SERVICE SPECIFICATION	
Service	Mental Health Residential Care and Rehabilitation (Hawkesbury Lodge)
Commissioner Lead	Coventry and Warwickshire Partnership NHS Trust
Provider Lead	
Period	1 October 2026 to 30 September 2029
Date of Review	

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1. Background

1.1. Introduction

Following the successful application of a capital bid to NHS England, Coventry and Warwickshire Partnership NHS Trust (CWPT) is repurposing one of its rehabilitation inpatient units (Hawkesbury Lodge) to a 14 bedded specialist Mental Health Residential Care and Rehabilitation setting for males and females.

The Trust is aiming for the repurposed Hawkesbury Lodge to provide a recovery focussed, person-centred, proactive and engaging model of residential rehabilitation care and support. This will include group and one-to-one activity focussed upon supporting self-management, recovery and maintenance of improved clinical and social outcomes. It will also involve greater/ enhanced participation in activities of daily living to support transition to supported accommodation/ independent living/ access to own tenancy etc.

The new service model introduces enhanced/ intensive step-down care, bridging the gap between hospital settings and standard step-down provision. The service will target:

- People in locked or high-dependency rehabilitation with no clear discharge pathway
- People requiring an alternative to hospital rehab admission i.e. step-up provision from community settings.
- People deemed 'Clinically Ready for Discharge' in acute settings awaiting inpatient rehabilitation due to complex needs exceeding the current step-down offer.

To address this, the Trust is looking to develop a partnership with a VCFSE / third sector organisation, specialising in clinical and other appropriate interventions for individuals with complex mental health needs to provide a stepped care approach and community rehabilitation. This would be to provide 24/7 enhanced community support by working with care teams to develop personalised plans that help people understand their condition, manage their health, and build skills for independent living. Addressing these needs will improve people's clinical and social outcomes, accelerate recovery, and free up resources for reinvestment in less restrictive settings.

2. Context

2.1. National policy context

This new service will support the delivery of key national policy priorities to ensure care is high quality, least restrictive and delivered close to home, whilst supporting the broader agenda of transitioning towards community-based service delivery, which promotes integration and accessible care.

It builds on expectations set out in key national policy documents including:

- NHS Long-term Plan (2019)
- Commissioning framework for mental health inpatient services (2024)
- Commissioner guidance for adult mental health rehabilitation inpatient services (2024)
- Culture of care standards for mental health inpatient services (2024)
- The 10 Year Health Plan for England and specifically the Hospital to Community shift.

In particular, it supports the delivery of the following policy objectives which are reiterated in the 2025/26 NHS planning guidance and the NHS England Medium-Term Planning Framework:

- End reliance on out of area placements, by providing a service which can support people with complex needs close to their homes and communities.
- Support the delivery of therapeutic, least restrictive models of inpatient care, which aim to promote independent living and harness the potential of people and communities, both supporting positive outcomes for individuals and improving NHS value for money.
- Improve patient flow through mental health acute pathways by ensuring people do not get stuck in acute inpatient settings when this is no longer clinically effective.

2.2. Local Context

Within Coventry and Warwickshire, there is a gap in the interface between acute and complex care, where patients with these needs can become stuck in the system, often in an inpatient bed which is no longer supporting their recovery. These individuals may not be well enough to live fully independently or transition to high-cost placements or use the broader step-down offer, but do not need traditional inpatient care settings.

With the right offer, we hope to ensure that people can be in the most appropriate, independence- and recovery-oriented settings for their changing needs as quickly as possible, improving flow across the system so that the right types of service capacity are available when they are required.

2.3. Vision

Presently the step from inpatient care to community is too big for some individuals to succeed when discharged. We need to fill this gap by creating a service which:

- Provides in-reach to the person whilst still in hospital to build a therapeutic relationship and reduce the reliance on the current inpatient staff.
- Continues a model of rehabilitation and continues to build on the person's independence as many will have become institutionalised after spending so long in hospital, and looks to move people towards more independent living.
- Allows for an overall integrated model with CWPT services so there is joint working and the opportunity to step services up and down for people as required, ensuring the therapeutic relationship and package of care is maintained at a time of crisis reducing the likelihood of placement breakdown.

