



Newsletter

May 2010

British Society of Rehabilitation
Medicine
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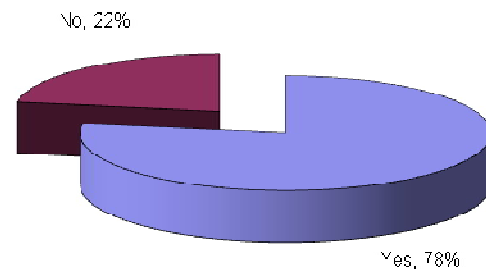
President's Report

This has been the coldest snowiest winter since my childhood in the North of England, and has delivered me a sharp message on musculoskeletal rehabilitation. On my way to a Rehabilitation meeting in London, my car abandoned in the snow, I fell on ice, sustaining ligamentous injuries to the right knee. Because no bones were broken I did nothing. A few days later a physio friend called me something not far short of an idiot, finding me in clinic, limping about with an unstable swollen knee. Now 3 months later I am still a member of the 8.15am knee class in physiotherapy, and although rather reluctant to do "squat body thrusts" am happily restoring muscle strength to the slightly damaged joint. This aspect of rehabilitation has largely eluded me in the past, but may be an increasing part of future practice in the specialty, and I hope that all our specialists and trainees become competent to examine and diagnose all major joints. I learnt a new sign, the 'pencil' sign, for diagnosing the posterior cruciate deficient knee – better to learn it without having the injury!

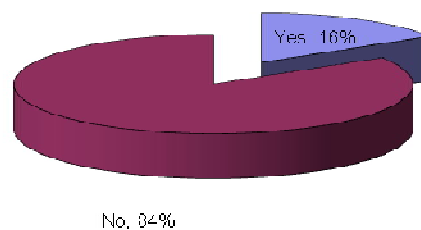
A big thank you to the 87 people who responded to the membership survey questionnaire. 78% of you believe that the BSRM should remain a medical organisation as per the current constitution and 84% of you do not want BSRM to become an open and equal multi-disciplinary organisation. Interestingly only 56% of you would like the Executive to explore the development of an additional non medical membership providing an internal multidisciplinary forum. The Executive are considering your ideas, are already committed to strengthening links with the UK Rehab Council, and encourage and welcome other disciplines to our meetings. The free comments reflect a wide range of

views but confirm members' interests in strengthening the educational role of BSRM and links with other societies. The detailed results of the survey will be on the website in due course.

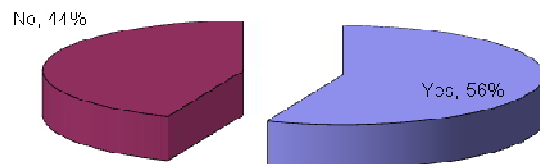
Do you believe that the BSRM should remain a medical organisation as determined in the current constitution?



Do you believe that the membership of BSRM should become open, with multidisciplinary and medical membership on an equal footing?



Would you like the BSRM Executive to explore the development of an additional non medical membership status, aimed at developing an internal, multidisciplinary forum with an educational role?



Consultation fever continues and I have now lost count of the number of stroke consultations that we have responded to and hopefully influenced. Recent responses to consultations on muscle disorders, non

invasive ventilation and motor neurone disease have been led by Margaret Phillips, who is also seeking funding for developing guidelines on the role of Rehabilitation Medicine for this patient group.

The publication on Vocational Rehabilitation for people with Long Term Neurological Conditions is in the final prepublication stage and we hope will be available very soon. We thank Vera Neuman for her tireless efforts as the RM lynch pin for this project. John Burn and Charlie Nyein are liaising with the British Geriatric Society on a Nursing Home Medicine publication with intention to highlight rehabilitation needs and access to Rehabilitation services for Nursing Home residents.

Tony Ward and I are chairing the rewrite of the RCP report on our specialty, which was first called "Physical Disability in 1986 and beyond". We have titled it "Rehabilitation Medicine in 2011 and beyond" to stir memories, and are trying to write an accessible and persuasive document for commissioners, as well as interested medical and lay people. Our deadlines are tight but we plan to launch it at the RCP Conference on November 25th which is called "The National Service Framework Five Years On". This has given us the opportunity for a mid term refocus on the NSF for Long Term Neurological Conditions. Chris Ward is coordinating this conference.

