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EDITORIAL

By the time you read this journal yet another APCP Conference will be fast approaching. The programme put together by the South West Committee looks excellent with something of interest for just about everyone. If you haven't booked your place yet, I am sure there will still be space for you. So come along and use the opportunity to build professional networks and share ideas and experiences. I look forward to meeting many of you in Bournemouth – don't forget it is always a great social occasion as well and a time to make new friends.

The future holds big changes that will affect us all. Agenda for Change is fast approaching along with the formal adoption of the National Service Framework for Children. It is important that we all keep up to date on both of these issues and represent physiotherapy and, in the case of Agenda for Change, ourselves and the departments we work in, to ensure that our profession and paediatric physiotherapy in particular is well represented in the big scheme of things. It is up to us as professionals to make certain that as events move forward they continue to serve and fulfil the needs of the children and families that we work with. Not only that; but they enhance and enrich the careers and provide job satisfaction for the paediatric staff and therapists in all walks of practice.

There could be turbulent times ahead. None of us relish change for its own sake but like it or not change there will be. We must use it to our advantage, treat it as a challenge and use it to drive our profession and our personal development forward, providing the foundation for a user led, user friendly and enhanced vehicle for service provision of the highest standard possible

Sally Braithwaite

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must be with the editor by

1st MAY 2003

The editorial board reserve the right to edit all material submitted

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Dear Sally

We are three Paediatric Physiotherapists with a special interest in Developmental Co-ordination Disorder, based in Lothian, Scotland. We provide physiotherapy to children in the community and mainstream schools in Edinburgh, East Lothian and Midlothian.

We have developed a mini assessment for children with DCD which is quite short and assesses what we feel are the main problem areas. We use this to reassess children on each review session. We are keen to evaluate its inter-user reliability as an assessment tool for all our Physiotherapy users, and also to ensure it is an acceptable standard and comparable with what is used in other centres.

Consequently we are looking for any colleagues with a special interest in DCD who are willing to evaluate and comment on our mini assessment, or to share with us what they use in their own centres as a quick assessment tool.

With many thanks in advance.

Please contact us.

Monika Vest, Sandra Rathjen and Gill McKelvie

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Dear Sally,

We are Chartered Physiotherapists, treating children privately within the London area. It has come to our notice from families that some Physiotherapists working in the NHS sector may alter their approach to treatment, once they know the child is being seen privately. This may include refusing to treat, reducing the number of treatments given, not being open to communication, only dealing with issues around equipment and/or orthotics or even discharging the patient.

We have sought advice from the CSP and they say that a child / family have a choice and the right to seek additional advice and treatment, and unless the private Physiotherapy input is going against that being delivered by the NHS, then treatment should continue, with both parties communicating effectively with each other. If they do not then this is going against the "Rules of Professional Conduct".

We believe that all professionals working with a child must communicate, co-operate and collaborate, both for the best interest of the child and family and to minimise parental anxiety. We would be interested to hear from Physiotherapists where this works well and where there is a good working relationship between the private sector and the NHS.

Kiki Von Eisenhart Sally Wright Thea Schlotterbeck
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Dear Editor

We are currently looking at the development of tremor post traumatic brain injury in children and particularly of delayed onset type. We would be interested to hear from any physiotherapists with similar experiences and in particular any objective measures to record this accurately.

Helen Miles

Catherine Whiteley
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Woodlands Unit
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Dear Sally,

I am a Paediatric Physiotherapist at Barnet Hospital. I have recently had several patients (0-6 months) presenting with torticollis and/or plagiocephaly who report that they have seen an osteopath or cranial sacral therapist who has advised that their treatment consists of being held upside down for 1 minute, 3 times a day.

Has anyone else heard of this practice or similar advice being given to parents?

I would be grateful to know if anyone else is aware of this practice. If anyone already has any written information/guidelines/protocols on head down tip in infants I would appreciate hearing from you as I plan to send information to GPs, Health Visitors and other therapists.

Please contact me at the above address with any information.

Thank you for your time.

Yours sincerely

Catherine Whiteley

LETTERS

Lesley Smith
Vice chair-person APCP.

Dear Editor,

At a recent meeting of APCP - the Private Practioners List which is currently held and disseminated by APCP was discussed. There have, over the last year, been less than twenty requests for this list which for reasons of equal opportunity requires to be sent in its totality. The majority of information will be of no use to the individual enquirer.

As you are also aware it provides no information as to individual specialist knowledge or expertise. The meeting therefore decided that APCP would no longer hold a private practioners list and that individuals should put their own information on to the CSP website.

I will write to each individual currenly on the list advising them of the above change.

Yours sincerely

Lesley Smith

Sarah Goulding
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Dear Ms Braithwaite,

I am a final year physiotherapy student with an interest in paediatrics and neurology. I am looking to apply for junior positions where I could gain experience particularly in these areas. I am not restricted as to what region I am applying. Any recommendations from yourself or your readers would be much appreciated.

Yours faithfully

Sarah Goulding

THE IMPACT OF NOCTURNAL VENTILATION IN DUCHENNE SYMPTOMS AND

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Introduction

The main causes of death in Duchenne Muscular Dystrophy (DMD) are respiratory failure which accounts for approximately 90% of all deaths and cardiomyopathy which is responsible for the remaining 10% (Rideau *et al.*, 1981; Hilton *et al.*, 1993). Prior to the introduction of nocturnal ventilation as a treatment for respiratory failure children rarely reached adulthood with most living only to about 19 years of age. Children with an early and severe cardiomyopathy that develops in the teenage years die even younger (Eagle *et al.*, 2002).

Nocturnal ventilation has been used as a treatment for respiratory failure for many years but it is not accepted by everyone and not all patients are given the opportunity to consider ventilation (Gibson, 2001). It is known that some professionals consider the quality of life in patients with DMD to be poorer than do the patients themselves and therefore do not wish to prolong it by ventilation (Bach *et al.*, 1991).

Throughout the 1980s and the beginning of the 1990s anecdotal reports of patients surviving into their twenties by use of negative pressure ventilation emerged (Johnson *et al.*, 1985). More portable, positive pressure ventilators addressed some of the complications associated with negative pressure ventilation such as collapse of the airways and poor mobility, and nasal ventilation as opposed to tracheostomy ventilation became more popular (Bach *et al.*, 1987). A Cochrane report published in 2000 found only four trials with a total of 51 patients that met their inclusion criteria (Annane *et al.*, 2000). They found weak evidence to suggest increased life expectancy and improvement in clinical signs but recommended further randomised controlled trials.

There are no accepted criteria for when is the best time to introduce nocturnal ventilation although international meetings held to determine a consensus of opinion broadly agreed that symptoms sleep studies or oxymetry and spirometry were useful measures (Rutgers *et al.*, 1996, Robert *et al.*, 1993). A review of the literature revealed that patients who were ventilated during the 1990s suffered from severe symptoms that included recurrent chest infections, insomnia, and severe fatigue, shortness of breath, headaches and nausea (Simonds *et al.*, 1998, Baydur *et al.*, 1990; Fukunaga *et al.*, 1993). Many patients were ventilated following emergency admission to hospital. Some patients refused ventilation when it was offered because they felt so unwell and probably did not wish to continue living (van Kesteren and Kampelmacher, 2000). In an attempt to rectify this, a study by Raphael (Raphael *et al.*, 1994) examined the impact of prophylactic ventilation and randomised patients into two groups. One group did not receive ventilation and the other did. Some patients in the ventilated group died earlier than expected and the trail was halted. It is possible that ventilation introduced at this stage induced hypercapnia or that the treated group were more severely affected despite a proper process of randomisation process (Muntoni *et al.*, 1994). Whatever the reason for these results, this study generated some reluctance in clinicians to ventilate patients with DMD too early.

Quality of life studies conducted in the 1990s revealed that at the time of ventilation patients and their families were often unaware that nocturnal ventilation could be used to alleviate symptoms and prolong life (Miller *et al.*, 1990; Miller *et al.*, 1988). Further evidence suggested that families prefer to know about ventilation long before it is introduced (Gilgoff *et al.*, 1989).

A desire to address some of these issues led to the work which was the basis of my PhD. It had three aims.

1. When was the best time to introduce nocturnal ventilation?
2. Does nocturnal ventilation improve survival?
3. What factors influence quality of life in patients with DMD and their families?

Patients and study design - Retrospective Study

The case notes of 154 patients who died between 1967 and 1995 were reviewed in a retrospective study to determine the signs and symptoms in patients who died before nocturnal ventilation was available. Sixteen patients who lost ambulation before their 13th birthday were excluded. As well as age at loss of ambulation, age and cause of death, forced vital capacity (FVC), details of spinal management, and any symptoms that may have been related to cardiac or respiratory insufficiency were recorded. Where post mortems had been conducted the details were noted.

Prospective Study

Forty nine patients with an FVC of less than 1.25 litres entered a prospective longitudinal study between 1995 and 2002. Systematic and repeated assessments were made of FVC and home overnight oxymetry. A standardised questionnaire was used to document signs and symptoms.

All patients had definite DMD determined by family history and/or DNA or dystrophin analyses.

Quality of Life study

Seven families were chosen to investigate quality of life so that patients who were newly ventilated, or had been ventilated for many years, those who were nocturnally ventilated and who used daytime ventilation were represented. Semi-structured questionnaires and the Schedule for the Evaluation of Quality of life (SEIQoL) were used to illuminate factors that affect quality of life in parents and patients (O'Boyle CA *et al.*, 1993).

Statistical Analysis

Kaplan Meier analyses were conducted to determine survival. Patients were divided into groups according to their decade of death and whether or not they were ventilated. Further analyses were conducted to determine the impact of cardiomyopathy and spinal surgery on survival. Since the age at loss of ambulation is traditionally taken as a measure of disease severity, statistical tests were conducted to ascertain the age at loss of ambulation for each group.

Results

The mean age walking became impossible was 9.3 years and there was no difference between groups.

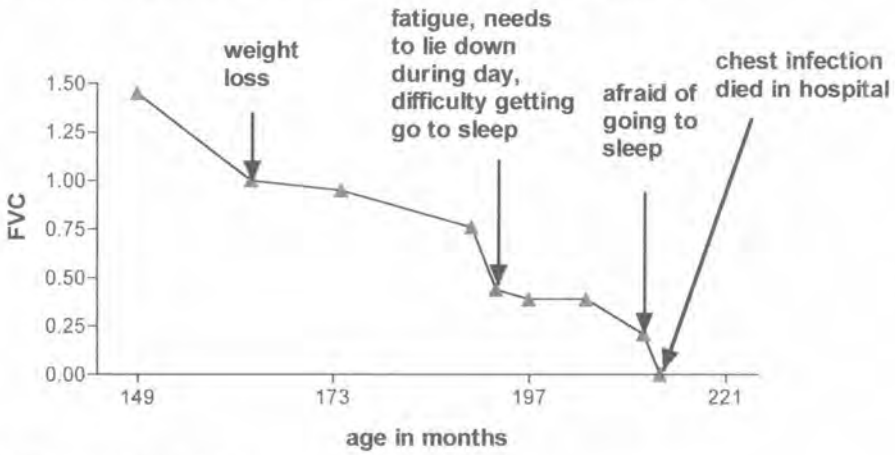
Results from the retrospective study

Retrospective analysis of case notes revealed that patients who were not ventilated suffered progressive symptoms related to respiratory insufficiency in the months before their death. The most commonly recorded symptoms were repeated chest infections, shortness of breath, difficulty swallowing, headaches, insomnia and severe fatigue. The presence of multiple symptoms in association with an FVC below 1 litre indicated a poor prognosis and the mean time to death once symptoms were elicited was five months. A number of patients were symptomatic with an FVC above 1 litre but these patients had a better prognosis with death occurring three years after the symptoms were elicited. Most patients were not symptomatic until their FVC fell below 0.5 litres. Figure 1 shows a typical decline in FVC and the association with symptoms.

