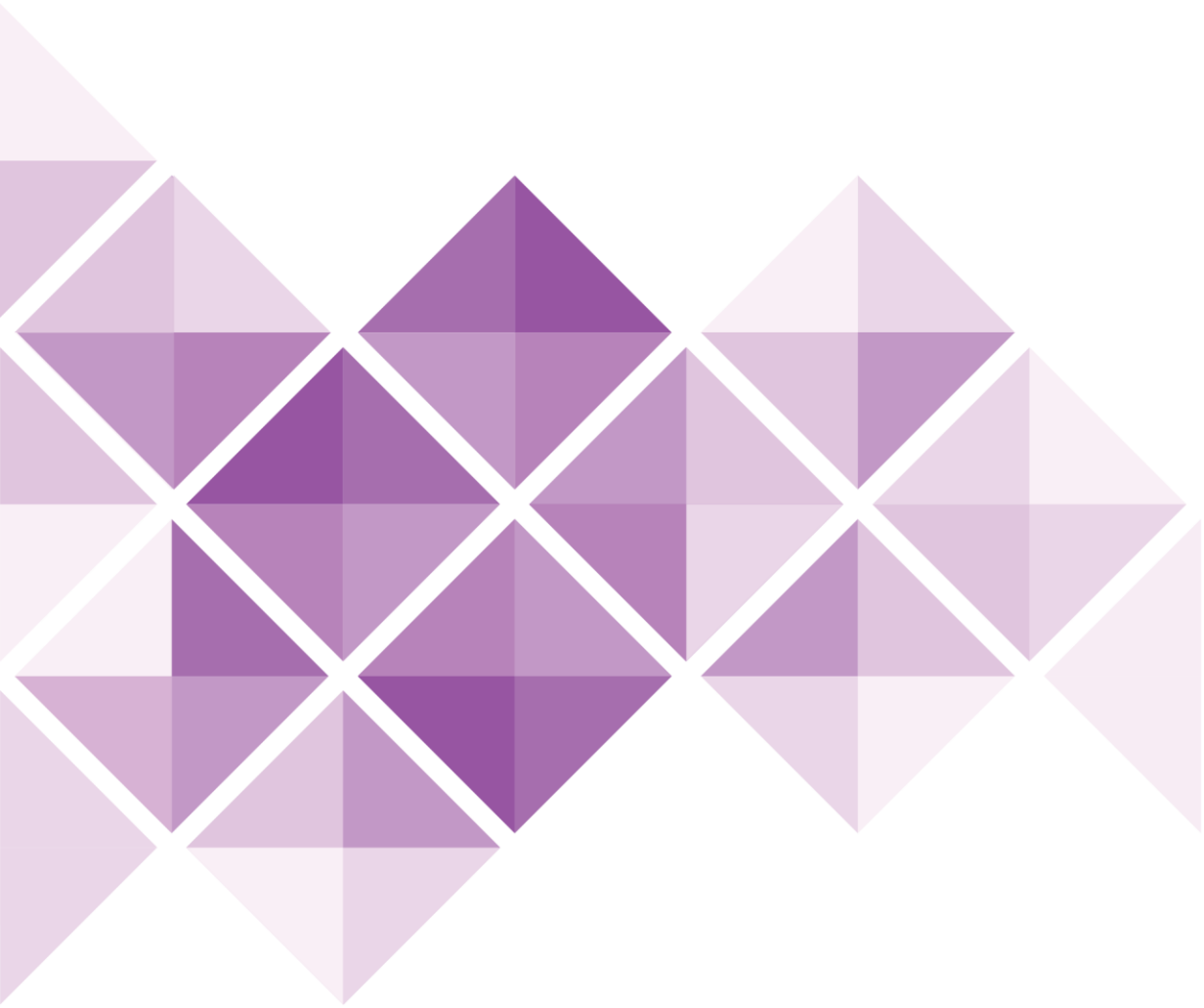
# Public Consultation on the Development of an NHS Rehabilitation Centre

Findings Report

October 2020

Version 1.0



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# Executive Summary

## Introduction

On the 27th July 2020, NHS Nottingham and Nottinghamshire Clinical Commissioning Group launched a public consultation on the opportunity to open an NHS Rehabilitation Centre in the East Midlands.

Specialist rehabilitation services are currently delivered from hospitals across the region, with neurological rehabilitation provided at Linden Lodge at Nottingham City Hospital. According to estimates by the British Society of Rehabilitation Medicine there is a significant shortfall of rehabilitation beds across the region.

Central Government has ring-fenced £70 million to build a Rehabilitation Centre for NHS inpatients on the same site as the Defence Medical Rehabilitation Centre on the Stanford Hall Rehabilitation Estate, near Loughborough. This would result in a net increase of 40 rehabilitation beds across the East Midlands and provide NHS patients with access to a skilled team of experts working in a purpose-built facility and use of the latest technology and equipment.

The development would mean transferring 21 of the 24 specialist rehabilitation beds in Linden Lodge to the new purpose-built facility. The three remaining specialist rehabilitation beds would be retained at Nottingham City Hospital in a dedicated rehabilitation unit. Patients would continue to access outpatient appointments and rehabilitation services in local hospitals throughout the East Midlands.

The eight-week consultation ran from the 27th July to 18th September 2020 and consisted of engagement events, focus groups and a survey. Direct submissions from individuals and stakeholders were also encouraged. In total, 876 people or organisations participated during the consultation period.

J. Harvey Research Ltd, an independent organisation from outside the region, was commissioned by the North of England Commissioning Support Unit to report the findings of the consultation.

## Key findings

Results from the survey show that:

- 77% strongly support the proposal to create a NHS Rehabilitation Centre at the Stanford Hall Estate. A further 9% slightly support it.
- 52% strongly support the proposal to transfer the service currently provided at Linden Lodge to the NHS Rehabilitation Centre. A further 15% slightly support this.
- 65% feel it is appropriate for NHS patients to be treated on the same site as military personnel. A further 22% perceive that it is to some extent.

- 33% feel that it would be very easy for them to access the NHS Rehabilitation Centre at the Stanford Hall Estate, whilst 19% perceive it will be easy. In contrast, 24% stated it would be difficult or very difficult and 24% neither easy nor difficult.

- 60% feel that the provision of three rooms for families to stay, free parking and super-fast broadband would help to reduce the impact of increased travel time that some might face. A further 26% perceive that it would to some extent.
- 73% feel that the care that patients would receive at the NHS Rehabilitation Centre will be excellent. A further 17% perceive it will be very good.

- 66% feel the range of health and social care professionals that patients would have access to is excellent. A further 21% perceive it is very good.

- 72% feel confident that patients' mental health is being taken into account. In contrast, 22% feel that although patients' mental health is being taken into account more could be done and 7% that more needs to be done.

**Benefits of the proposal**

Numerous benefits of the development of a NHS Rehabilitation Centre were identified by consultees. These include:

- Providing NHS patients with access to a purpose-built rehabilitation facility with all expertise under one roof, in addition to the state-of-the-art facilities at the Defence Medical Rehabilitation Centre.

- Increasing access to specialist inpatient rehabilitation, addressing the unmet need that exists and reducing the demand on acute NHS services.

- Improving patient outcomes.

- Collaboration with the Defence Medical Rehabilitation Centre in terms of sharing of resources and best practice.

- Transforming how rehabilitation is delivered across the system, setting a 'blue print' for other parts of the country.

- Opportunity for local public sector collaboration in the areas of education and research.

Furthermore, most survey respondents perceive the main benefit of the NHS Rehabilitation Centre's location at the Stanford Hall Estate is the rural, tranquil setting which provides access to fresh air and open space - a stark contrast from that of a busy hospital environment. A smaller proportion feel the Stanford Hall Estate is centrally located in the East Midlands region, as well as in the UK, and accessible by car and

public transport (42% & 14% of survey respondents who responded to this question cited these benefits, respectively).

**Concerns about the proposal**

In contrast, strong concerns were raised about the proposal, particularly with regard to the NHS Rehabilitation Centre's location at the Stanford Hall Estate. A number of extensive submissions were received by stakeholders, particularly professional bodies/organisations, which challenged the proposal on a number of grounds and perceived that the proposal lacked significant detail.

Specific concerns/objections to the proposal include:

- The poor accessibility of the Stanford Hall Estate which will create difficulty for visitors and staff to access, in terms of increased travel time and cost. This was considered a particular issue for those reliant on public transport as well as older and/or vulnerable individuals.

- The knock-on effect on patients' wellbeing if they are unable to see their friends and family on a frequent basis, as well as the difficulty for these individuals to be involved in their relatives' rehabilitation. The vital role that family and friends play in the process was repeatedly emphasised.

- Patients who require inpatient rehabilitation need access to a range of acute medical and surgical services due to their medical instability and complex needs. For this reason, concern was raised about the medical safety of patients if the current caseload at Linden Lodge were to be managed in this new service. Additionally, there was concern about the rehabilitation options available to those who are ineligible to receive their care at the NHS Rehabilitation Centre and/or are unable to engage in intensive rehabilitation.

- It was felt that patients will have reduced continuity of care beyond inpatient stay due to the distance of the Stanford Hall Estate from acute NHS services. It was noted that transferring patients to and from these services will eat into their 'rehabilitation time' and deplete their energy to engage, whilst also requiring the availability of staff to escort.

- The distance from, and inability for patients to practice 'real world' situations e.g. crossing busy roads, getting on and off public transport, going to a shop, was perceived to limit the ability and relevance of rehabilitation. For this reason, many consultees highlighted the importance of receiving rehabilitation care within local communities.

- The closure of Linden Lodge, a facility considered to be more easily accessible, providing a high standard of care and benefitting from the proximity to acute NHS services and provide local inpatient care.

- The impact the location on the transition from inpatient to community care, as well as concern as to whether the 'step-down' care available within local communities is able to maintain, and build upon, progress achieved at the NHS

Rehabilitation Centre. This is a particular concern in Lincolnshire, which is felt to not have the aftercare support in place to continue the care required post discharge.

- Potential conflict between the Defence Medical Rehabilitation Centre and the NHS Rehabilitation Centre in terms of the shared use of facilities as well as the issues of dealing with two very different population cohorts and the potential for inequalities in treatment to be highlighted.

- Practicality of having a three-bedded rehabilitation unit at Nottingham City Hospital.

- Difficulties in the recruitment of specialist staff as well as the impact on staff at Linden Lodge.

- Suitability of the site for the placement of trainees in rehabilitation medicine.

- The impact on the surrounding area at Stanford due to the increased volume of traffic, which many already perceive to be a problem.

- Other including; financial modelling and sustainability, safety of visitors travelling and accessing the site, decisions already being made, privatisation, commissioning and equity in access for all areas.

**Considerations**

In light of these issues and the strong concern that some stakeholders have about the feasibility of the proposal as it stands, a number of significant modifications to the proposal were put forth by consultees:

- Investing in the existing building/-facilities at Linden Lodge

- The reorganisation of rehabilitation provision within existing buildings and organisations.

- Developing the NHS Rehabilitation Centre as an additional facility to Linden Lodge – helping to increase inpatient rehabilitation capacity whilst catering for patients with different rehabilitation needs.

- Developing the NHS Rehabilitation Centre as a tertiary service/national centre for specific cohorts of medically stable patients, who are well enough to engage in a benefit from a very intensive residential rehabilitation programme.

- Incorporation of a dynamic outpatient service.

- Opportunities for day-case/weekly boarding.

Additional, less significant, suggestions were made in relation to increasing accessibility to the Estate through methods such as improving public transport links and/or the provision of shuttle bus services from local hospitals, increasing the number of family rooms, and enhancing the mental health support available to patients through the presence of more mental health professionals and the provision of a wider range of therapy options.

## Next steps

This report will be provided to the NHS organisations leading the consultation. A Findings Consideration Panel will consider the report and make recommendations on how best to reflect the consultation findings in their final proposals.

A Decision Making Business Case will then be developed and considered by the CCGs' Governing Body, before making a final decision on the development of the NHS Rehabilitation Centre. This is expected to take place by the end of 2020.

# 1 Introduction

On the 27th July 2020, NHS Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) launched an eight-week consultation on the opportunity to open an NHS Rehabilitation Centre (NHSRC) in the East Midlands.

Specialist rehabilitation services are currently delivered from hospitals across the region, with neurological rehabilitation provided at Linden Lodge at the City Hospital in Nottingham. Patients who require specialist rehabilitation generally have complex disabilities, often with a range of medical, physical, sensory, mental, communicative, behavioural and social problems. They may have experienced:

- Major trauma following, for example, a road traffic collision or an accident at work
- Neurological problems such as an injury to the brain
- Complex musculoskeletal injury with damage to the bones, joints and muscles
- Traumatic amputation
- Incomplete spinal cord injury resulting in paralysis
- Post Covid-19 (Coronavirus) conditions.

The British Society of Rehabilitation Medicine (BSRM) recommends that the ideal level of rehabilitation beds should be 45 to 65 beds per million people. There is currently a significant shortfall of these beds in the East Midlands.

Central Government has provided £70 million to build a Rehabilitation Centre for NHS inpatients on the same site as the Defence Medical Rehabilitation Centre (DMRC) on the Stanford Hall Rehabilitation Estate (SHRE), near Loughborough. The owner of the SHRE is prepared to provide the land needed for the NHS facility at no cost.

The new centre would result in a net increase of 40 rehabilitation beds across the East Midlands and provide NHS patients with access to a skilled team of experts working in a purpose-built facility with access to the latest technology and equipment.

The development of the centre would mean transferring 21 of the 24 specialist rehabilitation beds in Linden Lodge to the new purpose-built facility. The three remaining specialist rehabilitation beds would be retained at Nottingham City Hospital in a dedicated rehabilitation unit.

Patients would continue to access outpatient appointments and rehabilitation services in local hospitals throughout the East Midlands.

It is anticipated that the NHSRC would:

- Create a high-quality centre of rehabilitation excellence
- Contribute to a deficit in rehabilitation capacity
- Improve access to services
- Improve outcomes and the patient experience through a new clinical model
- Enable NHS Nottingham and Nottinghamshire CCG to respond to changes in future service needs and models
- Reduce pressures on the acute bed base.

The proposal being consulted upon, builds upon the findings from two pieces of engagement conducted in July and October 2019 which aimed to understand initial perceptions about the development of the NHSRC among patients and staff. While those engaged with were mostly positive about the proposal, concerns were raised about the location and accessibility of the facility, the potential for patients to feel lonely and isolated, as well as the impact on local services. The CCG has carefully considered how best to respond to these concerns within the current proposal.

The public consultation ran from the 27th July to 18th September 2020 and consisted of online engagement events, focus groups and a survey. All activity was required to take place online due to Covid-19 social distancing measures introduced earlier in the year. Individuals with direct or indirect experience of rehabilitation – either as a patient, through family members or friends as well as staff, carers and other stakeholders, were invited to give their views. This included those living in Nottinghamshire and neighbouring areas such as Leicestershire, Derbyshire and Lincolnshire, due to their proximity to existing specialist rehabilitation services.

J. Harvey Research Ltd, an independent organisation from outside the region, was commissioned by North of England Commissioning Support Unit to report the findings of the consultation.

The report will be provided to the NHS organisations leading the consultation. A Findings Consideration Panel will consider the report and make recommendations on how best to reflect the consultation findings in their final proposals. A Decision Making Business Case will then be developed and considered by the CCGs' Governing Body, before making a final decision on the development of the centre. This is expected to take place by the end of 2020.

# 2 Methodology

The North of England Commissioning Support Unit (NECSU) supported NHS Nottingham and Nottinghamshire CCG with their communications and engagement.

The objectives of the activity were:

- To ensure the maximum numbers of people were made aware of the consultation. This included those living in Nottingham and Nottinghamshire, Derbyshire, Leicestershire and Lincolnshire.
- To encourage as many individuals as possible to take part in the consultation.
- To continue to meet NHS legal duties for engagement, equality and best practice in engagement and communications.

Due to Covid-19 social distancing measures all engagement activity was online and included engagement events, focus groups and a survey.

## 2.1 Communications activity

An initial briefing was cascaded to a wide range of stakeholders inviting all their communication staff to an online meeting about the consultation and asking for their support in cascading information to their networks. Follow up emails were sent with details of the engagement events and focus groups, as well as reminders about the importance of their input.

The stakeholder list included:

- Local CCGs - NHS Nottingham and Nottinghamshire CCG, NHS Derby and Derbyshire CCG, NHS Leicester City CCG and NHS Lincolnshire CCG
- Local Councils - Nottinghamshire County Council, Nottingham City Council, Leicester City Council, Derby City Council, Lincolnshire County Council, Derbyshire County Council, Leicestershire County Council, Lincoln City Council, Mansfield District Council, Newark & Sherwood District Council and Rushcliffe Borough Council
- Regional MPs
- Local NHS Trusts - Nottingham University Hospital, Nottinghamshire Healthcare, Sherwood Forest Hospitals, Royal Derby Hospital, Chesterfield Royal Hospital, East Midlands Ambulance Service, United Lincolnshire Hospitals, University Hospitals of Leicester and University Hospitals of Derby and Burton
- Local Universities - University of Nottingham, Loughborough University, University of Leicester, University of Derby and University of Lincoln

- Healthwatch – Nottingham and Nottinghamshire, Leicester and Leicestershire, Derbyshire and Lincolnshire

- Health Education England East Midlands and NHS England

- Other organisations and professional associations/bodies including but not limited to: CityCare, Optum, British Dietetic Association, Royal College of Occupational Therapists, Chartered Society of Physiotherapy, Highground UK, College of Podiatry and Mind UK.

An initial press release was sent to local media outlets at the start of the consultation, with a second on the 9th September reminding people to take part in the consultation. The table shows the media coverage achieved, along with the sentiment of each.

***Table**: Media coverage*

| Type | Date | Organisation | Sentiment |
|---|---|---|---|
| **Article** | 13th July | Nottingham Post /Nottinghamshire Live | Negative |
| | 14th July | Leicester Mercury/Leicestershire Live | Positive |
| | 17th July | Leicester Mercury | Positive |
| | 27th July | National Health Executive (Web) | Neutral |
| | 27th July | Nottingham Post/Nottinghamshire Live | Neutral |
| | 29th July | Loughborough Echo | Positive |
| | 1st August | Nottingham Evening Post | Neutral |
| | 5th August | Loughborough Echo | Positive |
| | 15th September | Leicester Mercury | Positive |
| **Online** | 14th July | National Centre for Sports and Exercise Medicine | Positive |
| | 14th July | AgenParl | Positive |
| | 14th July | Leicestershire Live | Positive |
| | 27th July | National Health Executive | Positive |
| | 27th July | Nottinghamshire Live | Neutral |

| | | | |
|---|---|---|---|
| | 31st July | Nottinghamshire Live | Neutral |
| | 26th August | Chartered Society of Physiotherapy | Positive |
| | 28th August | AT Today – Assistive Technology | Positive |
| **Broadcast** | 13th July | BBC East Midlands Evening News | Positive |
| | 14th July (x2) | BBC Radio Leicester | Unknown |
| | 27th July (x2) | BBC Radio Nottingham (Drive-time) | Positive |

Throughout the consultation period, NHS Nottingham and Nottinghamshire CCG posted on Facebook, as well as using paid for advertisements to target specific demographic profiles.

