and also the rural nature of Norfolk
3.1.6 To provide cost effective support that achieves improved outcomes
3.1.7 To engage and use volunteers and to develop peer support to extend the range and coverage of the service
3.1.8 To provide services in locations used by the target population and which engage people in their communities and maximise use of community assets
3.1.9 Longer term, to enable people with services funded through a personal budget to be supported with all their personal budget funded services, including direct payments, and personal health budgets through an Individual Service Fund process operated by Providers.

4. **Core Service Requirements**

**Key features of service delivery**

4.1 The Service will comprise a community support service that delivers **support to people aged over 18 with severe and enduring mental health needs in Norfolk in their own homes and communities**. The support is ‘attached’ to the person, not the property and can follow the person if they move to another address (subject to exclusions). It includes supported living schemes included in the specification. Support is wide ranging and covers:

4.1.1 Assistance in setting up and maintaining a home / tenancy, including cleaning, support with maintenance, repairs, payment of rent and arrears, being a good neighbour
4.1.2 Independent Living Skills, including support with budgeting and paying bills, support to apply for benefits, support with finding and securing alternative accommodation and through the move
4.1.3 Well-being and general support, including emotional support and advice, support with monitoring own health and well-being and signposting to health services

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2 WHAT IS AN ISF? An ISF is an internal system of accounting within a Provider that makes the personal budget transparent to the individual or family. This helps provide flexible support by making the organisation accountable to the person.

http://www.thinklocalactpersonal.org.uk/_assets/Resources/SDS/TLAPISFsContractingFINAL.pdf.
4.1.4 Support in overcoming social isolation by linking people to local social, faith and leisure activities and supporting people to develop a range of opportunities likely to increase independence, including employment and education

4.1.5 Advice, advocacy and liaison, including support to access and secure other services, signposting to specialist advice services and community groups, developing self-advocacy skills

4.2 The service is not expected to provide the full range of personal care and prompting support to service users eligible for support from social services which constitutes personal care as defined by CQC\(^3\) in the Scope of Registration under the Health and Social Care Act 2008. However the service will be required to develop working relationships with local domiciliary care providers, in order to ensure that individuals in supported living and the community who need personal care can receive a more holistic and integrated service.

**Eligibility Criteria**

4.3 The service is for people with severe and enduring mental illness\(^4\) aged 18 over and will include adults over the age of 65 who do not have dementia or complexities associated with ageing. The Department of Health has defined people with 'severe mental illness' as individuals who:

- are diagnosed as suffering from mental illness (typically schizophrenia or a severe affective disorder, and including dementia);
- are substantially disabled because of their illness, e.g. they are unable to care for themselves or independently, sustain relationships or work;
- are currently displaying florid symptoms or are suffering from a chronic, enduring condition;
- have suffered recurring crises leading to frequent admissions/interventions;
- may at times present significant risk to their own safety or that of others

4.4 The service will be expected to support people who would fit within the client group historically served by assertive outreach\(^5\)\(^6\). These clients will often have a history of severe mental illness with:

- sporadic or non-engagement with mental health services that may not meet their needs;

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3. [http://www.cqc.org.uk/content/what-registration#accordion-1](http://www.cqc.org.uk/content/what-registration#accordion-1)

4. Payment by results is a Department of Health initiative to change the way that health services are commissioned (paid for), moving away from block contracts to a system where funding is linked directly to the care service users receive. A care cluster is a grouping of service users of similar clinical needs. This group corresponds to people in the Payment by Results clusters of 5-15. [www.gov.uk/government/publications/mental-health-payment-by-results-arrangements-for-2013-14](http://www.gov.uk/government/publications/mental-health-payment-by-results-arrangements-for-2013-14)


6. This is likely to correspond to people in the Payment by Results clusters of 16 and 17.
- sporadic or non-compliance with medication resulting in their impaired mental health;
- frequent unplanned psychiatric admissions;
- frequent involvement with the police because of mental illness;
- complex multiple problems in addition to severe mental illness, (such as alcohol/drug misuse,
- frequent periods of homelessness
- a personality disorder
- an additional learning disability.

4.5 The service will comprise funding from two funding streams:
- Adult Social Services for supported living and community outreach
- Clinical Commissioning Groups (CCGs) for community outreach

The provider will need to operate to the different eligibility criteria and referral/access routes for both service elements which will have their own activity levels (hours delivered and service users).

Social care eligibility criteria

4.6 The support service will be the core commissioned element of the package to meet service user’s social care needs. Service users in the service who are assessed as eligible for support under the Care Act will have personal budgets to meet their outcomes. Their personal budget will form part of the contract which will be expected to meet the majority of their support needs. The provider will work with NCC staff to make sure that service users are aware of this and will offer support with the Norfolk County Council financial assessment and charging processes. Staff will be expected to contribute to support planning and review as part of the personal budget process, building on the Care Act assessment. The provider will be expected to meet the needs of people referred via
a) the mental health funding panel for those whose needs are deemed to be most appropriately met in supported living
b) the social work service/Care Arranging Service for others

The referral arrangements set out above may change during the life of this contract.

NHS funded service eligibility criteria

4.7 This service element will focus on meeting the needs of Norfolk residents on the mental health acute wards or who are with the crisis response and home treatment team. The Service will provide an in-reach service to the wards for this group in order to support timely hospital discharge, with a focus on housing and related debt and benefit issues. Generally this group will need some on-going post discharge support to promote their recovery and this will be expected to be provided for a time limited period and at reducing intensity following hospital discharge.

4.8 The Provider of the lot in which a mental health acute hospital is situated will be expected to pick up all discharge referrals from those wards, including for Norfolk residents who are placed in mental health acute wards out of their local area (but still within Norfolk). In addition the Provider of the service in Great Yarmouth will be expected to deal with initial referrals from Carlton Court in Lowestoft for Norfolk
residents who are placed there. The Provider will be expected to have arrangements for transfer of service users between the other providers commissioned to provide comparable services in each area, so that support follows them with any change in placement. The Provider of Lot 2 will also be expected to pick up issues around hospital discharge for people served by the Norwich intensive support service (Lot 4), in the first instance.

4.9 The Provider will be expected to produce a joint protocol with mental health acute hospitals and NSFT’s crisis response and home treatment team for the element of service delivered to people in acute settings within 3 months of the start of the service contract. This will be reviewed annually thereafter, in both cases the protocol will be agreed with the commissioners. At present NSFT have a bed management team to support discharge and the Provider will be expected to work closely with them and to operate to shared protocols. As NSFT may change the location of beds during the lifetime of the contract, the location of service capacity provided for this service element may need to be adjusted accordingly, in agreement with commissioners.

4.10 Criteria for prioritisation of referrals will be agreed with commissioners, including CCGs, and NSFT teams. The following factors will be used when determining priorities for access to the Service:
4.10.1 People who may be at risk of admitted to hospital
4.10.2 People who are being discharged from hospital
4.10.3 People in the forensic service/ low secure service where a move into the community is planned
4.10.4 Security of current accommodation
4.10.6 People who have few other support systems in place and are socially isolated
4.10.7 People who because of the consequences of their mental ill health are at increased risk in the community, including self neglect
4.10.8 People who are unlikely to sustain their independence and accommodation without on-going low level support for an indefinite period in order to maintain their recovery and mental health

Transition to new contract

4.11 The Provider will be required to support the transition of service users from the existing services to the new contract, to ensure continuity of services. Commissioners will finalise eligibility criteria with the Provider during the transition phase from the current service to the new contract.

Referral Criteria and pathways

4.12 There will be a written policy on acceptance and exclusion criteria for referrals which will be agreed with the Council, including NCC Mental Health Social Care Service, and appropriate NSFT teams who can refer into the NHS funded service elements.

4.13 Potential grounds for non-acceptance or exclusion for the service are where:
4.13.1 People do not meet the agreed eligibility criteria
4.13.2 People have substance misuse as their primary diagnosis with no significant mental health needs;
4.13.3 People have learning disabilities as their primary diagnosis, excluding people with Asperger syndrome and high functioning autism, where the mental health needs are paramount;
4.13.4 People have predominant forensic issues over psychiatric issues;
4.13.5 People are no longer mentally ill and/or who cope independently with little or no support
4.13.6 People with low level mental health needs e.g. mild to moderate depression who have been supported in primary care or the Wellbeing Service (IAPT), or in other forms of community support
4.13.7 People who are already living in high-support residential or institutional settings (such as residential care, forensic or inpatient accommodation) and who are likely to stay there for the foreseeable future;
4.13.8 People who normally live in independent supported living schemes not included in this contract or in subsequent contract variations where no move on is planned,
4.13.9 People who live outside the defined catchment area i.e. the county of Norfolk.
4.13.10 The level of risk is deemed unacceptable as a result of the outcome of an evidenced needs and risk assessment and in view of the Provider’s policies and procedures

The service will be expected to work with people in residential care, supported living and in-patient accommodation where move on is being progressed to plan and support service users in the process.

4.14 In addition people who fit within the NSFT eligibility criteria for complexity in later life will not be eligible for the NHS funded service. This includes people of all ages with dementia, and people with mental health problems who also have complexities associated with ageing. However the social care funded service may be asked to work with younger people with dementia, including people with Korsakoff’s and people with Huntingdon’s disease, who need support in the community.

4.15 Structured assessments should be used to assess clients referred for the service. The mental health recovery star or other appropriate methodology for assessment, goal setting and outcome monitoring should be central to this approach.

Service levels

4.16 More detailed descriptions of what is expected to be included in supported living schemes is appended in Appendix 2, and in each locality based contract lot area in Section 6, and the separate specification for the intensive outreach service in the Norwich locality. The Provider shall deliver the service requirements as outlined in this Service Specification using a fair and equitable approach to the allocation of resources across each lot area. It is not envisaged that the Service will differ significantly between localities, unless specified in Section 6. However as commissioning plans develop during the lifetime of the contract, it is anticipated that the Provider will actively engage with partners and seek to develop the service in line with local needs and by agreement with Commissioners.
4.17 The Provider will ensure that people with mental health needs are key partners in shaping the service and work with them, their carers and Commissioners to adapt the service to meet changing needs in an appropriate way.

4.18 The Provider should use a range of methods for delivering the service to maximise coverage and capacity and to meet people’s needs in a personalised way. The Provider will ensure that contact is maintained with service users in a range of ways, including those set out below, to ensure that ‘missed visits’ are minimised and people’s needs are met. The service delivery model should include:

4.18.1 Opportunities for planned 1:1 face to face contact in a variety of locations, including the service user’s home, the Provider’s premises, partner agencies’ premises, community venues, hospital

4.18.2 Opportunities for service users to attend drop in sessions to deal with pressing issues that need an urgent response, e.g. eviction notices, completion of claim forms within deadlines

4.18.3 Opportunities for people to ‘buddy up’ to access opportunities in the community

4.18.4 Opportunities for group sessions in a range of locations across the locality and county to promote opportunities for social interaction and provide general information and support. Groups will be primarily linked to meeting the needs of those eligible for service. Whilst only those eligible for the service may be counted in any contract performance management reporting, including families and friends, or members of the local community, could improve people’s willingness to engage and the outcomes delivered, therefore groups can be opened up to people who are not service users. Where groups are being provided for social interaction and engagement, and networks in community activities, the provider is expected to work to develop the independence of the groups and to ensure that they remain open and welcoming to new members. The provider will be expected to support groups to access funding eg third sector grants, to develop and sustain their activities.

4.18.5 Women only support groups /networks should be developed in each locality and across the county. There should be a women only safe space /group offer available in each locality for the commencement of the contract, with services further developed through co-production.