The Department of Health published a statement on its intention to honour the long term health needs of veterans, and in our response, formulated by Jai Kulkarni, chair of SIGAM we are emphasising the need to avoid a two tier prosthetic service by recommending that prostheses are provided according to clinical need, not military occupation.

John Pickard, current chairman of the Joint Neurosciences Council is seeking support for the establishment of an Intercollegiate faculty of Neurosciences and we would like to be part of this group. You can see that with all these demands on our time, those who hold modern NHS contracts, have limited facility or time for involvement in these interesting developments. Please do not hesitate to express an interest in helping with any of these or future projects. We are doing

our best to work with other specialties on overlap projects, and other recent and ongoing topics have include the Trauma Care Network Standards and Critical Care Discharge Quality Requirements, to which we have made some contribution.

The weather is now improving and I encourage you all to dust down your bikes, and include a ride in your daily routine. Look out for potholes. If you start now you may be ready to join in the World Medical Cycling Championships in Zakopane in Poland, from September 8-11th. The Polish Medical Chamber support these championships and have sent BSRM an invitation. I do not know if they have classes for slow but determined female super veterans, but I think some of our younger members should rise to the challenge and represent us. Look it up on www.medicycling.pl. Please let Sandy know if you decide to enter! Our BSRM website achieved its highest number of hits during our Silver Jubilee bike ride last year, and if you enter we will put you on the web site. The web-site development is a task in hand which is receiving Sandy's full attention and she is negotiating moving the contract to a new web site host. The potential of the site to improve the strength of BSRM, achieve publicity and raise professional and public awareness is huge.

By the time of the next Newsletter we will have voted in a new Government and the more serious effects of the recession on government spending and public sector services will be starting. BSRM will try to support any members who feel they or their services are threatened, but your best support will come from your colleagues in referring specialties and your patients. Look after them!

Spring Greetings

Christine Collin
President

Dinner – 6 June?
We look forward to seeing you at the Spring meeting in Glasgow – please see page 10 for your invitation to the BSRM Dinner

Research Corner

Postgraduate Bursary Awarded to Manoj Sivan

BSRM is delighted to have awarded the 2009 Postgraduate Bursary to Dr Manoj Sivan, Specialist Registrar in Rehabilitation Medicine in Leeds, to help fund an MD on 'Development and clinical trial of a home based computer assisted arm rehabilitation (hCAAR) system for upper limb therapy in stroke patients'.

One adjudicator commented that Manoj should be encouraged to undertake a PhD!

HTA launches call for trauma research in a military or civilian context

The NIHR HTA programme's new specific call for research into the management of disability after trauma was announced in March by Health Minister Mike O'Brien. Application forms and guidance will be available after 7 May.

<http://www.hta.ac.uk/news/newsitem240310.shtml>

E-Learning for Healthcare (e-LfH)

Would you like to be part of a major national project? Would you like to influence what is known about a number of frequently occurring medical conditions? If so read on. We are looking for volunteer authors from Rehabilitation Medicine for the E-learning for healthcare project.

In case you haven't heard of it before this is an "award winning e-learning programme providing national, quality assured online training content for the healthcare profession". It aims to enhance traditional learning, support existing teaching methods and provide a valuable reference point which can be accessed anytime, anywhere. If you check out the website you will notice that a large number of different specialties have already been covered.

In the field of neurology the project is being dubbed "E-Brain". This scheme for enhancing knowledge of long-term Neurological

Conditions supports the development of competences within non-specialist groups, with the aim of improving care for patients with common neurological disorders. The learning material covers many of the areas originally included in basic Neurological, Rehabilitation Medicine, and stroke subspecialty training but is also relevant to a number of specialities, and different professionals including general practitioners specialist nurses and therapists, pharmacists etc. (http://www.e-lfh.org.uk/projects/e-brain/mo_long_term.html) There are approximately 200 sessions of e-learning being created, each around twenty minutes long. The e-learning will be available to use in late 2010.

The Long-term Neurological Conditions e-learning curriculum includes blackouts, dizziness, epilepsy, headaches, tremor and Parkinson's disease. Two major sections are Multiple Sclerosis and Stroke

Dr Ruth Kent is module editor for Stroke Rehabilitation and Dr Rory O'Connor is module editor for Multiple Sclerosis. Within each subject area the e-learning will deal with both initial assessment and diagnosis and disease management of common neurological problems. We hope however that the quality of the sessions will be such that they will give generalists an understanding of symptom management which they will be able to apply to a number of other disabling neurological diseases and this will enhance access to knowledge about how to manage many of these symptoms and indeed when it is appropriate to refer to specialist care.