The analysis of the case notes revealed a group of patients who were offered ventilation between 1989 and 1991, but refused. These patients were offered ventilation when they had severe symptoms and were hypercarbic, after refusing ventilation they all died within weeks or days.

Figure 1

Progressive deterioration of FVC and development of symptoms over time



Results from the prospective study

Twenty eight patients were ventilated between 1991 and 2002. The first eight patients to be ventilated were not part of the prospective study but were included because clinical information including FVC and symptoms was available and also to exclude these patients from survival analysis could have biased the data. Figure 2 shows the relationship between the FVC and the way ventilation was introduced. Emergency ventilation was much more likely once the FVC fell below 0.5 litres, above this level elective ventilation (either because of a chest infection or other more subtle symptoms) was more common. Most of the patients who were ventilated in the early 1990s had emergency ventilation. As shown in figure 3, once the prospective study was established in 1995, only two patients had emergency ventilation and all the rest were ventilated electively because of the presence of mild symptoms and deteriorating FVC and overnight oxymetry or because of chest infection.

Figure 2 FVC and situation in which ventilation was introduced

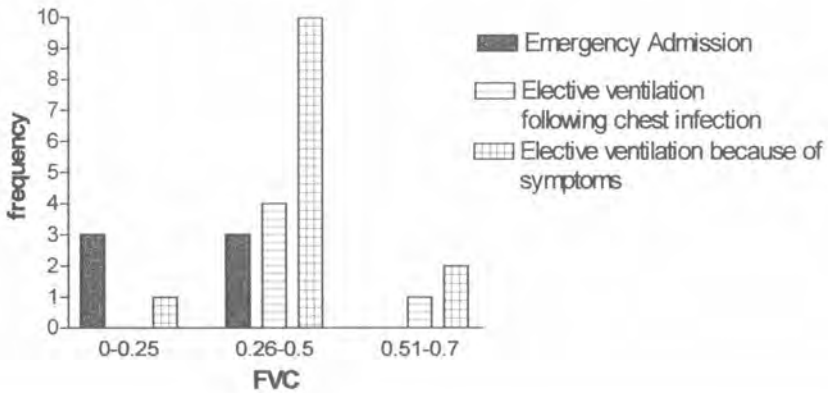


Figure 3 Frequency of elective and emergency ventilations between 1991 and 2002

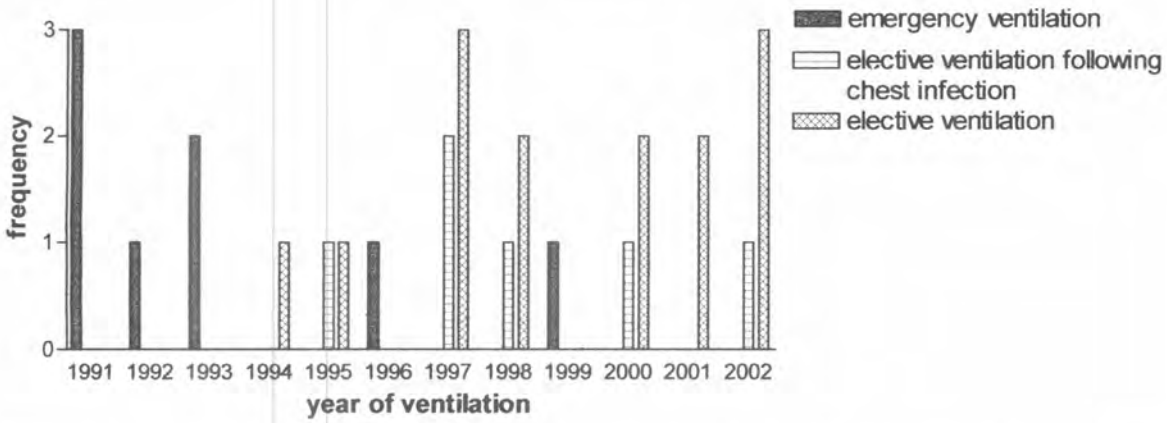


Figure 4 shows a typical overnight oxymetry trace taken at the time of referral for home ventilation and figure 5 shows a trace from the same patient after ventilation was introduced. As can be seen, the overnight oxygen levels were restored to normal and on clinical assessment the patient was no longer symptomatic. Typically, at the time of referral for ventilation, about 20% of the time asleep was spent below 90% SAO2. Often the trace was abnormal in asymptomatic patients but prior to ventilation most patients became symptomatic. Occasionally patients were ventilated because of recurrent chest infections and in these patients the overnight trace could be normal but the FVC was below one litre.

Figure 4 Typical trace at the time of referral for home ventilation

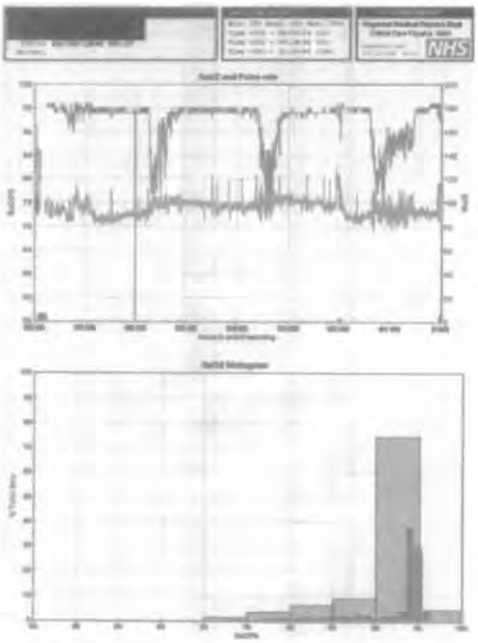
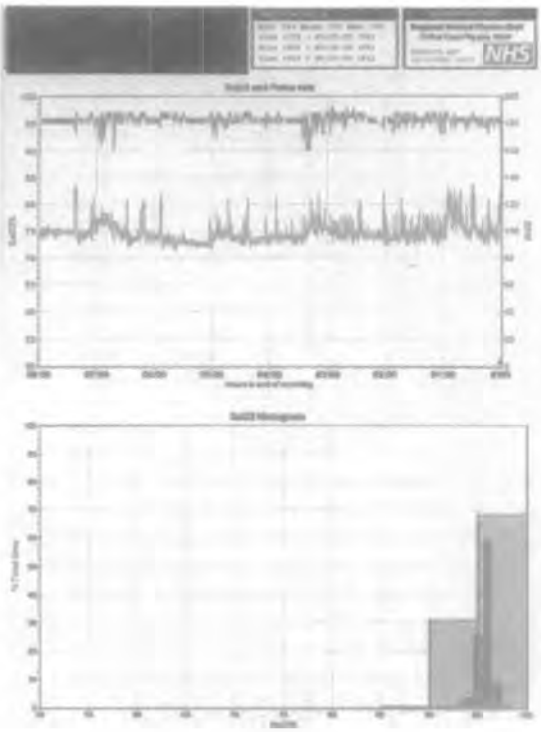


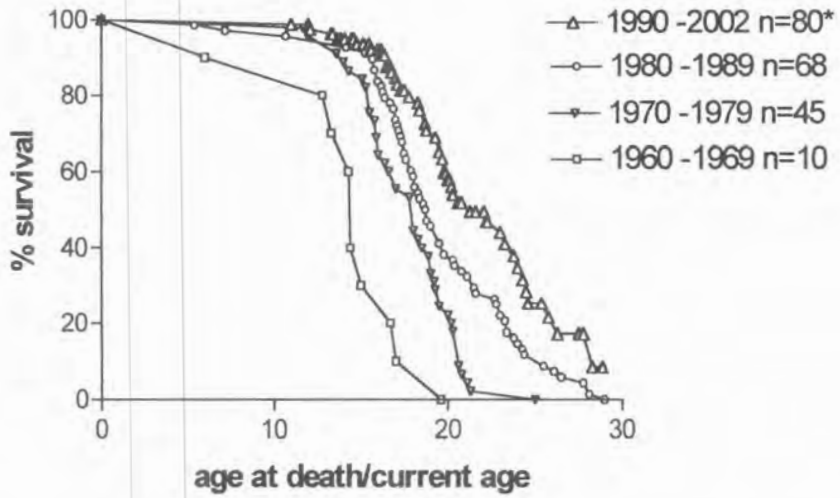
Figure 5 Normal overnight oxymetry, one month after ventilation (Trace taken whist being ventilated)



Patients who were ventilated did not progress to the severe symptoms documented in the retrospective study. At the time of ventilation the most frequently documented symptoms were poor sleep, feeling un-refreshed in the morning, chest infections and loss of energy during the day. There was a tendency for parents and patients to deny the presence of symptoms or to provide alternative explanations for them. The mean FVC at the time of ventilation was 0.47 litres. Following ventilation the FVC often stabilised or increased but in a few patients it continued to decline. Twenty four hour ventilation is not an inevitable consequence of night time ventilation, although over the years patients do increase the number of hours spent using the ventilator each day. Use of the ventilator for longer in the morning or starting earlier in the evening relieves tiredness that may develop after some years of night time ventilation and use of the ventilator around meal times relieves post prandial hypoxia. Some patients do go on to require daytime ventilation but in our experience tracheostomy has not been required and Nocturnal Intermittent Positive Pressure Ventilation (NIPPV) continues to be effective.

Survival analyses showed a significant improvement in life expectancy over the decades (figure 6). The age of death in the 1960s was only 14.4 years whereas in the 1970s it was 18 years and in the 1980s it was 18.7 years. Patients with cardiomyopathy had a significantly poorer prognosis with a mean survival to 16.6 years. However, a number of patients with cardiomyopathy were ventilated and the survival was improved in comparison to patients with cardiomyopathy who were not ventilated. Figure 7 shows the impact of ventilation on survival between 1990 and 2002. Kaplan Meier analysis shows significantly increased survival in ventilated patients to 25.8 years whereas in patients who were not ventilated during the same time period survival was only 19.7 years.

Figure 6 Decade on decade survival



* 39 censored observations

Figure 7 Survival curves in ventilated and non-ventilated patients between 1990 and 2002

Quality of Life Study

The semi-structured interviews revealed that information about ventilation should be given to families and patients at least one year before ventilation was required. All of those interviewed felt that is was up to the parents and their sons to decide whether or not ventilation was appropriate for them. Advantages of ventilation included 'feeling better, having more energy, feeling safer, better nights sleep, and fewer chest infections'. Without exception all families said the only aspects of ventilation that caused them concern were difficulty getting the mask comfortable and pressure sores on the nose as a result of wearing the mask.

SEIQoL assessments showed that the family was the most important factor for quality of life in both ventilated individuals and their parents. Mothers were dissatisfied with their social lives but most ventilated individuals responded to the lack of a social life outside the immediate family, by using computers for leisure and intellectual stimulation. Having said that, all the ventilated individuals who were interviewed had active lives that included attending university or college, going to football matches, going abroad on holiday, shopping, eating out and going to the cinema. These activities tended to be with family rather than friends. Aids to daily living and technological advances were very important to enable comfort and independence in ventilated individuals. Good quality of life for ventilated patients was enabled by the use of specialised equipment such as electric beds, electric wheelchairs, environmental control systems and adapted vehicles. The family, independence, leisure activities and intellectual stimulation are important for both parents and ventilated individuals, although the latter are more reliant on computers and the internet. Parents needed to maintain a level of intellectual stimulation and personal development for their own self esteem.

Discussion

Predicting the need and the timing of the introduction of ventilation is central to the effective implementation of home ventilation particularly if emergency ventilation is to be avoided. A number of factors need to be taken into account when considering when respiratory failure is likely to occur. There are indications, even before the FVC begins its decline, which can alert the clinician and assist in planning the long-term management of the child. Age at loss of ambulation, and the peak FVC correlate with the age of ventilation and age at death. These measures of disease severity can be used to highlight children at risk of an earlier than average need for ventilation, or to give reassurance in the case of children who are milder in their disease severity.