4.18.6 Peer support groups which are led by staff or volunteers from the service and peer led groups. In the latter, where the organisation and running of the group is provided by service users/volunteers from the community, the groups should be able to access support from the provider when needed.

4.18.7 Access to advice and support using a range of technologies and media, for example social media, online/telephone support, Skype, smartphones

Service provision will mainly consist of 1:1 support, however all methods above need to be utilised. There is an expectation that providers will become familiar with, and utilise, community assets and capacity to promote recovery for service users.
Access and equality

4.19 Equal opportunities will be promoted through:
4.19.1 Ensuring services are equally accessible and relevant to the needs and issues faced by people with mental health needs
4.19.2 Ensuring that staff are experienced in and responsive to providing services that are sensitive to the wider issues for this client group
4.19.3 Promoting social inclusion for service users in the wider community
4.19.4 The use of appropriate recruitment and employment practices and procedures

4.20 The Service must be suitable, accessible and appropriate for all potential service users, including all minority and hard to reach groups within the County. The range of times and locations of the Service will complement and enhance those provided by other community, statutory and independent providers in order to be effective in and appropriate to the differing geographic makeup of the county – urban centres, villages and rural settings. Within the service the provider is expected to provide services designed to meet the needs of vulnerable women, this may include women only groups and activities.

4.21 Access arrangements to the Service should be easy for referrers and service users and carers to understand. The Provider shall provide the Service using a range of formats which are accessible and appropriate. These may include:

- Social Media
- Texting
- Smartphone Apps
- Web-based information
- Local community TV channels and radio
- Leaflets and written information – these should follow Norfolk County Council’s guidelines on accessibility
- CD and audio visual including ‘spoken’ web information with BSL/subtitles
- Braille
- Access to Interpretation and translation for people who need this for people who are deaf or people whose first language is not English eg through the INTRAN partnership

4.22 The Service will be ‘tenure neutral’ and people living in the following tenures will be able to access this service:

4.22.1 Supported living services as specified in this specification and other supported living services where the service user is ‘moving on’ to live in the community
4.22.2 Private rented accommodation
4.22.3 Bed and Breakfast Accommodation
4.22.4 Accommodation let by a registered social landlord under any form of tenancy agreement
4.22.5 Owner occupation
4.22.6 Other forms of accommodation, such as mobile homes etc
4.22.7 Rough sleepers
4.22.8 Homeless hostels where additional support is needed for eligible service users and a clear role has been identified for the Provider
Referral and signposting

4.23 The Provider will operate to clear eligibility criteria to ensure appropriate referrals, to minimise barriers to access, prevent gaps in service and to avoid service users being passed between services unnecessarily. The Provider will be expected to work flexibly with a range of other Providers and statutory services to prevent inappropriate exclusions.

4.24 The Provider will work with other key stakeholders to develop and manage referrals between organisations, to ensure that referral and signposting is fully effective and that these arrangements lead to people’s needs being met. Key stakeholders include Norfolk County Council Mental Health Social Care teams, and Norfolk and Suffolk Foundation Trust for NHS funded services.

4.25 Other key partners and relationships include:
- Acute, Primary and Community Health care including GPs
- Substance misuse services
- Benefits Agencies
- Local authorities including local housing departments, housing options and homelessness teams
- Other supported housing and care providers
- Voluntary and community sector organisations
- Private and social landlords
- The Police and Probation

4.26 The Provider will ensure that there are effective systems in place so that enquiries and referrals can be logged and followed up in a timely way, eg within 48 hours. The Provider will be expected to operate a single acceptance/assessment and screening process for service users to identify presenting needs and eligibility. This process with timescales will be agreed in the transition period to the new contract and be reviewed annually.

4.27 The Provider will be expected to provide feedback to referrers on support provided in line with the statutory referrer’s review timetables and to support the Provider’s work to discharge service users from the service. This is required in particular when the Service is struggling to engage successfully with the service user and when further multiagency support is needed to engage and deliver support and achieve desired outcomes.

Service organisation

4.28 The community outreach service should be available between 8:30am – 8:00pm weekdays or as required with some elements of the Service available outside of ‘normal working hours’. During year one the proportion of hours delivered across the week will be agreed with commissioners, it is expected that this will reflect:

4.28.1 Monday to Friday 8.30am - 8pm
4.28.2 Some weekend 1:1 support as required as part of individual’s support plans or to support the NSFT crisis response and home treatment team in providing an alternative to admission to mental health acute wards
4.28.3 Within the 24/7 supported living service, staff to provide limited telephone support at weekends and evenings to known service users in the community outreach as part of their support plan. This is envisaged as a reactive service to support people and to reduce escalation to crisis, it is not intended to replace e.g. the MIND crisis support line for NSFT service users. The service may replace demand on Norfolk County Council Emergency Duty Team, in enabling reassurance to be given e.g. on the phone or via a weekend drop in.

4.28.4 Some early evening and weekend group work to support engagement of service users requiring intensive support or community integration. Staff contracts should be flexible enough to accommodate changes to the operating times of the Service, which will be shaped by the needs of service users, and as agreed with Commissioners.

4.29 Staff will be expected to stay in contact with service users in order to build a relationship between the individual and mental health services, this will include in-reach to existing service users who are in mental health acute wards in order to facilitate transition and re-integration into the community. Workers will aim to establish a trusting relationship with each service user in a flexible, creative and needs-focused way that enables the delivery of a social care package that fits each client’s own specific needs. The delivery model should include the approaches set out in 4.18 and 4.21 above.

4.30 Service users will be supported by Provider staff working in a multi-disciplinary way with the NCC Mental Health Social Care team and NSFT community mental health teams across the county, and working to jointly agreed outcome based support plans. The service will also work with other NCC and NSFT teams as dictated by the needs of service users. Reference to the ‘team’ or ‘support team/workers’ in the detailed service description relates solely to the staff and volunteers provided by the Provider.

Integrated delivery

4.31 The Provider is expected to deliver an integrated service across all settings and funding streams, in order to improve service user’s experience and to create the capacity to manage fluctuations in demand and to meet urgent needs.

4.32 The Provider is expected to explore fully the potential for delivering joint working practices with other providers involved in this contract and other partners e.g. as listed in 4.25, to deliver continuous improvement in service quality, avoid duplication and achieve economies and savings where possible.

4.33 Areas are likely to include:
- **4.33.1** Recruitment and induction
- **4.33.2** Learning and development especially training in implementing psychologically informed environments
- **4.33.3** Record keeping
- **4.33.4** Outcomes, performance and quality frameworks
- **4.33.5** Sharing good practice and problem solving
- **4.33.6** Enabling peer challenge and opportunities for staff to act as ‘critical friends’ across services
4.33.7 Shared premises and access arrangements
4.33.8 Elements of shared delivery e.g. drop ins, groups
4.33.9 Resource development e.g. information on local groups and services
4.33.10 ‘Branding’ of the service as one entity across Norfolk to create a clear understanding by key stakeholders and service users of the role of the service.

Support planning

4.34 The service provided to individuals will be personalised, flexible, based on identified strengths, needs and risk, and evidence full engagement with people using the service.

4.35 The Provider should use support planning as the principal means of identifying strengths and meeting needs with service users. Support planning should clearly reflect the strengths and expected outcomes of the individuals, how these strengths will be built upon, the projected duration of the service, the involvement where relevant of other agencies, how community assets will be utilised, and planned outcomes, including when the service may no longer be needed. The support plan should be agreed with Norfolk County Council, if they are the referrer. Where individuals eligible for social care funding have additional specific needs that incur incidental costs, their social worker will arrange a spot contract to cover eg travel costs of a support worker accompanying someone on public transport so that they may eventually travel independently.

4.36 The support plan must identify and record the service user’s needs arising from specific ethnic, religious, cultural, gender, sexuality, disability or age requirements.

4.37 The Provider will support a recovery philosophy in the service by using the Mental Health Recovery Star or other agreed Outcomes Star e.g. the Homelessness Star to set goals jointly with service users and to measure progress towards achievement of outcomes. In addition the provider will adopt the REQOL outcome measure and in particular the short form version\(^7\). The Provider will be expected to be flexible, review people’s needs regularly and make appropriate adjustments to ensure that people’s varying levels of need can be met within contract capacity. The Provider will be required to provide Norfolk County Council with monthly reports of the number of hours/services provided to service users. The service users’ strengths and needs should be reviewed and the support plan updated accordingly on a regular basis and at least annually with statutory referrers.

4.38 The Provider will be expected to work closely with family and carers. Family and carers should be involved, where appropriate in all client support planning and may also be offered access to group activities (see also 14.18.4). Staff should also be aware of the conflicting demands that may be placed upon them by family/carers and clients.

\(^7\) http://www.reqol.org.uk/p/overview.html
Information sharing

4.39 The Provider shall seek the consent of people who use the service to share their information with the Council or other partners where appropriate in the delivery and monitoring of the service provided and in accordance with the requirements of the Data Protection Act and good practice in data protection. The Provider will work with Norfolk County Council to agree and deliver read only access to key parts of the client record for people who meet the social care eligibility criteria.

4.40 Where appropriate and within Data Protection guidelines, the Provider will notify and liaise with responsible agencies over concerns in relation to a person’s health / well-being / medication. The Provider will sign up to the Norfolk Information Sharing Protocol between third sector and statutory Providers, and with other key providers.

4.41 A clear written policy on the Provider’s approach to recording client and agency contact is required to ensure standardisation of practice. This policy should include how recording in external agency files (e.g. in-patient ward visits) is to be done. Periodic random audits of case recordings should be performed to ensure quality and up-to-date recording as an on-going practice.

Staffing

4.42 The Provider must staff the Service with appropriately qualified, trained, knowledgeable and experienced staff/volunteers with the competencies to deliver the number of units contracted to ensure that individual outcomes are met, levels of quality are achieved and that the Service remains safe and effective for everyone involved. The diversity and skills of staff / volunteers should reflect the needs and profile of service users in Norfolk.

4.43 Staff /volunteers should be supervised and provided with access to appropriate induction, training, appraisal, supervision and professional development opportunities. The breadth, depth and nature of training should be appropriate to meet the needs of the people supported in the Service. The service should adopt the principles of a psychologically informed environment\(^8\) \(^9\), ensure that staff are trained in these principles and that the training programme supports the development and implementation of this approach.

4.44 The Provider should ensure that staff/volunteers have key competencies as outlined below:

- Excellent communication / engagement skills
- A positive attitude to supporting people with mental health needs
- An empathic / non-judgemental approach
- Working in person centred ways, using a supportive and empowering approach
- Ability to inspire trust and confidence


\(^9\) [http://pielink.net/](http://pielink.net/)
4.45 The Service is expected to adopt an approach of key working within a team approach. Overall responsibility for service users or groups of service users will be shared by the whole team or groups of staff within the team but each client should be allocated a keyworker with lead responsibility for his or her support. When this worker is absent other members of the team should provide cover so that service continuity will still be guaranteed. As the Provider’s team will be expected to work closely with NCC Mental Health Social Care teams and NSFT staff, it is expected that the keyworker role will be agreed across the wider multi-agency team working with an individual.

4.46 Effective leadership will be critical to the success of the service and multi-disciplinary working. The Provider’s Team Leaders will need diverse skills, which should include the ability to motivate staff, plan and advocate for the service and cope with crises as well as finding solutions for more mundane daily problems. It is essential for team leaders to be able to integrate the team’s work within the local mental health services. The Provider’s Team Leaders will need to be able to clearly define the roles and relationships between their team and key statutory partners.