So, what if you want to be a module author?

First of all it is not like being a book chapter author, in that it is not meant to be a great slog and indeed is meant to be quite fun. It is however going to take some work and we ask that people allocate up to 30 hours over a three-month period. The process involves initially the editor writing a basic outline of the session plan which they will pass on to the author to construct a first thousand word draft or PowerPoint presentation. This will then be taken on by an instructional designer who designed the first draft of the software and the basic look of the presentation. Further discussions take place between the author

and their instructional designers to try and produce the most interesting and exciting interactive learning experience.

Compared to an average lecture you will have opportunity to produce something really creative and glossy. You will also need to decide what sort of assessment that you want your reader to self conduct to check that they understand what you've been trying to tell them.

Still interested?... please contact Ruth Kent. r.m.kent@leeds.ac.uk or Rory O'Connor r.j.o'connor@leeds.ac.uk

Trainees Section

I find it difficult to believe that my two year term as Trainee Representative is due to come to an end this summer. I find it equally hard to believe that I've now been a Rehabilitation Medicine registrar for over two years, but that's another matter! Acting as Trainee Rep has given me a great insight into how the specialty is progressing across the country and how we interact with the myriad of other bodies that seem to govern medicine in the UK today. Moreover it has been a pleasure and a privilege to meet and correspond with so many highly skilled, insightful and motivated trainees from such a wide variety of backgrounds. As a specialty we seem curiously prone at times to introspection regarding our roles and future direction, but I can honestly say that the current trainee body inspires in me great hope for our future.

Currently I'm out of programme doing stroke training and trying to move my research along in my oh-so-copious free time. Doing general medical on calls again after so long is making me feel rather old and unfit. I have no idea how I'll manage with a baby as well come October! As always though if anybody is interested in taking up a Stroke Medicine post or taking up research, or wants assistance or advice with any other training issue, I am always happy to try to oblige (or at least point you in the direction of better advice). This might also be a good point to put in a plug for the FARM meeting at the summer BSRM conference – anyone with an

interest in research or teaching is welcome to attend and participate.

There are many fantastic training opportunities in the coming months, including Clive Bezzina's ultrasound and EMG day in Cambridge on the 9th July. I hope this is a real success and is repeated in future years. The European board is running their 10 day posture and movement course at the beginning of July which is always highly regarded. There are of course many others which can be located on the BSRM website, European board website and ISPRM websites.

As in previous years, interested candidates in becoming my successor should put themselves forward at the summer BSRM (or by email around that time). Manifestos will then be circulated and an email election will take place soon afterwards. If anyone feels like developing a more formal and anonymous voting system I would be extremely grateful, although the usual system has never brokered complaints in the past.

Hopefully I'll see many of you in the summer. If anybody has finished training or just started training could people please let me know so that the mailing lists can be updated.

Matthew Smith matthewsmith@nhs.net
Trainee Representative

My Experience of MSK Training in Leeds

Among all the medical specialties, I always wondered which one is best suited to manage the complex medical, psychological and vocational issues in chronic musculoskeletal (MSK) conditions, eg chronic back pain, degenerative arthritis, etc. It has to be us, without any doubt!! Rheumatology is moving more towards an immunological basis of musculoskeletal conditions and biologics. Sports Medicine tends to focus more on acute sporting injuries, exercise physiology and sport psychology. Orthopaedics and Neurosurgery are understandably least interested in cases with no surgical indications. So who manages chronic non-inflammatory musculoskeletal conditions in the UK? Something to be debated... In spite of our training curriculum

emphasising the need for training in MSK Medicine and Rehabilitation, my general impression speaking to fellow trainees and consultants is that for some reason we do not focus on this area as much as we should and perhaps less than within Rehabilitation Medicine training programmes in the rest of Europe and the US.

Leeds Rehabilitation Medicine trainees fortunately have the opportunity to train in the MSK service run by the Leeds PCT. The service is very unique in its set-up and most of the non-inflammatory MSK cases are initially managed within the service and then select cases are triaged to different specialties like Rheumatology, Orthopaedics, Neurosurgery and Pain services. The service comprises of MSK physiotherapists, Extended Scope Practitioners (ESPs), Podiatrists and is led by three full time MSK physicians. The Rehab Medicine trainee in his/her MSK training year spends two/three sessions a week with them attending their clinics and works alongside the therapists. The training is very flexible in terms of time and skills acquired depending on training requirements of the individual trainee. These MSK sessions along with rheumatology and amputee rehab constitute one year of the rotation for the rehab trainee in Leeds.