None of the assessment techniques (FVC, respiratory questionnaire, overnight oxymetry) should be used in isolation. There are always exceptional patients who do not fit the typical pattern and clinical judgment and skill will be required to fit the pieces together. It is important that the patient is monitored at regular intervals by clinicians who know the family well because they will be more able to observe subtle deterioration. Factors that increase the risk of emergency ventilation or death in patients with respiratory insufficiency include

- Progression of mild symptoms to severe symptoms
- FVC below 0.5 litres
- Denial of symptoms
- Non-attendance at clinics
- Not sleeping during overnight oxymetry assessment
- Obesity

All of these circumstances may result in premature death or emergency ventilation. The physiotherapist is often the person who is in most frequent contact with the family and who is most likely to pick up subtle changes in wellbeing. The assessment skills and knowledge required to conduct these assessments could be easily conducted by a physiotherapist under the guidance of the nearest muscle centre.

Nocturnal ventilation significantly improved life expectancy in patients with respiratory failure and DMD and furthermore the progression of symptoms was halted by the introduction of ventilation. Many years of good quality and active life can be expected following the introduction of nocturnal ventilation (current mean time is 61 months and the longest is over 11 years to date. Patients with cardiomyopathy may also benefit from the use of positive pressure ventilation both in a palliative way and also with the aim of improving survival but further studies are needed.

The quality of life studies showed how important independence was to both parents and young men with DMD. It is the duty of health professionals to ensure that equality of access and opportunities are not denied to families with DMD. This means providing quality assistive aids, environmentally suitable housing (either in the family home or for an independent disabled adult) and appropriate respite or home care. It also means promoting different attitudes and expectations in health professionals and families, even from the time of diagnosis, so that children with DMD can live to be fulfilled and independent (albeit supported) adults.

Recommendations

1. The FVC should be measured 6 monthly as soon as the child can cooperate (usually from the age of 6 or 7 years). The age at loss of ambulation should be noted. Weight should be measured 3-6 monthly.
2. Serial assessment of respiratory function, home overnight oxymetry and detailed documentation of clinical symptoms should be conducted 3-4 monthly once the FVC falls below 1.25 litres.
3. A referral should be made for home ventilation when there are;
   - Mild or early symptoms of respiratory insufficiency including
     - Fatigue
     - Loss of appetite
     - Weight loss
     - Poor sleep with increased need for attention through the night
     - Un-refreshing sleep
     - Chest infections which may occur recurrently without the preceding symptoms
   - An FVC below one litre in the presence of symptoms or an FVC below 0.5 litres even if symptoms are not elicited
   - Deterioration in the time spent below 90% Sao2 and/or a reduction in the mean SaO2 when previous traces have been normal.

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INTRODUCTION TO PAEDIATRIC – CYMRU 2000 CASE STUDY

DONNA WILSON
Cardiff Children's Centre

Introduction

Dyspraxia is a "delay or disorder of the planning and execution of complex movements".[1] It may be developmental – an inherent part of a child's makeup – or can be acquired as a result of brain illness or injury at any stage in life. Children with dyspraxia may have a spectrum of problems, some obvious and others less apparent. Features such as low tone, impaired balance, and poor motor co-ordination (both fine and gross) may be noted. More subtle problems, including difficulties with vision and motor perception, motor planning and tactile dysfunction, leading to poor body awareness, have been described. Difficulties with speech, reading and writing, as well as emotional and behavioural problems, are also well documented.[2]

Case Selection

Chris has been selected for this presentation because I have a special interest in children with dyspraxia. He is 11 years old and I wanted to explore the problems facing the older child with dyspraxia and the effects of therapeutic intervention in this age group. Lee and French state that "children who have struggled but overcome their difficulties throughout junior school may encounter significant problems with the change in pace of secondary education." [3]

History of Present Condition

Chris was referred for physiotherapy by his GP at the request of his parents as his difficulties had come to the forefront since starting secondary education. The diagnosis of dyspraxic tendencies was made approximately seven years ago. Shortly after diagnosis, he received a course of physiotherapy and had also been assessed and treated by an occupational therapist. Over the years, Chris had been seen occasionally on a review basis only. Chris was given a Statement of Special Educational Needs in 1995 as a result of assessments made by education and health professionals in collaboration with his parents. The 1981 Education Act came into force in 1983 and abolished individual categories of handicap, instead defining children with special needs as having "learning difficulties". The Act states that: "A child has learning difficulties if he has significantly greater difficulty in learning than the majority of children of his age, or has a disability which either prevents or hinders him from making use of educational facilities of a kind generally provided in schools for children of his own age." [4]
Chris seemed to cope reasonably well in Primary education with extra support in the classroom.
He had a teacher's aide most mornings to help him complete tasks set so that he could still access the National Curriculum. He started secondary education in September 2000 and now in High School teachers expressed concerns regarding a number of issues which will be discussed later.

Drug History

Chris takes 200mg twice daily of Epilim Liquid.

Past Medical History

Chris was diagnosed as having atypical myoclonic epilepsy at the age of 18 months. His epilepsy is well controlled by medication and his parents reported no seizure activity for over a year.
He had 2 febrile convulsions as an infant, one requiring hospitalisation.

Birth History

Chris's mother reported that he was born after a normal delivery and at full term. He required minimal resuscitation at birth as mum had pethadine close to delivery. He had difficulty maintaining his body temperature

for a day or two, needed a nasogastric feeding tube for low blood sugar, but did not require special care.

Developmental History

Chris was sitting at six months but did not crawl until 13 months. He started walking at 16 months. Mother always felt that Chris was a bit floppy and loose-jointed and a neurologist seeing Chris for his epilepsy said he had dyspraxic tendencies when he was four.

Social History

Chris is the eldest of three children. No-one else in his family has epilepsy or any co-ordination difficulties.

Assessment

1. Subjective assessment
I wanted to gain as much information as possible from Chris's teachers, his parents, and, most importantly, from Chris himself as to the difficulties he was now experiencing, so that my approach would be a holistic one. I also spoke to an occupational therapy colleague and she was able to accompany me during the assessment process.

The school

We were able to visit the school, and talk with the teacher who was the Special Educational Needs Co-ordinator (SENCO).

She highlighted the school's concerns as below:

(i) Safety
- In busy corridors and stairways during lesson changeovers – staff were worried that Chris might accidentally get knocked over and fall.
- In lessons requiring good manual dexterity, such as technology and science, when potentially dangerous tools and chemicals were being used.
- In PE lessons when Chris was participating in contact sports or using various equipment

(ii) Organisation
- Getting himself and his work organised in the classroom.
- Finding his way around the school

(iii) General weakness and low exercise tolerance
- He seemed to get increasingly tired as the day progresses
- Easily loses his balance and falls leading to safety issues

(iv) Confidence
- Chris seemed to lack confidence in his own abilities and needed constant reassurance

During our visit we were able to observe Chris getting around the school. His progress was slow and he was a little unsteady on his feet. There are a lot of stairs inside and out of the school and this could present a safety concern during the general mayhem of breaktimes and lesson changeover.

PE lessons were a problem for Chris. He took a long time to get changed and other pupils kindly helped him by doing his football laces up. I observed him practising his football skills and he had a go at everything. When it came to a match, though, he was quite happy to stay back and avoid contact with other players. He was obviously tired at the end of the lesson and it took him a long time to get dressed again.

The staff had implemented a number of strategies in order to minimise some difficulties such as:

- Allowing him to leave each lesson five minutes before the other pupils thereby minimising the risk of Chris getting bowled over in the rush
- Having an aide working with him during science and technology lessons
- Allocating a buddy to help him find his way around the school
- Ensuring all staff were aware of Chris's difficulties, and thereby accepting that instructions needed to be clear and concise
- Working on computer skills to supplement writing abilities in the future

The parents

Chris's parents understood his condition very well and had encouraged him in many ways to maximise his potential. Their main concerns now were regarding the extra demands put on Chris in the high school situation and the effects these would have on his self-esteem.

Chris

Chris said he liked school and his favourite classes were English, Geography and Science. His worst subjects were Maths, French and Welsh. In all lessons he found it hard to keep up with the written work although sometimes the teacher would modify his work so that he could give one-word answers.

He said he got very tired during the day and found it hard to concentrate during the last lesson. He felt a bit unsafe on the stairs around the school because he was wobbly. He enjoyed PE but felt silly because he could not get undressed quickly enough nor could he keep up with running in football and rugby and he often fell over.

2. Objective assessment

Chris came with his parents to the Children's Centre in Cardiff. He was wearing his school uniform – a polo shirt and sweatshirt and trousers with zip and button fastenings. His mum had put a popper fastening behind the trouser button, as he was unable to do the button up. His shoes had a Velcro strap, as he is unable to tie laces. He had an insert in his shoes supplied by the orthotic team to maintain a good foot position. His footwear is under annual review.

Chris was quite slow at undressing and his mother helped him. Observing Chris in his underwear he stands with an increased lumbar lordosis and anterior pelvic tilt. His knees tend to be in valgum and his feet pronated. He is a slight child for his age and he has underdeveloped limb muscle bulk.

Motor Skills

Children with learning difficulties, whatever the severity, often have motor problems. A number of dyspraxic children have low muscle tone. It is important to assess the full range of movement, hypermobility of any joints and general muscle strength.[2] I carried out a number of observations to identify Chris's strengths and weaknesses, to ascertain his general tone, muscle strength and range of movement. I followed guidelines documented by Lee and French.[2]

(i) Walking and running - Chris walks and runs with a wide base. He slaps his feet down flat and has little spring to his gait. He has winging of his scapulae when he runs. All of these features are consistent with low muscle tone.

(ii) Jumping - Chris can jump with two feet together. He tends to land with his knees only slightly flexed and doesn't use his arms to propel himself upwards.

Shoulder and hip stability

In prone lying with weight bearing on arms reaching for objects, Chris tended to abduct his arms and had to lean over the supporting arm. Standing on one leg, Chris was unable to maintain trunk extension and keep his balance for any longer than a few seconds. The lifted leg was adducted and flexed and there was overuse of the arms to maintain his balance.

Eye hand co-ordination

Throwing and catching a ball – he could manage a football but not a tennis ball. Throwing the ball across his body, i.e. crossing the midline, was really quite difficult.

Directional awareness

Chris responded appropriately when asked to move forwards, but hesitated when asked to move backwards and sideways. His mother reported that he often bumps into furniture and misjudges distances. These features may indicate a spatial awareness problem.

Symmetrical integration

Chris has difficulties doing up buttons. He also found it difficult to initiate jumping forwards and then backwards with both feet together. Difficulties moving both sides of the body simultaneously in identical patterns of movement can indicate difficulties with symmetrical integration.[2]

Bilateral integration

This refers to the ability to move both sides of the body simultaneously in opposite patterns of movement. Chris was asked to perform star jumps – he was unable to perform this task smoothly and got muddled up.

Dominance

Chris is left-handed, but performs some tasks, such as batting, right-handed. He uses a gel ink pen in class with a rubber grip to it. His writing is painfully slow and he prints still. He tends to smudge his own work and his writing is spidery.

Body perception and proprioception

Chris found it very difficult to imitate my movements when face to face. His mother reported that he still occasionally puts clothes on back to front and shoes on the wrong feet.

Gross motor sequencing/motor planning

I asked Chris to do a jump followed by a hop followed by a clap. He did the jump but could not remember the rest of the sequence. If a child is showing problems with task organisation or essay construction, there may be impaired ability to plan the movements necessary to move from one position to another.[2] This is a feature seen in some dyspraxic children.

Chris's mother reported how difficult he finds planning a homework assignment; he doesn't seem to understand that he often needs to gather information before he starts the task.

Throughout my assessment Chris was able to maintain good eye contact and was reasonably attentive. I needed, however, to demonstrate many of the activities before he was willing to try them. My instructions needed to be clear and concise. He talked to me appropriately throughout the assessment and, although his speech was slow, he did not appear to have any verbal dyspraxia.