Our overall ambitions are to:

- Develop and deliver an inpatient and community rehabilitation care pathway for people with:
    - Psychosis / severe and enduring mental illness
    - Complex Emotional Needs (in keeping with the NHSE Rehabilitation Guidance regarding 'all is all' (fitting well with the patient cohorts that we currently have placed out of area).

Please note that care must be inclusive of co-existing needs, and needs-led in line with the best available evidence.

- Enhance our Community Enablement and Recovery Team to:
    - provide community mental health rehabilitation services in line with the new national guidance
    - deliver therapeutic interventions to support and sustain recovery and enhance / improve life skills
    - reduce relapse and minimise the chance of admission / readmissions for the people resident in the service, people accessing day support (and those on the Community Enablement and Recovery Team caseload/s)

- Re-purpose Hawkesbury Lodge to create suitable accommodation for 14 patients, a therapeutic environment/ setting and facility for provision of specialist day support (i.e. this specification).

3. Scope

3.1. Service Aims

The aims of the service are to improve the mental health and / or prevent the mental ill health of adults through a specialist mental health residential rehabilitation service that will:

- Provide an alternative to restrictive inpatient and community placements and care packages
- Facilitate the transfer of people from hospital and / or residential placements back into the community settings
- Facilitate those leaving a hospital or other low secure settings and who require care and support and a bespoke mental health rehabilitation residential placement
- Provide a flexible and individualised time-limited rehabilitation service for a minimum of 3 months and maximum of 18 months for rehabilitation beds and for 3 months to a maximum of 6 months for step-down beds from local inpatient provision.

The service will provide people with a proactive, time-limited and intensive rehabilitation programme. The programme will be flexible, person-centred and ultimately promote recovery, and it should enable the individual to reintegrate into the community following move on from the residential service to (for example):

- access and maintain supported housing accommodation with their own tenancy
- access and maintain their own tenancy in general needs or specialist supported housing / housing
- facilitate move on to the person's own home / family home or other appropriate accommodation.

The service will provide an individualised package of support that will enable the person to return to independent living in the community, particularly following circumstances where the individual may have been detained in hospital or had a history of previous failed tenancies or residential care placements because of their mental ill health. The service will develop methods of support that will reflect the language, cultural and spiritual aspects of the individual, recognising those as potentially key dynamics in the recovery process.

People will have an individual care plan which will be based on their identified needs, interests and aspirations and which will be subject to regular review. The service should be delivered with a 'person-centred' and holistic approach, therefore ensuring that support is designed around the individuals' needs and have a robust assessment and review procedure.

3.2. Service Description / Pathway

The service will be provided to adults of working age who may require care support and treatment regarding / in relation to:

- Mental illness / SMI (Severe / Serious Mental Illness)
- Neurodevelopmental conditions/s
- Complex Emotional Needs
- Rehabilitation care treatment and support to gain independence, prevent relapse and progress recovery journey
- Step up from community / step down from hospital
- Repatriation / transfer from out of area / in area placements / packages of care

- Support to break cycle of frequent / lengthy mental health related admissions including and especially patients currently placed in out of area 'rehabilitation' hospital placements
- Prevent entry / re-entry / discharge / release from criminal justice system/ health and justice services
- Alcohol and substance use
- Dual diagnoses/ multiple vulnerabilities
- Community placement breakdowns
- Requirement for 24/7 specialist mental health support via an MDT approach to progress recovery journey.

Care will be inclusive and needs-led paying attention to the implications of providing high-quality, personalised care to people with multiple diagnoses and co-existing needs including complex social issues.

This service will provide 14 people (at any one time) step-down accommodation from hospital environments. Of the 14 bedrooms, two will be assisted rooms for people with physical complexities such as mobility issues or bariatric care requirements.

Supplementing the residential provision will be a recovery and relapse prevention focused day service (which we are calling a Care Hub), delivering support and intervention for residents and a small number of community outpatients daily (up to 8 patients maximum daily). This will offer a wide range of psycho-social interventions that form part of the rehabilitation model including:

- one to one and group interventions focused on mental health recovery and ADL skill development
- self-efficacy and independent and community living
- personal goal setting
- family interventions
- managing mental health symptoms e.g. anxiety, depression, hearing voices
- medicines optimisation
- emotional regulation
- employment, leisure, social activities, education
- housing and welfare rights/ wider determinants of mental health
- delivering physical activity/ supporting people to participate in physical activity and exercise.

