# SCHEDULE 2 – THE SERVICES

1. **Service Specifications**

Mandatory headings 1 – 4: mandatory but detail for local determination and agreement. Optional headings 5-7: optional to use, detail for local determination and agreement. All subheadings for local determination and agreement.

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| V1 | HNM | 06/02/17 |

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| **Service Specification No.** |  |
| **Service** | Ipswich & East Suffolk and West Suffolk Marginalised and Vulnerable Adults Service |
| **Commissioner Lead** | Ipswich & East Suffolk Clinical Commissioning Group (I&ESCCG)  West Suffolk Clinical Commissioning Group (WSCCG) |
| **Provider Lead** | TBC |
| **Period** | October 2017 Onwards |
| **Date of Review** | TBC |

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| **1. Population Needs** |
| **Shared Ambition**  A multi-agency, co-ordinated and sustainable approach to providing services which ensure the most vulnerable and marginalised in our communities are supported to access mainstream services and independence or where mainstream services are not appropriate, alternative provision is in place. I&ESCCG and WSCCG wish to commission a service model thatdelivers the above ambition of supporting marginalised and vulnerable adults, such as Migrants, Refugees and Asylum Seekers, homeless people, Gypsies and Travellers and Ex-offenders / Offenders. The service shall be required to be flexible and take into account the changing evidence base in order to maintain best practice. The service shall continuously measure improved outcomes for service users, and, through memorandums of understanding with other providers across the system, be able to clearly describe where service users have been on their pathway.  **National / Local Context & Evidence Base**  A guiding principle of the NHS is that good healthcare is available to all, but whilst progress to improve the health outcomes of the population as a whole has been made, health inequalities remain between different population groups. Commissioners recognise that people from disadvantaged groups can experience barriers to access mainstream services, and despite increasing financial pressures, we recognise there remains a need to ensure people with complex and marginalised lifestyles receive support and can access primary care services in Ipswich, East Suffolk and West Suffolk. The CCGs fund this service in order to address these barriers and enable early access to mainstream services. The service shall offer a consistent approach across Ipswich and East Suffolk and West Suffolk CCGs to ensure parity across all CCG localities.  The key challenges to be addressed through the reprocurement of this service are:   * Lack of cultural awareness in mainstream services - language, culture, behaviour and understanding * Those with the most complex needs are often less likely to access mainstream services * Thresholds have increased within many public services, leaving some vulnerable people without support until they reach crisis point * Capacity of mainstream to support complex needs - need more time and flexibility of approach to connect with other services * Some individuals will never effectively engage with mainstream services   **The Suffolk Needs Assessment**  This service specification is informed by the GAROD Report (Groups at Risk of Disadvantage), a needs assessment by Suffolk Public Health. The needs assessment recognises that the MVA service is ‘valuable and supports the health needs of the most vulnerable individuals within Suffolk’ and suggests that ‘health inequalities are being perpetuated within Suffolk’ and that system leaders needed to work together to implement change and it proposes a strategic group to oversee implementation. The service has an important role to play in this strategic approach. In addition, I&ESCCG and WSCCG recognise that this service is only a small part of a wider strategic response needed for a growing population of people with disorganised and complex lifestyles who are being referred to primary and secondary health and social care services. Any system-wide coordinated response must include activity being undertaken by local authorities, public health bodies and existing providers of Mental Health, Drug and Alcohol and housing services.  It is essential that the MVA service supports the Making Every Adult Matter (MEAM) framework and approach locally as a means to ensure that local people covered by this contract with multiple needs living chaotic lives and facing premature death receive a coordinate response from a range of agencies including local authorities and housing. This will involve being part of a cross-sector partnership of providers, service users and commissioners.  **MEAM Framework**  In every local area, people with multiple needs and exclusions are living disordered lives and facing premature death because as a society we fail to understand and coordinate the support they need. Yet evidence shows that by working together local services can develop coordinated interventions that can transform lives. The MEAM approach provides a non-prescriptive framework for developing a coordinated approach in your local area. Individuals who experience a number of problems at the same time such as homelessness, substance misuse, mental health problems and offending usually also have ineffective contact with the services that should be there to help, and end up living disengaged and expensive lives.  It is therefore expected that the service provider will take these findings into account when planning service delivery in order to ensure the service meets the needs of the people living in Ipswich, East Suffolk and West Suffolk. The service provider will need to ensure that services delivered are in keeping with current best practice. Services will therefore need to be flexible and take into account the changing evidence base in order to maintain best practice.  **Co-production**  Existing forums for identified groups will support the ongoing development of the service as outlined below:  a. understanding of need (include locality specific)  b. agree a set of shared outcomes which are specific to the cohort of targeted individuals  c. map current activity and gaps  d. re-design pathways based on what is working and what is not working well (informed by service user engagement) throughout the duration of the contract  e. agree how gaps/improvements can be resourced making better use of existing resources (envelope of resources), aligning budgets and seeking additional funds where appropriate |
| **2. Outcomes** |
| **2.1 NHS Outcomes Framework Domains & Indicators**  Overall, the Marginalised and Vulnerable Adults Service will contribute to the delivery of the nationally agreed NHS Outcome Framework domains and indicators as well as the locally defined outcomes outlined below.  **This service supports domains 1-5 of the NHS Outcomes Framework:**   |  |  | | --- | --- | | Domain 1 | Preventing people from dying prematurely | | Domain 2 | Enhancing quality of life for people with long-term conditions. | | Domain 3 | Helping people to recover from episodes of ill-health or following injury. | | Domain 4 | Ensuring people have a positive experience of care | | Domain 5 | Treating and caring for people in safe environment and protecting them from avoidable harm |   **Health and Wellbeing Board Strategic Outcomes (2016-2019)**   * Outcome One: Every child in Suffolk has the best start in life * Outcome Two: Improving independent life for people with physical and learning disabilities * Outcome Three: Older people in Suffolk have a good quality of life * Outcome Four: People in Suffolk have the opportunity to improve their mental health and wellbeing   **2.2 Local Defined Outcomes**  The service will cover Ipswich, East Suffolk and West Suffolk CCGs’ localities working with disadvantaged people in most need and at greatest risk. Access issues can be compounded if people trying to access services have limited knowledge of how the NHS works, so the service has an important role to play in informing clients on procedures around making appointments and expectations over referrals. People from marginalised groups can experience a range of barriers when accessing mainstream services, including:   * Language barriers * Over complicated registration processes in Primary Care * Discrimination and stigmatisation, especially from frontline staff * Western mental health concepts unacceptable / not understood / not culturally appropriate * Inflexible appointments * Lack of trust with health professionals * Poor communication or limited translation * Limited access to services due to rural transport and cost * The health service’s inability to accept information from overseas health professionals, resulting in service users having to ‘start from scratch’ in the NHS   This service seeks to deliver/support the delivery of the following outcomes as part of the overall system-wide offer:   1. To improve the health and wellbeing of people from highlighted groups in Ipswich, East Suffolk and West Suffolk. 2. To deliver a culturally aware and culturally competent service that demonstrates appropriate behaviours, attitudes, policies and structures which enable effective working across marginalised and vulnerable communities. 3. To support and assist MVA clients to overcome barriers in accessing mainstream services including Integrated Neighbourhood Areas (e.g. Connect), providing advocacy, client support, staff training and partnership working to remove barriers which reduce access to primary and secondary services. 4. Provide initial urgent care and support as required. 5. To work collaboratively with GP Practices and support registration of new Service Users from the highlighted groups and ensure people with complex needs are supported flexibly depending on need. 6. Ensure liaison and working with partner agencies to provide an integrated approach to the health and social care needs of MVA and avoid service duplication, including substance misuse services. 7. To reduce did not attend appointments (DNAs) and inappropriate use of mainstream services through education and support by maintaining robust data collection/reporting to support future planning 8. To provide advice and support to mainstream primary and secondary care services to enable them to meet the needs of MVA appropriately and effectively. 9. To provide appropriate ‘bridging’ and support to ensure individuals do not drop out of services. 10. To provide client education regarding the NHS, appointment making, form filling, advocacy, provision of translated information, help with transport to facilitate access to primary care services. 11. To provide signposting and links into networks of support. 12. To ensure strong links and partnership working with other agencies in East and West Suffolk via sharing of information within agreed Information Governance guidelines, regular multi-agency meetings, joint training and joint working. 13. To proactively promote services to appropriate local communities, to include developing links with Suffolk County Council housing support services, particularly those communities with the most complex needs and disengaged behaviour. 14. To provide outreach services for appropriate communities such as the homeless. 15. To provide access to interpreting services including when appropriate face to face interpreting and/or translation services. 