Summary of assessment – formulation of therapy plan

From my assessment I ascertained that Chris has low tone. His limb and trunk stability are decreased with poor muscle strength, thus affecting his balance. His proprioception is affected and he has poor bilateral and symmetrical integration. His motor sequencing and planning are also poor. All these factors lead to the difficulties he has been experiencing at school and these can, in turn, lead to a decrease in confidence and self-esteem.

The findings of my assessment were discussed with Chris and his parents. We then talked about aims and modality of treatment.

Aims of treatment

- To improve trunk and limb girdle stability and strength
- To improve posture, balance and the ability to grade movement
- To improve symmetrical and bilateral integration
- To maintain self-esteem and confidence
- To advise parents on a home programme
- To give advice to teachers where necessary

Therapy plan

The treatment modality used is dependent on the age and degree of concentration and attention span of the child. [5] Lee and French write: "Group activities help the child to be aware of others, help learning by watching, and using others in partnership and teach them about sharing and taking turns." [6] I chose Group Therapy for Chris because of his age, his ability to concentrate and good attention span during assessment. As Chris is quite sociable, I also thought group environment would suit his personality.

At this point I wrote a report to the SENCO at Chris's school to discuss my findings on assessment and to inform them of my therapy plan. I felt that this might lead to a better understanding of Chris's condition and acceptance of why he found many activities challenging.

Senior Physiotherapists in Cardiff have organised recreational therapy sessions, which are offered in a block of 6 classes. They run during the school lunchtime so little lesson time is lost. Each group consists of no more than 6 children of similar age and ability. The parents are encouraged to attend to enable some carry over in a home programme.

During the first session several activities are undertaken that provide baseline scores against which progress and treatment outcomes can be measured. The three that would provide the best objective evidence of Chris's progress were:

Task 1: The subject lies on his back with the arms slightly away from his sides, then lifts his head off the floor and holds it up for as long as he can. Count the seconds. This is a measure of truncal tone – Chris managed ten seconds.

Task 2: The subject lies on his back, tucks his knees onto his chest, holds them with both hands and lifts his chin onto his chest. This test provides information about truncal tone, balance and bilateral integration. Chris found this very difficult and could hold this position for just 1-2 seconds.

Task 3: This task tests shoulder and hip stability and upper limb strength. The subject supports his weight on straight arms and gives his legs to a grown up. A "wheelbarrow walk" is performed and the number of steps achieved is counted. Chris could do 5 steps and then collapsed!

Subsequent sessions focused on achieving the aims of treatment. A typical session would start with stretching exercises and then might include the following:

A Bench work – walking along it sideways, pulling body weight along in prone or supine, doing bunny hops over either side, walking along the upturned bench.
B Mat work – cat lick press-ups, bridging, lifting the mat up and down in pairs, log-rolling down a row of mats trying to stay straight the whole way
C Ball work – throwing against a wall and catching it, working in pairs, bouncing the ball to one another, dribbling a ball between cones, batting a ball
D Floor work – crab walking, star jumps
E Obstacle courses – over, under, through equipment
F Parachute – using whole body movements, teamwork and fun

At the end of each session, I spoke with Chris's mother about a home programme of muscle strengthening exercise for 5–10 minutes a day. The importance of such home programmes has been emphasised. They allow for treatment to be continued on a regular basis and will further promote muscle strength and abilities.[2]

Unfortunately Chris did not comply with the home programme regularly. He said he was too busy!

Chris co-operated well with the sessions and seemed to enjoy them. He tried all the activities, finding some more difficult than others. He was quite tired at the end of each session but did not complain of any pain or discomfort.

At the conclusion of the six-week period the baseline scores were redone and Chris showed an improvement in most areas. For example, he was able to do Task 1 for 15 seconds, Task 2 for ten seconds and he was able to take ten wheelbarrow steps (Task 3) before collapsing in a heap!

He was given a Certificate of Achievement for his efforts.

Chris and his parents were asked to fill in an evaluation sheet. Chris wrote to say how much he enjoyed the sessions particularly using the parachute. His parents said it was rewarding to see the quantitative improvements he had made on the baseline scores. His mother felt Chris seemed stronger and she could see he was managing to carry his heavy school rucksack more easily. She felt that his confidence levels had increased. Both Chris and his mother said he would like to come to another session if it were offered in the future.

I stressed to Chris and his parents the importance of maintaining his improvements by continuing physical activities. Lee and Smith write: "The children must be made aware that in the long term they should consider additional sports in order to maintain their strength and skills. The improved self-confidence and esteem will certainly encourage them to attempt new activities." I advised swimming groups, karate, Tao-Kwon-do and trampolining. It remains to be seen whether this advice is taken and whether any improvements are sustained, however there are some encouraging factors:

His family is very keen that he should be given every opportunity to succeed. He has tried various swimming groups over the years and is currently succeeding with an individual tutor. (He has recently gained a 50m badge). He attends a church youth club and has weekly cookery classes. The family participates in local Dyspraxia Foundation meetings and activities.

At the conclusion of the recreational therapy sessions I spoke to the SENCO at the school as well as sending my formal report. I asked if improvements had been seen in Chris since starting the sessions. She said that staff had commented on how much more confident he seemed. He seemed to be steadier on his feet and more willing to have a go at new tasks. The PE teacher in particular commented that he was less worried about Chris as he seemed stronger and more able.

Other modalities

Elizabeth Atter, one of my physiotherapy colleagues, has set up a Rebound Therapy class i.e. the therapeutic use of a trampoline. In her report *Evolution of a Physiotherapy Service for Children with Co-ordination Difficulties* she states that "The properties of the trampoline bed mean that the physiotherapist can facilitate or resist the child's movement without hands on, allowing the child to feel the movement for themselves. It stimulates the vestibular and proprioceptive systems, can be used to challenge balance and co-ordination, visual tracking for ball skills, teach the language relating to movement and improve the child's ability to follow sequences of instructions whilst having to concentrate on their foundation skills".[5] I have added Chris's name to a waiting list for this facility.

A group is being set up for Riding for Therapy for children with co-ordination problems and Chris's parents are in the process of applying for a place on that, too.

Other agencies involved

At the time of referral, occupational therapists were not involved in Chris's management. However, as stated previously, an OT colleague accompanied me during assessment and she has been seeing Chris regarding fine motor control and a variety of strategies to help control of organisation in the classroom.

Many of Chris's difficulties have been or are being addressed. An Information Technology Advisor had already seen Chris and he might be having a laptop computer for use in the school.

Conclusions

Chris's dyspraxia affects him in ways far beyond the planning and execution of his motor skills. It has an impact on his development, education and socialisation. A course of therapy was instituted following a thorough assessment. The use of the base line score outcome shows that physiotherapy did have a positive effect on Chris's dyspraxia. The comments from his parents, his school and indeed himself, were very encouraging, particularly regarding his increased confidence. However, it is important that improvements are maintained in the long term. Lee and Smith write of these children: "difficulties develop quickly, and schoolwork can deteriorate rapidly and self-esteem soon drops".[7] This is especially true when the child has a growth spurt.

Chris will be seen in 3 months time for a review and then yearly in accordance with his Statement of Special Educational Needs.

Again, Lee and Smith write that regular "reviews ensure that any current difficulties are identified and dealt with so those physiotherapists can help to maintain the long-term improvement. With these additional management suggestions, it is believed that dyspraxic children will be able to fulfil their maximum potential throughout childhood and into adulthood".[7]

Acknowledgements

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REPORT ON TWO INTERNATIONAL CONFERENCES ON DEVELOPMENTAL COORDINATION DISORDER

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DCD-V Conference
Developmental Coordination Disorder:
MECHANISMS, MEASUREMENT, MANAGEMENT
5th Biennial Workshop on Children with DCD
May 14-16 2002, Banff, Alberta, Canada

DCD-V was the follow-on from workshops held in previous years in Groningen, Netherlands (1999), Cardiff (1997), Leeds (1995) and London (1995). Participant numbers continue to swell. Gathered together for three days, were 200 professionals from a wide variety of clinical and research departments drawn from health, education, psychology and sociology. Five major continents were represented.

I attended the meeting as a participant invited to present a paper entitled "Service provision for children with DCD – one example of an audit" (Peters and Henderson) and a poster entitled "Sub-types of 'Clumsiness'/ DCD Developmental Coordination Disorder" (Peters, Owen and Henderson). We were pleased to receive the accolade of 'Best Poster'.

The two-day research meeting was preceded by a clinical day. This included lecture and workshop sessions. An evaluation study of paediatric physiotherapy for children with DCD from the Netherlands suggested that the application of motor learning principles by therapists (e.g. giving instructions and feedback) increased the effectiveness of intervention. Other topics included features of play with children with DCD; motivation; social behaviour; effectiveness of different treatment approaches and a multidisciplinary panel discussion on "How can we best advocate for the child with DCD".

I was fortunate in being given a place on the half day advanced "CO-OP" workshop tutored by Angie Mandich and Helene Polatajko (Professors of Occupational Therapy at the University of Western Ontario and Toronto respectively). This new intervention package for helping children with DCD is grounded in cognitive and motor learning theories and dynamic performance analysis. Many of the underlying concepts are common to the problem-oriented goal setting methods presently adopted by some physiotherapists and to the approach pioneered by Henderson and Sugden (1992) from UK in their Movement ABC Manual. Look out for COOP as a treatment approach mushrooming in the UK in the near future!

The research days were divided into three streams: Mechanisms; Measurement; Management. This had the advantage of opportunity for 30 papers to be presented but the disadvantage that parallel sessions meant that one missed two thirds of the topics. Plenary sessions were organised to allow participants to discuss the current state of DCD research as well as encouraging dialogue about future directions of DCD research internationally.

Research covered areas such as longitudinal educational monitoring of children with DCD; control strategies and timing in aiming, reaching and underlying mechanisms of catching a ball; DCD and balance. Papers were

presented on somatosensory-motor coupling in DCD; auditory and motor coupling and reaching under visual perturbations in children with and without DCD. There was discussion regarding an automization deficit. More intervention-based topics included evaluation of a physiotherapy programme; analysis of a school-based intervention and the use of self-instruction training. Measurement issues were addressed in papers on alternatives to assessment for DCD referral screening and evaluating motor and functional abilities.

Alongside empirical research issues, which seek to answer questions about the processes underlying DCD, there were also more immediate practical concerns. Increasing numbers of referrals and recognition of children with DCD/dyspraxia appear to be common. Lengthy waiting lists and discussion about efficacy of various interventions remain current topics. There is a trend away from 1:1 sensory integration approaches toward more directive therapy and group intervention, not necessarily by health professionals.

The Movement Assessment Battery for Children (M-ABC) is a standardised test of motor function presently used in all 13 countries represented at the conference. This supports the pertinence of the recent M-ABC one-day workshop for therapists organised jointly by the Association of Paediatric Chartered Physiotherapists (APCP) London Branch and London University's Institute for Education.

The DCD-V Workshop in Banff yet again stressed the continued interest and concern regarding the child with comparatively mild movement difficulty that is at risk of compromising the attainment of their potential in many areas of function in addition to this motor domain. The idea of co-morbidity seems generally accepted and there are increasing links between research into dyslexia, dyspraxia, Asperger's syndrome and other psychiatric diagnoses.

The Clumsy Child

Aetiology, Pathogenesis and Treatment

Groningen, The Netherlands June 6-8th 2002

This meeting was organised by Dr Mijna Hadders-Algra and colleagues from the departments of neurology and medical physiology, Groningen University Hospital. The 200 delegates were predominantly from The Netherlands or Belgium with UK, Scandinavia and Israel well represented and a lesser number from North America, Slovenia and Switzerland. The theme of the meeting was quite different to Banff with greater emphasis on the medical perspective. Dr Sheila Henderson opened the meeting with an overview of problems of definition, diagnosis and prevalence of clumsiness. Dr Hadders-Algra then talked about the aetiology of brain lesions at an early age and this was followed by a key-note paper by Professor Christopher Gillberg who addressed the issue of comorbidity in clumsy children. The next group of papers reviewed phylogeny of motor systems and particularly explored the principles of force gradation in skeletal muscle, and the role of motor cortex and dexterity.

