National Neuro-Rehabilitation Strategy: An Overview

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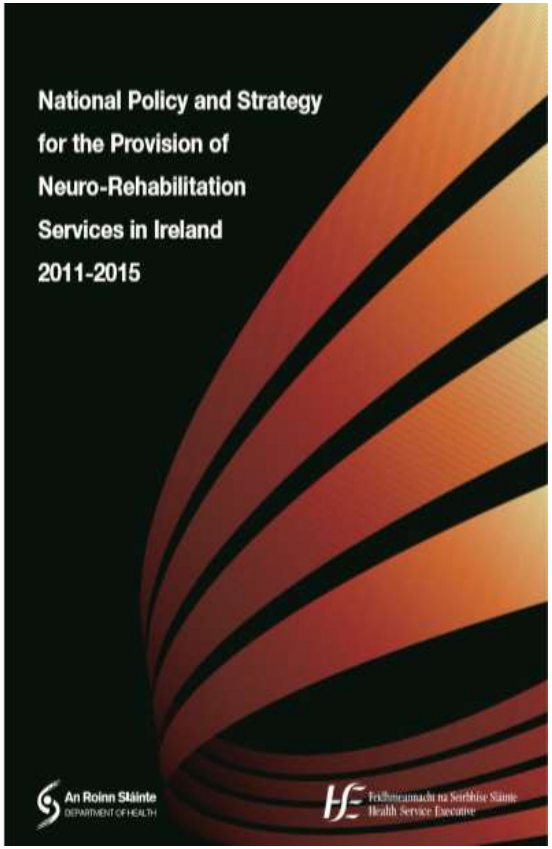
The Strategy



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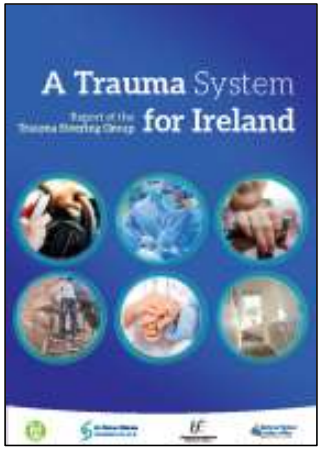
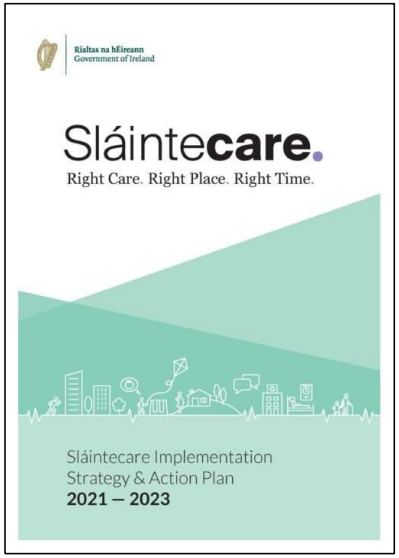
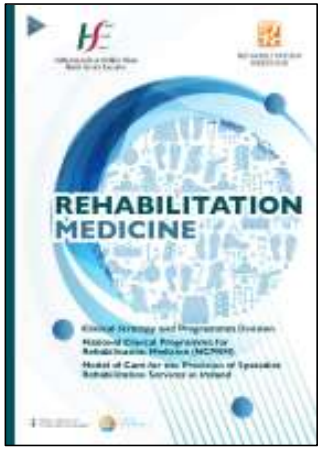
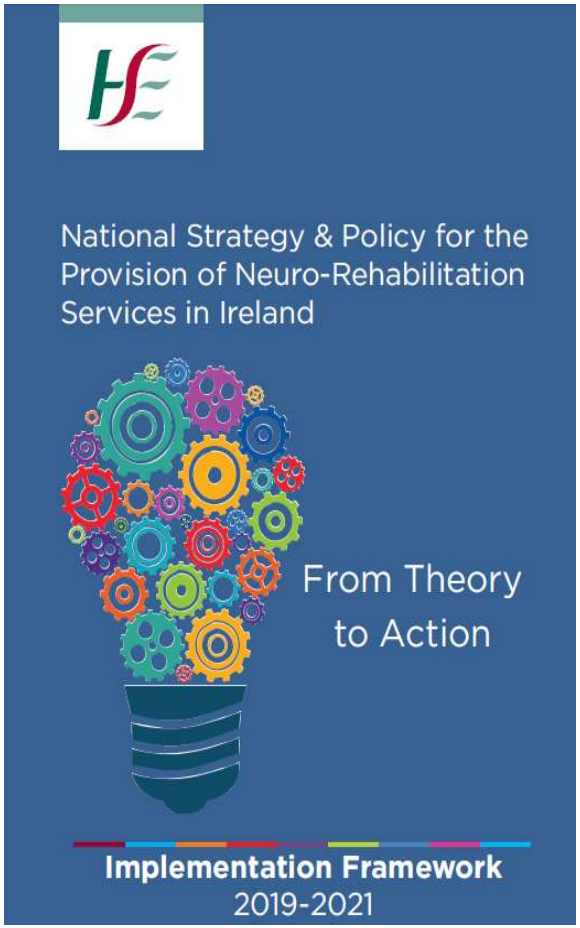