16. To develop a communication and engagement strategy for working with different stakeholder groups that includes meaningful participation of individual clients in decision making around their care and major stakeholders in the development, provision and evaluation of services. 17. To include use of drug and alcohol and mental health link workers and healthy lifestyle practitioners (such as stop smoking advisors, physical activity advisors, weight management advisors and health champions in service design and delivery through agreed Memorandums of Understanding with providers. 18. To provide support and build on existing health related work currently being provided by local community and voluntary organisations. 19. To inform I&ESCCG and WSCCG when the service is experiencing difficulties in making referrals to existing services, such as mental health and drug/alcohol services by utilising the Escalation Policy/Protocol - to be developed in consultation with the new service provider. |
| **3. Scope** |
| **3.1 Aims & Objectives of Service**   |  |  | | --- | --- | | **In scope** | **Out of scope** | | Adults (18 and over) as described in Section 1 of this specification, including safeguarding adults and children whose circumstances make them vulnerable and protecting them from avoidable harm. | Children and young people up to the age of 18) as part of separate arrangements. | | Marginalised and vulnerable adults who struggle or have issues engaging with NHS services as outlined in Section 1, by providing effective support, signposting and brief interventions as appropriate and facilitating GP registration for those individuals. | Screening Services; Drug and Alcohol Services | | Urgent prescribing as described in Section 1 of this specification. | Routine prescribing | | Facilitating GP registration of defined groups, working to specific groups as highlighted. | LAC Assessment |   The provider will work with I&ESCCG and WSCCG to address barriers that prevent people from disadvantaged and marginalised groups accessing primary care services, across the east and west of the county, enabling individuals to seamlessly transition over to mainstream services.  Commissioners require that the provider will support a horizontal and vertical integrated approach to delivering the service. This will include:   * Care planning and continuity across community settings and service provider boundaries. * Enabling clients to continue to receive continuity of care even if they lose the address that originally gave access to that care. * Care planning, multiagency working promoting continuity of care * Offering a clear expectation of compassion, communication and continuity between secondary, primary and community care.   **3.2 Service Description / Care Pathway**  The model promotes a service with an integrated pathway with linkage across the system.  The benefits to this approach are to prevent unnecessary accident and emergency attendances and secondary care admissions, prevent inappropriate emergency readmissions and promote onward care and resettlement and improve health outcomes whenever possible.  The provider will need to ensure the service is developmental, working with CCG commissioners, district and borough councils, acute hospitals and primary care, along with other stakeholders, over the lifetime of the contract to regularly review improve and develop the service offered.  The provider will:   * Facilitate integration into primary care services at the earliest appropriate opportunity * Provide / facilitate high quality and safe care * Create a supportive environment for Service Users who are often traumatised and vulnerable * Enable Service Users to develop personal skills to build confidence, knowledge and capability to care for their own health and access services when needed * Support healthy lifestyle behaviour and self-care * Encourage community action to provide networks of care and support for Service Users * Promote equity and fairness and advocate for the needs of this patient group with NHS policy and service developments   **Service Model**   * The service shall only work with specific groups of people as outlined in Section 1. The service shall be of a high quality, giving service users a feeling of worth that they otherwise lack, and enhancing the mutual values regarding dignity and respect * Needs led, the service shall be based on high quality needs and risk assessment led by experienced professionals in specialist fields. * The service shall offer specific interventions and pathways based on detailed individual need which are significantly more likely to be successful than any ‘off the shelf’ intervention. * The service shall work in partnership with hostel drop-ins, as many people placed in Suffolk from other areas do not know where health services are located, and many have mental health problems and place a high burden on mainstream services * Service users perceive that general practice on the whole makes it difficult for clients to register and access medication in the required timescales - the service shall liaise and support access to GPs in Ipswich, East Suffolk and West Suffolk. * The service shall contribute to reducing the number of preventable deaths amongst MVA clients in Suffolk. * The service shall act as a named patient advocate when clients are in crisis and no emergency appointments are available for GP, mental health or substance misuse, keeping clients safe and engaged whilst monitoring wellbeing during the interim period whilst awaiting services to engage with the client. * The service shall share its expertise and experience with other professionals, carers and the public * The service shall offer outreach groups (e.g. women, networking events)   It is essential that the provider remains flexible and responsive to the constant shifting needs of key core groups and provide regular feedback of emerging trends and issues. For example, evidence suggests that many MVA clients have issues with physical and mental wellbeing. This is often related to the poor standards of accommodation and food in some marginalised communities, gaps in provision of support e.g. no recourse to public funds, clients may be able to access health services but may not be able to receive support from other statutory providers (sometimes long term), destitution, periodic detention, lack of continuity of care and barriers to accessing health services.  