NEWSLETTER

May 2008

British Society of Rehabilitation Medicine
c/o Royal College of Physicians
11 St Andrews Place,
London NW1 4LE
admin@bsrm.co.uk
www.bsrm.co.uk

Inside this issue: *Appeals for help with website development and volunteers for RCP Open Day, Update on Research Network, details of Neuromuscular workshop, work on ethical issues in medicine and more !*

Not another strategy surely?

Strategy may be an overworked word these days, but it has never been more important to know where we are going and why we are going there. Vera Neumann established the principle that the BSRM's activity should be guided by goals, and the Executive has recently developed this idea further through a strategy document. Each of five priority areas has some associated aims, and also some smart goals. None of this can happen without the active involvement of individual members, so I am appealing for **your** ideas and **your** participation.

1 Influencing local and national policy

A key BSRM role is to influence people both within and outside the NHS. We all recognize that Rehabilitation Medicine needs to be audible and more visible. Hence one of the BSRM's goals will be to improve the impact of our website: this will require considerable investment *(see separate item)*. Our publications are an essential foundation for our identity, and we are committed to maintaining a stock of up-to-date, clinically useful, guidelines. Nationally, we aim to influence policy and members have been working harder than ever to ensure that consultations incorporate BSRM advice. Another method of increasing our influence will be to improve the effectiveness of the specialty's network of Regional Advisers and other experts who can provide evidence-based specialist advice rapidly and publicly.

2 Developing and maintaining an appropriate distribution of consultant posts across the UK

In this competitive age we are all well aware that posts in Rehabilitation Medicine must be fought for constantly. Specific goals in this area include:

- an updated manpower survey
- a 'How to do it' toolkit to assist those developing new posts
- an action plan whereby the BSRM centrally can be more helpful when RM posts are threatened.

To support these activities we are committed to producing and disseminating evidence to support the case for RM and to promote RM to students, trainees and others.

3 Ensuring that Rehabilitation Medicine services provide for the specialised needs of different patient groups

Who is competent to provide spinal injuries services, neurological rehabilitation (not forgetting stroke), musculoskeletal rehabilitation and amputation rehabilitation? This question becomes critical where Consultant job descriptions are concerned. The BSRM has always had a central role in the development of appropriate education and specialist training and we have committed ourselves to disseminating a competency-based model specifying the BSRM's recommendations for the provision of services for specific patient groups.

4 Promoting cost-effective services

Work under this heading was discussed more fully in my last contribution to the Newsletter. To meet specialist clinical needs we require appropriate resources, and with developments such as Payment by Results on the horizon we need to be able to justify our costs. The development of standardised measurement methods is therefore a central plank in the BSRM's strategy. Evidence of cost-effectiveness will be crucial both nationally and in negotiations with local commissioners.

5 Promoting high quality research

Evidence is a theme running through all the above priority areas and research is a vital foundation for the future health of our specialty. The strategy therefore highlights the continuing development of our research network *(see separate item)*. At the same time, the BSRM must use its influence to improve our academic base (which is currently weak), and the BSRM will aim to support the establishment of two clinical academic posts in association with each medical school. In addition, the BSRM will be looking to become a named collaborator in research studies and scientific publications.

A draft version of the strategy was tabled at the AGM in Newcastle, a revised version received the full support of the Executive in February and the strategy will form the framework for our annual reports at future AGMs.

Your contributions to these five priority areas, either locally or nationally, are essential and one of my own underlying aims is to widen the range of people who can contribute to the BSRM's activities. We have discussed a number of ways of achieving this, such as:

- monitoring the representativeness of BSRM committees
- encouraging 'new blood' to take on specific roles
- facilitating the role of the Regional Representatives meeting and allowing additional participants to contribute to those discussions if they wish. You are invited to ensure that at least one member form your Region is present at a lunchtime meeting in Birmingham on May 20th.

So yes, this is yet another strategy, but one which encapsulates most of what the BSRM stands for, translating our ongoing commitments into the language of rehabilitation: priorities, aims, goals and actions.

Chris Ward

President

News from the Education Sub-Committee

Dear all

Organising meetings, reviewing the rehab medicine curriculum and looking at assessment methods are the three big themes occupying the training and education subcommittee.

First, the Rehabilitation Medicine curriculum: we are fortunate to have an expert panel consisting of Christine Collin, Debbie Short, Wagih El-Masri, Fred Middleton, Stephen Kirker and Tony Ward to review the Rehabilitation Medicine curriculum. The aim is to develop Level 3 competences in each of the four specialty areas: amputee and limb loss, spinal injuries, neuro rehabilitation and musculoskeletal medicine. We have agreed that the rest of the generic competences should be Level 2 competences, and that these should be mandatory for all trainees. Level 3 competences in one clinical area will also be mandatory. So far this committee has developed competences for musculoskeletal medicine and are developing the competences for spinal injuries.

Second, assessment methods: There's a lot going on here. First, Rory O'Connor is developing a multidisciplinary teamwork observation tool. The aim of this will be to facilitate the assessment of trainees working within a multidisciplinary team, for example, in chairing case conferences, goal setting meetings or family meetings. Rory is arranging to video some case conferences using actors rather than patients. A number of trainees have kindly volunteered to perform in these scenarios. These videos will be shown at the next BSRM meeting in Birmingham, and we are looking for volunteers to score these and also to comment on the feedback form. If anyone is interested in doing this and are going to the Birmingham meeting please could they let Sandy know.

The knowledge-based assessment continues to exercise us. I recently went to a meeting of MRCP UK in which the financial implications of setting up a specialty-based exam were made clear. For small specialties this may be too financially onerous. It is however, clearly important that trainees are assessed with the same rigour and professionalism as in large specialties such as Gastroenterology or Respiratory Medicine. I put this point to Professor Gilmour, and he was in agreement that some form of knowledge-based assessment must be made available for trainees. At the moment the plan is to wait until the specialty exams are put in place this Autumn and to revisit the question in the light of the experience of the larger specialties putting the exams into practice.

The College themselves are developing a number of assessments for trainees and these include an audit tool in order to allow the audit of the quality of audits! In addition, there will also be a patient survey similar to the one developed for consultants and an acute care assessment tool

that is not relevant for trainees. The College is looking for volunteers to use and feedback about these tools and anyone who is interested in doing so can contact me or Joe Booth at the Royal College.

The final issue is, of course, meetings. The next meeting is in Birmingham . I am very grateful to Chris Ko-Ko for organising an excellent programme and I hope as many of you as possible will be there. The Autumn meeting will be in Holland with the VRA on 30 and 31 October 2008 - please put this in your diary now.

Diane Playford

Chair – Education Sub-committee

Trainees Section

Le plus ca change le plus ca le meme chose. In the three and a half years since I entered specialist training, the working conditions, prospects, morale and worldview of the junior doctor has changed enormously. As the dust settles from the MMC debacle, it is clear that as a group we feel more unsettled and uncertain about how our working lives will be in the future. The expansions and contractions of consultant and trainee numbers undulate with time and the overarching direction of the NHS seems to change almost at whim. There is every prospect that, by the time I obtain a consultant post, trainees within the same rotations will be working on three different curricula, simultaneously, and the assorted assessment techniques that are being tailored to these educational frameworks may also be very different.

Given how difficult it can be to see light at the end of the tunnel, one wonders why the bright, dedicated, empathetic and talented individuals I meet who are training in our specialty haven't departed en masses to work in the city or some equally lucrative venture. Fortunately, beyond the bellicose Government rhetoric and manic change-generation, the essence of what we do remains the same. When doctors from other specialties come and look around our inpatient rehab unit or sit in on multi-disciplinary meetings, they are, almost uniformly, regretful that they were not aware of our specialty at an earlier stage in their careers. Most of them are also envious of the variety and sheer human interest that characterises what we do.