The MSK training I have received has been excellent. I had extended my training by a few additional sessions during my attachment. I've seen and managed a variety of musculoskeletal conditions such as acute and chronic back pain, chronic tendon problems (tendinopathy), degenerative arthritis, traumatic and overuse soft tissue injuries. The patients seen within this training are completely different from the kind of patients I came across in my rheumatology attachment. Not wishing to put too much of a personal spin on my experiences, I thought it would be useful to illustrate my experience with some personal data from my logbook. I have seen approximately 500 patients with a variety of musculoskeletal conditions during my attachment. The multidisciplinary assessment and discussion of interventions was very useful. I had the opportunity to undertake training in diagnostic and interventional (guided injections) ultrasound used by the MSK physicians in their clinics. Based on this training, I also undertook a PG Certificate degree in MSK ultrasound from the University of Cumbria. I have performed

close to 200 diagnostic scans and 100 interventional scans during the period. On the spinal intervention lists, I have performed around 50 fluoroscopic guided spinal injections during the attachment. Figures really do not matter in this current competency- driven training, but these are an indication of the training opportunities available to any trainee on the rotation. Within the context of multidisciplinary rehabilitation, in addition to the generic and topic specific competencies there is also a need to be competent at relevant procedures so that patients can receive appropriate care in a timely manner (preventing the need for unnecessary waits while patients get referred from one clinic to another).

It was interesting to find out that the breadth of training opportunities in the UK seems very different to the US and many European countries. More than 90% of Rehabilitation physicians (Physiatrists) in the States practice MSK Medicine and Rehabilitation. These figures are very similar in some European countries as well. One US resident poll showed our specialty was among the 10 most preferred specialties! Speaking to some of the UK rehab trainees on discussion forums, they seem to echo the feeling that our training programmes should have more of MSK Medicine and Rehabilitation. The main problem seems to be the availability of a local MSK service which could provide appropriate training. It is a challenge to find a unified solution to this problem. One option would be for the interested trainee to approach his/her programme director and discuss how a tailor made attachment could be arranged locally to enable training in this area or potentially in another deanery if local provision is not possible.

<http://medliorate.wordpress.com/2009/06/10/top-10-most-competitive-residencies-2009/>

Manoj Sivan

NIHR Academic Clinical Fellow / ST5 Rehab Medicine, Leeds

SIGAM News

The new SIGAM Committee has been reasonably active since its inception in September 2009. The Committee held their first telephone conference via BT

conferencing facility with help from Sandy Weatherhead. Now that this link has been successful and established, our plan is to hold most of the meetings via telephone conferences apart from getting together as a small group during BSRM Conferences.

The next programme for a **SIGAM Seminar is at the PMG Conference in SECC Scotland on 9 June 2010, morning session.** Ken Dunn, Consultant Plastic Surgeon will talk on stump revision surgery. We would encourage members and other delegates to attend this seminar.

We are pursuing a forum/update on advances in amputee/prosthetic rehabilitation at the Autumn BSRM Meeting in Leamington Spa on Wednesday, 22nd September 2010, PM session.

Our Committee has responded to the Ministerial Statement of January 2010 regards amputee/prosthetic rehabilitation for the War amputees and also established formal links with the Associate Parliamentary Limb Loss Group.

Claire Myint attended the Vascular Society of Great Britain and Ireland Seminar at the Royal College of Surgeons on 3 February 2010 and her summary is as follows:

Quality Improvement Framework for Major Amputation Surgery

Four RM consultants including myself participated in a productive stakeholder meeting on the above Quality Improvement Framework, held by the Vascular Society of Great Britain and Ireland at the Royal College of Surgeons on 3rd February 2010.

The framework concerns amputation for vascular disease and diabetes, and aims to reduce the peri-operative mortality rate after major amputation surgery to less than 5% by 2015. With majority of the 25 attendees being consultant vascular surgeons, I am proud to say that our presence was not only valued, but more importantly our contribution was incorporated into the framework which had been completed in draft by the close of the meeting. It is anticipated that the final version of this document will be ratified by the Vascular Society Council this autumn.