4.47 The service will be working alongside NSFT colleagues who will have duties that involve prescribing, administration and management of medication. There are likely to be service users who experience serious relapses as a result of erratic or non-compliance with medication. Provider staff should be aware of recent developments in pharmacology. Team members should continually listen to each service user’s reactions to and experience of medication, and support service users in raising issues with clinicians.

4.48 The Provider should ensure that staff/volunteers have good knowledge and understanding of mental illness and mental health issues and knowledge of specific issues relating to the support and care of people with mental ill health such as:

4.48.1 Substance abuse and eating disorders
4.48.2 Planning with individuals with mental health problems
4.48.3 Recovery and outcome based approaches
4.48.4 Mental health legislation
4.48.5 Medication awareness
4.48.6 Good knowledge of services, facilities and organisations in local communities
4.48.7 The Care Programme Approach and statutory systems of care
4.48.8 Working safely and positively with risk
4.48.9 Working with aggressive behaviour
4.48.10 Deliberate self-harm
4.48.11 Risk identification and safety planning for suicidal individuals
4.48.12 Safeguarding vulnerable adults
4.48.13 PIE related training e.g. basic awareness of trauma informed care and tools such as CBT, DBT etc.
4.48.14 Housing issues and working with district council housing options staff and landlords
4.48.15 Skills and training for some staff in Welfare Benefits

4.49 The Provider must develop a delivery model which incorporates the use of both volunteers and ‘experts by experience’ as staff and/or volunteers to increase capacity of and access to the service and to provide personalised support based in local communities. It is expected that no more than 10% of the hours set out in the
specification will be provided by volunteers in order to meet performance targets. The ‘experts by experience’ will be recruited from people who have experience of mental health services and can provide peer support to people currently experiencing mental ill health. The Provider will establish defined roles for volunteers and ‘experts by experience’ and provide appropriate induction, training and on-going supervision and support. The Provider is expected to work with other providers of peer support to develop best practice and opportunities for peer supporters.

Health, safety and risk management.

4.50 The safety and well-being of staff in the delivery of services and that of people with mental health needs who access the service is considered to be of paramount importance. The Provider must ensure that all relevant health and safety requirements are applied as required. This includes (but is not limited to):

4.50.1 Carrying out suitable and sufficient risk assessments

4.50.2 Ensuring that employees are competent to carry out the work they are engaged in

4.50.3 Providing relevant information, instruction and training.

4.50.4 Monitoring health and safety performance

4.50.5 Reporting any significant incidents to NCC as follows:

- Major injury, fatality and significant near miss – by telephone as soon as possible and including NCC in relevant areas of health and safety investigation and corrective action.

- Minor injury and other violence related incidents (not included above) – report on a quarterly basis (including corrective action).

4.50.6 Attending relevant meetings with NCC to review performance.

NCC will carry out a percentage of health and safety monitoring visits to ensure the adequacy of these health and safety arrangements.

4.51 In particular:

4.51.1 The Provider must have clear written policies on safety for service users and staff as well as periodic training and discussion of current on-going practices. These policies should cover lone working, and dealing with aggression and the threat of violence. Risk assessment policies and practices should be reviewed on an on-going basis.

4.51.2 The Provider will need to ensure that policies, training and working practice enable all staff to work safely but positively with issues of risk, balancing issues of safety with approaches which allow individuals to make their own choices about how they live their lives.

4.51.3 The Provider must ensure that staff receive training appropriate to carrying out risk assessments for people with complex mental health needs who might be at risk of self-harm and/or risk of suicide.

Discharge and Exit from the service

4.52 The model of support offered by the Provider will be recovery based\(^\text{10}\) and will promote independence and empowerment at all times. People using the service will

\(^{10}\) [http://www.mentalhealth.org.uk/a-z/r/recovery/](http://www.mentalhealth.org.uk/a-z/r/recovery/)
be supported to move out of it when appropriate and/or referred to appropriate services in the community

4.53 The duration of work required by each service user will vary widely and may be long term. However, in some cases, intensive input over a relatively short or distinct period will be sufficient. There should be a written policy agreed jointly with commissioners, Mental Health Social Care and the linked NSFT teams that outlines the criteria and process for managing discharge which will include any statutory reviews required.

4.54 Specific criteria to determine when a service user is ready to 'move on' may be time based, involving a pre-determined period of:
4.54.1 time without unplanned psychiatric admissions
4.54.2 improved and sustained relationships
4.54.3 improved coping skills in managing daily living
4.54.4 sustaining employment or other meaningful daytime activities
4.54.5 abstinence from severe substance misuse
4.54.6 avoidance of previous patterns of police / forensic involvement

4.55 Exit from the Service will be determined following a review of the service user which should be a joint review with the statutory referrer. When service users become more well and sustain an improved level of coping, plans should be made to ensure alternative support such as peer support or other community support services. It will be important to start preparing service users for discharge in advance to prevent crises from emerging or re-emerging.

4.56 Where people are ready to exit from the Service they will need to be provided with details on how to access the service if they require a further service. This could include self-referral to the NHS element of the service or to the social services element for short term 'light touch' support. The Provider, working with commissioners and NCC/NSFT staff, will provide clear guidelines, as to the nature of support for which self-referral is appropriate, and the timescales involved.

4.57 The provider will need to devise a 'post contact' system whereby, assuming permission has been granted, people’s needs are checked six months after support has ceased.

5 Outcomes

5.1 The Provider will need to devise a mechanism for measurement of aggregating and reporting outcomes at a frequency to be agreed with the commissioner. Key outcomes developed by Norfolk’s service users are listed over.
Outcomes for mental health support in Norfolk. Co-produced January 2017

Outcomes in Meaningful Activity
I will
- Have a range of individual hobbies and interests which I enjoy
- Be able to find out easily what is available in my community and have support to access these opportunities
- Be able to give back through volunteering when ready to do so
- Have a job which gives me satisfaction
- Have help/peer support to find networks with other like-minded people

Outcomes in belonging and relationships
I will
- Have friends I can rely on and be able to make new friends and connections
- Have good or improved relationships with family
- Have good relations with my neighbours
- Feel part of my local community
- Live in a safe and friendly neighbourhood which is a place of my choice
- Will experience less stigma and discrimination
- Experience that people listen to me and that my views are valid and worthwhile

Outcomes for choice, control and autonomy
I will
- Be able to choose how and with what I am supported, in a way that builds on my strengths
- Be in control of my life, not a passive recipient of care and a burden on society
- Be able to choose where to meet professionals e.g. in the home if that is what I want
- Be able to meet with everyone involved in my care and support at the same time, so that we have an open dialogue about how to go forward
- Be able to self-refer into services when I become unwell
- Have a choice around treatment and therapy
- Have peer support from people with lived experience of mental health issues
- Have enough money to live on, be financially stable and have enough money to fund activities in the community
- Have support to access the right help when needed, such as benefits advice, legal advice, and what other things I need to know, so I can make informed choices
- Have good housing and feel safe in the community
- Be clear about what is possible with my personal budget, working with my social worker and support provider

Outcomes for Hope
I will:
- Feel positive about today and the future
- Be able to meet and be supported by people who have experienced what I'm going through and who can give me advice on what helped them and hope for the future
• Have understanding from family and friends to support my recovery
• Have equal, trusting relationships with the people who support me
• Have access to inspirational counselling and other opportunities eg Recovery College which generate hope
• Be able to be more independent

Outcomes for self-perception
I will
• Feel/ recognise I have things I can offer others and am of value - not just a patient ‘with mental health problems’
• Be able to recognise when things are becoming difficult
• Understand how I’m perceived and what I can do to influence that
• Become more self-confident by being aware of my assets and strengths
• Recognise the different roles I play in my own life and that of others

Outcomes for well being
I will
• Know what keeps me well and be motivated and supported to keep doing these things
• Understand what makes me feel unwell and learn to avoid these triggers
• Know what to do when I am unwell and to be able to access any services easily
• Living in an area where I feel safe
• Feeling included in the community and having meaning in my life

Outcomes for Physical Health
I will:
• Be aware of the importance and benefits of good physical health and the relationship with mental health
• Have support to access activities and services that will help me be healthy
• Have help me to identify what I like to do and when something I do isn't working for me
• Be able to take communal exercise, such as walking groups
• Get regular check-ups to avoid problems developing or getting worse
• Benefit from an holistic approach by professionals to my mind and body

The importance of the right staff in enabling people achieve positive outcomes
Staff will
• Be ambitious and energetic in promoting recovery to maintaining momentum
• Work with people’s unique needs and not take the approach that ‘one size fits all’
• Operate on a shared decision-making approach and at individual’s pace
• Be non-judgemental and offer compassion and time
• Believe in people and not make assumptions about their capacity to be well
• Be practical and flexible in their approach to issues
• Take managed risks that are based on a creative approach
• Include people with lived experience of mental health problems
• Demonstrate the values of their organisation
• Have support to maintain staff wellbeing
5.2 A framework for outcomes linked to potential measurements is outlined in Appendix 6. This will be finalised post contract award and is expected to evolve over time.

5.3 The Provider will support a recovery philosophy in the service by using the Mental Health Recovery Star or other agreed Outcomes Star e.g. the Homelessness Star, to set goals jointly with service users and to measure progress towards achievement of outcomes. The Provider will also adopt the REQOL measure of recovery.

6 Service levels and activity for each lot

6.1 Although the service is expected to serve the same needs county wide, the core service will be let in three lots, reflecting current investment levels by social services and CCGs, as well as the level of need in the local population. In addition in the Norwich locality area only a specific intensive support outreach service lot will support people in their own homes. This lot (Lot 4) will cover service users who do not engage with statutory services and whose mental health needs are high. This group will be comparable to the group traditionally catered to by the Assertive Outreach service, with unstable housing and often dual diagnosis. Elsewhere in Norfolk this group will be catered to by the core service outlined above. The Norwich Intensive Outreach Service has its own Specification in Lot 4.

6.2 The Provider is expected to keep service demand under review and to discuss and agree with Commissioners how best to meet changing levels of demand if there is significant variation from the indicative levels. During the lifetime of the contract(s) it is expected that the Provider will continue to develop the service, by agreement with Commissioners and to expand the service to ensure better access to services, especially in rural areas. This will include options using technological solutions. The procurement for each lot will cover the supported living and community requirements for the area defined in the lot. During the life of the contract the number of hours required in the community may go up due to the following reasons:-

- Currently coverage of spot contracted outreach services in some rural areas is limited. There is potential therefore for additional hours /service users to be added to the contract in a planned way with funding attached.
- Social Services continuing the trend of supporting people in their own homes or supported living rather than in residential care.

6.3 If the Council establishes another supported living scheme within a geographical lot during the life of the Contract, it will be expected that the Provider for that lot will provide the support based on the prices submitted during this procurement exercise and contained in the Contract unless:-

- The Provider’s performance has been or is unsatisfactory
- Benchmarking by the Council shows that the Provider is more expensive and that efficiencies would be gained by competing the requirement
6.4 The Provider is expected to provide services within the numbers of hours of support indicated per 4 weekly period, or greater, if and as specified by the Provider in their tender response. The number of hours of support are defined as:

- Direct support hours, excluding staff travel time, staff supervision, meetings and admin time
- Day time support ie excluding ‘sleep in’ hours between 11pm and 7am
- Group hours: if 10 people in a group have been referred to the service and the group work is part of their support plan then the group will count as 10 hours of support provided. Only hours provided to people in the service can be counted eg if accompanied by family members the family members cannot be counted.

