

Community Neurological Rehabilitation Service (CNRS):

Referral Information

1. Service Offered

The Community Neurological Rehabilitation Service offers specialist multi-disciplinary rehabilitation to adults with neurological conditions. The service provides assessment, advice, therapy, treatment and offers advice and support to family, carers and other professionals.

The objectives of the service are to:

- To provide specialist rehabilitation focussed health interventions via interdisciplinary assessment and treatment programmes.
- To alleviate or reduce impact of specific impairments or complications associated with neurological conditions.
- To provide an appropriate level of support for people to gain, retain and/or regain independence and function.

The service provides inpatient, outpatient and day patient services at the Community Neurological Rehabilitation Centre, St Mary's Hospital, and community services at a variety of locations in Leeds. The service uses an approach that takes into account the bio-psycho-social needs of each individual in order to maximise their quality of life and function.

All interventions are delivered on a goal focussed, time limited approach

CNRS is staffed by occupational therapists, nurses, physiotherapists, dietitians, rehabilitation assistants, Consultants in Rehabilitation Medicine and clinical neuro-psychologists, together with administrative support. The Community Stroke Rehabilitation Team also has speech and language therapists. The teams work with a range of social care, housing, education, leisure, voluntary services as well as other health care providers.

2. Referral criteria

CNRS has referral criteria that apply to all elements of our service, and specific criteria that apply to particular parts of the service.

2.1 General referral criteria

The criteria for the service are that patients must:

- Be aged 16 and above
- Have a neurological condition

- Be registered with a Leeds GP (except for CNRC inpatients or spasticity clinic, which is able to accept referrals from out of Leeds if funding is approved)
- Require input from two or more of the disciplines
- Be able to engage in and benefit from the rehabilitation services offered by CNRS
- Be willing to consent to assessment / intervention or, if not able to consent, it has been established that the assessment is in the client's best interests
- Have specialist rehabilitation needs not already or able to be met by existing services

Referrals can be made by any health or social care professional. We also accept self referrals.

We are generally not able to accept referrals that only require input from one discipline, with the exception of CHC funded patients who require physiotherapy.

2.2 Specific criteria

The Community Stroke Rehabilitation Team is only able to accept referrals directly from the discharging hospital.

If you are unsure if a referral is appropriate, please contact us.

If the referral is not appropriate for CNRS, we will try and indicate if an alternative service is appropriate.

a) Inpatient service

The unit provides planned, short stay (usually 2 weeks) inpatient rehabilitation.

In addition to the general CNRS referral criteria, patients are suitable for admission to the CNRC if they:

- Require multi-disciplinary rehabilitation that cannot be delivered in the community e.g. night-time rehabilitation needs, input required over several sessions in one day, regular interventions over a period of consecutive days, simultaneous multi-disciplinary input required or specific equipment/environment required
- Need a period of extended assessment or assessment/ treatment not possible in their home environment
- Require specific interventions such as Intrathecal Phenol

b) Day service

We also offer a day service for service users who meet the general CNRS referral criteria and who:

- Need more intensive multidisciplinary input than available in the community setting but who do not require overnight admission.

Both inpatient and day services provide treatment and support to improve quality of life and to help achieve or maintain desired potential and independence. Service users are able to access one-to-one rehabilitation sessions with different disciplines,

group rehabilitation sessions, clinics, opportunities for peer discussions and signposting to other appropriate support.

c) Community neuro service

The Community Neurological Rehabilitation Team (CNRT) provides multidisciplinary input which is delivered on a one to one, group or clinic basis. These are delivered in a variety of home or community venues or as an outpatient at St Mary's hospital.

In addition to the general CNRS referral criteria, service users are suitable for input from the team when:

- Interventions need to be delivered in the service user's own home due to the need to involve carers or their own home environment in the activity
- The therapy needs to be provided in other community venues e.g. workplace, college, shopping or leisure facilities
- Therapy is best delivered through one of the group or clinic sessions offered by the team

The team provides rehabilitation in order to optimise function, participation, quality of life and independence. This includes support for young adults with neurodisability making the transition from paediatric to adult services.

d) Community stroke service

The Community Stroke Rehabilitation Team (CSRT) provides a 7 day service, delivering early stage specialist rehabilitation in the community for a 10 week period for patients:

- Who have a new clinical diagnosis of stroke or subarachnoid haemorrhage
- Who are due to be discharged from hospital within 12 weeks of onset of stroke
- Whose transfers can be safely managed at home

Referrals are only accepted directly from the discharging hospital.

The team aims to reduce length of hospital stay for stroke patients by expediting discharge home from hospital for continued specialist neuro-rehabilitation. They work to maximise rehabilitation potential and to improve quality of life for stroke patients and their carers.

e) Community Parkinson's nurse specialist service

The community Parkinson's nurse specialist provides input to people with Parkinson's to effectively manage their condition. They work with GPs, consultants, Parkinson's nurse specialists from LTHT and community matrons as well as other health and social care staff, to deliver a citywide service. Input is delivered in people's own homes, care homes as well as community based clinics. This service is currently under development in conjunction with Parkinson UK.

f) Specialist Clinics

Spasticity management clinic

Patients who require assessment and management of spasticity are seen in a consultant led clinic at St Mary's Hospital. New patient assessments are multidisciplinary with input available from a Consultant in Rehabilitation Medicine, specialist physiotherapist and occupational therapist with expertise in splinting.

Following assessment, management plans are agreed that may involve use of medication, botulinum toxin or intrathecal phenol, as well as therapy, splinting or postural management interventions. Involvement of other services e.g. wheelchair service, tissue viability, continence may also be instigated.

For appropriate patients it may also be possible to arrange community visits.

Other clinics

Patients who are known to our service may be seen in a consultant led review clinic.

This clinic also sees young adults with complex neuro-disabilities who have recently moved from paediatric to adult services in order to maintain continuity of care and manage the transitions process.

Our dieticians run outpatient clinics to review patients from all parts of the service.

3. Referral process

Referrals to the Community Stroke Team are accepted from the discharging hospital

Referrals for the other parts of the service:

Please complete the CNRS referral form (available on Leeds Health Pathways or from Leeds Community Healthcare website) or send a letter stating clearly the current problems the person is experiencing and the reason for referral. Please also include any recent clinic letters.

Referrals directly from service users or carers are accepted by telephone.

Referrals are screened by a senior team member and then allocated for assessment as appropriate.

Contact details:

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