



# Newsletter

December 2011

British Society of Rehabilitation  
Medicine  
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## President's Report

This is the time of year when tradition dictates we look backwards and look forwards. In looking back, my first thought is how valuable I found our Autumn conference to be. Seldom can I remember finding in a conference so many personal learning points from the main speakers – exactly fitting the aim of an 'update on neurology'. I hope you enjoyed it too, and join me in thanking Diane Playford for organising this. I was also very encouraged by the session held to launch the musculo-skeletal Special Interest Group (SIG). It is our aim that each SIG should take responsibility for educational sessions, with one or more at each conference. As well as informing those in the same field, it's a chance for the rest of us to update our knowledge on matters that are part of our specialty, but which we may encounter less frequently. I'm pleased also that the spinal SIG has attracted a lot of interest, and look forward to when they also can emulate our existing groups in producing high quality educational sessions. Remember, if you wish to join any of the SIGs, they are free; just let Sandy know so she can put you in touch with the right people.

What of looking forward? Well, re-organisation will always be with us. One of our concerns is the defence of the value, and necessity, of skilled, experienced input into our services – perhaps especially those linked to technology and equipment provision. We need to emphasise the key clinical roles Rehabilitation Medicine plays here. SIGAM and SIGEAT are at different stages of providing guidance on this, which we hope will have an impact on commissioners. One of the uncertainties is how the concept of "Any Qualified Provider" will affect our work. We will be considering the implications of that at our next Executive, but would welcome your own view of the likely effects. What would you like BSRM to be doing in this regard?

Another area on which we would welcome your views is the future Conference schedule. I discussed at the AGM that it is getting more difficult to obtain both time and funding for study leave. Do we still try to maintain two national meetings a year? Is there a better way? Please give us your thoughts, through Sandy.

What about Regional representation? John McCann, our President-Elect, met with a number of regional reps at the Conference, and is considering what the role,

and perhaps the geographical areas covered, of regional reps should be now. With so much else changing in the Health Service, it's important that we review our structures to see if change is needed, or whether the current model still serves well. Again, your input would be welcome.

So much for looking forward. New Year always brings uncertainties; but before that we have our times of celebration. Whether you celebrate Christmas, Hanukkah, other festivals, or none, can I wish all joy of the Season, and a "Guid New Year".

*Chris Roy*  
**President**

## News from the Musculoskeletal Rehabilitation SIG

The Musculoskeletal Rehabilitation Special Interest Group (MSK SIG) was officially launched at the recent BSRM meeting in November. Our opening session on Rehabilitation for those with Spinal Pain provoked plenty of discussion and received many positive comments.

We hope to run a seminar at the forthcoming BSRM conference on the 14th & 15th June 2012, this time on musculoskeletal problems following trauma. Some obvious areas for us to focus on will be rehabilitation for:

- soft tissue injuries
- bony & joint injuries
- heterotopic ossification & contractures

But, as a newly formed SIG, we are very open to ideas and suggestions from any of you.

We would also like to set up a national BSRM course to help address any local training gaps in musculoskeletal rehabilitation and ensure that we all keep up to date and have the opportunity to learn from experts in this field. So watch this space!

*Vera Neumann*

**Chair – MSKSIG** vera.neumann@leedsth.nhs.uk

## SIGAM Update

### SIGAM Seminars:

The SIGAM seminar as part of the BSRM Summer meeting at the University of Keele in July 2011 was very successful and the feedback was excellent. There was notable interactive discussion, after and during all of the presentations, which included a 'live' demonstration of Rigid Removable Dressing for immediate stump management in below knee amputees.

### Consultations:

SIGAM contributed to the recently published Murrison report on War Amputees of October 2011.

### Committee:

We would like to thank retiring members of the SIGAM committee (David Abankwa, David Henderson-Slater and Lynne Hutton) and welcome three new members to our group (Alison Hatfield, Portsmouth; Yogen Jagatsinh, Cumbria and Imad Sedki, Stanmore. We look forward to new ideas and topics for future SIGAM meetings.

In this age/climate of financial austerity, we have been efficient in conducting SIGAM Committee meetings by telephone conference, rather than meeting up in London.

Wishing you all the very best of festive seasonal wishes.

*Jai Kulkarni*      Jai.Kulkarni@uhsm.nhs.uk

**Chair – SIGAM**

## SIGEAT Update

There was considerable interest and enthusiasm amongst those attending the SIGEAT session at Keele University in July, that EAT service providers and manufacturers need to prepare themselves for the new commissioning arrangements due in 2013. A similar sentiment was expressed at the recently concluded RAate conference at Warwick. The SIGEAT will be joining hands with other stakeholders to produce a document that will hopefully be of assistance to the national commissioning board when they seek to commission specialist EAT services. SIGEAT sees this as an opportunity rather than a threat. Service providers must continue to provide high quality assessment and equipment provision to significantly disabled users. However EAT providers must be prepared to comply with a uniform set of service specification and SIGEAT and other stakeholders hope to be able to clarify exactly what these specifications should be to assist commissioners. If there are lessons that EAT services should be learning from other rehab services, please do not hesitate to suggest them.

*Ajoy Nair*

**Chair – SIGEAT**

ajoy.nair@nhs.net

## VRSIG Update

First I would like to take this opportunity to say a big thank you to Diane Playford for all her hard work in chairing the committee for the last 3 years and for so successfully completing the mapping survey of Vocational Rehabilitation Services in the UK. As retiring chair Diane has said that she would like to extend her thanks to all BSRM members who responded. The report is now available on the DoH website. It demonstrates that NHS VR services probably meet less than 10% of need!

[http://www.ltnc.org.uk/download\\_files/final%20reports/Oct\\_11/Vocational%20Rehab/Final\\_Report\\_Voc\\_Rehab.pdf](http://www.ltnc.org.uk/download_files/final%20reports/Oct_11/Vocational%20Rehab/Final_Report_Voc_Rehab.pdf).