Discussions continue around a formal written exit examination, but this remains at an embryonic stage and I would be surprised if this affects any of those currently in post. The other assessment methods (DOPS, CEX, Multi-source feedback) are very much becoming integrated with the new curriculum and, therefore, I would suggest that you discuss with your educational supervisor how and when these assessments should be delivered.

There are a number of courses/conferences coming up *(details on the BSRM website)* and a rumour that the Autumn meeting this year will be in Holland! As ever, I would urge you to try and attend these where possible, not only as an educational resource, but also as an opportunity to engage with your peers! It would also be beneficial for everyone in the specialty if you could continue to try and promote local teaching events to trainees nationally

Given the understandable anxiety about the availability of consultant posts at CCT, I have tried to be pro-active in terms of identifying trainees approaching their CCT without a definite post in an attempt to gather information on what the particular issues are. I regret to say that of the 3 trainees identified in this position at the end of last year, one has gone abroad and another is considering this. Please do let me know if you are likely to be affected, although I can't magic jobs out of a hat, it can be helpful to have some support.

I will be due to stand down as trainee representative this year and if anyone would be interested in taking over the role and would like to know more about it then please drop me a line.

lbradley@doctors.org.uk

Lloyd Bradley

Trainees' Representative

The next meeting of Trainees is on 19 May at the Spring Meeting in Birmingham.

www.bsrm.co.uk
Tell us what you think

Nowadays, a website has two functions for organisations such as ours:

- as a resource for the public at large and
- as a communication and educational tool for members.

As an image-maker, our website must be competitive with those of other comparable organisations. Geeks may wish to take a look at some, such as
the Association of British Neurologists http://www.theabn.org/

the British Society of Rheumatology http://www.rheumatology.org.uk/

the British Thoracic Society http://www.brit-thoracic.org.uk/ or

the Chartered Society of Physiotherapists http://www.csp.org.uk/director/about.cfm.

We would like your views on questions such as these:

1. How confident are you in recommending our website to opinion-makers such as NHS Commissioners? How does its impact compare with other sites? How useful is it for new visitors?
2. What enhancements do you think would help the site to raise the profile of Rehabilitation Medicine?
3. How useful is the website for members?
4. What enhancements would make it more useful to members?
5. For meetings and courses, would online submission of abstracts and/or registration be a good or a bad thing?
6. Would you find a members area useful, with confidential resources such as job descriptions, CPD materials, bulletin boards etc?
7. [Most importantly] Can you offer the BSRM any help in the design and management of a website?

Note that resources are limited and that some good ideas are not affordable. Please send your views to Sandy or myself.

Chris Ward

BSRM Research Network Pages

Apologies to all for the delay in getting the research network pages up and running. We had a few gremlins causing uploading problems, which are now sorted.

There are a few people who have sent documents – thank you, and a few others who are due to.

I'd be really grateful if others could send a contribution. As a reminder, the idea behind the pages is to encourage research by providing information that can help with research – articles on how to carry out various aspects of research, projects that people are doing at present or have finished, calls for collaboration with projects, etc. Don't worry if your level of research experience isn't high – the whole idea is to nurture research, and I won't let anything by that looks too bad, although I'll discuss it with you and try to improve it. If you are experienced in research see it as a duty to contribute!

As a basic guide, this is the sort of material we need:

- **Calls for collaboration** – if you have a project in mind but will need to collaborate with another centre.
  This could be because of the numbers of subjects you need, or a specific type of expertise you require, or because you want to use more than one setting for your study, etc.
- **Research methods** – this for people who are experienced in research to contribute.
  Articles could be about a particular type of study design, or about completing R&D or ethics applications, or a particular aspect of statistics, or studying a particular type of intervention, questionnaire design, etc.
- **Hot topics –** this is for rehabilitation research that has been in the news lately.
  Contributors could volunteer to report about research published in a specific journal, or concerning particular aspects of rehabilitation, or even rehabilitation research that has been in the papers (particularly useful in clinic).
- **Abstracts from recent BSRM meetings –** *anyone who has an abstract accepted for a meeting can have it put on the pages afterwards provided they give a commentary on how the research went, what problems they came across, what they think they did well, how they would improve on it next time, and could link it to a call for collaboration if they wished. The idea here is not just to showcase research but to reflect on it and give others the benefit of that reflection as well.*
- **Projects in progress –** this is for projects you are doing at present.
  You might want to put them on the pages if you are thinking of going onto another stage afterwards, or just to show people the type of research you are doing.
- **Training opportunities –** if you are involved with an event connected with training in any types of research you can advertise it for free on these pages.
- **Research meetings –** please let us know about any research meetings here.
- **Useful links –** if you know of any other interesting research orientated links please let me know.

Don't worry about the format too much. I would prefer documents in Word, and would prefer them

to be concise and less than about 500 words, unless they are about a particularly complex subject. There will probably be a need to edit contributions but I'll check with the sender before releasing it to check it still conveys their original meaning. If you're not sure if something should go on just contact me
– Margaret.Phillips@nottingham.ac.uk

Margaret Phillips

Special Interest Group for Electronic Assistive Technology (SIGEAT)

More change

Technology has moved on apace over the past decade and at the same time there has been unprecedented upheaval within equipment services. Most specialist services have come through unscathed compared to the turmoil that has enveloped much of the community based provision, but there remains need in every locality for clinicians to be involved. This is even more necessary now that management structures within both the NHS and Local Authorities have been altered once more and it is important that BSRM members identify and then work with service commissioners to optimise provision. We are regularly told that assistive technology offers undreamt of opportunity to minimise disability and reduce demand for in-patient hospital care, but many of those commissioning services need practical, realistic and unbiased advice.

The BSRM supports the provision of assistive technology efficiently and in a timely manner, but considers it imperative that providing the technology should be recognised as being only a single aspect or component of care. Many disabled people will exhibit changing need as illness progresses or circumstances change, so there is need for service providers to employ knowledgeable personnel able to offer holistic advice and guidance to a group of people who all too often are confused, frail and vulnerable.

Despite much promotional publicity, the Department of Health's new policy 'Transforming Community Equipment Services' is not a mandatory requirement for implementation by PCTs and it appears to be withering on the vine. It espouses the laudable concept of improving access to assistive technology and whilst this is accepted by both the statutory and non-statutory sectors, there is widespread agreement that the timetable decreed for its implementation was unrealistically short. Staff training programmes are being established, but this requires considerable organisation and will take time[1].

The Bercow Review

Bercow began last year as a Departmental review of speech and language support services for children, but is now likely to have a wider remit including the opportunity to better align communication aid and computer access provision with EAT services. An Interim Report is presently at the printers.

Meetings and symposia with EAT content

BSRM Spring Meeting, Birmingham
19th & 20th May 2008
admin@bsrm.co.uk

EAT [NW] Summer symposium , Liverpool
4th July 2008
Tia.jones@thewaltoncentre.nhs.uk

Enabling People with Long-Term Conditions
London 16th September 2008
neil@innervate.co.uk

BSRM Winter Scientific Meeting
The Netherlands 30th & 31st October 2008
admin@bsrm.co.uk

Reference

1 Jones T, Lloyd S, Turner-Smith A, Williams E. Training requirements for equipment services. Equipment Services Supplement pp 11-15 International Journal of Therapy and Rehab-ilitation, London 2008

Further information with regard to meetings and venues can be obtained from the BSRM Secretariat or from SIGEAT committee members below:

Dr Andrew Bradford	*Newcastle*
Dr Ali Hassoon	*Salford*
Dr Emer McGilloway	*London*
Dr Emma Murphy	*Bournemouth*
Dr Ajoy Nair	*Hillingdon*
Dr Jenny Thomas	*Cardiff*
Dr Emlyn Williams	*Liverpool*

together with

Judith de Ste Croix — *Royal College of Speech & Language Therapists*

Ruth Groves	*College of Occupational Therapists*
Roger Potter	*The Institute of Physics & Engineering in Medicine*

Emlyn williams

Chair - SIGEAT

European & International Affairs

The UEMS Section of Physical and Rehabilitation Medicine is currently busy putting together a series of educational sessions at the forthcoming ***European Congress in Bruges*** from 3-6 June 2008. I hope very much that there will be a large British contingent there, as it will be a wide-ranging meeting and Bruges is, of course, on our doorstep. It is literally 30 minutes' drive from Calais and will, in fact, be easier for many of you to go there than to get to meetings in many parts of the UK. Please look at the web page, www.ecprm2008.org and you will see a programme packed with things to interest you.