***Figure**: Screenshots - media coverage / Facebook posts*








To increase participation from hard-to-reach groups, a number of organisations were contacted specifically by the CCG, providing their members/service users with the opportunity to discuss the proposal and respond to the survey in a one-to-one, telephone feedback session with a representative from Healthwatch Nottingham and Nottinghamshire. The organisations contacted included Nottinghamshire Carers Hubs, MH:2K – an organisation working with young people and Nottingham's Engagement Team for Children and Young People.

The following table documents the number of visits to the NHSRC's web page and document downloads, as well as ausmmary of the social media activity.

***Table**: Website and social media activity*

| | | |
|---|---|---|
| **Website** | Web page visits | 4,747 |
| | Web document downloads | 1,014 |
| **Social media** | Animation link clicks | 2,814 |
| | Animation reach (unique people seeing) | 95,327 |
| | Animation impressions (total displays) | 247,646 |
| | Social media engagement | • 170 reactions<br>• 128 comments<br>• 119 shares |

## 2.2 Engagement activity

### 2.2.1 Engagement events

Three online engagement events were held during the consultation period. It was originally planned that these would be face-to-face, however due to Covid-19 restrictions these were all conducted online via Microsoft Teams.

Prior to the event, attendees were given the opportunity to submit any questions they had. This was in case individuals wanted to do this anonymously or were unable to use the chat function during the event.

At the start of each event, attendees were given an overview of the consultation by;

- Amanda Sullivan; Accountable Officer for Nottingham and Nottinghamshire CCG
- Dr James Hopkinson; Clinical Chair of Nottingham and Nottinghamshire CCG.

Attendees were then given the opportunity to ask any questions they had to the clinical leads or provide any comments they had about the consultation using the chat function.

A number of additional speakers were on hand to answer questions, this included:

- Miriam Duffy; NHSRC Programme Director at Nottingham University Hospital NHS Trust

- Sandeep Walsh; Rehabilitation Case Manager at East Midlands Major Trauma Centre; Nottingham University Hospital NHS Trust

- Hazel Buchanan; Associate Director of Strategic Programmes at NHS Nottingham and Nottinghamshire CCG

- Daren Forward; Consultant Orthopaedic Surgeon and Major Trauma Consultant at Nottingham University Hospital NHS Trust

- Adam Brooks; Major Trauma Consultant and Clinical Director at East Midlands Major Trauma Centre; Nottingham University Hospital NHS Trust

- Allan Cole; Consultant Anaesthetist at University Hospitals of Leicester NHS Trust, and recent recipient of complex trauma care.

Note: Not all these individuals were able to attend all of the events.

In total, 37 individuals attended the events, the breakdown of which is shown in the table below.

***Table**: Engagement events*

| Date | Time | No. of attendees |
|---|---|---|
| Tuesday 4th August 2020 | 3-4pm | 11 |
| Thursday 10th August 2020 | 2.30-3.30pm | 13 |
| Wednesday 19th August 2020 | 6-7pm | 13 |

### 2.2.2 Consultation survey

Members of the public, patients, staff, family members and other stakeholders were invited to complete an online survey developed to gather opinion upon the proposal.

In addition, paper and easy-to-read versions were available on request.

In total, 763 individuals responded to the survey.

### 2.2.3 Focus groups

Individuals who had a specific interest or experience of rehabilitation services were given the opportunity to join two online focus groups. For individuals, who expressed an interest but were unable to attend or felt uncomfortable using this technology, one-to-one telephone interviews were offered.

A discussion guide was used to create consistency between the groups / interviews and ensure that key questions were addressed. With permission of the participants, the

groups were audio recorded and an anonymised transcript produced for analysis purposes.

In total, 10 individuals participated in the focus groups / interviews, the breakdown of which is shown in the table below.

***Table**: Focus group / interviews*

| Date | Time | No. of attendees |
|---|---|---|
| Monday 24th August 2020 | 2-3pm | 4 |
| Tuesday 1st September 2020 | 6-7pm | 4 |
| One-to-one telephone interviews | - | 2 |

### 2.2.4 Stakeholder and other submissions

To ensure as fair an opportunity as possible was given for all to provide a contribution to the consultation, direct communications were encouraged and included in the process.

In total, 66 submissions to the consultation were received from members of the public through social media activity and stakeholders.

## 2.3 Total sample

In total, 876 people or organisations participated during the consultation period.

## 2.4 Analysis and reporting

J. Harvey Research Ltd was commissioned to provide an independent analysis of the findings of the consultation. The specific methods applied to analyse the findings were:

- Qualitative analysis: the findings from the engagement events and focus groups are constructed on an approach where the data from the session notes is analysed and responses grouped into themes that most closely represent the views expressed. Qualitative data does not allow for commentary on the specific number of times comments are made within these themes.

- Quantitative analysis: the survey was structured to include both closed and free text (open) questions giving respondents the opportunity to comment on the proposal in more detail. All free text responses were assigned a code, and codes grouped into categories to allow a quantitative representation of the feedback. For all questions, responses have been presented as a proportion of the number of individuals who responded to each question.

It is important to note, that respondents to the survey are self-selecting, representing the views of those who wanted to give their views. This is very important opinion but cannot be treated as statistically reliable.

This report presents the result of that independent analysis and is intended to inform decision makers of the views of consultees and to provide them with a summary of any additional information which they wish them to take into conscientious consideration.

# 3 Feedback from the engagement events

Three online engagement events were held during the consultation period, with a total of 37 individuals. This consisted of members of the public, past service users, NHS staff, health professionals as well as other stakeholders.

Attendees were given an overview of the consultation, followed by the opportunity to ask any questions they had to the clinical leads or provide their comments about the proposal. In total, 42 questions were asked and three comments provided.

The anonymised transcripts from the engagement events are available in the Appendix - these include responses from the clinical leads to the questions asked. The questions asked and comments provided have been summarised under the headings below to provide an overview of the themes of discussion.

## 3.1 Discussion themes

### 3.1.1 Planning and delivery of the NHSRC

- Managing organisation(s)
- Level of rehabilitative care
- Benefits, compared with current specialist inpatient provision
- Facilities/equipment available through the DMRC as well as availability/access of these to NHS patients
- Building layout/lift access
- Access for privately-funded patients
- Opportunities for day care
- Timescale for developing the National Centre for training and education
- Comparisons and learnings from equivalents in other countries.

### 3.1.2 Care and treatment

- Availability of medical cover
- Anticipated lengths of stay

- Continuity of care - neurological journey for complex patients
- Access to medical specialties i.e. dialysis facilities for renal patients.

*"Currently there is neurophysiotherapy support from Linden Lodge on the acute neuro wards and reablement/outpatient ongoing support which is planned seamlessly on site."*

### 3.1.3 Criteria for admission

- Eligibility criteria
- Access to the NHSRC for patients who are currently eligible for rehabilitative care at Linden Lodge
- Availability of neurobehavioural/neuropsychiatric beds at the NHSRC.

"*I have multiple sclerosis, I have many concerns about losing this facility, at the moment there are 24 neurorehabilitation beds, I am concerned that because we cannot be 'cured' we will be put at the back of the line for beds."*

### 3.1.4 Capacity and demand

- Access to/number of beds available for Nottingham/Nottinghamshire patients.

### 3.1.5 Geographical catchment

- Access to, and impact for Lincolnshire patients requiring inpatient rehabilitation
- Access for Northamptonshire patients.

*"There are very little current services for inpatient brain injury rehabilitation in Lincolnshire now. Many patients have to go out of county for rehabilitation anyway."*

### 3.1.6 Workforce

- Recruiting specialist staff given the ongoing workforce issues
- Recruitment criteria/staff banding (i.e. opportunities for Band 5 therapists/students)
- Access to on-site staff accommodation and travel-to-work schemes
- Attitudes/feelings of staff at Linden Lodge
- Opportunities available to staff who do not want to relocate/rotate.

### 3.1.7 Discharge and outpatient care

- Movement of patients from the NHSRC to step-down provisions and/or multi-disciplinary teams (MDTs) for further rehabilitation
- Role of the NHSRC in providing rehabilitation within the community
- Opportunities to link with private organisations to support the discharge process
- Location of outpatient care for Nottingham/Nottinghamshire and Lincolnshire patients
- Continuity of care for Lincolnshire patients
- Capacity of community rehabilitation services in the counties able to refer patients to the NHSRC.

### 3.1.8 Financial

- Length of the lease on the SHRE site
- Running costs (i.e. where will the money come from to run the service?)
- Financial impact on other NHS services due to the acute beds made available being filled by other patients
- Financial implications for the care and treatment of veterans.

*"Great for us patients but are there knock-on effects to affordability for other NHS services."*

### 3.1.9 Location

- Potential impact of family members/other visitors being able to see their loved ones less frequently.

### 3.1.10 Other

- Timeline for the decision-making process
- Use of the current inpatient building at Linden Lodge.

# 4 Feedback from the consultation survey

## 4.1 Participant demographics

A total of 763 individuals responded to the survey; 66% of which were from Nottingham City or Nottinghamshire. Furthermore, 11% were from Leicester/Leicestershire, 10% from Derby/Derbyshire and 4% Lincoln/Lincolnshire. The remaining individuals stated that they were from another part of the UK (8%) or lived within the East Midlands (1%).

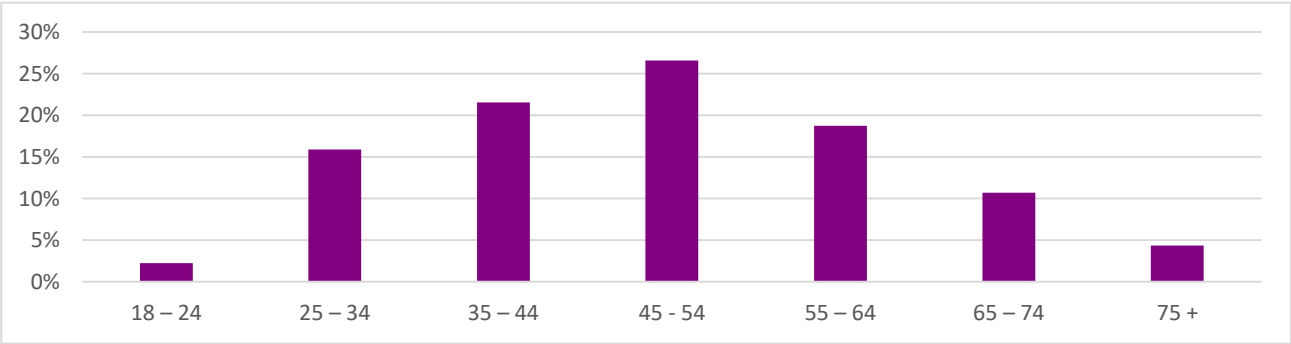
***Table**: Location of respondents*

| | No. | % |
|---|---|---|
| Rushcliffe (Nottinghamshire) | 181 | 25% |
| Nottingham City | 114 | 16% |
| Leicester/Leicestershire | 79 | 11% |
| Broxtowe (Nottinghamshire) | 74 | 10% |
| Derby / Derbyshire | 69 | 10% |
| Other part of the UK | 60 | 8% |
| Gedling (Nottinghamshire) | 47 | 7% |
| Newark and Sherwood (Nottinghamshire) | 30 | 4% |
| Lincoln/Lincolnshire | 27 | 4% |
| Ashfield (Nottinghamshire) | 16 | 2% |
| Mansfield (Nottinghamshire) | 10 | 1% |
| East Midlands – not specified | 7 | 1% |
| **Total** | **714** | **100%** |

The demographics of respondents are summarised below, with a full breakdown available in the Appendix.

- The majority were female (78%), whilst 21% were male and <1% other. All indicated that their gender matched their sex registered at birth.
- The age profile of respondents was normally distributed, with most aged between 45 to 54 years (27%). Furthermore, similar proportions were aged 35-44 years (22%) and 55 to 64 years (19%). Slightly smaller proportions were aged 25 to 34 years (16%), 65 to 74 years (11%), 75 or older (4%) and 18 to 24 years (2%).

***Figure**: Age distribution of respondents*



- The vast majority was White (94%), smaller proportions were White – Irish (2%), Asian/British Asian - Indian (1%) and Asian/British Asian – Pakistani (1%).
- Just 2% were currently pregnant or had been in the last year.
- Most were married (64%), whilst 14% were cohabiting and 11% single. Smaller proportions were divorced/civil partnership dissolved (3%), separated (1%) or in a civil partnership (1%).
- The majority had no known impairment, long-term illness or health condition (69%). Of those that did, the most common were; a long-term illness or health condition such as HIV, diabetes or epilepsy (8%), a physical impairment (8%), a mental health difficulty (5%) or an impairment, health condition or learning difference not listed in the survey (5%).
- Less than a fifth were an unpaid carer of a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or addiction (15%).
- The majority were heterosexual or straight (93%), whilst 3% identified themselves as asexual, 2% bisexual and 2% gay woman/lesbian or gay man.
- Most did not have a religion (47%) or stated being a Christian (40%).

Individuals were asked to indicate how they were responding to the survey, to which the majority indicated they were answering as a member of the public (69%). Smaller proportions responded as a current or former patient of rehabilitation services (10%), a carer/friend/family member of an individual who is accessing/has accessed a rehabilitation service (9%), a member of NHS staff (8%) or as a charity/voluntary organisation (1%). The latter included organisations such as POW Nottingham, Lincolnshire Neurological Alliance, Nottingham Multiple Sclerosis Therapy Centre, The Disabilities Trust, The Brain Injury Rehabilitation Trust and the Armed Forces Para-Snowsport Team.

Furthermore, 3% selected ‘other’; this included health professionals such as a physiotherapist or dietician, organisations such as University of Nottingham, Neuro Rehab Kent, Physio Where You Are Ltd, Fresh Physio Ltd, Great Northern Physiotherapy Ltd, Rempstone Parish Council, Vanclaron CIC, Agile Nottingham and forums such as Health Scrutiny Committee for Lincolnshire and United Kingdom Acquired Brain Injury Forum.

***Table**: How individuals responded to the survey*

| | No. | % |
|---|---|---|
| A member of the public | 217 | 69% |
| A current or former patient of rehabilitation services | 73 | 10% |
| A carer/friend/family member of an individual who is accessing / has accessed a rehabilitation service | 71 | 9% |
| Member of NHS staff | 57 | 8% |
| Other | 25 | 3% |

| | | |
|---|---|---|
| Charity / voluntary organisation | 8 | 1% |
| **Total** | **751** | **100%** |

## 4.2 Survey responses

### 4.2.1 Support for the proposal

The majority strongly support the proposal to create a NHSRC at the Stanford Hall Estate (77%), with a further 9% slightly supporting it. In contrast, 10% either strongly or slightly oppose, whilst 4% neither support nor oppose it.

***Figure**: To what extent do you support or oppose the proposal to create a NHSRC at the SHRE near Loughborough?*

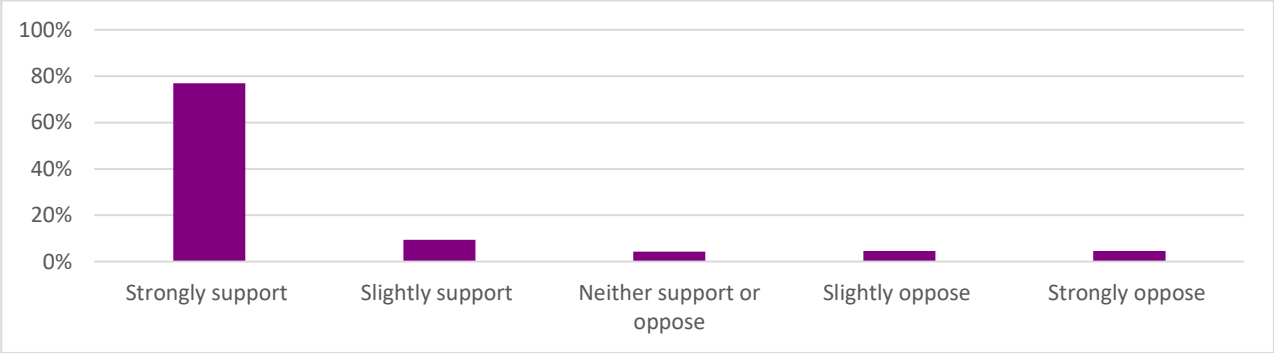



***Table**: To what extent do you support or oppose the proposal to create a NHSRC at the SHRE near Loughborough?*

| | No. | % |
|---|---|---|
| Strongly support | 585 | 77% |
| Slightly support | 72 | 9% |
| Neither support or oppose | 33 | 4% |
| Slightly oppose | 35 | 5% |
| Strongly oppose | 35 | 5% |
| **Total** | **760** | **100%** |

Furthermore, 52% strongly support the proposal to transfer the service currently provided at Linden Lodge at Nottingham City Hospital to the NHSRC, with a further 15% slightly supporting it. In contrast, 18% either strongly or slightly oppose it and 15% neither support nor oppose this.

***Figure**: To what extent do you support or oppose the transfer of the service at Linden Lodge at Nottingham City Hospital to the NHSRC?*

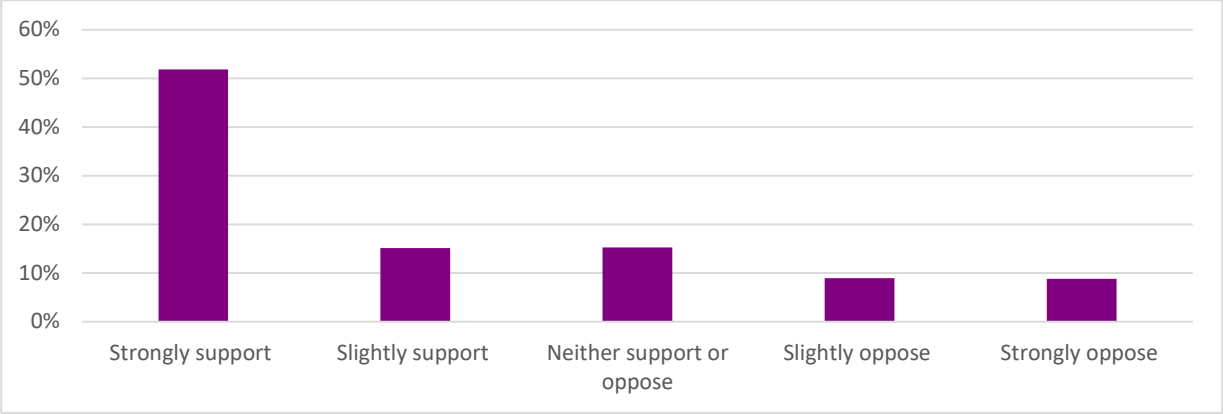



***Table**: To what extent do you support or oppose the transfer of the service at Linden Lodge at Nottingham City Hospital to the NHSRC?*

| | No. | % |
|---|---|---|
| Strongly support | 394 | 52% |
| Slightly support | 115 | 15% |
| Neither support or oppose | 116 | 15% |
| Slightly oppose | 68 | 9% |
| Strongly oppose | 67 | 9% |
| **Total** | **760** | **100%** |

Respondents were given the opportunity to comment upon the transfer of beds from Linden Lodge to the NHSRC.