The day service (Care Hub) will be an integrated service delivered jointly by the Provider and CWPT. The details of the partnership working are not overly prescribed here as it will partly depend on the provider's experience in this area and we anticipate it will take time to evolve. But we also want to allow the provider scope to help shape the joint working arrangements, within the first 12 months of service delivery. Further detail will be provided at the final stage of the tender.

Within the Care Hub will be a base for the Trust's Community Enablement and Recovery Team (CERT) to facilitate the above activities and deliver the integrated model in partnership with the VCSE/ Third Sector organisation.

<u>Key Service Principles:</u>

- To promote physical and mental wellbeing in a safe and supportive manner via MHLDA rehabilitation focused interventions delivered by a range of professionals including nursing, OT, psychiatry, psychology, social work, HCAs, recovery workers, peer support and experts by experience.

- To link into and foster opportunities within mainstream mental and physical health services
- To develop service user involvement and encourage participation
- To deliver empowerment as part of a coordinated spectrum of community and statutory based provision
- To provide a strengths-based and personalised approach to risk assessment, risk management, assessment and care & support planning
- To be safe, confidential and non–stigmatising and prevent othering
- To deliver a holistic approach to health and wellbeing including physical health
- To be accessible and inclusive, autism and neurodiversity friendly, equalities focused, trauma informed, culturally competent and least restrictive
- Offer value for money, optimising resources while delivering high-quality care
- Work collaboratively with clinical teams, ensuring integrated, high-standard care
- Adopt a flexible, creative, and innovative approach to meet individual needs
- Promote social inclusion, supporting individuals to engage with their communities
- Enhance physical and mental well-being, working closely with service users and their support networks
- Contribute to building a sustainable community, fostering long-term stability and engagement.

3.3. Provider Responsibilities and Deliverables

Within the *financial contract value, the Service provider is expected to:

- Apply for CQC registration (for residential accommodation with nursing setting) and take on all related responsibilities, including the provision of a registered manager
- Provide a 24/7 staffed residential setting 365 days per year
- Complete an initial care plan for each service user prior to entering / accessing the service and a detailed co-produced personalised care plan for each service user within two weeks of their admission date
- Ensure a written Welcome Pack concerning its services is given to residents, families and carers no later than the first contact.
- Reduce dependency on services and enable people to develop skills to live independently, such as daily living skills and medicine management.
- Encourage people to access employment, training and education, leisure and social activities to facilitate inclusion.
- Encourage and support people to maintain and develop family connections and bonds and friendships and friendship groups
- Provide a safe environment where individual service users can live and thrive without risk of exploitation or victimisation
- Deliver Care Hub services during standard business hours, Monday to Friday, 9am to 5pm, in partnership with the CERT
- Offer a range of stimulating and therapeutic activities with rehabilitation focus some of which delivered in partnership via the Care Hub with CERT
- In conjunction with the CERT and other health, social care housing and VCSE support agencies, work with the service user to develop personalised support plans that will facilitate smooth transfer into supported housing
- Deliver evidence-based risk assessments, holistic assessment, and collaborative and personalised care
- Improve life chances and opportunities via access to safe, sound and supportive holistic person-centred, evidence-based care and goal-setting to optimise recovery and independence
- Improve quality of life for residents and their carers

- Work in line with key national commissioning and clinical guidance and quality standards enabling service users to become independent, improve their wellbeing and ultimately to manage their own mental health and contribute to their own care package
- Focus on enabling individuals to develop 'life and employability' skills appropriate to their level which is identified through assessment and review
- Ensure service users can access a range of services that meet their needs, in line with the principles of independence, choice and control and the concepts of personalisation
- Develop the resident's capacity to live independently following the completion of a time-limited programme of support using specific personalised goals and outcomes
- Provide access to a range of additional opportunities for individual residents which may include advice and guidance in housing options, access to training, employment opportunities, welfare rights advice, employment and education support to meet the needs of the resident
- Deliver interventions that promote 'self-help' and wellbeing in group or one-to-one settings, signposting to self-help groups and computerised self-help packages
- Make appropriate other use of digital interventions and innovations to support improved clinical and social outcomes for residents
- Hold responsibility for the Medicines Management of residents (see specific section for further detail)
- Follow best practice for carers involvement and support such as the Carers Trust Triangle of Care.