The VRSIG has produced responses to two significant DWP consultations this year;

- Disability Living Allowance reform Consultation (February 2011)
- Professor Malcolm Harrington's Consultation on the Work Capability Assessment; Call for evidence year 2 (having contributed to the initial consultation last year, September 2011).

Members of the VRSIG have also represented the BSRM at the following (relatively young) multi agency rehabilitation professionals meetings.

- The Council for Work and Health; (The BSRM now has a representative on this council – currently me)
- UK Rehabilitation Council (After working with members on the PAS 150 and members of the VRSIG speaking at several of their meetings, the BSRM have been invited to nominate a BSRM rep as a co-opted member of the Council)
- VRA (Vocational Rehabilitation Association)
- College of Occupational Therapists (Speaker at meetings of Special interest group on work).

Thank you to the BSRM members who have kindly elected me to the Chair. I look forward to liaising with you all to set up an exciting VRSIG session at the next SIG slot available at a national BSRM meeting.

Finally; a call for reaffirming interest in membership of the group please. Many members attended the founding open meeting of the group but have not been so actively participating in consultation feedback/meetings recently so I would like to invite all BSRM members to register their continued interest with Sandy or myself (Judith.allanson@addenbrookes.nhs.uk) so that we can invite you all to an open meeting at the next national BSRM meeting and make sure you are included in any information on future consultations/meetings of interest.

*Judith Allanson*

**VRSIG Chair** Judith.allanson@addenbrookes.nhs.uk  
Chair - VRSIG

## Research Corner

Playford ED, Leff A, Farmer S, Leff D, Duport S, Ali A, Elwell C, Rees G. Optimising therapy and characterising brain function in low awareness states. Neurodisability Research Trust/Royal Hospital for Neurodisability June 2011 £758,260

Diane with colleagues from the Royal Hospital for Neurodisability and UCL Institute of Neurology has been awarded £758, 260 for a project entitled 'Optimising therapy and characterising brain function in low awareness states'. Two medical registrars have been employed as PhD students on this grant including a trainee in Rehabilitation Medicine Dr Kudret Yelden.

Dr Mohamed Sakel is co-investigator of two PhD projects with collaboration of University of Kent.

"Developing a Multiparameter Assessment Tool for Upper Limb Motion in Neurorehabilitation."

"Can Caloric Vestibular Stimulation enhance behavioural & Electrophysiological responses in PVS patients?"

## Trainees Section

Firstly, I would like to thank all the trainees who attended our meetings this Summer and Autumn. It is fabulous see such engaged and motivated colleagues sharing information, opinions and lively debate. I only wish we had more time to discuss the issues pertinent to our specialty.

### Trainee representative elections January 2012

As many of you now know, Surendra Bandi is stepping down from his role as trainee representative in January 2012 to take up a Locum Consultant post. We would like to congratulate him on his appointment, wish him all the best in the future and thank him for his contributions to the trainee body. Not only is Surendra stepping down, I am pregnant and embarking on an entirely different journey to parental life. This means there will be two fabulous opportunities for trainee representatives within the BSRM: a three-year post to replace Surendra and a shorter post to cover my maternity leave. The latter could provide the perfect opportunity for a trainee to 'dip their toes' into the world of the BSRM without having to commit to three years. Elections are open, please forward your manifesto including an introduction, statement of intent, previous relevant experience and any innovative ideas you have for the trainee representative roles by email on or before the 8th of January 2012. Voting will be closed on the 30th of January 2012. The maximum word limit is 150 and the new representatives will be in post from February 2012. The posts are a fantastic opportunity to make a difference in our specialty and represent the views of the trainee body. I would encourage all trainees to apply.

### Trainee email list

It is vital we keep our list of trainees up to date, not only to ensure effective communication within the trainee body, but also to make certain that all new trainees have the opportunity to stand for BSRM representative if they wish. If you know of any new trainees please

pass their contact details either to Surendra or me so we can add them to our list.

### Training Issues

2012 is likely to be a year of change within Rehabilitation Medicine. Firstly, we should begin to see the National Training Programme slide set being delivered in regional teaching. Secondly, 2012 should bring about our first knowledge based assessment for final year trainees. At the moment, the plan is for this to be a non-compulsory paper of short answer questions based on the competencies required for completion of training in Rehabilitation Medicine. Some members of the trainee body have met some of these changes with apprehension but as with all things new, sometimes it takes a bit of time and trial to adjust to the changes. Furthermore, we can only give accurate feedback if we experience them. Lots of other specialties have a similar assessment and on a positive note this change will bring us more in line with our Consultant colleagues of the future.

There is also a period of uncertainty about training requirements for those interested in SCI or trauma rehabilitation and potentially some curriculum changes in the near future. I hope that we will get some clarity soon and think it is important to continue to garner opinions and debate around these topics.

### Collaboration

We are all working within a small specialty and one way to increase our 'national voice' is to collaborate on research and/or audit projects. Not only would this increase our publishing potential but also allow us to share our knowledge and experience in the context of different training completed in different regions. Good collaborations and networks of trainees should blossom into effective working relationships as consultants and hopefully strengthen our voice in the world of Rehabilitation Medicine overall. Remember, it is possible to call for collaborators via the Research Network area of the BSRM website.

### Recruitment

Some specialist trainee posts in certain areas of the UK have remained unfilled. This is both a concern and disappointment for a specialty that can offer so much to doctors in training. As trainees, we are in a unique position. We have directly experienced some of the recent changes to medical training and can relate to and advise doctors contemplating their future careers. This means we are in the perfect position to sell our specialty and I would encourage trainees to do as I have done and talk in careers fairs and at BMA conferences, (see Poorna Ramamurthy's account of the West Midlands Careers Fair in this Newsletter). By increasing the 'visibility' of the specialty, we can highlight how desirable it is. I believe we are working within an exciting and evolving field of medicine and increased competition for posts will ultimately drive quality.

