

Autumn/Winter 2008

Syn'apse

- ▶ **Research for patient benefit: an opportunity to undertake clinically relevant research**
- ▶ **A review of predictive outcome measures for patients recovering from stroke**
- ▶ **Physiotherapy after stroke**



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Syn'apse

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ACPIN'S AIMS

1. To encourage, promote and facilitate the exchange of ideas between ACPIN members within clinical and educational areas.
2. To promote the educational development of ACPIN members by encouraging the use of evidence-based practice and continuing professional development.
3. To encourage members to participate in research activities and the dissemination of information.
4. To develop and maintain a reciprocal communication process with the Chartered Society of Physiotherapy on all issues related to neurology.
5. To promote networking with related organisations and professional groups and improve the public's perception of neurological physiotherapy.

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FROM THE CHAIRS

A warm welcome to the autumn edition of Synapse from your co-chairs of ACPIN! We are now well into our first year of "office" and so far so good! Well, we hope you agree...it is not an easy job following in the footsteps of Nicola Hancock! Just in case you are missing her, she hasn't escaped ACPIN entirely as you will see later in this edition where she reports on the 3rd edition of the National Clinical Guidelines for Stroke. We would like to take this opportunity to thank both Nicola and Dr Sheila Lennon for their continuing work on behalf of ACPIN at the Royal College of Physicians.

As this goes to press we are in the last throws of planning what we hope will have been a very successful neurology strand at this year's CSP Congress in Manchester. An enormous "thank you" goes to our new vice chair Siobhan MacAuley for leading the organisation of this programme alongside the CSP and other related interest groups. We are pleased to confirm that ACPIN will continue to be actively involved in next year's Congress in Liverpool.

The 3rd UK Stroke Forum in Harrogate (2nd – 4th December) promises to be another excellent event. Professor Ann Ashburn has been the ACPIN representative since the inception of this multidisciplinary forum for stroke care and is due to step down from this post later this year. ACPIN would like to extend their thanks to Professor Ashburn for all her hard work and we are delighted to welcome Dr Fiona Jones as her successor.

Next March will see the combined conference and AGM return to Northampton where we will be host to a number of national and international speakers within the field of upper limb rehabilitation. Please see our website (www.acpin.net) for further programme details and an application form. We hope you will find this to be a stimulating and thought provoking day by providing a broad programme that is reflective of current practice and research as

well as looking into possible future directions of neurophysiotherapy. Please remember we are always seeking ideas for upcoming conferences so be sure to pass on any ideas you may have!

Two of the features in this edition of *Synapse* will give you an idea of some of the work that has been started since the spring. Firstly, the national committee has begun the process of reviewing the ACPIN constitution, (this is a formal document that outlines the role and details the processes that guide the work of ACPIN as a special interest group of the CSP). In particular please note the proposed change in the name of ACPIN from "Association of Chartered Physiotherapists Interested in Neurology" to the "Association of Chartered Physiotherapists in Neurology". We are now seeking further comments and views on this working document from the wider membership before presenting it at the AGM on March 21st 2009 where a vote will be taken on any proposed amendments and its submission to the CSP for final approval.

Secondly, it is well recognised by the national committee that the wider ACPIN membership contains many experts in the field of neurophysiotherapy and associated areas; we want to make better use of this knowledge...so please see the feature on the Information Mapping network to see how you can help!

So all that remains for us to say at this point is thank you for your continued membership and don't forget to renew next year!

Jo and Cherry

PRESIDENT'S ADDRESS

Don't give up the quest!

Professor Sue Mawson MCSP Bsc (Hons) PhD

I left the CSP congress in Manchester last weekend with very mixed feelings. On the Friday morning I was fortunate to be asked by ACPIN to chair the inspired keynote lecture given by Professor Anne Shumway-Cook in which she identified the research evidence underpinning balance rehabilitation and the implications for practice. This was followed by an excellent session on publishing research findings in the *British Medical Journal*. Whilst I didn't agree totally with the concept of the double blind randomised controlled trial as being the 'gold standard' methodology for neurological rehabilitation research, a view supported that morning in the press by the Director of NICE, I found the lecture stimulating and worthy of future debate. Fired with enthusiasm for the need to do more research and publish more evidence in the field of neurological rehabilitation, I went to set up my own invited presentation about the NIHR research for patient benefit programme. On arriving at the AV support room I asked for a roaming mouse as I like to engage with my audience by walking around the room. The technician laughed and said 'I don't know about a roaming mouse there isn't even room to swing a cat in that room!' Rather deflated I went along to the venue to be faced by a small and from what I could ascertain a rather disinterested audience. Whether they were there simply for the following lecture is a mystery to me. They claimed to know nothing about the NHS research strategy published in 2006 or the National Institute for

Health research our main funding body in England. Those who know me well and the way I lecture will know I love talking to colleagues about ways to increase our knowledge of best evidence and best practice but on Friday afternoon I quite simply died on stage!

So what are my reflections? Why did the CSP put me in the smallest room, presumably because they knew few colleagues would want to hear about Research for Patient Benefit funding, incidentally one of the best opportunities for research funding for Allied Health Professionals. More importantly why did the young audience of physiotherapists know nothing about the significant changes in health research in recent years? Is this our problem as managers and educators or is it a reflection on the current state of the NHS where the research and innovation agenda in acute and primary care trusts has been lost in the productivity and efficiency drive.

What ever the reason I left congress on a low note not just for myself as a presenter but for my profession in the UK. I believe members of ACPIN are interested in undertaking high quality research and I hope you all take the time to read the article I have written for this edition of *Synapse* (see page 4) on 'how to be successful in gaining research funding'. Again I have written this about the Research for Patient Benefit programme as I truly believe this large funding stream is ideal for our profession. Good luck and don't give up the quest to undertake applied health research.

“Why did the CSP put me in the smallest room, presumably because they knew few colleagues would want to hear about Research for Patient Benefit funding...”

Research for patient benefit

an opportunity to undertake clinically relevant research

Professor Sue Mawson MCSP PhD President of ACPIN

In 2006 the Department of Health published the new NHS research strategy in a document entitled *Best Research for Best Health*.

The strategy represented a huge change in the way research would be funded in England with the existing Research and Development levy (Support for Science and Priorities and Needs) ceasing from 2006/7. All current funding being withdrawn in a transition period to be completed in 2009/10. The National Institute of Health Research (NIHR) was created to hold all the research funding for programmes (Figure 1), infrastructure, faculty, systems and research.

Figure 2 illustrates how the NIHR's major research initiatives fit into the 'innovation pathway'. The pathway starts with the 'creation' of an innovation – which would include basic research in a laboratory, through to its use in a patient care setting. The diagram is not intended to show formal relationships between programmes and organisations.

This pathway covers the full range of interventions - pharmaceuticals, biologicals, biotechnologies, procedures, therapies and practices – for the full range of health and health care delivery – prevention, detection, diagnosis, prognosis, treatment and care.

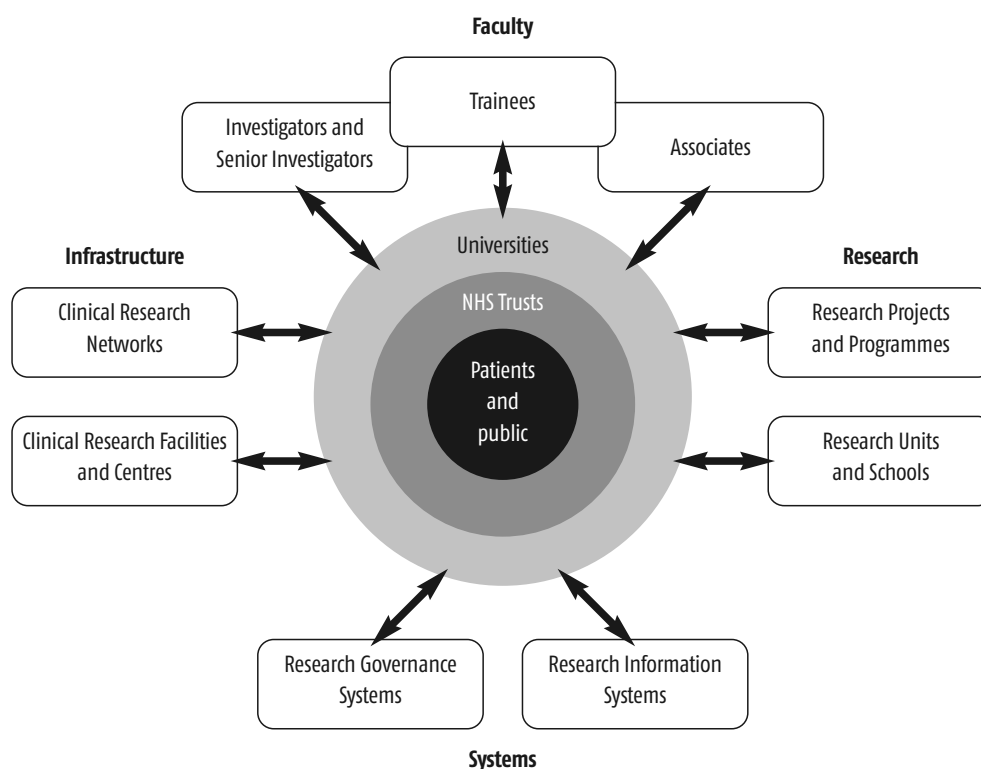


Figure 1 National Institute for Health Research

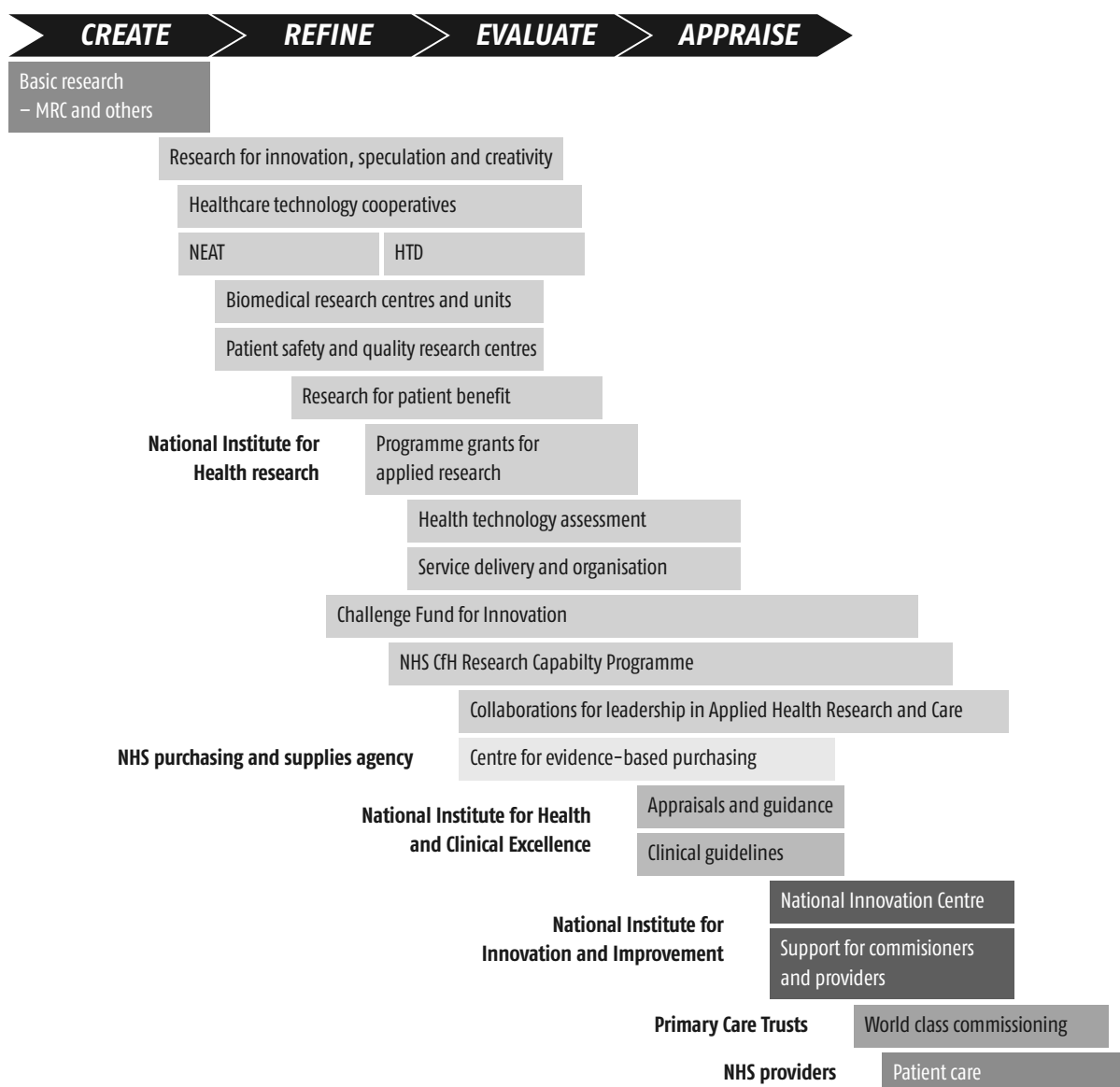


Figure 2 The innovation pathway

Many of these grants such as the programme grants, Health Technology Assessment (HTA) and Service Delivery and Organisation (SDO) grants are very prestigious awards for teams of researchers from the NHS and academia with impressive track records for research not therefore appropriate for novice researchers. However, one NIHR programme is a responsive funding scheme called Research for Patient Benefit (RfPB). (www.nihr-ccf.org.uk/site/programmes/rfpb). Allied Health Professionals are in a unique position to apply for this funding as they play a pivotal role providing front-line services and support to patients and carers. This enables them to have patient-focused insights into the kind of research described within the brief for the RfPB programme, research that will offer the greatest benefits to patient care.

The RfPB programme is:

- Located in the NIHR, coordinated through the central commissioning facility (CCF),
- Regionally implemented via ten regional commissioning panels covering government office regions and is
- Budgeted proportionally to regional population.
- Has a national budget which will build up to £25 million per annum over the next three years
- The projects can last up to 36 months with a budget of up to £250,000.

The programme is intended to support research, which is related to the *day-to-day practice* of health service staff and capable of showing a *demonstrable impact* on the health or health care of service users. Proposals which have emerged from *interactions* with patients/service user experience and developed with them and other agencies like voluntary/public bodies are

particularly welcomed. The funding is inclusive of qualitative and quantitative methods unlike other funding streams such as the HTA programme, which is specifically for randomised controlled trials.

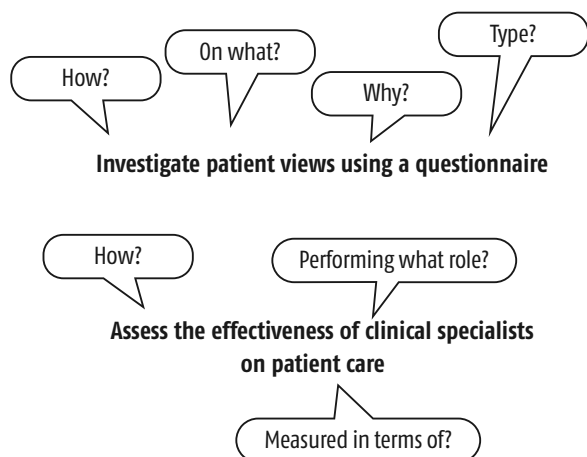
WRITING A SUCCESSFUL PROPOSAL:

Whilst application forms may vary from funding stream to funding stream there are some important points to consider when writing a proposal to undertake a research project. Most research and development departments in NHS organisations have guidelines for proposal writing as all proposals have to undergo an 'independent scientific review' (ISR) prior to submission for ethics approval.

All proposals should have a literature review or background section, which provides the clinical and scientific justification for the study. Here you should include evidence of the clinical significance of the proposed work, whether this work has been carried out before and how the proposal fits into the defined needs of the funding call. The application reviewer should feel confident that the research team are fully aware of relevant literature and ongoing studies in the area. When doing your literature review be mindful of the national research register that contains all current research activity (www.nrr.nhs.uk).