The meeting starts with a Vocational Rehabilitation pre-Congress Workshop, which has been put together by Professors Anne Chamberlain, Charles Gobbelet (CH) and Veronkia Fialka-Moser (A). This will enable us to see how we in the UK compare with elsewhere in Europe. The Congress will also host the Trans-European Scientific Contest, a light-hearted competition between the best papers of each European nation – and, what's more, we have a better chance of winning than we do in the Eurovision Song Contest! Dr Tarek Gaber from Wigan is representing the UK, so, do come along and support him!

The Congress will be full of new research - 881 abstracts have already been submitted to date. We will all have the chance to network with our colleagues from mainland Europe – and, of course, Bruges is an ancient & beautiful city!

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

Dr Shrikant Pande
Dr Rajib Purkayastha
Dr Wajid Raza
Dr Elizabeth Stoppard

We have a 100% record of achievement of success in those taking the exam right from the first candidates (John Burn and Anbananden Soopramanien) in 1994. As well as something to put on your CV and in your Appraisal folder, 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 3-13 July 2008.

This leads us on to 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 to confirm that yours requires to be updated, if you so wish to do.

The UEMS website is close to completion of a major overhaul and the new site (www.euro-prm.org) should be up and running by 1st April. You will be able to find out how to reapply for board-certification and re-certification through the web pages.

The Physical & Rehabilitation Medicine (PRM) Section remains very active in promoting the rights of people with disabilities to access specialist rehabilitation services and concerned with implementation of policies & legislation in this area such as the UN Convention of Human Rights for People with Disabilities. Another area of work is the development of a more unified approach to the education of medical and other undergraduates and graduates regarding the management of disability. There is strong Europe-wide support for the use of ICF as an international language for our area of work.

Although there are a large number of PRM specialists in Europe, specialist rehabilitation, like in the UK, remains patchy both in terms of distribution of services and their quality. The White Book on PRM in Europe highlighted the workforce differences across the countries of Europe and we, along with Ireland, are firmly at the bottom. We should continue to use this argument here in the UK to push for greater numbers of Rehabilitation Medicine physicians, whilst also ensuring that all those appointed conform to high European standards.

The Programme Accreditation System, which will be presented at the Bruges Congress, is being developed to provide us with a valid means of developing standards of practice for services (as opposed to individuals), across the Continent. The system has already gone through its pilot phase and though further work is required, it not too difficult to follow and will be a valuable way of

ensuring that we offer high quality rehabilitation programmes for our patients.

Sometimes we Brits think we are the best. Well, we may have quite a bit to learn from our neighbours in the rest of Europe!

Anthony B Ward (01782 556 226)

anthony@bward2.freeserve.co.uk

Vera Neumann (0113 392 4614)

veran@firenet.uk.com

RCP OPEN DAY – 5 July 08 VOLUNTEERS PLEASE!

Volunteers are required to promote Rehabilitation Medicine at the RCP Open Day on Saturday 5 July 2008 – The day is aimed primarily at school children of 14 years upwards and provides an excellent opportunity to showcase Rehabilitation Medicine to potential medical students and the general public, showing how the specialty has evolved since the creation of the NHS 60 years ago. If you have some 'props' you can bring that's great but enthusiasm for the specialty is sufficient to get you the job!!!

Please contact Sandy Weatherhead at the BSRM to volunteer (01992 638865)

BABY TAXI APPEAL

BABY TAXI FOR THE CRP, BANGLADESH

BSRM raised £1000 – further donations still accepted – Target is £2000.

Many thanks!!!

Cheques payable to 'BSRM' but marked Baby Taxi on the back

WORKSHOP ON REHABILITATION FOR PEOPLE WITH PROGRESSIVE NEUROMUSCULAR CONDITIONS

Tuesday May 20th 3 .30pm – 5.30pm
(to follow the BSRM Spring Conference).
Lakeside Centre, Aston University, Birmingham

This is a workshop, initiated by discussions with the Muscular Dystrophy Campaign, to discuss:

- The state of rehabilitation for people with progressive neuromuscular conditions in the UK today
- How much should Rehabilitation Medicine physicians be involved in this?
- What steps do we need to take if we feel we should have greater involvement with this group of patients?

The workshop is sponsored by the Muscular Dystrophy Campaign and we envisage three products from it:

1. A position document to report back to the MDC and the BSRM regarding the above questions. For those who wish to contribute this will involve some work after the workshop to finalise the document.
2. A decision as to whether an application should be made to the BSRM for a special interest group for those working with people with progressive neuromuscular conditions.
3. A decision as to whether an application should be made to the BSRM to produce guidelines on rehabilitation management for people with progressive neuromuscular disease.

This is an area of rehabilitation which has been relatively neglected in the past, in comparison to the 'upper motor neurone' group of conditions. There are now several people around the country who are becoming involved in rehabilitation for this group of people and organisations like the MDC are becoming increasingly aware that rehabilitation physicians may be able to play a role. So, the time is right for us to consider our role, hence this workshop.

There is no need to pre-book, but we do need an idea of numbers so could anyone interested in attending please contact Margaret Phillips (01332 785680, margaret.phillips@nottingham.ac.uk). Anyone who is interested in the topic but cannot make the workshop also please contact me.

Margaret Phillips

Book Review

MULTIPLE SCLEROSIS CARE
A practical manual

John Zajicek, Jennifer Freeman, Bernadette Porter, Oxford University press
July 2007-08-21 ISBN 13: 978-0-19-856983-1
Paperback £19.95

This is an excellent pocket guide to MS, whose value is enhanced by having a multidisciplinary authorship. From the physicians' point of view, it is packed with the answers to questions they are frequently asked in clinics (eg 'What are the chances of my children getting this disease?). For the patient, there are useful chapters on how to assess the severity and progress of their disease, and the explanation of the WHO model is particularly helpful.

There is inconsistency in the advice about repeating MRI scans. Many people with MS ask if their MRI scans will be repeated in order to monitor their condition. In practice, this is not frequently done except for clinical trials, or when clinically isolated syndromes are being assessed, but there is an impression on page 38 that MRI *is* used routinely to monitor disease, although this is corrected in a later chapter.

The 'apples and pears' analogy to randomised controlled trials, illustrates the value of using language that an untrained person can understand and is a useful reminder to all doctors of the importance of doing this. Junior doctors often find it very difficult to talk to patients about their condition in non medical language, and this book will be helpful in showing how to explain things simply.

Although I can understand the authors' reluctance to elaborate on the Benefits system in the UK, when there is likely to be an international readership, I do think that a more comprehensive description of the benefits available would have been of invaluable assistance to patients and clinicians in the UK, who are presumably the prime target of this book.

Nonetheless, 'MS Care' is an excellent book and should be read by neurologists, rehab doctors, GPs, nurses, managers and people with MS.