The provider will recognise the importance of early referral to primary care medical services, mental health and drug and alcohol services and facilitate access to social support networks to minimise social issues. For some clients’ health needs might not manifest themselves until after they have been settled for some time, especially mental health has so this needs to be taken into account when assessing and treatment planning for individuals. Service provision must take into account the very different ways services are accessed by various MVA communities so that the service remains responsive to their needs yet recognises the importance in educating clients to attend and keep appointments.  Where service users have been registered with service providers but fail to engage effectively, they can return to the service for further support.  I&ESCCG and WSCCG have identified a range of services that are required to be delivered. These include:  ***Partnership Board / Multi-Disciplinary Forums***  A key element of this service is collaboration and partnership working with organisations, stakeholders and communities. The provider will be responsive to the needs of MVA clients and adapt services as appropriate. The provider will set up and maintain a partnership board / multi-disciplinary forum(s) that meet regularly and include representation from local organisations and community groups supporting the MVA, the design of which will be co-produced by organisations across the system and reviewed as appropriate throughout the duration of the contract.  ***Assessments & Care Plans***  Each individual accessing the service will have an initial assessment and a care plan developed. Assessments where required should be carried out using an appropriate recognised assessment tool. The assessment should have regard to cultural diversity and should be developed through outreach and community consultations and in conjunction with local community organisations and other stakeholders. Each individual’s care plan should be reviewed and evaluated at each contact throughout the intervention; at the request of the patient or carer, and at team case planning meetings.  Care plans will include:   * The relevance of the plan to needs and circumstances * Progress/outcomes since previous contact (from patient and professional perspective) * Risk Stratification Tool(s) * Any unmet needs, feeding back this detail to the CCGs in order to inform future commissioning * Service will engage with other services through Memorandums of Understanding * Setting short term goals and agreeing expected outcomes * The date/time of the next review   All client / carer information should be translated as necessary for effective communication with the patient / carer; i.e. each client will be given a copy in English and, as appropriate in their own language, Easy Read or other appropriate format. Health information materials will also be provided in a translated format as appropriate.  **3.3 Urgent & Immediate Clinical Care to the Homeless**  Homeless people are less likely to be registered with a GP than the general population and have lifestyles which make it difficult for them to make and keep appointments and to access GP healthcare during surgery hours. They are also more likely to experience complex multiple health and social issues.  Those individuals identified as homeless will be offered brief interventions to address their current health needs as well as identification of any chronic conditions. They will be referred to appropriate services to meet any immediate physical or mental health needs. Individuals will be supported to register with a GP practice within an agreed timescale. For practices using SystmOne as their clinical system, the service will agree to share records where appropriate. A treatment summary report will be provided for those practices not linked to SystmOne.  The service will act as the interface between GP practices and the individuals so that any issues identified from either can be addressed at the earliest opportunity. The service will follow up on homeless clients registered with a GP to ensure they access regular healthcare where appropriate.  **The following core clinical interventions should be provided to clients not registered with Primary Care and for a time limited period only**. However, this list is not exhaustive and individuals may present with other long term conditions that may require clinical interventions. The costs for clinical interventions will be met by the provider.   