There should then follow a clearly defined and answerable question based on the literature section. Your proposal should contain a clear statement of objectives and a demonstration that the design of the project is appropriate to meet those objectives (www.trentnhs.uk). For example: 'Investigate patient views using a questionnaire' or to 'Assess the effectiveness of clinical specialists on patient care'.

You must also answer the following questions in your proposal:



A successful bid will always provide a good justification for the research design chosen:

Research design needs to match research question	
Quantitative study	Qualitative study
Patient population	Sampling strategy
Outcome measures validity and reliability	Method eg semi structured interviews, diaries, focus groups
Sample size and its basis	Data collection
Descriptive and inferential statistics	Analytical process

You will also be expected to outline how the project will be managed with steering group meetings that should involve not only the project team but also someone to represent the patient group under investigation. It's quite useful for example, if you are studying the effects of a balance training intervention on falls frequency in a care home, to work with your local Age Concern group inviting them to review your application and be on your project steering group.

One area where you will certainly need help is costing the bid. All NHS Trusts and Universities have teams to work on this with you and it is advisable to always seek help from the start. Whilst you will know what you require in terms of a research assistant, travel costs and dissemination costs the complexity lies in the need to identify 'excess treatment cost' the annual 'up lift' for inflation and of course the rather thorny issue of overheads. Most NHS organisations will have their own overhead which usually runs at around 30%. However universities now have to use what is called a full economic cost model (FEC) which virtually doubles the staffing costs in the bid.

In your application you should also demonstrate that current research governance frameworks and procedures for ethics approval have been followed. For more information on these processes see the following websites:

- National Research Ethics Service based within the National Patient Safety Agency
www.nres.npsa.nhs.uk

- Department of Health for Research Governance Framework
www.dh.gov.uk/Policyandguidance/researchanddevelopment/research
- Medical Research Council Guidance on ethics and best practice
www.mrc.ac.uk/index/publications/publications-ethics

TEN TOP TIPS FOR SUCCESSFUL BID WRITING:

1. Read the application form and guidance notes many times highlighting with a marker pen key words and the submission deadline.
2. Don't reinvent the wheel, the reviewers are all experts in the field and they will be up-to-date with current or previous work in the area.
3. Seriously consider public/patient involvement. (<http://www.invo.org.uk>)
4. Work with academic partners, most reviewers would expect this. However don't just go for the big names you must clearly identify the role of the partners in the project.
5. Get advice from a statistician and a health economist if appropriate and tell the reviewer in the text where and how the advice was sort.
6. When describing your dissemination process don't just talk about conferences and journal articles, try and demonstrate how you will influence not only practitioners but also policy makers.
7. Get your costing right.
8. Don't dismiss pilot work, pre-pilot work or clinical audits that may have been done prior to your application, tell the reader what you have done in the background section.
9. Outcomes should be patient focused where possible using well designed outcome measures.
10. Don't panic there are plenty of people to help many of whom need your clinical expertise to provide important clinical questions.

SOURCES OF FURTHER INFORMATION.

- www.nihr.ac.uk
- www.mrc.ac.uk
- www.rdinfo.org.uk

Each Strategic Health Authority has within it a Research Support Unit soon to become a Project Support Unit and these can be hugely helpful in writing a research application, see www.trentrdsu.org.uk as an example of an RDSU. Also remember your local universities, some with have Clinical Trial Support Units (CTSU), and your own healthcare organisation all of whom will be able to offer help and support in writing a good, scientifically rigorous, and potential clinically beneficial research application.

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Predictive outcome measures for patients recovering from stroke – a review

Kathy Weston Physiotherapist, Princess Royal University Hospital, Farnborough, Kent

Approximately 150,000 people per year in the UK will have a stroke (Stroke Association, 2008) and with the ever-increasing financial pressure on the limited resources of the NHS, the ability to accurately predict outcome after stroke plays an important role in both clinical management and allocation of resources (N.U Weir 2003 et al, Counsell et al 2004, Schulz 2004).

Prediction of outcome can help in communicating with patients and relatives, for whom the outcome has great consequences in decision making regarding future life-choices. A huge number of tools have been developed to assist in predicting outcome following stroke, and this article will review the most significant. To identify the tools currently available for prediction of recovery post-stroke, as part of the background work for my BSc dissertation, a literature search was conducted on the electronic databases CINAHL, Medline, EMBASE and AMED, using the search terms 'prediction', 'outcome', 'CVA' or 'stroke', 'recovery' and 'function'. The search was restricted to articles published after 1990 to reflect current practice. Further articles were included from the reference lists of articles identified by the search. Articles taken from the reference lists were limited to those published after 1985 unless they were deemed significant in the introduction of a new idea in the field.

Before selecting a predictive measure of outcome, it is essential to decide at which level the measurement is to take place. Using the International Classification of Functioning, Disability and Health (ICF) (World Health Organisation 2008), prediction of discharge destination should incorporate measures at a level of disability rather than at a level of impairment, while physical motor recovery should be meas-

ured at impairment level. Patients with a high level of impairment do not necessarily have a high level of disability.

The World Health Organisation (WHO) (1980) define impairment as: "the loss of function as a result of organic abnormality or pathology" and Williams et al (2001) describes disability as: "the functional consequence of impairment that occurs at a personal level".

The papers identified incorporated many variables such as outcomes, timescales, age of onset and stroke type which makes it difficult to select a measure that could be considered efficient and suitable for use in the general stroke population. In addition, in their review, Counsell and Dennis (2001) found very few of the measures to be effectively constructed or properly validated.

Tools such as the Orpington Prognostic Score (OPS) (Kalra and Crome 1993) and the National Institute of Health Stroke Scale (NIHSS) are well known and widely used.

The predicted outcomes at three months post-stroke in the NIHSS are: 'alive at home', 'alive in care' or 'dead'. Clearly, these outcomes do not indicate the level of functional motor recovery achieved and make no allowances for the level of family or carer support that may be available to allow a heavily dependent individual to remain living in their own home.

In a comparison of the OPS and the NIHSS Lai et al (1998) found the NIHSS to be reliable in predicting global outcomes but not in predicting functional outcomes. In contrast, the OPS was found to be a better indicator for activities of daily living (ADLs), such as washing, dressing, feeding, toileting, sphincter control and higher levels of physical function. These factors were identified by the German Stroke Study Collaboration (2004) as being of greater significance to both patients and carers, as these activities may be central in determining whether or not a person will need

long-term institutional care.

The NIHSS consists of 13 items and requires extensive training and certification before it can be administered. It is time-consuming to complete and, because of the assessment of a larger number of items there is a greater chance of the data being incomplete (Lai et al 1998). There are also cost implications associated with the necessary specialist training.

In contrast, the OPS assesses only four fields (Kalra and Crome 1993). It takes only five minutes to complete and does not require any specialist skills to administer (Lai et al 1998). Inouye et al (2000), Counsell et al (2002) and CJ Weir et al (2003) all emphasize the need for prognostic tools to be simple, accurate, reliable and reproducible in order for the complete collection of data to take place, so that they may be considered valid. Clearly, the OPS holds several advantages over the NIHSS in this respect.

The Lai et al (1998) study was conducted on 184 individuals recruited from 12 hospitals in the Greater Kansas City area. The majority (88%) of patients in the study were identified as having had a 'mild' or 'moderate' stroke based on their baseline OPS/NIHSS scores, which may limit generalisation of the results for a wider sample. This may be significant as many authors agree that degree of severity of neurological impairment on admission is a strong predictor of outcome (Jongbloed 1986, de NAP Shelton et al 2001, Tilling et al 2001, Hendricks et al 2002, Petterson et al 2002, German Stroke Study Collaboration 2004, Weimar et al 2004, Christensen et al 2005). All patients were assessed using both tools and data was collected within 14 days (baseline assessments), and at one, three and six months post-stroke with the aim of comparing the accuracy of both tools in predicting disability. The OPS was designed and validated to be administered once the patient's neurological condition has stabilized, at least two weeks post onset of symptoms (Kalra and Crome 1993). In this study it was administered between 0 and 14 days which may have confounded the results. Despite these anomalies Lai et al (1998) concluded that the OPS was a better choice than the NIHSS for predicting outcome in mild and moderate strokes.

Interestingly, Studenski et al (2001) later found that OPS assessments carried out between three to fourteen days post-stroke could also be considered reliable in predicting outcomes at three and six months, in the fields of personal care, meal preparation, administration of medication and community mobility. This was a much larger study with 415 participants initially enrolled but data collection was not completed on all subjects, with

18.1% of subjects withdrawing from the study prior to its completion. The authors suggest that the individuals who did not complete six months of follow-up were those who had suffered a severe stroke and were lost to follow-up, which seems to support the findings of Lai et al (1998) in demonstrating that the OPS is reliable in predicting outcome for those with mild to moderate stroke.

Counsell et al (2002) developed a new tool by identifying six common variables that previous studies had found to be significant in predicting outcome. All six were easy to collect and based on history and examination. The variables are: age at onset, living alone prior to stroke, prior disability, normal Glasgow Coma Scale (GCS) for verbal component after stroke, able to lift both arms to horizontal, able to walk without help from another person (may use stick or frame). By combining these variables their aim was to predict two clearly defined outcomes: survival at 30 days and survival in an independent state at six months. They went on to validate this model in two independent cohorts of stroke patients whose characteristics were similar to those recruited for the development of the tool (Counsell et al 2002). The inclusion criteria for the development phase of the study included both ischemic and haemorrhagic strokes, first strokes and second or subsequent strokes, those assessed within 48 hours of onset and those not assessed until later. This broad spectrum allows for generalisation to a wide population. Results indicated that predictions for those patients seen within 48 hours were generally more accurate, although not significantly so. The authors identify short-comings in the analysis of their results which led them to recommend that the model is not used in clinical practice but rather as an aide in epidemiological studies and clinical trials. This recommendation is supported by Schulz (2004) who perceives the outcome of being alive and independent at one year as 'limited' and 'crude', as it does not take into account the type of disability and social factors present.

Rather than develop new tools, some studies investigated whether measures previously developed for other purposes could reliably be used to predict outcome after stroke. CJ Weir et al (2003) examined whether the Glasgow Coma Scale (GCS) (Teasdale and Jennett 1974) could be used to predict two week mortality and three month recovery. Originally developed to assess consciousness levels in head-injured patients, the GCS has been shown to be valid and reliable in predicting outcome for both traumatic and non-traumatic altered consciousness levels (Teasdale et al 1978). The scale is quick and easy

to use and measures eye, motor and verbal responses. In particular, the study sought to determine whether it was acceptable to use the verbal component in patients with dysphasia. The study was conducted on 1232 patients admitted to a stroke unit with a diagnosis of acute stroke. All patients were assessed with the GCS within 48 hours of admission and outcome data were available for 99% of them. It could be argued that less severely impaired stroke patients were excluded from the study by virtue of not being admitted to the stroke unit, which may have led to the findings being valid for only moderately to severely impaired individuals, although this factor is not acknowledged by the authors. Results indicated that the GCS score could predict both two week mortality and three month outcome, although it was more accurate in predicting the former. The authors concluded that the verbal component contained valuable prognostic information and should therefore, be recorded for all patients, including those with dysphasia. It was further acknowledged that the predictive value of the GCS should not be used as the sole basis for clinical decision-making in stroke patients but would benefit from being combined with other known prognostic factors. However, this introduces the need for multiple assessments, counteracting any benefit gained from the speed and ease of use of the GCS.

Tilling et al (2001) and Petterson et al (2002) both used the Barthel Index (Mahoney and Barthel 1965) to predict outcome after stroke. The Barthel Index indicates only whether or not a task can be performed. It does not indicate how the task was performed ie the quality of movement or activity. It has also been found to have a "ceiling" effect once a certain level of function has been achieved (Ashburn 1997, Duncan et al 2001), reducing its sensitivity to change.

In a small study of 142 patients Petterson et al (2002) found that the Barthel Index score measured in the early stages of recovery was a stronger predictor of long-term outcome than either the Rankin Scale or Frenchay Activities Index (Pederson et al 1997), which are also widely used in stroke rehabilitation.

Tilling et al (2001) developed a multi-level model that could be used to predict outcome at various stages of recovery, allowing for day-to-day and between individual variation. The authors suggest that this approach allows for an evolving and individually tailored prediction of recovery. The analysis of multi-level models takes into account that the data are observational and based on individuals, and allows for adjustments to be made with regard to incomplete data, thus improving the validity of the study (Goldstein 1995). The model was developed using 229 stroke patients and its predictive performance was validated in an independent cohort of 710 stroke patients who were matched for age, gender, ethnicity and level of function. Both ischemic and haemorrhagic stroke patients were eligible for inclusion. Patients were excluded if they could not transfer from bed to chair independently or with the help of their usual caregiver. Clearly, patients included in the study had a relatively good level of physical mobility and, therefore, this is not necessarily a representative sample. This limits the validity of this model if used with more severely impaired individuals. The authors dismiss the importance of this, stating that more severely impaired patients do not usually receive rehabilitation and discounting the relevance of this model for that sub-group. This controversial opinion disregards the 8 -11% of patients who, despite severe upper and/or lower extremity paresis on admission, do go on to achieve functional independence after a period of rehabilitation (Olsen 1990).

Clearly, there are a huge number of outcome measures designed to predict recovery from stroke and this is an ongoing focus for research. The measure or measures chosen by the clinician will need to reflect their patient group, locality and methods of treatment. Each patient and each stroke is individual and unique and this along with the time available and skill mix of the clinicians involved will also be a factor and may influence whether a single measure or 'basket' of measures is used.

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Physiotherapy after stroke

are the National Clinical Guidelines for Stroke being achieved in physiotherapy ?

Claire Moloney Senior Clinical Leader, Stroke Services, The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, Bournemouth, Dorset and **Shari Rone-Adams** (MSc supervisor)

A dissertation submitted in part fulfilment for the Master of Science in Neurorehabilitation, Brunel University, April 2008

BACKGROUND

Outcomes for stroke in England appear to be worse than many other European countries that spend less on their stroke services. As physiotherapists are an essential part of the specialist stroke team and the provision of stroke rehabilitation, it is appropriate that they are involved in any intervention to improve stroke outcomes in England. The National Clinical Guidelines for Stroke (NCGS) make recommendations regarding the timing of initial physiotherapy assessment, intensity of physiotherapy input and the opportunity patients should have to practice skills gained in physiotherapy whilst they are in hospital following stroke. At present, apart from the time taken to undertake initial physiotherapy assessment, there is no record of current inpatient physiotherapy practice in England following stroke or opportunity to determine whether NCGS recommendations are being achieved.

METHODS

A postal survey of physiotherapists working with stroke patients whilst they are in hospital was undertaken. Eligible physiotherapists were recruited through the Association of Chartered Physiotherapists Interested in Neurology. Following pre-testing and piloting, a questionnaire was sent to 131 physiotherapists. Data was collected on the timing of initial physiotherapy assessment, intensity of physiotherapy input and patient opportunity to practice.

RESULTS

A response rate of 60% was achieved, with 67 physiotherapists taking part in the study. Ninety-five percent of respondents indicated that patients

are being seen by a physiotherapist within 72 hours. Key factors influencing the timing of this assessment are the day of the week the patient is admitted to hospital and their location within the hospital. Fifty-nine percent of respondents indicated that patients are not seen daily during the week by a physiotherapist and only 20% indicated having a weekend physiotherapy service available. Only 34% of respondents agreed that patients are receiving as much physiotherapy as they need and can tolerate, with the amount of physiotherapy time available being the key influencing factor. Forty-seven percent of respondents indicated that patients may not be getting the opportunity to practice skills gained in physiotherapy in their daily routine in a consistent manner. Key factors identified as influencing this are the ward staffing levels, the ability of the patient to practice and the rehabilitation knowledge of ward staff.