The following day delved further into neonatal insults with papers on neonatal cranial ultrasound findings and motor competence at school age alongside a presentation on the relationship between neonatal brain MRI and perceptual-motor abnormalities at age 5 – 6 years. Dexterity was an overriding theme in presentations of research on proprioception and dexterity, basal ganglia and dexterity and cerebellum and dexterity.

The final morning focussed on treatment of clumsy children. The first paper outlined physiotherapy intervention in the Netherlands. "A familiar complaint from parents is that the motor problems have been diagnosed late (not before school age)". Intervention, following a multidisciplinary assessment, aims to coach complex motor skills, improve body awareness, achieve coping strategies and disseminate information on the child's abilities/disabilities to parents and teachers. A second paper presented results of two studies. One study evaluated a 9-

week physiotherapy programme on a small group of children with gross/fine motor and handwriting problems. Significant effects of treatment were found. The second study used a standardised writing scale to compare function in children with ADHD when on or off Ritalin medication. The results reflect my own clinical findings and I suggest there are implications here for recording at each assessment whether a child is on medication in an attempt to improve the validity of our outcome measures.

Alongside the verbal papers, were structured times for well-organised poster presentations. Authors gave short explanations of their poster display to each group of delegates, with opportunity for question and discussion. Posters included the project underway on the revision and upward extension of Age Band Four of the Movement ABC to include teenagers; imitation problems in autistic children; postural control during reaching in children with CP; characteristics of postural adjustments during reaching in pre-term infants.

Hopefully this report provides a flavour of the content of two contrasting international multidisciplinary meetings on the theme of "DCD" / "clumsiness". The conferences provided an excellent opportunity to keep abreast of the current research and clinical activity in the field of Developmental Coordination Disorder. I am grateful to the CSP and to Great Ormond Street Hospital NHS Trust for financial support to attend and present research at these meetings.

This article first appeared in the December 2002 edition of this journal with the incorrect set of references. Sincere apologies to Linda Fisher – the article is re-printed in full with a complete set of references.

A PAEDIATRIC PHYSIOTHERAPIST'S DREAM OR NIGHTMARE? (A LECTURE FOR APCP CONFERENCE 2002)

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Introduction

Children and young people with disabilities and their families often have complex needs that require provision from more than one agency and there are complex barriers encountered in trying to achieve co-ordinated support. It is well known that single agency working has not fully supported the needs of children and families. Families have been asking for a co-ordinated service for many years (since the Court report in 1976). Co-ordinated services require agencies to work together and interagency practice supports physiotherapy being embedded into children and young people's everyday curricular, social, play, rest and sleep activities - one of our dreams!

National overview to support interagency working

Government initiatives and national trends accompany the 'duty of partnership' placed upon services to work together. Recent initiatives include:

- Quality Protects, a programme committed to transforming the management and delivery of children's social services. One key component is the development of the framework for assessing children in need and their families to ensure a timely reponse and effective provision. It is a holistic assessment and recognises the importance of collaboration between all agencies.
- The Special Educational Needs (SEN) Code of Practice 2001 (DfES 2001) *'provides a framework for developing the strong partnership between parents, schools, LEAs, health and social services and voluntary organisations that are crucial to success in removing the barriers to participation and learning'.*
- The SEN Regional Partnership is a network of 11 Partnerships each including a range of local partners from education, health, social services, employment and the voluntary and private sectors sharing practice, solving problems and discussing key issues. The idea being to take forward the cause of interagency working locally and regionally.
- The Health Act (1999) offers a greater flexibility where services are delivered in partnership between the NHS and local authorities, including LEAs. The flexibility encourages partnership working through arrangements such as lead commissioning, integrated provision and pooled funding.
- The new Connexions Services, for all young people from 13 to 19 years old, aims to support young people to further develop their skills, knowledge and self confidence equipping them to successfully cope with life transitions and challenges. The concept is that the Connexions Services should enhance and complement established and developing services and the 'personal advisers', (PAs) will work with young people in a variety of settings - not necessarily school based. For young people with complex needs the support may be intensive and on going and may extend beyond the age of 19. Their 'profiling kit' is a holistic approach

to planning and supporting the co-ordination of services, the PA becoming, perhaps, a 'key worker' - another crucial element within the multi agency arena.

- Valuing People (DoH) document is the strategy for the 21st century for children and adults with learning disabilities. One of its key elements is the support for 'person centred approach to planning'. The realisation of the goals identified through person centred planning may require flexibility in service delivery and agencies working closely together.
- The presently developing Children's National Services Framework discusses the need for multi agency working
- 'Health For All Children' draft consultation document 2002 talks about joint plans, joint agency reviews, joint assessments and states that multi agency working is essential.

So, with this ever increasing emphasis surrounding multi agency working, it is being encouraged to provide packages of support that are comprehensive, co-ordinated and comprehendible - what makes it so difficult to do?? And is this a physiotherapist's nightmare?

The obstacles of multi agency working?

It has been said that, with each individual agency, obstacles exist based around the emotional responses of the five 'Ts' - traditionalism, tribalism, territorialism, timidity and terrorism. In addition there may also exist the uncertainties of losing control, suspicion and lack of trust, different value bases and the lack of clarity about other agencies roles. Certainly the specific terminology used by different agencies makes inter-professional collaboration even more difficult. There are further real issues centred around the emphasis on the statementing procedure, the finance and /or resources being owned by different agencies, the differing definitions of disabilities and the fragmentation of Health and Social Services structures.

What do physiotherapists, as change agents, bring to the multi agency arena?

Physiotherapists have skills, beyond that of clinical expertise, to contribute to this arena. The skill of being good communicators, problem solvers, team players, holistic planners, initiators and instigators and no less the fact that we are independent practitioners. These all contribute to the physiotherapist having a vital and important role within the multi agency arena. Mutual recognition should be given not only for the 'time taken' to effect change but also to the additional skills.

BUT WHAT ARE THE SOLUTIONS?

The Multi Agency Resource Centre, MARC project potential solutions

MARC helps everyone work together to help each other help my child' quote from a parent

The MARC project is based around two special school sites in Essex. It is a joint funded project and has developed through Essex County Council reviewing the role of special schools in the 21st century. MARC is now 20 months old and is an ever developing and evolving project. It is being evaluated through Essex University and is an action research project. MARC is organised through dedicated county and local steering groups. Each of these groups have multi agency representation and all plans and actions are well and truly consulted, encapsulating the varying views of all agencies. There is parent / carer representation.

Its aims are to:

- promote positive family life
- ensure that children, young people and their families are at the centre of all decision making
- support increased inclusion

It is felt that these aims are achievable by:

- co-ordinated delivery of support
- re-configuration of resources / changes in practice
- person centred approach to planning
- reviewing of attitudes towards children and young people with complex disabilities

Designing the project revolves around the cycle of planning, acting, observing and reflecting. The research questions were:

1. What are the current practices of multi agency working?
2. What are the preferred models of multi agency working?
3. Have the preferred models created multi agency provision that is workable, sustainable and in line with best practice?

The results from the parent's questionnaire influenced the planning of the project. In brief, it highlighted how meeting professionals was a priority, how much they valued the good communication with school, the importance of having a 'one stop shop' concept and a key worker to support them through the 'information maze'. They were less positive about whether they felt truly involved in the decision making process.

TO SUPPORT CHILDREN AND YOUNG PEOPLE WITH THEIR FAMILIES:

The results from the professional's questionnaire indicated that the present way of working is around multi disciplinary practice and the preferred way of working is towards the transdisciplinary approach but time, or rather the lack of time, was highlighted as a key inhibiting factor in trying to work together.

To work together, beyond that of established good working relationships, requires the identification of each other's roles and responsibilities. The project has prepared a Roles and Responsibilities document to support this process of understanding.

Developments such as child focused plans, the 'team around the child' concept, joined up planning and transdisciplinary approaches are key elements to the promotion of interagency working practices. Interagency working practices support multi agency provision. Piloting the combining of the educational and social services statutory reviews for some children highlighted the many differences between the two services. The project has afforded the opportunity to identify and attempt to resolve some of the complex organisational issues to promote such reviews becoming good practice.

A framework has been developed to support the process of joined up planning which begins with involving parents/carers and young people, inviting their views, and initiating a 'joining up the plans' meeting for members of the 'team around the child'. Joint objectives and short-term goals are discussed and confirmed and each team member then prepares their strategy to support the realisation of the goals. This then builds together to form an Individual Learning and Action Plan or an extended Individual Education Plan and is in preparation for the child's statutory review for further consultation and confirmation. The planning and preparation process supports therapy being embedded into every day activities and facilitates transdisciplinary approaches.

Key working, as a 'co-ordinator of services', or as a key person supporting an individual child has a role to play in implementing the plans to facilitate working together. Within the MARC project, there are future plans to develop the role of the 'generic worker' to offer a more holistic and seamless approach to support and intervention.

Sharing the responsibility of developing the holistic curriculum is another way of jointly planning and working together. This could include being involved in whole school approaches, shared training and development sessions, actual curriculum planning, sharing therapy outcome measures, designing joined up planning processes and promoting interagency thinking.

Child and family focused plans, therapy being embedded into everyday activities, co-ordinated seamless services and the opportunity for therapists to use their infinite skills - including those they cannot give away - are dreams that become realities through the development of interagency working practices. It would be also true to say that these are key to the successful implementation of interagency working.

National guidelines and trends support partnership working. Partnerships support interagency working practices thereby facilitating the seamless and co-ordinated delivery of the multi agency provision necessary in supporting children with complex needs and their families.

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'Providing related services to learners with severe handicaps in educational settings: Pursing the least restrictive option' M. Giangreco, J. York, B. Rainforth

TO SUPPORT CHILDREN AND YOUNG PEOPLE WITH THEIR FAMILIES:

'Delivery of therapeutic services in special education programs for learners with severe handicaps' M. Giangreco

'Parents reviewing annual reviews' British Journal of Special Education 2001

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'Transdisciplinary team work and integrated therapy: Clarifying the misconceptions' J.York, B. Rainforth, M.Giangreco

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NOTICE

The 30th Annual General Meeting

of the

Association of Paediatric Chartered Physiotherapists

will be held on

Friday 4th April 2003

at

The Marsham Court Hotel, Bournemouth

beginning at 11.30am

All paid up members of the Association are entitled to attend. Voting will be restricted to full members of the Association and a current membership card will be required.

Minutes of the last AGM are available from the Secretary on receipt of a S.A.E.

Nominations are invited for three committee vacancies.

Nominations should be sent to the Secretary by **Friday 14th March 2003** together with the names of a proposer and seconder who must also be full paid up members of the Association.

A nomination form is located towards the back of this journal

DEVELOPING A COMPETENCY FRAMEWORK FOR CHILDREN'S SERVICES

Report from a meeting held in London on 8th January 2003 for the Children National Reference Group.

Care Group Workforce Teams (CGWTs) are multi-disciplinary advisory bodies that have been established to support the National Development Board and Service Taskforces in delivering serving developments.

CGWTs have a common responsibility to identify skill requirements in order to deliver services to defined standards and develop strategy to fill skill gaps. The proposal is for 'Skills for Health' (SfH) to support each CGWT in the development of competency frameworks. SfH is the body approved by the four UK Departments of Health and the Department of Education and Skills to develop competency frameworks across the health sector.

