Reference: FOI.ICB-2627/061

Subject: Open Rehabilitation and Step-Down Provision

I can confirm that the ICB does hold some of the information requested; please see responses below:

QUESTION	RESPONSE
1. Current Demand and Placement Need a. Does your organisation currently commission or utilise open rehabilitation or step-down rehabilitation services from independent providers? b. Approximately how many individuals are currently placed within open rehabilitation or community rehabilitation settings? c. What are the most common presenting needs requiring this type of placement?	a. BNSSG ICB commissions open rehabilitation inpatient units from our commissioned mental health provider, Avon and Wiltshire Mental Health Partnership (AWP) NHS Trust. AWP can be contacted directly here: awp.freedomofinformation@nhs.net There is not a recognised form of service provision that is known as "step-down rehabilitation services" and as such the ICB cannot answer this question. Whether or not a placement would be considered "step-down" depends on the history of the individual when set against the type of placement that is proposed for them. For example, a level 2 rehab admission would be a "step-down" placement for an individual coming from a secure ward, but not for an individual coming from an acute ward. b. BNSSG ICB commissions Open Rehab wards from AWP via a block contract. AWP hold the information regarding numbers of individuals. There is not a recognised form of service provision known as "community rehabilitation" and therefore the ICB cannot answer this element of the question. Whether or not a placement would be considered to be rehabilitation focussed

	would be dependent on the presentation of each individual. For example, depending on the nature of an individual's illness, an identical placement in a residential care home could constitute a rehabilitation focussed placement for one individual but not for another. c. The ICB does not have sight of the individuals accessing open rehabilitation inpatient units, this question would need to be posed to AWP, please see contact details above. In terms of "Community Rehabilitation", this is not a recognised type of placement and therefore the ICB cannot answer this question.
2. Hospital Discharge and Delayed Transfer Pressures a. Approximately how many individuals are currently experiencing delayed discharge from: i. Acute mental health wards ii. Rehabilitation wards iii. PICU or low secure settings iv. Specialist autism or learning disability services b. What are the most common barriers to discharge?	a. i. There were 16 BNSSG patients with Delayed Transfer of Care from Acute mental health wards ii. There is one current delayed discharge from an ICB commissioned level 2 rehabilitation ward. AWP would need to be asked about delayed discharges from their Open rehab wards. Please see contact details above. iii. There were zero BNSSG patients with Delayed Transfer of Care on PICU wards iv. The number of patients is less than 10; therefore, they have not been included as this could potentially make them identifiable. b. The most common barrier to discharge from level 2 rehab wards is the treatment resistant nature of the illnesses from those currently utilizing these wards. The risks posed to themselves or others due to their illnesses typically cannot be safely managed in the community.

	Other barriers include: • Ministry of Justice (MoJ) delays related to the section they are delayed under • Local Authority brokerage searches for appropriate provision AWP would need to be contacted directly about delayed discharges from Acute mental health wards, open rehab and PICU (Psychiatric Intensive Care Unit).
3. Out-of-Area Placements a. Does your organisation currently place individuals outside of its local area for rehabilitation or step-down support? If yes: i. Approximately what proportion of placements are out-of-area? ii. What are the primary reasons for out-of-area placements? iii. Is reducing out-of-area placements a current strategic objective?	a. BNSSG ICB currently commissions out of area placements in level 2 inpatient rehabilitation units. Individuals requiring support in Open Rehabilitation Units are supported in area through AWP. For community placements, there is no recognised form of service provision that is known as “step down” or “rehabilitation” support and therefore the ICB cannot answer this question. Whether or not a placement would be considered a rehabilitation focussed placement would be dependent on the presentation of each individual. i. There are no level 2 rehabilitation units in the geographical area covered by BNSSG. As such, 100% of placements are out of area. All Open Rehab units are in area, so 9% of placements are out of area ii. That there is no level 2 rehabilitation provision in area iii. Yes, BNSSG ICB has radically reduced its use of these out of area placements
4. Service User Cohorts	a. Individuals with LD/A (Learning Disability & Autism) and MH conditions and with forensic histories. There is no form of recognised provision that is known as “community rehabilitation”. In terms of community placements, in general, individuals most

a. What service user groups are currently most difficult to place within community rehabilitation settings? b. Are there identified gaps in provision for individuals with: • Autism • Learning disabilities • Dual diagnosis • Personality disorder • Complex trauma • Forensic histories • Behaviour that challenges	difficult to place are those with multiple diagnoses. For example, individuals with a learning disability, autism, who also have a mental health diagnosis. b. There are no identified gaps for the listed cohorts. The gaps in provision relate to individuals with highly complex needs, that often relate to their having multiple diagnoses.
5. Current Provider Market and Sufficiency a. Does your organisation currently identify a shortage of rehabilitation or step-down placements? b. Are there specific rehabilitation models or service types currently required but limited in availability? c. Does your organisation have a current rehabilitation, mental health, or accommodation sufficiency strategy? If so, please provide a copy or link where available.	a. There is not a recognised form of service provision that is known as “step-down rehabilitation services” and as such the ICB cannot answer this question. Whether or not a placement would be considered “step-down” depends on the history of the individual when set against the type of placement that is proposed for them. For example, a level 2 rehab admission would be a “step-down” placement for an individual coming from a secure ward, but not for an individual coming from an acute ward. b. Please contact AWP directly for this information, see details above. c. BNSSG has a mental health strategy which can be accessed here Bristol, North Somerset and South Gloucestershire