### And Finally,

Communication is key. I would love to hear your thoughts and views regarding the world of rehabilitation. Please come and find me at meetings if you see that I am on the delegate list. If you have any questions or queries about Rehabilitation Medicine I will do my best to answer them or put you in touch with someone who

can. I have started work on trainee resources, careers advice and other general information and am more than happy to share these, just ask. And last but not least Seasons Greetings to all.

Sarah Leeder sarahleeder@doctors.org.uk

**National Trainee Representative**

## **Update!** **National Training Programme for Rehabilitation Medicine**

The national training programme project (NTP) is making highly satisfactory progress since its instigation in May 2010 when the initial working party was formed. To date 40 complete peer-reviewed presentations have been received and reviewed by me. It is with great pride that I highlight the outstanding quality of all the presentations to date, and the commitment of all contributors has been inspirational - heartfelt thanks to all involved and particularly to Sandy for her unerring input and support.

An additional presentation on complex polytrauma has been suggested and I have approached colleagues at Headley Court, to provide this, but anyone willing to contribute to such a presentation is warmly welcomed to contact me c/o admin@bsrm.co.uk.

I am pleased to report that the NTP working party falls under the auspices of the Education Subcommittee who will continue to provide support not just for the working party but also for trainers across the UK to ensure effective delivery of the programme in due course.

As a result of discussions between the SAC, Education Subcommittee and NTP working party, the next step of this important project is for up to 5 pilot centres ('hubs') to test out the training material in January and February 2012, and for the pilot centre leads to report back findings including, trainee and trainers feedback, to the next NTP working party meeting on 21 March 2012. This will then inform the next stages for national roll-out. At the time of writing the four pilot centres and respective pilot leads are: Dr Angela Gall for London; Dr Kate McGlashan for East Anglia; Dr Laura Graham for the Northeast and Dr Eluzai Hakim for Wessex/Isle of Wight and volunteers for a fifth pilot centre have been requested via STC's chairs and regional training leads.

The knowledge based assessments pilots are being led and rolled out under the leadership of Dr Rory O'Connor and Dr Diane Playford, and although these are closely related pieces work, the pilots remain independent.

Clearly the NTP project continues in evolution and the pilot stage will be a very helpful insight to inform the next stages. Members may find the list of frequently asked questions below helpful. This is not an exhaustive list and if there are further queries from trainers or trainees regarding this project, please do not hesitate to contact me via admin@bsrm.co.uk .

## **National training programme: FAQ for trainers and trainees**

### **Q: What is the National Training Programme project (NTP)?**

**A:** It has been acknowledged by trainers and trainees across the UK that tutorial/lecture-based training across the country varies for a multitude of reasons, and hence the national training programme is an attempt to provide an equitable method of ensuring trainees have regular tutorial lecture-based input as an adjunct to competency-based training.

The project was instigated by members of the Education Subcommittee in May 2010. The aim is to facilitate trainees to acquire the core knowledge as set out in the Rehabilitation Medicine August 2010 curriculum (available on BSRM & JRCPTB website) by providing a resource base of presentations for use by trainers across the UK.

### **Q: Who is on the National Training Programme Working Party?**

**A:** The Working Party consists of Consultants in Rehabilitation Medicine spanning the subspecialties of neurological rehabilitation, spinal cord injury rehabilitation, musculoskeletal rehabilitation and amputee rehabilitation. The members are Chair and Project Manager Dr Roshni Beeharry, Dr Tarek Gaber, Dr Angela Gall, Dr Laura Graham, Dr Eluzai Hakim, Prof Rajiv Hanspal, Dr Julian Harriss, Dr Ruth Kent, Dr Stephen Kirker, Dr Rory O'Connor, Dr Margaret Phillips and Dr Diane Playford.

Although at this current point in the project development, there is no trainee representation, trainee feedback will be essential in the pilot centres (See below). However queries from any trainees are welcome via the NTP Project Manager Dr Roshni Beeharry and BSRM Executive Secretary, Sandy Weatherhead via [admin@bsrm.co.uk](mailto:admin@bsrm.co.uk).

### **Q: How does the National Training Programme fit in with the rest of the BSRM structure?**

**A:** The National Training Programme (NTP) was instigated after on-going discussions between Consultant trainers, members of the Education Subcommittee and the RM SAC.

The NTP Working Party is now a subgroup of the Education Subcommittee whose role is to support the Working Party and also trainers in ensuring delivery of the core curriculum provider programme.

### **Q: What does the content look like and who are the contributors?**

**A:** The complete NTP resource-base will consist of 51 PowerPoint presentations spanning the knowledge base depicted in the *core curriculum* of the August 2010 curriculum, with a presentation on complex polytrauma also being commissioned. Currently 40 of these presentations are complete and have been peer-reviewed then edited by the NTP Project Manager.

Authors include all members of the Working Party plus their multidisciplinary colleagues, who are involved in both writing and peer reviewing presentations, hence creating a rich source of expertise.

**Q: How will the programme be delivered?**

**A:** The presentation formats are designed for one to two hour, *face-to-face* delivery including interactive sessions and multimedia as appropriate, and cannot realistically cover all the specialist knowledge and skills. That can only be attained through clinical training and attendance at specialist courses and curriculum.

*This programme is not intended for delivery of e-learning.*

The suggested format is a 15 month rota of monthly study days consisting of 3 to 5 presentations, in a modular fashion. The sample delivery timetable is available from BSRM.