Towards the end of the meeting our surgical colleagues commented on how little feedback is given to them about the suitability of their amputation stumps for subsequent prosthetic rehabilitation. They have requested some guidance for major amputation surgical practice to optimise prosthetic rehabilitation outcomes, which I have offered to initiate. I will be circulating some ideas to all concerned and hope that as many of you as possible will put your views forward. This is an excellent opportunity, not only to enhance such open-minded communication links but also to achieve better outcomes for our amputees.

Claire Myint.

Lastly regards re-establishing the National Amputee Database: this work is still in progress, lead by the University of Salford and there is a meeting planned in the middle of June 2010 to move this further forward.

I look forward to getting feedback from all SIGAM members and also any constructive suggestions.

Jai Kulkarni

SIGAM Chair

European Affairs

The UEMS Section of Physical and Rehabilitation Medicine recently met in Marseille and is currently busy putting together a series of educational sessions at the forthcoming European Congress in Venice from 23rd – 26th May 2010. The web page is at www.cesprm2010.eu for the programme and registration details. Unfortunately, we have not organised ourselves to participate in the Trans-European Scientific Contest for a light-hearted competition of presentations by trainees from the various member states of the ESPRM.

Description of Rehabilitation and of PRM

At our meeting in Marseille, there was a detailed discussion of the conceptual description of rehabilitation and the following is the Section's statement with ICF terms marked in bold.

Rehabilitation is the health strategy which, based on WHO's **integrative model of functioning, disability and health**,

- applies and integrates
- approaches to assess human **functioning** in light of **health conditions**
- approaches to optimise a person's capacity
- approaches that build on and strengthen the resources of the person
- approaches that provide a **facilitative environment**
- approaches that develop a **person's performance**
- approaches that enhance a person's quality of life in light of health conditions

This should take place in partnership between person and provider and in appreciation of the person's perception of his or her position in life

- over the course of a health condition;
- for all age groups;
- along and across the continuum of care, including hospitals, rehabilitation facilities and the community; and across sectors including health, education, employment and social affairs with the goal of enabling people with **health conditions** experiencing or likely to experience **disability** to achieve and maintain optimal **functioning** in interaction with the **environment** and in partnership between person and provider

In addition, the ICF-based conceptual description of Physical and Rehabilitation Medicine (ICF terms are marked in bold) is as follows:

Physical and Rehabilitation Medicine is the medical specialty that, based on WHO's integrative model of **functioning, disability and health** and rehabilitation as its core health strategy,

- diagnoses health conditions, taking into account the International Classification of Diseases
- assesses **functioning** in relation to **health conditions, personal and environmental factors**

- performs, applies and/or prescribes biomedical and technological interventions to treat health conditions suitable for
 - stabilising, improving or restoring **impaired body functions and structures**
 - preventing **impairments**, medical complications and risks
 - compensating for the absence or loss of **body functions and structures**
- leads and coordinates intervention programmes to optimise **activity and participation**
 - in a patient-centered problem-solving process
 - in partnership between person and provider and in appreciation of the person's perception of his or her lifestyle
 - performing, applying and integrating biomedical and technological interventions, as well as psychological and behavioral; educational and counselling, occupational and vocational, social and supportive, and physical environmental interventions
- provides advice to patients and their immediate **environment**, service providers and payers
 - over the course of a **health condition**
 - for all age groups
 - along and across the continuum of care, in acute settings, post-acute settings and in the community and
 - across sectors including health, education, employment and social affairs
- provides education to patients and relatives to promote functioning and health
- manages rehabilitation, health and multi-sector services
- informs and advises the public and decision makers about suitable policies and programmes in the health sector and across the other sectors that
- facilitates a broad approach in respect of the wider **physical and social environment**;
 - ensures access to rehabilitation services as a human right
 - and empowers PRM specialists to provide timely and effective care
 - with the goal to enable persons with health conditions experiencing or

likely to experience disability to achieve and maintain optimal functioning in interaction with the environment and in partnership between person and provider

1st Baltic and North Sea Forum

A meeting of this forum was held in Stockholm from 14th-16th April 2010 and this will be followed up by another next year in Vilnius, Lithuania. The idea of the Forum is to facilitate a process of contact between the countries of Northern Europe, whose health systems and philosophies are closer together. It is analogous to the Mediterranean Forum, of south European states and is a response to build a cooperation between the participating countries. The countries, who have agreed to join are Germany, Poland Sweden, Norway, Denmark, Finland, Lithuania, Latvia, Estonia and The Netherlands. The Chairman is Professor Christoph Gutenbrunner from Hanover and the secretary is Professor Alvydas Juocevicius from Vilnius. Professor Kristian Borg is organising the Stockholm meeting. Everyone is keen for the UK to join in and we have put both ourselves and Ireland forward as members. There is no subscription and the aim is to facilitate educational exchange between the countries. As a result, we will be represented at the Stockholm meeting. The meeting starts with a session on vocational rehabilitation with inputs from both Professor Anne Chamberlain and Dr Andrew Frank.