RECOMMENDATIONS

Further research is needed to establish the optimal amount of physiotherapy patients should receive whilst in hospital after stroke and whether certain patient groups would benefit more from physiotherapy than others. It will also be important to determine how to improve the opportunity patients have to practice skills acquired during physiotherapy in their daily routine in a consistent manner, in order to maximise the benefits of their physiotherapy and enhance their recovery.

CONCLUSIONS

A fuller understanding of both current and optimal physiotherapy practice and patient activity levels whilst in hospital after stroke is needed. This would provide more objective guidance within the NCGS which could be incorporated into the National Sentinel Stroke Audit. This may facilitate improvements in clinical practice.

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Association of Chartered Physiotherapists In Neurology

Revised constitution

November 2004 Revised from previous constitution dated November 2004 & 17th July, 1996

ACPIN are in the process of revising the group's constitution to reflect ongoing changes in healthcare delivery. As part of this procedure we wish to consult the membership for further comments and ideas. Please send any comments to Cherry Kilbride at cherry.kilbride@brunel.ac.uk by January 31st 2009. Comments will be collated and incorporated into a final document to be voted in at our AGM on March 21st 2009 before going on to be ratified by the CSP. Many thanks.

1. TITLE

- 1.1 This Clinical Interest Group shall be known as the 'Association of Chartered Physiotherapists In Neurology'. Herein referred to as ACPIN, or 'The Group'.

2. TERMS OF REFERENCE

- 2.1 To promote and facilitate collaborative interaction between ACPIN members across all fields of practice including clinical, research and education.
- 2.2 To promote evidence informed practice and continuing professional development of ACPIN members by assisting in the exchange and dissemination of knowledge and ideas within the area of neurology.
- 2.3 To provide encouragement and support for members to participate in good quality research (with a diversity of methodologies) and evaluation of practice at all levels.
- 2.4 To maintain and continue to develop a reciprocal communication process with the Chartered Society of Physiotherapy on all issues related to neurology.

- 2.5 To foster and encourage collaborative working between ACPIN, other professional groups, related organisations ie third sector, government departments and members of the public.

- 2.6 Any other objective not in conflict with 2.1 to 2.5 above which appears to be appropriate to the needs and interests of the members of ACPIN.

3. **ACPIN** shall not take any action or express any view which in any way affects or concerns the general policy of the Chartered Society of Physiotherapy (CSP) without the express agreement of the Council of the Chartered Society.

4. MEMBERSHIP

Membership shall be available upon completion of an application form and payment of the appropriate subscription in the following terms:

- 4.1 **Full members** shall be registered Chartered Physiotherapists in good standing with the CSP (This section includes CSP members who live overseas. This is the only group entitled to full voting rights).
- 4.2 **Associate members** shall have a professional interest in neurology and thus, in the opinion of the Executive Committee are suitable to become associate members of ACPIN. Associate members will not have the right to vote in any ACPIN election, nor to hold any elected post within ACPIN. Assistants whose names appear on the register maintained by the Chartered Society of Physiotherapy shall be eligible for associate membership.

- 4.3 Overseas members** shall be qualified Physiotherapists who are members of any professional body which is recognised by the CSP (ie belong to the World Confederation of Physical Therapists) and who are in good standing with that body.
- 4.4 Student members** shall be Undergraduate Physiotherapists who are student members of the Chartered Society of Physiotherapy.
- 5. REGIONAL STRUCTURE**
- 5.1 Application Procedure**
Applications for full, associate and student membership shall be submitted in the first instance to the Membership Secretary. A new member will be allocated to one Regional Group, according to the location of his or her place of work or residence in accordance with the map annexed hereto. A member who works or lives close to the boundary of any region may elect to join an adjacent region.
- 5.2 Capitation**
Regional Groups shall be entitled to receive a proportion of the annual subscription paid by each member allocated at a level determined by the National Committee.
- It shall be open to the National Committee to set different levels of local subscription allocations among Regional Groups.
- 5.3 Regional Constitutions**
Each Regional Group shall adopt a written constitution in accordance with guidelines at Appendix 1 of this constitution. A Regional Group may not amend its own constitution without prior agreement of the National Committee, signed by a resolution passed by a majority of committee members present.
- 6. EXECUTIVE COMMITTEE**
Shall comprise of:
- 6.1** Nine honorary officers: Chair, Vice Chair, Secretary, Treasurer, Membership Secretary, Research Officer, Public Relations Officer, Minute Secretary, Diversity Officer Post, or any others holding office in accordance with Clause 7.2 below.
- 6.2** Not more than four full members elected at the Annual General Meeting (AGM) who shall be entitled to serve as members of the Executive Committee for such period as shall be permitted in the case of an Honorary Officer.
- 6.3** The Executive Committee shall be empowered to co-opt four members to serve in addition to those elected members, should the need arise. The total number of co-opted members shall never exceed one third of the total membership of the committee. The Executive Committee hereafter referred to as Executive shall be responsible for the general management of the Group.
- 6.4** If any Executive Committee member fails to attend two-thirds of the yearly total of meetings without good reason, where good reason is decided at the discretion of the majority of the remaining Executive members, their term of office shall be deemed to have lapsed. The vacancy may be filled by the Executive Committee at its discretion.
- 7. THE HONORARY OFFICERS**
- 7.1** Only full members shall be eligible for election as Honorary Officers. Any candidate for election as an Honorary Officer must submit a written nomination, countersigned by at least two other full members to the Chair.
- 7.2** The Honorary Officers, whose numbers shall not exceed nine, shall comprise Chair, Secretary, Treasurer, Membership Secretary, Research Officer and Diversity Officer and such other officers that the Executive consider expedient for the efficient management of the affairs of the Group.
- 7.3** Honorary Officers shall be elected by ballot of enfranchised members of the group at the AGM, save and except the Chair, who shall be elected by a ballot of all Executive Committee Members at the first Executive Committee Meeting to be held after the AGM in the year of the Chair's retirement.
- 7.4** Honorary Officers will hold office for two years, and may offer themselves for re-election for not more than three consecutive terms. (Giving a maximum of six years service). A former Honorary Officer may offer him or herself for first election not less than two years after retirement from any earlier honorary office. An Honorary Officer may transfer from one honorary office to another for the aggregate length of continuous service. An Honorary Officer shall not exceed a period of six years, as set out above. (See exception below for Chair).

- 7.5 The Chair Person must be on the Executive Committee for a minimum of two years prior to becoming Chair for up to a maximum of four years ie two terms with at least one year prior to taking the Chair as Vice Chair.
- 7.6 In normal circumstances the Chair and Secretary shall not retire in the same year as each other.
- 7.7 Retiring Honorary Officers shall leave office at the AGM and newly elected replacements take office immediately, so that the Chair shall hand over office at the first National Committee Meeting following the AGM.
- 7.8 The Office of President shall be occupied by a person suitably qualified and distinguished who has been invited by the Executive Committee for a period not exceeding four years. The President shall be entitled to attend all meetings of the Executive, but shall not have voting rights.
- 7.9 Should any casual vacancy arise among the Honorary Office, except Chair, that vacancy shall be filled by co-option of a suitably qualified member of the Group, who shall hold office until the next AGM. A casual vacancy for the Chair shall be filled by vote of the National Committee as set out above. Any period of office served as a result of the appointment following a casual vacancy shall not count towards the maximum six year period of office for any member of the Executive Committee.
- 7.10 Committee members will hold office for two years and may offer themselves up for re-election for not more than two consecutive terms for a maximum of four years. However, a Committee Member who goes on to hold an Honorary Officer's post can remain in this Honorary post for up to six years, offering themselves up for re-election at two yearly intervals during this period. Thus maximum service on the Executive Committee can total ten years.

8. NATIONAL COMMITTEE

- 8.1 The National Committee shall consist of the Executive and one Representative elected from each Region. This may be the Regional Chair or the Regional Representative and shall be full members of the Regional Group whom they represent.

9. ANNUAL GENERAL MEETING (AGM)

- 9.1 The AGM shall be held in the month of March at a convenient time and place, to be decided by the Executive, providing that no more than 54 weeks shall elapse between AGM's.
- 9.2 Notice of the date, time and place of the AGM shall be given to all members by the Chair not less than 28 clear days in advance. Such notice shall be accompanied by a provisional agenda.
- 9.3 The AGM shall receive reports from the Honorary Officers, consider the accounts, and appoint an Auditor for the following year, hold elections for office by means of a secret ballot and transact such other business as notified to the Secretary in writing not less than 14 days before the said AGM.

10. EXTRA-ORDINARY GENERAL MEETING (EGM)

- 10.1 An EGM may be called by the Secretary upon receipt of instructions from the Executive or upon written representation from not less than one third of the full membership.
- 10.2 Not less than 28 days clear notice of an EGM shall be given, specifying date, time and place, to all members of the Group. Such notice shall also include an agenda which comprises a full and exhaustive programme for the business which is to be considered at any such meeting.

11. VOTING

- 11.1 All voting at Annual General Meetings or Extraordinary General Meetings shall be by secret written ballot conducted as directed by the Secretary. The Secretary shall devise ballot papers, a means of collection of the ballot and appoint tellers to count the ballot and inform the Secretary of the result which shall then be announced.
- 11.2 Any full member may appoint another full member to act as his or her proxy at any Annual or Extraordinary General Meeting by giving notice in writing to the Secretary. Such notice specifying whether the said proxy is directed to vote in accordance with the wishes of the members or given discretion in the casting of any vote.
- 11.3 Voting at all Committee Meetings shall be by a show of hands.

11.4 An Annual General Meeting or Extraordinary Meeting shall not be deemed quorate unless at least 50 full members, or one third of the total full membership attend, whichever be the less.

11.5 Any Committee Meeting shall require a quorum of not less than one third of the membership of the Committee.

12. WINDING UP / DISSOLUTION

The Group may be wound up by a resolution passed at an Annual or Extraordinary General Meeting supported by a simple majority of full members casting votes. In the event of a motion to wind the Group up being passed the assets of the Group shall be handed over to the Members Benevolent Fund of the Chartered Society of Physiotherapy.

13. AMENDMENT

This constitution may only be amended by a resolution passed by an Annual or Extraordinary General Meeting of the group provided:

13.1 The proposed amendment has been notified to the Secretary in writing and is supported by the signatures of not less than ten full members.

13.2 At least 14 clear days notice has been given to each full member of the proposed amendment.

13.3 The proposed amendment receives the support of at least two thirds of the votes cast at the relevant meeting.

13.4 The amendments must be approved at CIGLC and PPC at the Chartered Society of Physiotherapy.

APPENDIX

When formulating a Constitution, Regional Groups shall have regard to the provisions of the National Constitution, and in particular shall adopt the provisions of Articles 1 to 5 thereof.

Regional Groups shall make provision for the election of a Regional Committee not less than one month before each Annual General Meeting of the National Group.

That Committee must include a Regional Representative who shall serve for two years on the National Committee. It is envisaged that each Region will also elect a Secretary and a Treasurer. The same time limits on service on a Regional Committee shall apply as in the case of the National Committee and Executive.

Not less than four meetings should be required to be held each year within normal circumstances.

Quorum shall be one third of the Regional membership of ACPIN.

Amendment to the Constitution shall be at a Regional Annual General Meeting or Extraordinary General Meeting, but shall only take effect when it has been approved by Resolution of the National Executive and by CIGLC and PPC at the CSP.

Winding up shall be by resolution of the members, save that if full memberships falls below ten a Regional Group will be deemed to have been wound up and its remaining members shall be allocated to other convenient group(s).

Regional assets shall pass automatically to the National Group.

A copy of the Constitution of each Regional Group must be supplied to the National Honorary Secretary.

The appropriate provisions of this Constitution may be adopted by Regional Groups by the making of amendments to meet the specific needs of such groups. It is envisaged that each Regional Group will adopt this Constitution subject to such amendments.

ARTICLES IN OTHER JOURNALS

**AMERICAN JOURNAL OF PHYSICAL
MEDICINE AND REHABILITATION**
Volume 87:1

- Sheffler LR et al *Functional effect of an ankle foot orthosis on gait in multiple sclerosis: a pilot study* pp26–32.

Volume 87:8

- Alon G et al *Functional electrical stimulation (FES) may modify the poor prognosis of stroke survivors with severe motor loss of the upper extremity: a preliminary study* pp627–636.

**ARCHIVES OF PHYSICAL MEDICINE
AND REHABILITATION**
Volume 89:1

- Caty GD et al *ABILOCO: A Rasch-Built 13-Item Questionnaire to Assess Locomotion Ability in Stroke Patients* pp284–290.
- Chestnut C et al *Functional Significance of Ipsilesional Motor Deficits After Unilateral Stroke* pp62–68.
- Elrod CS et al *Determinants of Utilization of Physical Rehabilitation Services for Persons With Chronic and Disabling Conditions: An Exploratory Study* pp114–120.
- Malouin F et al *Reliability of Mental Chronometry for Assessing Motor Imagery Ability After Stroke* pp311–319.
- Niessen MH et al *Proprioception of the Shoulder After Stroke* pp333–338.
- Stoquart GG et al *Effect of Botulinum Toxin Injection in the Rectus Femoris on Stiff-Knee Gait in People With Stroke: A Prospective Observational Study* pp56–61.
- Strasser DC et al *Team Training and Stroke Rehabilitation Outcomes: A Cluster Randomized Trial* pp10–15.

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- Bovend'Eerd TJ et al *The Effects of Stretching in Spasticity: A Systematic Review* pp1395–1406.
- Fisher BE et al *The Effect of Exercise Training in Improving Motor Performance and Corticomotor Excitability in People With Early Parkinson's Disease* pp1221–1229.
- Morris JH et al *A Comparison of Bilateral and Unilateral Upper-Limb Task Training in Early Poststroke Rehabilitation: A Randomized Controlled Trial* pp1237–1245.
- Wain HR et al *Patient Experience of Neurologic Rehabilitation: A Qualitative Investigation* pp1366–1371.

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- Brauer SG et al *Prediction of Discharge Destination After Stroke Using the Motor Assessment Scale on Admission: A Prospective, Multisite Study* pp1061–1065.
- Noonan VK et al *Impact of Associated Conditions Resulting From Spinal Cord Injury on Health Status and Quality of Life in People With Traumatic Central Cord Syndrome* pp1074–1082.

CLINICAL REHABILITATION
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- Dalton C et al *A novel cause of intrathecal baclofen overdose: lessons to be learnt* pp188–190.
- Lennon O et al *A pilot randomized controlled trial to evaluate the benefit of the cardiac rehabilitation paradigm for the non-acute ischaemic stroke population* pp125–133.
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- Vickery CD et al *Self-esteem in an acute stroke rehabilitation sample: a control group comparison* pp179–187.

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- Klassen L et al *An exploratory study of two measures of free-living physical activity for people with multiple sclerosis* pp260–271.
- Lord S et al *How feasible is the attainment of community ambulation after stroke? A pilot randomized controlled trial to evaluate community-based physiotherapy in subacute stroke* pp215–225.
- McCullagh R et al *Long-term benefits of exercising on quality of life and fatigue in multiple sclerosis patients with mild disability: a pilot study* pp206–214.

- Vaz DV et al *Treadmill training for ataxic patients: a single-subject experimental design* pp234–241.

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- Brittle N et al *Short-term effects on mobility, activities of daily living and health-related quality of life of a Conductive Education programme for adults with multiple sclerosis, Parkinson's disease and stroke* pp329–337.
- Chang WC et al *Balance improvement in patients with benign paroxysmal positional vertigo* pp338–347.

- Meilink A et al *Impact of EMG-triggered neuromuscular stimulation of the wrist and finger extensors of the paretic hand after stroke: a systematic review of the literature* pp291–305.