**Q: Who will have access to the presentation database and how often will this be updated?**

**A:** All consultants involved in training will have access to presentations via a password protected database on the BSRM website prior to national roll out.

Pilot hub centre leads will be the initial people to have access to 40 existing presentations for piloting in 2012.

To keep the information up-to-date with changes in medical practice, author will be asked to update their presentations in 2013 with input from existing trainers across the UK who deliver the presentations, enabling all involved to incorporate their own expertise. This will be co-ordinated by Hub Training Leads and the NTP Chair.

**Q: Who will be presenting the study days?**

**A:** The presenters will normally be Consultants in each region but may be a senior member of the Therapy Team depending on the topic to be presented and local trainer availability. This is at the discretion of local hub training leads and their colleagues. Each training region will nominate a Consultant to act as local hub training lead, organising the study days and speakers and informing the trainees. It is anticipated that areas with few trainees within close geographical reach of each other will form training 'hubs' to share trainer resources.

**Q: What if we do not have enough speakers for our 'hub' to deliver all presentations?**

**A:** The NTP Working Party anticipates that not all regions will have access to particular specialists in all the subspecialties eg amputee rehabilitation consultants, or at times there may not be enough speakers in a region to cover particular training days. Hence, local training leads will be asked to identify trainers that are willing to travel to different regions to deliver specific presentations again allowing sharing of expertise. This will facilitate the NTP to keep a 'trainers database' and act as a point of contact for trainers wishing /needing to share resources. The Education Sub-committee will also support this process.

**Q: I am an existing trainer and already have written presentations for some of these topics – do I have to use the new ones? I will find it hard to deliver someone else's presentation!**

**A:** The NTP Working Party recognises this may be a common feeling amongst colleagues. Although no one should feel coerced into delivering material if they are not comfortable to do so, BSRM encourages trainers to use this resource. Authors have included speaker's

notes where appropriate on their slides to assist others to deliver their presentations.

Trainers have the option to use the presentations as they stand or integrate/adapt them with their own material as long as they seek permission from the original authors. ***Presentations remain the intellectual property of the authors involved.***

**Q: Can trainers change the order of modules and presentations in the sample delivery programme?**

**A:** The sample delivery programme is not intended to be prescriptive, but was felt by the NTP Working Party to provide a reasonable framework for modular delivery of related curriculum matter. It is entirely reasonable to adjust the order of modules or presentations within a module as long as the order makes logistical sense for trainees to follow and build on in subsequent months. *The final decision for local delivery will lie with the hub training leads.*

**Q: When will the programme be rolled out?**

**A:** The next stage is to pilot some of the presentations in the form of two study days in January and February 2012, and review trainee and trainer feedback before national rollout towards the Summer of 2012, allowing for any modifications to the programme based on the pilot process.

Currently four pilot centres with respective training leads, have volunteered and been allocated in London, East Anglia, Wessex and Newcastle.

**Q: As a Consultant trainer am I entitled to CPD points for presenting/attendance?**

**A:** This is currently being explored via the BSRM's CPD Lead.

**Q: Is attendance compulsory for trainees?**

**A:** Local specialist trainee study days cannot be made compulsory, but the consensus is that trainees should discuss training needs with their educational supervisor and that part of their personal development plan should involve attendance at monthly teaching within the programme which has been specifically designed for this purpose for trainees across the UK.

**Q: What if a trainee cannot attend a session or misses a session eg due to illness?**

**A:** As with any unexpected non-attendance, the trainee should contact the local hub training lead as soon as possible, who can then arrange for copies of hand-outs or other relevant teaching material to be passed onto the trainee.

**Q: Can anyone attend the sessions?**

**A:** The intended *priority audience* are specialist trainees in Rehabilitation Medicine as the purpose is to ensure delivery of the knowledge base of the core curriculum, but there is no reason why junior trainees, other Consultants or therapy colleagues cannot attend the sessions. This should be at the discretion of the local hub training lead and speakers.

**Q: What is the relationship of the NTP to the knowledge base assessments (KBA)?**

**A:** The KBA will be one of the assessments used by the JRCPTB to establish competences in Rehabilitation Medicine. It will add to the other evidence on the e-

portfolio for trainees at the time of their PYA. The knowledge required for the KBA should be already available to trainees from their reading of textbooks and journals in Rehabilitation Medicine. The NTP will facilitate acquiring this knowledge, but cannot replace personal study.

**Q: Will the programme replace existing local training and specialist courses?**

**A:** No! The aim of and focus of this programme is to provide an adjunct resource to trainers to deliver the *basic core knowledge* needed by all trainees in Rehabilitation Medicine, from which trainees can build on their knowledge through their clinical training and acquisition of skills and attitudes. It also maps out a suggested delivery timetable and framework to ensure all areas are covered in each region.

**Q: Who do I contact if I have further queries about the National Training Programme?**

**A:** Please contact the Project manager  
Dr Roshni Beeharry or Sandy Weatherhead via  
admin@bsrm.co.uk.

Roshni Beeharry

**Chair – BSRM National Training Programme  
WP**

**"Exciting times for rehabilitation services in south London - Integration of community and post acute rehabilitation."**

There is a reconfiguration of neuro-rehabilitation proposed to improve the service provided to patients across South West London. Currently over 65% of inpatient rehabilitation is provided at the Wolfson Centre. A new configuration has been identified that offers a number of benefits clinically and in terms of patient experience.

An interim configuration has also been identified that offers more equitable service to patients. Currently neurorehabilitation is provided at the Wolfson Centre in Wimbledon, a 32 bed unit, and from 14 beds at Queen Mary's Hospital, Roehampton (QMH).