2009 Examination

Congratulations go to the following for their success in passing the European Board examination.

Dr Ahmad Al Khayer Dr Rabia Din
Dr Sreedhar Kolli Dr Naveen Kumar
Dr Gaid Mohb Dr Sarafudheen Villan

We have a near perfect record of achievement of success in those taking the exam right from the first candidates in 1994. As well as something to put on your CV and in your documentation, the diploma also gives holders the opportunity to attend (for free) the **European School, Marseille**, which runs an excellent annual course on gait & mobility. The next school will be in Marseille

from 1-10 July 2010. It is currently fully subscribed, but the course next year remains available. Each country is restricted to two candidates

European Board Diploma Renewal

Recognition by the European Board is valid for ten years and diploma holders can apply for renewal on presentation of evidence of CPD. I have given Sandy a list of the names of those people, whose certificates have expired. Please contact her for confirmation that yours requires to be updated, if you so wish.

Rehabilitation Programme Accreditation

This is now up and running. It is a good time to consider achieving UEMS recognition for the PRM programmes. A number of good sites have already undergone the relatively simple process and these can be viewed on the website at www.euro-prm.org, which will be presented at the Venice Congress. The aim is to enhance standards of practice for services (as opposed to individuals') across the Continent through high quality rehabilitation programmes for our patients.

Europe remains fun, so please don't hesitate to contact the European Board through the website.

Tony Ward & Vera Neumann

Consultants and Clinical Supervision

From time to time the BSRM discusses mentoring schemes for consultants but currently I am thinking about a related idea, clinical supervision. The term is somewhat deceptive since 'supervision' refers to reflective discussions about clinical incidents or issues raised by an individual; there is no implication of managerial supervision. My interest has been increased since I have been undertaking training in systemic psychotherapy where, of course, supervision is de rigeur.

I notice that the NICE Guideline for the management of depression in people with physical health problems recommends that

practitioners involved in this work should receive adequate supervision. Psychiatrists sometimes do receive supervision, and the concept of clinical supervision is familiar to many therapists - but what about physicians? Most of us use our colleagues to help us through specific issues as they arise, but is this just for crises? How much opportunity do we have to reflect formally on day-to-day practice, and adjust our ideas and approaches accordingly?

I would be glad to hear members' reactions to this issue and would be especially grateful for descriptions of any supervision schemes currently operating among Rehabilitation Medicine consultants.

Christopher Ward

c.d.ward@nottingham.ac.uk

The Sheffield Acute Brain Injury Pathway

The development of an Acute Brain Injury Pathway represents a significant improvement in the quality of head injury care for patients and their families. At a time when Rehabilitation Medicine needs to show its value in a contracting NHS budget, it represents an opportunity to expand our role.

Prior to the introduction of the pathway in Sheffield, head injuries were allocated to whichever service fitted their immediate need without due thought to overall coordination. Patients could end up in general surgery, orthopaedics, neurosurgery, ENT, Care of Elderly, A&E beds or be discharged. The impetus from the introduction of NICE Head Injury guidelines, the NSF for LTNC and a general awareness of the clinical governance risk from a lack of responsibility led to stakeholders in brain injury working to set up a pathway in 2007.

Six beds were ring fenced as the Head Injury Observations Unit. An Acute Brain Injury Team consisting of a Specialist Doctor, a Nurse Specialist and a Social Worker was created under the Rehabilitation directorate. All patients admitted with brain injury are

admitted to the observation unit as are step-down patients from ITU.

Each day, the team join the A&E ward round and after 48 hours of admission, takes over responsibility for patients. The team is a key link between the disparate services involved in brain injury including community services and it provides for smooth transitions and facilitates appropriate follow up or review by relevant specialists. If longer admission is required then transfer to a neurorehabilitation bed is arranged. A Brain Injury clinic has been set up for follow-up and for patients discharged from A&E.