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- Bakhtiary AH and Fatemy E *Does electrical stimulation reduce spasticity after stroke? A randomized controlled study* pp418–425.
- Britton E et al *An exploratory randomized controlled trial of assisted practice for improving sit-to-stand in stroke patients in the hospital setting* pp458–468.
- Coote S et al *The effect of the GEN-TLE's robot-mediated therapy system on arm function after stroke* pp395–405.
- Dahl AE et al *Short- and long-term outcome of constraint-induced movement therapy after stroke: a randomized controlled feasibility trial* pp436–447.
- Moseley AM et al *Serial casting versus positioning for the treatment of elbow contractures in adults with traumatic brain injury: a randomized controlled trial* pp406–417.

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- Dalemans R et al *Measures for rating social participation in people with aphasia: a systematic review* pp542–555.
- Donovan K et al *Mobility beyond the clinic: the effect of environment on gait and its measurement in community-ambulant stroke survivors* pp556–563.
- Ma H et al *Handle size as a task constraint in spoon-use movement in patients with Parkinson's disease* pp520–528.

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- Braun S et al *Using mental practice in stroke rehabilitation: a framework* pp579–591.
- Krause P et al *Changes in spastic muscle tone increase in patients with spinal cord injury using functional electrical stimulation and passive leg movements* pp627–634.
- McGrath JC *Fear of falling after brain injury* pp635–645.
- Page SJ et al *Resistance-based, reciprocal upper and lower limb locomotor training in chronic stroke: a randomized, controlled crossover study* pp610–617.
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- Plummer-D'Amato P et al *Interactions between cognitive tasks and gait after stroke: A dual task study* pp683–688.
- Yang YR et al *Relationships between gait and dynamic balance in early Parkinson's disease* pp611–615.

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- Unsal-Delialioglu S et al *Effects of ideomotor apraxia on functional outcomes in patients with right hemiplegia* pp177–180.

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- de Abreu DCC et al *Muscle hypertrophy in quadriplegics with combined electrical stimulation and body weight support training* pp171–175.
- Salter KL et al *Health-related quality of life after stroke: what are we measuring?* pp111–117.

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- Michal Emanuel M et al *Effect of Focus of Attention and Age on Motor Acquisition, Retention, and Transfer: A Randomized Trial* pp251–260.

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- Page SJ et al *Modified Constraint-Induced Therapy in Chronic Stroke: Results of a Single-Blinded Randomized Controlled Trial* pp333–340.

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- Blum L and Korner-Bitensky N *Usefulness of the Berg Balance Scale in Stroke Rehabilitation: A Systematic Review* pp559–566.

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- Ellis T et al *Effectiveness of an Inpatient Multidisciplinary Rehabilitation Program for People With Parkinson Disease* pp812–819.

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- Deutsch JE et al *Use of a Low-Cost, Commercially Available Gaming Console (Wii) for Rehabilitation of an Adolescent With Cerebral Palsy* doi:10.2522/ptj.20080062.

PHYSIOTHERAPY RESEARCH

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- Tessem S et al *Weight distribution in standing and sitting positions, and weight transfer during reaching tasks, in seated stroke subjects and healthy subjects* pp82–94.

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- Pyöriä O et al *Validity of the postural control and balance for stroke test* pp162–174.

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- Ansari NN et al *Inter- and intrarater reliability of the Modified Modified Ashworth Scale in patients with knee extensor poststroke spasticity* pp205 – 213.

- Fulk GD et al *Clinometric properties of the six-minute walk test in individuals undergoing rehabilitation poststroke* pp195 – 204.

NEWS ACPIN

The National Clinical Guidelines for Stroke 2008

Nicola Hancock ACPIN representative to the Intercollegiate Stroke Working Party at the Royal College of Physicians

The Guidelines Process

The Clinical Effectiveness and Evaluation Unit Stroke Programme at the Royal College of Physicians is guided by the Intercollegiate Working Party for stroke (IWPS). The IWPS is made up of representatives from those organisations which support the different disciplines involved in the management of stroke across the country and patient organisations. It includes the development, updating and coordination of guidelines, patient information and clinical audit.

Physiotherapists are key members of the IWPS team and the lead representatives – Dr Sheila Lennon for the CSP, Christine Fitzpatrick for AGILE and Nicola Hancock for ACPIN – are supported and informed by a team of peers with a special interest in specific areas of stroke rehabilitation.

National Clinical Guidelines for Stroke were first published in 2000 with an update supplement in 2002. The work on updating continued, with a second edition published in July 2004. The new, third edition of the guidelines, incorporating recommendations on acute stroke management made by the National Institute for Health and Clinical Excellence (NICE), was published in summer 2008.

The 2008 Guidelines

The newly updated Royal College of Physicians stroke guidelines are the authoritative guide to evidence-based practice for people with stroke. The aim of the guidelines is to help clinicians keep up-to-date in their practice and to make commissioners, patients and carers aware of best practice for stroke recovery and rehabilitation.

The strength of these guidelines is that they provide a thorough review of the relevant literature, which has been appropriately interpreted by a multidisciplinary working party representing all key stake holders involved in stroke care.

If the guidelines are embraced by trusts, and in particular those that commission stroke services, they become a powerful tool for ensuring that the expected standard of care delivered to every patient and their family is the same – independent of geographical location.

Following the introductory chapter 1, the new guidelines document is structured in the following way: Chapter 2 addresses the commissioning of services, a major change from the second edition; chapter 3 focuses on systems underlying stroke management; chapter 4 on acute phase care; chapter 5 on secondary prevention and chapters 6 and 7 present guidelines on the recovery phase from impairments and active rehabilitation, and longer term management.

This is the first time that the guidelines have specified the intensity of therapy that should be delivered. Adequate resources will need to be made available to ensure that it is possible to deliver this intensity of therapy, an important challenge for commissioners and service leads.

Studies on well-organised services in the UK show that it is rare for patients to receive more than two hours therapy each day; comparative studies in Europe suggest that in the UK face-to-face therapist-patient contact time is lower than in other countries.

Recommendations

- **3.13.1A** Patients should undergo as much therapy appropriate to their needs as they are willing and able to tolerate and in the early stages they should receive a minimum of 45 minutes daily of each therapy that is required.

- **3.13.1B** The team should promote the practice of skills gained in therapy into the patient's daily routine in a consistent manner and patients should be enabled and encouraged to practice that activity as much as possible.
- **3.13.1C** Therapy assistants may facilitate practice but should work under the guidance of a qualified therapist.

Included in the current document are 21 recommendations considered by members of the working party to be the essential foundations of good quality stroke care. The recommendations particularly relevant to physiotherapy are:

- **3.2.1.C** All patients discharged home directly after acute treatment but with residual problems should be followed up by specialist stroke rehabilitation services at home.
- **3.3.1.A** Each acute stroke unit should have immediate access to:
 - medical staff specially trained in the delivery of acute medical care to stroke patients, including the delivery of thrombolysis and the diagnostic and administration procedures needed for safe effective delivery of thrombolysis,
 - nursing staff specifically trained and competent in the management of acute stroke, covering both its neurological and its general medical aspects,
 - imaging and laboratory services and
 - rehabilitation specialist staff.

The Concise Guide

Another change of note to ACPIN members is the inclusion of the *Physiotherapy Concise Guide* as part of an overall profession-specific concise guide section at the end of the complete tool. This has ensured that key recommendations to the profession are available immediately on publication with no delay whilst the separate tool was compiled.

Conclusion

The physiotherapy members of the working party hope that all physiotherapists involved in the management of stroke will utilise the new guidelines, to ensure that practice is informed by current evidence and patients and their carers experience high standards of rehabilitation regardless of their geographical location.

For more information and to purchase a copy of the guidelines please call 020 7935 1174 ext 358 or visit: www.rcplondon.ac.uk/pubs/brochure.aspx?e=250

Membership Update Important Information for 2009

Well done to all who have successfully negotiated the new online registration for 2008! We would like to update you on what will happen next.

Registration for 2008 with close 31 October 2008.

Registration for 2009 will open online 1 December 2009.

All members MUST go online to update or validate their details for 2009 to activate their membership. Even if you pay by direct debit, you must update or validate your details to be a current member beginning January 2009. If you currently pay by cheque, and would like change to paying by direct debit, there will be an option to do this as well.

Any queries, please contact: Sandy Chambers, Honorary Membership Secretary, at email: memsec@acpin.org

Feedback from the ACPIN National Conference and AGM 2008 – Acquired Brain Injury – competency with the complex

Louise Rogerson Honorary Minutes Secretary ACPIN Executive Committee

ACPIN organise conferences on a regular basis, and at each conference delegates are requested to complete a feedback form. These feedback forms are collated to provide feedback to the speakers, advise the committee of the merits of individual components of the conference, and to inform the planning of future conferences.

From this year's conference, we received 129 feedback forms. A list of the lectures is shown in *Table 1*, and a summary of the feedback scores in *Table 2*. All lectures were listed as 'about right' on level of content, the scores are for usefulness with 1 for very useful, 2 useful, 3 OK only, 4 not useful, and 5 no use at all.

We also received a large proportion of free text comments, these are much harder to collate, but they are all reviewed to pick out key themes. The key themes from this conference are summarised below with the ACPIN response.

Comment The physiotherapy presentations were frequently commented upon with a request for more case studies, video clips, and clinical treatment based presentations.

ACPIN response ACPIN will seek to include more of these presentations in the future.

Comment The patient presentation was well received, but there were requests for more of a critique of the physiotherapy treatment to be included and more of a question and answer session.

ACPIN response It is very difficult to get patients who are willing and able to present to such a large audience and so ACPIN are looking at a number of different options for this type of lecture. The options will include involving the treating physiotherapists in the presentation with the patient, a panel discussion including one or more patients, or working with patients to produce the presentations.

Comment There were a number of requests for car sharing information and clearer information about accommodation for the night before the conference.

ACPIN response The committee are seeking to produce a delegate list on the website for those interested in car sharing. It will need to be included in the application form as a request to share the information. Hotel information will be provided for the night before conference at the next residential event.

Comment A suggestion was made to provide time for the delegates to network with their regional representative.

ACPIN response This will be included in the next conference.

Lecture	Lecture title
1	Intensive care management of traumatic brain injury
2	Physiotherapy management in early brain injury: practical, proactive intervention
3	Cochrane review: Botulinum toxin for spasticity in non-progressive brain lesions
4	Interactive poster session
5	New technologies for rehabilitation of traumatic brain injury
6	Service provision in Acquired Brain Injury rehabilitation: current drivers
7	Unsticking the stuck: physiotherapy challenges in post acute brain injury rehabilitation
8	Challenging behaviour after brain injury: the physiotherapist's role
9	A patient's perspective
10	Discharged and forgotten: managing the effect of minor brain injury
11	Physiotherapy in research

Table 1 Lecture titles

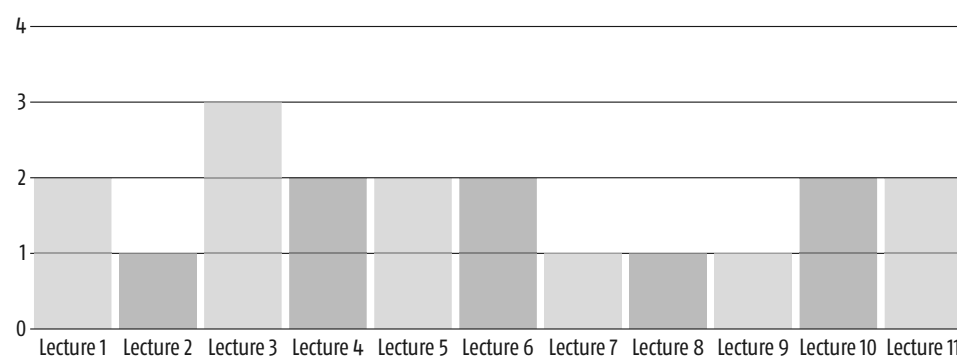


Table 2 Scores

Comment There were several comments about the quality of presentations and the availability of handouts. Specific requests were made for complete reference lists.

ACPIN response The committee will seek to review presentations prior to the conference and address any sizing issues to improve visibility for the audience. With regard to handouts or access to the presentations on the website, very few speakers will give permission for the publication of their work. Where speakers are prepared to share their work, the email address for the speaker will be made available for delegates to contact them directly. This is in line with

other conferences. Speakers are asked to provide a full reference list with their abstract, this will be re-iterated for the next event. All comments about the venue have been shared with the hotel.

ACPIN will continue to use the feedback from delegates to improve conferences on an ongoing basis. Thank you to all who took the time to complete their feedback forms, and thank you to all those whose contribution produced such a successful conference.

Guidance for applicants for ACPIN research bursary

The ACPIN research bursary exists to support members undertaking small scale clinical research projects and research projects for masters and doctoral degrees. It is awarded twice yearly. Up to £1000 is available to the successful applicant. Successful applicants are then invited to publish all or part of their study in *Synapse*. If you think you may have a project which may be suitable please feel free to discuss it with me, via email at julia.williamson@nuth.nhs.uk it's not that scary – honest.

ACPIN offers a research bursary to members. The purpose of the award is to encourage research activity among the membership and to assist members undertaking research as part of their current workload or undertaking research as part of an educational course. Bursaries of up to £1,000 are available to cover research-related costs.

Awards

- The maximum award is £1,000.
- Awards made cover research-related costs in relation to a specific project eg equipment; materials/consumables; specialist software; travel expenses.
- Awards will not be granted to cover the following: course fees; computers, staff time (secretarial support of data entry; blinded Rx)

Eligibility

- Applicants will be full members of ACPIN of at least two years standing.
- Applicants will be resident in the UK.
- Research must be related to physiotherapy for neurological conditions.
- Members conducting research as part of an educational course are eligible to apply for support.
- Applicants must be the lead researcher on the proposed project.
- Applicants cannot apply for more than one bursary.

Application Procedure

- Applications for the award must be submitted on the standard application form downloadable from the website or obtained from the Honorary Research Officer.
- Applications will be considered twice annually. Completed application forms must be received by 1st December or by 1st June for consideration at the National Committee meetings in January and July respectively.
- An application once submitted may only be re-submitted upon invitation.
- Funds will only be released once the researcher demonstrates proof of ethical clearance.

Section 1

Applicants must include their ACPIN number. Applications received without an ACPIN number will be returned unread. This may mean that the deadline for submission is missed.

Section 2

Detail must be provided as to what the bursary will be spent on. For example; participants' travel expenses must be broken down into number of participants, number of journeys, exact cost of each journey. Equipment must include manufacturer and cost including VAT.

Section 3.

Should be no more than 250 words excluding references. Applications received without reference to the literature will not be considered. References should be listed in a recognised style. This section should place the project and the chosen methodology in context both clinically and in light of available literature.

Anonymised applications will be considered in competition bi-annually. Completed applications will be considered and graded independently by members of the ACPIN Research Committee.

Recommendations for awards will be reviewed by an independent expert referee should the research committee feel they cannot adjudicate or in the event of a conflict of interest. Awards will not be given automatically for each competitive round. Applicants will be informed of the decision of the

2009 ACPIN national conference The upper limb – reaching into the future

March 21st 2009

Call for posters

Do you have a piece of work relating to the rehabilitation of the upper limb that you would like to share with your colleagues? A small pilot study or audit perhaps? Or maybe a case study detailing the use of technology, a new technique or management of spasticity? Are you a student or recently graduated physiotherapist who would like to share the results of your BSc or MSc dissertation? Then this is the forum for you.

You will have the opportunity to display a poster in a supportive environment created to highlight

new work. You will be able to discuss your ideas with your peers and network to expand your plans.

It really is not as daunting as you think and may help you achieve your KSF requirements! Support can be offered in the development of your idea although ACPIN cannot print the posters themselves.

ACPIN is pleased to announce that a prize of £50 will be awarded to the best poster, to be judged on the day.

Please contact Julia Williamson (Hon research officer) via: Julia.Williamson@nuth.nhs.uk or 0191 282 1841 for additional information.

Deadline for expressions of interest is 11 January 2008.

committee within two months of the application deadline. The decision of the committee is final.