**Future Plans:**

The neurorehabilitation services provided at QMH would increase from the 14 current beds to a total of 36 beds and this would be done by commissioning empty shell space on the site to provide 16 additional beds including four en-suite single rooms. A further six beds that are currently under-utilised on the existing neurorehabilitation ward at QMH would be allocated to the Wolfson services. Additionally, 10 beds would be provided at St George's Hospital which would allow patients that still have acute clinical needs to begin neurorehabilitation earlier. Out-patient based services, namely the Pain Management Programme (PMP), the Spasticity service, the Vocational Rehabilitation Service (VCOG), the Wolfson Cognitive Assessment Programme (WCAP) and the Orthotics service will also be relocated to QMH.

The proposed pathway with some beds on the St George's hospital site and the majority co-located with the neurorehabilitation service at QMH, means that the current cohort of patients enter earlier in the rehab pathway – often from intensive care (ITU) or high dependency care (HDU). The patients that would be treated in the St George's acute beds would be those that are ready for neurorehab and medically stable, but still requiring medical support and 24 hour cover, for instance patients with tracheotomy tubes.

Queen Mary's Hospital is purpose built for rehabilitation and has on site a far greater array of support services (such as orthotics and wheelchair service), access on site to other outpatient services and diagnostics such as radiology.

There is not provision at the current time in South West London for acute hospital neurorehabilitation services which means that this service can additionally provide Level 1 rehabilitation to patients following complex trauma, traumatic brain injury and complex stroke. Consolidating services on fewer sites will also reduce the need for patient transport and improve patient experience.

Pradeep Deshpande

**BSRM regional co-ordinator South London**



*Queen Mary's Hospital, Roehampton, London.*

**Northern Ireland (NI)**

Exciting new changes are happening in brain injury services in NI! A reception was held at the Kings Hall in Belfast on 15<sup>th</sup> November 2011 to mark the launch by the Dept of Health of three new initiatives and new care pathways developed by the Regional Acquired Brain Injury Implementation Group (RABIIG). RABIIG was originally established in June 2010 with membership from the five Health and Social Care Trusts, statutory bodies, voluntary organisations, service users, parents and carers. The group aims to improve health and social care service provided for all users and carers of brain injury services in NI.

The first initiative was the establishment of a 'Guide for Brain Injury Support in NI'. This comprises eight leaflets detailing hospital and support services, family issues, recovery, early rehabilitation and much more. This will be an invaluable resource for patients, families and care givers in the future. The second initiative was the development of Acquired Brain Injury (ABI) 'Service Standards and Quality Indicators'. This details the standard of care that people of all ages with ABI should

expect to receive, irrespective of post-code in NI. The final initiative launched was the establishment of three new care pathways for patients with ABI in NI;

1. Children and young people with ABI
2. Adult inpatients with ABI.
3. Community pathway for ABI patients.

The launch was led by Health Minister, Edwin Poots, and proved to be both informative and educational. The Minister reminded the audience of the devastating and lifelong impact that brain injury has on those affected both directly and indirectly. He also went on to state that;

*“Around 2000 people a year in Northern Ireland sustain, and are living with, the long- term effects of brain injury. It brings with it countless symptoms and challenges including memory loss, mobility problems, personality changes and behavioural issues. Of course, we also have to remember the impact of the brain injury on family members and friends, who will also be living with the effects it has had on their loved one.”*

The new initiatives and pathways can be viewed at <http://www.hsboard.hscni.net/RABIIG/>.

Finally to digress, Bon Voyage to our friend and colleague Dr Josephine Hillan! Having recently completed her CST in Rehabilitation Medicine, she will be starting work at the Spinal Cord Injury Unit, in Christchurch, New Zealand, in December 2011. We hope she enjoys her experience there and wish her all the best for her future endeavours and career. She will certainly be missed!

Danny Smith ST5 &  
Dr Sheena Caldwell  
Regional Coordinator

## All the fun of the fair In the West Midlands

The West Midlands Deanery held the Medical Careers Fair on Saturday, 8<sup>th</sup> October 2011 in the Postgraduate Centre of Birmingham City Hospital which offered an excellent opportunity to meet prospective trainees to promote the specialty of Rehabilitation Medicine.

The Careers Fair attracted 260 trainees including medical students who were able to meet doctors working in 30 specialties, to discuss the specialty in detail; the skills and qualifications required and career opportunities available locally and nationally.

The Rehabilitation Medicine (RM) stand, represented by two Registrars (Dr Sunil Ankolekar and myself) and the Training Programme Director, Dr Eliezar Okirie, created a lot of interest amongst attendees. We had two posters from BSRM. One represented patients in different phases of rehabilitation; assessment, working with therapists and mobilising with an aid. The other demonstrated use of robotics and assistive technology in rehabilitation. We gave out leaflets explaining what the specialty involved, the training and career opportunities in RM. We also had leaflets on Brain Function Recovery. Also on display was a PowerPoint presentation with a RM career overview. There were some sweets too!

Most visitors were not aware of what Rehabilitation Medicine was, most thought that we worked closely with elderly care and some even thought we acted as an interim prior to appropriate discharge into the community. We were pleased to be there to explain the role of our specialty, the different facets of training and the expanding career opportunities and inspire visitors to explore RM as a career. Being located close to the RCP stand we were able to attract most of the attendees who were interested in the medical specialties. We were visited by the Post Graduate Dean who also said that she had recommended the attendees to visit our stand in her inaugural speech. The general feedback from the event suggests that it was a resounding success and we have been invited next year. The attendees scored the RM stand “very useful” in their specialties specific feedback questionnaire.

Having seen the unfilled vacancies for training posts in our specialty following the national recruitment I do wonder why our specialty is not more popular amongst medical graduates. I strongly feel it is due to the lack of understanding of what the specialty involves. RM involves a wide spectrum of skills, very little/no out of hours’ commitments, flexibility of job pattern, mixture of inpatient and outpatient, hospital and community based work, which when explained makes it very attractive.