One of the key benefits of the pathway has been to educate hospital staff as to the significance of brain injury and its treatment. A rolling programme to train nursing staff, junior doctors and therapists is in place and the profile of brain injury management has been raised. The team act as advocates for the future development of brain injury services.

We do not know of any other similar service under Rehabilitation Medicine in the UK and suggest that this pathway may be a model for RM to provide better care to individuals with brain injury and their families. It would also extend our role into acute services and show our importance and enthusiasm to play an active role at all stages of rehabilitation.

References

Department of Health (2007). *National Institute for Health and Clinical Excellence; Clinical Guidelines for Head Injury* CG56. <http://www.nice.org.uk/CG056>

Department of Health (2005) *National Service Framework for Long Term Neurological Conditions*. <http://www.dh.gov.uk/en/Healthcare/Longtermcondition/s/index.htm>

Vitaz, T W, McIlvoy L, Raque GH, Spain D, and Shields CB. Development and Implementation of a Clinical Pathway for Severe Traumatic Brain Injury. *J Trauma* 2001; 51: 369-375

Please contact me for further information.

Rajiv Singh

rajiv.singh@sth.nhs.uk

Clinical Excellence Awards

Consultant Members will receive, with this Newsletter, an invitation to self-nominate for BSRM support of their application for a Clinical Excellence Award in the next round, with details of the process. Self-nominations should reach BSRM by **15 October 2010**

Welcome to the Following New Members

Dr Waseem Ahmed, *ST3 - Rehabilitation Medicine, Southampton*

Mr James Colthurst, *Eumedic Ltd, Hungerford*

Dr Sarah Leeder, *Specialty Doctor - Rehabilitation Medicine, West Sussex*

Dr Cara McDonagh, *Specialist Registrar in Rehabilitation Medicine, National Rehabilitation Hospital, Co. Dublin*

Dr Kappaganthu Prasanna, *Specialist Registrar in Rehabilitation Medicine, Oswestry*

Dr Diba Shariat, *ST3 - Rehabilitation Medicine, Manchester*

Exciting opportunities for training at the Combined BSRM/PMG/SPMN meeting Glasgow 6-9th June 2010
www.mobility2010.org

Sandy and I have had lots of fun planning our Spring meeting in Glasgow in collaboration with PMG and SPMN. In addition to a packed main programme running Monday to Wednesday with many contributions from eminent BSRM members running workshops, SIG sessions and the plenary sessions, I would like to recommend the Sunday pre-training workshops. These sessions are intentionally low-priced and focus on areas of our training curriculum which may not be easily available to trainees in all regions. Sessions include practical outcome measures, spasticity, muscular dystrophy, tissue integrity and the chance to learn practical wheelchair skills by being wheelchair users for the day and doing basic manoeuvres. I think this will be an invaluable experience and would encourage everyone to get signed up for Sunday!

Also see invitation to dinner to follow.

Laura Graham

Laura.graham@ntw.nhs.uk

Invitation to BSRM Dinner – 6 June - Glasgow

BSRM invite you to dine with other BSRM members at the **BSRM Dinner on Sunday 6 June 2010, 8.15 for 8.30** (after the whisky tasting!). The Dinner will be at one of Glasgow's finest restaurants – the Ubiquitous Chip, 12 Ashton Lane, Glasgow, Scotland G12 8SJ Tel: 0141 334 5007

<http://www.ubiquitouschip.co.uk/>

To book your place at the dinner please email me to confirm your attendance and with details of any special dietary or other requirements you may have. We are able to invite you to the dinner free of charge thanks to sponsorship from Ipsen. Please note that the dinner is for BSRM members only.

I hope you are able to join us and look forward to seeing you in Glasgow.

Registration for the Spring Meeting in Glasgow is via the conference website

www.mobility2010.org

Sandy Weatherhead

admin@bsrm.co.uk

CPD AWARDED TO BSRM MEETINGS

**BSRM Silver Jubilee Meeting
'Silver Goals, Golden Outcomes'
30 September-2 October 2009**
Event Code 51615 – 14 credits

**BSRM/University of Nottingham
Specialist Rehabilitation Course
28 & 29 January 2010**
Event Code 54162 – 10 Credits

**BSRM SIGAM 10th Advanced Prosthetic
& Amputee Rehabilitation Course – 15-
17 March 2010**
Event Code 55679 – 18 credits