Margaret Rice-Oxley, Chichester

Welcome to the following new members

Dr Surendra Bandi, *Registrar*
Haywood Hospital, Stoke on Trent

Dr Helen Burrows, *ST3 - Rehabilitation Medicine, Royal Berkshire Hospital, Windsor*

Dr Esther M Crawley, *Consultant Paediatrician/Senior Lecturer, Royal National Hospital for Rheumatic Diseases*
Bath

Mr Manish Desai, *ST3 - Rehabilitation Medicine*
Northern Deanery

Dr Colette Griffin, *Principal Consultant,*
Royal Hospital for Neuro Disability, London

Dr Julian Harriss, *Department Head*
Rehabilitation Medicine Dept Qunite Healthcare Cor, Canada

Mr Yogendrasinh Jagatsinh, *Specialist Registrar, Walkergate Ctre for Neuro Rehab & Neuro Psychiatry, Newcastle upon Tyne*

Dr S M Javaid, *Staff Grade - Spinal Injuries and Amputee Rehab, Rookwood Hospital,Cardiff*

Mr Antony Kallur, *Specialist Registrar - Spinal Injuries, North West Regional Spinal Injuries Centre, Southport*

Dr Roderic MacDonald, *Specialist in Musculo-skeletal Medicine, London*

Dr Shagufay Mahendran, *Rehabilitation Medicine Trainee, Walton Centre for Neurology & Neurosurgery, Liverpool*

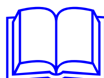
Dr Hanan Osman, *Specialist Registrar in Rehabilitation Medicine, Leeds Teaching Hospitals NHS Trust*

Mr Sohail Salam, *ST3 - Rehabilitation Medicine*
Northern Deanery, Gateshead

Dr Matthew Smith, *ST3 - Rehabilitation Medicine, St Mary's Hospital, Leeds*

Mr Sachin Watve, *ST3 - Rehabilitation Medicine*
Pinderfield General Hospital, Wakefield

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)

BSRM MEETINGS

BSRM SPRING MEETING 'From Science to Clinical Practice – The future of rehabilitation', ***19 & 20 May 2008, Birmingham***
Contact: Sandy Weatherhead, BSRM 01992 638865
admin@bsrm.co.uk www.bsrm.co.uk

11th BSRM/UNIVERSITY OF NOTTINGHAM ADVANCED REHABILITATION COURSE, 10-12 September 2008, Derby
Contact: NCORE, Devonshire House, Derbyshire Royal Infirmary, London Road, Derby DE1 2QY (Tel: 01332 254934
ncore@derbyhospitals.nhs.uk

3RD UK DUTCH REHABILITATION MEETING, *30 & 31 October 2008, Ermelo, the Netherlands*
vra@revalidatiegeneeskunde.nl
More information will be available soon

OTHER MEETINGS

2008

BSRM SPRING MEETING 'From Science to Clinical Practice – The future of rehabilitation', ***19 & 20 May 2008, Birmingham***
Contact: Sandy Weatherhead, BSRM 01992 638865
admin@bsrm.co.uk www.bsrm.co.uk

RSM CONFERENCE PATHWAYS TO WORK, ***21 May 2008 at the Freemasons Hall, Bridge Street, Manchester.***
http://www.rsm.ac.uk/academ/pathmay08.php
Contact: Chloe Waite: 020 7290 3844 chloe.waite@rsm.ac.uk

KEY ADVANCES IN ANTIPHOSPHOLIPID SYNDROME AND **JUVENILE ARTHRITIS IN THE ADULT, *RSM, London, 21 May 2008***
Contact: RSM 020 7290 3856

16TH EUROPEAN CONGRESS OF PHYSICAL & REHABILITATION MEDICINE, *3-6 June 2008,* *Bruge, Belgium 'From Cell to Society'*
www.ecprm2008.org

RSM conference *DIAGNOSTIC PROBLEMS IN THE PAIN CLINIC, 12 June 2008, Liverpool*
Contact: Joyce Achampong, RSM, tel: 0207 290 2980 Email: joycee;achampong@rsm.ac.uk www.rsm.ac.uk/diary

PIECING IT TOGETHER: Partnership Working to Meet the Palliative and End of Life Care Needs of People with Neurological Conditions, *16th June 2008 the Royal College of Nursing, London*
Contact: Mridu Rana 020 76971520
E mail: m.rana@ncpc.org.uk
www.ncpc.org.uk/events/piecing.html

EUROPEAN SCHOOL MARSEILLE 'MOTOR DISABILITIES: POSTURE AND MOVEMENT ANALYSIS, REHABILITATION, NEUROPHYSIOLOGY' *30 June-11 July 2008, Marseille*
Contact: alain.delarque@ap-hm.fr
jean-michel.viton@ap-hm.fr
laurent.bensoussan@ap-hm.fr
http://mediterranee.univ-mrs.fr/esm/

RM SpR Training Day, PRESSURE ULCERS AND SWALLOWING ISSUES, *Salisbury, 15 July 2008*
Contact: Dr Subha Vandabona
Email: Subha. Vandabona@salisbury.nhs.uk

SRR SUMMER MEETING, ***2-3 July 2008, Preston***
Contact: Denise Forshaw, Clinical Practice Research Unit, Brook 418, UCLan, Preston Campus, PR1 2HE (tel: 01772 893713)
dforshaw@uclan.ac.uk

7TH CAMBRIDGE / UCLA COURSE ON 'CLINICAL EXERCISE TESTING AND INTERPRETATION - A PRACTICAL APPROACH', *24 & 25 July 2008 , Addenbrooke's Hospital*
Contact: Dr Jenner, c/o
michelle.joyce@addenbrookes.nhs.uk

ABN Winter Meeting, *10-12 September 2008, Aviemore, Scotland*
Contact: info@theabn.org

11th BSRM/UNIVERSITY OF NOTTINGHAM ADVANCED REHABILITATION COURSE, 10-12 September 2008, Derby
Contact: NCORE, Devonshire House, Derbyshire Royal Infirmary, London Road, Derby DE1 2QY (Tel: 01332 254934
ncore@derbyhospitals.nhs.uk

ENABLING PEOPLE WITH LONG-TERM CONDITIONS - HOW TELECARE, ELECTRONIC AND COMPUTER-BASED TECHNOLOGIES CAN HELP, ***16th September 2008, New Connaught Rooms, London***
Contact: Innervate Limited, 117 Waterloo Road, London SE18UL (tel: 020 7921 0002 Email: info@innervate.co.uk)

5TH WORLD CONGRESS FOR NEUROREHABILITATION, *24-27 September 2008,*
***** *NEW VENUE* – Brasilia *****
http://www.wcnr-brasilia2008.com

3RD UK DUTCH REHABILITATION MEETING, *30 & 31 October 2008, Ermelo, the Netherlands*
vra@revalidatiegeneeskunde.nl
More information will be available soon

ISPO UKNMS ANNUAL SCIENTIFIC MEETING, *31 October-1 November 2008, Chester*
Contact: info@ispo.org.uk

CPD AWARDED TO RECENT BSRM MEETINGS

BSRM Spring Meeting 'From Science to Clinical Practice – the future of rehabilitation' – 19 & 20 May 2008
Event Code Number 41894 – 11 credits

8th Advanced Prosthetic & Amputee Rehabilitation Course – 17-19 March 2008
Event Code Number 41308 – 18 credits

BSRM EAT Training Day – 8 February 2008
Event Code Number 38994 – 4 Credits

BSRM Winter Meeting & AGM
7-9 November 2007
'Debates & Dilemmas in Rehabilitation Practice'
Event Code Number 39007 – 12 Credits

Ethical Issues in Medicine

The Royal College of Physicians has asked the Society for its views on ethical issues in medicine. Jail Kulkarni has a wealth of experience in this area and is co-ordinating the BSRM's contribution for Rehabilitation Medicine.