The frameworks will set out what people need to know and should be ble to do to perform a task. Such competency frameworks could be used to:-

- inform workforce planning
- review individual or team learning needs
- design training programmes
- plan appraisal and development
- commission education
- identify skill mix
- develop services

Many skill requirements will be shared between all or a number of care groups. This work will dovetail with the ongoing work on the Knowledge and Skills Framework (KSF) and the Electronic Staff Record (ESR).

The overall aim of the children CGWT project is to develop a competency framework that will describe the range of competencies required to deliver children's services. This framework will be used to develop at least two workforce tools in line with the CGWT work programme.

It was agreed that children needing acute/hospital care, children in special circumstances and Children and Adolescent Mental Health Services would be the main priority areas for the development of the competencies.

The project will work with local sites identified by members of the CGWT to develop the competency framework and tools. Sites will be selected to reflect an appropriate mix of settings and conditions.

The following will be taken into consideration:

- care settings
- employers
- geographic locations
- staff groups
- service users

The information gathered will be used to prepare workforce development "tools".

A National Reference Group has been established by Skills for Health (this is the group I was representing in London on 8th Jan.) and this group will be consulted at key stages in the development of the competency framework and will sign off project outputs.

The project will take approximately 12 months to complete.

The next meetings are scheduled for June and October to review the products of the project and there will be ongoing advice and correspondence by e-mail.

I will keep APCP members informed as the project progresses, so please look in the Journal for updates.

Adare Brady, Chair APCP

PEER REVIEW

It has long been the wish of the editorial board to introduce peer review into some of the articles in this journal. This does not mean every piece that we include for publication -because we want every one to feel that they can take an active part in the ideas, work and correspondence it contains. However, in these days of continuing professional development and evidence based practice many of you wish to see some articles which you can use to support this in a more concrete way. Obviously peer review is one way forward in this direction.

Everyone has aspirations and it is mine to see if I can make this happen during the time I sit at the editors desk but IT IS YOUR JOURNAL and to make peer review happen even in a small way the editorial board need YOUR HELP.

Do you have an area of expertise? Would you be willing to peer review pieces of work that fall within that area? Please let us know who you are. Contact Sally Braithwaite, Journal Editor with your name and a short curriculum vitae outlining and illustrating the areas in which you feel you are able and willing to help. Please send your offers of help to –

Sally Braithwaite
APCP Journal Editor
531 Church Road, Yardley, BIRMINGHAM, B33 8PG
email Sally.Braithwaite@btinternet.com

I look forward to hearing from all of you

Sally Braithwaite
Editor

PAEDIATRIC MSC MODULE AT QUEEN MARGARET UNIVERSITY COLLEGE, EDINBURGH IN CONJUNCTION WITH APCP

This very successful double module that takes a theoretic approach to paediatric physiotherapy will be running for the year 2003/4. Each block focuses on a particular area of paediatrics – musculo-skeletal, neurology, cardiorespiratory and integrates within these themes the principles and concepts of epidemiology, communication, family, systems, psychosocial, legal and ethical issues, clinical effectiveness and standards of practice.

Blocks are for one week each in October and April and a two week block in January. The double module can stand alone or be studied in conjunction with other modules in the programme. An exciting development for this year is the use of the WebCT facility to improve support and communication for students.

Further details of the course can be obtained from:

Senior Lecturer, Physiotherapy
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Email: Jhooper@QMUC.ac.uk

RESEARCH NEWS

Next APCP research meeting

The next APCP research meeting will be held in London this September 2003. Our original date in June has had to be postponed due to the many regional study days planned at this time. The day will include workshops in the morning to spend time discussing the use of different methodologies, a guest speaker to talk about their particular project and a free paper session in the afternoon. There will be opportunities to discuss problems, questions and project ideas. If you would like to develop your understanding of research methodology and project design, and wish to hear how others are undertaking research in paediatrics, please join us on this day. I am sure it will be as enjoyable and inspiring as the one held last year. If you have some research you can share with us, large or small, perhaps a MSc project, please do apply for the free paper session. A programme and application details will be published in the next Journal and earlier in Frontline. For the free paper session, please apply to myself at 10A Record Road, Emsworth, Hants PO10 7NS or e-mail scrombie@srtl.co.uk The closing date for applications for free papers will be July 31 2003.

Research skills afternoon in York

For those of you near to York, the Northeast APCP region have organised a research skills study day on 7 June 2003. Details are posted on www.interactivecsp.org.uk

NEW FOR 2003: Stats For Scaredy Cats!!

A Simple Look At Descriptive Statistics

When we are reading research papers there are many terms used which need to be understood to enable us to make sense of the data collected. To start with something simple – have you ever wondered what the difference is between the terms: the mean, the median and the mode? Look at the following collection of data and see if you can find these values. Have a go, but don't worry for if you get stuck the answers are at the back of the Journal!

Data : 4,6,9,14,14,15,19,20,21

What would be the mean, the median and the mode of these numbers?

New APCP research grant

The APCP have discussed the proposal of allocating a sum of money each year to assist prospective researchers in carrying out their projects. As we are considering a substantial amount of money, we feel it is important to consult our members as to whether they are in agreement to the principle of this. There will be stringent criteria for this grant, in order to ensure that the successful applicant will have the skills and support necessary to carry out a useful and successful project. This will be discussed at the AGM in April this year in Bournemouth, but if you are unable to be there and wish to register an opinion in this matter, please use the slip below.

I am in / not in agreement for the APCP to allocate a sum of money (variable each year depending on finances) to support paediatric research projects as selected by the education committee.

Name: .....

Signed: .....

New CSP initiative: Sharing effective physiotherapy practice

The CSP are starting a new initiative to help promote examples of good practice in physiotherapy. A set of criteria has been developed against which physiotherapy services can be reviewed. The service models will then be available in an accessible format so that practice can be shared easily across the UK and within all clinical areas.

Both a publication and a database will be developed this year with the launch expected at the CSP congress in October. The database will be accessible through the CSP website, to help members to share practice. The CSP are inviting contributions from all sectors of the profession. If you feel that your service is delivering good care and would like the opportunity to gain some recognition of that service, please obtain an entry form from www.csp.org.uk/effectivepractice/sharing_effective_practice.cfm

Networking

If you are undertaking any piece of research, however small, please fill out the form at the back of this Journal to let me know what you are doing. By having a list of those involved in projects, it has enabled me in the past to put others in contact with those researching similar fields. I will also be able to let you know when there are research meetings planned.

Useful Websites

This section of the Research and Education pages will be moving to the APCP website following this journal and only new websites will be displayed here in future.

RDInfo: This database is now funded by the DoH and is available on www.rdinfo.org.uk It is easily searched to find over 800 funding sources for healthcare research in the UK. This covers 1700 different awards totaling over £45m. Well worth a look.

RDAnnounce: This new web-based NHS R&D alert facility carries details of the most recent announcements from the DH?NHS R&D. It includes funding calls, key publications and other developments such as policies It is found on www.doh.govuk/research/rdannounce.htm

PEDRO: http://ptwww.cchs.usyd.edu.au/pedro/ This is a database of abstracts of randomized controlled trials of physiotherapy topics

NICE database: http://.nice.org.uk/database/db_ind.htm

Current controlled trials:

http://controlled-trials.com/ligin.cfm?=form&returnto=home_page.cfm

www.ex.ac.uk/stloyes/schhom.htm Electronic distance learning module: the university of Exeter have produced a module to introduce principles and application of evidence based practice

Chartered Society of Physiotherapy: www.csp.org.uk

CIRRIE is the Centre for International Rehabilitation Research Information and Exchange. They have a free database for international research on rehabilitation. It also has a directory of international research centres and conferences. http://cirrie.buffalo.edu/search

(PIER) Paediatric Information and Education Resource

This is a free web site developed by the Sheffield Children's Hospital to encourage communication between health professionals involved in the care of children. The site contains many national and local guidelines for paediatric care, examples of patient leaflets, educational material and research findings. http://www.pier.org.uk Username: PIER Visitor, Password: Browse

OMNI (Organising Medical Networked Information). Provides a gateway to many quality Internet sites dedicated to health and medical sciences. Based at the University of Nottingham, at http://omni.nott.ac.uk

Useful websites to search for funding opportunities

Department of Health

This site gives details of all funding and policy initiatives within the Department of Health. It also gives useful links to other important sites. http://www.doh.gov.uk/research/

RdInfo database

This is a useful database to search for health related funding and training opportunities. http://www.rdinfo.org.uk/

HERO

This is the official site for UK's university, colleges and research organisations. It gives information on all aspects of higher education opportunities. http://www.hero.ac.uk/

PPP foundation

The PPP Foundation have launched an award for all healthcare practitioners who wish to carry out research as a means of enhancing their ability to make a significant difference to the quality of patient care or the health of

the population. The deadline for the first round of applications is November 25th and the second is August 2003. www.pppfoundation.org.uk

Physiotherapy Research Foundation awards

These awards are allocated annually in September and are now organised into three funding bands depending on your experience and type of project.

Further information from Marion Attew at the CSP, e-mail:attewm@physio.org.uk

MRC funding

The MRC provide funding for Clinical Research Training Fellowships and MRC/Royal Colleges Training Fellowships. They offer three years support for research, with Fellows normally registering for a PhD. Awards are allocated annually with applications in September. www.mrc.ac.uk/funding

Funding in Scotland

This site may be worth investigating if you are working in Scotland.

RDAnnounce

This web-based NHS R&D alert facility carries details of the most recent announcements for funding calls. www.doh.govuk/research/rdannounce.htm

Answers to statistics quiz

The mean, the median and the mode, are all measures of central tendency. In a single figure they give us an idea of the typical value of a set of scores.

The mean is the technical term for what is usually called the average by most of us. It is found by adding together each score and dividing the total by the number of scores. Therefore 4+6+9+14+14+15+19+20+21 =122. Divide this by the number of scores (9) and you have 14. The mean score is therefore 14. This measure is most commonly used as it summarises all of the data and is useful for more advanced statistical analyses.

The median is a measure of location. It is defined very simply as that value which has as many scores above it as below it. Therefore for these scores, the median would be 14. All you need to do with a set of scores, is to rank the scores in order from lowest to highest and then find the central value.

The mode is defined as the most frequently occurring value in a set of scores. For a small number of values as those in this set of data, it may not tell you much, but for a larger set of values it may be more useful in telling us which is the central value of the scores. The mode for this set of data is 14. It is useful when a quick and very approximate figure is needed.

For this set of data the mean, the median and the mode are all the same because the scores are symmetrically distributed about the central value. There is a roughly even distribution between all of the numbers. This would not be the case if you added two scores which were wildly different from the rest e.g 40 and 48. In this scenario the median might be the preferred measure of central tendency as it still remains a 'typical' value of middle, while the mean would be misleading..

Sarah Crombie
Research Liaison Officer

EDUCATION

The education committee have been busy again working on several projects.

CPD Course - Introduction to paediatrics - Harrogate Nov 2003

This is a 5 day course which is held annually in a variety of locations throughout the UK. The most recent one was in Harrogate. The course covers the main aspects of paediatrics (Musculoskeletal, Neurological and Respiratory) and is aimed a senior II Physiotherapists or established physios moving specialities who are new to Paediatrics.

The course evaluated extremely well overall. All of the participants rated using the good, very good, and/or excellent responses. Comments were very positive (not only with regard to the very nice hotel and the Turkish baths!) with some useful suggestions for future developments of this course and ongoing APCP events. Next introduction to paediatrics course is due to be in September 2003 in Liverpool, further details will be announced when formalised.

Outcome measures pack

Work is ongoing in collaboration with the CSP, PPIMs and BABTT in relation to updating the outcome measures pack. We aim to produce a document that enables members to work through a framework of questions to decide upon a suitable outcome measure. A wide range of measures will be evaluated and summary critiques will be published to help you find the right measure for your specific needs.

I am trying to ensure we cover all the relevant areas of paediatrics

(Neurological, orthopaedic, respiratory, neuromuscular, JIA, etc) and I'm looking for help.