Rehab Diary



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

Contact for BSRM Meetings:
www.bsrm.co.uk or Sandy Weatherhead,
(admin@bsrm.co.uk or 01992 638865)

Next Meeting
BSRM Spring Meeting 6-9 June –
Register at www.mobility2010.org

BSRM MEETINGS

BSRM, PMG & SPMN Joint INTERNATIONAL CONFERENCE on POSTURE AND WHEELED MOBILITY, “Best Practice - Hit or Myth?”, 6-9 June 2010, Glasgow

Contact: Meeting Makers +44 (0) 141 434 1500
pwm2010@meetingmakers.co.uk www.mobility2010.org

BSRM AUTUMN MEETING, 22-24 September 2010, Leamington Spa

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

BSRM/RCP CONFERENCE ‘NSF for Long-Term Conditions – 5 years on’, 25 November 2010, RCP, London

Contact: Claire Harries tel 020 3075 1436 Email:
Claire.harries@rcplondon.ac.uk

11th ADVANCED PROSTHETIC & AMPUTEE REHABILITATION COURSE, 14-16 March 2011, Stanmore

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

OTHER MEETINGS

2010

EUROPEAN CONGRESS OF PRM, Venice
23-27-May 2010 www.cesprm2010.eu

MUSIC TECHNOLOGY SOLUTIONS TO CHALLENGES, 11 & 12 June 2010, London

Contact: Phil Denning, 0208780 4500 X5140 or
institute@rhn.org.uk

VRA CONFERENCE ‘Workplace Disability Management And Vocational Rehabilitation’ 30 June & 1 July, Nottingham

Contact: Ian Martin, PO BOX 2043, Glasgow G23 6YH Tel:
0560 226 4502 Email: ian@vra-uk.org
www.vra-uk.org/civicrm/event/info?reset=1&id=12

EUROPEAN SCHOOL GAIT & MOBILITY COURSE, 1-10 July 2010

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 <http://www.univmed.fr/esm/>

SRR SUMMER MEETING, 7 & 8 July 2010, Sheffield

Contact: Conference21 tel: 0114 225 5336
conference21@shu.ac.uk

Study Day - US & EMG Injection Localisation in Rehabilitation Medicine, 9th July 2010, Cambridge

Contact: Dr Clive Bezzina (Organiser)

Tel: 07530697568

E-mail: ckb@doctors.org.uk or Ms Marlina Judd

Tel: 01223217870

UKABIF Conference Acquired Brain Injury Behind Closed Doors - unspoken issues and possible solutions, 11 November 2010, London

Contact: Chloe Hayward, UKABIF, tel: 01752 601318 Email

5TH OSWESTRY SPINAL TRAUMA SYMPOSIUM, 10-12 November 2010, Oswestry

Contact: Alison Whitelaw, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust
Oswestry, Shropshire, SY10 7AG Tel: 01691 404661
Email alison.whitelaw@rjah.nhs.uk

BSRM/RCP CONFERENCE ‘NSF for Long-Term Conditions – 5 years on’, 25 November 2010, RCP, London

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Joint Award of Medical Students Essay Prize 2009

The standard and number of entries for the Medical Student's Essay Prize continues to rise and we are pleased to announce that two prizes were awarded in the last round. Congratulations to the following who we hope will be able to attend the Autumn Meeting in September.

Ciara Largey's essay entitled 'What about us? The needs of caregivers of persons with traumatic brain injury (Queen's University, Belfast), and

Tamsin Bell's essay entitled 'Mobility problems in childhood – the management of traumatic lower-limb amputation in paediatric patients' (Barts & The London School of Medicine & Dentistry).

See Research Corner on page 3 for news of the successful applicant for the 2009 Postgraduate Bursary.

BSRM Prizes 2010

The closing date for submissions is **September 28th**. It remains the right of BSRM not to award a prize if no application of sufficient merit is made.

Further information, criteria, marking schemes www.bsrm.co.uk

BSRM Philip Nichols Prize Now open to new consultants Value: £500

The Philip Nichols Prize is awarded annually on a competitive basis and is awarded for excellence. 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 may include case reports, literature reviews and original research. 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 awarded 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.

BSRM Travelling Scholarship Value: Up to £600

The BSRM Travelling Scholarship is awarded 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 an 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 28th and the Education Sub Committee of BSRM will adjudicate and decide to whom the Scholarship will be awarded by December 1st. 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.