Service levels will be subject to review on a quarterly basis, including through the performance management meetings. The core elements of the supported living schemes covered by the specification are outlined in Appendix 2 and the details of individual schemes provided in Appendix 3.

6.5 Community Outreach Support: West

6.5.1 This lot comprises Boudicca Court, Kings Lynn, and community outreach hours. The Provider will offer support in the locality which will be delivered flexibly across the locality as needs change or fluctuate. In particular it is anticipated that some people in the NHS funded service element may need more intensive support of averaging 3-4 contacts per week or as agreed with the NSFT teams operating a FACT service model. This will be reviewed regularly and more often if circumstances dictate e.g. support has been stepped up to prevent the likelihood of a mental health crisis occurring.

<table>
<thead>
<tr>
<th>Lot</th>
<th>Services</th>
<th>Number of hours per 4 weeks</th>
<th>Annual Total Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>Supported Living</td>
<td>640</td>
<td>£512,000</td>
</tr>
<tr>
<td></td>
<td>Community Support Services</td>
<td>1120</td>
<td>(£512,000 which includes £114,000 CCG funding and £25,000 for women only services)</td>
</tr>
<tr>
<td></td>
<td><strong>Total for lot</strong></td>
<td><strong>1760</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Average number of service users at any time</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

6.5.2 Adding the maximum number of hours specified in each Category (across all the supported living schemes and people in the community) gives the total number of support hours that shall be available in the locality at any time (the “Locality Hours”). Providers shall have a staff team capable of providing these Locality Hours flexibly across all Services. People meeting social services eligibility criteria will have an agreed number of hours to be provided per week or month; it will be for the provider and the service users to agree when these are provided during this period, and also to look at ‘banking hours’ for use for specific purposes, including increasing support in line with temporary increases in need. Providers will be required to report on a monthly basis on the hours/services delivered to individuals in the social services’ funded service.
6.5.3 The table sets out the core service that will be purchased but there is the possibility of purchasing additional hours of social care eligible support to meet individual need as described in the service specification. A referral shall not be excluded from these Services because an individual has needs in excess of those that can be supported with the average core locality hours. Where significantly higher levels of support are required, the Provider shall consider if the needs could be met if additional support hours were purchased from the Provider or from another organisation. The hourly rate for such support will be the direct service hourly unit rate as set in out in the open book submitted with the Provider’s tender. In addition Providers will be required to look at the most cost effective way of meeting an individual’s needs; this may include using resources in another lot area by agreement with the Provider in that area, and paying for them from the contract funding or a reciprocal agreement on support.

6.5.4 Across the locality the Provider shall be capable of providing support that offers a real alternative to residential care and that supports Service Users to develop the skills that they need to live independently. The Provider shall therefore be capable of:

6.5.4.1 Supporting people who are referred with significant and complex needs to sustain a tenancy, be socially included and to recover
6.5.4.2 Supporting Service Users to move in to supported housing from care homes or from an acute ward
6.5.4.3 Supporting Service Users with a wide range of complex needs including Service Users with personality disorder, physical disabilities, a dual diagnosis with substance misuse and people who challenge the Service.
6.5.4.4 Supporting Service Users to prepare to move on to fully independent accommodation and to access move on accommodation. This shall require good understanding of Choice Based Lettings (CBL) and local housing options as well as effective relationships that enable Service Users to access private sector tenancies
6.5.4.5 Supporting Service Users to feel safe where they live

6.5.5 The Service shall accept as referrals service users who have very high and complex support needs. The Provider shall work proactively with each referrer to agree how the individual can be supported to sustain their tenancy. This may mean negotiating additional support and inputs from the referring organisation. No referral should be refused without evidence that it has not been possible to agree a total support package with inputs from all relevant providers and organisations.

6.5.6 The service is expected to be recovery focussed and it is anticipated that the Service Users referred will be motivated to engage with the support service. However, the Provider shall be providing support to Service Users with complex needs and will therefore have experience in using a range of different strategies to engage and maintain engagement with Service Users to achieve positive outcomes.

6.5.7 This service is recovery focused and recognises that some Service Users will require support for several years before achieving greater independence. This may include supporting people in supported living who have relatively low levels of support needs but who need regular support in a safe environment. However, the Provider shall also offer short and intensive approaches that enable Service Users to move on quickly, sometimes within weeks of the referral.
6.5.8 The supported living service may offer short term reablement placements for people needing a period of assessment and reablement. It may also offer an alternative to admission service in conjunction with NSFT. Both services are operated at Boudicca Court at present but this may be subject to change before the contract is let, and during the lifetime of the contract.

6.5.9 As Service Users recover and their support needs reduce, the Provider shall support them to move on to more independent accommodation or to managing without funded support. Working in partnership with housing associations and private sector landlords to promote moving on shall be an important aspect of this service.

6.5.10 The Provider shall have excellent relationships with mental health social work services and secondary mental health services to meet the complex and challenging needs of Service Users referred and to support them to sustain their tenancies. This should involve the development of shared support plans.

6.5.11 There is significant NHS funding in this service so the provider will be expected to provide services to meet the whole range of eligibility criteria as set out in 4.10 above.

6.6 Community Outreach Support: East

6.6.1 This lot comprises Astley Cooper Place, Great Yarmouth, and community outreach hours. The Provider will offer the following support in the locality which will be delivered flexibly across the locality as needs change or fluctuate. The NHS element will focus on hospital discharge and related support as the key priority.

<table>
<thead>
<tr>
<th>Lot</th>
<th>Services</th>
<th>Number of hours per 4 weeks</th>
<th>Annual Total Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>East</td>
<td>Supported Living</td>
<td>760</td>
<td>£383,000 which includes £27,000 CCG funding and £20,000 for women only services</td>
</tr>
<tr>
<td></td>
<td>Community Support Services</td>
<td>600</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total for lot</strong></td>
<td><strong>1360</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Average number of service users at any time</strong></td>
<td><strong>110</strong></td>
<td></td>
</tr>
</tbody>
</table>

6.6.2 Adding the maximum number of hours specified in each Category (across all the supported living schemes and people in the community) gives the total number of support hours that shall be available in the locality at any time (the “Locality Hours”). Providers shall have a staff team capable of providing these Locality Hours flexibly across all Services. People meeting social services eligibility criteria will have an agreed number of hours to be provided per week or month; it will be for the provider and the service users to agree when these are provided during this period, and also to look at ‘banking hours’ for use for specific purposes, including increasing support in line with temporary increases in need. Providers will be required to report on a
monthly basis on the hours/service delivered to individuals in the social services’ funded service.

6.6.3 The tables set out the core service that will be purchased but there is the possibility of purchasing additional hours of social care eligible support to meet individual need as described in the service specification. A referral shall not be excluded from these Services because an individual has needs in excess of those that can be supported with the average core locality hours. Where significantly higher levels of support are required, the Provider shall consider if the needs could be met if additional support hours were purchased from the Provider or from another organisation. The hourly rate for such support will be the direct service hourly unit rate as set in out in the open book submitted with the Provider’s tender. In addition Providers will be required to look at the most cost effective way of meeting an individual’s needs; this may include using resources in another lot area by agreement with the Provider in that area, and paying for them, or a reciprocal agreement on support.

6.6.4 Across the locality the Provider shall be capable of providing support that offers a real alternative to residential care and that supports Service Users to develop the skills that they need to live independently. The Provider shall therefore be capable of:

6.6.4.1 Supporting people who are referred with significant and complex needs to sustain a tenancy, be socially included and to recover

6.6.4.2 Supporting Service Users to move in to supported housing from care homes or from an acute ward

6.6.4.3 Supporting Service Users with a wide range of complex needs including Service Users with personality disorder, physical disabilities, a dual diagnosis with substance misuse and people who challenge the Service.

6.6.4.4 Supporting Service Users to prepare to move on to fully independent accommodation and to access move on accommodation. This shall require good understanding of Choice Based Lettings (CBL) and local housing options as well as effective relationships that enable Service Users to access private sector tenancies

6.6.4.5 Supporting Service Users to feel safe where they live

6.6.5 The Service shall accept as referrals service users who have very high and complex support needs. The Provider shall work proactively with each referrer to agree how the individual can be supported to sustain their tenancy. This may mean negotiating additional support and inputs from the referring organisation. No referral should be refused without evidence that it has not been possible to agree a total support package with inputs from all relevant providers and organisations.

6.6.6 The service is expected to be recovery focussed and it is anticipated that the Service Users referred will be motivated to engage with the support service. However, the Provider shall be providing support to Service Users with complex needs and will therefore have experience in using a range of different strategies to engage and maintain engagement with Service Users to achieve positive outcomes.

6.6.7 This service is recovery focused and recognises that some Service Users will require support for several years before achieving greater independence. This may include supporting people in supported living who have relatively low levels of support needs but who need regular support in a safe environment. However, the Provider shall also
offer short and intensive approaches that enable Service Users to move on quickly, sometimes within weeks of the referral.

6.6.8 The supported living service may offer short term reablement placements for people needing a time limited period of assessment and reablement. This service is operated at Astley Cooper Place at present but this may be subject to change before the contract is let, and during the lifetime of the contract.

6.6.9 As Service Users recover and their support needs reduce, the Provider shall support them to move on to more independent accommodation or to managing without funded support. Working in partnership with housing associations and private sector landlords to promote moving on shall be an important aspect of this service.

6.6.10 The Provider shall have excellent relationships with mental health social work services and secondary mental health services to meet the complex and challenging needs of Service Users referred and to support them to sustain their tenancies. This should involve the development of shared support plans.

6.7 Community Outreach Support: Central

6.7.1 This lot comprises
- Supported living in Norwich: Vanguard Court, Bakery Court, Devonshire Place
- And community outreach support hours across North, Norwich and South localities

The Provider will offer the following support in the locality which will be delivered flexibly across the locality as needs change or fluctuate. In particular it is anticipated that some people in the NHS funded service may need more intensive support of averaging 3-4 contacts per week or as agreed with the NSFT teams operating a FACT service model. This will be reviewed regularly and more often if circumstances dictate e.g. support has been stepped up to prevent the likelihood of a mental health crisis occurring.

<table>
<thead>
<tr>
<th>Lot</th>
<th>Services</th>
<th>Number of hours per 4 weeks</th>
<th>Annual Total Value</th>
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<td>Central</td>
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<td>which includes £241,000 CCG funding</td>
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<td>and £75,000 for women only services of which</td>
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<td>at least £15,000 must be spent in North</td>
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<td></td>
<td></td>
<td></td>
<td>locality and £15,000 in South</td>
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<td>Community Support Services - North</td>
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<tr>
<td></td>
<td>Community Support Services - South</td>
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<td></td>
<td>Community Support Services - Norwich</td>
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<td><strong>Total for lot</strong></td>
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</tr>
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<td></td>
<td><strong>Average number of service users at</strong></td>
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<td></td>
</tr>
<tr>
<td></td>
<td><strong>any time</strong></td>
<td></td>
<td></td>
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</tbody>
</table>
6.7.2 Adding the maximum number of hours specified in each Category (across all the supported living schemes and people in the community) gives the total number of support hours that shall be available in the locality at any time (the “Locality Hours”). Providers shall have a staff team capable of providing these Locality Hours flexibly across all Services. People meeting social services eligibility criteria will have an agreed number of hours to be provided per week or month; it will be for the provider and the service users to agree when these are provided during this period, and also to look at ‘banking hours’ for use for specific purposes, including increasing support in line with temporary increases in need. Providers will be required to report on a monthly basis on the hours/service delivered to individuals in the social services’ funded service.