Terms and conditions

- Awards are made on the understanding that the investigations comply with ethical and safety requirements of the involved institutions. Evidence of ethical approval and insurance arrangements may be requested.
- Bursaries must be used solely for the purposes set out in the application procedure. Any changes in proposed expenditure must be agreed to by ACPIN. At the end of the research project, any remaining balance should be returned to ACPIN.
- A summary of expenditure accompanied by receipts (where appropriate) will be required.
- ACPIN must be notified of any further changes in the proposed project eg timescales etc.
- Recipients of a research bursary will be required to produce a report for *Synapse* on completion of the research project. The report will be expected within six months of completion of the project.
- ACPIN is not responsible for any additional costs not covered in the original application.

Information Mapping Team

- Are you an ACPIN member?
- And a senior practitioner?
- In a clinical, managerial or research role?
- And contactable by email?

Then you are invited to join ACPIN's Information Mapping Team...

We occasionally need to gather opinions, comments and informed perspective at a local, regional or national level to help guide ACPIN's position on topical issues and we would like your help to do this.

What's in it for me?

- Contribute opinions which will shape neurological physio practice
- Links with your KSF evidence
- Be the first to know what is going on in neuro-rehab: clinically, politically and managerially

Please contact your regional representative (details on www.acpin.net) for more information

...because the more the merrier!

FOCUS ON...

The Paralympics

Emma Proctor North Trent Regional Representative

Hopefully the glow of team GB's success in the Olympics hasn't worn off yet. Whilst watching the spectacle that sport can give us it is sometimes easy to forget all the work that goes on in the background - one such individual is physiotherapist Sarah Leighton whom we caught up with just before she left for Beijing.

Sarah is a Senior I Physiotherapist at the Princess Royal Spinal Injuries Centre at the Northern General Hospital in Sheffield and was on her way out to the Paralympics to work as a classifier for the wheelchair rugby.

Wheelchair rugby (originally called murderball) was developed in Canada in 1977 by a group of tetraplegic athletes, who had insufficient hand and arm function to participate equally in wheelchair basketball. It has elements of basketball, ice hockey and rugby – the object of the game is to carry the ball across the opposing team's goal line. Two wheels must cross the goal line for a goal to count, and the player must have firm control of the ball when he or she crosses the line.

The majority of wheelchair rugby players are tetraplegics. Other disability groups who are represented include polio, cerebral palsy, some forms of muscular dystrophy, amputations, and other neurological conditions such as Guillain-Barré. Men and women are classified equally and compete on the same teams; there are not separate teams for men and women's competitions. It was recognised as a Paralympic sport in 1996 in Atlanta and became a full medal sport in 2000 at Sydney.

All the players are classified the week before the opening ceremony. As with all disabled athletes they are designated into a 'class' – for wheelchair rugby between 0.5 and 3.5. The cumulative score of the four-man team must not exceed 8. This ensures that teams are fairly matched. Classifying

an athlete is a complex assessment process.

Firstly, classifiers assess muscle strength, range of movement, sensation, and muscle tone. There is a functional assessment observing balance, how they propel their chair and their ability to throw and catch. The athlete is then observed performing both ball handling and wheelchair skills prior to and during game play, if necessary. In addition, the athlete's execution of ball and wheelchair handling skills are observed on court during actual game play.

It is a little different from assessing people for rehabilitation but Sarah feels that the experience from working in rehabilitation definitely helps. Cheaters are uncommon but mistakes in classification will occur and adjustments to their class are made accordingly including once the tournament has started. If players are found to be intentionally cheating or non-cooperative with the process of classifying they can be disqualified. If they are cheating it is generally revealed in game play where it is harder to cover things up – therefore the classifiers have to watch all the matches.

Sarah became a classifier back in 2000, when she attended a wheelchair rugby game with a colleague who happened to be a classifier and suggested that she train as one as well. The training is on the job. You start as a trainee classifier working along side another. You can then work your way from level 1 up to a level 4. Sarah became a level 2 international classifier in 2002 and a level 4 in 2007. You don't have to work within spinal injuries to become a classifier however you do need to use manual muscle testing as part of your day to day job. Classifiers are not all physios either, there are also doctors, sports scientists and OTs. Although Sarah has eight years experience working in spinal injuries (she qualified in 1997 and became a Senior II on spinal injuries in 2000) you don't need a lot of experience to become a classifier and they are

always looking for more. It does, however take up a lot of your spare time, Sarah has given a lot of weekends but there are a lot of plus sides.

The work is essentially voluntary you get expenses paid and sometimes a nominal fee. On occasion you may even get a free t-shirt! For Beijing, Sarah will stay in the athletes village and be provided with a uniform. It is really important that you stay impartial so that means she can't help out or socialise with any of the athletes and as Sarah says she can't go around festooned in the Union Jack singing the National Anthem. However she will be able to spectate at other Paralympic events and will have time for some sightseeing.

Sarah does all this in her spare time and is taking annual leave to go out. In the past people got unpaid or sometimes even paid leave but the financial climate in the NHS has changed. However she feels its worth it and knows some of the other classifiers so they will be able to socialise and see some of the sights Beijing has to offer.

On a more serious note it is important to remember the influence of sport on rehabilitation. Those playing at the Paralympics are at the top of

the sport – there are many playing in local teams or just starting a wheelchair sport not long after injury.

At the spinal injuries unit the athletes start playing sport in gym sessions as soon as they can mobilise in a chair. It helps with strengthening, balance and fitness, which has a positive effect on their functional rehabilitation. It also provides peer support, helps with socialising and return to normal. Some of the players come back to the spinal injuries unit specifically to talk to the newly injured clients. Sport as rehabilitation in something that spinal injuries units do best. Sarah couldn't comment upon why that was, maybe it is the younger client group but maybe other areas of rehabilitation has something to learn from the way sport is used for such positive effect.

So next time you see any disability sport, have a thought for all those in the background or if you are interested in becoming a classifier yourself Sarah would be happy to hear from you on seleighton@hotmail.com

For more information about wheelchair rugby go to www.GBWR.co.uk or www.iwrf.com

The client's future?

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SHARING GOOD PRACTICE

A therapy led bed service at a community hospital

Bhanu Ramaswamy Consultant Physiotherapist in Intermediate Care

Derbyshire County Primary Care Trust (DCPCT) provides for a total population of 710,000. The older people services for Chesterfield, a town in the north of the county have been developed in a community hospital into a tri-faceted system better utilising expert clinical skills of their consultants. The hospital's two consultant geriatricians, a nurse consultant and a consultant physiotherapist each have responsibility for a different ward at the hospital, and collectively provide for the health needs of the local older population who require sub-acute hospitalisation. The nurse consultant admits patients with sub-acute conditions from home to avoid admission to the acute hospital, the geriatricians admit a frailer older population for rehabilitation, and as the consultant physiotherapist at the PCT, I admit a more medically stable older patient for rehabilitation. This report shares aspects of my practice with you, in leading a therapy-led in-patient rehabilitation service for older people.

BACKGROUND

In 2001, a review of the PCT and Derbyshire Social Services Strategy for Older People highlighted the need for additional services to meet the demands for provision on the increasing older population.

The National Health Service Plan (Department of Health 2000) had set out key ideals focussing on promotion of independence for older people and in particular, on care closer to home. These objectives were further detailed in the National Service Framework for Older People (DH 2001) advocating the development of community-based services to prevent avoidable acute admissions and to provide a seamless transition for patients from hospital to home. The financial resources

that accompanied these initiatives permitted the development of Intermediate Care (IC) services across DCPCT.

As part of the newly agreed services, a nurse consultant for older people was appointed in 2003 to set up a pilot service working alongside the hospital geriatricians. The evaluation of the six to eight nurse-led rehabilitation beds was positive in terms of a reduced average length of stay, decreased re-admission rates, improved physical functioning, and patient/carer satisfaction (Rawle 2004). This review paved the way for the second phase of the pilot, with the advertisement of a consultant allied health professional (physiotherapist or occupational therapist) in intermediate care (IC) to complete the service development and to develop therapy-led beds.

I was appointed in January 2004 with the post part financed (0.2 WTE) by the Sheffield Hallam University (SHU), in line with the higher education institute's drive to produce 'lecturer/practitioner' posts with access to aid clinical research.

ABOUT THE THERAPY-LED BED SERVICE: HISTORY TO PRESENT DAY

Rehabilitation in this context involves a process of restoring maximum possible function (physical or mental), or role (within the family, social network or workforce*). It requires mixed professional input to address issues relevant to the person's physical and social environment, plus is expected to be responsive to users' needs and wishes (Audit Commission 2000).

As therapy input is the predominant active intervention for these patients, it was considered appropriate that a consultant therapist lead the interdisciplinary team (IDT). The therapy-led beds are conceptualised to offer an in-patient environment for active rehabilitation of older people who satisfy the IC criteria (*Table 1*).

The admission protocols were developed during

* 'Workforce' remains an appropriate term with the older population given the rising age proposed for retirement, plus the fact that increasing numbers of older adults in Derbyshire remain in employment (especially in family run farms and businesses) or work in a voluntary capacity.

DH (2001) IC criteria
<ul style="list-style-type: none"> • Patient is aged 60 years or over. • Intervention is designed to maximise independence, enabling a patient to remain or resume living at home. • Provided on the basis of a comprehensive assessment, with a resultant, structured individualised care plan involving active treatment and rehabilitation. • Involves short-term interventions typically lasting no longer than six weeks, and frequently less time than that.
Patients must be medically stable, with the cause of admission, plus results of investigatory tests available.
Patient and their family must have realistic goals.

Table 1 Admission criteria to a therapy-led bed

a six-month preparatory period for agreement through clinical governance: these are updated as and when service developments occur. Initially regular 'stakeholder' meetings were held to ensure smooth transition of staff into the newly proposed service. As the ethos of the therapy-led beds was a move away from the conventional medically led, multidisciplinary model of rehabilitative care to an interdisciplinary rehabilitation service, training on issues such as 'interdisciplinary working', or on the use of specific measurement tools such as the Functional Independence Measure (FIM) was necessary prior to the beds becoming active.

With regards to medical cover, a GP with a special interest in intermediate care (GPwSI) was employed to provide routine medical support for the therapy beds. To ensure provision of basic clinical skills across the three consultant positions for the older rehabilitation services I have since trained in first contact practice (FCP) and non-medical (supplementary) prescribing (NMSP) which have developed my recognition of illness patterns in the patients, assuring detection of deterioration and enabling swift intervention when necessary (DH 2005, Sheffield Hallam University 2004).

The medical consultant ceased to admit patients from June 2004 and the ward became operational as a combined nurse and therapy led rehabilitation ward.

Now the service is established, admissions are co-ordinated through the PCT Admission, Discharge and Transfer Team, rather than my physically going out to screen each potential patient. Senior ward team members have the authority to admit and discharge patients in my absence according to the admission protocols.

Currently, the twelve therapy-led beds (TLB) are housed on Amber Ward at Walton Hospital, and allocated according to the patient needs described in Table 2:

Bed type	Description
Therapy beds	For older people with general rehabilitation needs (anticipated to take up 65% of bed allocation); patients can be transferred from other hospitals for ongoing rehabilitation, or come straight from the community, thus avoiding an acute admission if they fulfil admission criteria
Surgical beds	For those who have undergone orthopaedic or spinal surgery, plus require specialist input from a visiting orthopaedic registrar (anticipated to take up 35% of bed allocation)
Podiatric beds	For those admitted following podiatric surgery who required short stay (five days) in-patient rehabilitation with no more than one person allocated to the ward at a time.

Table 2 Allocation of therapy beds

A list of 'diagnostic reasons' records the reason patients are referred for rehabilitation. Examples from each category might be as follows:

- **Medical** Myocardial infarction, urinary tract or chest infection, cellulitis
- **Falls** From known medical or neurological cause; those with no cause identified; mechanical fall. Fallers still constitutes the largest number of patients requiring rehabilitation
- **Orthopaedic/rheumatological** Exacerbation of osteoarthritis or low back pain decreasing mobility; recent orthopaedic surgery e.g. knee or hip replacement with post-op complications
- **Surgical** Vascular eg amputation; spinal eg decompression; cardiac eg pacemaker
- **Neurology** Decreased mobility from stroke or Parkinson's Disease – these are the patients we sometime organise admission for in the hope of pre-empting crises by topping-up functional ability.

EVALUATION OF THE THERAPY-LED BEDS

Evaluation of the therapy-led beds utilises both service and patient outcome data and I attempt to produce an annual report for the PCT. Some results from 2007 are provided in Table 3:

'Readmission' is calculated on the basis of rehabilitative success, as the ultimate goal of rehabilitation is for a return home with necessary support on discharge.

The 20 people admitted for an acute hospital review required medical investigation for conditions such as seizure, cardiac complications etc all without the remit of a physiotherapist, hence not regarded as a 'readmission' for the purposes of this report.

Length of stay (Table 4) is determined in two ways; the number of nights a bed was occupied,

Data	Numbers split to bed types
Admission numbers	134, with 2–3 admissions per week
Ages of patients – three are below admission criteria age group	Population mean = 80 years; Median = 82 years Range 48 – 95 years
Readmissions numbers – ie within one month of discharge	1 back to Walton 20 to the Acute Trust
Occupancy	91.6% – above required National Standard of 85%

Table 3 Outcomes and information about therapy beds from 2007

Data	Numbers of days split to bed types
Average length of stay for all admissions	29 days
Range for the length of stay	1 – 143 days
Average length of rehabilitation days	24 days
Range for rehabilitation days	4 – 117 days
Number with a timely discharge	51% (69 patients)

Table 4 Details of length of stay

plus the number of days taken for the patient to complete their rehabilitation process ie *rehabilitation days*. I record the latter as the process of rehabilitation does not always run smoothly, especially with the older population; illness and lack of discharge support often prolong the rehabilitation period and this not only has financial implications to the Trust, but more importantly can erode the patient's confidence in their own ability if they are not discharged at the optimal time. This is backed by the PCT use of the 'Jonah' system.

We use the 8-category tool developed for use in community care that categorises by patient need (Enderby and Stevenson 2000) to monitor the appropriateness for rehabilitation on a therapy-led bed. The majority of patients admitted to a therapy bed meet the criteria for categories 5 and 8 of this tool where category 5 patients include patients who require intensive rehabilitation in either a rehabilitation ward or intermediate care setting, and category 8 patients are considered those who require rehabilitation for complex profound disabling conditions, which can be given by a specialist multidisciplinary team and on a rehabilitation ward setting.

In 2007, 59 patients (44%) were recorded under

category 5 and 70 (52%) category 8 at admission. By discharge, 54 patients (40%) had progressed in their ability to be classed under category 1 which means they were carrying out their own exercises to maintain their condition without specialist input, and 56 (42%) were category 5 requiring further rehabilitation, but which could be carried out in the home setting by the intermediate care team we referred to for follow-up intervention on discharge. These results demonstrate a shift in rehabilitation trend from complexity of need at admission toward more self care by discharge.

Finally, a record of the patient's verbalised goals of rehabilitation is made at admission, and on discharge or at follow-up discussions with the patient, the achievement of goals are agreed as 'Achieved in full' (78% in 2007), 'Partially achieved but more than half' (7%), 'Partially achieved, but less than half' (1%) or 'Not achieved' (0). For those not capable of setting goals, a 'Not applicable' (14%) category is recorded.

On average, each patient stated three personal outcomes they expected from their period of rehabilitation. Where possible, goals were revisited, and occasionally revised, and some were specifically discussed with family members.

The goals ranged from statements about discharge destination eg a wish to be able to return home following rehabilitation, to personal needs eg to be able to walk independently, or a wish to be independent with personal and domestic activities of daily living, to expectations of support eg a wish for help from Social Services at discharge.