*The indicative annual contract value is £810k (which excludes the lease cost as this will be a passthrough).

3.3.1. Service Provider Requirements

The provider must:

- Have a proven track record in delivering community-based, clinically-led and recovery-oriented services for individuals with complex care and/or forensic needs. This may include people with co-occurring substance use issues, neurodiverse needs etc.
- Demonstrate experience in managing alternative bed models within the community.
- Have the capacity and capability to deliver 24-hour supported living services.
- Have a track record of working effectively in partnership with NHS clinical teams to deliver integrated care aligned with core NHS values.
- Demonstrate a clear understanding of and track record of delivering biopsychosocial care and social models of mental health care including strengths-, rights- and asset-based approaches.
- Comply with key NHS governance frameworks around quality of care and safety of service users and carers.
- Ensure the provision of appropriately trained and experienced staff for supporting individuals with high-risk and complex mental health needs in a safe but also the least restrictive manner.
- Comply with all relevant legal, regulatory, and safeguarding requirements.

3.3.2. Hours of Cover & Core Service Requirements

The provider must deliver a 24-hour residential service, including waking night specialist staff cover. The service must be safely and appropriately staffed 365 days a year, including bank holidays.

The Care Hub will operate during standard business hours, Monday to Friday, 9am to 5pm, providing a consistent and predictable structure for its therapeutic programme.

3.3.3. Referral Pathway

Referrals to the residential unit will be made via the Trust's Community Enablement Team. The Service Provider will arrange an 'Initial Assessment' appointment within 2 weeks of referral date where all required parties can attend, such as the Care Coordinator or Carer. This assessment should identify the key outcomes that can be achieved through a rehabilitation placement and whether the individual will be accepted.

3.3.4. Population Covered

The service will support the GP registered population of the NHS Coventry and Warwickshire Integrated Care Board catchment area including patients placed in hospital and community placements outside the Coventry and Warwickshire footprint where there is a Section 117 requirement for care, support and commissioning entitlement for the ICB and/ or Coventry and Warwickshire Local Authorities (Coventry City Council and Warwickshire County Council).

3.3.5. Medicines Management

Where individuals require assistance with their medication regime, the Provider shall offer a tiered approach—ranging from prompting and supervision to advocacy and coordination with health professionals—based on assessed need. Support may include prompting for oral medication, assisting with collections, attending reviews, and promoting understanding of prescribed treatments. A personalised medication support plan must be agreed with each Service User and reviewed regularly in partnership with relevant professionals. The provider must ensure staff are trained, competent, and administer and dispense medication as required.

In addition the Service Provider is expected to:

- Have local arrangements to establish and evidence competence for these activities, including training, assessment, supervision, and review processes, specific to the service setting
- Ensure that clear arrangements are in place for the accurate, timely, and auditable recording of medicines assistance, prompting, or observation, in line with local medicines policy and legal requirements
- Be able to demonstrate compliance with these requirements as part of contract monitoring and quality assurance processes.

Where the Service Provider permits staff other than registered nurses to assist, prompt, or observe the use of medicines, appropriate systems must be in place to assess, authorise, and maintain staff competence.

3.3.6. Staff Competency, Training and Supervision

The Service Provider must ensure all staff are appropriately trained, supervised, and supported to deliver safe, high-quality, person-centred care. This includes a robust induction programme, regular reflective supervision, and access to ongoing professional development. The Provider must ensure that competency assessments, supervision, and appraisals are in place and regularly reviewed. Staff conduct must align with the

progressive values of the service as set out within this specification, with clear and proportionate procedures in place to manage any concerns.