We as trainees have to take responsibility for raising awareness and the reputation of the specialty and generate interest amongst junior colleagues. We also have to reach out and build strong relations with local colleagues and develop joint initiatives with Neurology, Orthopaedic, Elderly Care, Palliative care team, Vascular team, Rheumatology and Pain Medicine colleagues to promote the specialty.

I found this a very good opportunity to advocate the exceptional difference we make to the lives of our patients and encourage aspiring doctors to take part in the same.

Poornashree Ramamurthy  
Specialty Trainee Registrar, RM, West  
Midlands Deanery

## Pain Medicine Training Fellowship Experience

Chronic pain is common in our practice, literature reports occurrence in 55% of multiple sclerosis patients and 75% of spinal cord injury patients. On the other hand, acute pain is reported in up to 80% of cranioplasty procedures and up to 90% of patients with spinal cord injury. More importantly, pain impacts negatively on the rehabilitation potential and outcome of patients with disabling conditions. The above observations made me keen to increase my expertise in this area, so I arranged a three months optional attachment in the Pain Medicine service in Glasgow. During this period, I appreciated that both Pain Medicine and rehabilitation medicine disciplines complement each other very well, and realised that coming up with an effective and safe pain management

plan for patients with chronic neurological and musculoskeletal conditions is very challenging.

Following on from my rewarding 3-month experience, I applied for a one-year post-CCT Pain Medicine Fellowship in Glasgow, and in fact became the first non-anaesthetist Fellow of Pain Medicine in Scotland. I wish to share my training experience with you all and hope interested trainees can get an idea of what the training involves.

The Fellowship in Glasgow follows a multidisciplinary approach to pain management which complements core Rehabilitation Medicine principles. It integrates acute pain, chronic pain, cancer pain, pain in the paediatric population and interventional pain. The faculty education programme is robust and consists of monthly subspecialty lecture, journal club, and local and regional meetings. The programme accepts two Fellows per year; one pre-CCT and one post-CCT. Training follows the Royal College of Anaesthesia advanced Pain Medicine guidelines. Assessments include Mini CEX, CbD, DOPS, MSF, structured logbook, and referenced case reports. It is also expected to attend relevant scientific meetings throughout the year and to take part in the clinical governance of the department.

The chronic pain service is run by multidisciplinary teams through outpatient clinics in three main hospitals; the New Victoria, the New Stobhill, and the Inverclyde Royal. These clinics typically deal with musculoskeletal, neurological, CRPS, fibromyalgia, phantom and post-surgical pain conditions. As a Fellow I was able to conduct two to three independent clinics per week after the initial supervised training. I also assisted consultants and performed independently interventional procedures including trigger point injections, cryoablation, peripheral nerves blocks, epidural steroid injections, stellate ganglion blocks, intravenous anesthetic blocks, fluoroscopic guided procedures, ultrasound guided procedures, and radiofrequency ablations. In addition to that, I learnt the principles of neuromodulation through the Glasgow spinal cord stimulation service.

The acute pain inpatient service manages postoperative and trauma acute pain complaints. I attended the acute pain ward round once a week and learnt about patient controlled analgesia (PCA) pumps, thoracic and lumbar epidural catheters and pre and post operation analgesic protocols. As we are currently involved in a big way in the development of trauma networks and major trauma centres, the knowledge and competency in acute pain management will be an essential part of the workload of trauma rehabilitation physicians and I feel experience in acute pain may prove very useful in such jobs.

In addition to the above, I spent two weeks with the palliative medicine team in the Beatson West of Scotland Cancer Centre and attended 12 paediatric pain outpatient clinics at Royal Hospital of Sick Children.

In the UK Pain Medicine Fellowships can be pre CCT or post CCT. Anaesthetic trainees prefer doing the Fellowship as part of their final year training. Hence, securing a post CCT Fellowship is easier for non-

anaesthetists. In my experience post CCT Fellowships come with huge responsibilities and ample opportunities for training; no need to take time off after busy anaesthetic on calls or worry about training time directive. Some places like Liverpool and Glasgow welcome non-anaesthetists, which reflect the multidisciplinary nature of the discipline. I was surprised to know that many pain physicians in Glasgow completed their Pain Medicine Fellowship in Australia, where Fellowships are commonly run by Rehabilitation Medicine departments.

Currently, non-anaesthetists like us cannot achieve formal recognition as Fellows from the Royal College of Anaesthesia after the completion of their Fellowship. As per rules, non-anaesthetists should satisfy the college of their Pain Medicine training and have an honorary or substantive consultant post in the NHS with pain management commitments in order to get a Fellow status. Since February 2011, anaesthetic trainees who join the Pain Medicine training will need to pass the Royal College of Anaesthesia Pain Medicine Fellowship exam. At the moment, non-anaesthetists are not eligible to sit for the exam. However, I believe things will be different in years to come, with openings of Pain Medicine to other specialties.

There are other options for trainees that are keen on formal academic recognition; they can pursue MSC in Pain Medicine in Cardiff, Leicester or Edinburgh universities, or apply for the Diploma in Pain Medicine in the Republic of Ireland. I did not do any of these but became a member of the British Pain Society, the International Association of Studies of Pain and the Canadian Pain Society. At the end of the year I had a letter to confirm completion of Fellowship training and eligibility for application to the Fellow status in future. Throughout the Fellowship I kept a logbook record of all my activities. These included assessing more than 400 chronic pain patients, 100 acute pain patients and 40 cancer patients and performing more than 400 interventions.