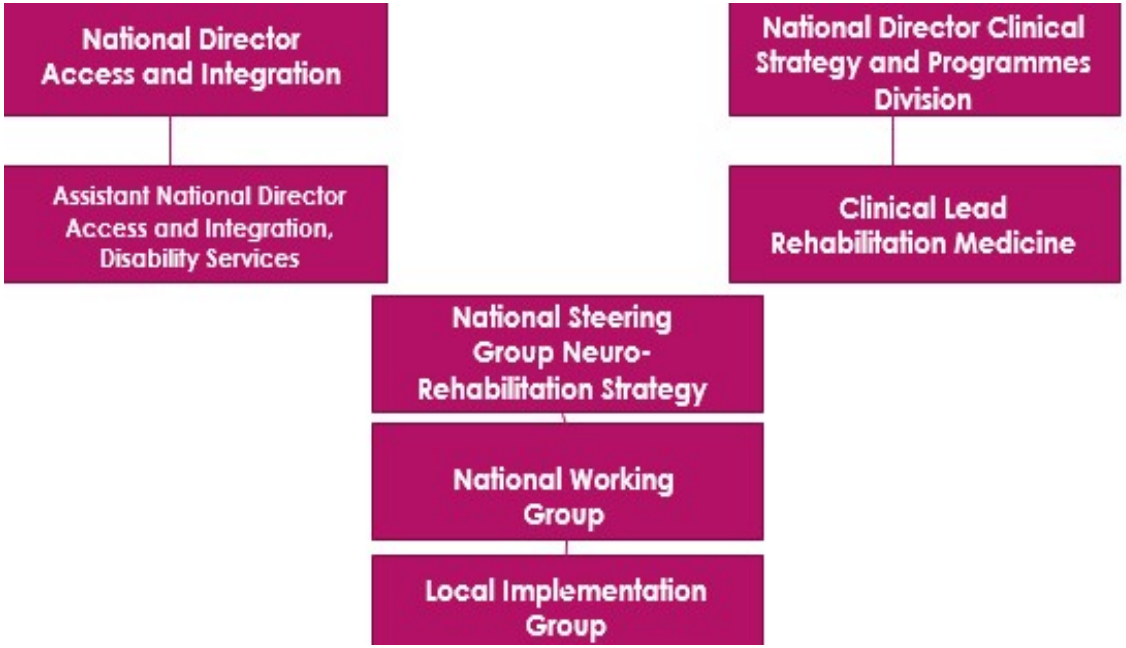
The Implementation Framework



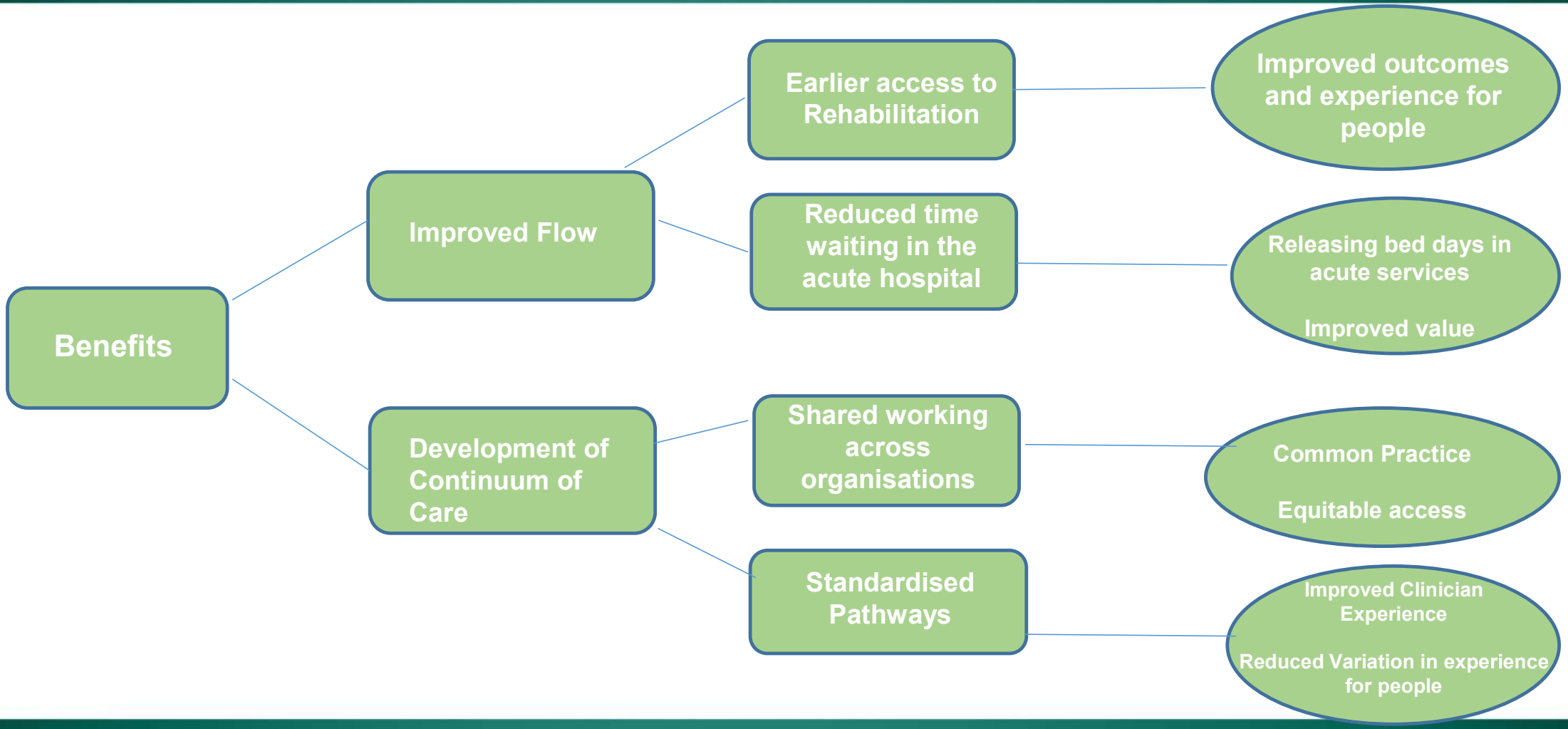
- Launched February 2019

- Timely access to appropriate rehab service
- As close to home as possible
- Based on rehab need not diagnosis specific

The Implementation Framework



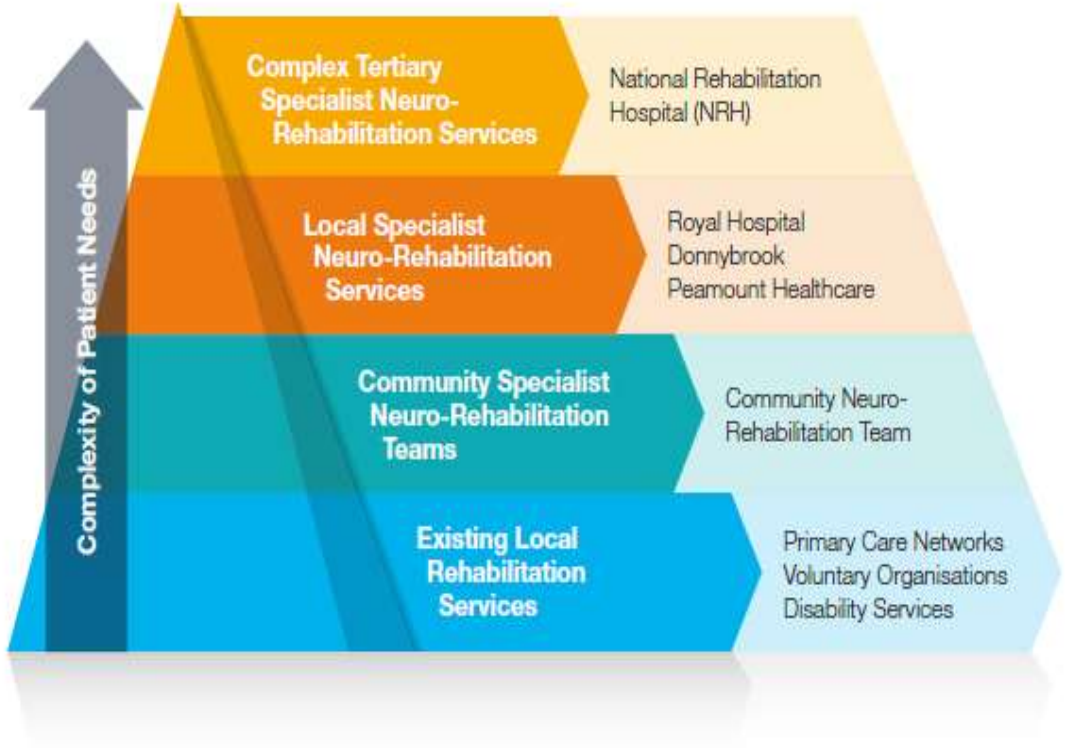
Benefits of the MCRN Model



Managed Clinical Rehabilitation Network (MCRN) Model

The new model sees the introduction of a mutli-tiered system , with access to services based on clinically assessed need.

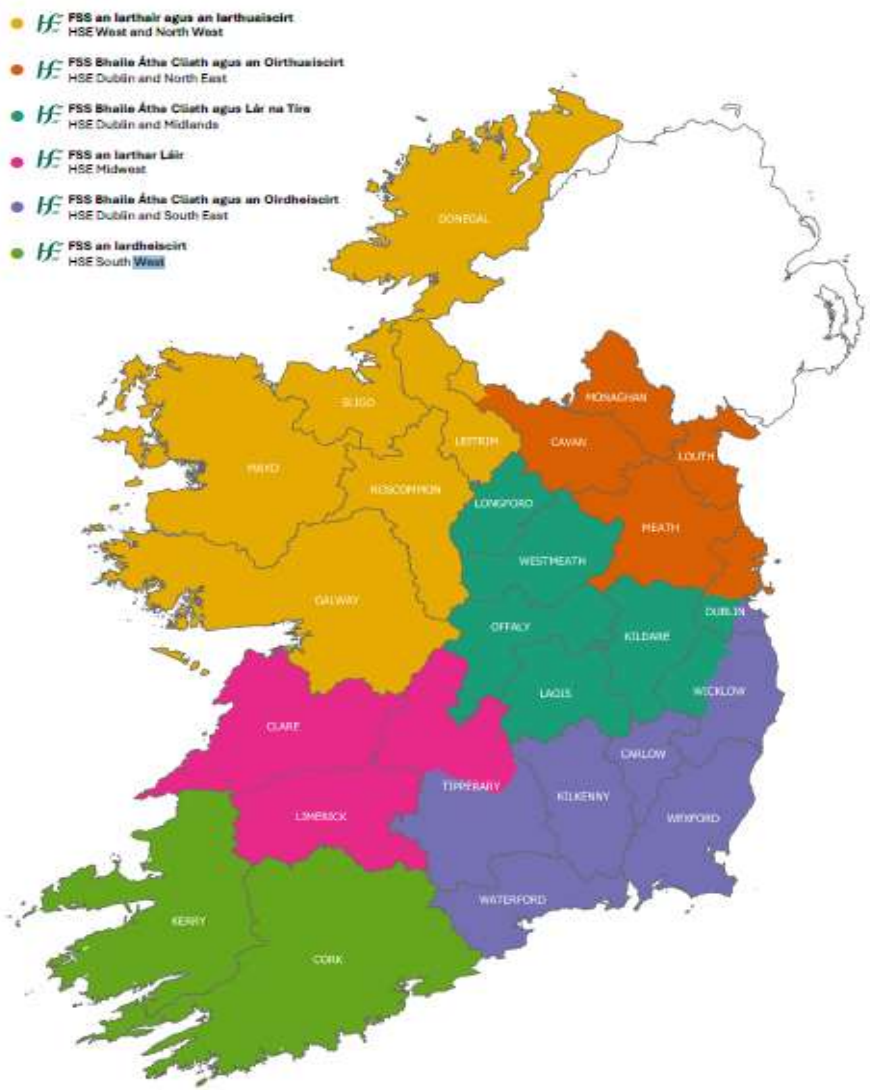
- Shared assessment protocols
- Shared Referral Protocols
- Shared waiting List Management Protocols
- Shared Discharge Planning Protocols