6.7.3 The tables set out the core service that will be purchased but there is the possibility of purchasing additional hours of social care eligible support to meet individual need as described in the service specification. A referral shall not be excluded from these Services because an individual has needs in excess of those that can be supported with the average core locality hours. Where significantly higher levels of support are required, the Provider shall consider if the needs could be met if additional support hours were purchased from the Provider or from another organisation. The hourly rate for such support will be the direct service hourly unit rate as set in out in the open book submitted with the Provider’s tender. In addition Providers will be required to look at the most cost effective way of meeting an individual’s needs; this may include using resources in another lot area by agreement with the Provider in that area, and paying for them with funding from the contract, or a reciprocal agreement on support.

6.7.4 Across the locality the Provider shall be capable of providing support that offers a real alternative to residential care and that supports Service Users to develop the skills that they need to live independently. The Provider shall therefore be capable of:
6.7.4.1 Supporting people who are referred with significant and complex needs to sustain a tenancy, be socially included and to recover
6.7.4.2 Supporting Service Users to move in to supported housing from care homes or from an acute ward
6.7.4.3 Supporting Service Users with a wide range of complex needs including Service Users with personality disorder, physical disabilities, a dual diagnosis with substance misuse and people who challenge the Service.
6.7.4.4 Supporting Service Users to prepare to move on to fully independent accommodation and to access move on accommodation. This shall require good understanding of Choice Based Lettings (CBL) and local housing options as well as effective relationships that enable Service Users to access private sector tenancies
6.7.4.5 Supporting Service Users to feel safe where they live

6.7.5 The Service shall accept as referrals service users who have very high and complex support needs. The Provider shall work proactively with each referrer to agree how the individual can be supported to sustain their tenancy. This may mean negotiating additional support and inputs from the referring organisation. No referral should be refused without evidence that it has not been possible to agree a total support package with inputs from all relevant providers and organisations. The service in Norwich will be expected to work closely with the Norwich intensive support team (Lot
4) to ensure that people are supported and can move between services and providers in an integrated fashion.

6.7.6 The service is expected to be recovery focussed and it is anticipated that the Service Users referred will be motivated to engage with the support service. However, the Provider shall be providing support to Service Users with complex needs and will therefore have experience in using a range of different strategies to engage and maintain engagement with Service Users to achieve positive outcomes.

6.7.7 This service is recovery focused and recognises that some Service Users will require support for several years before achieving greater independence. This may include supporting people in supported living (Bakery Court and Devonshire Place) who have relatively low levels of support needs but who need regular support in a safe environment. However, the Provider shall also offer short and intensive approaches that enable Service Users to move on quickly, sometimes within weeks of the referral.

6.7.8 The supported living services may offer short term reablement placements for people needing a time limited period of assessment and reablement. This service is operated at Devonshire Place at present but this may be subject to change before the contract is let, and during the lifetime of the contract.

6.7.9 As Service Users recover and their support needs reduce, the Provider shall support them to move on to more independent accommodation or to managing without funded support. Working in partnership with housing associations and private sector landlords to promote moving on shall be an important aspect of this service.

6.7.10 The Provider shall have excellent relationships with mental health social work services and secondary mental health services to meet the complex and challenging needs of Service Users referred and to support them to sustain their tenancies. This should involve the development of shared support plans.

6.7.11 In supported living, the Provider is expected to work closely with landlords around housing management (Appendix 2, section 2.3). Some landlords have confirmed that they would prefer the Support Provider to take on full housing management functions eg at Bakery Court (landlord Norwich Consolidated Charities) and at Bridewell Street flats, Wymondham and Wicklewood Bungalows (landlord Orbit Housing). Bridewell Street flats and Wicklewood are not 24/7 schemes but receive floating support/community outreach. Referrals to these services come through the mental health funding panel. The future use of Wicklewood Bungalows is under discussion and they may not form part of the future service model in Lot 2.

7 Quality Assurance and Performance Monitoring Framework

Quality: Key principles

7.1 The Council is committed to the principle of continuous improvement and will work with Providers to look at ways of improving performance with emphasis on the service being person centred and outcomes focused. Involvement of Service Users and their views is critical to providing an ‘inside out’ assessment of the service. Any
conversations will be honest, open and transparent with the needs of the Service User central to any discussion. The Council reserves the right to undertake or commission any research, evaluation, monitoring or auditing on any activity that it funds.

Quality Assurance Monitoring

7.2 Quality will be assessed through Contract Meetings, service reviews, planned or unannounced visits or through any other appropriate method. As part of such monitoring the Provider may be required to submit to Officers of the Council copies of the following:
- Policies and procedures as identified by the officers of the Council
- Records and certificates as identified by the officers of the Council
- Up to date records of all Support staff employed by the Provider, including DBS checks, training undertaken

7.3 The Quality Assurance Team will monitor the performance of the Contract with the emphasis on the quality of service provision and will do so by:
- Carrying out QA Monitoring meetings as and when required
- Conducting planned and/or unannounced visit to individual schemes or the Provider's office in order to view documentation considered relevant to said monitoring
- Requesting relevant information as deemed necessary

7.4 The Quality Assurance Team may make enquiries regarding issues relevant to the performance of the Contract by requiring the Provider to collect and submit information through the use of questionnaires and/or forms or any other system which may be developed and notified to the Provider.

7.5 The Provider will be responsible for informing the Quality Assurance Team at the earliest opportunity of any Safeguarding alert, concern or complaint it becomes aware of. The Quality Assurance Team expects close and prompt liaison from the Provider on all quality issues highlighted by concerns expressed by Service User or their families, Practitioner, CQC or other Professionals. The Quality Assurance Team will endeavour to discuss with the Provider in a clear and transparent manner any issue of concern, offering guidance as and when required, while setting clear expectations and timescales to remedy any issue of concern if and how appropriate

7.6 If, as a result of such assessment and monitoring the provider fails to achieve the desired levels of quality they will be required to submit a Specific, Measurable, Achievable, Realistic and Timely (SMART) action plan within one month and to report on achievement of the action plan against agreed timescales.

Performance

7.7 The Provider will be required to complete a core client record form for each new service user in their client management system. The client record forms will be used to provide statistics on who is using the service, referral sources etc. The exact content will be agreed with providers in the transition period.
7.8 The Provider will be required to use locally developed monitoring formats, which will be developed post contract award in partnership with commissioners, and which may be amended from time to time (the Performance Indicator Workbook). Individual targets for the service may be devised in conjunction with the Provider, to facilitate provider and stakeholder focus on improving and maintaining positive outcomes for service users. Likely content for the Performance Indicator Workbook is listed in 7.11 and 7.12 below.

7.9 The Provider must complete the Performance Indicator Workbook for the service at the quarterly dates provided by the Integrated Commissioning Team, and within 2 weeks of the end of the quarter. The Provider must provide details of a PI contact who will be available to respond to queries regarding the return. It is the responsibility of the Provider Contract Manager to ensure that performance workbooks are completed on time and are accurately completed.

7.10 Performance will be monitored quarterly through performance indicator workbooks and client record forms. Contract Meetings and service reviews may also be used, from time to time to validate performance. In year 1 contract meetings will be held quarterly. Providers are encouraged to review their own performance against local and national benchmarks for comparable services e.g. floating support.

7.11 The key performance indicators below are derived from the performance workbooks and it is essential that each individual’s support and move on plan can evidence how these KPIs have been achieved. Targets beyond the first year will be agreed with the Providers. Performance must meet the KPI targets and these will be reviewed quarterly. Failure to meet these targets will be subject to performance management measures which may include funding being withheld on a pro-rata basis to allow for review. If the failure to meet KPIs cannot be justified, then funding will be reduced accordingly until target levels are achieved.

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Target Year 1</th>
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<tbody>
<tr>
<td>KPI-1 Service users achieving or maintaining independent living</td>
<td>97%</td>
</tr>
<tr>
<td>KPI -2 Service Utilisation (hours)</td>
<td>95%</td>
</tr>
</tbody>
</table>

Service Planning and Efficiency

7.12 The Provider will be required to provide information to inform service development and planning and to determine the efficiency of the service, as and when required by Commissioners. This includes areas such as:

7.12.1 Referrals, throughput, waiting lists and waiting times
7.12.2 Self-referrals, re-referrals and time between exit from service and re-referral
7.12.3 Numbers of missed visits/contacts and action plan to address this issue
7.12.4 Numbers receiving a service and hours of support provided through different routes e.g. face to face, groups including those provided by volunteers (which should not exceed 10% of the total) using Appendix 5

7.12.5 Number and nature of complaints, including any incidents of racial inequality, discrimination, harassment and other forms of abuse.

7.12.6 Equality data such as ethnicity

7.12.7 Value for money data

7.12.8 Staff numbers

7.12.9 Staff changes

7.12.10 Staff skills and training progress

7.12.11 Induction and training provided to staff and volunteers

7.12.12 Development of peer support including numbers of volunteers used and roles in which they have been used; numbers of people employed as peer support workers

7.12.13 Key stakeholder perceptions about the extent to which the service is available at the point of need and ease of access to services

7.12.14 Changes the provider made to service delivery in order to make efficiencies and an assessment of the impact

and any other information areas that may help to inform service development and planning. Information should be collected in such a way as to allow it to be analysed by different geographical areas e.g. mental health social work team areas, CCGs, district council areas.

**Monitoring Outcomes**

7.13 The Provider shall comply with delivering all outcomes specified in the Contract and Service Specification. Targets for specific outcomes may be negotiated as part of the contract management process.

7.14 The Provider will be expected to monitor achievement of individual outcomes, including those achieved through groups, through the use of an agreed outcome monitoring tool, for example the Mental Health Recovery Outcomes Star, the Homelessness Outcomes Star or REQOL. The Provider will be required to submit aggregated data from the agreed Outcomes Star tool to the Commissioners at a frequency to be agreed to demonstrate the effectiveness of the service in particular areas. The REQOL tool will also be used to support self-reporting of recovery by service users. The provider will also complete an annual contract review report and an annual continuous improvement plan. A template for the annual contract review plan is attached at Appendix 4 and an outline performance management framework at Appendix 7. Performance management may involve the Provider collecting information on service users’ past history eg mental health hospital admission to enable change to be measured.

7.15 The Provider will be expected to work with Norfolk County Council using the principles of Open Book Accounting as part of the process to determine value for money and efficiency of the Service. This means providers will be expected to provide budget and cost breakdowns as requested by the commissioner in order to demonstrate that the service is being run efficiently.
7.16 The Provider must complete a separate copy of the Pricing workbook for all service elements (Attached as Appendix 6) within 20 working days of the end of the first 12 month period and each subsequent 12 month period for the duration of contract.

**Monitoring of contract compliance**

7.17 The specification sets out a number of areas of operational policy which the Provider is required to develop for sign off by commissioners. For ease of contract monitoring these are listed below:

7.17.1 The Provider will be required to finalise eligibility criteria with commissioners during the transition phase from the current service to the new contract (4.11). These will include with CCGs for the NHS funded element, and these criteria may vary between CCG areas according to local needs and the funding available.

7.17.2 The Provider will be expected to produce a joint protocol with mental health acute hospitals and NSFT’s crisis response and home treatment team for the element of service delivered to people in acute settings within 3 months of the start of the service contract. This will be reviewed annually thereafter, in both cases the protocol will be agreed with the commissioners. (4.8)

7.17.3 There should be a written policy on acceptance and exclusion criteria for referrals which will be agreed during the transition period. These will be agreed jointly with commissioners and

- the NCC Mental Health Social Care service
- appropriate NSFT teams who can refer into the NHS funded service elements. (4.12)

A single acceptance and screening process will be developed for service users to identify presenting needs and eligibility. This process, with timescales, will be agreed in the transition period to the new contract and be reviewed annually.