1. Wound care - the service will provide regular wound care and dressing services 2. Respiratory service - the service will support individuals with respiratory problems 3. Drug & alcohol treatment - the service will refer individuals to Turning Point specialist services 4. Mental health - the service will refer individuals to Mental Health or the Suffolk Wellbeing Primary Mental Health Service 5. Health promotion - the service will undertake health promotion work on an opportunistic and individual basis and refer individuals to the Healthy Lifestyle Service for interventions. All staff will attend Making Every Contact Count training 6. Service users are entitled to a flu vaccination if they fall into one of the categories as outlined in the link below – usually carried out by the GP practice where the individual has been registered: <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/529954/Annual_flu_letter_2016_2017.pdf> 7. Hepatitis A, Hepatitis B and MMR vaccination shall be provided by the Service and charged to Public Health England - please see link below for details regarding who should be vaccinated with these: <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book#the-green-book>   **3.4 Urgent & Immediate Care for other Marginalised & Vulnerable Adults**  It is anticipated that individuals from the highlighted disadvantaged and marginalised communities will mostly require advocacy, support and guidance to go to other appropriate support organisations. However, should a client require any of the core brief clinical interventions, these should be offered on a greatest needs basis only. Individuals from these communities shall be educated about healthcare services available, what is provided within each service and how to access services appropriately. Individuals not already registered with a GP practice will be supported to do so and as with the homeless, the service will act as the interface between the GP practice and the individual to provide support where issues are identified.  Immediate clinical care will only be provided where absolutely necessary and where there is a significant risk that the individual will not attend an appointment with a GP practice, and therefore their immediate health is likely to suffer as a result. Where urgent and immediate clinical interventions are provided the service will facilitate booking of an appointment with the GP practice and provide a treatment summary for those practices not linked to SystmOne.  **3.5 Outreach**   * The service will provide outreach clinics to the groups identified in Section 1 of this specification across East and West Suffolk according to the identified need. * Access - the service should facilitate access to mainstream healthcare services in a timely manner. A care plan will be developed for individuals accessing the service which will include a timescale for GP registration. Where possible, and taking into consideration patient preference of GP practice, registration of individuals should be spread amongst practices. This will ensure in the long term that all practices develop skills and expertise in supporting the long term health and social needs of MVA clients. The service will support the homeless in particular to make the transfer to primary medical care services so they are able to access long term care and be less reliant on immediate and urgent care provided by the service. * Advocacy and Support - Individuals from marginalised communities may face social issues which impact on their physical health and wellbeing. The service will provide advocacy support and signposting to appropriate organisations that will support individuals in this situation. The service will advocate on behalf of individuals where barriers to accessing healthcare services are experienced. The service will work collaboratively with GP Practices around registration of new Service Users and ensure people with complex needs are supported flexibly depending on need (including attending MDT meetings). * The service will be required to develop close working relationships with partner, third sector and voluntary organisations so that individuals can be referred and then followed up where issues continue to be raised.   **3.6 Community Engagement**  An annual engagement plan will be developed by the service and agreed by I&ESCCG and WSCCG. The plan will have particular regard to:   * Plans to promote the service * Examples of how it will engage with, for example, the Gypsy and Traveller communities housed, roadside and caravan communities * How it plans to link with partner organisations and feedback on the engagement work already undertaken to promote joint working and avoid duplication * Provide plans of training to be delivered and how this will be promoted   **3.7 Collaborative Working with Partner Organisations**  Commissioners expect that the provider will work with linked services to ensure that they work effectively and collaboratively with partner organisations to optimise service delivery and avoid service duplication. They will also be expected to work with all other health care staff so that integration is enhanced and reducing the ‘silo’ delivery of health care. Collaborative working with partner organisations means directly engaging with leading community organisations to assess and meet the diverse and culture specific health needs and requirements.  **Unaccompanied Asylum Seekers**  The Service will become involved in providing the initial medical assessment of unaccompanied minors when funding outside of this contract is agreed. For example, the service shall provide up to date lists of Syrian refugees that arrive in Suffolk; the CCGs will subsequently complete claims for appropriate funding (currently a total of £600) and return to the Home Office, listing each individual. The service shall then invoice the CCG per person at a cost of £300; the respective GP surgery invoice the CCG £300 per person.  **a)** **Training** - a limited resource within the existing service, commissioners expect the service to explore if this could be developed to bring in additional funding. Ongoing training will be provided to primary care staff that will educate and support them in managing the ongoing care of marginalised and vulnerable adults.  **b)** **Mental Health Services** - the MVA service will offer identification and assessment of tier 1 levels services and then signpost to Mental Health or the CCG Primary Mental Health Services along with the provision of good quality information and signposting.  The service will work jointly with organisations providing drug and alcohol and mental health services in Suffolk to facilitate integration for marginalised individuals into mainstream services and develop appropriate pathways to ensure marginalised individuals do not fall through the net of existing services.  The service will work with partners to break down barriers to accessing mental health services and advocate for the individual. This will include escalating access issues to I&ESCCG and WSCCG via the Escalation Policy/Protocol, to be developed in consultation with new service provider.  **c)** **Counselling service** - the MVA service will make referrals to Primary Care Mental Health Services and support the transition to current caseload of Service Users receiving PTSD counselling. This service should be phased out within the first year.  **d) Drug and alcohol services** - the service will make referrals to Turning Point and work effectively and collaboratively.  The service will work to break down barriers to accessing Drug and Alcohol Services and advocate for the individual establishing. This will include escalating access issues to I&ESCCG and WSCCG via the Escalation Policy/Protocol, to be developed in consultation with new service provider.  **e) Interpreting services & translated materials** - the service will ensure clients have access to high quality interpreting services (either over the phone or face to face when necessary) wherever appropriate.  **f) Prescribing** - this will be a limited service to only to the most vulnerable individuals, and will be clearly monitored on an ongoing basis. The service shall also work with other agencies to ensure service users have access to prescribing as clinically appropriate.  **g) Screening** - generally, the MVA service will only signpost to these resources.  **h) Patient Special Allocation Scheme** - the MVA service should continue to provide a secure base as part of the Suffolk Special Allocation Scheme. Currently Two Rivers in Ipswich area is commissioned by NHS England to provide a scheme for aggressive, intimidating and violent Service Users, and are running the scheme with the support from the MVA service.  **3.8 Population Covered**  The service is available to adults 18+ living in Ipswich, East Suffolk and West Suffolk areas where it is the most appropriate to meet needs. The service is available regardless of sexual orientation, race, or gender. The service shall ensure that it is accessible and appropriately responsive to people with Learning Disabilities. When required the service shall work with local Learning Disability Services (including Home Treatment Teams).  Staff in the Service should attend mandatory training on equality and diversity. The Service provider is required to ensure that the facilities provided offer appropriate disabled access for Service Users, family and carers. When required the providers will use translators and printed information available in multiple languages including Easy Read. The provider has a duty to co-operate with the commissioner in undertaking Equality Impact Assessments as a requirement of race, gender, sexual orientation, religion and disability equality legislation.  **3.9 Interdependence with other Services / Providers**  A multi-agency approach is essential – please see Section 3.7. The service provider shall work on building relationships with all stakeholders. Commissioners expect the provider to fully engage with the system and continue to do so throughout the duration of the contract.  **3.10 Referral Route, Criteria & Sources**  **3.11 Information Sharing & Consent**  Service information covering key areas of service provision will be recorded at patient level and shared with commissioners via their data warehouse on a monthly basis. These at minimum must include but are not limited to:   * Source of referral * Referral destination * Relevant referral / contact / event dates * Service user / patient details   The data requirements will be refined further and agreed with the service provider in keeping with service evaluation requirements.  **3.12 Response Times & Hours of Operation**  The Hours of Operation are 09.00-17.00 Monday to Friday. It is anticipated that at times there will be a requirement to be flexible, with service provision required at weekends and at least two evenings per week.  **3.13 Safeguarding / Mental Capacity**  The Service shall:   * Maintain awareness of safeguarding risks and referral processes, contact points and resources * Uphold and champion the rights of service users * Recognise and know how to appropriately report safeguarding concerns and follow up as necessary |
| **4. Applicable Service Standards** |
| **4.1 Applicable national standards (e.g. NICE)**  Standards for commissioners and service providers The Faculty for Homeless and Inclusion Health.  The Provider must adhere to all relevant NICE guidance.  **4.2 Applicable standards set out in Guidance and/or issued by a competent body**  **4.3 Applicable local standards** |
| **5. Applicable quality requirements and CQUIN goals** |
| * 1. **Applicable Quality Requirements (See Schedule 4A-D)**   This should include any cross reference with the Quality Schedule.   * 1. **Applicable CQUIN goals (See Schedule 4E)**   N/A |
| **6. Location of Provider Premises** |
| The Provider’s Premises will be located in Suffolk, in order to best serve the needs of the population of Ipswich & East Suffolk and West Suffolk CCGs. |
| **7. Individual Service User Placement** |
| N/A |