Jai has indentified the following ethical principles:

- A respect for autonomy
- Maleficience: avoiding harm
- Beneficience: providing benefits
- Justice: distribute costs

In addition to the above generic ethical topics, pertaining to rehabilitation/ neurological rehabilitation, some specific ethical dilemmas are as follows:

- Patient selection for in-patient neurological rehabilitation: the factors are medical/prognostic issues and non-medical factors of age related issues, post code related issues, bed availability issues etc. Non-selected patients need to be informed of availability of any follow-up evaluation to determine future reviews/selection.
- Ethical dilemmas of teamwork issues/multidisciplinary team. Issue of conflict within the team itself between the team and the patient and unrealistic patient expectations.
- Ethical dilemmas of goal setting.
- Ethical dilemmas of clinical necessity principle and best interest principle.

The above are just some of the issues and we would be most grateful if BSRM members could inform/email Jai with any other relevant ethical topics that could be included in this spectrum and which are specific to our specialty.

email: jai.kulkarni@smtr.nhs.uk

Spirituality in Health Care

A small group met in at the November 2007 BSRM meeting in Newcastle to discuss the place of spirituality and spiritual care within rehabilitation.

Spirituality is difficult to define, but certain aspects are clear eg spirituality is part of being human, spirituality is not the same as organised religion and a person may be deeply spiritual without belonging to a specific faith group. The Government stresses the importance of recognising spirituality in health care, although many chaplaincies find themselves having to justify their existence despite providing a huge amount of support for staff and patients. In rehabilitation we see patients and families who have to face major life changes and often re-think what is meaningful and important in their lives.

Nurses are expected to offer spiritual care as part of routine nursing care, but research suggests that many feel uncomfortable and ill equipped to work in this area. Many health professionals feel anxious about addressing some of the questions that patients or relatives may raise about why a trauma has occurred, what it means to them and how belief systems have been challenged.

We recognised that this area takes us beyond our scientific paradigm and this may contribute to our discomfort in that we do not address these questions as experts, but as fellow travellers.

We all felt this area is one that should be explored in more depth to gain understanding of the views of health care professionals, patients and relatives in relation to perceptions of spirituality and spiritual care.

If you are interested in exploring this further please contact me and we will see how we can develop this as an area of enquiry within rehabilitation.

Barbara Chandler

Centre for Neuro-rehabilitation and Neuro-psychiatry, Walkergate Park, Benfield Road, Newcastle upon Tyne, NE6 4QD

email: b.j.chandler@ncl.ac.uk

WINTER MEETING AND AGM– 7-9 November 2007, Newcastle upon Tyne
Poster Abstracts

*****AWARDED CERTIFICATE OF MERIT*****

Electric Powered Indoor/Outdoor Wheelchairs (EPIOCS): effects of use on carers

A O Frank[1], *C Neophytou*[2], *J Frank*[2], *L DeSouza*[2]
[1]*Stanmore Specialist Wheelchair Service, Stanmore*
[2]*School of Health Science and Social Care, Brunel University, Uxbridge*
Email: Andrew.frank1@btinternet.com

Objective: To investigate whether EPIOC provision provides benefits to user's family or informal carers. This has not been studied to date.

Data collection: All EPIOC users receiving their chair between February and November 2002 (N=74) were invited to participate in a telephone questionnaire/interview and 64 agreed. This study examined responses to the question '*Has the use of your EPIOC affected your family or friends in any way?*' and other related comments made elsewhere during the interview.
Interviews were analysed using a qualitative framework approach. Participants were interviewed 10 to 19 (mean=14.3) months after chair delivery.

Results: Forty nine (77%) users responded and a further 4 commented on carers elsewhere (83% in total). Twenty six users (40%) specifically commented on the advantages to carers of not having to push users in manual chairs. Twenty seven (42%) users commented on other advantages to the carer eg enhancing friendship, going out with children/grandchildren and specific benefits to partners.

Disadvantages were also highlighted. Twenty-seven (42%) users commented on the physical strain on carers of facilitating vehicular travel or negotiating kerbs and slopes. Fifteen (23%) discussed other disadvantages to their loved ones from the use of EPIOCs. Thirteen (20%) users discussed carers' anxiety or worry in relationship to EPIOC use eg weather conditions, personal safety (muggings), use of ramps and kerbs.

Discussion: When prescribing EPIOCs the advantages and disadvantages to the carers need to be discussed. The advantages of 'not pushing' need to be weighed against the disadvantages such as the increased physical and emotional stress that can occur during vehicular travel.

****POSTER PRIZE WINNER****

Evaluation of the Addenbrooke's Cognitive Examination: validity in a brain injury rehabilitation setting

T Gaber *and S Mannemela, Leigh Infirmary, Greater Manchester*
Email: tarek.gaber@wwl.nhs.uk

Background: Several reports have warned of the Mini Mental State Examination's (MMSE) inability to detect gross high executive function, memory and non-dominant hemisphere impairments, therefore, the routine use of MMSE in brain injury patients is unjustified. Addenbrooke's Cognitive Examination – Revised (ACE-R) has gained enormous popularity in dementia screening as it addresses the main shortcomings of MMSE and possesses its main advantages, being quick and needing minimal training to use. ACE-R use in a brain injury setting has never been reported

Aim: Our study aimed at evaluating the use of ACE-R and to establish its sensitivity compared to MMSE in a cohort of brain injury patients.

Method: ACE-R was administered to a cohort of chronic brain injury patients. All patients had a cognitive impairment which was severe enough to prevent them working or studying. Patients with significant sensory, communication or physical impairments were excluded.

Results: Thirty six patients were recruited, 31 males with a mean age of 37 years. For an upper cut off value of 27/30 for MMSE and 88/100 for ACE-R, their sensitivities were 36% and 72% respectively. For a lower cut off value of 24/30 and 82/100 the tests sensitivities were 11% and 56% respectively. Analysis of the ACE-R subtests indicated that memory and verbal fluency subtests showed the most dramatic impairment in our population. ACE-R was completed in 12-15 minutes in most cases.

Conclusion: MMSE is insensitive as a screening test in brain injury patients. Our results showed ACE-R to be a sensitive, easily administered test.

Evaluation of a lifestyle management programme in the functional abilities and fatigue for chronic fatigue syndrome (CFS/ME) patients

T Gaber, *J Priest, Bolton PCT, Bolton*
Email: tarek.gaber@wwl.nhs.uk

Background: Bolton and Bury CFS/ME specialist service was established in 2004 as part of a UK wide £8.5 million investment to improve the care and equity of service provision for CFS/ME patients.

Aim: To evaluate the impact a lifestyle management programme has had on the functional abilities and severity of fatigue.

Method: The lifestyle management programme is delivered as a group or individual basis. The group programme is delivered over six fortnightly sessions of two hours. The programme integrated the principles of promoting graded activities (exercise) and cognitive behavioural therapy in an informal setting. Functional outcomes were measured before and after the programme using SF36 and severity of fatigue using Chalder's fatigue scale. Patients' subjective views following the programme were also documented.

Results: Full data was available for 70 out of 112 participants in the programme. 49 were females. The mean (SD) of SF36 and Chalder's scale before the programme was 15.7 (4.8) and 8.8 (3.1) respectively and after the programme was 15.7 (5.4) and 6.1 (4.4). Using the T test, there was no significant difference between the mean values pre and post intervention. In general, the participants praised the programme and felt that it helped them to cope with their symptoms.