As with all open questions in this survey, responses were coded and codes grouped into themes. In many cases, it was necessary to assign more than one code to an individual's response. This method allowed responses to open questions to be represented quantitatively.

Most comments related to the accessibility of the NHSRC with the difficulty that visitors would have in travelling to the Stanford Hall Estate, particularly those reliant on public transport, being highlighted. There was concern that this would have a knock-on effect on the patients' recovery as they would receive less support from their loved ones, a vital part of the rehabilitation journey.

*"This is a move away from Nottingham and Nottinghamshire, which would move patients further from their home communities. I think this will work against real rehabilitation in some ways as well as increasing difficulty of visiting for family and relative which is so vital."*

*"When you are in rehabilitation you need your family near you and they should be able to visit you easily, one of the best medicines is family support and contact."*

In contrast, many provided a positive comment perceiving that the proposal provides an excellent opportunity to bring together all expertise under one roof – improving access to inpatient rehabilitation and patient outcomes, as well as resolving the issue of Linden Lodge not being fit for purpose.

*"Linden Lodge has outgrown the building. It's too old fashioned and this is a wonderful opportunity."*

*"The facilities will be state-of-the-art at the NHSRC in awesome surroundings conductive to healing the mind and body."*

Alternatively, a number of individuals felt that investment should be made in the existing building/facilities at Linden Lodge and/or that the NHSRC is used as an additional facility to Linden Lodge. It was thought this latter approach would help increase inpatient rehabilitation capacity, whilst providing provision for patients with different rehabilitation needs. Other suggestions related to the provision of free parking at the NHSRC and ensuring that the NHSRC is accessible by public transport.

*"I think keep both. Linden Lodge needs to remain as a local unit to maintain bed capacity and then use Loughborough to increase capacity."*

*"Surely it is better to increase the provision rather than diluting the improvement by closing an already existing facility."*

*"Nothing stopping the proposed model being offered at Linden Lodge. Proposed building is in the middle of nowhere. No good reason to move."*

Further comments are summarised in the table below and relate to concern about the closure of Linden Lodge which is considered to be more easily accessible and provide a high standard of care, the impact on staff who work at Linden Lodge, the importance of receiving inpatient care within local communities as well as concerns about the continuity of care for patients at the NHSRC in terms of access to specialist medical facilities (i.e. dialysis, acute care) and post discharge.

*"We need these services here in Nottingham to better treat the people in the Midlands. Linden Lodge is a vital part of our NHS."*

*"Movement of rehabilitation beds - in the place of maximum need and adjacent to acute trauma and neurological services to a rural location with no clear plan of how acute service links will be maintained."*

***Table**: Comments on the proposal to transfer the inpatient beds from Linden Lodge to the NHSRC (N=307)*

| Response theme | No. | % |
|---|---|---|
| **Positive comments** | | |
| Development of the NHSRC | 89 | 29% |
| **Negative comments** | | |
| Accessibility of the NHSRC at Stanford Hall | 116 | 38% |
| Closure of Linden Lodge | 28 | 9% |
| Impact on Linden Lodge staff | 19 | 6% |
| Local rehabilitation services are needed | 16 | 5% |
| Continuity of care during the inpatient stay / post discharge | 11 | 4% |
| Eligibility criteria for the NHSRC | 7 | 2% |
| Excessive demand on beds at NHSRC | 6 | 2% |
| Other, including:<br>• Increased traffic around SHRE<br>• Sustainability of a three-bedded unit at Nottingham City Hospital<br>• Centralisation is not always best | 19 | 6% |
| **Considerations** | | |
| Suggestion / modification to the proposal | 55 | 18% |

| | | |
|---|---|---|
| Query / detail absent in the proposal | 15 | 5% |

### 4.2.2 Co-location with the DMRC

It was explained to respondents that;

> The NHSRC would be located at the SHRE near Loughborough - a 360-acre countryside estate which hosts the DMRC, providing rehabilitation facilities for military personnel.
>
> The DMRC would continue to operate independently and prioritise military rehabilitation, while the NHSRC would provide treatment for NHS patients only. NHS patients would be able to benefit from the state-of-the-art facilities that the DMRC has e.g. the hydrotherapy pool, the gait analysis system and the Computer Aided Rehabilitation Environment – CAREN.
>
> The location would provide peaceful, tranquil surroundings for NHS patients to focus on their rehabilitation.

Two thirds feel it is appropriate for NHS patients to be treated on the same site as military personnel (65%), with a further 22% perceiving that it is to some extent. In contrast, 8% are not sure and 5% feel it is not suitable.

***Figure**: Do you think treating NHS patients on the same site as military personnel will be suitable?*

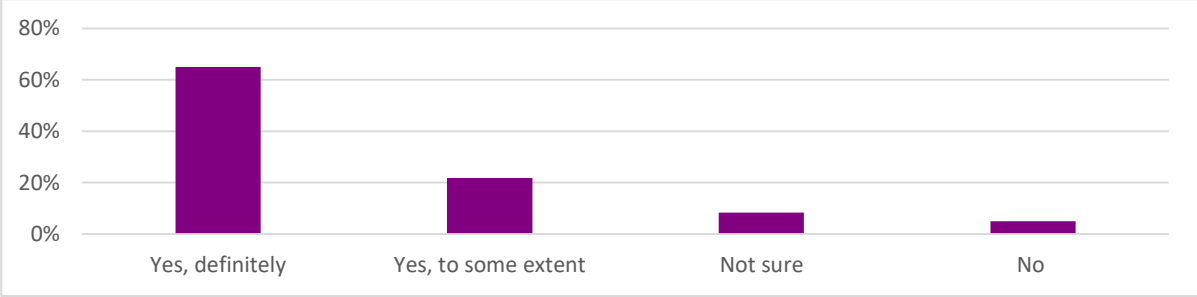



***Table**: Do you think treating NHS patients on the same site as military personnel will be suitable?*

| | No. | % |
|---|---|---|
| Yes, definitely | 493 | 65% |
| Yes, to some extent | 165 | 22% |
| Not sure | 63 | 8% |
| No | 38 | 5% |
| **Total** | **759** | **100%** |

The main concerns relate to the fundamental differences between these groups in terms of their mentality, needs, goals and ability to deal with adversity, as well as the increased demand that will be placed on the facilities at the DMRC, with the perception that military personnel will get priority.

*"Cultural, behavioural and procedural differences can (and quite often do) create friction, confusion and divisive problems."*

*"I would be interested to see how this works - I am ex-Army and set up DMRC in 2018, a lot of the facilities are used all the time during the working week so fitting in another 63 patients will be interesting."*

Additional concerns related to the site being too overwhelming and/or traumatic for some patients and the security risks associated with the co-location.

*"For the community I represent - Refugees, Asylum seekers, BAME community - this will form a barrier to access, as previous traumatic experiences and other factors might limit their ability to engage."*

*"The security needed for military personnel/security has not been satisfactorily explained to indicate it wouldn't clash with patient need."*

***Table**: Comments on the suitability of treating NHS patients and military personnel on the same site (N=38)*

| Response theme | No. | % |
|---|---|---|
| **Positive comments** | | |
| Military and NHS patients will be separated anyway | 4 | 11% |
| **Negative comments** | | |
| Differences between military and NHS patients | 9 | 24% |
| Excessive demand on facilities / military would get priority | 8 | 21% |
| Site too overwhelming / traumatic | 7 | 18% |
| Security risks | 3 | 8% |
| **Other comments** | | |
| Location of the NHSRC | 7 | 18% |
| Other comment | 6 | 16% |

### 4.2.3 Accessibility of the NHSRC

In terms of accessing the NHSRC at the Stanford Hall Estate, 33% feel this would be very easy and 19% easy. In contrast, 14% perceive it would be difficult, 10% very difficult, and 24% neither easy nor difficult.

***Figure**: If you wanted to visit patients at the NHSRC, how easy would this be for you?*

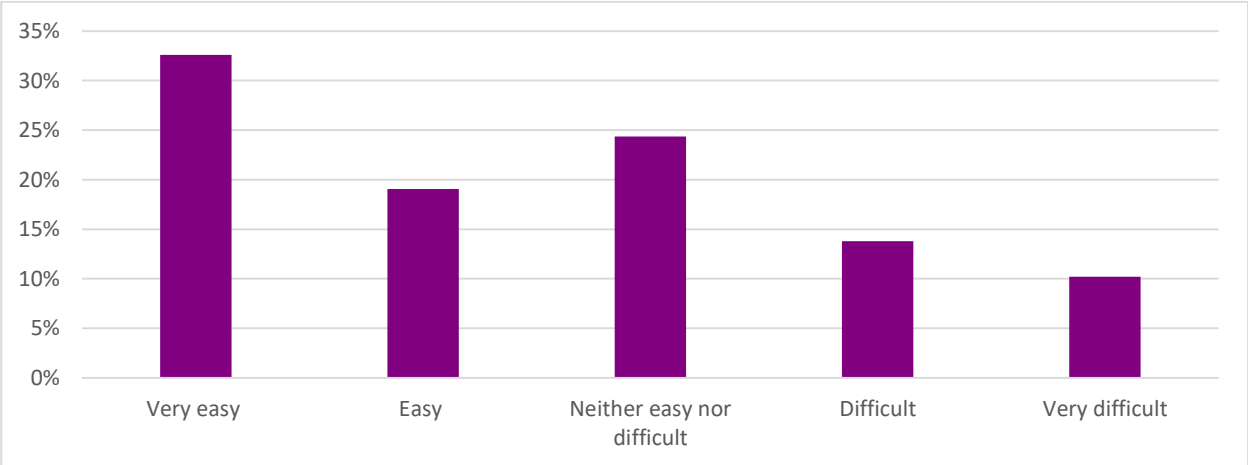



***Table**: If you wanted to visit patients at the NHSRC, how easy would this be for you?*

| | No. | % |
|---|---|---|
| Very easy | 246 | 33% |
| Easy | 144 | 19% |
| Neither easy nor difficult | 184 | 24% |
| Difficult | 104 | 14% |
| Very difficult | 77 | 10% |
| **Total** | **755** | **100%** |

Respondents were given the opportunity to comment further upon any difficulties they might have accessing the Stanford Hall Estate.

Most comments related to concerns about the increased distance and travel time that individuals would have in accessing the Estate as well as the poor public transport infrastructure in place, which many are reliant upon.

*"I live in Ashfield, the Nottingham hospital sites are already quite a distance and this would be a lot further."*

*"I do not drive. Public transport from north of Nottingham to Nottingham City Centre and then to Stanford Hall would be a nightmare."*

However, some suggestions were put forth to help address this, these included:

- Improved public transport including re-routing of the Sky Link bus/more direct bus routes
- A shuttle bus from each hospital site
- Free park and ride schemes
- Free, and adequate, car parking facilities
- Transport links from the nearest train station
- Installation of a public footbath between Rempstone and Stanford Hall.

*"As a non-driver there is no way I could access this site. My late Mother required rehab on several different occasions. She expected daily visits. I was working and had a family to look after. If I was late, never mind missed a visit, my life was not comfortable. Elderly people, in particular, expect their family to visit. So while I applaud the proposed increased benefits there needs to be proper provision for public transport."*

Although it was recognised that travel to the Estate would be less of an issue for those who live close and/or have access to a car, other concerns related to the expense, the vital role that family members have in the patients' rehabilitation journey, the problems that older and/or vulnerable individuals will have as well as the safety of visitors. The latter related to concerns about security for visitors accessing the site, the safety of individuals using public transport at night, the limited pedestrian access as well as the surrounding busy roads and junctions.

*"Can't imagine public transport there is great. Yet another reason to get the car out. Cycle there and risk becoming one of their patients."*

***Table**: Comments on the accessibility of the NHSRC (N=228)*

| Response theme | No. | % |
|---|---|---|
| **Positive comments** | | |
| No problem for those who drive / live close | 31 | 14% |
| Development of the NHSRC | 6 | 3% |
| **Negative comments** | | |
| Increased distance and travel time to access | 59 | 26% |
| Poor public transport access to the SHRE | 55 | 24% |
| Individual reliant on public transport | 44 | 19% |
| Travel costs | 18 | 8% |
| Not an accessible location for all | 12 | 5% |
| Vital role of family in the rehabilitation process | 9 | 4% |

| | | |
|---|---|---|
| Access for older / vulnerable visitors | 8 | 4% |
| Safety of visitors | 6 | 3% |
| Other, including:<br>• Local services are needed<br>• Stress associated with travelling to an unfamiliar location<br>• Impossible for respondent to travel to<br>• Distance from hospitals | 25 | 11% |
| **Considerations** | | |
| Suggestion to improve accessibility | 38 | 17% |
| Query, including:<br>• Will there be free parking?<br>• What are the plans for those who don't drive?<br>• What public transport is available? | 8 | 4% |

It was explained to respondents that;

> To reduce the travel impact for relatives, friends and carers, it is proposed that the NHSRC would provide free family accommodation with three family rooms available, free parking as well as super-fast broadband to enable patients to keep in touch with their families via communication channels such as FaceTime and Skype. Discussions are also taking place around enhancing local public transport.

Approximately two thirds feel that these factors would help to reduce the impact of increased travel time that some might face (60%); with a further 26% indicating that they would to some extent. In contrast, 11% feel these factors would not help, whilst 3% are not sure.

***Figure**: Do you feel that these factors would help reduce the impact of increased travel time that some might face?*

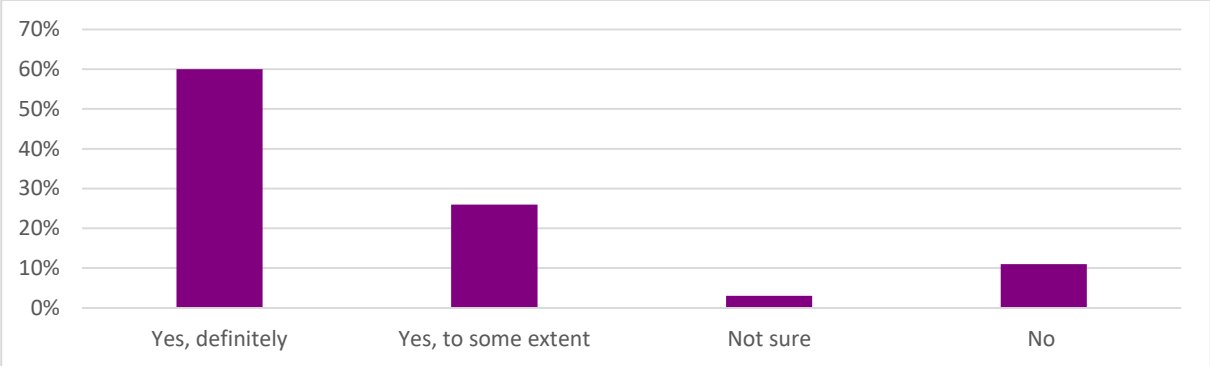



***Table**: Do you feel that these factors would help reduce the impact of increased travel time that some might face?*

| | No. | % |
|---|---|---|
| Yes, definitely | 451 | 60% |
| Yes, to some extent | 196 | 26% |
| Not sure | 26 | 3% |
| No | 83 | 11% |
| **Total** | **756** | **100%** |

Respondents were given the opportunity to suggest how individuals could be better supported in accessing the NHSRC.

Suggestions to improve accessibility related to:

- Improved public transport with more direct bus routes to the NHSRC
- Direct shuttle buses from each of the hospitals
- Subsidised travel i.e. discounted taxis/bus fares
- Free park and ride schemes
- A hospital car service.

In addition, a number of individuals felt that three family rooms are not adequate for 63 inpatients, with the suggestion that more should be made available.

*"From personal experience - 3 will not be enough."*

Other comments related to the importance of providing local services (i.e. keeping Linden Lodge open); overnight stay not being an option for some families due to work and/or childcare/caring responsibilities, the integral role that family members play in the rehabilitation process and/or the inappropriate use of NHS money being spent on family accommodation.

*"It's not just transport. Many people have other caring commitments that mean they could not stay overnight."*

*"Feels very unfair that you can provide these perks for a vanity project like this, whilst at the same time the NHS is happy to charge patients and staff to park at NUH. I don't understand why this would be a special case."*

***Table**: Suggestions to support individuals to access the NHSRC (N=80)*

| Response theme | No. | % |
|---|---|---|
| **Suggestions** | | |
| Improve accessibility | 25 | 31% |
| Provision of more family rooms | 17 | 21% |
| **Issues / concerns** | | |
| Keep services local / Stanford Hall too far away | 15 | 19% |
| Overnight stay not possible | 15 | 19% |
| Regular contact with family is essential | 8 | 10% |
| Inappropriate / waste of NHS funding | 5 | 6% |
| Disadvantage for some (i.e. elderly who are unfamiliar with FaceTime / Skype) | 2 | 3% |
| **Other comments** | | |
| Other comment | 12 | 15% |

### 4.2.4 Benefits and concerns of the location

Respondents were asked to identify the benefits of locating the NHSRC at the Stanford Hall Estate.

Most perceived that the Estate offers a rural, tranquil setting with access to fresh air and open space - a stark contrast from that of a busy hospital environment. Many noted how this would help boost wellbeing, aiding the recovery process.

*"Away from a hospital environment and in a beautiful countryside, hopefully would help with rehabilitation."*

*"The estate is wonderful - overlooking open countryside, so would be tranquil and serene."*

Furthermore, respondents noted how the location provides patients with access to specialist facilities and equipment, including those at the DMRC, as well as a great opportunity for collaboration with the DMRC in terms of the sharing of resources and best practice and longer-term prospects for education, training and research.

*"A purpose built environment for rehabilitation with better facilities that currently are on offer at Linden Lodge."*

*"Cross-fertilisation of experience with established military state-of-the-art facilities."*

A smaller number perceived the location to be centrally located in the East Midlands region, as well as in the UK, and accessible by car and public transport.