7.17.4 Norfolk County Council mental health social work service will develop and agree with the Provider how Care Act assessments will be incorporated into support plans and the subsequent reporting and reviewing process (4.6).

7.17.5 The Provider will work with Norfolk County Council to agree and deliver read only access to key parts of the client record for people who meet the social care eligibility criteria (4.39).

7.17.6 There should be a written policy agreed jointly with commissioners, Mental Health Social Care and the linked NSFT teams that outlines the criteria and process for managing discharge which will include any statutory reviews required (4.52). This will also cover options for self referral into services (4.56).

7.18 Performance monitoring information and outcomes achieved by the wider service indicators, such as numbers maintaining their housing or avoiding homelessness, will be used in conjunction with provider stakeholder intelligence to shape services according to local need. Norfolk County Council will conduct periodic audits on the
recording of outcomes and completed programmes, including examination of anonymous support plans and files. The Provider is expected to use an approved pro forma to collate this information. The key performance indicators and the related targets will be reviewed annually.

7.19 The Council may monitor contract compliance from time to time as part of any proactive monitoring processes or in response to feedback from a range of sources. Such monitoring may include, but is not limited to, any of the following:

7.19.1 Announced visits to the Provider’s premises
7.19.2 Subsequent unannounced visits to the Provider’s premises
7.19.3 Gathering views from people who use the service (e.g. using a questionnaire)
7.19.4 Gathering the views of staff (e.g. using a questionnaire)
7.19.5 Discussion with individual service users about service provision and outcomes
7.19.6 Discussion with individual members of staff about policies, procedures and practice
7.19.7 Inspection of policies, procedures, records and certificates
7.19.8 Gathering views from stakeholder organisations e.g. District Councils, NSFT
7.19.9 Review of inspection reports by any other statutory monitoring organisations

7.20 The Provider must notify the Council’s Authorised Representative within 5 working days where the number of hours delivered is greater than 10% below the locality area values in Section 6

7.21 The Council’s Authorised Representative upon receipt of notification in accordance with 7.20 reserves the right to arrange a contract review meeting with the Provider in order to agree an action plan to increase service delivery.

7.22 Should the number of hours delivered consistently be greater than 10% below the locality area values in Section 6 for a period of 8 weeks, the Council may reduce future funding by the value of the hourly unit cost of the hours not provided, starting at the next 28 day payment period, until such time that service levels are achieved.

7.23 Where the Provider is able to support the number of people as agreed in the final contract Section 6 within 90% or less of the hours specified, the Provider must utilise the remaining number of hours available for service delivery to additional eligible people as agreed with commissioners. This may include people on waiting lists. The Council’s Authorised Representative reserves the right to arrange a contract review meeting with the Provider to review service levels and which may result in a variation to current service levels.

7.24 Similarly, the Provider must notify the Council’s Authorised Representative within 5 working days where the number of hours delivered is greater than 10% above the total and/or locality area values in Section 6. Should the number of hours delivered consistently be greater than 10% above the total and/or locality area values in Section 6 for a period of 8 weeks, the Council will discuss future funding of the contract at the
next quarterly contract review meeting with a view to agreeing future funding or other action.

7.25 The commissioners have made provision for a sum of up to 2.5% of the total contract value to be available in addition to the contract value as follows:

- In years 1 and 2 for unavoidable and additional set up costs such as new IT systems.
- From year 3 onwards to fund innovation in service delivery as agreed between the provider and the commissioners. This sum will not be available if providers have failed to meet their performance targets in year and part payment may be withheld if performance against the plan for delivery of the innovation is unsatisfactory in the same year as the funding has been awarded for innovation. Innovation funding will also require learning from developments to be shared with other providers of services let under this contract.
Mental health support: detailed activities

Support to set up and maintain a home

- Supporting people through the process of moving home
- Support for people to maintain their accommodation or access more suitable accommodation during mental health crisis or the processes of recovery
- Advice and support on acquiring essential household items
- Support with arranging the connection of utilities
- Support with paying rent/dealing with arrears
- Support with maintaining the property including reporting / organising repairs, and cleaning/maintaining tidiness levels and addressing hoarding
- Support with maintaining the security and safety of the property including supporting people to establish security routines that minimise risk, eg testing smoke alarms and the safe use of appliances
- Assisting people who are temporarily admitted to hospital or about to be discharged from hospital to maintain their accommodation so that they can return home through liaising with relevant agencies such as a landlord and Benefit Agency

Support to live independently

- Support with household budgeting, including paying bills and budget planning
- Support to maximise income including checking that individuals have the benefits that they are entitled to
- Support with applications for benefits, including DLA/Personal Independence Payments, Housing Benefit and Council Tax Benefit
- Support with managing any debts
- Supporting people to develop and maintain good neighbour relationships
- Supporting people to address any aspects of anti-social behaviour
- Advice and support to maintain tenancy conditions, eg overnight visitors, noise levels etc
- Supporting people to comply with any conditions of licences and other community sentences
- Supporting people to undertake essential daily living tasks related to maintaining their tenure with a view to them being able to undertake these tasks for themselves or sustaining them at their current level of capability.
- Enabling people to access information about alternative housing options
- Supporting people to apply for alternative housing and subsequent support to move in to new housing

Advice, advocacy and liaison / social and community links

- Signposting to providers of specialist information, advice and advocacy services, including Citizens Advice Bureaux, Welfare Rights agencies
• Supporting people to deal with statutory and voluntary agencies, including attending appointments with them
• Enabling people to develop self-advocacy skills to further independence
• Support to develop and/or maintain social and community links
• Support in overcoming social isolation by linking people to local social, faith and leisure activities
• Creation and support for communities of interest and mutual support groups
• Supporting people to develop a range of opportunities likely to increase independence, including employment, education and leisure activities
• Enabling clients to obtain impartial mediation or legal advice, if required, including liaison and advocacy support from the same ethnic group

Health and well being

• Supporting people to monitor their own health and well-being and to access information and services where needed, for example on health, nutrition, mental health, well-being, sexual health, managing problem drinking, smoking cessation and physical activity
• Signposting people to specialist services, eg counselling, drug treatment, specialist debt advice
• Supporting people to deal with anxieties relating to practical circumstances, eg dealing with bills, unsolicited callers and arranging maintenance to the property
• Supporting people to comply with treatment / activities relating to maintaining their health and well-being eg repeat ordering of prescriptions, attending medical appointments and regular health checks to support all areas of health
• Supporting people to maintain contact with family and friends
Service Specification for Supported living schemes

This accommodation based service for people with severe and enduring mental health needs is commissioned by Norfolk County Council adult social services, local strategic housing authorities and the social landlord. The service will provide accommodation and housing related resettlement support.

1 Service Specification

1.1 Title of Service
TBC

1.2 Vision
1.2.1 Provision of self-contained flats for people with severe and enduring mental health issues with a staff meeting room/office and sleepover facilities.
1.2.2 Eligibility criteria for the scheme will be based on priority housing and support need, which will include the need to acquire independent living skills. Potential tenants are likely to include:
   - people leaving long stay residential care
   - people leaving acute or forensic mental health wards
   - people who have never lived independently from their families
   - people who have lived independently but not successfully.
1.2.3 Support provided at the service will be based on the recovery ethos and will:
   - Develop individuals' independent living skills
   - Provide an environment that facilitates access to employment, training, education and wider community activities
   - Provide a flexible, responsive service where service users' needs are central to the support process and service delivery
   - Provide a service ethos and practice which maximises choice and control for service users
   - Provide a service culture that empowers people and enables them to increase their confidence, assertiveness and awareness
1.2.4 Support will be provided in addition to a 24/7 presence at the scheme to ensure that individuals are safely accommodated and provided with the skills and ability to move on to independent living.

1.3 Who is the service for
1.3.1 People aged 18+ with severe and enduring mental health issues who are assessed as being able to live in a more independent setting.
People with severe or enduring mental health issues whose vulnerability due to lack of independent living skills and mental health issues would mean they are unlikely to be able to live independently without a period of assessment and support.
1.3.2 The service will therefore play an essential role in meeting the accommodation and support needs of people who have not lived independently or succeeded in living independently. People will be supported to consider their housing options and develop the skills necessary to live as independently as possible.

1.3.3
### 1.3.4
It will be a fundamental principle of all policies and practices that all people are equally valued regardless of their gender, disabilities, race, ethnic origin, language, religion or sexual orientation. Equality of opportunity must be promoted through:
- Ensuring that services are equally accessible and relevant to the needs and issues facing this client group
- Ensuring that staff are experienced in and responsive to providing services that are sensitive to the wider issues for this client group and are aware of the discrimination and social exclusion faced by this client group
- Promoting social inclusion for service users in the wider community
- The use of appropriate recruitment and employment practices and procedures.

The Provider must seek to ensure discrimination, harassment and attacks on any group or individual are eliminated. The Provider will ensure that monitoring arrangements are in place, which can evidence these requirements, and that continuous improvement in this area is sought.

### 1.3.5
The expected length of stay at the project will be variable depending on the assessed housing and support needs of each individual. Resettlement and move on should be discussed and form part of support planning from the start of the tenancy. It is anticipated that most individuals would have been supported to consider and make appropriate housing choices within 2 years, but there may be some individuals who may require longer to make this transition.

In particular, the service will meet the needs of individuals who are leaving residential care.

### 1.4
#### 1.4.1
The Property

The property is located in XXX and consists of XXX self-contained one bedroom furnished flats.

### 1.5
#### 1.5.1
Access to the Service

All nominations and referrals to the scheme will be through Norfolk County Council. Applicants will also need to be on a local housing register of a Norfolk strategic housing authority, or be eligible to be on a housing register.

#### 1.5.2
Referrals to the service will be considered by a panel consisting of the manager of the service and a Norfolk County Council Social Services team manager. The social landlord will also be involved in tenant selection. Applicants will be considered solely on their housing and support needs and all referrals will be considered equally. The panel process may change over time.

#### 1.5.3
Access to the service will be monitored by Norfolk adult social services. Planned vacancies will be reported to the Norfolk social services in advance to allow for forward planning for new tenants and to minimise vacancies.

### 2
#### 2.1
Service Delivery

#### 2.1.1
Outcomes

The service will address and contribute to the following targets and outcomes:

1. **Key Target**
   - Vulnerable people supported to achieve independence

   Targets for this indicator will be agreed as part of the contract award process.

2. **Direct Influence on the following outcomes**
• **Achieve economic well being**
  Not representing as homeless within two years
  Maximising income including receipt of benefits and reducing debt.
  Obtain / participate in paid work

• **Enjoy and achieve**
  Participating in training/education, achieving desired qualifications
  Participating in chosen leisure/culture/faith/learning activities
  Being in contact with external services/groups/friends/family

• **Be healthy**
  Starting to see a GP
  Physical/mental health remained stable or improved
  Avoidance of mental health acute hospital admission, and in the event of an admission, an early discharge
  Drug/alcohol use stabilised or reduced

• **Stay safe**
  Maintained accommodation and avoided eviction
  Move on in a planned way
  Reduce levels of offending behaviour

• **Make a positive contribution**
  Be compliant with statutory orders/related processes
  Become involved in this service or other community activities
  Greater choice and/or involvement and/or control at service level within the wider community.

2.1.3 Outcomes for this service will be assessed through evaluation of the service via the Recovery Star and REQOL and achievement of individual self-directed support plans, and the overall performance management framework for the service.