National Picture

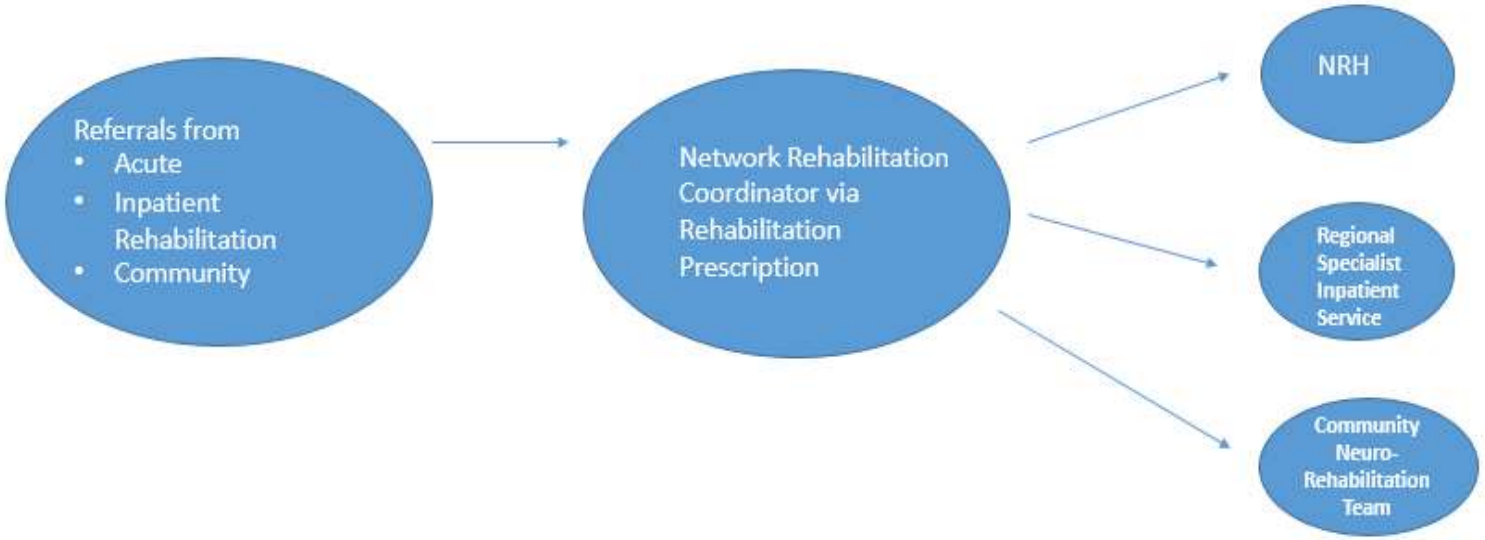
6 MCRN's Nationally, one per Region:

- Complex Specialist Tertiary Neuro-Rehabilitation Services- National Rehabilitation Hospital
- 6 x Regional Specialist In-patient services (Level 2)
- 6 x Community Neuro-Rehabilitation Teams (CNRTs)



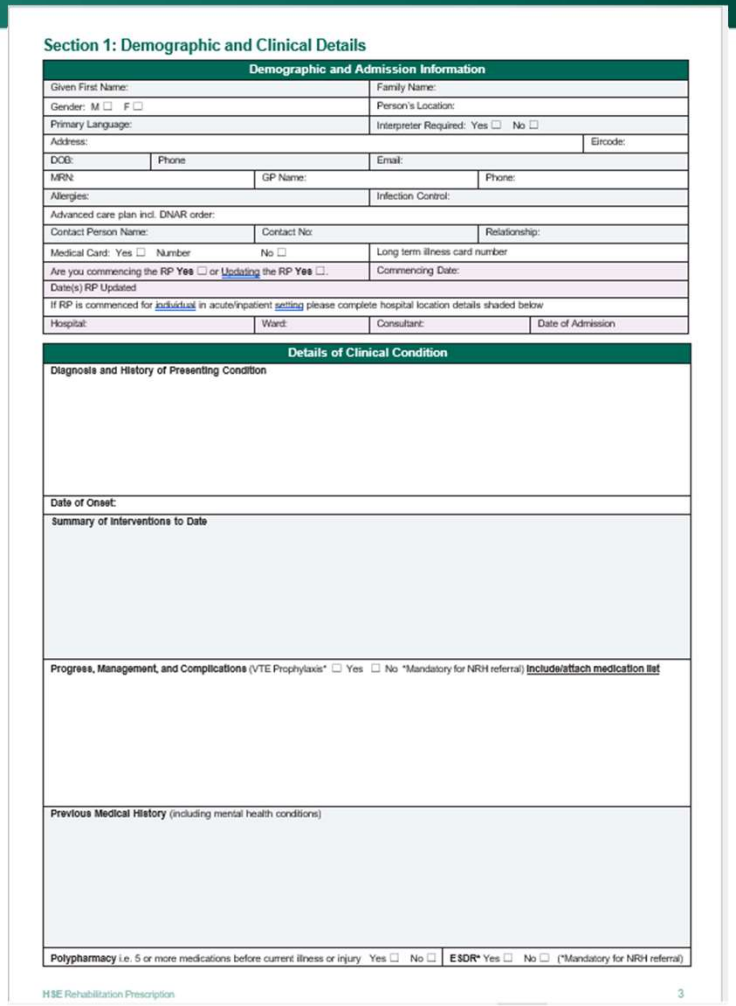
MCRN Network Rehabilitation Co-ordinator

- Pivotal Role
- Single point of entry for all referrals



Rehabilitation Prescription

- National standard approach for assessing people's rehabilitation needs
- Used to develop management plan that addresses a persons goals
- Acts as the referral form for MCRN Neuro-Rehabilitation services
- Currently in use through Trauma, NRH Adult services,
- Neuro-Rehabilitation services in the demonstrator sites
- Live document that follows the person and the individual is informed that they are referred to a network of services



Section 1: Demographic and Clinical Details

Demographic and Admission Information			
Given First Name:		Family Name:	
Gender: M ☐ F ☐		Person's Location:	
Primary Language:		Interpreter Required: Yes ☐ No ☐	
Address:			Eircode:
DOB:	Phone	Email:	
MRN:	GP Name:	Phone:	
Allergies:		Infection Control:	
Advanced care plan incl. DNAR order:			
Contact Person Name:	Contact No:	Relationship:	
Medical Card: Yes ☐ Number	No ☐	Long term illness card number	
Are you commencing the RP **Yes** ☐ or Updating the RP **Yes** ☐.		Commencing Date:	
Date(s) RP Updated			
If RP is commenced for individual in acute/inpatient setting please complete hospital location details shaded below			
Hospital:	Ward:	Consultant:	Date of Admission

Details of Clinical Condition
Diagnosis and History of Presenting Condition
Date of Onset:
Summary of Interventions to Date
Progress, Management, and Complications (VTE Prophylaxis* ☐ Yes ☐ No *Mandatory for NRH referral) **Include/attach medication list**
Previous Medical History (including mental health conditions)
Polypharmacy i.e. 5 or more medications before current illness or injury Yes ☐ No ☐ **ESDR*** Yes ☐ No ☐ (*Mandatory for NRH referral)