*"It's in a central location with good road networks and trains."*

Others highlighted the benefits associated with having all rehabilitation expertise in one location.

*"Critical mass of resources and well resourced."*

Further benefits, some of which reflect the wider proposal for a NHSRC, included improved access to focused rehabilitative care, reduced demand on acute NHS services, NHS savings through the utilisation of available land and better patient outcomes, and the pro-rehabilitation culture and ethos that will be embedded at the NHSRC.

*"Allowing the NHS to use existing facilities and services at Stanford Hall would enable this area to have a centre of excellence without duplication. Financially it would be an investment to support both patients and staff."*

*"It would be good to have a larger pool of patients going through similar journeys and a peer support and it may help from a psychological perspective."*

***Table**: Benefits of the location (N=594)*

| Response theme | No. | % |
|---|---|---|
| Rural, tranquil setting | 252 | 42% |
| Access to facilities/equipment inc. those at the DMRC | 196 | 33% |
| Collaboration and shared learning with the DMRC | 143 | 24% |
| Good accessibility | 82 | 14% |
| Centralised service | 72 | 12% |
| None/negative comment | 53 | 9% |
| Improved access to specialist, focused rehabilitative care | 35 | 6% |
| Reduced demand on acute NHS services / increase in the number of beds | 32 | 5% |
| NHS savings (through shared costs and better patient outcomes) | 16 | 3% |
| Pro-rehabilitation culture and ethos | 15 | 3% |
| Other benefit / comment, including:<br>• Provision of family accommodation | 64 | 11% |

| | | |
|---|---|---|
| • Local economy boost/job opportunities<br>• Much needed improvement from Linden Lodge | | |

In terms of concerns of the location, over half of those that responded to the question cited this to be travel and accessibility, an issue relevant for both visitors and staff. Concerns related to the increased travel time from Nottingham and other areas, the cost and poor public transport access.

*"Concerns about accessibility - not on a bus route, away from a train station, harder for those without vehicle access."*

*"Distance from Nottingham, accessibility issues particularly for those who don't have transport or are elderly."*

Although some did make a positive comment or felt there are no issues, others commented upon:

- Stanford Hall's poor geographical position within the East Midlands region.
- The impact on patients' wellbeing if they are unable to see their loved ones on a frequent basis.
- Conflict between the DMRC and the NHSRC in terms of the shared use of facilities, with concern that the military personnel get priority, as well as the issues associated with dealing with two very different population cohorts and the potential for inequalities in treatment to be highlighted.
- Reduced continuity of care beyond inpatient stay due to the distance of the location from acute hospitals, with concern about what would happen in cases of emergency.
- The impact on the surrounding area at Stanford due to the increased volume of traffic, which many already identified to be a problem.

*"Find a location more central."*

*"I imagine a lot of patients will end up being far away from home and this can have repercussions for mental health, wellbeing and relationships with family. Particularly for those who live far away."*

***Table**: Concerns about the location (N=569)*

| Response theme | No. | % |
|---|---|---|
| Travel and accessibility | 316 | 56% |
| None/positive comment | 124 | 22% |
| Poor geographical position | 52 | 9% |
| Isolation of patients | 48 | 8% |
| Sharing/conflict with DMRC | 33 | 6% |
| Continuity of care/distance from other NHS specialties | 32 | 6% |
| Impact on surrounding area | 23 | 4% |
| Limited access to community amenities for rehabilitation purposes | 18 | 3% |
| Security of the site | 16 | 3% |
| Continuity of care post discharge/no outpatients service | 13 | 2% |

| | | |
|---|---|---|
| Safety of travelling visitors (i.e. busy roads/junctions, limited pedestrian access) | 11 | 2% |
| Impact on Linden Lodge staff | 9 | 2% |
| Other concern/comment, including:<br>• Referral & eligibility criteria<br>• Location too intimidating<br>• Recruitment of staff<br>• Loss of service at Nottingham City Hospital<br>• Difficulty of home visits<br>• Lack of other inpatient rehabilitation options<br>• Proposal assumptions<br>• Financial concerns<br>• Difficulty for families to be part of the process<br>• Inadequate family accommodation | 76 | 13% |

### 4.2.5 Treatment and care at the NHSRC

Respondents were informed that;

The NHSRC will take a fresh and innovative approach to rehabilitation, putting the patients at the centre of care.

- It would be staffed by a multi-disciplinary team consisting of rehabilitation consultants, orthopaedic consultants, therapy assistants, physiotherapists, mental health nurses, occupational therapists, speech and language therapists, social workers and other professionals as needed.
- There would be a focus on occupational and vocational rehabilitation to help people get back to work.
- Each patient would be assigned a dedicated person (a clinical case manager) to coordinate their care throughout – from referral through to discharge.
- There would be an increase in the number of hours of therapy per patient per week (one-to-one and group sessions), with patients being able to spend their additional time on the rehabilitation estate supported by occupational and vocational therapists.
- Patients would have access to facilities such as a gym, hydrotherapy pool and a system to help patients practice their mobility and balance on a range of different services.

Most described the care that patients would receive at the NHSRC as excellent (73%), with 17% perceiving that it would be very good. Furthermore, 7% stated that it would be good, 1% fair and 1% poor.

***Figure**: What are your thoughts about the care that patients would receive at the NHSRC?*

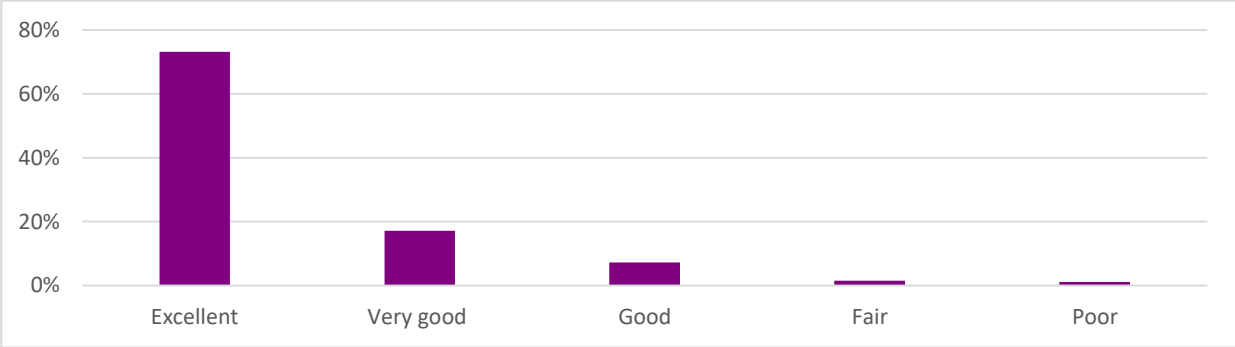



***Table**: What are your thoughts about the care that patients would receive at the NHSRC?*

| | No. | % |
|---|---|---|
| Excellent | 550 | 73% |
| Very good | 129 | 17% |
| Good | 54 | 7% |
| Fair | 11 | 1% |
| Poor | 8 | 1% |
| **Total** | **752** | **100%** |

Two thirds feel that the range of health and social care professionals that patients would have access to at the NHSRC is excellent (66%). Furthermore, 21% perceive this to be very good, 7% good, 4% fair and 1% poor.

***Figure**: What are your thoughts about the range of health and social care professionals that patients would have access to at the NHSRC?*

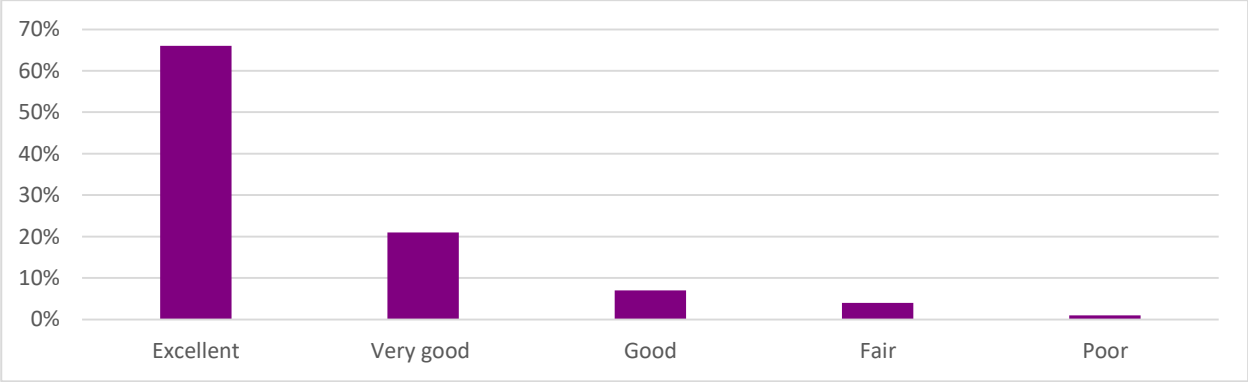



***Table**: What are your thoughts about the range of health and social care professionals that patients would have access to at the NHSRC?*

| | No. | % |
|---|---|---|
| Excellent | 499 | 66% |
| Very good | 160 | 21% |
| Good | 54 | 7% |
| Fair | 27 | 4% |
| Poor | 11 | 1% |
| **Total** | **751** | **100%** |

The following was explained to respondents;

> We recognise that it is important that patients' mental wellbeing is equally considered alongside their physical rehabilitation. It is therefore essential that proposals for the NHSRC take mental health, particularly helping patients to avoid feelings of isolation and boredom, into consideration. This will be done in relation to:
>
> - The way in which clinical and other staff will help patients create an environment of support, helping to minimise any feelings of social isolation.
> - Making assessment of patients' mental health part of ongoing assessments at least three times a week.
> - Support provided by a mental health nurse.
> - The design of the social facilities and use of the grounds. Evidence suggests that 'green spaces' are linked to improvements in patient wellbeing, mental health, levels of stress and positive behaviours.

The majority feel confident that patients' mental health is being taken into account (72%). However, 22% perceive it is being taken into account but more could be done and 7% that more needs to be done.

***Figure**: What are your thoughts on the approach to managing the mental wellbeing of patients during their time at the NHSRC?*

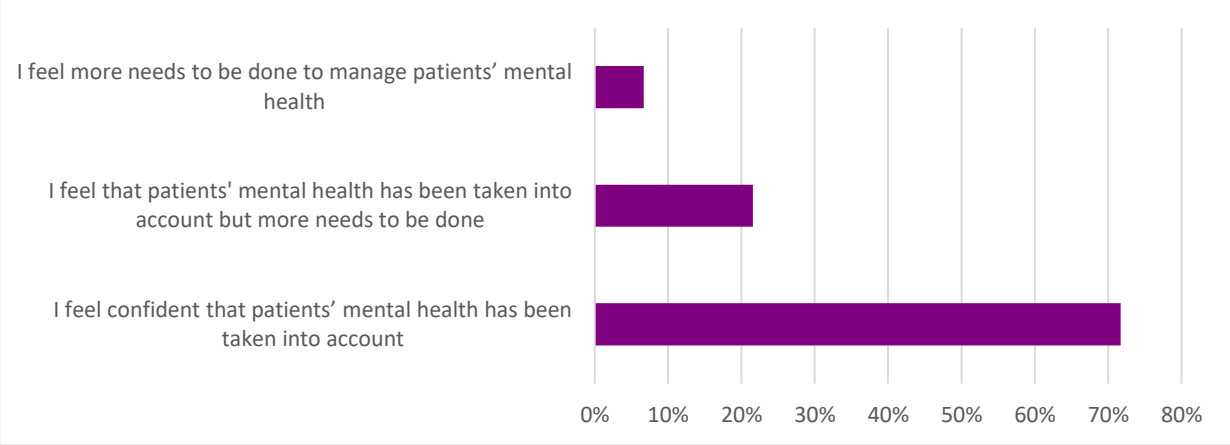



***Table**: What are your thoughts on the approach to managing the mental wellbeing of patients during their time at the NHSRC?*

| | No. | % |
|---|---|---|
| I feel confident that patients' mental health has been taken into account | 535 | 72% |
| I feel that patients' mental health has been taken into account but more needs to be done | 161 | 22% |
| I feel more needs to be done to manage patients' mental health | 50 | 7% |
| **Total** | **746** | **100%** |

Respondents were given the opportunity to provide any further suggestions as to how they thought patients' mental health could be better managed.

Most comments related to the need for greater support for patients due to the complexity of their needs, with suggestions that the following professionals should be included in the staff mix:

- Mental health occupational therapist
- Neuropsychiatrist
- Clinical psychologist/neuropsychologist/counselling psychologist/pain psychologist/psychologist
- Registered general nurse with mental health training
- Counsellors
- Activity coordinator.

*"The correct professionals need to be involved. Mental health nurses may not be trained in the psychological impact of health conditions, mental illness is rare in this group."*

*Major injury is life changing where are your clinical psychologists, activity coordinators and psychiatric team? A nurse asking if you are ok isn't good enough especially if you can't physically be with your family. Just look at lockdown a few face time calls isn't the same."*

Furthermore, incorporation of a range of therapy options was also considered important:

- Cognitive behavioural therapy
- Garden therapy
- Acceptance and commitment therapy
- Music therapy
- Art therapy
- Family-centred mental health practices.

Other suggestions included maximising the involvement of friends and family through improved access, providing access to mental health services post discharge, having a space for patients to socialise, providing opportunities for patients to explore the local community, inclusion of and mental health support for family members, provision of functional activities and ensuring that regular, meaningful assessments are undertaken.

*"Anyone can be trained to ask questions, it's what you do afterwards. Mental health nurses unless extremely experienced in physical and mental health in combination will not add that value as many do not understand their interconnection."*

A number of other comments/issues were raised including the importance of taking mental health seriously, not just playing it 'lip service', and the need for patients to be treated within their local community.

***Table**: Suggestions to help manage patients' mental health (N=139)*

| Response theme | No. | % |
|---|---|---|
| **Suggestions** | | |
| Greater support needed through the involvement of other professionals and different therapy options | 62 | 45% |
| Maximise involvement from friends & family through better access | 13 | 9% |
| Access to mental health support post discharge | 6 | 4% |
| Space for patients to socialise | 5 | 4% |
| Opportunity for patients to explore the local community | 5 | 4% |
| Inclusion of and mental health support for family members | 4 | 3% |
| Provision of functional activities | 4 | 3% |
| Regular, meaningful mental health assessments | 4 | 3% |
| Information Hub | 1 | 1% |
| **Issues / concerns** | | |
| Remoteness and boredom associated with location | 12 | 9% |
| Mental health must be taken seriously (implication for funding and staff training) | 11 | 8% |
| Patients must be treated within their local community / local services needed | 4 | 3% |
| Query over access for patients detained under the MHS or have MOJ restrictions | 2 | 1% |
| **Other comments** | | |
| Other comment | 24 | 17% |

### 4.2.6 Other comments/considerations

A wide range of other comments and considerations were made by respondents, these are summarised in the table below.

***Table**: Other comments (N=321)*

| Response theme | No. | % |
|---|---|---|
| **Positive comments** | | |
| Great opportunity/beneficial | 133 | 41% |
| **Issues / concerns** | | |
| Local services needed/don't close Linden Lodge | 21 | 7% |
| Location of the NHSRC at Stanford Hall | 10 | 3% |
| Financial sustainability/perception - cost saving initiative | 10 | 3% |
| Capacity inadequate to cope with regional demand | 6 | 2% |
| Criteria inappropriate to meet existing needs of rehabilitation referrals from acute hospitals | 6 | 2% |
| Impact on Linden Lodge staff / recruitment difficulties | 5 | 2% |
| Decision has already been made / consultation a tick-box activity | 4 | 1% |
| Lack of local rehabilitation options for those not eligible to access the NHSRC | 4 | 1% |
| Issues with running NHSRC alongside DMRC / careful thought needed | 4 | 1% |
| Impact on the local area (Stanford) | 2 | 1% |
| Issue of mixing patients with differing needs | 2 | 1% |
| **Considerations** | | |
| Access for other patient cohorts, including:<br>• Children / those aged 16+<br>• Those with spinal injuries<br>• Stroke patients<br>• Other causes of limb amputation<br>• Complex polytrauma patients | 38 | 12% |

| | | |
|---|---|---|
| • Non-trauma patients (i.e. oncology, knee replacement)<br>• Tracheostomy / ventilator dependent patients<br>• Medically discharged patients with continuing rehabilitation needs | | |
| Adequate staffing required with additional support / services, including:<br>• Neuro specific staff<br>• Psychologist<br>• Dietician<br>• Chaplain<br>• Orthotist<br>• Dog/art/music/recreation therapy<br>• Access to BSL interpreters. | 24 | 7% |
| Request for more information in relation to:<br>• Timescales<br>• National or local facility?<br>• Long-term funding plan<br>• Referral criteria and pathways<br>• How available the facilities at the DMRC will be/how will patients be transferred to these facilities<br>• Occupational therapist interventions<br>• Length of stay<br>• Discharge management and local step-down provisions<br>• Medical specialties at the NHSRC<br>• Evidence to support the proposed model. | 24 | 7% |
| Accessibility of the NHSRC must be improved | 13 | 4% |
| Development of existing community rehabilitation provisions | 10 | 3% |
| Referral pathways and equity in access from all local areas | 8 | 2% |
| Mental health support is imperative, including family support | 6 | 2% |
| Links to charities/other organisations to support community integration/return to work/discharge | 4 | 1% |
| Strong links with social care | 2 | 1% |
| The NHSRC must deliver on promises | 4 | 1% |
| **Other comments** | | |
| Other comment | 30 | 9% |

# 5 Feedback from the focus groups

A total of ten individuals participated in the online focus groups and one-to-one telephone interviews. The reasons for the interest of these individuals are shown in the table below. A summary of this feedback is provided in Section 5.5.

***Table**: Focus group / interview participants*

| Interest | No. |
|---|---|
| NHS staff member/health professional | 3 |
| Past specialist rehabilitation inpatient | 3 |
| Representative from an independent organisation supporting neurological patients | 1 |
| Representative from a charitable organisation supporting neurological patients | 1 |
| Carer of a past specialist rehabilitation inpatient | 1 |
| Member of the public accessing outpatient care at Linden Lodge | 1 |

## 5.1 Benefits of the proposal

Participants identified many benefits of the proposal, not only to patients, but in terms of improving the delivery of rehabilitation services across the East Midlands. These included:

- Development of a purpose-built rehabilitation facility for NHS patients with expertise under one-roof
- Improving patient access - addressing the large gap in provision for multiply-injured patients
- Improving access to up-to-date treatments, including the state-of-the-art facilities at the DMRC
- Collaboration and shared learning with the DMRC.