	Integrated Care System All Age Mental Health and Wellbeing Strategy 2024-Bristol, North Somerset and South Gloucestershire Integrated Care System All Age Mental Health and Wellbeing Strategy 2024-2029Bristol, North Somerset and South Gloucestershire Integrated Care System All Age Mental Health and Wellbeing Strategy 2024-2029Bristol, North Somerset and South Gloucestershire Integrated Care System All Age Mental Health and Wellbeing Strategy 2024-2029Bristol, North Somerset and South Gloucestershire Integrated Care Bristol, North Somerset and South Gloucestershire Integrated Care SystemBristol, North Somerset and South Gloucestershire Integrated Care System BNSSG also has a Population Health and Strategic Commissioning Plan 2026 to 2031which contains a section on current priorities areas within mental health services. Population Health and Strategic Commissioning Plan for 2026 – 2031
6. Placement Models and Support Levels a. What support levels are most commonly commissioned? • 24-hour staffed rehabilitation • Waking-night support • Positive Behaviour Support models • Transitional or move-on support	In terms of the rehabilitation inpatient wards, all are staffed 24 hours per day with waking night support. a. In terms of community placements, the list provided for this question refers to possible characteristics of individual placements rather than types of service provision. So, a placement could include all of the characteristics included on this list. 24 hour staffing and waking night provision are rare in the community. Positive Behaviour Support Models are typically used for placements whereby the individual has a learning disability and or autism and as such also represent a small minority of

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<td>b. What are the most common referral pathways into these services?</td>
<td>placements, as the mental health cohort is much larger. A much higher proportion of cases would involve an element of transitional or move on support.
b. For inpatient placement referral would be from AWP. For community placements referral would usually be from the relevant Local Authority.</td>
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<td>7. Spend and Commissioning
a. What was the approximate total spend on independent rehabilitation or step-down placements in the last financial year?
b. How are such services typically commissioned?
• Framework agreements
• Spot purchasing
• Approved provider lists
• Block contracts</td>
<td>These services are typically commissioned on a spot purchase basis, depending on the service user need. However, other commissioning arrangements may also be considered due to the limited number of providers available for such specialised services.

The total spend for Section 3 placements in 2025/26 was £5.5 million split between LD and MH as below:

<table>
<tr><th>Total 25/26 Actual Spend</th><th>£000s</th></tr>
<tr><td>S3 - LD Placements</td><td>£2,446</td></tr>
<tr><td>S3 - MH Placements</td><td>£3,021</td></tr>
<tr><td></td><td>£5,467</td></tr>
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<td>8. Quality and Outcomes
a. What are the most important factors considered when sourcing rehabilitation placements?
b. What outcomes are considered most important when evaluating placement success?
c. What are the most common reasons for placement breakdown?</td>
<td>The ICB commission as a hospital inpatient stay not specifically as rehab. The inpatient journey in a private LD/A hospital includes assessment and treatment of which rehab would be part of that.

There is not a recognised form of provision that is known as “rehabilitation” in the community. It is a characteristic of some individual placements, depending on the presentation of the person.

In terms of inpatient placements in level 2 rehabilitation:</td>
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	a. The track record of the provider in providing safe and effective care. This would include a review of CQC inspection reports. The location of the unit, in order that the individual can be supported to maintain social support networks. The specialism of the unit as it relates the individuals' presenting needs. b. The most important outcome is whether or not the individual is successfully rehabilitated, enabling them to leave hospital and live in the community. c. The most common reason for placement breakdown is a level of violence and/or aggression that cannot be safely managed in the context of a level 2 rehab unit.
9. Commissioning Contacts a. Please provide the structure or generic contact details for the teams responsible for: i. Rehabilitation commissioning ii. Complex mental health commissioning iii. Learning disability/autism commissioning iv. Hospital discharge pathways	If you wish to contact any of these departments within the ICB, please use the following contact details, stating which department you require: bnssg.customerservice@nhs.net Tel: 0117 900 2655 or 0800 073 0907 (freephone)

The information provided in this response is accurate as of 15 June 2026 and has been approved for release by Rosi Shepherd, Chief Clinical Leadership and Delivery Officer (Nursing) and Caroline Dawe, Deputy Director of Performance and Delivery, Acute and Integrated Care, MHLDA and EPRR for NHS Bristol, North Somerset and South Gloucestershire ICB.