Rehabilitation Prescription and Regional Engagement

- RP revised, regional webinars

- RP and referral processes and procedures

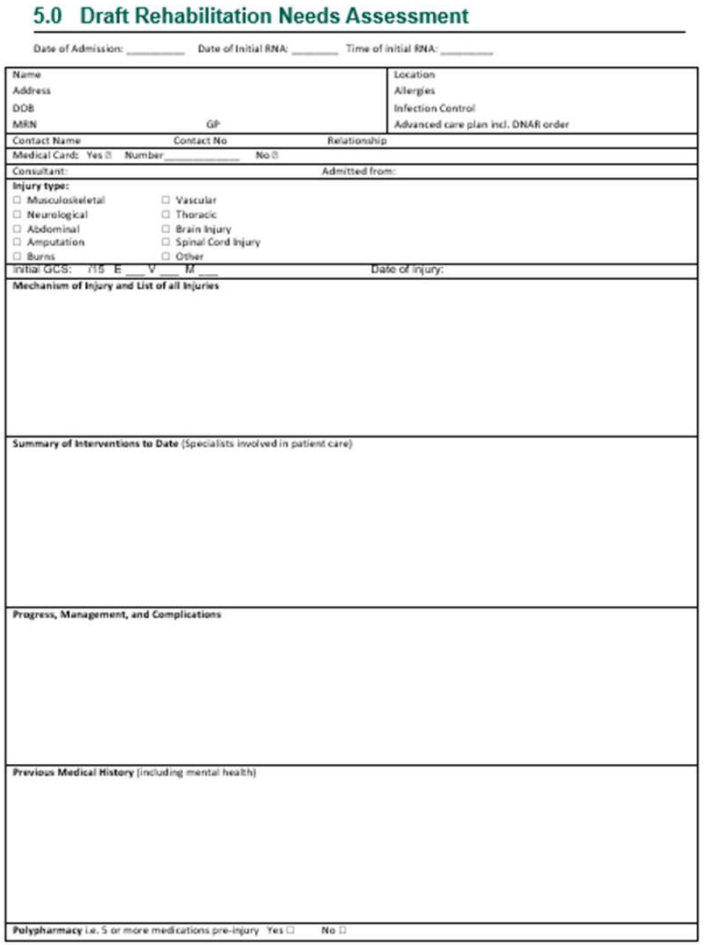
- Excellent attendance

- Further engagement with GP Leads

Rehabilitation Prescription is available:

NRH Website
Trauma HSE Landing Page
Neuro-Rehabilitation Strategy HSE Landing page

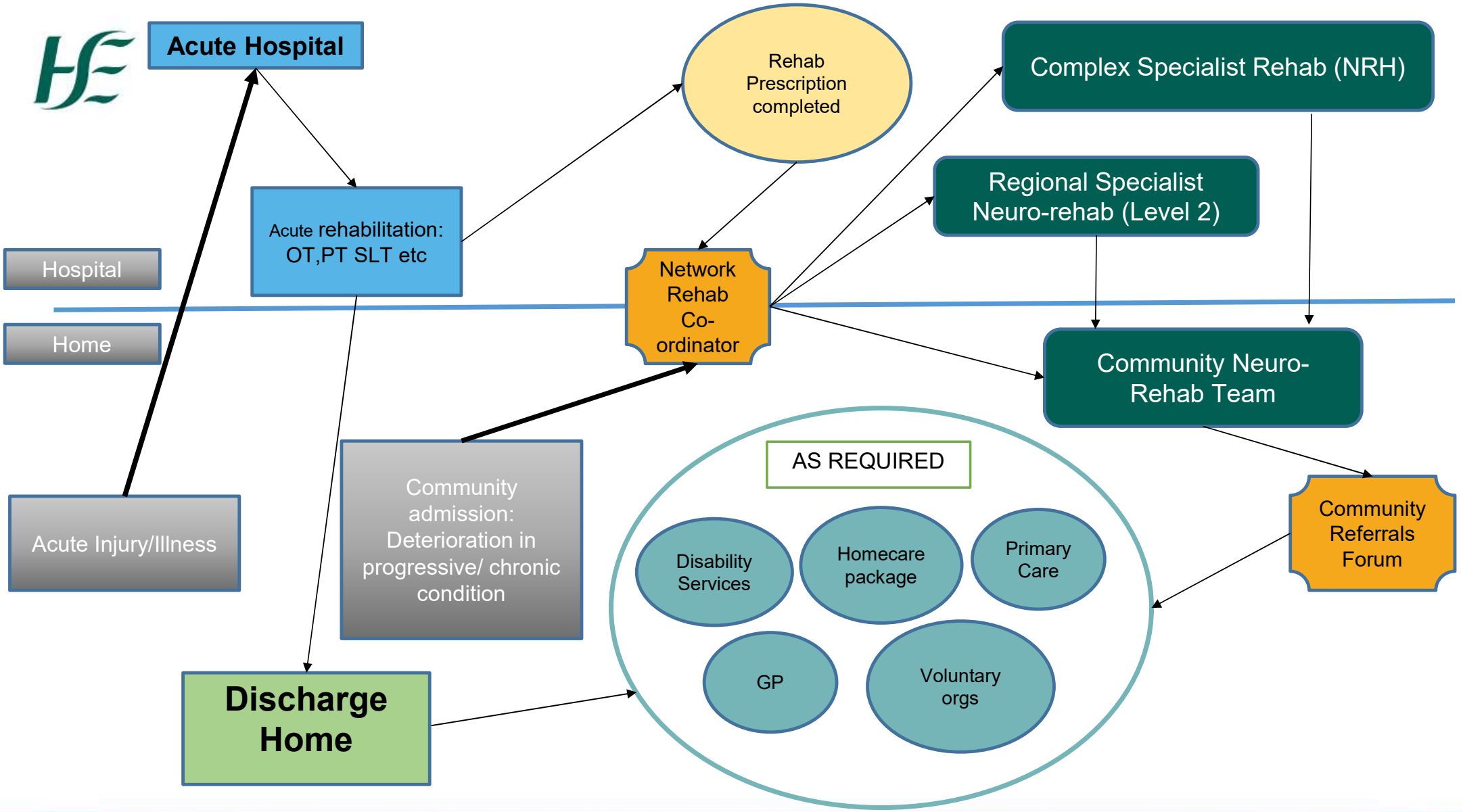
- Go Live with revised RP end of September



5.0 Draft Rehabilitation Needs Assessment

Date of Admission: _____ Date of Initial RNA: _____ Time of Initial RNA: _____

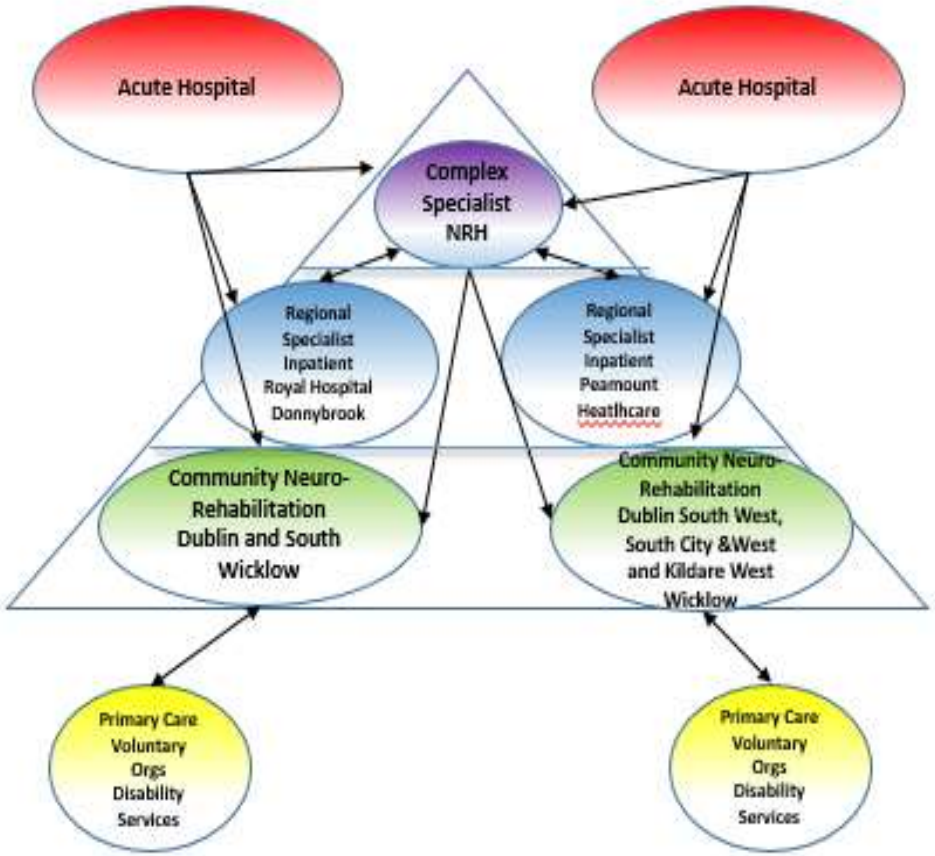
Name Address DOB MRN GP	Location Allergies Infection Control Advanced care plan incl. DNAR order
Contact Name Contact No Relationship	
Medical Card: Yes ☐ Number_____ No ☐	
Consultant: Admitted from:	
Injury type: ☐ Musculoskeletal ☐ Vascular ☐ Neurological ☐ Thoracic ☐ Abdominal ☐ Brain Injury ☐ Amputation ☐ Spinal Cord Injury ☐ Burns ☐ Other	
Initial GCS: /15 E___ V___ M___ Date of injury:	
Mechanism of Injury and List of all Injuries	
Summary of Interventions to Date (Specialists involved in patient care)	
Progress, Management, and Complications	
Previous Medical History (including mental health)	
Polypharmacy i.e. 5 or more medications pre-injury Yes ☐ No ☐	