*"There has been a massive gap in provision for multiply-injured patients for many years, so I welcome it for them. We aren't able to provide the rehabilitation that they need in an outpatient setting."*

*"It is a phenomenal opportunity for the NHS to bring all of that expertise across rehabilitation to one place. The military centre is obviously state-of-the-art, in terms of their technology/facilities and there are lessons to be learnt probably both ways."*

The proposal was also felt to provide a great opportunity for Lincolnshire patients who frequently have to travel out of the area to receive specialist care, due to the lack of local facilities available to them.

*"We are extremely interested in the proposal because services in Lincolnshire are very poor and we are interested in how our patients can benefit from something locally. Our patients are used to going out of the county for care."*

Furthermore, one participant described how she felt the current inpatient facility at Nottingham City Hospital was not fit for purpose, perceiving that the lack of facilities available hindered her brother's recovery.

*"The staff were very good but it was like a small prison due to the lack of facilities. We had to take our own TV in for him. It needs knocking down; it is not fit for purpose."*

This individual described how her brother only received 45-60 minutes a day of intense rehabilitation during his two inpatient stays and therefore perceived that a more intensive rehabilitation programme would be extremely beneficial.

*"His recovery could have been quicker if he had received physiotherapy/occupational therapy support like in the stroke unit whereby patients receive intensive, daily physiotherapy and occupational therapy sessions leading to a speedier recovery and a reduction in time in hospital of three days on average."*

A small number commented upon the location of the NHSRC at Stanford Hall and the benefits that this will bring to patients in terms of health and wellbeing.

*"It's a super opportunity. Linden Lodge has a small patio area, so the ability for patients to get outside and have some fresh air at the NHSRC would be fantastic."*

## 5.2 Concerns about the proposal

In contrast, a number of concerns were raised about the proposal, many of which related to its location at the Stanford Hall Estate.

### 5.2.1 Poor accessibility

Many felt the location would be difficult for visitors to access, particularly those who don't drive and rely on public transport as well as those who have other day-to-day commitments e.g. work and childcare / caring responsibilities.

*"For those relying on public transport it will be very difficult."*

*"I lived with my parents when I had my accident, for them having to travel to Loughborough would have been a big problem as they both worked full time."*

Difficulty in access was felt to have a knock-on effect upon the frequency that patients could see their family/friends, potentially contributing to feelings of low mood and/or depression.

*"Not being able to see your family is exceptionally hard and contributes to the mood swings and depression."*

Although super-fast broadband was perceived to help some families to keep in touch, it was noted that many patients would be unable to use technology such as FaceTime and Skype.

Whilst the provision of accommodation for family members was felt to mitigate the travel issues that some might face, three rooms was felt to be insufficient given the centre's 63-bed capacity. It was further recognised that for various reasons including work and childcare/caring responsibilities, staying at the centre would not be an option for some.

*"Three family rooms are great but I imagine there will be a huge demand for them."*

*"What about the families that can't stay? These patients are likely to be there for many months."*

A suggestion was made by the participants that a shuttle bus service is provided from the various hospital sites to improve accessibility.

### 5.2.2 Segregation from society

Comments were made about Stanford Hall Estate being segregated from society with concerns about the impact that this will have on the patients' rehabilitation process. Participants in one focus group suggested that there should be cafes, shops and other facilities within the NHSRC to make the environment 'more normal' and allow patients to practice these day-to-day activities.

*"They so love to go Costa, to get away from the ward and get outside, they love to speak to each other and see a wide range of people, they don't want to see the same faces."*

### 5.2.3 The involvement of relatives in the patients' rehabilitation journey

There was concern that the remoteness of the location would create difficulty for family members/carers to be involved in their relatives' rehabilitation journey. This was felt to be particularly important given the vital role that these individuals play in the patients' wellbeing throughout the rehabilitation process and beyond.

*"Patients need to have links with their families and they need to be maintained."*

One health professional explained how much of a shock it can be to family members when they realise how impaired the individual actually is.

### 5.2.4 Access to medical specialties and continuity of care

Questions were asked about the medical facilities and specialties that will be available at the NHSRC to deal with patients' complex medical needs and how patients will access specialist care, which isn't available in the centre.

*"While in Linden Lodge, my brother had appointments for haematology and ophthalmology as well as repeated lung function tests, either myself or a staff member would take him for these."*

Discussions regarding inpatients who suddenly become unwell and require acute care, led to concerns as to what would happen in these situations and whether the receiving emergency departments will have the expertise available to deal with the patients. This was identified to also have implications on staffing at the NHSRC as patients would have to be accompanied by a member of staff.

*"I collapsed when at Linden Lodge and had to be taken back to intensive care, what will happen in cases of emergency?"*

There was a great deal of uncertainty as to whether patients would be able to receive the same seamless care as they do currently at Linden Lodge, due to the distance of Stanford Hall Rehabilitation Estate from hospital settings.

*"It's the links to the hospitals and how that is managed for communication purposes."*

*"I was admitted to intensive care in Queens Medical Centre and then the acute neuro ward. I was seen by a Senior Physiotherapist from Linden Lodge who put in place the*

*start of my rehabilitation process. I was then transferred to Leicester for a short while, the specialist brain unit. I was concerned about the fracturing of care, but everyone kept in touch, so when I came back from Leicester I had seamless care and everyone was made available to me."*

### 5.2.5 Discharge of patients to their local communities

Many questioned how the discharge process would work and further how the distance of the NHSRC from some counties might impact on this.

*"We would normally invite a member of the local community neuro teams to case reviews – the distance may not allow that to happen."*

*"The reablement team, the transition between inpatient and outpatients – will there still be a reablement team to support you to settle back home?"*

Additionally, it was asked what 'step-down' rehabilitation is available within communities to continue to support patients in their rehabilitation journey, with concern that the lack of provision available will reverse the benefits of the intensive rehabilitation.

*"Even if we have this development, the step-down after that, when people go into their local areas – where is the step down rehab within communities, is it going to undo the benefits of the intensive rehab?"*

Participants in one focus group positively discussed the idea of a rehabilitation flat to support patients in becoming more independent prior to their discharge. A suggestion was made that the CCG should explore opportunities to collaborate with the independent sector which already provides similar facilities.

*"We provide flats which support the discharge process primarily for neurological patients. One of the things we have found is that, post-brain injury – the person is going home with a different skill set, needs and sometimes a different personality. It's important that when the family is having to support that individual at home that they can all practice together with professionals around to iron out any wrinkles before they are left to go it alone."*

### 5.2.6 Criteria for admission and the referral process

Participants repeatedly questioned who would be eligible for treatment at the NHSRC, with concerns about what would happen to those who weren't eligible or chose not to receive their care there.

*"What will happen to those who can't receive care at the NHSRC, what will be available for them?"*

Clarification was sought upon the criteria for MSK patients, with one health professional stating that most major trauma patients who need MSK rehabilitation go home directly from the major trauma centre and receive their rehabilitation within the community. The same health professional highlighted how once medical co-dependencies has been investigated, the patient cohorts that can be safely treated at the NHSRC will be limited.

*"There are multiple specialties you would have to have on site."*

Furthermore, questions were asked about the referral process and how equity in access will be ensured, with concerns about how accessible the service will be for Lincolnshire patients.

*"It may be that those consultants who shout the loudest get the majority of access to the unit, so there may be people whose consultant isn't able to get them access or they may be unaware of what is available there."*

*"How will our (Lincolnshire) patients be able to access the service? If connections aren't made between hospitals then there is nowhere for our patients to go. I don't think we've had any patients attend Linden Lodge, which is interesting in itself, will this new facility push us out even further?"*

### 5.2.7 Financial issues

A small number expressed concern as to whether £70 million is sufficient to build what is being proposed and furthermore whether the CCG will have enough money to fund the facility day-to-day.

*"£70million doesn't sound enough to me, to adapt what is already there and to build what is needed for the number of patients it seems inadequate for what they want to do. I'm concerned that when they see the final bill they will realise it's twice as expensive as they thought and that it will finish up being a poor man's service not the top notch one they wanted it to be."*

One individual described the proposal as a 'fantasy' given that whilst patients are 'bed blocking' in acute NHS services they don't receive intensive physiotherapy/occupational therapy whilst they are waiting, and therefore there isn't a cost that can be transferred.

### 5.2.8 Workforce issues

A handful of comments were made regarding staffing and whether the CCG will be able to recruit the specialist staff required, given the workforce issues that are currently being experienced. These issues were highlighted by a past inpatient who stayed at Linden Lodge earlier this year/during the Covid-19 lockdown;

*"We had nights were there wasn't sufficient staff and they had to get bank staff at short notice."*

Furthermore, a small number questioned whether staff are happy about being relocated/travelling to the new development.

### 5.2.9 Other issues

Other concerns, identified to a lesser extent, related to:

- The differences between rehabilitation care for military personnel and NHS patients.

*"It's a job, place of work, some military personnel who don't have cognitive deficit arrive on a Monday morning and go home at the end of the week."*

*"Statistics are being compared to the military and their approach is very different."*

- Patient safety - ensuring that security is in place for access as well as precautions to prevent patients from absconding.

- Participation in intensive rehabilitation being more dependent on patients' physiological ability i.e. fatigue, rather than their willingness and motivation.

*"I know from my own condition, fatigue was a huge thing. I'd manage half an hour before they had to put me to bed."*

### 5.3 Mental wellbeing of patients

Mental health support was perceived as vitally important for patients at the NHSRC, and their families, to help them to come to terms with what has happened, as well addressing any feelings of low mood or isolation that may be associated with being at the centre.

*"The psychiatric consultant was invaluable in supporting my brother at Linden Lodge and us as a family."*

*"If you are going to isolate patients and they don't have visitors from one week to the next, it will be so important."*

Participants emphasised that support must be available from a wide range of mental health professionals including psychiatrists and psychologists, that it must cover a range of specialisms and that it must be very accessible to patients.

*"You have psychologists for neuro with brain injury, neuro without brain injury, then there is the psychology for people with major trauma, that psychology is completely different to that of feeling isolated."*

One individual explained how disengaged she was with the psychological support that she received during her inpatient stay at Linden Lodge, noting how she would have found the support more valuable post-discharge.

*"Seeing a psychologist every week, I would pretend to be asleep, I didn't want to engage. It didn't really work, I didn't think it was important; I just wanted to get up and walk. I would have benefitted from having access to a psychologist after I left."*

Participants made a number of suggestions to help to ensure that patients are kept occupied and motivated during periods of down-time, particularly if their relatives aren't able to see them as frequently:

- An information hub – a place where patients can go and ask any questions they might have or find out information.

*"Somewhere people can go and ask questions about anything. People don't expect to be in rehabilitation, it is difficult to navigate the system, the pathways, the jargon, the 'what happens next' – all those worries and anxieties can play on your mind – it would be great if they had somewhere to go and ask a question"*

- Peer support – using those who have been through intensive rehabilitation to provide support to those currently on their journey.

*"There is great value in talking to people who have been there before, to share experiences."*

- Giving patients access to iPads and other devices with quizzes and other interactive games.

*"Interactive things are better than talking to a professional. It's nice to have reassurance that you still know some things."*

### 5.4 Other queries/points for consideration

- What will happen to the site at Linden Lodge? What will happen to the building? Will outpatients be expanded?

- What measures will be in place if the facilities at the DMRC are fully subscribed/needed by the military and therefore access for NHS patients is limited?

- How will it work with pharmacy, given that neurological patients need speedy access to medication?

- How will patients be supported to return to work when they aren't necessarily in that mind-set or consider that a priority in their rehabilitation journey?

- How will the three-bedded service that remains at Nottingham City Hospital operate as a dedicated rehabilitation unit?

- How will the NHSRC link with social services?

### 5.5 Summary

Participants identified many benefits of the proposal, the key ones being:

- Development of a purpose-built rehabilitation facility for NHS patients with expertise under one-roof.

- Improved patient access - addressing the large gap in provision for multiply-injured patients.

- Improved access to up-to-date treatments, including the state-of-the-art facilities at the DMRC.

- Collaboration and shared learning with the DMRC.

In contrast, a number of concerns were raised, many of which related to the NHSRC's location at the Stanford Hall Estate:

- Difficulty in access for visitors – particularly those who don't drive and are reliant on public transport as well as those with other day-to-day commitments.

- Feelings of low mood and/or depression associated with patients seeing their family/friends less frequently.

- Segregation from society, with concern that patients won't be able to practice normal, day-to-day skills which are an essential part of rehabilitation.

- Difficulty for family members/carers to be involved in their relatives' rehabilitation journey.

- Reduced access to medical specialties, including acute care, impacting upon patients' continuity of care.

- Distance of the NHSRC from local communities and the impact this has on the transition from inpatient to community care.

- Availability of step-down care within local communities, with concern as to whether this will be adequate enough to continue to support patients in their rehabilitation journey.

- Options available to those who are ineligible to receive their rehabilitation care at the NHSRC or chose not to.

- Financial modelling and sustainability of the new facility.

- Recruitment of specialist staff as well as opinion of those currently working at Linden Lodge.

# 6 Feedback from stakeholders

To ensure as fair an opportunity as possible was given for all to provide a contribution to the consultation, direct communications were actively encouraged and included in the process.

A summary of this feedback is provided in Section 6.6.

***Table**: Responses received from stakeholders and via social media*

| | |
|---|---|
| **NHS Trusts** | • Nottingham University Hospital<br>• University Hospital of Leicester<br>• University Hospitals of Derby and Burton |
| **CCGs** | • NHS Leicester, Leicestershire and Rutland<br>• NHS Derby and Derbyshire |
| **Professional bodies / associations** | • The British Society of Rehabilitation Medicine<br>• Rehabilitation Medicine Specialist Advisory Committee<br>• Royal College of Physicians<br>• The Paediatric Neuroscience Governance Council |
| **Charity organisations** | • Healthwatch Lincolnshire<br>• Headway |
| **Social media** | • Facebook |

## 6.1 Submissions from NHS Trusts

### 6.1.1 Nottingham University Hospital NHS Trust Board

A response was received from the Chief Executive Officer and Chairman of the Trust Board on the 4th September 2020.

The response emphasised the Trust's continued support for the proposal, specifically in terms of:

- The benefits that would be brought to the patient population, recognising that many patients in acute beds require rehabilitation to regain a fulfilling life
- The increased access to specialist inpatient rehabilitation
- The transformation of how rehabilitation is delivered across the system, setting a blue print for others
- The significant health and social care savings associated with patients' improved outcomes
- The opportunity to deliver a national centre of excellence which creates further opportunity for local public sector collaboration in the areas of education and research.

### 6.1.2 University Hospitals of Leicester NHS Trust

A response was received on the 17th September 2020 from the Acting Chief Executive of the University Hospitals of Leicester NHS Trust.

The response details that the Trust fully support the proposal as it provides opportunity to not only reduce the demand on acute and community services, but also for the region in hosting such a prestigious flagship centre. The Trust is also enthused by the involvement of the University of Leicester, which will form part of the academic consortium, and further the positive influence of the NHSRC to other areas of the country.

*"The East Midlands has been presented with a golden opportunity to deliver a national centre of excellence which will greatly benefit our patients and creates further opportunity for local public sector collaboration in the areas of education and research."*

### 6.1.3 University Hospitals of Derby and Burton NHS Trust

An extensive response was received from the Rehabilitation Medicine Department of University Hospitals of Derby and Burton NHS Trust. It states that the Department 'neither supports nor opposes' the proposal for the development of the NHSRC and further that they 'slightly oppose' the transfer of the service at Linden Lodge stating that neurorehabilitation services in Nottingham will be in a poorer state from this. The main reasons for their objections are summarised below:

- NHSRC patients will lose the benefits of easy access to urgent care and diagnostics, as well as to specialist physicians/surgeons. They will therefore not have continuity of care beyond inpatient stay, which is standard in all neurorehabilitation units.

- The NHSRC is much less accessible than Linden Lodge and will be difficult, time-consuming and costly for those travelling by public transport.

- The remoteness of the SHRE does not allow patients to practice 'real world' situations.

- Managing split sites (i.e. the NHSRC and the three bedded facility at Nottingham City Hospital) will be costly and difficult.

- The significant number of patients who would normally be in a level 2b inpatient unit who will be ineligible to receive care at the NHSRC, with the Department questioning where those patients would go other than the three acute neurorehabilitation beds remaining at Nottingham City Hospital.

  The Department noted that in a typical neurorehabilitation ward at least a third (of patients) are not compatible with the ethos of the ideal NHSRC patient cohort. It is therefore felt that there will be two cohorts of patients with different rehabilitation needs.

The Department strongly emphasises that a dynamic outpatient service is a must for the success of the NHSRC. Their argument is provided on a number of reasons:

- The current proposal is not compatible with research, innovation and training, primarily because patients need to be engaged with over a longer term.

- There will be two types of patients needing vocational rehabilitation at the NHSRC - MSK patients and neurorehabilitation patients, which for differing reasons would require ongoing input post discharge.

- Complex prosthetics is unlikely to be relevant to inpatient stays for MSK patients – these are longer term issues, which only an outpatient service will deal with.

- It is assumed that patients will be sent back to local rehabilitation services for therapy and medical follow-up; however the reality is that they could be waiting for many months before they are picked up.

- For neurorehabilitation patients, typically the immediate and discharge goal is to help them to manage in their home environments. Therefore, facilities such as Gait analysis, CAREN and the hydrotherapy pool are more beneficial for neurorehabilitation patients in the longer term than during their inpatient stays.

- Access is needed to a wheel chair service, which either needs to be subcontracted to a regional service or the NHSRC has its own in-house service. Due to the distance, it will be difficult for the regional service to provide timely input.

The Department therefore urges that these issues are considered before moving forward to make the project successful.

The response also highlighted a number of further points for consideration, including:

- Inclusion of other types of professionals within the skill mix i.e. neuropsychologists (to provide cognitive and behavioural assessments), psychiatrists, orthotists and general physicians.

- Safeguarding measures for ‘wandering’ patients.

- Suitability of high intensity therapy for patients - physical and cognitive fatigue.

- Unrealistic lengths of stay within the Pre-Consultation Business Case and Workforce document.

- The NHSRC should employ the whole of the consultant workforce to allow negotiation with trusts and ensure all consultant staff are guided by the same set of regulations, managerial structures and training requirements.

- Inadequacy of three family rooms for 63 inpatients.

- Super-fast broadband may benefit some, for others it will be of no use.

- At times of major conflicts, NHS rehabilitation beds may be absorbed by the DMRC.

## 6.2 Submissions from Clinical Commissioning Groups

### 6.2.1 NHS Derby and Derbyshire CCG

A response was received from NHS Derby and Derbyshire CCG (DDCCG) on the 17th September 2020.

In principal, DDCCG considers the proposal to increase the number of rehabilitation beds within the East Midlands - a positive step for improving patient outcomes and meeting the existing unmet demand.