Conclusion: Most patients felt that the lifestyle management programmes improved their ability to cope with their disability. However, the programme failed to achieve either functional improvement or reduction in fatigue in CFS/ME patients. Further evaluation of the role of such management programmes for CFS/ME patients is needed.

A systematic review of Transcutaneous Electric Nerve Stimulation (TENS) for the management of chronic low back pain (CLBP)

M Gaid, *A Cozens, Department of Rehabilitation Medicine, NHS Grampian, Aberdeen*
Email: moheb.gaid@nhs.net

Objective: To examine the literature for the evidence of using TENS in the management of CLBP since the latest systematic review in April 2005 which was inconclusive.

Search Strategy: Cochrane library and MeSH database using the following headings "Low Back Pain" [MeSH] AND "Transcutaneous Electric Nerve Stimulation" [MeSH] were searched up to July 2007. This resulted in 67 articles.

Methodology: The abstracts of these articles were screened. Controlled trials that reported the use of TENS in CLBP management were selected for detailed review.

Results: Three controlled trials were identified, with 257 patient randomized to receive TENS vs sham treatment or conventional therapy. Visual Analogue Scale (VAS) was used as a primary outcome measure in

all three trials. The treatment period of the studies varied from 12-32 weeks. The results of the trials showed 29-52% reduction in the VAS. There was significant effect from the use of TENS at six weeks (Intervention CI=-4.38 to -0.74 & control CI=0.75 to 2.89). This improvement was not maintained at three months (Intervention CI=-2.34 to 0.84 & control CI=-1.01 to 2.13). The high-frequency TENS was reported to have higher spasm and pain reduction.

Discussion: Most of the studies included in the Cochrane review were not powered enough to detect a significant difference. The recent RCTs provide larger sample size and add more power to the results. New collective evidence is emerging to support the use of TENS in the treatment of CLBP. However, TENS effect may be limited to the first six weeks of its use.

*****AWARDED CERTIFICATE OF MERIT*****

An audit of documentation (and effect of a prompt sheet) of botulinum toxin injections in a spasticity clinic to National Guidelines

Y Jagatsinh, *M Desai, S Stark, J Macfarlane, Walkergate Park Centre for Neurorehabilitation and Neurosurgery, Newcastle upon Tyne*
Email: yogendrasinh.jagatsinh@ntw.nhs.uk

Background: Regular audit of services is an NHS requirement and our Trust has identified audit of medical records as one of five audit priorities in its current clinical governance strategy. The spasticity service is a significant part of our outpatient services and hence the subject of this audit.

Quality issues: We examined the quality of information recorded in patient files on botulinum toxin injections in the spasticity outpatient clinic to ensure compliance with national standards and how this improved after an intervention.
Standards/Guidelines[(1).]

Methods: A baseline audit in 2004 identified significant shortfalls in the data recorded in patient files (n=60) and then a prompt sheet was displayed in the outpatient clinic to remind staff. All new patients referred to the spasticity clinic from 2005-2007 were selected and from this a random sample of 100 were selected. The files of these were examined and those who received botulinum toxin were selected for audit (n=45). A proforma sheet (which included new items not in baseline audit) was used to collect the data on each file and then these were entered onto an Excel spreadsheet.

Results: After the introduction of the prompt sheet, there was significant improvement in most items with stated goals increased from 15% to 80%, outcome measures from 12% to 53%, dose per muscle 90% to 100% and dilution 17% to 100%.

Changes implemented: This closure of the audit loop demonstrated the prompt sheet did improve documentation but significant items (new in this reaudit) were identified as poorly recorded. We are currently devising a user-friendly proforma to roll-out and re-audit its effectiveness.

References:
[(1)] Guidelines for the use of botulinum toxin in the management of spasticity in adults, RCP 2002.

fMRI analysis of ankle dorsi-flexion during active, passive and functional electrical stimulation in healthy subjects

X Lin[1], *M Phillips[1], S Francis[2], S Aboushoushah[2], R Bowtell[2], C Constantinescu[3]*
[1]Derby Hospitals NHS Foundation Trust, Derby, [2]The University of Nottingham, Nottingham
[3]Queen's Medical Centre, Nottingham
Email: xia.lin@nottingham.ac.uk

Background: Functional Electrical Stimulation (FES) is used in rehabilitation to improve mobility in patients with spastic foot drop. How FES affects cortical plasticity and rehabilitation gains is unclear. This study was

to define the brain regions that participate in motor integration for ADF using functional magnetic resonance (fMRI).

Methods: twelve healthy volunteers lay supine in the MRI scanner and performed a block design with 20s rest alternating with 20s of visually cued active, passive or FES-stimulated ankle-dorsiflexion (ADF) of the foot for 10 repetitions. Electromyography (EMG) was used to monitor the tibialis anterior muscle. fMRI analysis was performed using Statistical Parametric Mapping.

Results: the amplitude and power of EMG was smaller in passive ADF than active (p=0.03, p=0.02) and FES-induced (p=0.0001, p=0.0001) ADF. Active ADF generated greater activation than passive ADF in supplementary motor area (SMA); contralateral primary motor (M1) and primary sensory (S1), secondary somatosensory cortex (SII) and cingulate motor areas (CMA); bilateral dorsal and ventral premotor (PM) and cerebellum VI. Contrasting of active to FES-induced ADF showed increased activation in SMA, contralateral PMdr; bilateral PMvr, dorsolateral prefrontal cortex and CMA; and ipsilateral cerebellum IV. FES-induced activation was greater in bilateral SII and insula than active ADF.

Conclusion: the increased activation in bilateral SII in response to FES-induced ADF may have implications for the use of FES in rehabilitation. The methodology used in this study serves as a prelude to the evaluation of cerebral plasticity in response to the FES therapy and motor performance gain in patients with MS/stroke.

*****AWARDED CERTIFICATE OF MERIT*****

Following Subarachnoid Haemorrhage: functional outcome and care need assessment

***KK Naing**, Southampton General Hospital, Southampton*
J Burn, Poole General Hospital, Poole
Email: kknaing@btinternet.com

Background: Patients classified as showing good physical recovery may still have deficits in higher psychological functions. These impairments will affect long-term functional outcomes and their level of care needs for which little information is available.

Objective: To determine the long-term outcome and unmet care needs of patients following less severe subarachnoid haemorrhage (SAH) (WFNS I - III), four to six years after onset.

Methods: A retrospective surgical cohort of 50 patients were offered face to face interviews at home. The Craig Handicap Assessment and Reporting Technique (CHART) and the Care And Needs Scale (CANS), were used to assess functional outcome and unmet care needs. Approved by the Hampshire and Isle of Wight Research Ethics Committee B.

Results: Thirty-four participants (68%; CI 67% - 81%) were left with only mild residual disability (CHART-total score 400 and above), indicating good participation in the community. Sixteen (32%) had significant residual limitations due to cognitive, social and occupational functional deficits. Thirty (60%; CI 46% - 73%) were assessed as fully independent on the CANS, but the needs of 12 (60%) of the 20 dependent participants were not fully addressed. A quarter of WFNS I patients had residual functional impairment.

Discussion: About a third of patients have significant residual disability and almost two-third of dependent patients encounter unmet care needs.

Conclusions: Long-term functional impairment is due principally to cognitive deficits rather than purely physical consequences. Unmet care needs of dependent patients are not adequately addressed.

Audit of dental care pathway as in-patient in Spinal Injury unit and survey of community dental care for Spinal Injury patients

S Pande, *Northwest Deanery, Manchester*
Email: shrikantpande@yahoo.co.uk

Background: Dental care is complicated by physical disability as disabled people receive less oral health care or care of lower quality than the general population, and their oral problems can affect systemic health.