2.2 Activities to deliver outcomes

2.2.1 The provider will operate a robust risk and housing needs assessment procedure that will ensure that all people supported have needs that the service can safely and appropriately accommodate. The procedures and principles of this process will need to be made available to the referring agency to encourage understanding of the service and ensure appropriate referrals are made.

2.2.2 When accommodated, the provider will develop individual housing support plans for each of the service users, designed to support them in gaining independent living skills. Research shows that people who suffer mental ill health are more likely to have physical illnesses, behavioural difficulties and drug and alcohol misuse. The service model will have to accommodate these challenges whilst achieving the required outcomes.

2.2.3 The service will need to have appropriate and inclusive drug and alcohol harm reduction policies and procedures.

2.2.4 This client group may have had little experience at living independently and is likely to need intensive support around developing pertinent life skills. Service users will be expected to have a wide range of needs and the provider will need to have experience in supporting individuals with the following (this list is not exhaustive):
  • Severe and/or enduring mental health problems
  • Behavioural difficulties
  • Self-harm
  • Personality disorders
| 2.2.5 | Service users will be supported to further develop their own self-directed support (SDS) plans, which will be funded through personal budgets to deliver outcomes in ways that they choose. |
| 2.2.6 | Genuine partnership working will be essential in ensuring that the range of individual needs, are met holistically and as comprehensively as possible. The support provider will be expected to provide this service in conjunction with other key workers, agencies. Partnership working should encompass:  
- Health professionals  
- Housing officers  
- Community Services  
- Drug treatment and support organisations  
- Voluntary and community sector organisations and community assets  
- Education and training organisations  
- The local Police  
- Other agencies as required. |
| 2.2.7 | The support provider will be expected to collaborate with local services providing employment support to maximise opportunities for access to employment and training for individuals at this scheme. |
| 2.2.8 | The provider will be required to engage regularly with the statutory agencies to ensure that good practice and challenges are discussed and explored fully. |
| 2.2.9 | The particular housing related support areas that should be provided in waking hours include:  
- Support in establishing a suitable home – help, advice and support locating and establishing an appropriate home for independent living in the community and understanding the expectations of being a good neighbour/tenant.  
- Support with daily living skills – help, advice and training in the day to day skills needed for living independently, such as budgeting, utility connections and cooking  
- Support in accessing benefits, health and community care services – information, advice and help in claiming benefits or accessing community care or health services that a household needs in order to live independently  
- Support in managing and improving mental and physical health  
- Help in establishing and maintaining social support – help in rebuilding or establishing friendships and relationships that can help counter isolation and help support independent living.  
- Support in moderating anti-social behaviour including signposting and referring to appropriate sources of help and advice.  
- Provision of support and resettlement services, which will include help identifying move on accommodation and accessing housing registers/options.  
- Help to access education, training, volunteering opportunities and work finding. |
2.2.10 The service is intended to provide support that enables service users to access suitable move-on accommodation (which may be other supported housing where appropriate) and resettle back into the community and this must include access to the private rented sector. Support activities and intended outcomes must be clearly defined within the support plan. The outcomes for individuals, agreed between the individual, provider and key agencies (as identified in the Individual's Support Plan), will be monitored through quarterly returns and service reviews. There is an expectation that the provider will use the Recovery Star to support user–led individual planning, monitoring and cross agency working.

2.2.11 The Provider will be expected deliver an integrated service with community outreach services to enable successful move on and maintenance of subsequent tenancies. In addition if people are moving out of the integrated service the provider will be expected to set up and monitor links between clients and other support services operating in the area in order to facilitate successful maintenance of recovery.

2.3 Housing Management

2.3.1 Housing management will be provided by social landlords (Broadland Housing Association and Cotman Housing) in Boudicca Court, Vanguard Court, Devonshire Place, and Astley Cooper Place. Housing management will include:

- Selecting occupiers and allocating properties in accordance within the agreed selection and allocation policy, working with the Provider and NCC
- Signing up new residents and explaining to them the terms and conditions of Assured Shorthold Tenancy (AST) rights and responsibilities and related

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|  | - Signing up new residents and explaining to them the terms and conditions of Assured Shorthold Tenancy (AST) rights and responsibilities and related |
### Specific Requirements

<table>
<thead>
<tr>
<th>2.3.2</th>
<th>The support provider will be expected as part of their support role for tenants to:</th>
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<tbody>
<tr>
<td></td>
<td>• Providing a day to day housing management service to residents to ensure they are able to maintain and sustain their tenancy successfully</td>
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<tr>
<td></td>
<td>• Notify the landlord of any known or suspected breaches of tenancy conditions and support the tenant, working with the Association, to agree any action to be taken in response</td>
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<tr>
<td></td>
<td>• Liaise with the landlord to minimise void periods in line with a 95% occupancy target</td>
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<tr>
<td></td>
<td>• Support tenants to report repairs and maintenance issues on the development to the landlord</td>
</tr>
<tr>
<td></td>
<td>• Monitor health and safety issues on the development</td>
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</tbody>
</table>

| 2.3.3 | NCC expects support providers to work closely with them and landlords to minimise voids and delays in filling empty properties. This includes advance notification to NCC and landlords of upcoming vacancies, including those where no specific date of departure is known. |

| 2.4 | To provide a housing related support service on a structured basis for each service user within an overall framework of a set minimum of waking hours of paid direct professional support per week, on 7 days a week. Administrative and management support will need to be factored in, in addition to this requirement. Support can be delivered according to the staffing structure, but should include weekend and evening delivery, and providing life skills training. The delivery of housing support provided by the service will be flexible enough to be shared between the tenants in a way that meets their individual needs. It will also take account of clients’ daily commitments, support plans, training etc, as well as the need to access external services during office hours. |

| 2.4.1 | 24/7 cover is essential although it is not expected that significant levels of housing related support will be delivered between 10pm and 7am, and it is anticipated that a sleep-in service will be provided during this period plus a concierge service in the evenings to support safety and security of the building. This should be reflected in the support/housing safety and security time split of staff working these shifts. However if NCC agrees an individual needs waking night support in addition to the sleep in service, this will be funded in addition to the contract value. |

| 2.4.2 | To agree individual housing and support plans with the service users as part of a multi-agency care & support package; to participate in multi-agency case monitoring & review. |

| 2.4.3 | In addition, 1 to 1 support per service user per week may be commissioned from the Provider or an alternative support provider, to deliver on elements of the users’ self-directed support plans which are funded through personal budgets. The hourly cost of this service will be based on the rate quoted by the provider in the tender process. |

| 2.4.4 | To provide an out-of hours emergency response service should this be required. |

| 2.4.5 | To explore resettlement and housing options with service users from the start of the support planning process and support people to move on from the service as far as possible in line with their preferred housing choices. |

| 2.4.6 | To develop effective working relationship with other support services operating in the area to facilitate move on from the service. |
| 2.4.8 | To maximise opportunities for access to employment, education and training for individuals accommodated through collaboration with agencies operating employment, training, education and voluntary services in the area. |
| 2.4.9 | To co-operate with Norfolk County Council, N&SFT, local housing authorities, the police and Housing Associations in the development of protocols and agreements that promote multi agency working and aid the management of specific cases. |
| 2.4.10 | To provide a weekend and evening telephone support service to known service users in the community in order to provide a limited but responsive support. This is not intended to replace eg the MIND crisis service for NSFT service users. |

### Resources

3.1 This service will be funded through

- A block gross payment. This will be paid as a block amount no matter how many tenants are resident at the project at any particular time.
- It is considered that a significant percentage of the evening and overnight component of this service (concierge and sleep –in) will be concerned with the safety and security of the building. The majority of the funding for this element will be through housing benefit. This will come from the rent and service charge which tenants pay to the housing provider and will then be fed through to the Provider of this service; this will have to be negotiated with the landlord. This requirement may change during the life of the contract and the costs eg of providing a waking night service will be discussed and agreed between commissioners and the Provider at this point.
- Personal budgets for any additional support on a 1:1 basis on an hourly rate to be agreed with the provider in the tender process(2.4.4). This will be paid as a spot contract per individual and will only be paid for the particular tenant resident at the project at the time.

3.2 The overall budget designated recognises the fact that this service is targeted at people with significant and sometimes complex needs. It is expected that staff employed at the service will need a high degree of knowledge of this client group, expertise and professionalism.
Details of Supported Living Schemes

West locality: Boudicca Court Kings Lynn

1. Support

In addition to the service outlined in Appendix 2, the service currently offers a short term reablement flat on a pilot basis and also an alternative to admission flat with additional staff funding from NSFT. Both of these services may continue into the new contract. The service has a mixture of service users who are expected to move on within two years, and those who need a longer period of reablement or who have recovered but who need long term supported living.

2. Night Time Support

There shall be a sleep in every night delivered in accordance with the service specification. This is currently provided as part of the evening concierge service funded 80% by Housing Benefit for safety and security at the scheme; the funding for this element is passed by the landlord to the support provider.

3. Buildings

There are 16 self-contained one bedroom flats with a further flat providing a meeting room/staff sleep in accommodation. There is a further self-contained staff office space. The flats form a self-contained development close to King’s Lynn town centre.

East locality: Astley Cooper Place Great Yarmouth

1. Support

In addition to the service outlined in Appendix 2, the service currently offers a short term reablement flat on a pilot basis; this service may continue into the new contract. The service has a mixture of service users who are expected to move on within two years, and those who need a longer period of reablement or who have recovered but who need long term supported living.

2. Night Time Support

There shall be a sleep in every night delivered in accordance with the service specification. This is currently provided as part of the evening concierge service funded 80% by Housing Benefit for safety and security at the scheme; the funding for this element is passed by the landlord to the support provider.

3. Buildings

There are 19 self-contained one bedroom flats with a further flat providing a meeting room/staff sleep in accommodation. The flats form a self-contained development close to
Northgate Hospital and Great Yarmouth town centre and share the site with five general needs family houses.

Central locality:
A Devonshire Place Great Norwich

1. Support
In addition to the service outlined in Appendix 2, the service offers a short term reablement flat for up to 6 months; this service is likely to continue into the new contract. The service has a mixture of service users who need a period of reablement exceeding two years, or who have recovered but who need long term supported living. Currently this service shares a manager with Bakery Court.

2. Night Time Support
There shall be a sleep in every night delivered in accordance with the service specification. This is currently provided as part of the evening concierge service funded 50% by Housing Benefit for safety and security at the scheme; the funding for this element is passed by the landlord to the support provider. This service also covers Bakery Court.

3. Buildings
There are 20 self-contained one bedroom flats plus a communal lounge, staff offices and staff sleep in accommodation. The flats form a self-contained development close to Norwich city centre and Bakery Court.

B Bakery Court Norwich

1. Support
The service has a mixture of service users who need a period of reablement exceeding two years, or who have recovered but who need long term supported living. Currently this service shares a manager with Devonshire Place. This accommodation is only accessible to people with a local connection to Norwich City Council area.

2. Night Time Support
There is an on call concierge and sleep in every night delivered in accordance with the service specification and based at Devonshire Place. This is currently provided as part of the evening concierge service funded 50% by Housing Benefit for safety and security at the scheme; the funding for this element is passed by the landlord to the support provider.

3. Buildings
There are 12 self-contained one bedroom flats. The flats form a self-contained development close to Norwich city centre and Devonshire Place.
C Vanguard Court Norwich

1. Support
The service provides reablement for a period of up to two years.

2. Night Time Support
There shall be a sleep in every night delivered in accordance with the service specification. This is currently provided as part of the evening concierge service funded 50% by Housing Benefit for safety and security at the scheme; the funding for this element is passed by the landlord to the support provider.