However, DDCCG has concerns about the location of and access to the service. Their response highlights that the calculations included within the travel impact assessment (TIA) do not cover the new DDCCG boundary, meaning it is likely that visitors will have to travel even further than that documented in the TIA.

In addition, the DDCCG has a number of specific queries in relation to;

- The extent to which clinicians from the relevant team at UHDB have been involved in constructing the proposal.

- Wrap around services and the impact on the community offer that would need to support patients who are discharged from the NHSRC.

- Equity of care for patients who receive their rehabilitative care at the NHSRC vs the Kings Lodge site, as well as an assessment of impact that the NHSRC would have on the Kings Lodge service.

- The route of referral and whether those under a legal framework, such as the Mental Health Act or Ministry of Justice restrictions, can access the service.

- The extent to which the development gives equal consideration to the mental health needs of the patient cohort.

- Validity of any assessment / outcome tools devised by the service.

- Arrangements to manage the quality of service.

- Assumptions which underpin the length of stay and non-elective admission efficiencies that have been applied for Derby and Derbyshire demand.

### 6.2.2 NHS Leicester, Leicestershire and Rutland CCG

A response to the consultation was received from Leicester, Leicestershire and Rutland (LLR) CCG.

The response explains how the proposal does not fit with LLR's Home First Strategy, the premise of which is that keeping patients in a hospital environment is not positive for their general health. Heavy investment has recently been made in outpatient rehabilitation, with LLR CCG now looking to improve day case rehabilitation services, not inpatient services.

As LLR does not have its own trauma centre, LLR CCG has little need to refer patients to a rehabilitation centre. Furthermore, a review has revealed that LLR CCG has small numbers of neurorehabilitation patients who would require this type of facility.

For stroke patients, LLR CCG has a cohesive acute and community team delivering rehabilitation to this patient group, with the services based around outpatient / home visits.

For these reasons, LLR CCG is not able to support the proposal, however if a day case model was to be considered they may be able to support it.

## 6.3 Submissions from Professional Bodies/Associations

### 6.3.1 The British Society of Rehabilitation Medicine

A response was received on the 17th September from the British Society of Rehabilitation Medicine (BSRM).

The response states that the BSRM strongly support the creation of the NHSRC, however has many reservations about its location at the Stanford Hall Estate, and further that they strongly oppose the transfer of inpatient beds from Linden Lodge. The key reasons for this are summarised below:

- Patients requiring inpatient specialist rehabilitation have multiple and complex needs, medical safety for these patients can only be assured by the co-location with those specialties that are most commonly needed on an acute basis.

  Concern was raised about the high proportion of patients currently receiving rehabilitation at Linden Lodge who need prompt access to acute medical and supporting services, which are not available on a stand-alone site.

*"Patients are therefore likely to be selected for rehabilitation at the NHSRC on the basis of predicted low medical needs, rather than true rehabilitation need."*

- Transfer of patients from the NHSRC to Nottingham City Hospital for investigations or acute care will require availability of additional staff.

- The significant lack of detail regarding medical cover raises concern as to whether the out-of-hours medical support will have the expertise to assess acute illness in complex rehabilitation patients. Further concern was raised about the processes for acute medical management, and how this will be delivered safely.

- The Stanford Hall location is reminiscent of the historical practice of ‘convalescence’ in a rural location, rather than active rehabilitation in an urban environment, close to patients’ homes.

- Public transport to Stanford Hall is inadequate with concerns about the safety of visitors travelling to the site, as well as the additional journey time and cost.

- Social isolation from family and friends will pose huge issues, with the potential for patients to become estranged from their families. Superfast broadband will only be useful to those who can use this technology.

- Home visits to facilitate discharge will prove time-consuming and costly in terms of staff time and in provision of transport.

- Three rehabilitation beds at Nottingham City Hospital will not meet the actual need for early rehabilitation following illness or injury.

- Training requirements for rehabilitation medicine trainees could not be fulfilled at the NHSRC, with the likelihood that the site will not be approved for the training of specialty trainees.

It is therefore felt that the NHSRC would be valuable as a tertiary service for specific circumstances, where there is currently inadequate and/or non-expert provision. These patients would be medically stable and won’t require acute medical care during their rehabilitation programme. Example cohorts of patients with chronic and debilitating pain, sports rehabilitation or patients who have suffered complex polytrauma were provided.

The response also highlighted a number of further points for consideration;

- Rehabilitation goals and aspirations of NHS patients are not comparable with those of military personnel.

- Unaccounted demand by patients who are not currently occupying beds, but have unmet rehabilitation needs.

- Three family rooms are inadequate for 63 patients.

- Many patients will initially only be able to tolerate rehabilitation/therapy sessions of 10 to 15 minutes.

- Specialist rehabilitation services have urgent needs of security support.

- On-site clinical psychology, neuropsychology and psychiatry services (from a consultant psychiatrist) are essential.

- Patients with multiple injuries are likely to have involvement of several orthopaedic surgeons. If consultations are delivered virtually, the effectiveness is significantly compromised.

- Follow-up appointments for neurosurgical and other specialties.

- Offer of a weekly boarding facility with patients going home at weekends – useful for vocational rehabilitation.

### 6.3.2 Rehabilitation Medicine Specialist Advisory Committee

An extensive response was received from a Professor and Consultant in Neurological Rehabilitation, Chair of the Rehabilitation Medicine Specialist Advisory Committee.

The response presents an extensive argument against the development of the NHSRC and the relocation of inpatient rehabilitation services from Linden Lodge, with strong concerns about the significant lack of detail contained within the proposal.

*"How can anyone comment on a proposal, and how could commissioners consider what patients might benefit, in the absence of any statement about the service to be provided."*

There are felt to be two fundamental problems with the proposal, specifically:

1. The isolation of the services from everything that is important – the proposal is felt to contradict the current focus of integrating rehabilitation into day-to-day practice in all hospital services, with concerns that moving rehabilitation away from other medical services would prevent integration of care / reduce the provision of holistic patient care to many patients.

   Furthermore, it is noted that services that are separated from the body of the NHS are at greater risk of developing unsafe practices or persisting with out-of-date practices.

2. A basic misunderstanding of the nature of rehabilitation - the remoteness of the location is felt to severely limit the ability and relevance of rehabilitation, with the proposal based on the assumption that patients will easily and simply, return to their home environment without further difficulties.

   Furthermore, it is noted that patients will see their family and friends less frequently and will not be exposed to any of the normal day-to-day stimuli experienced at home, fundamental parts of rehabilitation.

The response further argues that only patients who are medically stable and are unlikely to need any urgent medical diagnostic or treatment input will be able to receive treatment at the centre, and that the patients being seen will not have any special characteristics. For these reasons, it is felt unlikely that the NHSRC will attract research resources as well as any academic departments.

Furthermore, it is felt much more appropriate to have any education centre associated with an academically active and clinically active university department of rehabilitation.

Additionally, the proposed rehabilitation centre is felt to be a totally unsuitable place to base a trainee doctor in rehabilitation due to the limited rehabilitation experience as well as the limited/absent training support.

*"At a time when the breadth of the curriculum has been widened markedly to meet the needs of all NHS patients, it would be inappropriate for a trainee to be based in a centre such as this which would limit experience and offer little training of value."*

Further concern was raised about the financial case which relies upon the centre meeting all the local inpatient rehabilitation needs which is felt to be unrealistic and the practicality of having a three-bedded rehabilitation unit.

The response suggests that local health services would obtain much more benefit for their money by reorganising the provision of rehabilitation within existing buildings and organisations.

### 6.3.3 Royal College of Physicians

A response to the consultation was received from the Royal College of Physicians (RCP) on the 18th September 2020.

The response states that while the RCP support the development of the NHSRC, they do not support its development on the proposed site at Stanford Hall. They further express confusion as to whether the proposal is for a national or local NHSRC – both of which are considered problematic.

The key reasons for their objection include:

- Patients who require a Level 1 or 2 rehabilitation service need access to a range of acute medical and surgical services due to their medical instability and complex needs. Significant concern was therefore raised about the medical safety of patients if the current caseload at Linden Lodge were to be managed in this new service.

  The RCP further highlights that due to the medical instability of Covid-19 patients, as well as the fatigue associated with this condition, it is unlikely that these patients will be able to benefit from the intensive rehabilitation being offered.

- Patients would need to be transferred to and from acute NHS services which will eat into their 'rehabilitation time' and deplete their energy to engage, whilst also requiring additional staff to escort.

- If the NHSRC was a national rehabilitation centre, it would need to fulfil a role that is not provided elsewhere in the UK. However, as the purpose of rehabilitation is to get patients back to their normal lives, the RCP states that it will be extremely difficult to re-integrate patients into their own local environment from a distance.

*"There could be an argument for providing short programmes of specialist inpatient rehabilitation for particular groups of patients who are poorly catered for elsewhere, but in this case the centre would need to link extremely closely with the local rehabilitation teams from all over the country to carry over the benefit once patients return to their usual environments".*

- Incorporating activities such as road safety, shopping, communicating with strangers, essential parts of the rehabilitation process, is difficult from a remote location.

- The provision of a three-bedded rehabilitation unit is not practical or possible.

- Difficulty for families, who play an integral part in the rehabilitation process, to travel to the NHSRC if they do not have a car and/or live within a reasonable distance. This was particularly a concern for mobility impaired visitors who rely on public transport.

- Suitability of the site for the placement of trainees in rehabilitation medicine given the limited nature of the caseload that could be provided.

- Providing home and work visits from such a remote site will be time-consuming and costly in terms of staff time and in provision of transport. Some patients require a phased discharge from a rehabilitation unit, which again may be difficult.

- Specialists may not be prepared/able to attend the centre on a visiting basis, and there may be little point in them doing so without access to the appropriate facilities onsite.

For these reasons, the RCP does not believe that the proposal is feasible as currently set out. Their view is that the proposed location at Stanford Hall could possibly fulfil a role as a national centre for specific cohorts of medically stable patients who are well enough to engage in and benefit from a very intensive residential rehabilitation programme.

A number of further points were put forth for consideration:

- The co-location with the DMRC will highlight the inequalities in the level of service being offered to military and NHS patients.

- NHSRC patients will only have access to the facilities at the DMRC in the evenings, by which time fatigue will make it difficult for patients to benefit, as well as falling outside the normal working hours of most NHS therapists.

- Gait analysis will be useful for a relatively small proportion of NHS patients and has proved to be more useful in a planned outpatient assessment.

- Free parking is not sufficient to compensate for the additional journey time and costs of frequent visits by car.

- Three family rooms are inadequate for 63 patients.

- Whilst broadband may help some, it does not replace actual face-to-face visits, and many patients with cognitive problems struggle to use Skype etc.

### 6.3.4 Paediatric Neuroscience Shared Governance Council

A response was received from the Paediatric Neuroscience Shared Governance Council on the 27th July 2020.

Support was expressed for the proposal in terms of the positive impact it will have on the outcomes for patients, recognising the deficit in rehabilitation capacity for adult services.

*"This is such a positive strive for adult rehabilitation"*

It was queried whether the proposal has considered accepting teenagers, due to the significant gap/grey area in provision for individuals aged 16-17 years.

## 6.4 Submissions from charity organisations

### 6.4.1 Healthwatch Lincolnshire

Healthwatch Lincolnshire submitted a response to the consultation on the 17th September 2020.

The response states that Healthwatch Lincolnshire welcome the proposal which will greatly enhance the quality of care for affected patients. However, they have three key concerns;

- Access, especially for those without cars and family support.

- Ensuring patients receive ongoing care following discharge which maintains, and builds upon, their progress achieved at the NHSRC.

  This is a particular concern in Lincolnshire, which does not have the aftercare support in place to continue the care required post discharge. It is asked whether the planning, design and delivery of the NHSRC can consider and ensure the ongoing care pathways for patients and families e.g. establishing and agreeing a suitable reablement package within a return to Lincolnshire services framework of collaboration.

- Commissioning, and how many Lincolnshire people will be able to access this centre.

The response requested information about what accessing the NHSRC would look like for Lincolnshire patients - the pathways, transport, discharge, and aftercare, as well as

the number of patients expected to be treated from Lincolnshire. Furthermore, Healthwatch Lincolnshire are keen to understand how well the Lincolnshire care system was involved and is prepared to cater for the delivery and aftercare of the centre.

### 6.4.2 Headway

A response from Headway – the brain injury association was received.

The response states that Headway slightly supports the proposal to create a NHSRC due to the increase in the number of rehabilitation beds that the proposal would have as well as the opportunity that would be provided for non-military brain injury survivors to access the state-of-the-art facilities at the DMRC.

However, the organisation raised concern about the transfer of the service at Linden Lodge due to the detrimental impact that the closure of Linden Lodge will have on those who are accessing the service.

Headway discussed how rehabilitation centres in hospital estates offer a smooth transition to community services, raising further concern about how the remoteness of the SHRE would provide little opportunity for brain injury survivors to re-learn lost skills such as how to use the bus or visit shops.

Their response emphasised the importance of ensuring that the new facility is accessible, particularly via public transport, due to the pivotal role that family members and carers play in a patients' rehabilitation process. Furthermore, it was suggested that the CCG should consider introducing financial support for families and carers when travelling or securing accommodation close by.

*"Public transport access is of particular concern and the CCG should look to work with transport providers to secure public transport options to the new site should it go ahead. If inpatients feel lonely or isolated due to lack of visits from family or friends this could seriously impact their rehabilitation in the acute phase."*

Headway requested a cost-benefit analysis to consider the establishment of the NHSRC vs upgrading existing provision across the region, and would like to ensure that if the development goes ahead that the pathways into community care are clear for patients who attend the NHSRC.

## 6.5 Social media

A total of 128 comments were made in response to the promotion of the consultation on social media, however only 81 of these were considered relevant. These comments were provided by 55 people.

As posts are directly identifiable, these were anonymised and summarised within the categories - positive, negative and other/neutral.

### 6.5.1 Positive comments

A total of 23 positive comments were recorded and covered the following themes:

- Great/brilliant idea.
- Provision of a centre of excellence with access to state-of-the-art facilities.

*"It is a logical step to offer a state-of-the-art facility for rehabilitation allowing patients to benefit from a focussed rehabilitation led by experts and with extensive support services."*

- Benefits of the co-location with the DMRC.

*"Amazing opportunity to have funding provided for this, co-located with a world leading military rehabilitation facility which means the expertise will already be there on site. Should be a world-class service. We are very lucky to have this chance."*

- A much needed facility for East Midlands patients, especially for those in Lincolnshire where there is a lack of provision.

*"A state-of-the-art centre is long overdue in the East Midlands; unfortunately it cannot be on everyone's door step."*

- Outdated / poor rehabilitation facilities at Linden Lodge.

*"Linden Lodge at the City Hospital is outdated, it's not a very big place, the communal room is small, one of the treatment rooms doubles as the exercise room, and the equipment is outdated. My son was in there for just over 6 months."*

- Other positive comment including; location accessible by public transport and willingness to travel to receive specialist care.

### 6.5.2 Negative comments

A total of 45 negative comments were recorded and covered the following themes:

- Remoteness of the location from Nottingham City Hospital and other hospitals, with limited public transport access.

*"Virtually no public transport at all in that area."*

- Difficulty for visitors, especially elderly individuals, to access the centre in terms of increased travel time and cost.

*"Many can't afford to stay overnight and I'm sure the NHS won't pay for all the time, travel and accommodation expenses."*

- Impact on patients of seeing their loved ones less frequently.

*"Never seeing family and friends because it's too far to travel is not beneficial to patients!"*

- Investment should be made into improving existing NHS facilities, not building new ones.

*"The money needs to be spent on existing hospitals, not building a state-of-the-art centre. Not a good idea at all when the NHS is already struggling."*

- Closure of local facilities which provide high-quality care.

*"We have this already at NUH and the care there is excellent."*

- Financial modelling and sustainability of the NHSRC.

*"The government is offering money to fund the building but there is no extra money for running costs. Will money be taken from other services to fund this? I worry that although it could provide an excellent service for those patients expected to make a good recovery (return to work etc.), other (perhaps older) patients might lose out."*

- Concern about privatisation of the NHSRC and the impact on the quality of care delivered.

*"If it's thought to be so good and you have the funding why do you need a public consultation? Is it going to be sub-contracted to a private health business so you are covering your backs?"*

- Concern that decisions have already been made and the consultation process is a tick-box exercise.

### 6.5.3 Other/neutral comments

A total of 13 other/neutral comments were recorded and are summarised as follows:

- Suggestion that the NHSRC is made available to major burns survivors with mental health issues.
- Discharge should be considered to convalescent homes.
- Query/speculation about the managing organisation (i.e. NHS or private).
- Query as to how staff in Nottingham, as well as other areas, feel about the location/relocation.
- Query as to whether the existing inpatient facilities in Derbyshire, Leicestershire and Loughborough will close.

## 6.6 Summary

Responses from stakeholders and comments provided by members of the public on social media varied in terms of their views upon the proposal.

The key advantages of the proposal are perceived as:

- Providing NHS patients' access to a centre of excellence as well as the state-of-the-art facilities at the DMRC.
- Increasing access to specialist inpatient rehabilitation, addressing the unmet demand that exists.
- Improving patient outcomes.
- Collaboration and shared learning with the DMRC.

- Transforming how rehabilitation is delivered across the system, setting a blue print for other parts of the country.

- Opportunity for local public sector collaboration in the areas of education and research.

In contrast, strong concerns were raised about the proposal, particularly with regard to the NHS Rehabilitation Centre's location at the Stanford Hall Estate:

- The remoteness of Stanford Hall from acute medical and supporting services, resulting in a lack of continuity of care beyond the inpatient stay. Patients would need to be transferred to and from acute NHS services which will eat into their 'rehabilitation time' and deplete their energy to engage, whilst also requiring staff to escort.

- The significant number of people who would normally be able to access specialist inpatient rehabilitation ward that will be ineligible/unable to receive care at the NHSRC due to medical safety issues and/or their ability to engage in intensive rehabilitation.

- The poor accessibility of Stanford Hall, which will be difficult, time-consuming and costly for visitors and staff to access, particularly those reliant on public transport.

- Isolation of patients from their family members, friends and carers - individuals who play an integral part in the rehabilitation process.

- The distance from, and inability for patients to practice 'real world' situations e.g. crossing busy roads, getting on and off public transport - limiting the ability and relevance of rehabilitation.

- The significant lack of detail within the proposal.

- A three-bedded rehabilitation unit at Nottingham City Hospital is not practical or possible.

- Closure of a local service which provides high-quality care, with concern about the impact it will have on those currently accessing the service.