Acute Hospital
Rehab Prescription completed
Complex Specialist Rehab (NRH)
Regional Specialist Neuro-rehab (Level 2)
Acute rehabilitation: OT,PT SLT etc
Hospital
Home
Network Rehab Co-ordinator
Community Neuro-Rehab Team
Acute Injury/Illness
Community admission: Deterioration in progressive/ chronic condition
AS REQUIRED
Disability Services
Homecare package
Primary Care
GP
Voluntary orgs
Community Referrals Forum
Discharge Home

Complete networks in Dublin and South East and Dublin and Midlands

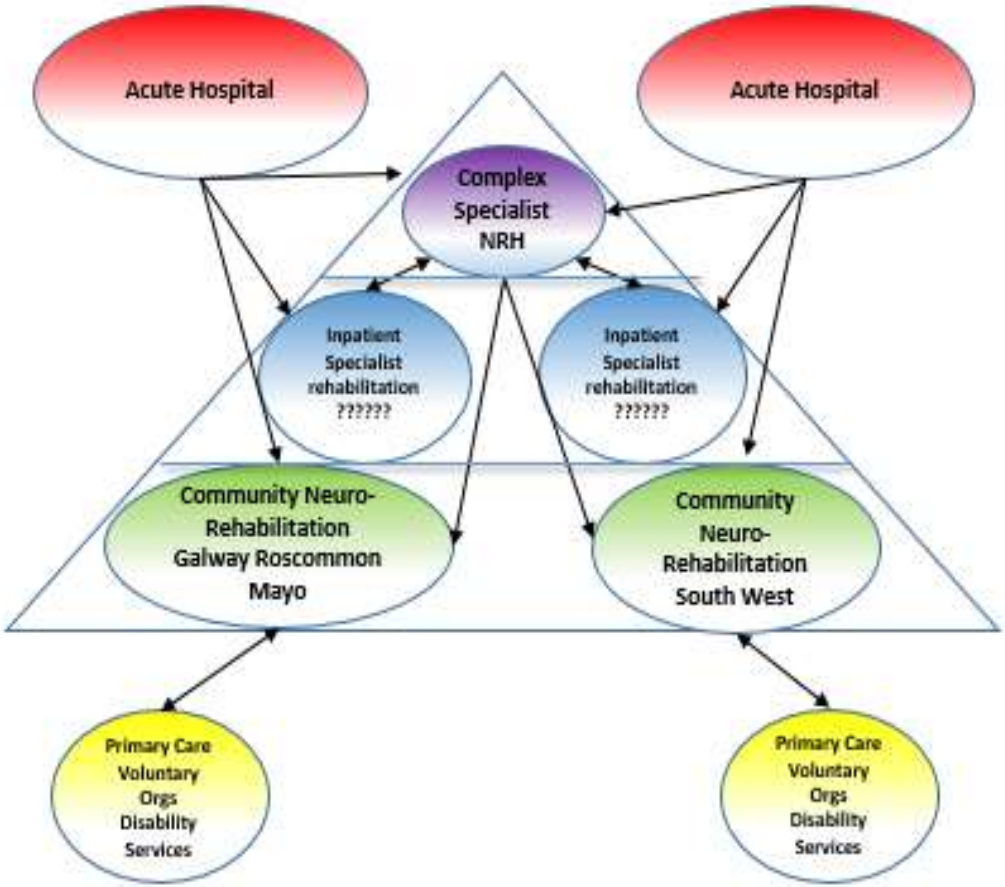
Demonstrator Site

- Network is live- April 2023
- All referrals through Network Rehabilitation Coordinator
- Community Neuro-Rehabilitation Teams onboarding



Partial networks in West and North West and South West

- Community Neuro-Rehabilitation Team onboarding
- Network Rehabilitation Coordinator
- Engage with relevant stakeholders to identify a Regional Specialist Inpatient Service for networks in these regions



Community Neuro-Rehabilitation Team (CNRT)

- Specialised, multi professional teams
- People with complex neuro-rehabilitative needs
- Don’t require an in-patient stay
- Must have rehabilitation goals
- Short period, intensive input
- Up to 12 weeks input

CNRT Team Make up

	WTE Approved
Clinical Nurse Specialist	1
Clinical Specialist Occupational Therapist Senior Occupational Therapist	1 1
Clinical Specialist Physiotherapist Senior Physiotherapist	1 1
Clinical Specialist Speech and Language Therapist	1
Social Worker, Senior Medical	1
Consultant in Rehabilitation Medicine	0.5
Operational Team Lead (Therapy Manager In Charge III)	1
Psychologist Senior Clinical	1
Therapy Assistant	1
Grade IV Admin	1
Rehabilitation Co-Ordinator	0.5
	12 WTE

Community Neuro-Rehabilitation Teams (CNRT)

Scope

- **Eligibility criteria:**
  - Over 18 years of age
  - Living within the IHA/RHA
  - Primary neurological diagnosis that is acquired or progressive
  - Be in agreement with the referral to the team
  - Suitability Criteria e.g.:
    - Ability to engage in rehabilitation
    - Clearly identified goals that the CNRT can meet
    - Medical, cognitive, physical, communicative and/or behavioural needs related to their neurological injury or disease process which can be met by the CNRT
  - Readiness for Rehabilitation e.g.:
    - Medically stable
    - All inpatient investigations completed

Community Neuro-Rehabilitation Team (CNRT)

-Go Live Critical Elements:

- Accommodation & Equipment
- Data Sharing
- Standard Operating Procedures
  - Waitlist and Prioritisation

-Education

-Estimates

Data Workstream

- Prove effectiveness of MCRN's
- Ensure measuring the correct outcomes
- Create structures for data measurement
- Create structures for data reporting

Measurement

- Network Rehabilitation Co-ordinator
- Network processes
  - Flow through network
  - Waiting times
  - Superspell LOS
- Network Services measurement
  - LOS
  - Patient outcomes
    - Functional
    - QoL

Data Workstream

- Grant Aid agreement with Trinity College Dublin:
  - Phase 1: Development of Neuro-Rehab network dataset
  - Phase 2: Validation and evaluation of data
- Data Sharing Documentation received- progressing to evaluation and report out
- Health Research Board Grant
- National Rehabilitation dataset being progressed through NOCA-Audit Programme Manager

Community Workstream

- Local HSE managed, advisory and assurance group.
- Representation from acute, community, network, statutory, voluntary sectors, lived experience representatives
- Integration and collaboration
- Tasked with identifying and exploring potential solutions to facilitate integration of network services with existing communitv rehabilitation services
- Neuro-Mapping Project:

Neuro-mapping Project
Phase 1

- The Neuro-mapping project was designed to respond to the challenge of capturing the breadth of voluntary provision to people with neurological conditions
- 3 outputs:
  - Service mapping template
  - Baseline mapping
  - Joint service initiatives

Neuro-mapping Phase 2 Project

- Collaborative project between HSE, DFI and NAI
- To further understand current service/support pathways
- Between existing and developing statutory and voluntary community-services
- For people with neuro-rehabilitative needs
- Aligned with the workplan of the Community Workstream

under the National Strategy Steering Group

Report Launched October 2024

Neuro-mapping Phase 2. Working together towards integrated care in the community for people with neuro rehabilitative needs.