3. Buildings
There are 20 self-contained one bedroom flats plus staff offices and staff sleep in accommodation. The flats form a self-contained development close to Norwich city centre and Devonshire Place/ Bakery Court.

D. Bridewell Flats Wymondham and Wicklewood Bungalows, South Norfolk.

1. Support
These two services house service users who need a period of reablement of up to two years. Support is currently provided on weekdays on a floating support basis, therefore the hours for these two services have been included in the community outreach totals for South Norfolk locality. The Wicklewood bungalows are currently only let to women.

2. Night Time Support
No night time or weekend support is provided.

3. Buildings
There are 6 self-contained one bedroom flats in Wymondham in a self-contained development. There are 6 bungalows next to the Ashcroft Care Home in Wicklewood.
### ANNUAL CONTRACT REVIEW REPORT

<table>
<thead>
<tr>
<th>Period covered by the report:</th>
<th>Contract name:</th>
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</table>

### COMPLETING THE REPORT TEMPLATE

Throughout the report, please identify any connected training and workforce development issues.

The most recent performance data report for this service will be considered as part of the review of the service.

Please complete the income and expenditure template provided separately.

All boxes will expand as you type into them. Please consult Commissioning Manager if you require guidance on completing this template.

### SERVICE OVERVIEW

Service governance describes a systematic approach to ensuring that the quality and safety of services are of a high standard and that they are continually improving.

All commissioned agencies have a contractual responsibility to ensure effective governance in the development and delivery of services.

Please use the template below to report on the service’s progress in each domain citing evidence from the past reporting period. Key areas to focus on and examples of appropriate evidence are included. Copies of supporting documents should be returned with this report.

### Workforce Information

Provide details of the current workforce (structure, roles, Full Time Equivalent and vacancies), volunteer contribution (numbers, hours and roles undertaken).

Matters relating to long-term sickness or absence and vacancy rates should also be provided in this section.

How the service ensures competency of volunteers staff e.g. *Completion of staff appraisal that includes checking competency against relevant standards.*
Staffing/Posts (FTE):  

Vacancies/Posts (FTE):  

No. of Volunteers  

Volunteer Hours:  

% of tenants maintained with named lead worker (unless change agreed) during the year  

Recruitment/retention issues:  

Developments to the service in the past reporting period:  

Examples of good practice/key achievements:  

Difficulties experienced by the service in the past twelve months:  

Main concerns for the next reporting period:  

Service user experience (case studies etc)  

Provide evidence of results and the systems, methods and actions in place to ensure service users receive a high quality service, that meets their outcomes e.g. Completion of a survey that monitors whether service users feel that their needs are being met. Compliments  

Report:  

Further action required in the next reporting period:
**Complaints (Quarterly)**

Evidence of the complaints and feedback process and impact for service users

Include details of the nature of complaints and actions planned to address any service issues identified.

<table>
<thead>
<tr>
<th>No. of new complaints:</th>
<th>No. of open complaints:</th>
<th>No. of complaints resolved:</th>
</tr>
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</table>

**Report:**

**Further action required in the next twelve months:**

---

**Exception Reporting**

Provide details of any incidents and systems in place to ensure learning from safety/other incidents

Situations where services are delayed or could not be provided.

**Key areas:**

<table>
<thead>
<tr>
<th>Examples of appropriate evidence:</th>
</tr>
</thead>
<tbody>
<tr>
<td>EG</td>
</tr>
<tr>
<td>Unplanned hospital admissions:</td>
</tr>
<tr>
<td>Safeguarding investigations</td>
</tr>
<tr>
<td>Risk management</td>
</tr>
</tbody>
</table>

**Report:**

**Further action required in the next twelve months:**
Service Development

How the views of service users are sought and taken into account in designing, planning, delivering and improving the service e.g. Establishment of service user involvement framework.

Promotion of equal access to the service for all members of the population e.g. Completion of a cultural competence assessment for the service that identifies actions needed

Systems which keep service users and staff safe e.g. Completion of a review of the service’s safeguarding policy that includes checking how effective it has been

Outline any examples of work with any other agencies to ensure service user’s needs are met e.g. Introduction of a new joint working and information sharing protocol between the service and another or alerting quality leads to areas of concern which lead to overall quality improvements in services in Norfolk

Partnership working

<table>
<thead>
<tr>
<th>Key areas:</th>
<th>Examples of appropriate evidence:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report:</td>
<td></td>
</tr>
</tbody>
</table>

Further action required in the next twelve months:

SERVICE OUTCOMES

Please rate the service’s contribution in the past reporting period to each of the outcomes listed in the service specification. Evidence should be provided in the form of outcome measurement data, patient feedback, key worker feedback and/or research which has demonstrated that a particular intervention has a positive impact.

<table>
<thead>
<tr>
<th>Rating – Red/Amber/Green</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined recovery star for the services</td>
</tr>
<tr>
<td>REQOL data for services</td>
</tr>
</tbody>
</table>

Thank you for taking the time to complete this report.
Appendix 5

Breakdown of support hours

Breakdown of Support Hours.xlsx
Appendix 6

Pricing Spreadsheet
Guidance Notes on Completion of Pricing Spreadsheet

Providers are required to submit a completed pricing spreadsheet for each Lot they bid for covering the combined costs of all elements of the service within that lot.

Listed below are some guidance / clarification notes to aid completion of the spreadsheet. These are not intended as comprehensive notes on the completion of the spreadsheet but instead aim to highlight some of the common issues encountered with previous submissions.

1. **Total Bid Price** (top right hand corner of the spreadsheet):

   Providers should ensure that this figure does not exceed the maximum financial limit for the relevant lot i.e. 1.5% above the figure given in the Specification.

2. **Staffing** (Service Support Staff and Management/Operational Staff)

   - Providers should ensure that the staffing details shown on the spreadsheet correspond with the organisational structures shown elsewhere in their response.
   - Where the staffing structure shown in main body of the submission shows roles with different job titles (mainly in the Service Support Staff section) these should be shown separately with the appropriate Salary and hours etc. for the specific role shown against them as this allows comparison of roles etc.
   - Where a member of staff works across the sections on “Service Support Staff” and “Management / Operational” enter their full details i.e. full salary, hours etc. in the section where they use most of their time and then just indicate the percentage of their time spent on providing support in the column “% of time spent on support” as splitting the salary and hours across both Sections makes comparison with other posts difficult and can under-estimate the number of support hours available as it can distort the calculations built into the spreadsheet.
   - If there are posts that have the same title but which are either paid a different salary or spend a different percentage of their time on support then enter them on separate lines as the spreadsheet uses this data to calculate the overall cost and the support hours available so needs separate entries where the percentages are different.
   - The column “% of time spent on support” is intended to identify how much time each post will spend on delivering direct support to service users and so allowances should be made for non-direct support elements of the role. Direct support could, for example, include things such as direct contact with service users (in person, phone etc.), time spent on assessments, calls made on behalf of the service user etc. However it should exclude things such as annual leave, training, supervision, travel etc.

3. **Other costs**

   If any costs in Sections 3, 4 or 5 are “one off” costs please indicate this in the Notes section next to the relevant entry

Pricing Spreadsheet.xlsx
## Outcome Measurement: performance management framework (version 4)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicators</th>
<th>Suggested format</th>
</tr>
</thead>
</table>
| People will have access to support and advice to set up and/or maintain  | • An increase in the number of people in stable accommodation (also NCC KPI)  
• Reduced number of people at risk of homelessness or homeless  
• Numbers entering the service who are at risk of eviction where eviction has been avoided.  
• Number of people in this service who have successfully moved accommodation                                                                 | Performance Indicator workbook                                                                                                                  |
| their tenancy or accommodation                                           |                                                                                                                                                                                                              | NHS Mental Health dashboard (reported by NSFT)                                                                                                   |
| People will have access to practical support and advice to help them    | • The number of people maintained in their accommodation                                                                                                                                                   | Performance Indicator workbook                                                                                                                  |
| maintain their home                                                      |                                                                                                                                                                                                              |                                                                                                                                                   |
| People will have further developed and be able to maintain their        | • An increase in the number of people who are maintaining their homes to standards that are enabling them to meet tenancy conditions                                                                     | Locally devised measure REQOL (1&4)                                                                                                              |
| independent living skills                                               |                                                                                                                                                                                                              |                                                                                                                                                   |
| People will have access to support at the point of need                 | • Numbers of people in receipt of more intensive support  
• Throughput on intensive support                                                                                                                                                                           | Locally devised measure                                                                                                                       |
<p>| People will have increased opportunities to access a range of community | • An increase in the number of people engaged in leisure, social or faith activities                                                                                                                                 | Locally devised measure/Recovery star                                                                                                           |
| networks                                                                | • An increase in the number of people who have developed social networks and relationships including via peer support groups                                                                         |                                                                                                                                                   |
| People will have increased social networks                              |                                                                                                                                                                                                              |                                                                                                                                                   |</p>
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicators</th>
<th>Suggested format</th>
</tr>
</thead>
</table>
| **People will experience improved economic well-being**                | • Numbers supported to access at least one community asset new to them per quarter  
• Numbers accessing at least one community asset independently incl with another service user  
• An increase in the number of people able to manage their budgeting  
• An increase in the number of people getting the right benefits and the amount of benefit claimed  
• A reduction in the number of people with unmanaged debt problems  
• An increase in the number of people in employment or in voluntary work or training which could lead to employment (NCC KPI)  
• People will experience improved physical and mental health  
• Increase in the proportion of people receiving peer support to enable self-management of their mental health  
• An increase in the number of people who have had physical health checks in primary care  
• Improvement in physical health  
• A decrease in the levels of substance misuse  
• An increase in engagement with mental health services in a planned way  
• Numbers maintaining mental health state/ recovery  
• A decrease in emergency mental health hospital admissions whilst in the service | Locally devised measure/Recovery star |
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicators</th>
<th>Suggested format</th>
</tr>
</thead>
</table>
| People will have increased knowledge about how to keep safe            | • An increase in the numbers with security routines e.g. safe use of appliances, testing of fire alarms  
• An increase in the numbers of people reporting good neighbour relations | Locally devised measure/service user satisfaction     |
| People will have improved knowledge about how to access specialist services and support | • An increase in the number of people who know what services are available or where to go to find out about them                                                                                       | Locally devised measure                                |
| People will have increased confidence and skills to advocate for themselves | • An increase in the number of people who have more choice and control over their lives e.g. who have gained confidence to self-advocate or be better able to deal with a benefits issue themselves  
• Numbers reporting overall improvement in quality of life | Locally devised measure/Recovery star/REQOL (8 & 10)/service user satisfaction                           |
| People benefit from recovery promoting services                        | • Reduced level of offending behaviour  
• Compliance with statutory orders                                                                                                                                  | Locally devised measure                                |
| Derived from [https://www.centreformentalhealth.org.uk/recovery-quality-and-outcomes](https://www.centreformentalhealth.org.uk/recovery-quality-and-outcomes) | • High levels of satisfaction:  
  o Service users feel that staff are trying to help them in recovery  
  o Service users feel in control of their support  
  o Service users are achieving or have achieved their goals | Locally devised measure/service user survey/exit surveys                                                                                                    |
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicators</th>
<th>Suggested format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carers are supported in their role so that they can continue caring</td>
<td>• Carer satisfaction with the support provided for the person they care for</td>
<td>Locally devised measure/survey/</td>
</tr>
<tr>
<td></td>
<td>• Carer satisfaction with the information/advice/support they have received from the service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Carers’ use of groups run by the service and satisfaction with these opportunities</td>
<td></td>
</tr>
</tbody>
</table>