Since an Interim report of the therapy-led beds (Ramaswamy 2005), no further details have been taken on the profession of the referrer as the profession of the referrer is of little consequence now the therapy-led bed service is established and functioning well

STAFFING FOR THE UNIT

Staffing (Table 5) varies with annual leave, study and sickness, and occasionally the ward has only a 1:2 skill mix of nursing staff to cover earlier and afternoon shifts, and therapists are rarely replaced during periods of leave due to the numbers already spread across the hospital.

THE FUTURE

I am sure I am no different to other therapists in that I have a long 'to do' list. The most pressing are:

- To look into the use of the International Classification of Functioning and Disability tools to record performance as the therapies utilised in general elder rehabilitation are most influential on the areas of activity and participation.

Profession	Numbers	Comments
Physiotherapy	0.5 WTE Consultant (Band 8B)	Provides leadership, physiotherapy, first contact practice input and supplementary prescribing.
	0.8 WTE Band 5 0.8 WTE Band 3 (PTA)	Physiotherapy assessment and intervention
OT	1 WTE Band 6 0.8 WTE Band 3 (OTA)	OT assessment and intervention OTA and PTA lead morning exercise class 3 to 4 times per week with assistance from N/As
Medical cover	GP w SI 3 sessions Visit from an orthopaedic registrar twice a week	The sessions are split between the ward and another IC facility and for general medical intervention Provides specialist orthopaedic assessment and advise to the patients on the Surgical-orthopaedic beds
Nursing	Ward Manger 1 WTE (Band vary from 1 to 8)	Nursing shifts vary allowing a pattern of ideal cover: Morning shift 2:2 of qualified: unqualified skill mix Afternoon also 2:2 Night shift 1:1
Care Manager		The ward has an allocated care manager who takes all the ward patients and acts as the one point of contact liaising with Main Stream (Community) Social Services

Table 5 Current staffing for the twelve beds

- As my specialism in older rehabilitation is neurological, I would like to work more with the community matrons establishing enhanced services for neurological patients, admitting for more holistic rehabilitation and maintaining their independence
- I am in the process, with other senior therapists across the PCT, of trying to standardise the outcomes we use and introduce a quality of life measure and consistent service satisfaction questionnaires across the rehabilitation services.
- Finally (for now), having just completed a formal service evaluation of the therapy beds showing no detriment to the patients under my care since the service was altered from a medically led one, I need to write this up for publication and boost the pitiful numbers of consultant therapists nationwide in this role.

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FIVE MINUTES WITH...

Mary Lynch Ellerington

Welcome to a new series in *Synapse* where ACPIN takes 'five minutes' to interview well known professionals about their views, thinking and influences on topics of interest to physiotherapists working in neurology.

We are delighted that Mary Lynch Ellerington FCSP, who is a past president of ACPIN agreed to be our first interviewee – thank you! Mary is also a renowned senior instructor of the International Bobath Instructors Training Association and a Fellow of the Chartered Society of Physiotherapy.

Who or what have been key influences on your clinical practice?

Most influential would be Jennifer Bryce. She was the Principle at the Bobath Centre from the early 70's until her untimely death in late 90's. Jenny was the most skilled practitioner of Bobath Concept I have ever seen. Her treatments were always exciting as her understanding of the clinical problems of patients was unique and her ability to facilitate movement control awesome.

The key influences on my clinical practice have been the study of neuro anatomy and neurophysiology of the central nervous system, initially starting with Geoffrey Kidd and his understanding of neuroplasticity. In the last 20 years I have continued to be mentored by Nigel Lawes. I truly believe you need to understand the system you are working with. I also believe if Bobath had met Bernstein it would have led to ultimate understanding.

How has neurophysiotherapy changed since you first qualified?

I qualified in the time of compensatory approach with tripod and slings, and nobody wanted to work in neurology because it was boring and largely manual labour. My career has spanned a time of great change where now neurology is one of the most exciting specialities.

If you were to give a newly qualified physiotherapist one small piece of advice today what would it be?

A good anatomical basis is really important, it has always been fundamental to my practice.

What article has inspired you recently?

Rosenkranz and Rothwell (2004) *The effect of sensory input and attention on the sensorimotor organisation of the hand area of the human motor cortex* from the Journal of Physiology 561 pp307–320.

Do you think some recent policy changes have an impact on the provision or development of effective management of patients?

Policy changes that have been the most damaging are the very restrictive manual handling policies in the UK – EC policy only practiced in Britain. Therapeutic handling is safe when well taught and underpins effective management of patients.

What do you think the future holds for neurophysiotherapy nationally/internationally?

Nationally – I think that it is going to be very challenging for neurotherapists to keep up to date and maintain an adequate CPD. An increasing number of therapists attending our courses do not get any funding at all. Some find it very challenging to get adequate support in the workplace to complete the project associated with the Basic Bobath Course and fewer and fewer apply to do an MSc. However there is such a great deal of talent within the profession if we can keep up the skill level and make sure that our profession maintain a commitment to rehabilitation and not go down the route of habilitation. Let us not lose sight of treating the impairment.

Internationally – well that depends where you go. Japan and South Korea have an excellent record of offering new hospitals totally ori-

entated to rehabilitation. However it is very challenging to teach the Bobath concept in some countries where rehabilitation has to take place in 13 days!

However I still enjoy my international teaching work very much.

What would be on your wish list for the future?

My 'wish list' is:

- More specialist nursing staff trained in therapeutic handling.
- A recognition that recovery can only come as a result of intensity of input and research trials that compare intensity with no intensity rather than one concept with another.
- More time in the garden?
- No more waiting in airports!



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ACPIN @ CSP Congress 2008

The CSP Congress this year was held in Manchester. In a change to the previous format it ran four programme strands. ACPIN was heavily involved in the production and running of the neurology strand.

Due to copyright the following abstracts are only a small selection of the lectures presented over the two days. Abstracts of all the lectures can be found on the CSP Congress website:

www.cspcongress.co.uk/neurology.cfm



ACPIN would like to thank Siobhan Macauley for her commitment and hard work in the planning and organisation of this event.

FRIDAY MOVING NEUROPHYSIOTHERAPY FORWARD KEYNOTE LECTURE

Evidence Based Balance Rehabilitation

Dr Anne Shumway-Cook PT PhD, Department of Rehabilitation Medicine, University of Washington, Seattle, WA

Purpose of the talk:

Review some of the research impacting balance rehabilitation, including:

- Sensorimotor basis for normal balance
- Factors contributing to impaired balance in neurologic populations
- Training to improve the underlying components of balance: is specificity required?

Biography

Dr Anne Shumway-Cook, a physical therapist, is a professor in the department of rehabilitation medicine at the University of Washington. Her clinical practice is currently focusing on two main areas: the management of the patient with balance and mobility impairments and the management of the patient with vestibular pathology. Her research interests include mechanisms underlying balance and mobility problems in geriatric and neurologic populations, and clinical methods for assessing and treating imbalance. Her book *Motor Control Theory and Applications* (Shumway Cook, Woolicott) is a staple of any rehabilitation physiotherapist's bookshelf. She has published over 50 articles and these are made meaningful for the practising physiotherapist as she bridges the gap between current motor control research and its application to clinical practice.

FRIDAY SESSION FOUR LECTURE 2

Coordination of reach-to-grasp following stroke

Paulette van Vliet PhD MSc B App Sc, Research Fellow, University of Birmingham

Recovery of upper limb movement after stroke is not ideal, with only 20% to 56% of patients regaining useful function in their arm after three months. One of the contributing factors is that the deficits in motor control in this group have not been characterised in sufficient detail, and so it has been difficult to formulate targeted treatments.

This presentation will focus on work that identifies deficits in coordination of reach-to-grasp after stroke, and provides a basis for hypothesising new interventions for patients.



The ACPIN Chairs, Jo Tucky (left) and Cherry Kilbride with keynote speaker Anne Shumway-Cook at the CSP Congress

Two experiments investigating coordination will be described. The first³ investigated whether a group of patients with hemiparetic arm movements had:

- temporal coupling of transport and grasp at the start of movement and at the time of peak deceleration,
- the ability to adjust transport appropriately for a different grasp size requirement, and
- to adjust grasp size for different movement speeds.

Twelve hemiparetic and twelve age matched normal subjects performed 32 reach-to-grasp movements in a laboratory setting, under four conditions: preferred speed to a large or small cup, and fast speed to a large or small cup. Motion analysis was used to collect information on kinematic variables. Both groups demonstrated a temporal coupling between grasp and transport components at the start of the reach and at the time of maximum aperture. Both groups increased the aperture of grasp for larger cups and increased the maximum grip aperture and had a shorter deceleration phase for faster movements. However, the deceleration phase of the hemiparetic patients was longer than normal subjects, and the components were not as tightly coupled.

The second experiment tested the hypothesis that when one component of reach-to-grasp is perturbed, in this case grasp size, people with stroke have an impaired ability to make appropriate on-line temporal adjustments in the other component, transport. Fifteen patients with a right parietal stroke and fifteen age matched normal subjects performed 60 reach-to-grasp movements. In one third of these movements, the object size was changed at movement onset, in order to examine the corresponding adjustment in the transport component. Motion analysis was used to collect information on kinematic variables. Preliminary results indicate that stroke subjects took longer to respond to the perturbation, and their response showed a later time to peak hand velocity and peak deceleration whereas healthy subjects showed a delay in peak deceleration only. This suggests some lack of skill in the stroke group.

An intervention for coordination, directly arising from these experiments has been formulated. This will be described and ideas for further interventions based on this work will be suggested. These experiments facilitate the process of translating findings of laboratory experiments to the formation of clinical interventions.

References

1. Parker M, Wade DT, Hewer RL (1986) *Loss of arm function after stroke: measurement, frequency, and recovery* International Journal of Rehabilitation Medicine 8 pp69-73.
2. Nakayama H, Jorgensen HS, Raaschou HO, Olsen TS (1994) *Recovery of upper extremity function in stroke patients: The Copenhagen Stroke study* Archives of Physical Medicine and Rehabilitation 75 pp394-398.
3. VanVliet PM, Sheridan MR (2007) *Coordination between reaching and grasping in patients with hemiparesis and normal subjects* Archives of Physical Medicine and Rehabilitation 88(10) pp1325-1331.

Biography

Dr Paulette van Vliet PhD MSc B App Sc is currently a Research Fellow at the School of Health Sciences at the University of Birmingham. She has worked as a physiotherapist in neurological rehabilitation in Australia, and completed her MSc in 1990 (Loughborough University) and her PhD in 1998 (University of Nottingham). Her research interests are recovery of upper limb motor control after stroke, evaluation and development of physiotherapy intervention for stroke patients, and motor skill acquisition following stroke. Past research has involved leading a randomised controlled trial comparing a Bobath-based and a Movement Science-based approach to stroke rehabilitation. Current research focuses on the temporal coordination of reach-to-grasp in patients with stroke and the effects of different types of feedback on motor learning after stroke. She has published widely and also lectures to post-graduate and undergraduate physiotherapy students on issues related to stroke rehabilitation.

SATURDAY PAEDIATRICS, MANAGEMENT AND SERVICE PROVISION LECTURE 1

"What's the point of rehabilitation – I've got a brain tumour?"

A study of patients' perspectives

Diz Hackman MSc Grad Dip Phy MCSP, Clinical Specialist Physiotherapist
Royal Marsden Hospital

Primary Brain Tumour (PBT) represents 2% of cancers and records the third highest mortality in cancer in the 18 to 35 age group in the UK today. Despite medical treatments improving, prognosis remains poor with surviving patients experiencing residual functional deficits. Rehabilitation for these patients is a scantily researched topic. Some quantitative studies demonstrate improved function following inpatient multi-professional rehabilitation. Others compare recovery in patients with PBT with differing oncological, and other neurological diagnoses. These all show similar functional improvements. A few qualitative studies explore patient's values regarding medical treatment demonstrating themes of hope and quality of life. Few studies have evaluated outpatient rehabilitation. No studies explore the meaning rehabilitation has for these patients.

This inductive study uses ethnography to explore the meaning rehabilitation has for people with this life limiting illness. It uses data from ten patients with PBT attending a specialist cancer hospital. It aims to give an insight into their perceptions of its role within their holistic management.

Data is collected from patients using written narratives, field-notes and interviews. Using thematic analysis, main emergent themes are presented. These findings are presented in an analogy offering an analytical framework to represent the impact and meaning of treatment and management of this patient group interpreted from their viewpoint.

This study concludes that physiotherapists and other rehabilitation professionals make important contributions to this patient group. It also identifies difficulty accessing services reported by patients. With equal access to cancer, rehabilitative and supportive services a key aim in healthcare today, advocated in national directives (NICE 2004, NSF 2004, NICE 2005, RCP, BSRM & NCPC 2008), it is essential that patients receiving medical treatment for a life limiting disease have timely access to rehabilitation services in conjunction with their medical treatment.

Biography

Since qualifying in 1990, Diz has specialised in the field of neurological physiotherapy within acute care, rehabilitation and community settings over the last twelve years. She has worked at The Royal Marsden Hospital for the past seven years using and applying this knowledge within oncology and palliative care.

Her current role as Clinical Specialist Physiotherapist in Neurology/Oncology provides clinical treatment and management of patients with neurological problems. She works with physiotherapy staff to develop the service in the holistic treatment of patients with neurological symptoms as a result of their cancer or its treatment. She has a particular interest in the treatment and ongoing management of patients with primary brain tumours which formed the basis for her research for her MSc in Advanced Practice awarded in 2007: *What's the point? The purpose of physiotherapy rehabilitation for patients with primary brain tumours: An ethnographic study of patients' perspectives.*

SATURDAY SESSION FOUR LECTURE 1

The National Clinical Guidelines for Stroke 2008:

Key Messages for Physiotherapy

Sheila Lennon (CSP), Nicola Hancock (ACPIN) and
Christine Fitzpatrick (AGILE)

Presented by Nicola Hancock BSc (Hons) MSCP SRP

The Clinical Effectiveness and Evaluation Unit Stroke Programme at the Royal College of Physicians is guided by the Intercollegiate Working Party for Stroke (IWPS), which is made up of representatives of all the organisations which support the different disciplines involved in the management of stroke across the country and patient organisations. It includes the development, updating and coordination of guidelines, patient information and clinical audit. Physiotherapists are key members of the IWPS team and the lead representatives are supported and informed by a team of peers with a special interest in specific areas of stroke rehabilitation.

National Clinical Guidelines for Stroke were first published in 2000 with an update supplement in 2002. The work on updating continued, with a second edition published in July 2004. The new, third edition of the guidelines, incorporating recommendations on acute stroke management made by the National Institute for Health and Clinical Excellence (NICE), was published in summer 2008¹. Key information from this edition relevant to physiotherapy will be addressed in this presentation. This edition has a wider scope than any before it. New recommendations on resource issues, commissioning services, cessation of treatment and intensity of therapy are included whilst covering the management of patients with TIA and acute stroke from onset, through rehabilitation and secondary prevention to longer term care.

The process of guideline development will be discussed to enhance understanding of how best available evidence was used to maintain or update existing guidelines, and formulate new recommendations.

The aim of these guidelines is for physiotherapists to make informed decisions about patient management alongside those patients, and to evaluate and support the development of clinical practice, based on evidence. The guidelines should be useful and safe to therapists and be implemented carefully nationally to enhance practice and reduce regional variations in rehabilitation care.

A key aspect of the role of the physiotherapy members of the working party has been the development of an updated audit tool, following the first multi-disciplinary pilot audit of stroke care in the UK, alongside colleagues from dietetics, nursing, occupational therapy and speech and language therapy. Comment on the audit report findings² and the importance and value of profession specific audit of stroke services will be made.

References

1. All stroke guidelines and audit tools from www.rcplondon.ac.uk
2. Lennon et al (2007) *Profession Specific Audit of Stroke 2006: A Multidisciplinary Pilot Study* Clinical Standards Unit, RCP London.

This presentation was given on behalf of the physiotherapy members of the Intercollegiate Stroke Working Party: Dr Sheila Lennon (representing the CSP), Christine Fitzpatrick (representing AGILE) and Nicola Hancock (representing ACPIN).