Pain Medicine in UK is predominantly practiced by Anaesthetists. However, this isn't the case worldwide; in the USA Pain Medicine is open to physiatrists, anaesthetists, neurologists and psychiatrists. The same is true in Canada and Australia and may other countries. From my experience, anaesthetists in the UK are open minded to have trainees from other disciplines and many of them recognise the need to open the specialty to other disciplines. Anaesthetists in Glasgow welcomed my skills as a Rehabilitation Medicine specialist, my holistic approach to patients care and my neurological and musculoskeletal rehabilitation training. On the same token, I found the Fellowship very useful, I felt that it added substantially to the skills I learned during my training in Rehabilitation Medicine and had positive influence towards my Rehabilitation Medicine practice.

I hope you found this article useful and am happy to be contacted in you need any further information.

*Ahmad Al khayer* hamadafirst@yahoo.com



## New Members

**Dr Wael Berro**, RM Trainee, Dublin  
**Dr Kanchana Devinuwara**, RM Trainee,  
 Newcastle upon Tyne  
**Dr Hoda El-Mahrouki**, RM STR Clinical Fellow,  
 Glasgow  
**Dr David Farrand**, Consultant Forensic  
 Physician, Chesterfield  
**Dr Branwen Melville**, RM Trainee, Southampton  
**Dr Mohammad Sharief**, Consultant Neurologist,  
 Colchester

## And the winner is .....

**Congratulations to the winners of the prizes at the BSRM Autumn Meeting in London last month. They were**

**Free Paper Prize:** Rory O'Connor from Leeds for his paper 'The case Conference Assessment Tool (cCAT): a new workplace-based assessment for Rehabilitation Medicine'

- Many of you will remember development of this tool and the laughter it brought! Those who were not involved in the development will soon become familiar with the tool as it is used in the workplace.

**Poster Prize:** Kanchana Devinuwara also from Leeds for her poster 'Does dependency determine discharge destination'

Both authors have received a certificate and a cheque for £100.

### CPD AWARDED TO BSRM MEETINGS

**Specialist Rehabilitation Course, Derby**  
 27 & 28 January 2011  
 Event Code 61552 – 11 credits

**BSRM SIGAM 11th Advanced Prosthetic & Amputee Rehabilitation Course**  
 14-16 March 2011  
 Event Code 63545 – 18 credits

**BSRM/SRR Joint Summer Meeting**  
 3-5 July 2011  
 Event Code 65306 – 17 credits

**'BSRM Autumn Meeting & AGM'**  
 8 & 9 November 2011  
 Event code 69780 – 11 credits

## Rehab Diary



Please note that all meetings advertised as BSRM meetings are approved for the purposes of CPD.

**BSRM Meetings details are posted at [www.bsrm.co.uk](http://www.bsrm.co.uk)**

### BSRM MEETINGS

**SPECIALIST REHABILITATION MEDICINE COURSE, 1 & 2 March 2012, Derby**

Contact: Karen.kirkland@nottingham.ac.uk Tel: 01332 724842

**12th ADVANCED PROSTHETIC & AMPUTEE REHABILITATION COURSE, 12-14 March 2012, Stanmore**

Contact: Sandy Weatherhead, admin@bsrm.co.uk

**BSRM SPRING MEETING, 'From Trauma to Recovery', including SIG sessions, 14 & 15 June 2012, Southampton**

Contact: Sandy Weatherhead admin@bsrm.co.uk

### OTHER MEETINGS

**PSYCHOLOGY, DISABILITY AND REHABILITATION (NC523), 10 January 2012, Strathclyde**

Contact: a.mckinnon@strath.ac.uk Tel: 0141 548 4157

**SRR WINTER MEETING, 24 January 2012, Cambs**  
[http://www.srr.org.uk/meetings\\_srr.asp](http://www.srr.org.uk/meetings_srr.asp)

**12th ADVANCED PROSTHETIC & AMPUTEE REHABILITATION COURSE, 12-14 March 2012, Stanmore**

Contact: Sandy Weatherhead, admin@bsrm.co.uk

**NINTH WORLD CONGRESS ON BRAIN INJURY, 21-25 March 21-2012, Edinburgh**

<http://www.internationalbrain.org/>  
 Discounted registration for BSRM Members

**FES FROM BASIC SCIENCE TO PATIENT EXPERIENCE, 27-29 April 2012, Birmingham**

Contact: [www.ifessuki.com](http://www.ifessuki.com) Tel +44(0) 121 4663281  
[info@ifessuki.com](mailto:info@ifessuki.com)

**WORLD CONGRESS OF NEUROLOGICAL REHABILITATION, 16-19 May 2012, Melbourne**  
<http://www.dconferences.net.au/wcnr2012/>

**18th EUROPEAN CONGRESS OF PHYSICAL & REHABILITATION MEDICINE, 28 May-1 June 2012 Thessalonika, Greece**

<http://www.esprm2012.eu/en/>  
 Contact: t.oflaherty@stchristophers.org.uk

**SRR SUMMER MEETING, 4 & 5 July 2012, Leeds**

Contact: Patricia Dziunka Tel 0115 8230244  
[patricia.dziunka@srr.org.uk](mailto:patricia.dziunka@srr.org.uk)

**EUROPEAN SCHOOL GAIT & MOBILITY COURSE, July 2012**

Contact: Professeur Alain Delarque, Pôle de Médecine Physique et de Réadaptation, C.H.U. Timone 13385 Marseille Cedex 5 Tel : 00 33 (0)4 91385601  
 Email: [alain.delarque@ap-hm.fr](mailto:alain.delarque@ap-hm.fr) <http://www.univmed.fr/esm/>

## BSRM Prizes 2012



### **BSRM Philip Nichols Prize**

***Open to RM trainees and new consultants***

**Value: £500**

The Philip Nichols Prize is offered annually on a competitive basis and is awarded for **excellence in original research**. Trainees and newly appointed consultants (3 years or less) are eligible to apply. In the case of consultants, the work submitted must have been undertaken whilst a trainee.