- Issues of ensuring a smooth transition from inpatient to community care and that ongoing care is able to maintain, and build upon, progress achieved at the NHSRC. This is a particular concern in Lincolnshire, which does not have the aftercare in place to continue the care required post discharge.

- Suitability of the site for the placement of trainees in rehabilitation medicine.

- Other concerns including; decisions have already been made, privatisation, financial modelling and sustainability, commissioning and equity in access for all areas.

In light of these issues and the concern that some stakeholders have about the feasibility of the proposal as it stands, a number of significant modifications to the proposal were suggested:

- Investing in the existing building/facilities

- The reorganisation of rehabilitation provision within existing buildings and organisations.

- Developing the centre as a tertiary service for specific circumstances, where there is currently inadequate and/or non-expert provision. These patients would be medically stable and wouldn't require acute medical care during their rehabilitation programme.

- Incorporation of a dynamic outpatient service.

- Opportunities for day-case/weekly boarding.

# 7 Conclusion

The proposal for a NHSRC provides a number of benefits not only in terms of providing NHS patients with access to a purpose-built rehabilitation facility on an existing specialist site and improving outcomes, but in transforming the delivery of neurorehabilitation across the East Midlands – addressing unmet needs, reducing demand on acute NHS services and providing opportunities for local public sector collaboration in the areas of education and research.

Survey results show that 86% support the proposal to create a NHSRC at the Stanford Hall Estate, whilst a slightly smaller proportion (69%) support the proposal to transfer the service currently provided at Linden Lodge, Nottingham City Hospital, to the NHSRC.

There are however, strong concerns about/objections to the proposal, particularly with regard to the NHS Rehabilitation Centre's location at the Stanford Hall Estate. These relate to:

- Poor accessibility of the Stanford Hall Estate – making access difficult for visitors and staff.

  Survey results indicate that 52% feel it would be very easy/easy for them to access the NHSRC, whilst 24% perceive it will be very difficult/difficult. Furthermore, 60% feel that the provision of family rooms, free parking and super-fast broadband would help to reduce the impact of increased travel time that some might face (26% stated that it would to some extent).

- Isolation of patients – contributing to feelings of low mood and/or depression.

- Difficulty for family members/carers to be involved in their relatives' rehabilitation.

- Medical safety of patients if the current caseload at Linden Lodge were to be managed in this new service.

- Options available to those who are ineligible to receive their care at the NHSRC and/or are unable to engage in intensive rehabilitation.

- Reduced continuity of care beyond inpatient stay due to the distance of the Stanford Hall Estate from acute NHS services.

- The distance from, and inability for patients to practice 'real world' situations.

- Closure of Linden Lodge, a facility considered to be more easily accessible, provide a high standard of care, benefit from the proximity to acute NHS services and provide local inpatient care.

- The impact on the transition from inpatient to community care, as well as concern as to whether the step-down care available within local communities is able to maintain, and build upon, progress achieved at the NHSRC.

- Conflict between the DMRC and the NHSRC in terms of the shared use of facilities as well as the issues of dealing with two very different population cohorts and the potential for inequalities in treatment to be highlighted.

  Survey results indicate that 65% feel it is appropriate for NHS patients to be treated on the same site as military personnel (a further 22% perceive that it is to some extent).

- Practicality of having a three-bedded rehabilitation unit at Nottingham City Hospital.

- Difficulties in the recruitment of specialist staff as well as the impact on staff at Linden Lodge.

- Suitability of the site for the placement of trainees in rehabilitation medicine.

- The impact on the surrounding area at Stanford due to the increased volume of traffic.

- Other including; financial modelling and sustainability, safety of visitors travelling and accessing the site, decisions already being made, privatisation, commissioning and equity in access for all areas.

In light of these issues and the strong concern that some stakeholders have about the feasibility of the proposal as it stands, a number of significant modifications to the proposal were put forth for consideration. These included the investment in and/or reorganisation of existing rehabilitation provision, the incorporation of a dynamic outpatient service and the development of the NHSRC as an additional facility to Linden Lodge or as a tertiary service for specific cohorts of medically stable patients.

This findings report will be provided to the NHS organisations leading the consultation, with a final decision expected to take place by the end of 2020.

# 8 Appendix

## 8.1 Engagement events – transcripts

### 8.1.1 Engagement Event #1; 4th August; 3-4pm

**Question: In terms of the current inpatient building at Linden Lodge will neuro outpatients be expanded?**

Response: We know that the building at Linden Lodge is not ideal but we are looking at how this centre would work and this is very much part of our next phase of work and we'd be keen to get peoples' views on this. How the centre, which is obviously an inpatient specialist centre, would work with the other services around i.e. the outpatients at the hospitals and also community settings as well. And also how we make sure that professionals who work in the centre are linked in with the local teams and able to share through care coordination, to make sure we get the right care plans in place for people who are leaving the centre. So I think that the outpatient part of it will be very much part of any final proposals, and we will build that in. And how much would need to happen at the City Hospital site where Linden Lodge is – how much would need to happen in other ways through community teams, we would need to work all of that through.

**Question: With ongoing workforce issues within the allied health professionals (AHPs), how and when do you anticipate recruiting the specialist therapists required to support these patients?**

Response 1: A huge amount of work has been undertaken to think about what the workforce requirements are, and not just based on current roles, but also thinking about what new roles we're going to need as well for this.

Response 2: It's a great question, and obviously one that's in the forefront of a lot of peoples' minds at the moment with the peoples' plan last week. So I think there are two things really to say. This does create an opportunity to support recruitment and retention within the AHP workforce. So all the work that's going on within the Chief AHP Office, and also within Health Education England, we're really going to try and take some of that forward. So rather than looking at current, rather traditional roles and ways of working, it does present an opportunity to look at the core skill sets that people need, the training and education around that, opportunities for advanced practice but also opportunities to really build in a skills escalator, so we can recruit more people into the profession in different ways. So we're exploring all of those at the moment with our academic partners and working on a workforce and a recruitment plan for exactly that reason.

**Question: What banding levels do you expect to recruit? As Ministry of Defence (MOD) therapists tend to be band 6 or above. Will you expand this down to band 5 therapists?**

Response: The MOD has their workforce in existence already and the MOD centre is already operational. You're right, they tend to recruit band 6 and above. We really want to see this as an opportunity to bring people through the skills escalator into profession. So we will be creating opportunities for band 5 staff and some band 4 roles in a rehabilitation instructor generic role, really to support the physical and mental aspects of rehabilitation. What's important is that we will be doing a lot of this training on the job so using apprenticeship schemes, some of which will be existing but some will have to be created in the next 2 to 3 years to fulfil that gap.

**Question: The animation referred to a National Centre for training and education. Can you say more about this?**

Response: We are only consulting on the NHS treatment centre because that's the money that we know we have allocated (£70million). We would then pay for the service to run, the service we are proposing about. In addition to that, the ambitions for that centre is that there is a development of research and innovation through university academic partners who have been appointed into that, and also linking in with education to really drive forward the new roles that have just been discussed, in a way that brings a centre of excellence. A longer term view would be that the learning that we get from the Stanford Hall site would be a model for how centres might be established elsewhere.

**Question: Will there be an increased number of rehabilitation sessions for inpatients to support speedier discharge? Previous experience shows inconsistencies.**

Response 1: The aim is that this is a much more intensive and proactive model of care, rather than, the quite patchy care that is received at the moment when people are in acute trusts.

Response 2: The model is really to bring people into a rehabilitation bed at the NHSRC as quickly as possible, as soon as they're able to do so in their journey. And to provide that intensive programme as much as they're able to cope with. But that doesn't necessarily mean 8 hours in the gym every day. The idea is that the environment will facilitate rehabilitation and independence and we'll be working through that given the feedback from the consultation, in terms of the internal layout of how the building works. The other thing is that we are developing this core generic set of rehabilitation skills alongside the work that Health Education England are doing for community rehabilitation skills, and really building on that, so that everyone has the same approach to the patient regardless of what that is.

**Question: I know from the video that patient rooms are at the top of the building, so patients can see out onto the view. Will there be a lift installed to ensure safety?**

Response: Yes there will probably be three lifts and we will be guided by safety and patients' ability to move, but also by fire regulations, so there are very strict rules to which we need to comply. It's quite a long building, so they will be spaced out in between. The patient rooms are at the top, on the first and second floors for exactly the reason you say. There will be therapy areas on both floors as well, but the main gym will be down on the ground floor.

**Question: Do you have criteria for admission? And any thoughts on likely lengths of stay?**

Response: Yes, there will be criteria for admission, in the same way we currently have criteria for the neuro rehab unit at Linden Lodge and the aim is to have assessment being done remotely via a team of people working within the rehab unit. So when people are referred to the unit they can be assessed very quickly and channelled into the rehab as appropriate. On the concept of lengths of stay it's dependent on the problem and clearly there are going to be differences depending on the reason why people are in the rehab unit, so the neuro rehab unit will I assume be having similar lengths of stay to the current rehabilitation time scales like we have at Linden Lodge. I think we're aiming for an average of 12 days for the musculoskeletal arm of rehabilitation. So again it will be very much dependent on the problem and the rehab required.

**Question: Will there be accommodation for staff on site and travel to work schemes?**

Response: Certainly accommodation for families planned on site, but I'm not aware of any for staff onsite. Travel to work schemes – that would be something we'd have to look at with the Trust, as to whether there was any facility for that or not.

**Question: How will patients go to a step-down unit from there? Will discharge be to local multi-disciplinary teams (MDTs) for more rehab?**

Response: I think it will be dependent on what's most appropriate. So yes there will certainly be a cohort of patients who do step-down to local MDT teams to continue their rehabilitation. The aim is to try and make it as seamless as we can with people gaining from the intense rehabilitation we can deliver at the centre but then get people back into their own homes or their own environments as quickly as we can.

**Question: As patients may have had a prolonged length of stay in the acute ward and then a duration within a neuro rehab unit, in order to prevent bed blockages within your unit, is there the opportunity to work with other private companies to support patients in returning home? This can also support with the transition and enablement ethos.**

Response: Yes we absolutely would only want people in the centre when they are really benefitting from what's required in the centre and if there are other types of care that people can have outside of the centre as part of their ongoing recovery then we would absolutely look at that. The care coordinator would help to move people on to their next destination. So that may well be that there's a specific arrangement for those individuals depending on what their needs are, which could be with a private company. There would be, and we would often do that where people have got ongoing continuing healthcare needs or other needs. This has got to work as a whole network of services. It won't work if it's just on its own and isolated without proper ongoing plans for peoples' recovery.

### 8.1.2 Engagement Event #2; 10th August; 2.30-3.30pm

**Question: I have multiple sclerosis and have benefitted from being an inpatient at Linden Lodge. I have many concerns about losing this facility, at the moment there are I believe 24 neuro rehab beds, can you guarantee that there will still be that many in the new facility? I am concerned that because we cannot be "cured" we will be put at the back of the line for beds. It is only due to me being at Linden Lodge that I can walk again. What will happen to staff that do not want to move? Will their expertise be lost to patients like myself? Also the distance from Nottingham is worrying as I know too well you need support from family and friends, I had a very frightened 9 year old who fortunately was able to visit me every day which helped both myself and him. If it was moved he would not have been able to visit as often, causing anxiety not just to me but him too, when you have lost the ability to move and been given a diagnosis such as MS, relationships are vital in your recovery and acceptance.**

Response: It's a really good question and sets out very well a lot of the points that we have given some consideration to and will continue to need to consider. So the numbers of beds in the new unit, create an additional 40 beds, and very much the model that we are putting forward does include the current neuro-rehabilitation levels of beds. So for anyone who currently needs – we don't think there will be a reduction in any neuro rehab bed capacity and we will make absolutely sure that people aren't left without care.

What we're also doing – and we're very keen to hear from people who do use the service – is thinking about how those services can best work with local community services. Partly for the reasons that have been described. We won't just commission the centre on its own, we would think about all of the local support that patients would need. And it would absolutely include all people who could benefit from the rehabilitation - so not just injuries and traffic accidents etc., if people with long term

conditions, such as MS, have got that ability and the willingness and drive to do the rehabilitation, and get back to a greater level of independence in various points in the disease, then they absolutely would remain eligible for the new service. The preference would be people who can benefit from rehabilitation, not putting at disadvantage people who have got long term conditions.

I think for staff not wanting to move, we will look at what redeployment opportunities there are within the hospital or surrounds, we would absolutely want to retain those skills if at all possible. We would work very flexibly around that. I think the point you make about visiting and isolation from families, especially with a young child as you've described – we're very sensitive around that. So I think some of that would be virtual access. There would be free virtual access and use of WIFI in the facility. And also the ability to stay over as well. So again I think as we go through the consultation we'd want any suggestions around how that could work best, because it's in everybody's best interests if people can maintain their networks.

**Question: Can you elaborate on how the proposal will affect Lincolnshire? How will people in Lincolnshire gain access to the service?**

Response: We are working with Lincolnshire CCG on what the opportunities are for this service as it's a regional one. The business case recognises that with NUH being a regional major trauma centre a number of patients will go into NUH whether they are Lincolnshire, Leicestershire etc., and they will have the opportunity to transfer directly to the rehab centre. Alongside that, it's what additional capacity would be beneficial to Lincolnshire for the patients that are also going through the Lincolnshire hospitals. We've presented to the Lincolnshire Health Scrutiny Committee and their questions have been taken into consideration in relation to the consultation as well. So there's been considerable input from Lincolnshire.

**Question: In Lincolnshire how will you ensure patients discharged back to the county are ensured an unbroken service and any ongoing services required, including social care, will be available?**

Response: The intention is that there will be a MDT who take the referrals and assess the referrals in terms of arranging admission to the unit. So Lincolnshire patients would be part of that system, as are Nottinghamshire patients or Derbyshire patients for example. The teams would include care coordinators who will work with the local areas and the patients and their families, to make sure that we plan the discharges back and do that right through the period of admission as well.

**Question: Is the rehab centre for long term or short term care, are you expecting to discharge them to the community and will the rehab centre provide support in the community?**

Response: The rehabilitation centre is going to be trying to deliver the most appropriate care for people, so whether it's long term or short term, if it's most appropriate to be delivered in that setting, that's the plan that it will achieve. The aim is that the rehabilitation pathway – the process the patient goes through - will be continuous with them going back into the community. The services that are already in the community –

that already provide those community rehabilitation services – will still exist. There will be a process were patients are handed over from the intense inpatient area into the community area so people can be rehabilitated closer to home and in their own home as appropriate.

**Question: How long is the lease on the site from the Grosvenor Estate?**

Response: The lease on the Grosvenor Estate is currently set to be around 65 years and that's basically in the capital business case, and we just have to go through a process of calculating the building depreciation life and it marries up to that.

**Comment: There are very little current services for inpatient brain injury rehabilitation in Lincolnshire now. Many patients have to go out of County for Rehab anyway.**

Response: That is certainly the case, and that's part of the discussions with the Lincolnshire commissioners as well. The discussions around how Lincolnshire patients might use the services at Stanford Hall are ongoing. But I think it would be obviously recognised and accepted that many people already do go out of Lincolnshire, so that would be part of the thinking around using that site. I wouldn't say it's no change, because it's not. It depends where you live in Lincolnshire and where you would have gone previously, but the notion of patients travelling for that service wouldn't be a new thing.

**Question: Will patients from Northamptonshire - which is also part of the East Midlands, have access to these services. Are the Northamptonshire CCGs involved in this?**

Response 1: The services are for the East Midlands trauma network, which doesn't include Northamptonshire. There were earlier discussions with them, and they didn't feel their patient flow would be towards a rehab centre. However, as mentioned for patients the flow through is NUH, so there may be some patients who are from Northamptonshire and who have been in NUH and it's appropriate for them to transfer to the rehab centre. So if that capacity is available it may be that they do transfer to the centre. But the key point is that the centre is for the East Midlands trauma network.

Response 2: It was just a geographical boundary that we offered to them, but they declined to be involved. Everybody from that area tends to go south towards Coventry to access their acute and rehabilitation services at the moment and they didn't feel that was necessary to change.

**Question: Are you clear on the extent of community rehab capacity in the counties who will refer patients? Do you have data that shows that capacity meets current demand, or do you already have community rehab capacity deficit which an increase in beds may exacerbate i.e. lead to more pressure on community rehab?**

Response 1: My perception is we need more rehabilitation services across the board. We'd benefit from more in the community, we'd benefit from more in secondary care, and we'd benefit from higher level – at the rehab centre. So my belief is if we provide more rehabilitation beds that should take some of the load that currently is in stretched

services in the community. The plan is that it would actually help address some of the need as opposed to add to the requirement.

Response 2: We have undertaken some workshops with community provider colleagues as well, to test out the thinking. We will continue to build up that work as we work through the proposals in more detail. It's still work ongoing and it's an area that is important.

**Question: I currently attend yearly appointments with my rehab consultant at Nottingham city hospital, would you envisage these appointments be moved to the new facility?**

Response: The short answer is I don't think they'll move. I think most of the out-patient service will remain in Nottinghamshire, within the outpatient service. There will be opportunities for going out to the rehab service but I suspect most of it will happen in Nottingham.

**Question: Will there be day care opportunities at the facility?**

Response 1: At the moment the main emphasis has been on the inpatient facilities.

Response 2: We have focussed entirely on inpatient facilities for patients who are currently in hospital beds who need that level of care. There are lots of different levels of rehabilitation and at the moment it is recognised that outpatient and community services are probably best served closer to home. So we don't have any plans for that as it currently stands.

**Question: Will there be dialysis facilities for those needing ongoing haemodialysis, like those provided at Lings Bar?**

Response: Really good question and it's something that we are addressing even at Linden Lodge at the moment with our current service being at the City Hospital. What we're actually trying to look to do, as dialysis takes up so much time, is one of two options which we haven't concluded – either yes having a dialysis facility there, or having more of an outreach service for patients who require that regular dialysis at the City campus. Any views on that would be very welcome.

**Question: What about outpatient services for Lincolnshire patients?**

Response 1: This is something we would need to work through with the local teams and the care coordinators would need to continue to work with the local teams. As far as possible we would keep outpatients and community services as close to where people live.

Response 2: One thing that we've really learnt from Covid is the ability to do quite a lot of consultations via video, and certainly we've changed a lot of our practice recently. So what we're also looking at is where we do that from, and if it's a virtual consultation and the multi-disciplinary team is at the NHSRC for example, then there might be an opportunity around that. But we haven't made any decisions about that. It's important to recognise what we have learnt through the last three to four months as well.

**Question: Will medical/nursing/physio/OT etc. students be placed at the new centre?**

Response: The ambition around the new centre is to be the national rehab centre and that includes the national training and education centre for rehabilitation. So yes absolutely there will be placement opportunities for students there and we hope from a number of disciplines – medical, nursing, physio, OT, and others including healthcare, scientists, pharmacists etc. as well. I think one of the ways that people are changing to support the Health Education England programme and the Five Year Forward View is to try and offer some of those student placements and clinical placements virtually and in a simulated way rather than face to face. But we can certainly help with all of those.