If you have a particular interest in outcome measurement and would be willing to help review the most common measures please let me know. I'm particularly looking for help with orthopaedic and respiratory measures as we are currently trying to establish the most frequently used and the most highly recommended measures in these areas. If your department regularly uses a standardised test for these specialities, please let me know..

S.E.N. code of practice

Work is ongoing to update our guidance document on Special Educational Needs. We anticipate it will be available at the next conference.

Advanced Cerebral Palsy course

This course has been developed following feedback from the questionnaire in the last journal. It is planned to take place over 2 days in November 2003. The course is designed to assist in clinical decision making with regard to treatment and management programmes of children with cerebral palsy. The course is designed for Senior 1 Physiotherapists and will use discussion, seminars and workshops to enhance knowledge base and problem solving. Watch out for the advert shortly.

Journal club

Title of article for review in next journal.

Stewart DA, Law MC, Rosenbaum P, Willms DG (2001) "A Qualitative Study of the Transition to Adulthood of Youth with Physical Disabilities" Physical and Occupational Therapy in Paediatrics. vol 21 (4) pages 3-21

Adele Moore
Education Liaison Officer.

Dan B, Bouillot E, Bengoetxea A, Noel P, Kahn A, Cheron G (2000)"Head Stability during whole body movements in spastic diplegia" Brain and Development (22) 99-101

Does the study have a clearly focused question?

Yes. It's clear that head control is important to visual and vestibular information and postural control. Although no explicit question is asked the study investigates a clearly defined movement component.

Is the methodology suitable to the research question?

Yes. 2 groups are investigated using a quantitative measurement tool. Details of the measurement tool are given and would allow the reader to repeat the measurement using the same process. No details of references for other studies using similar measurement techniques are given in reference list although these are cited in the method section. Opto-electronic ELITE system markers placement is clearly described. The 0.67mm error would not be clinically relevant. This marker placement and angle derivative will only allow investigation of the tilt in one plane, demonstrating flexion and extension. This is a valuable measure and is frequently observed as a movement anomaly in children with spastic diplegia, however gives no indication of asymmetry as a result of side flexion or rotation. These could be key factors in the discrimination of severe postural impairments.

24 subjects repeated the measure 10 times resulting in 240 measures for each movement element. This number of measures and the ratio data enabled a high level of statistical testing using parametric statistical testing; however the changes seen due to any practice effect over the 10 repetitions is not discussed.

The nature of the end of the squat to stand phase and visa versa is not documented however it is referenced to previous studies in adult populations and therefore could be investigated by the reader if required.

The experimental method leads to reliable results with minimal confounders biasing the results.

Were all the participants suitable for the project?

Clearly defined sample group, pathology, age and physiotherapy intervention are all well documented. The age range of the sample is broad (3-12 years) in this age range significant differences of head posture and control in the squat task would be expected.

Severity is assessed using retrospective collation of achievement of "major motor milestones" and mean Gross Motor Function Measure scores. These can only give a rough guide to difficulties of motor function in this experimental group and can give only an approximation of the group's functionality. The motor milestone achievement shows variation in levels of disability from a mild delay of walking at 21 months up to a significant delay at 40 months. Although the mean and standard deviations represent a significant functional motor delay in the experimental group, individual variations are not demonstrated. The Gross Motor Function Measure mean score gives only partial information on the group's disability without considering the specific problematic items. Again the standard deviation of 0.28 and 0.34 demonstrates the variability of the group.

This heterogeneity of group is a significant problem in research involving children with cerebral palsy. This study attempts to compare the movement parameters of these children with a normal group, however little information is given as to how these 2 groups were selected. This study by using differential measures reduces the error induced as a result of the group variation.

Control is group age matched. Clinical experience has shown that the child delivered at 33 week gestational age may have a normal ultrasound scan but may have some mild developmental changes. The method of determining normal development and lack of disability is not documented.

Eight of the patients had lesions involving the optic radiations bilaterally, with marked asymmetry in 2 patients, however the functional impact of these is not discussed. As the visual system is discussed as being closely linked to the postural and head righting system in the introduction and the discussion this element could have been considered more closely.

Were all the participants accounted for at the conclusion?

It is not clear whether all participants or all the data was included in the end results. Raw data is not given to demonstrate inclusion, no exclusion or faulty data is discussed.

Were the participants in all groups followed up and data collected in the same way?

Yes. Data collected on one visit, 10 repetitions, standardised format.

Did the study have enough participants to minimise the play of chance?

This is a small number of participants and the results could not reasonably be extended to the whole population of children with CP. However the statistics demonstrate limited play of chance.

How are the results presented and what is the main result?

Graphs are clear, well titled and demonstrate the changes seen.

The differential angle demonstrates the changing angle of the FP plane relative to the horizontal during the task in each child. These are then plotted as a % in 5 degree bars on bar chart. The mean values for each group is also given in the text.

In the squatting condition the mean differential angle in diplegic group was -24.8 degrees whereas it was -1.9 degrees in the normal group. Approximately 90% of normals demonstrated a differential angle of between -15_ and +15_ (Fig 1 A), where as only approximately 65% of the diplegic children were within this range (Fig 1 C). This demonstrates that little head movement normally occurs in squatting, but that children with diplegia tend to make larger head movements.

In the straightening condition the mean differential angle in diplegic group was +26 degrees whereas it was +0.7 degrees in the normal group. approximately 95% of the normals demonstrated a differential angle of between -15° and +15° (Fig 1 B), where as only approximately 40% of diplegic children were within this range.(Fig 1 D)This demonstrates that when straightening normally only a small range of head movement is seen. However in the children with diplegia larger ranges of movement where seen.

Fig 1B also demonstrates that squatting diplegic children tend to have a negative tilt, some extreme angles of negative tilt (>55°) Negative tilt is cervical flexion in this study. Fig 1D demonstrates that diplegic children straightening up tend to have a positive differential tilt, some extreme results (>55°) Positive tilt is cervical extension in this study

Lack of significance difference in resting position is observed in standing prior to movement initiation. This would suggest that diplegic children use excessive head movement in one direction (Flexion in squatting and Extension in straightening) as part of their typical movement strategy.

How precise are these results?

Statistical testing using ANOVA reveals significant difference in the differentiated angle in both squat and stand up at a high level of significance. $p < 0.001$

Are all important outcomes considered?

Discussion relates to the poor orientation of the head as a result of either adaptive motor strategies or incomplete development of the axial righting function. These theories seem to apply to the movement disorders seen in clinical practice and demonstrate the clear implication of head righting in functional tasks of sit to stand and visa versa. The inertial biproduct theory is discounted demonstrating that this head movement is an active component; either learned compensation or incomplete modification of neonatal reflexes.

In Summary

This study gives a clear, repeatable and reliable reference informing movement analysis. It is limited in its inclusion of only flexion and extension movements during stand -squat and squat - stand. and can only be related to children under 12 years old with periventricular leukomalacia resulting in spastic diplegia. This study quantifies the change in head posture seen in the experimental group however, it does not offer suggestions for treatment.

It is hypothesised that head posture must be corrected and remain stable in order to encourage maximal visual acuity and perceptual development and therefore treatment should be aimed at encouraging this stability.

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TRENT

Trent region are now fighting fit, with a fully staffed committee who are keen to run courses in 2003.

On March 20th we have a study day at Sheffield entitled "Sleep systems and 24 hour postural management" run by Terry Poutney. This will include lunch and the AGM.

In June, Gill Stern has agreed to run a study day in Nottingham on "Care of the neonate".

We hope to run a dyspraxia course towards the end of the year, and look forward to continuing the hard work into 2004.

Any ideas for courses into 2004 will be greatly appreciated.

CLAIRE HILL

EAST ANGLIA

Following a busy October organising the APCP Conference which was held in Birmingham with the CSP Congress, we ran a very successful study day in St Albans in November covering the new SEN Code of Practice. It was an extremely useful and informative day, and the location of the venue was helpful to those members who live more to the west of our region.

We have a very full schedule planned for 2003, starting with our AGM to be held at Addenbrookes, Cambridge in March. Following her excellent talk at Conference, we have asked Michelle Eagle to run a study day for the AGM, to expand on her experience of other aspects of the management of neuromuscular conditions, including the use of steriods and orthotics, as well as night-time ventilation.

In June we are planning a study day on rheumatology, which will also be held at Addenbrookes in Cambridge. Then in September we are planning to run a study day on the legal aspects of note writing. This was previously planned to run as part of our AGM last year, but was cancelled due to insufficient numbers. However, we have since had some interest in this important topic, with the suggestion that it is run the day on a weekday, rather than a Saturday and we hope to run this in St. Albans.

Finally, on 31st October and 1st November we will be running a two day follow up to the excellent course on gait analysis run by Elaine Owen last summer.

Details and application forms for the study days will be available on our website: www.apcp-eastanglia.org.uk as well as being advertised in this journal, and in Frontline.

We are also planning next year's programme of study days, topics to include Sensory Integration and Developmental Co-ordination Disorder. We would welcome your suggestions for topics that you would like included in future programmes.

Finally, we would like to thank Fiona Down, who is stepping down in March as our current Chairman. She has, during her time on the East Anglia committee, taken on a number of roles as well as Chairman, including Treasurer and Regional Representative, and at one point was having to do all three at the same time! Our Committee have expressed admiration and thanks to Fiona for all the work she has put in to maintain East Anglia as an active, well supported region of the APCP, including setting up our own website, and the book/video library. She will be greatly missed, and a hard act to follow.

SUE COOMBE

WALES

January 15th saw a number of us listening to Geraldine Hastings' masterly talk about Consent - an update of assessment and treatment of children and adolescents within the NHS. This left everybody present with a great deal of food for thought on their approach to their working life and the general desire to update their working practice. So much so that a decision was made to put to the membership at the AGM the motion that we form a working party to consider in more detail the aspects raised at the Consent day, and work towards some standardisation of response in our area.

The March journal may or may not reach you before our AGM, but you will have had plenty of information about it - this year to be held at the Children's Centre, Princess of Wales Hospital, Bridgend on March 13th. Phillipa Ford, the CSP Policy Officer for Wales will be speaking on her review of the previous year at the Welsh Assembly with respect to paediatric physiotherapy. The AGM will follow Phillipa's talk at 4 pm. We have two vacancies this year to replace Caroline Gray, who has come to the end of her second term of office, and Lisa Hutchens who, although still working in Wales, has gone to live in England. We would like to thank both Caroline and Lisa for all their hard work and unfailing good humour over the last few years, and we will miss them very much.

On April 10/11, we are running the second stage of our Respiratory course, as mentioned in the last Journal. You will have received information about this, and I urge you to apply as soon as possible, as places are limited to 30.

After the Respiratory course has come and gone, and after two new Committee members have hopefully joined the rest of us, we must take some time for reflection. Many of our members feel that all A.P.C.P business should really take place within working hours, and not impinge on our other lives by being conducted in the evenings. While quite correct in theory, it may be difficult for some members to obtain leave to go to meetings in the working day. However, the fact of having to turn out on a dark wet evening and drive a good many miles, even if the carrot was a swim in a hotel swimming pool thrown in with the price of a conference room, may mean that daytime meetings have a greater attraction, with less problems in obtaining babysitters, and less wear on the nerves of those who hate driving in the dark.

We also have to reflect on another point. Do we continue having a variety of day/evening courses running over the autumn, winter and spring periods, which have been successful and have made money, but have been a lot of hard work and at times anguish for the organising committee, and involving our own time? Or do we, in this time of budgetary constraints, lack of financial backing, and difficulties with obtaining study leave, restrict ourselves to producing one or two big events within those periods? Hopefully obtaining finance from other sources to part support the events, so that we may offer the membership places at low rates, continuing to achieve a high uptake of places.

Please let us know how you feel about these thoughts, and especially if you would be happy to become a Committee member, but only if meetings were held in the working day, or, if you are more than happy to contemplate the M4 on a dark night in January, come and join us anyway.