The upper limb

ACPIN NATIONAL CONFERENCE AND AGM 2008

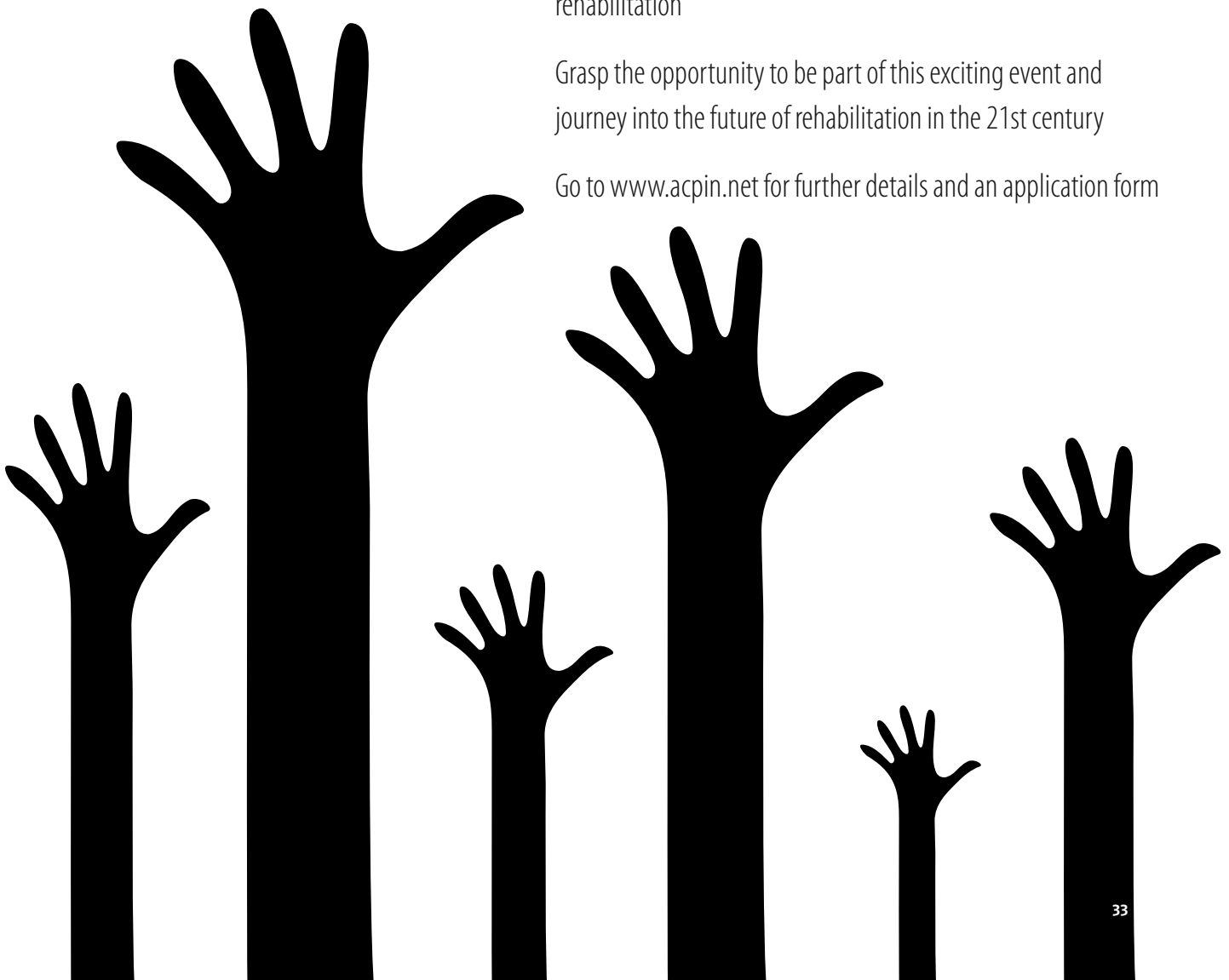
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REVIEWS ARTICLES BOOKS COURSES

Reviews of research articles, books and courses in *Synapse* are offered by regional ACPIN groups or individuals in response to requests from the ACPIN committee. In the spirit of an extension of the ERA (evaluating research articles) project they are offered as information for members and as an opportunity for some members to hone their reviewing skills. Editing is kept to a minimum and the reviews reflect the opinions of the authors only. We give the authors of the original book or paper the opportunity to respond. We hope these reviews will encourage members to read the original article and not simply take the views of the reviewers at face value.

BOOKS

On the Edge: My Story

Richard Hammond

Review by Kate Goddard

East Anglia Committee member

I love *Top Gear*. It's not the cars, they're all much the same to me! It's the friendly banter that goes on between the presenters with their competitive good humoured rivalry about anything car related and more.

It was therefore terrible news when I heard about Richard Hammond's high speed car crash that had left him with a serious head injury. From my experience, that could not be good news. Even if he made a good physical recovery the chances that he had been left with cognitive, memory and personality changes were high. How would that affect the trio of *Top Gear*?

When *On the Edge* was published I was intrigued to read and find out the detail that the press had not covered at the time.

It was an easy book to read with Richard recounting in the beginning about his early life, career and steps towards becoming a *Top Gear* presenter. It revealed how close the team are. This was then highlighted after the crash with tremendous support that came from all. He told the story right up to the fateful moment when the car rolled and then everything was black... I must admit that with such a prolonged PTA I did wonder if the recollection of events up to the crash could have been as clear to him as is written.

The story continues with his wife Mindy, her fears and how she managed to keep everything going with small children to reassure, relatives and media to deal with and update. She was very involved in his hospital care in Leeds, staying with him most of the time, which in comparison to the places I have worked was unusual. She seemed to be the only one who could calm him in his agitated state.

The nurses would call her back at all hours of day and night if she had to leave. He had very bad short-term memory problems that persisted for several weeks. He needed lots of notes to remind him what had happened and where he was. He kept repeating the same questions over and over. As the narrative continues, Richard and Mindy's accounts interlink as he starts to recount how he felt during this amnesic time, how paranoid and scared he was. It was a very real and moving account that made me appreciate more what so many of my patients have been through over the years.

It was bad enough dealing with all of this but Mindy also had to juggle with the press and all care was taken to keep them away from Richard, as the stress was more than he could deal with. He needed routine and consistency otherwise his agitation was a real problem. The first time that therapists are mentioned was when he was transferred to Bristol despite the fact that he was ventilated on ITU and was very unsteady on his feet for the first couple of weeks while in Leeds. I'm sure they were there but nurses and doctors were perhaps more important at the time.

The book finishes after he has been discharged from the rehab hospital in Bristol and having a family holiday/convalescence away from the public eye. During this time he began to appreciate each day how bad things had been the day before both physically and mentally although his desire for familiarity and routine remained.

He has been remarkably lucky to recover, what would appear to be, completely from what was a severe traumatic brain injury. He is now back on our screens with Jeremy and James, who now have another line in leg pulling when he's driving a little bit too fast round the track testing the latest model of some car or another!

COURSES

'The neurological foot' study day

Surrey and Borders ACPIN study day, 1st March 2008, Royal Surrey County Hospital, Guildford, Surrey

Review by Louise Everard Committee Secretary

Following on from the success of previous study days it was decided to take a holistic approach to the subject matter of 'The neurological foot'.

The day kicked off with a much-valued overview of the anatomy of the foot and ankle by extended scope practitioner Sylvia Wojciechowski. Next followed an introduction to podiatry principles with a lecture from Paul Harradine who focused on the normal biomechanics of the foot and ankle and deviations following neurological impairment. This provided a very interesting insight into differing methods of assessment and analysis compared to more traditional methods.

Mr Alex Wee, orthopaedic consultant at Frimley Park Hospital, provided us with a whistle-stop tour of just some of the surgical procedures that were possible, indications for surgery and consideration of rehabilitation needs post operatively.

The afternoon began with presentations from two orthotists, Paul Charlton and Jim Ashworth-Beaumont. Orthotic principles and types of devices were explored and case studies of incomplete spinal cord injury clients were discussed and illustrated.

The day was completed by clinical specialist physiotherapist Amanda Edwards and her presentation on the principles and uses of FES. She also provided a helpful insight into the running of an FES service and discussed a range of case studies.

The day provided much thought around the need for a team

approach to management and the involvement of a range of specialists where able to provide a comprehensive management programme to this client group.

Following such a well-rounded and successful day, the committee are already planning a further study day for 2009, further details to follow in *Frontline* and *iCSP*.

REGIONAL REPORTS

East Anglia

Nic Hills

Thanks to the great work by the committee members, 2008 has been much more successful for East Anglia ACPIN. Thus far this year we have held the following courses;

- April *AGM with Medical Management of Spasticity* lecture by Dr Simon Shields
 - June *Saeboflex study day*, this included case studies and patient demonstrations
 - July *Treadmill training evening lecture* by Jo Tuckey
 - October *Ataxia and lycra* afternoon
- All courses have been well received and most have had good attendances.
- The future course plans include;
- February 2009 *Neuro-pilates study day*
 - April 2009 *AGM with Parkinson's and multiple sclerosis update*

We are keen to involve East Anglia ACPIN members as much as possible in forming our course programme. If anyone has any ideas for courses or speakers please get in touch, we will be pleased to hear from you!

As the region covers such a large geographical area, we are keen to extend our committee; in particular we are looking for representatives from Peterborough, West Suffolk and South Essex. If you are interested in joining the committee and want to know what this would entail please e-mail me on Nicola.Hills@Ipswich.hospital.nhs.uk I look forward to hearing from you.

Kent

Janice Champion

We have had another good year with membership numbers staying high for Kent and therefore our committee has been strongly supported led by Cathy Kelly-Jones, our chairperson.

Our 2008 programme continued with a study day 'Managing the Post-Neurosurgical patient in a District General Hospital' which was held in April at the Kent and Canterbury Hospital. This was led by three senior clinicians from the Royal London Hospital and covered both respiratory and neurological management and treatment. Our lunch was sponsored by Allergan and everyone found the day very useful.

Our planned vestibular rehabilitation study day which was to be held in June in conjunction with our neighbouring Sussex region has been postponed until 2009.

Future courses in the planning stage include a weekend Saeboflex course and a study day on conversion disorders.

Any ideas from members for future courses are always welcome.

London

Leigh Forsyth

London ACPIN has had a busy year! We had a number of successful evening and weekend lectures building strong links with colleagues in the National Physiotherapy Network and in the specialist section of OT's in Neurological Practice, we hope to build upon this and continuing to bring high quality evidence based lectures at the forefront of research and clinical practice.

Membership is continuing to grow and we thank you for bearing with us with the initiation of the new membership system, we know this did cause some delays and was difficult at the start of the year but these problems have now resolved. The fruits of this will become apparent from the start of December when you need to re-register/update your details with us; this is a simple online process and needs to be completed by all members (even if you do pay by direct debit!)

Our committee has had several new faces join and a number of key members taking active roles in the ACPIN executive committee. We also have had a few committee members leave us either moving out of the area or to start a family. Congratulations and our best wishes are with all of you.

Stroke has been very high on the agenda in London this year and hopefully most people are aware of who locally is involved in the planning of services for each sector, Healthcare for London are driving this forward through the development of five 'local' networks to identify the 'as is' and co-ordinate delivery of the performance standards and implementation of the stroke strategy. I have placed the contact details of each network on the London section of the website, it is a prime opportunity to get involved in revolutionising the delivery of stroke care and having your opinion heard! On a similar note we (ACPIN) are getting an information mapping network of clinicians together (see page 22 for full details).

Thanks for all your support and feedback – we do listen to it all!

Manchester

Helen Dawson

We have had a great year so far with a mixture of lectures and more practically based sessions.

We kicked off the year with an informative session on vestibular rehabilitation from Nova Mullins in January, followed by a practical treatment demonstration from Lynn Fletcher at our AGM meeting in March. In May we had an MS update from a specialist nurse and our last session to date was from Kristina providing us with a taster of adapted pilates exercises for the neurological patient.

Thank you to all our speaker so far this year for their time and effort that they put into creating inspiring sessions for us.

Plans for the rest of the year include a cheese and wine evening as a forum for discussion on clinical issues or recent topics. We had also hoped to run a two day splinting course however due to proposed dates clashing with existing courses which may have meant our members possibly missing out we plan to delay this until next year.

Thank you to everyone who has continued to support Manchester ACPIN and the committee for all their hard work this year. Our committee is always open to new members and fresh ideas so if you are interested please feel free to contact us.

Our Manchester ACPIN email continues to be a useful way of us receiving suggestions, feedback, questions so do email us.

Northern Ireland

Joanne Wrigglesworth

As the summer fades (!) and the nights draw in, fear not, for NI ACPIN has an exciting programme to keep you wide awake until spring! We have welcomed a couple of new faces to our committee, bringing enthusiasm and fresh ideas, not to mention youth!

We have kicked off our new year with our annual review of neurological assessment and an update on the *National Clinical Guidelines for Stroke Care*. These lectures will be followed in November by an equipment night, taking the form of an information exchange on a variety of pieces of equipment used around the country. Following our Christmas break, an evening focusing on 'Spasticity, Botulinum Toxin and Injection management' will be held. Our AGM will, this year, be supported by a workshop on 'Cerebellar rehabilitation'. The spring programme comprises of information evenings on what services are available through the intermediate care and voluntary sectors. We are hoping to round off the year and get trim for a blazing bikini summer with a pilates workshop!

We are always keen to welcome any new members to ACPIN, so keep your eyes open for the monthly flyers, check the website or contact me at joanne.wrigglesworth@belfasttrust.hscni.net

Northern

Pam Thirlwell

Northern ACPIN continue to run numerous courses over 2008

In September we had the 'On the Ball' course with Joanne Elphinstone - this was held at James Cook University Hospital and was well subscribed and attended. The course was enjoyed by everyone and gave people lots of new ideas for using the gym ball.

Also in September we had a 'Stroke update' talk from Professor Chris Gray this was held at the Neurosciences Centre at Newcastle General.

On 6th/7th December we have a Bobath course on the trunk and pelvis with Catherine Armstrong as tutor. This will be held at Walkergate Park in the new Regional Rehabilitation Centre.

Plans for 2009 include:

- Introductory Bobath weekends with Paul Johnson as tutor - the dates for these weekends are 9th/10th January, 27th/28th February and 3rd/4th of April. The venue is to be confirmed.
- Movement Science 'Reach to Grasp' course is to be held on 21st February.

Other ideas for courses in 2009 are

- a further Bobath course with Linzie Meadows as tutor
- a course on musculoskeletal techniques for neurophysiotherapists.
- using pilates in neurology

Please get in touch with a committee member if there are any other courses you would like Northern ACPIN to arrange or if you would like to join the committee new members are always welcome.

Oxford

Sophie Gwilym

All is well in Oxford Region!

Membership numbers are good, the committee remains stable and evening lectures and courses are well attended. The summer programme included an excellent study day titled 'Pain, the Brain and the Real World', with Lorimer Moseley, this was a funny, thought provoking and very well received day course. Therapists from the Oxford Centre for Enablement updated us on their exciting work with saebotex.

While summer is now long gone, our evenings have been considerably brightened by an interesting and useful talk by Dr Rachel Tams, 'Psychologist about the cognitive changes occurring in Multiple Sclerosis' and also the anticipation of our November spinal injuries workshop at Stoke Mandeville Hospital.

The programme for 2009 is being finalised at present. Topics will include management of patients in vegetative and minimally aware states, neuro-orthoptics, PNF, local research projects feedback and a spasticity update. We are also in the process of arranging a day course with Martine Nadler.

All details of forthcoming events are advertised on iCSP, *Frontline* and sent round to local physiotherapy departments. Please contact me if you wish your department to be added to the mailing list.

As always, suggestions for topics, venues or committee volunteers are gratefully received. Thank you for your ongoing support.

Scotland

Dorothy Bowman

2008 has been a busy year, with courses being well attended. Membership numbers are down but this may be to do with members getting up to speed with the new membership system.