**Question: In which case, will there be accommodation available locally for students?**

Response: That will work, I think, in the way it does now. So there won't be accommodation on site as such, but there will be access to that nearby if students need that.

**Question: Is there a timescale for developing the national offer?**

Response 1: The current consultation is very much around the clinical facility, at the same time there is a lot of work for developing how we work with academic partners around education, but also the research as well. As we said at the beginning the vision is that this then becomes a model that is rolled out more nationally.

Response 2: We've developed an academic consortium with 26 universities, the direct partners of which are the University of Nottingham and Loughborough University, to develop that national offer. That focuses on training and education, but also around research and innovation, so that we attract skills and expertise into the region and really maximise the opportunity that we've got. The overall timescale on that, after the consultation and the next part of the process, we're still looking at another probably 18 months' worth of business case process and then a two year build. That's not to say that some of that activity, particularly the academic activity, will be able to start before then, and that's very much what we're hoping to deliver.

**Question: Will there be medical cover 24/7 please? Currently there is neuro physio support from Linden Lodge on the acute neuro wards, and Reablement/outpatient ongoing support which is planned seamlessly on site. Will this new development fracture the neuro journey of complex patients?**

Response 1: Yes, recognising the fact that we want to bring people through into the centre as early as possible. There will be 24/7 medical cover there – that's very, very important. For MSK/orthopaedic patients there will also be the ability to go back to the site for any reconstructive surgery, and that will all be in a planned way.

Response 2: The ongoing seamless approach to this is something we want to continue on at the NHSRC. There certainly will still be the acute neuro physios on the acute wards but also we're planning a rotational aspect of these staff, so that we spread that expertise across the pathway, but also learn from them and share that learning further down the pathway as well. There's definitely work underway already to look at the whole pathway not just the NHSRC, the neuro reablement team that you talk about will

still exist and it will continue to run out of the NHSRC, so that we can continue that seamless work as patients progress through to discharge.

**Question: I have spoken with therapists who are concerned about rotation due to childcare, length of shifts and travelling time. Can they refuse to rotate?**

Response: Yes, rotation offers an opportunity to specialise in certain clinical areas, at some point in everybody's career most people rotate. There will be a combination however of static posts in the NHSRC and rotational posts, so people do have that choice. So yes is the short answer. There are also static posts in the acute trust as well. We hope that people will see this as an opportunity rather than anything else, and an opportunity to rotate not just through the NHSRC and the acute trust but also into community services as well.

### 8.1.3 Engagement Event #3; 19th August 2020; 6-7pm

**Question: Which organisation will be responsible for the management of the Rehab Centre?**

Response: What we anticipate is that this centre will have to work really well with community services, mental health services and other services, so it will be part of a pathway; we envisage that the care pathways will be managed by a range of NHS organisations. There will be one that takes the lead or provides most of the care. We believe there needs to be some sort of partnership and integration where people live as well. So we think it will be an NHS service with NHS organisations involving more than one organisation to have the correct input particularly around mental health. We can't finalise that at this stage, we have to take all the comments from the consultation, go through the process I have described with the independent analysis and then we confirm that at a later date. So that is not something we can categorically confirm at the moment but we think it will be an NHS body with input from a whole range of health professionals across.

**Question: What additional facilities/equipment will available through the DMRC?**

Response: The DMRC has a large range of different therapy gyms, it's got a very impressive hydrotherapy suite with several pools and it's got some hi-tech equipment that we don't have in the NHS such as the CAREN equipment, which was shown on the slides. These are things where you can use computer feedback to try and help people regain balance and start to learn movement patterns so there is quite a lot of significant amount of opportunity within the DMRC.

**Question: What will be the benefits of the new service compared with what's available now?**

Response 1: I think the key thing is that it is all in one place in a facility that is designed specifically for rehabilitation with all the equipment and expertise in one place. What people say to us now is that sometimes they have to travel in between places as all the care they need is not necessarily available in one place. Also, because there will be individual care plans, agreed with the individuals, with a whole range of professionals, it's probably a more intensive, more rapid sort of programme of rehabilitation. We do believe from the international evidence that gives people a better chance of a better recovery and getting back to the normal activities of life as far as possible really. It's about reaching that absolute potential.

Response 2: We have noticed with the creation of a major trauma centre and specialising things in one area and getting a lot of expertise, the initial care has

improved dramatically. I guess what we are hoping is that by getting our patients to a specialised rehab place, those kind of benefits - from dedicated staff working together, working with the defence union next door – will really accelerate their recovery after resuscitation and surgery so the whole journey is just as good as it possibly can be and there is no wasted time and there is no loss of condition so that the patients are just flying through their rehab. I think that this will deliver that for us.

**Question: I am concerned that, as there is no extra money to run the new centre, patients with less intensive rehabilitation needs will experience a worse service as a result of money being transferred to this more expensive, intensive service.**

Response 1: The way that the business case is constructed, is that in order not to have a negative impact on other services, we are transferring the resources from Linden Lodge in that neurological rehab facility and putting those together with other resources which we don't think we are using to the maximum effect at the moment. We know that in NUH, at any one time, there are people on the wards who really are waiting for their rehabilitation. They are in hospital and that obviously has a resource implication but they are not getting the type of care and rapid forward movement that has been described. The resources for this would be taken from Linden Lodge primarily as well as the money that we are currently spending in not such a good way for people who are in hospital waiting for their rehabilitation journey. It's a combination of both of those two things and some other areas as well. For example, continuing healthcare, where we believe there will be some benefits to people's long term progress and level of dependence. We're not actually taking money from other types of rehabilitation in order to fund this new centre; this was quite a deliberate thing because we know that we can't negatively impact the other areas in order to accommodate this.

Response 2: At the major trauma centre, we see patients who need rehabilitation and can't access it; essentially money is being spent ineffectively - keeping them in an acute hospital. The idea of the business case is to gain the efficiency of them moving to the rehabilitation centre rather than take any finance away from other areas of rehabilitation that we are providing to patients with less acute requirements. Hopefully we will actually be able to spend NHS money more wisely and appropriately than we are currently able to.

**Question: Will there be fewer beds for people from Nottingham and Nottinghamshire?**

Response: We don't believe so, because as we have just described, the way we have worked out the resources for the running of the centre is on the number of beds in Linden Lodge, which would directly transfer, plus the number of people who are currently sitting on the wards waiting for this type of care to move. We believe there are some people from outlying areas as well, but often they will already be in NUH because of the major trauma centre, so we don't believe there will be fewer beds for people in Nottingham and Nottinghamshire based on how those proposals have been built up.

**Question: Last year it was in the news that the MOD would only pay for serving personnel, not veterans. Veterans would need to be paid for by the NHS. What is the situation?**

Response: That is slightly outside of this facility. The normal funding for NHS care for veterans would continue should they need specialist rehabilitation as it does in other walks of life. My stance, the CCG commissions care for veterans. I believe that is the correct position.

**Question: How do the staff at City Hospital feel about transferring to Stanford Hall? Will you be able to recruit the skilled staff to work there?**

Response: There has been a lot of engagement with staff at Linden Lodge and showing them what the opportunities are. Like for any move some people are slightly concerned but we are engaging with them on a regular basis, trying to give them enough knowledge to allay those views and to see the tremendous opportunity. We don't see that we will have a huge difficulty in recruiting additional staff, we already have the skilled staff at Linden Lodge to work there and I think that's been shown in the recruitment that the military did at Stanford Hall as well. This will be a world leading rehabilitation centre and anybody with interest in rehabilitating this group of patients will be very keen to work there so we don't feel that we would have difficulty in recruiting and we are working closely with our Linden Lodge colleagues to make sure they are informed every step of the way.

**Question: There will be no extra money for running this service. Where will the savings be made to fund the running costs?**

Response: I think we may have covered this, so this is the transfer of the cost of running Linden Lodge and the cost of the patients in NUH, who are waiting for rehabilitation services, so that funding of running those beds will transfer effectively.

**Question: Could you please explain what the impact/changes for patients in Lincolnshire requiring inpatient neuro-rehabilitation would be?**

Response 1: Lincolnshire has a 2B unit already and a 2A unit neuro rehab unit so this would provide some additional neuro rehab capacity to that. Then there's also the MSK beds that Lincoln clinicians would be able to refer into or that people would transfer from NUH, so it would be some additional rehabilitation capacity for Lincoln.

Response 2: I'm the clinical case manager at the NHSRC. In addition to the Lincolnshire beds that already exist, we know that there big gaps in Lincolnshire, not only for inpatient neuro rehab but also for outpatient care. Providing the additional beds at the NHSRC would give patients the choice that if they don't want to wait in an acute bed, for often 3 or 4 weeks, they could transfer to the NHSRC and receive their rehab in a much timelier manner but also have access to the additional resources that are available there. We are working quite closely with Lincolnshire colleagues to perhaps develop services in the future where we do joint clinics and things like that so hopefully this should improve services for the entire region.

Response 3: A lot of the patients in the major trauma centre are from around the region, although this centre will be situated in Nottinghamshire itself, the patients that we deal with coming to the major trauma centre are from around the whole of the East Midlands and so I think there will be direct benefit for all patients from the whole region not just local patients. This should definitely be considered as a region wide centre despite its location.

**Question: Will the MoD facilities be freely available to NHS patients or will they be hugely restricted in terms of access and staff availability? Also thinking of infection control.**

Response 1: We've got an agreement with the MoD for the facilities to be available, clearly we will need to arrange timing so it won't be anytime day or night but there will be sessions where NHS patients have access to CAREN, the gym and the hydro therapy pools and equally it is mentioned that there is access to the entire estate for NHS patients as well. So there will be a time table that is set out and obviously with COVID, that will be taken into account when the timetable is drawn up.

Response 2: We are in the process of many discussions with the DMRC, talking about the facilities and they have shown an open appreciation of what they might be able to

help us with. It's also important to realise about the staffing - that the use of those facilities in the gyms, hydro therapy pools will be staff by the NHS staff from the NHSRC, not the military staff.

**Question: How will the service compare with, and learn from, equivalents in other countries?**

Response 1: We are sending a few of our team members to state of the art facilities around the world and we have taken a lot of inspiration from some amazing rehab centres in North America but also in Switzerland and Sweden. There is a real opportunity here to give us that state of the art rehab centre that the entire county is lacking and we've got the opportunity here to be a leader, to put the region on the map, to really highlight the fact that we can learn from all these other areas and different countries to make sure that we get the service right. So there's lots of involvement with counterparts internationally to make sure that we get the service right but also making sure we get the service right for our cohort of patients so that's certainly something that's been taken into consideration.

Response 2: The UK does compare rather poorly with many other western countries, particularly in Europe and also North America when you compare the number of patients who can return to work and we believe this is a very powerful reason that we need to have increased resources within the rehabilitation - there is a very powerful argument for the NHSRC centre.

**Question: It frees up the beds at the current facility which is excellent, however does this cause the commissioner an issue if these beds are then filled by other patients? Great for us patients but are there knock on effects to affordability for other NHS services.**

Response: It's a very good question and it something that as we have developed the proposals that we have had to think very carefully about. The funding that has been released from the government or is going to be released from the government to build the facility, is on the basis that we are able to pay for the running of it within an affordable level so, as described in the business case, we do need to make sure that we transfer those resources across. That's a condition on the release of the money to build the facility so we all need to make sure that we work together to ensure that is the case. We do have to commission a range of rehabilitation services as well and other services, we have to make sure there is a good spread of services in line within what the NHS needs to offer, so I think as was mentioned earlier, we do need to use the money as wisely as we possibly can.

**Question: Will there be patients who are eligible for Linden Lodge now who will not be eligible for the new rehab centre?**

Response 1: No, absolutely not. We were doing a lot of work on our current eligibility criteria for Linden Lodge and actually we're realising that more and more patients actually need access to that service. So there certainly won't be any patients who are eligible now that won't be eligible. We will be transferring the current Linden Lodge service as it is over to the NHSRC, so that will remain. If anything, we will be improving the access to rehab for many patients who don't get rehab at present, so we envisage there will be more access to rehab not less.

Response 2: In the business case it has been identified that there is probably the equivalent of three beds of activity that currently go through the Linden Lodge, that wouldn't be fit for the rehab centre. What we have included in the business case is maintaining the capacity at NUH for these patients. There are some patients that currently go to Linden Lodge that won't be able to go to the NHSRC according to the

audit that has been carried out. We have factored that in to the business case and that is included in the financial model and all the elements around that.

Response 3: When we have looked at those patients, three patients were identified as not being eligible for the NHSRC. However, we have actually determined that aren't suitable for Linden Lodge either but for whatever reason and whatever pathway, they have ended up there but actually, that just means we could manage their discharge and facilitate that discharge in the community. They might not be in the right service and we can signpost them to the right service. There will always be an element that we don't get it right 100% of the time but it does mean that we can just facilitate their transition the same way as we would do for any of the other patients.

**Question: Will the service take privately funded patients?**

Response: Our business case and our proposals are purely for NHS patients.

**Question: Will the centre be Level 1, 2a, 2b or mixed?**

Response 1: This will not be a level 1 service but there is a huge overlap in 2a and 2b and the NHSRC will be expected to take patients that are currently categorised, some as 2a and some from 2b. There is actually a national consideration of trying to combine 2a and 2b because the categorisations are not working very accurately in the sense that they are currently being used.

Response 2: There is also the consideration of how the service is commissioned, so there are specifically 2a units so 1 and 2a units that are commissioned by NHS England. The thing that we are working with NHS England on overall is what we do have within the East Midlands for level 1, 2a and 2b and how the rehab centre can support that, it would predominantly be 2b.

**Question: Will there be neurobehavioral/neuropsychiatric beds available? Will any of these be managed under the MHA?**

Response: This a cohort of patients that we're currently doing some work on at the minute - to actually find out where best meets their needs. As we know, some neuro behavioural patients often have lots of complex needs – some of these can be addressed at the NHSRC but some can't. We do have in our region, Lemington and some others, which is purely for neuro behavioural patients or neuro psychiatric patients, so we are looking at those pathways to better understand where these patients would most appropriately be looked after. We certainly haven't ruled it out, that being the NHSRC. We will have neuro psychiatry and neuro psychology access at the NHSRC so this is certainly something that we can look into and work is being done at the moment to look into that.

**Question: When will the final decision be made?**

Response: We anticipate that it will be towards the end of the year, sort of early December time.

**Comment: I hear what you say about the funding but it really sounds impossible to run such an enhanced service on the same money. I can't see how you can save money by freeing up beds in NUH as they will of course be used by other patients.**

Response: We will need to transfer the resources across to the centre. Every year we always do quite a detailed exercise around how best to spend the NHS pound that we've got to treat a whole range of conditions. The other point to make is obviously this is a new service and we will develop the evidence over time, but based on international

evidence and we are doing some further analysis around this, when we move towards developing the final business case is what possible savings there might be elsewhere in the system.  I did mention earlier on that we believe that the enhanced recovery people will have with a shorter perhaps more intensive rehabilitation, will save us money further down the line for people who get a higher level of functioning back as a result of the rehabilitation and therefore they need less healthcare later down the track.  What we would like to do is have a look at this and try and understand it across not just NHS spend, but also whether it helps people get back to work and the benefits from that point of view in terms of benefits and savings across a whole range of areas.

## 8.1 Demographics of survey respondents

***Table**: Age (n=714)*

| Response | % |
|---|---|
| 18-24 | 2% |
| 25-34 | 16% |
| 35-44 | 22% |
| 45-54 | 27% |
| 55-64 | 19% |
| 65-74 | 11% |
| 75+ | 4% |

***Table**: Gender (n=703)*

| Response | % |
|---|---|
| Woman | 78% |
| Man | 21% |
| Other | <1% |

***Table**: Gender identity match sex registered at birth (n=704)*

| Response | % |
|---|---|
| Yes | 100% |

***Table**: Pregnant or had child in the last year (n=699)*

| Response | % |
|---|---|
| Yes | 2% |
| No | 98% |

***Table**: Marital status (n=678)*

| Response | % |
|---|---|
| Married | 64% |
| Cohabiting | 14% |
| Single | 11% |
| Divorced or civil partnership dissolved | 5% |
| Widowed or a surviving partner from a civil partnership | 3% |
| Separated | 1% |
| In a civil partnership | 1% |

***Table**: Disability, long-term illness or health condition (n=713)*

| Response | % |
|---|---|
| No known impairment, health condition or learning difference | 69% |
| A long standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease or epilepsy | 8% |
| A mental health difficulty, such as depression, schizophrenia or anxiety disorder | 5% |
| A physical impairment or mobility issues, such as difficulty using your arms or using wheelchair or crutches | 8% |
| A social/communication impairment such as speech and language impairment or Asperger's syndrome/other autistic spectrum disorder | 1% |
| A specific learning difficulty such as dyslexia, dyspraxia or | 2% |

| | |
|---|---|
| AD(H)D | |
| Blind or have a visual impairment uncorrected by glasses | 1% |
| Deaf  or have a hearing impairment | 4% |
| An impairment, health condition or learning difference that is not listed | 5% |

***Table**: Unpaid carer of a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction (n=691)*

| Response | % |
|---|---|
| Yes | 15% |
| No | 85% |

***Table**: Race / ethnicity (n=683)*

| Response | % |
|---|---|
| White | 94% |
| White - Irish | 2% |
| Asian/British Asian: Indian | 1% |
| Asian/British Asian: Pakistani | 1% |
| Asian/British Asian: Bangladeshi | <1% |
| Black/British Black: African | <1% |
| Mixed – White & Asian | <1% |
| Mixed – White & Black Caribbean | <1% |
| Other Asian background | <1% |
| Other mixed background | <1% |
| Chinese | <1% |
| Mixed – White & Black African | <1% |

***Table**: Sexual orientation (n=638)*

| Response | % |
|---|---|
| Heterosexual or straight | 93% |
| Asexual | 3% |
| Bisexual | 2% |
| Gay woman / lesbian | 1% |
| Gay man | 1% |
| Other | <1% |
| Queer | <1% |

***Table**: Religion (n=664)*

| Response | % |
|---|---|
| No religion | 47% |
| Christian | 40% |
| Christian – Roman Catholic | 5% |
| Christian – Other denomination | 3% |
| Other | 1% |
| Christian – Church of Scotland | 1% |
| Spiritual | 1% |
| Hindu | 1% |
| Buddhist | 1% |
| Muslim | <1% |
| Christian – Church of Ireland | <1% |

| | |
|---|---|
| Christian – Methodist Church in Ireland | <1% |
| Christian – Presbyterian Church in Ireland | <1% |