Lived Experiences and Service

Neuro-mapping Phase 2. Working together towards integrated care in the community for people with neuro rehabilitative needs.

What are the challenges of living with a neurological condition in the community

Lived experience voices*

Challenges

Not enough specialist services

- Frustration at the lack of expertise and services available.
- Reluctantly paid for private services, as fearful of their condition regressing.

It's difficult to find out what services are available

- It's very difficult to identify what services were available to them in the community.
- Feelings of abandonment following discharge

> "I have to contact multiple organisations for different things, none of which are connected and there is no one point of contact. I have to figure out what it is that I maybe want and then figure out how to access it"

There are not enough long terms supports

- No long-term management plan
- Living with their disability for the rest of their lives is not factored into their overall treatment.

> "It feels like when the emergency is over there are no services. We go home and live with the disability every day"

Many obstacles to access services

- Constant fight and battle to access services.
- Challenges in physically attending services
- Accessible transport is very limited.

What are the challenges of providing community neuro rehabilitation services?

Service Provider insights

Challenges

Inadequate investment in the development of services

Frustration with the negative impact of under-staffed and under-resourced services.

Transitioning between services

- The lack of knowledge of available services is a barrier to individuals accessing relevant and appropriate services.
- Services work in silos, with inefficient referral methods, and limited use of digitalisation

> "Its such a complicated process to make a referral for somebody within the community. You could spend days shading a phone number to find out who to send the referral form to"

Inequitable access to services

- Age and diagnosis criteria
- Limited accessible transport and
- Poor support networks

> "Accessing services to follow on can be challenging, and I suppose it depends on multiple factors in terms of where they're living, their age what services are available to them"

Improvements Lived Experiences

Neuro-mapping Phase 2. Working together towards integrated care in the community for people with neuro rehabilitative needs.

Improvements Needed

More specialised staff

Access to **full range of specialist services** in the community to maintain independence.

Person-centred follow-ups

Follow-up calls by specialist services a few weeks post discharge would help reinforce the discharge messages

Increase knowledge on services available

A **service directory** on services available to address the frustration and being overwhelmed when discharged from hospital/specialist services

More peer support networks

Support networks are a key component to benefiting from and accessing neuro rehabilitative services.

> We formed a very good group of patients in there because we could share our experiences with each other

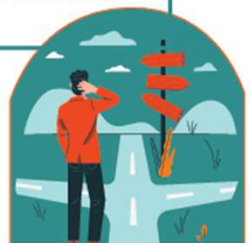
Improvements Needed

Increase knowledge on services available and improved liaison

- **Service directory** to signposting and integration between services.
- **Care coordinator** or key worker to act as a contact point.

Person centred systems

- Follow-up post discharge
- Easier re-entry options



More specialised staff

This will address the complexities of living with a neurological condition in the community across the life span

Long term goals

- Rehabilitation goals across the life span.
- Introduction of maintenance groups, tele-health rehab, local clinics

Improvements service providers

Recommendations

Neuro-mapping Phase 2. Working together towards integrated care in the community for people with neuro rehabilitative needs.

8.2 Knowledge of services

1. **A directory of services should be established.**
2. **Education and information about neurological conditions and services that are available to support rehabilitation should be readily available**
3. **An information resource of potentially relevant services, e.g., an information pack, should be sent to individuals a short time after discharge**
4. **Further development of the Service Mapping Template is required to facilitate signposting and mapping of services** (cref 1)

8.3 Services working together

1. **A standardised referral process across Neuro-Rehabilitation services should be developed**
2. **Standardised and centralised assessments should be introduced so that service-providers can track an individual's progress as they transition**
3. **Increased investment in information technology infrastructure is required to maximise the cross flow of information**

8.4 Access to services based on need

based on the individual's circumstances, a range of home-based, clinic-based and telerehabilitation options, along with satellite rehabilitation clinics should be available.

2. **Maintenance groups should be offered to individuals following an intervention block**
3. **As part of the discharge plan from a service, individuals should receive timely follow-up contact**
4. **Access criteria such as age/diagnosis should be removed to ensure equitable access to services.**
5. **Re-entry pathways for individuals should be part of discharge planning and should not require a new referral.**

8.5 Need for specialist services

1. **All community services that respond to the rehabilitative needs of people with neurological conditions should be fully staffed and resourced.**
2. **There should be a full complement of Community Neuro-Rehabilitation Teams in each region and these teams should be fully staffed and resourced as per the recommendations of the National Neuro-Rehabilitation Strategy and model of care for rehabilitation medicine.**
3. **Each Community Neuro-Rehabilitation Team should have a consultant in Neuro-Rehabilitation medicine as a member of the team.**
4. **Each region should provide the same standard and range of services.**

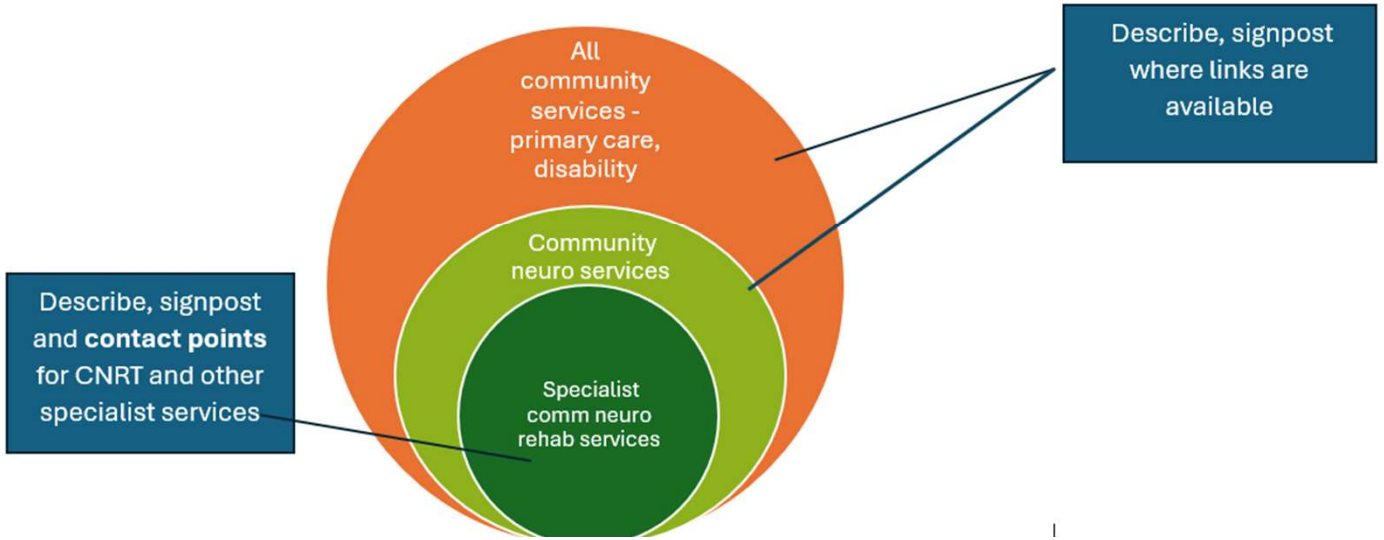
8.6 Service design to support continuum of care

1. **Establish the role of community rehabilitation coordinator,**
2. **Clinical specialist posts should be developed in primary care**
3. **Provide comprehensive and integrated access to disability services to adults with neuro-rehabilitative needs**
4. **A comprehensive accessible transport service should be resourced to support access to services.**
5. **Provision of Personal Assistance services should be resourced to support access to services and maximise benefit from specialist services.**

Digital Service Directory and Signposting Project

Project Parameters

- **People with neurological conditions and their families** – target user group
- **General information** and links to Primary care services, Disability services, services from voluntary providers, Information about access to benefits/housing
- **Specific information** and **contact points** for CNRT and other specialist neuro rehabilitation services



Community Workstream

- **<u>Community Referrals Forum:</u>**
  - Forum to bring network and community rehabilitation services together to discuss referrals and pathway for people beyond MCRN network services
  - Network Rehabilitation Coordinator developing implementation plan and education sessions planned once teams go live
  - Data Sharing
  - Roll out once teams go live

Neuro-Rehabilitation Competency Project

- Neuro-Rehabilitation Competencies Project
  - Neuro-Rehabilitation specific competencies developed for use with CNRTs
  - Excellent buy in and collaboration from network services, lead role taken by project team members to carry out discipline specific workshops across network services, CNRTs primary care etc to develop the competencies
  - Welcomed as a structure to guide professional development and standardise competency frameworks
  - Agreed to implement
  - Review and iterate in one year

Education and Competency Project

- <u>Education and Competencies research proposal with NRH and UCD</u>
  - Explore education needs across Neuro-Rehabilitation stakeholders in the demonstrator sites
  - To build a picture of what education structures are required and align this with the competency work with a focus on Inter-Disciplinary competency development across network structures
  - Progressing this with NRH and UCD

Communication and Conferences

- <u>Communications and Conferences:</u>
  - Integrated Care Conference:
    - Channel 2 recording afternoon session
  - NRH Grand Rounds 17th September
  - DFI/NAI Member Organisation Updates
  - Neuro-Mapping Project Poster at Patient and Partnership Forum September

What does this mean for the NRH?