At the beginning of the year a lecture on 'Exploring the Brain' by Dr Gilie McNeill in Glasgow was very well received and we are hoping to organise a follow up lecture.

Pauline Pope gave an excellent course on 'Positioning and Seating for the Complex patient', it was very interesting with lots of clinical examples and practical ideas. A neuro-physiotherapy research forum ran in September. This was an interesting day with a range of speakers and presentation and a valuable opportunity for therapists from across Scotland to update on recent research and network. This may hopefully be run as a yearly event from now on. We also have Debbie Strang (Bobath Tutor) giving a weekend course on the 'Trunk and Shoulder'. Debbie has done several courses for ACPIN Scotland and they always prove very popular.

Forthcoming programme:

- Bobath Course - Planned for foot and locomotion (tbc)
- Cognition And Perception (tbc)
- Anatomy Trains (tbc)

Details for these and further courses will be circulated once confirmed.

South Trent

Becky Sammut

After a successful and much enjoyed 2008, we look forward to a varied and dynamic programme in 2009. Our highlight of the year was a very well attended and received pelvis and trunk workshop with Sue Armstrong in August.

Firstly, a huge thank you must go to our retiring committee members Jan Jolly and Ruth Cutts. Furthermore, we would like to congratulate our chairperson Cilla White who is now Cilla Williams.

As we go to press our forthcoming programme for 2009 is:

- March 14th/15th *Gait Workshop* with Sue Armstrong. The venue is likely to be the Derbyshire Royal Infirmary – a Bobath Workshop featuring a lecture, patient demonstration and practical sessions.
- November 14th/15th *Ataxia* with Lynne Fletcher. Venue tbc – a practical Bobath workshop.
- We are also planning a series of possible evening lectures throughout the year, so watch this space!

Thank you to all the committee who continue to work hard arranging the courses and attending committee meetings. We welcome any ideas or suggestions for lecture or courses and continue to look for new venues for events. If anyone would like to join the committee we are always happy to welcome new members and currently have several vacancies. Please feel free to contact us informally if you would like any further information via e-mail becky.sammut@nhs.net or on 07828 787186.

South West

Kate Moss

South West ACPIN have had some changes in committee membership over the summer of 2008. Lizzy Shaw has taken over as committee secretary and we have two new committee members, Kirsty Page and Kirsten Stillman. Phil Meakin has resigned as course organiser – thank you on behalf of South West ACPIN for all of your hard work Phil and good luck with your move. Thanks to all our committee members for their continued hard work.

A successful day course on neurophysiology and AGM was held earlier in the year and was well received. Further courses running over the summer/autumn period have included an evening lecture on managing spasticity and a day course on left-right integration in stroke rehabilitation. Further evening and day courses are planned for the winter and into spring next year.

A questionnaire was sent out to the membership to investigate ideas for future course needs and to gain opinions about which locations were most popular for courses to be run. Thank you to all who responded to the questionnaire. If anyone has any comments or ideas about courses/locations please contact me on katy.moss@glos.nhs.uk

Further information about forthcoming courses can be found on www.southwestacpin.net

Surrey and Borders

Kate Moffatt

Surrey and Borders ACPIN have had a successful year with a growing membership. We welcome Michelle Green to our committee and open the invitation to all you members, if you are interested in joining us – it is not as much work as you think! Our evening lectures have been diverse, including 'Constraint induced therapy', 'Fatigue management and discharge from stroke physiotherapy'. These have normally been well attended, but we do encourage all members to chivvy along their colleagues; including junior members of staff and the MDT! If you have any topics that you would like us to consider for future lectures or courses, do let me know!

Forthcoming programme:

- December 9th (evening lecture) *Update in Multiple Sclerosis* Elizabeth Gradwell, MS Specialist Practitioner, Royal Surrey County Hospital, Guildford
- January 29th 2009 (evening lecture) *Specialist Seating in the Developing World: challenges and solutions* David Constantine, Farnham Community Hospital
- February 28th 2009 *AGM and half day course on outcome measures* Sara Demain, Sarah Tyson, Paula Kersten, PGMC, Royal Surrey County Hospital, Guildford (Program and further advertisement to follow)
- mid April (evening lecture) *Acupuncture in Neurology* Val Hopwood
- FOTT day course – tbc
- November 2009 (evening lecture) *Pain* Dr Markham

We will be advertising future courses and lectures by fliers, on iCSP and in *Frontline* closer to the time, so do check regularly that the dates and venues have not changed! We have tried to make the forthcoming lectures as innovative as possible! We hope you enjoy them! Any queries please do not hesitate to contact me on: ksmoff@hotmail.com

Sussex

Clare Hall

On behalf of Sussex ACPIN I would like to thank Maggie Ndini-Smith for her hard work over the last six years of being treasurer. We are delighted to be able to welcome a new treasurer and other members to the committee.

The AGM and study day on 'The complex neurological assessment' in February was so well received that we would like to plan a sequel!

The evening lecture on 'The interpretation of CT scans' was extremely interesting and useful.

The next evening lecture was on 'Conversion disorders and their physiotherapy management'. This was an excellent presentation, clinically very relevant and highlighted the role of physiotherapy in this area.

The 2008/9 programme continues with:

- November 8th *Spasticity study day*, Worthing Hospital.
- Vestibular rehabilitation study day, joint event with Kent ACPIN. Details TBC.
- December *Effects of exercise following TIA* Margaret Hewett, Clinical Specialist in Neurology, Conquest Hospital.
- February 2009 *AGM and study day*. Details TBC.

As ever we are always seeking further ideas for topics, speakers and venues. Please let us know about your wishes for next year's programme: contact details are on the website.

Wessex

Hayden Kirk

2008 has been a busy year for Wessex and we have had a good variety of evening lectures. These have ranged across topics from updates in MS to sexual dysfunction in stroke and MBT footwear. Our more substantive course this year was pilates for neurological patients which was run by Jo Gilmore and proved very popular.

Perhaps the greatest success over the past twelve months has been input for the evening lecture programme coming from nearly all the regional health centres (Poole, Bournemouth, Salisbury, Portsmouth and Southampton). This regional involvement is vitally important if we are to provide strong and inclusive programmes so please continue to put forward any suggestions or ideas that you want and/or can provide from your area.

The committee and general membership remains strong although we would always welcome any members who would like to join and play an active role on the committee. We would also like to say thank you to Ros Cox for supporting the new committee as she is leaving after years of dedicated service to Wessex ACPIN. Our congratulations are also sent to Mary Vincent on the birth of her daughter Lily. If you have any ideas, suggestions or queries for the committee contact details are on the website or feel free to email me directly at hjsk1k06@soton.ac.uk

Finally, as always, a big thank you to those members who travel all across the region to support the committee and evening lecture programme and we look forward to seeing you in 2009.

West Midlands

Fiona Wallace

West Midlands ACPIN has had another good year with membership numbers remaining high in the region. I would like to thank all ACPIN members for their continued support and all committee members who have worked hard this year organising and hosting the 2008 course programme.

Following the AGM, which took place in February, Dr Nick Davies presented a highly enjoyable and informative evening lecture at Birmingham University in May titled 'Neuromuscular Disorders'.

On the 20th and 21st September at Birmingham Heartlands Hospital Nikki Rochford was due to present a two-day theory and practical course titled an 'Introduction to PNF'. Unfortunately this course had to be cancelled due to unforeseen circumstances. We are planning however to reschedule it for spring 2009.

On the 8th of November West Midlands ACPIN is hosting an 'Orthotic versus FES' study morning. The 2008 course programme then draws to an end in December with an evening lecture on 'Spasticity Management and Botox'. Dates and details are yet to be confirmed but will be advertised to members by post or by email closer to the event.

I am at this time standing down from my position to have a baby and am pleased to announce Katherine Harrison as the new regional representative.

The committee continue to be busy organising the 2009 Programme. Please contact Katherine via email (katherine.harrison@heartofengland.nhs.uk) if you have any suggestions or queries about future events. We always value any ideas or opinions you may have.

Yorkshire

Jill Fisher

We were very pleased to welcome new members to the committee – Chris Robbins, Vanessa Churchhouse, Nicki Bradford and Kirsty McClaren. Sincere thanks go to Ina James who resigned from the committee at the AGM having given much support to Yorkshire ACPIN as a committee member especially in her role as membership secretary.

Mary Lynch Ellerington led an excellent day course in February on 'Functional re-education of the hand'. Paul Johnson assisted on that course and kindly agreed to lead a very successful day in July on the same subject.

The AGM, which was held this year in Bradford during a study day related to gait, was a popular and well supported event. Sarah Daniels led a workshop on gait analysis and Paul Charlton, Orthotist, spoke on AFOs.

In May Dr Duffy gave a talk in York about dystonia. Those who attended found this a very interesting lecture.

Unfortunately, Debbie Strang had to cancel a day course on the shoulder girdle this summer because of family problems. We are hoping that she will be able to run it at some time next year. Members who had places on the August course will be given priority.

Janice Champion led a practically based day course in September with a focus on patients with more severe complex problems. Other future events include Jill Shelton giving a talk on adult CP, a clinical psychologist will give an evening lecture, and on 11th March Lyn Fletcher will be the tutor for an 'Ataxia' day.

We welcome members using the new e-mail address for any queries yorkshireacpin@yahoo.co.uk

LETTERS**BPPV or Mal de Debarquement Syndrome (MdDS)?**

A growing number of neurological physiotherapists are involved in the diagnosis and management of vestibular disorders; ACPIN recently received an email from Jane of the Mal de Debarquement Syndrome Society:

I would like to make everyone aware of a little-known condition that is triggered by travelling, be it by boat, plane, car, train ... in fact any kind of motion. The condition is called Mal de Debarquement Syndrome (MdDS). The main symptom of this condition is an 'illusion of movement' which the sufferer can either see or feel or often both. It is most noticeable when you are still. In fact sufferers often feel 'normal' again once they are back in motion, and this is often the only way of diagnosing MdDS as all inner ear tests and neurological ones come back negative. This main symptom is often described as 'rocking' and 'rolling' like being on the deck of a ship in rough seas. The sensation of being 'all at sea' is with you constantly, with no let up, except as I say when back in motion. I can't stress enough that with MdDS you do not 'spin' in the rotational sense, so by describing the sensations as feeling 'dizzy' often leads to confusion especially when it comes to a diagnosis. GP's then often diagnose the more common disorders such as Menieres, labyrinthitis or Benign Paroxysmal Positional Vertigo. However some people are helped by vestibular rehabilitation, particularly if there is an actual balance problem.

For more information /and or contact please email at: jane@mdds.org.uk or visit the web-site www.mdds.org.uk.

GUIDELINES FOR AUTHORS

Synapse is the official newsletter of ACPIN. It aims to provide a channel of communication between ACPIN members, to provide a forum to inform, instruct and debate regarding all aspects of neurological physiotherapy. A number of types of articles have been identified which fulfil these aims. The types of article are:

Case Reports

Synapse is pleased to accept case reports from practitioners, that provide information which will encourage other practitioners to improve or make changes in their own practice or clinical reasoning of how to influence a change or plan a treatment for that condition. The maximum length is 2000 words including references. An outline is given as follows:

Introduction

State the purpose of the report and why the case is worth reading about to include in short sentences:

- The patient and the condition.
- How the case came to your attention.
- What is new or different about it.
- The main features worth reporting.

The patient

Give a concise description of the patient and condition that shows the key physiotherapeutic, biomedical and psychosocial features. The patient's perspective on the problem and priorities for treatment are important. Give the patient a name in the interests of humanity, but not the real name. Do not include any other identifying details or photographs without the patient's permission.

Intervention

Describe what you did, how the patient progressed, and the outcome. This section should cover:

- Aims of physiotherapy.
- Treatment, problems and progress.
- Outcomes, including any changes in impairment and disability.
- Justification of your choice of treatment; clinical reasoning
- The patient's level of satisfaction and the outcome and the impact on quality of life.

Method

This should clarify what intervention took place and what measurements were taken. It should include:

- Description(s) of outcome measures used and reference
- Interventions carried out (where, when, by whom if relevant)

Implications for practice

Discuss the knowledge gained, with reference to published research findings and/or evidence about clinical effectiveness. For example:

- Outcome for the patient.
- Drawbacks.

- Insights for treatment of similar patients.
- Potential for application to other conditions.

Summary

List the main lessons to be drawn from this example.

References

These should be in the Harvard style (see section on 'Measurements' below).

Further guidelines for writing case reports were published in the Spring 2001 issue of *Synapse*, page 19.

Abstracts of thesis and dissertations

Abstracts from research projects, including those from undergraduate or postgraduate degrees, audits or presentations. They should be up to 500 words and where possible the conventional format: introduction, purpose, method, results, discussion, conclusion.

Audit Report

A report which contains examination of the method, results, analysis, conclusions and service developments of audit relating to neurology and physiotherapy, using any method or design. This could also include a Service Development Quality Assurance Report of changes in service delivery aimed at improving quality. These should be up to 2000 words including references.

Review of Articles

A critical appraisal of primary source material on a specific topic related to neurology. Download the ACPIN information sheet *Reviewing research articles for further guidance from the ACPIN website*.

Product News

A short appraisal of up to 500 words, used to bring new or redesigned equipment to the notice of the readers. ACPIN and *Synapse* take no responsibility for these assessments, it is not an endorsement of the equipment. If an official trial has been carried out this should be presented as a technical evaluation. This may include a description of a mechanical or technical device used in assessment, treatment, management or education to include specifications and summary evaluation.

Review of books, software and videos

Short reviews of up to 500 words to include details of availability, price and source for purchasing.

Letters to *Synapse*

These can be about any issue pertinent to neurological physiotherapy or ACPIN. They may relate to material published in the previous issue(s) of *Synapse*.

PREPARATION OF EDITORIAL MATERIAL

Copy should be produced in Microsoft Word. Wherever possible diagrams and tables should be produced in electronic form, eg Excel, and the software used clearly identified.

Hard copies should be as close to journal style as possible, on one side of A4 paper with at least a 25mm margin all around, consecutively numbered.

The first page should give:

- The title of the article
- The names of the author(s)
- A complete name and address for correspondence
- Professional and academic qualifications for all authors, and their current positions
- For research papers, a brief note about each author which indicates their contribution and a summary of any funds supporting the work

All articles

- The text should be well organised and written in simple, clear correct English. The positions of tables, charts or photographs should be appropriately titled and numbered consecutively in the text.
- All abbreviations must be explained.
- Any photographs or line drawings should be in sharp focus with good contrast for best reproduction.
- All charts should be in black and white only and captions should reflect this.
- References should be listed alphabetically, in the Harvard style with punctuation as follows: Bloggs A, Collins B (1998) The use of bandages in treating head injuries *Physiotherapy* 67,3 pp12-13.
- In the text, the reference should be quoted as the author(s) names followed by the date: Bloggs A (1994)
- Acknowledgements are listed at the end.

Measurements

As the International System of Units (SI) is not yet universal, both metric and imperial units are used in the United Kingdom in different circumstances. Depending on which units were used for the original calculations, data may be reported in imperial units followed by the SI equivalent in parentheses, or SI measurements followed by imperial measurements in parentheses. If the article mentions an outcome measure, appropriate information about it should be included, describing measurement properties and where it may be obtained.

Permissions and ethical certification

Protection of subjects: Either provide written permission from patients, parents or guardians to publish photographs of recognisable individuals, or obscure facial features. For reports of research involving people, written confirmation of informed consent is required. The use of names for patients is encouraged in case studies for clarity and humanity, but they should not be their real names.

Submission of articles

The disk and two hard copies of each article, should be sent with a covering letter from the principal author stating the type of article being submitted, releasing copyright, confirming that appropriate permissions have been obtained, or stating what reprinting permissions are needed.

For further information, please contact the *Synapse* co-ordinator:

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Note: all material submitted to the administrator is normally acknowledged within two weeks of receipt.

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