Royal National Orthopaedic Hospital NHS Trust

Community Liaison team

Case management

Case Managers are an integral part of the multidisciplinary team, and are professionals with specific knowledge of spinal cord injury and discharge planning. On admission, patients are allocated a Case Manager who will facilitate patient led goal planning throughout the rehabilitation phase.

Case Managers will obtain patients' consent prior to liaising with community teams. They will identify care needs and liaise with health and social services regarding how any needs will be met in the community, and who will fund the care package.

Case Managers can arrange for patients and their relatives or carers to have appointments with visiting representatives from the Department of Work and Pensions (in relation to benefits advice or applications), solicitors, and independent living advisors upon patient request.

Community Liaison Clinical Nurse Specialists (CLCNS)

The CLCNS provide ongoing (life-long) follow up of individuals who have sustained a spinal cord injury. They offer a telephone support and advice service post hospital discharge for patients, carers, family members and community professionals, or visit patients in hospitals, nursing homes or their own homes to give advice and support.

Teaching is an integral part of the role for both patients and relatives as well as to professionals both community and hospital based.

The CLCNS coordinate and oversee patients' admissions to ring fenced beds for periods of rehabilitation post discharge. Their role also incorporates several clinics at the RNOH, including new patient consultations in conjunction with the rehabilitation consultants, facilitation of a nurse led patient follow up clinic, attendance at the monthly multidisciplinary clinic, working closely with the Tissue Viability Nurse Specialist in a combined wound care clinic and paediatric review clinics.

Advanced Spinal Reintegration Practitioners (ASRPs)

The ASRP team work with SCI patients on the ward to promote/teach independence and work towards discharge. They are highly skilled and work with all levels of spinal cord injury and are trained in care of ventilated patients.

ASRPs will facilitate patients' social visits to the community, and co-ordinate activities. They can also carry out overnight stays with patients in the Graham Hill Unit (Independent Living Unit) on site at the RNOH, or at the patient's home.

ASRPs often discharge patients from the SCIC, using the centre's own adapted vehicles. Part of the discharge process can involve the ASRP providing patient specific training for care staff at the patient's home or care home as required.

For further information, please contact the Community Liaison Team Administrator on: 020 8909 5367.