3.3.7. Access to Clinical Records – Data Protection and Information Governance

Where access to clinical or electronic patient records is required, the Provider must ensure that only appropriately trained and authorised staff are granted access, in line with NHS Information Governance (IG) best practice and General Data Protection Regulation (GDPR). Key members of the Provider's team will be supported to interface with relevant clinical systems, with access protocols and responsibilities clearly defined. The Provider must ensure the confidentiality, accuracy, and security of patient information at all times. A data protection impact assessment (DPIA) must be completed for any processing of personal data that is likely to result in a high risk to individuals' interests, rights and freedoms. Should this apply to the activities of this service, a DPIA must be completed in liaison with the Information Governance team in CWPT.

3.3.8. Safeguarding and Managing Risks

The Service Provider is required to maintain robust, up-to-date policies and procedures for identifying, assessing, and managing safety and safeguarding risks in line with CWPT protocols. Risk Assessments and Crisis Plans must be person-centred, evidence-informed, and developed collaboratively with the resident and multidisciplinary team. The Provider is responsible for ensuring these are completed and must proactively engage relevant multi-agency partners to manage shared risks effectively, where necessary. In situations of immediate or severe risk, referrals to emergency and crisis services must be made without delay.

3.3.9. Service Monitoring and Key Performance Indicators

The Service Provider will be required to produce regular performance reports against a set of pre-agreed Key Performance Indicators (KPIs). Outcome Measures and KPIs will be developed in conjunction with the provider and will focus on clinical and social outcomes, , and experience. The Service Provider will be expected to use validated outcome measurement tools and flow appropriate data into local and national datasets. As a minimum we expect these to include:

- Patient Reported Outcome Measures (PROMs)
- Clinician Reported Outcome Measures (CROMs)
- Patient Reported Experience Measures (PREMs)
- Length of stay
- Number of people supported into successful community placements and how long this has taken
- Individual Recovery Outcomes Counter (IROC) scores
- Resident, carer and family feedback, including narrative feedback
- Number of people referred to inpatients, crisis team
- Admission and readmission rates into bedded care

In addition, the Provider will be expected to report on safety/ safeguarding incidents, serious incidents, complaints and use of restrictive interventions.

The Provider will also work collaboratively with relevant teams within the Trust to assess the service's impact on system flow, particularly in relation to rehabilitation and acute mental health pathways.

3.3.10. Quality Assurance Requirements

The provider must implement a robust quality assurance framework that ensures the delivery of safe, effective, and person-centred services. This framework must include:

- Regular internal audits and service reviews to monitor performance, identify risks, and drive improvements.
- Structured service user feedback mechanisms, enabling routine collection and integration of user experiences to inform service delivery.
- Monitoring and promotion of staff wellbeing, including proactive strategies to prevent burnout and support workforce resilience.
- A clear commitment to co-production and continuous improvement, including the meaningful involvement of service users and carers in service design, evaluation panels, and feedback forums.

4. Building and Property Management

CWPT has secured capital funding from NHSE to re-purpose Hawkesbury Lodge into a 14 bedded specialist Mental Health Residential Care and Rehabilitation setting for males and females. The refurbishment work commenced in January 2026 and is anticipated to finish in April 2026. A floor plan is provided as part of the suite of tender documentation and shows what the building will look like once the work is complete. Below is a summary of the work which is taking place:

- Design features aim to be in keeping with the service model i.e. distinct day provision area and residential whilst encouraging integration
- Aiming for ‘hotel-like’ feel to align with transitional stay
- Anti-ligature furniture and fittings will be provided, which will not be the same as hospital inpatient standard in order to maximise the sense of an independence-enabling environment
- Single main entrance with specific internal to the residential area
- 2 x downstairs bedrooms with disabled access
- Re-fit to the three downstairs kitchen, installing heavy duty fittings
- Central base for the community enablement and recovery team
- 12 upstairs bedrooms, M/F segregation (as with downstairs)
- Re-decoration of all rooms, new vinyl flooring, curtains and furniture throughout
- Existing bedroom doors to be renovated to provide individual look
- Sanitaryware in en-suites to be replaced with new standard sanitaryware to conceal pipework
- Workstream to be established to involve staff and experts with experience re colour schemes, naming of areas and signage.

The Service Provider will be required to enter into a lease of the premises. The details of that lease are not included as part of the first stage of the procurement process as we are seeking feedback from bidders on the lease terms. That detail will be made available as part of the second stage. CWPT is intending for the cost of the lease to be a passthrough and therefore not form part of the contract value.