Submissions must be pertinent to Rehabilitation Medicine and original. Entries should be between **5,000-7,500** words and should demonstrate

- solid understanding of research skills
- scientific rigour including suitable discussion of strengths and weaknesses, a suitable critical appraisal of the existing literature and what steps authors have taken to ensure that their knowledge of the literature is complete, eg details of their search technique.

Submissions will, in the first instance, be peer reviewed by a relevant independent panel member after which feedback will be provided to authors who may wish to revise their submission prior to formal adjudication.

Successful authors will be invited to present their work at a national meeting of the BSRM.

### **Medical Student's Essay Prize**

**Value: £250**

The BSRM Medical Student's Essay Prize is offered annually on a competitive basis. All UK Medical Students are eligible to apply.

There is no application form but submissions should be

- up to 2,500 words in length
- on a subject pertinent to Rehabilitation Medicine from a medical, biological or sociological point of view
- Include a review of relevant literature.

Particular credit will be given for original thought and accounts of personal experience. Further details of criteria and mark scheme are available from BSRM and on the BSRM website.

### **BSRM Travelling Scholarship**

**Value: Up to £600**

The BSRM Travelling Scholarship is offered annually on a competitive basis to facilitate travel for the purpose of furthering experience in Rehabilitation Medicine. It is open to all medical doctors, in training posts, in Non Consultant Career Grade posts, and Consultant posts working within the NHS in the UK.

Applications should be made to BSRM upon the application form, supported by a submission of not more than 1000 words outlining:

- the objective of travel
- potential benefits to the applicant
- relevance of the travel to practice of Rehabilitation Medicine

Applications must be submitted by September 28<sup>th</sup> and the Education Sub Committee of BSRM will adjudicate and decide to whom the Scholarship will be awarded by December 1<sup>st</sup>. In the event of two or more applications being of equal merit, preference will be given to applicants with limited access to alternative funding.

The Scholarship has a maximum value of £600. This may not be used to meet the costs of the travel in full. Applicants must indicate from where other funding has been sought.

It is a condition of the award of the Scholarship that the recipient must submit a written report to the BSRM on the travel within 3 months of its completion.

The decision of the Education Sub Committee is final and no communication can be entered into between applicants and the BSRM on this matter.

### **The BSRM New Postgraduate Bursary Scheme**

Applications should be on the appropriate form, submitted by September 28<sup>th</sup>, and may be made for a grant of up to £2,500 to support a postgraduate student registered for either a PhD or an MD research degree. The bursary is open to RM trainees in the UK or Ireland who are members of the British Society of Rehabilitation Medicine. Applications will be assessed under three criteria; the applicant, the training environment, and the project.

- Successful applicants will demonstrate evidence of academic potential, judged from their academic record and achievements such as research publications, as well as evidence that their clinical training is proceeding satisfactorily.
- The application must be supported by evidence that the applicant's nominated academic supervisor and institution will provide effective training support within an appropriate University department, and that there will be adequate facilities to enable the degree to be submitted within the agreed time period.
- The project will be judged on:
  - (a) suitability as a vehicle to acquire research competencies as described in the Rehabilitation Medicine training curriculum
  - (b) *its* potential to contribute to scientific advancement in Rehabilitation Medicine
  - (c) potential for high quality peer reviewed publications and presentations.

Further information and application form are available from BSRM.

It remains the right of BSRM not to award the bursary if no application of sufficient merit is made.

### **A time for giving? Postgraduate Training Fund**

Due to the generosity of an anonymous donor, BSRM has re-launched the postgraduate bursary scheme. BSRM would like to secure the future of the bursary and are therefore asking members if they would be willing to contribute to the fund. Any donations received from UK tax payers can be given under Gift Aid, thus enabling the BSRM to benefit from an additional 25p for every pound you donate. Since the fund was first established in 2003, five members have successfully applied and received help with the cost of undertaking an MD. The scheme supports the BSRM's Strategic Priority 5 'to promote high quality research' and the new Research Strategy (available at [www.bsrm.co.uk](http://www.bsrm.co.uk)). Further details of the bursary scheme are available from Sandy. BSRM views this as an investment in the specialty's future and we hope that you will feel able to help. Payment can be accepted by cheque (to BSRM) or credit card.

### **New Executive Committee Members**

We look forward to welcoming Khalid Anwar, Manus McCaughey and Eli Okirie as new members to the Executive Committee in 2012. Also to welcoming back John Burn as Deputy Honorary Secretary.

Congratulations to them all.

First Announcement  
BSRM Spring Meeting  
'From Trauma to Recovery'

14 & 15 June 2012

at the Macdonald Botley Park Hotel, Southampton

Hosted by the Wessex Regional Group

BSRM warmly invites you to attend the Wessex Region for this two day meeting with a strong focus on Trauma Rehabilitation. The excellent scientific programme includes presentations on the topics below, as well as providing ample opportunity for networking and sharing of research in extremely pleasant surroundings. Please place these dates firmly in your diary – more information will be available very soon together with a call for abstracts.

The faculty of eminent speakers will talk on

- *Rehabilitation and Trauma Centres*
- *Acute Musculoskeletal Rehabilitation*
- *Brachial Plexus Injury*
- *Trauma Rehabilitation in Countries With Few Resources*
- *The Psychology of Spinal Cord Injury*
- *Longer Term Problems After ITU Care*
- *Psychological Issues and Resettlement after Military Conflict*
- *Specialist Rehabilitation in Care Homes*
- *The Existential and Spiritual Challenges of Injury*
- *Mild Head Injury: Nosology and Pathogenesis*
- *Mild TBI in the Injured Athlete*
- *Mild Head Injury: Management Within NHS Services*
- *Special Interest Group sessions to be announced soon*

Updates available at  
[www.bsrm.co.uk](http://www.bsrm.co.uk)