- Rehabilitation Prescription: Standardised national approach to assessment and referral
- Reduced waiting list and waiting times for inpatient and outpatient services
- Profile of people accessing the NRH
- Increased rehabilitation services closer to home – increased discharge options for people leaving the NRH, enhancing flow and may reduce LOS
- Out-patient service
- Building Networks Together!

Role of the Rehabilitation Coordinator

- 1 Rehabilitation Coordinator per RHA in a 0.5WTE capacity
- Pivotal role in terms of the functioning of the network
- Receive, review and direct referrals to the most appropriate service
- Main single point of contact
- Support the onboarding of the new Rehabilitation Coordinators, CNRT and RHA teams
- Redirection of referrals

Other Roles of the Rehabilitation Coordinator

Standardizing document, creating cheat sheets and guides for referrers and network sites

Community Workstream, Data Workstream and digital strategy

Service development and Improvement- prioritization tools, streamlining processes, Community referral forum

Engagement sessions with Stakeholders and support change and completing RP's

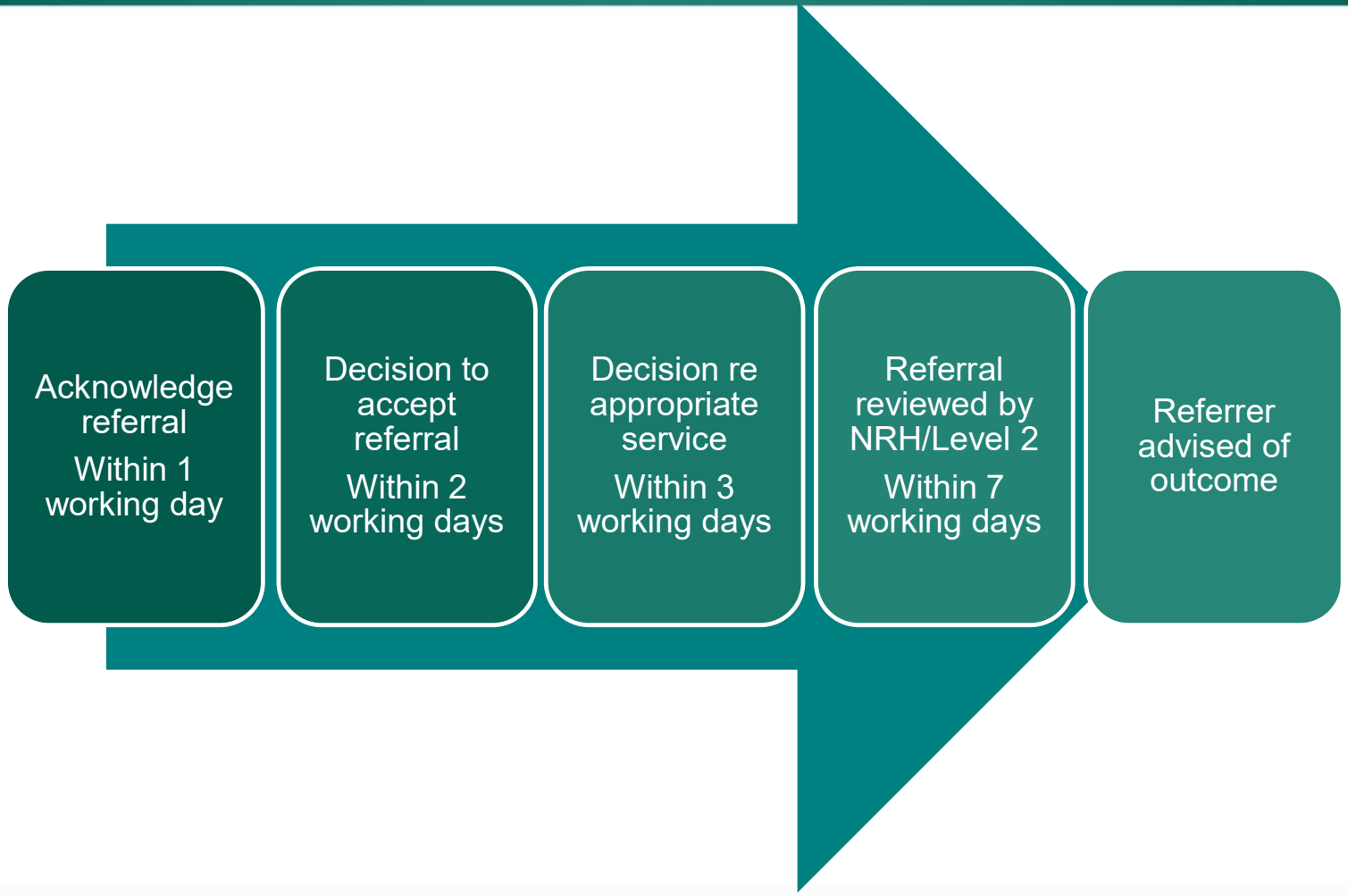
Present at conferences

Maintain KPI's and perform Data analytics

Process

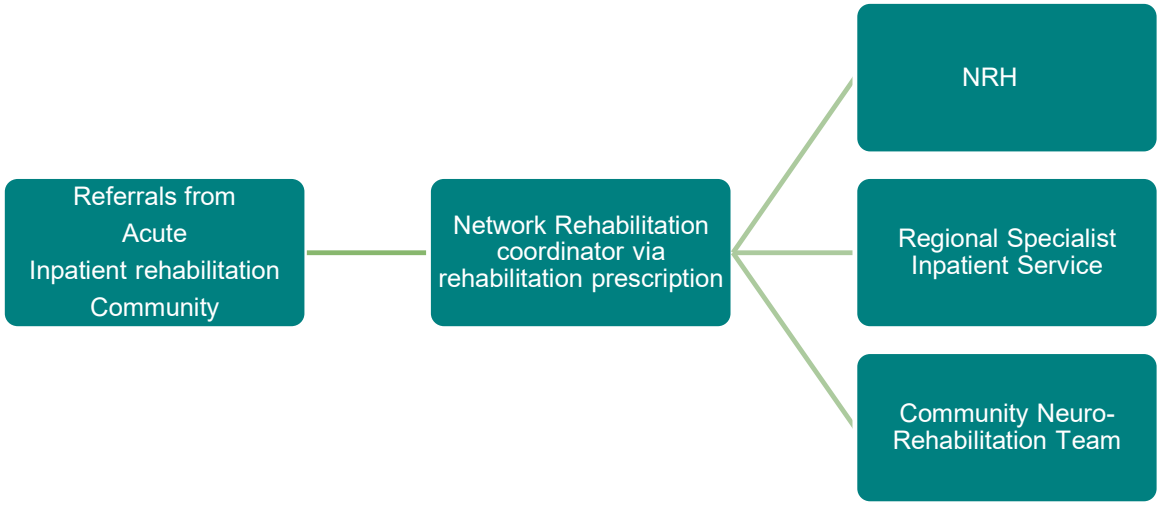
- Receive RP, decide on acceptance to network and direct to most appropriate service
- Attend MDT meetings in each site to discuss referrals and be informed of decisions made
- Liaise back to the referrer on decisions made within the MDT
- Provide reasons for non-acceptance and suggest other services
- If an individuals needs change, the rehab coordinator notifies the original service and redirects to a more suitable network service