Improving oral health for them is possible through community dental care systems. Education of patients and carers with regards to prevention and treatment of oral disease must be planned from an early stage. This minimises disease and operative intervention.

Spinal injury patients are particularly vulnerable either due to poor arm function or due to poor access to a dentist because of lack of wheelchair access in community. An Audit was performed regarding existing use of "Mouth care protocol" (45) on a spinal injury unit.

Questionnaire survey addressing: dependence for oral care, access to community dentist was carried out.

Results: Protocol was used for only 10% patients.
15% were dependent for their oral care as inpatient and post discharge. 10% of patients had OT aids.
10% of patients were aware of the oral care pathway. Only 50% of the patients had wheelchair access to the dentist.

Recommendations: To implement the existing "Mouth care protocol" more effectively. The staff should have basic training to review for; debris, coating, smell, hydration, gingival status, need of suction and dentures.

Staff should provide information regarding the oral care pathway, access to hospital dentist. Increased participation of OT for adaptations/aids. Encourage the use of Electric toothbrushes.
Discharge plan should check: registration with dentist, wheelchair access or devise contingency plan. Further audit to review these changes in 12 months time is suggested.

Trends of prophylactic agents used in acute management of spinal cord injury

W Raza, *TS Aulakh, AO Osman, DJ Short, Midlands Centre for Spinal Injuries, Robert Jones & Agnes Hunt Orthopaedic Hospital, Oswestry*
Email: wajidaliraza@yahoo.com

Objective: To observe the practice of spinal injury specialists with regard to DVT, stress ulcer, UTI prophylaxis and use of high dose methylprednisolone in the acute management of spinal cord injuries.

Methods: In the year 2000, questionnaires were sent to 28 consultants in various UK spinal injury centres. Six years later, this was followed by a telephonic survey based on the same questionnaire.

Results: 20 (71.4%) consultants replied. 13 (65%) were using prophylaxis for stress ulcers. 5 (38.5%) were using H2 antagonist, 3 (23.0%) used proton pump inhibitors. Follow up survey revealed, all the 20 (100%) consultants were using prophylaxis and 17 (85%) were using proton pump inhibitors.
18 (90%) were using prophylaxis for deep venous thrombosis. Duration of using prophylaxis was up to 12 weeks. LMW Heparin (11) was most used drug. Follow up survey reported a 100% DVT prophylaxis with majority using it for a maximum of 12 weeks.
Only 5 (25%) consultants were using short term prophylaxis for converting indwelling catheter to intermittent catheterization. Drugs mainly used were norfloxacin, trimethoprim and single dose of I/M gentamicin. Follow up survey revealed 10 (50%) using antimicrobial prophylaxis.
In 2000, 11 (55%) were in favour of using high dose steroids, 9 (45%) were against. Seventeen consultants ($p = 0.008$) were against using high dose steroids in 2006.

Conclusion: The results point to highly variable practices across these centres and there is a need for uniformity. We suggest introduction of a set of guidelines agreed by professionals from these spinal injury centres.

*****AWARDED CERTIFICATE OF MERIT*****

The role of hemispheric laterality (left versus right hemisphere) in the functional outcome of younger stroke patients after inpatient rehabilitation

S Chesney, *St Andrews University Medical School, St Andrews, Fife*
L Sloan, Fife Rehabilitation Service, NHS Fife, Windygates, Fife
Email: lancesloan@fife-pct.scot.nhs.uk

Background: Stroke is a leading cause of death and disability worldwide. The effect of hemisphere laterality on functional outcome is unclear. This is a retrospective analysis of the outcome of younger (<65) ischaemic stroke victims following in-patient rehabilitation.

Methods: 85 patients with a first unilateral ischaemic stroke, confirmed by CT scan, were retrospectively identified from database of consecutive admissions to a rehabilitation unit. UK FAM was used to assess function at admission and discharge. Analysis was by SPSS using Mann Whitney, regression analysis and X2.

Results: 45 had left hemisphere strokes (LHS) and 40 had right hemisphere strokes (RHS). There was no gender difference between the groups and age and length of stay were similar (LHS mean age 53 years; length of stay 66.5 days; RHS mean age 54.3; length of stay 67.1).
At admission, LHS patients were significantly more disabled than RHS patients , principally due to language impairments. At discharge, there was no statistically significant difference between overall functional recoveries. As expected LHS patients remained significantly more disabled with respect to communication. Despite a trend towards LHS patients (82% to 68%) there was no statistical difference (p=0.12) between the affected hemisphere and recovery of independent walking.

Conclusions: Hemispheric laterality was a significant predictor of functional disability using the FAM upon admission only. Achieving independent walking was unrelated to the affected hemisphere although favoured LHS. The results indicate hemispheric laterality should not be used as a discriminating factor when assessing stroke patients most likely to benefit from in-patient rehabilitation.

*****AWARDED CERTIFICATE OF MERIT*****

A study of bone mineral density in lower limb amputees at a national rehabilitation centre

E Smith, *A Carroll, N Ryall, National Rehabilitation Hospital, Dublin*
Email: eimear.smith@rnoh.nhs.uk

Background: Lower limb amputees (LLAs) have higher fracture rates, with more complications than the general population. No studies classify bone mineral density (BMD) of LLAs according to World Health Organisation (WHO) criteria, the best available estimate of fracture risk.

Aim: To determine numbers of LLAs in each WHO diagnostic category, as an estimate of hip and vertebral fracture risk.

Design, subjects & setting: Cross-sectional study of 52 LLAs at the National Rehabilitation Hospital, Dublin, all at least 3 months post-amputation.

Methods: Subjects completed a questionnaire examining details of disability, had laboratory measurements of 25-hydroxyvitamin D, parathyroid hormone and sex hormones, and DXA assessment of lumbar spine and both hips.

Results: 39 males and 13 females participated, mean age 61.9 years, mean duration of disability 58.1 months. Twenty-two (42.3%) had vitamin D deficiency, 11 (21.2%) insufficiency. Considering all diagnostic sites, only 10 patients (19.2%) had normal BMD. Considering lowest hip value, sound or amputated neck of

femur (NOF) or total proximal femur (TPF), 19 (36%) had osteopenia, 21 (40%) had osteoporosis. Amputated NOF and TPF BMD were significantly lower than sound values ($p<0.001$). Hip BMD was not associated with either ambulatory ability or amputation level. Duration of disability was an independent predictor of all amputated hip BMD measurement ($p=0.001$ - 0.004).

Discussion: At 3 months post-amputation, DXA assessment, including both hips, and measurement of 25-hydroxyvitamin D is warranted in all LLAs.

Conclusion: Among 76% of all LLAs, hip fracture risk was at least doubled, risk increasing with time since amputation.

Prevalence of skin problems and associated factors in functional users of lower limb prostheses

***KM Tan**, N Ryall, National Rehabilitation Hospital, Dublin*
Email: tankitmun123@hotmail.com

Introduction: Skin problems are recognised complications of prosthetic wear. This survey aimed to determine the prevalence of skin problems and associated factors in established adult functional users of lower limb prostheses in our busy national prosthetics clinic.

Methods: Patients were surveyed prospectively over 6 months from October 2006 – March 2007.

Results: 80 patients (75% male) with average age of 55.4+/-16.5 years were surveyed; 68 were unilateral and 12 were bilateral amputees.

34 (42.5%) patients had skin problems involving 35 limbs. Patients with skin problems were more likely to be younger, in full-time employment/education and less likely to have diabetes and/or peripheral vascular disease ($p<0.05$).