KPIs for Rehabilitation Coordinator role

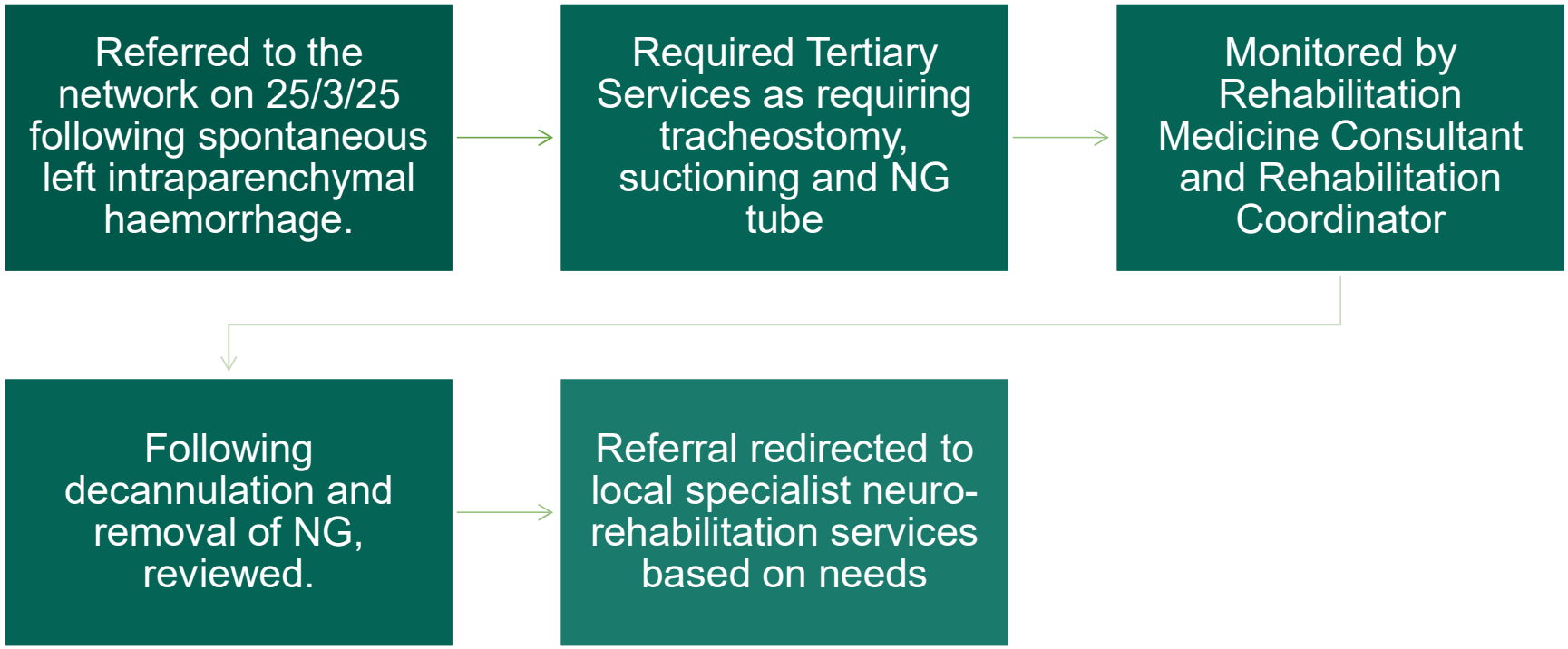


Benefits

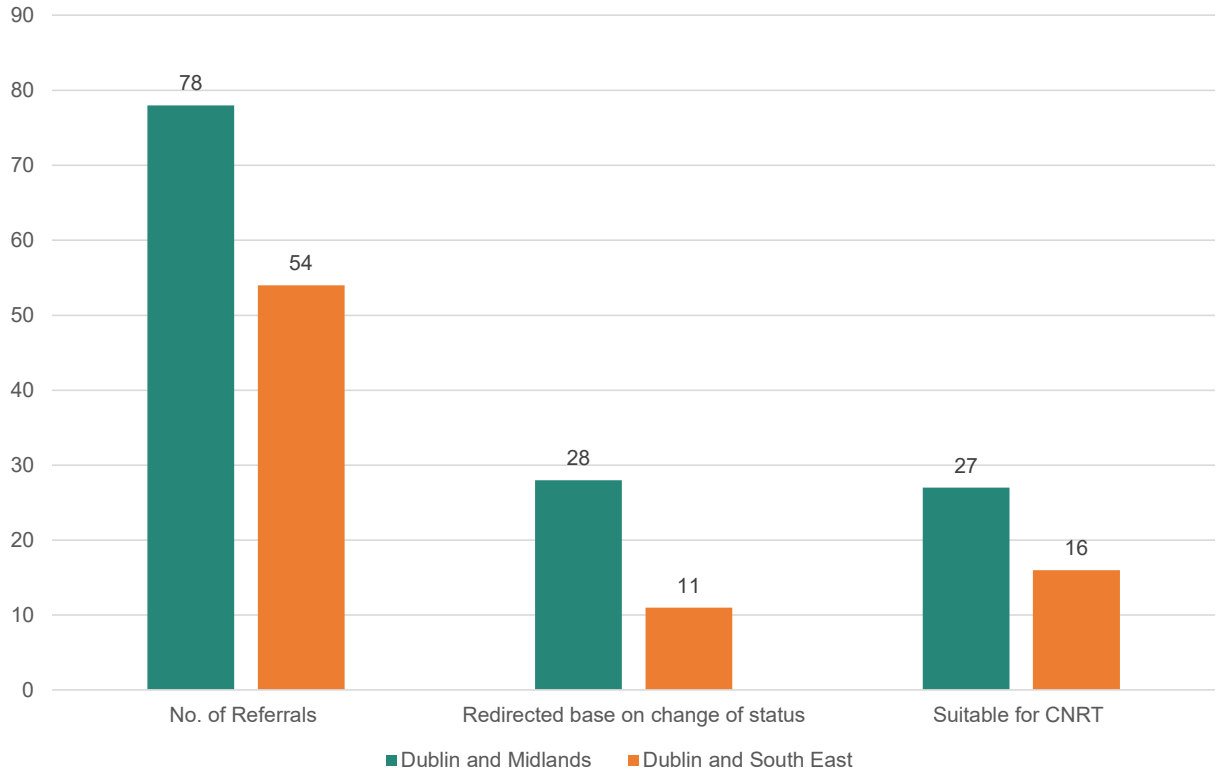
- Single point of entry for all referrals
- Single point of contact
- Single national referral form – rehabilitation prescription
- Redirection as per individuals needs
- Centralised waitlist
- Reduce duplication
- Access to appropriate rehabilitation services efficiently
- Right service, right place, right time



Patient Experience



2025 Referrals



- Data collected between January until July 2025.
- Two RHAs: Dublin and Midlands and Dublin and South East

Snapshot of NRH Inpatient Stroke and BI Waiting List 2022 Vs 2025

Stroke Programme 2022	Stroke Programme 2025
70 people waiting 483 days – 4 days waiting Number of patients waiting >100 days; 24 3.5 persons waiting for each inpatient bed on the stroke programme	31 people waiting 188 days – 5 days waiting Number of patients waiting >100 days; 13 1.5 persons waiting for each inpatient bed on the stroke programme

Brain Injury Programme 2022	Brain Injury Programme 2025
74 people waiting 432 days – 4 days waiting Number of patients waiting >100 days; 29 ~ 2 people waiting for each inpatient bed	72 people waiting 383 days – 7 days waiting Number of patients waiting >100 days; 27 2 people waiting for each inpatient bed on the stroke programme

Looking Forward

- Community Referral Forum
- CNRT’s joining the existing networks
- Other Network areas coming on board

Contact Information

- Rehabilitation Prescription is available:
  - NRH Website
  - Neuro-Rehabilitation Strategy HSE Landing page
  - Trauma HSE Landing Page

- Gina McLoughlin Network Rehabilitation Coordinator
  - Email: Neurorehabilitation.referrals@hse.ie
- Emma Shortall NRH Brain Injury Programme Manager-
  - Email: emma.shortall@nrh.ie
- Ciara Lynch Programme Manager National Neuro-Rehabilitation Strategy
  - Email: ciara.lynch6@hse.ie

Questions

Reflections

Comments

National Grand Rounds

National Rehabilitation University Hospital

Next **NRH National Grand Rounds:** 28th January 2026 – 1.00-2.00pm.

NRH POLAR Programme - presented by The POLAR Programme team at the NRH

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Link to mailing list for future NRH National Grand Rounds Lectures