The 3 commonest problems were skin erosion (37%), erythema (28.6%) and infections (28.6%). The 3 commonest symptoms were pain (65.7%), discomfort (40%) and discharge (37.1%). 12 patients (35.3%) sought attention elsewhere for their problems prior to attending the clinic. 27 limbs (77.1%) needed prosthesis-related interventions, 9 (25.7%) required medical/nursing intervention and 14 (15.6%) needed patient self-intervention. 14 patients (41.2%) had skin problems for over a year. 3 patients (8.8%) described their problems as intermittent or recurrent.

Discussion: Skin problems can be related to mechanical forces and friction between the skin and prosthesis. Younger more active patients have more skin problems. It may be patients with other co-morbidities are better educated on skin care or have better supports to reduce problems developing. Patient education regarding stump hygiene and daily examination of skin is vital. Early intervention can prevent further morbidity and loss of function.

Are FIM™ scores useful in predicting discharge destination following inpatient stroke rehabilitation in younger adults?

***E Thomas,** M Homer-Ward, Portsmouth Hospitals NHS Trust, Portsmouth*
Email: em@doctors.org.uk

Background & aim of study: FIM™ scores can be useful in helping to predict discharge destination for patients in an acute stroke setting (mean age 69; mean length of stay 18-21 days)[1] . A discharge FIM™ score over 80 is clinically significant and almost always associated with discharge home. We wanted to establish whether this finding was valid for a younger adult population following specialist inpatient neuro-rehabilitation.

Design, subjects and setting: Retrospective case-note review from a 10 bed neurological rehabilitation unit for adults under 65 admitted with a diagnosis of ischaemic or haemorrhagic stroke between 2001- 2007.

Methods: Excel™ was used to tabulate discharge FIM score, change in FIM™ score and discharge destination for all stroke patients. Only patients with complete data were included in the analysis.

Results: Complete data existed for 86 out of 131 patients (65%). Mean age was 55 years, mean length of stay 95 days, mean admission FIM™ 65 and discharge FIM™ 94.

	Home discharge	**Discharge to Nursing/Residential Care**
Discharge FIM <80	19 (70%)	8 (30%)
Discharge FIM >=80	59 (100%)	0 (0%)
Change in FIM < 20	18 (82%)	4 (18%)
Change in FIM >=20	60 (94%)	4 (6%)

Discussion: Our data complements previous literature and confirms that a correlation exists between discharge FIM scores and home discharge destination for younger stroke patients following longer term rehabilitation.

Conclusions: Measuring changes in FIM™ score during rehabilitation can give important information about predicted outcomes and can help patients, their families and the multidisciplinary team with discharge plan

1. FIM score, FIM efficiency, and discharge disposition following inpatient stroke rehabilitation. Rehabilitation Nursing Jan/Feb 2006; Vol 31:22-2.

Amputation after Childhood Meningitis- a long-term follow up study

***R Thomas*[1]**, *L Graham*[1], *N Fyfe*[2]
[1]*Walkergate Park Centre for Neurorehabilitation & Neuropsychiatry, Newcastle upon Tyne*
[2]*Disablement Services Centre, Freeman Hospital, Newcastle upon Tyne*
Email: raji.thomas@ntw.nhs.uk

Background: Meningococcal septicaemia is a life-threatening illness of childhood with a high mortality rate. Those who survive often have multiple, complex limb amputation which presents a challenge to the prosthetic rehabilitation service. The practicalities of prosthetic use and rehabilitation goals of limb wearers change as they grow. Little is known about the long-term needs and outcome of this challenging group.

Aims: To clarify the level of prosthetic limb use and identify stump-related morbidity in survivors of meningococcal meningitis attending the disablement services centre.

Methods: Retrospective case note review of meningitis survivors who were using prosthetic limbs on a regular basis in 2000. Complications of prosthetic use, the need for further surgery, psychological issues and level of functional independence were assessed.

Results: Data over a seven year period was reviewed for ten patients mean age 16 years. Prosthetic prescription changed over time for all patients. The median number of replacement limbs was 5. Stump revision surgery was required in 5 (50%)- for infection in 2 and growth related reasons in 3. Half had psychological issues during rehabilitation, low mood being the commonest problem 6 (60%) were full time wearers of their prosthetic limbs, the rest wearing part time. Those with a complex course who required further surgery were less likely to be full time wearers. Five were attending mainstream school and 3 were employed full-time. For 2 patients, specialised prosthetics were provided for sporting activities.

Conclusions: Amputees after meningococcal septicaemia can continue to maintain independent and successful lives with specialised prosthetic provision.

Are patients with MND seen in a timely fashion by appropriate professionals within the community neurological rehabilitation team? An audit

***Vandabona S*[1], *Hutchings C*[2]**
[1] *Poole Hospital, Poole*
[2] *Southampton General Hospital, Southampton*

Background: Multidisciplinary team seeing all patients with long term neurological conditions.

Quality Issues: MND patients have diverse needs that change quickly. This audit investigated whether MND patients are seen in a timely fashion, and whether all their problems were addressed.

Standards and Guidelines: were adapted from the MNDA care guidelines. As the study was retrospective, we used seeing 5 different members of the team as a surrogate measure of having addressed all problems.

	Standard	Exception	Target
1	MND patients will be referred within 3 months of diagnosis.	Patient refuses referral	100%
2	Patients with MND will see all five professionals from CNRT during their illness	None	100 %
3	MND referrals will be contacted within 3 days and seen within 2 weeks	None	100 %

Method: Two years retrospective case note audit.

Results: 35 patients identified.

Standard	Exceptions	Target	Achieved	Data unavailable
1	None	100%	49%	23%
2	None	100%	55%	0
3	None	100%	Initial contact 9% Initial assessment 29%	75% 26%

Changes Implemented:

1) Ensure better awareness of service amongst patients and referrers
   New MNDA care centre
   Regular meetings with MNDA
2) Team members felt that most patients had all their problems addressed – and that seeing five professionals was not a valid surrogate measure. We agreed to test this with a prospective audit.
3) Poor records were a problem with this standard. We aim to improve patient records – especially recording of telephone calls

Completing the audit cycle: Repeat audit in 2 years, using a prospective method.

References:

1. MND Association Care Guidelines

2. Guidelines For the Management of MND, Experta Medica MND Advisory Group, ABN

An audit of intrathecal baclofen pump in the treatment of spasticity of spinal cord injury - Compliance with the national ITB forum document in 2006

B Zhang, *M Saif, A Gall, Spinal Injury Unit, Royal National Orthopaedic Hospital, Stanmore*
Email: bbp@doctors.net.uk

Background: Spasticity is one of the most common problematic symptoms in patients with spinal cord injury. Intrathecal Baclofen (ITB) is one of the effective treatments of this spasticity. ITB therapy is an invasive and potentially dangerous treatment and requires careful assessment and follow-up.

Standard: In 2006, the National ITB Forum Document launched standards for the use of ITB as a treatment, including:

(1) patient selection
(2) intrathecal Baclofen test dose
(3) outcome measurement and
(4) oral Baclofen backup.

Methods: Medical notes were reviewed in the 8 most recent patients who had a pump implanted for ITB, and patients were telephone interviewed for the clarification of outcome and availability of oral Baclofen backup.

Results: 100% of the patients met the patient selection criteria and 100% of the patients undertook an Intrathecal Baclofen test before insertion.

All patients achieved desirable outcome after ITB although one patient required additional oral Baclofen to reduce upper limb spasticity.

5 out of 8 of the patients had oral Baclofen available as a backup in case of pump failure.

Conclusion: Most standards were met but many patients did not have a supply of oral Baclofen.

Changes implemented:

(1) Doctors should raise awareness of the potential pump failure and patients need to be continually informed.
(2) Patients attending refill clinics are questioned to ensure they have a supply.
(3) In our current checklist of the ITB, a column will be added to check oral Baclofen supply.

Completing the audit cycle: We plan to re-audit in 24 months.