Hwyl.

JILL WILLIAMS

SOUTH WEST

The Conference!

This is the final plug for the national conference to be held in our region on the 3-5 April this year. Please attend this if you can and make the most of an interesting programme. Applications are to go to Gill Smith and Rob Shaw at Poole Hospital.

Please attend the regional AGM as we need to vote on any volunteers for vacant posts

Once we have breathed a sigh of relief at getting this over and done with, we will probably hold one more course this year. ANY burning topics?

RUTH DAVIES

NORTH WEST

Happy New Year!

The NW continues to be busy and I hope you will all be joining us on Saturday 8th March for the AGM. We will be appointing 2 new members to Regional Committee. We are grateful to Michelle Eagle for taking time out of her busy schedule to come and speak to us about Nocturnal Ventilation, after hearing her speak at congress I'm sure it will be a very interesting and informative talk.

Please can I remind all members to ensure that you have renewed your membership and encouraged colleagues to join the APCP. I do think you get your money's worth with the journal and all the work that is done on you behalf including the production of evidence based literature. Can I also remind those of you who pay by direct debit to ensure that all you personnel details are kept up to date on our records? People often miss mail shots with information about courses etc. due to us having the wrong details.

Later this year we will be running a gait analysis course and a respiratory course so please keep you eyes open for further information.

Can I also remind you all about the regional video library and bursaries which you can utilise for your own professional development? With the Agenda for Change soon to be upon we all need documented evidence of our professional development and these are ways in which APCP can support you!

PAM BLAND

NORTH EAST

By the time you receive this Journal, we will have had our AGM and Study Day in March. There will be 2 vacancies on the local committee, so if you would like to join a friendly active group, do please get in touch.

The committee has been busy planning study days for 2003 and well in to 2004.

These are as follows:-

7th June 2003	AM Muscle Imbalance PM Research Workshop
18th September 2003	AM Legal Issues PM Caseload Weighting
6th March 2004	AGM and Ponsetti Approach for Talipes.
19th June 2004	Paediatric Hydrotherapy.

In due course you will receive a flyer for the relevant study day

It has been encouraging to see so many renewing their membership for 2003. If you have forgotten to renew, there is still plenty of time. I have application forms on request or details can be sent directly to the membership secretary of APCP.

Any ideas for future study days gratefully received or any comments about the network on the interactive website would be appreciated.

MARY HARRISON

NORTHERN IRELAND

We held our AGM on the 10th February 2003, and were delighted to have Cathy Boyd come and give us an update on Paediatric Chest Physiotherapy. The last evening meeting on this years programme will be held at the Children's Hospice where Ruth Graham Senior Physiotherapist is going to talk to us on her role within the hospice.

Julie Tagg and Dorothy Irwin are busy organizing the Hydrotherapy Course, which will take place on the 22nd/23rd May 2003, at Sandalford School in Coleraine.

I have now completed 8 years on the N.I.A.P.C.P. committee and it is time for me to step down, the experience of being on the committee and the opportunity to attend National Committee meetings has been very educational, enjoyable and rewarding. I will miss being on the N.I.A.P.C.P. committee and all the friends I made on the National Committee.

Alison Mounstephen will be taking over as chairperson of the N.I.A.P.C.P., I wish her and all the committee all the very best for the future. Finally I would like to thank everyone on the committee for all their help and support, during my time as chairperson.

JUDITH MCARTHUR

LONDON

Firstly on March 10th There will be a study day on Orthotic Management In Paediatrics at Northwick Park. The speaker is Paul Charlton Senior Orthotist from Peacocks who may be known to some of you via the London Orthotics Interest Group. We will give you lunch and to crown the event ther will be the Branch AGM for members to hear what we have been up to on your behalf over the past year and your chance to tell us what you think. Fliers will soon be on their way to CDC's etc and also information will be in Frountline.

On May 13th we have arranged an evening talk on Hypermobility in Children. Sue Maillard Clinical Specialist in Rheumatology is the speaker and the venue is the physiotherapy gym at Great Ormond Street Hospital. Space will be limited so please book in plenty of time via me at GOSH.

We are also hoping to run study days on Pain in Cerebral Palsy in July and Research and Outcome Measures in November as well as an evening lecture on Strength and Treadmill Training for Children with Cerebral Palsy. Dates and venues are yet to be confirmed.

We hope that there will be something to appeal to most of you and that you will continue to support the meetings as well as you did last year. All ideas for future talks are always gratefully received

JEANNE HARTLEY

SOUTH EAST

Slightly belated Happy New Year wishes to everyone.

Lets hope with your support we can make it a successful one for the region.

So far this year we have 156 members in the South East region. National membership secretary reports that overall membership is rising rapidly and feels we will have reached the 2000 mark by next year. We are one of the largest CIG's within the CSP. We have one new member and this means that there are around 15 members who so far haven't got round to renewing their subs for this year. Perhaps a quick reminder to colleagues at work that it is that time of year again would help!

The next study day is being held on 14th March 2003 at the post-graduate centre, Brighton. The Committee are really keen for your support for this day as the future of the regional group could well be at stake. We do not want to find ourselves in the position we were in last year when we had to cancel the AGM because we didn't have enough members attending.

The title of the day is 'Challenging Children' and includes a morning session 'Strategies for physiotherapists working with children with emotional and behavioural difficulties'. The speaker is Sarah Allcock, Clinical Psychologist. The aim of this session is to discuss different scenarios relating to behavioural issues and can include such things as what do you do about the child who flatly refuses to comply? Sarah Allcock would like members who are attending to send in scenarios they may have come up against in their working practice for her to attempt to address on the day. Please contact Ann Martin with any thoughts. Address below.

Lunchtime we will be holding the AGM. There are places to be filled on the Committee, so how about it? We would love to have some new blood to make decisions, give advice and help us to come up with ideas for future study days etc. This next year will be an important one for us all which will see the effects and proposals of the National Service Framework for Children. It is up to us as an association to represent our profession and to ensure we are consulted and to offer our views and expertise in any decision making relating to Childrens' Physiotherapy services.

Please contact Carol Dooley, Chairman if you would like to nominate yourself or someone else for a Committee place. Telephone 01959 562156.

Also please submit items to be included in AOB to Carol prior to the meeting

The afternoon session is well recommended and is entitled **'Physiotherapy for children with ME/ Chronic Fatigue Syndrome'** the speaker is **Melanie Bladen,** Clinical Specialist Physiotherapist from

Great Ormond Street Hospital who works with these children.

Fees : Members £35.00 Non-Members £45.00 cheques made payable to APCP SE Region, please contact Ann Martin for application and further details. Tel 020 8311 5419 Goldie Leigh Therapy Centre, Lodge Hill, Abbeywood, London SE2 0AY.

Reminder too for those of you hoping to attend National Conference in Bournemouth 3rd-5th April, to get your application forms in asap.

See you all there!

PETA SMITH

SCOTLAND

Thank you to most members for prompt renewal of membership and a little reminder to the few who forgot.

In November we held an orthopaedic study day in Edinburgh which was fully subscribed and well received on the day. We had a limited response to our questionnaire asking for your suggestions for future study days and thoughts around representation on the committee. In general respondents were happy with the venues selected. There was some interest in longer courses but some thought that funding could cause difficulty. Some topics suggested for future study days included Neuromuscular conditions, Paediatric respiratory conditions/C.F. and 24hr. postural management. It is possible that we are not reaching smaller departments.

Some of you will be aware of the February meeting arranged in conjunction with the paediatric managers group to look at caseload weighting. Our A.G.M. and study day is being held on 14th March in Perth. Once again we will have a "Mixed Bag" of speakers with a short A.G.M. at lunchtime. Following this meeting Gillian Henry who has been course organiser and Lynne Paterson will leave the committee. As you may be aware, Gillian and Lynne have contributed to the committee for several years and will be greatly missed. A huge thanks to you both!

LAURA WIGGINS

INAUGURAL MEETING OF THE NEONATAL SPECIAL INTEREST GROUP (AFFILIATED WITH THE APCP)

November 22nd 2002 saw the inaugural meeting of NNSIG at St Thomas's Hospital London.

This Group consists of Paediatric Physiotherapists who are specialists in the assessment and early intervention of high-risk infants in the Neonatal Intensive Care Units throughout the UK. This also includes being involved in the "follow-up" of these infants after discharge, to help identify those children with neuro-developmental problems as early as possible and to ensure early referral to the relevant therapy services in the Community setting.

The group was set up with the full support of the Association of Paediatric Chartered Physiotherapists and is recognised by them as a professional sub-group of the Association.

It is acknowledged that the role of the Physiotherapist in the Neonatal Intensive Care Unit setting is a relatively new, expanding and developing one in this country. Physiotherapists already working in this field acknowledge the need for specialist training, peer support and review that will enable them to deliver a high standard of care to this highly vulnerable client group. The group feels it is up to us to set our own professional standards as most NHS Trusts do not require or dictate any specific level of expertise for therapists working in this field.

The Group also acknowledges the need for further research in this field and aims to encourage and support members in setting up Research projects both in the fields of respiratory care and neuro- developmental care.

Objectives therefore include

- The use of the group as a vehicle to encourage and develop peer support and review of clinical practice.
- To address the identification of training needs and to develop structured education pathways for Physiotherapists who are wanting to specialise in this field.
- The encouragement and support for further Research and Development.
- To encourage and support the development of national best practice guidelines, based on the evidence available to us.
- To ensure that Physiotherapists working in this field have developed or have the ability to develop competency to work with this highly vulnerable client group.

The meeting was attended by 41 neonatal physiotherapists with apologies from 30 more, a most encouraging start for the group.

Peta Smith and Ali Carter who along with Emma Sinamon organized the day, the setting up of the SIG and made the introductions for the day. A great deal of hard work, done very well.

There was an interesting talk by Terri Poutney on clinical research 'Appraising the Evidence'. Which gave us all something to think about when looking to compile evidence based guidelines.

Regional meetings have been organized and will take place in March 2003. At these meetings members will look at current handouts/leaflets in an attempt to pull together a national package.

The next national meeting will take place on the 27th June 2003 in Rotherham. More information will be published nearer the time.

For more information on the regional groups or national meeting please contact Secretary Nicola Mcnarry on e-mail at nicola.mcnarry@qmcuh-tr.trent.nhs.uk

We are hoping to forge links with the other Professional Groups who work as part of the Neonatal team. We are also hoping to approach Bliss, the Premature baby charity, who are committed to the training and support of medical, nursing and therapy staff who take care of premature babies, to inform them of our formation and the will to liase and exchange ideas and views with them.

The first meeting of the Neonatal Special Interest Group was a great success and our appreciation goes to the team who made it possible. It is great to begin to get know your peers when on the whole as a neonatal physiotherapist you work in isolation a lot of the time.

Barbara Haederle

APPLICATIONS FORM FOR APCP PUBLICATIONS - 2002

NEW 2002 PUBLICATIONS:

Obstetric Brachial Plexus Palsy - A guide to physiotherapy management: £10.00

Hip Dislocation in Children with Cerebral Palsy - A guide to physiotherapy management: £7.50

Paediatric Physiotherapy - Guidance for Good Practice (Revised 2002) members £2.00
until end of Conference 2002 - thereafter £5.
non members £5.00

Evidence Based Practice in Paediatrics:

- Management of Obstetric Brachial Plexus Palsy £3.00
- Hip Subluxation and Dislocation in Children with Cerebral Palsy £3.00

OR ..... £5.00 for the pair

Paediatric Manual Handling - Guidelines for Paediatric Physiotherapists £10.00

Human Postural Reactions - Lessons from Purdon Martin by Dr. John Foley £5.00

Postage and Packing included in the price with all of the above

P & P <u>not included</u> in the following prices:

Tests & Measures Resources Pack (2nd edition) £3.50
Baby Massage £1.00
The Children Act 1989 "A synopsis for Physiotherapists" £2.50
Statutory Assessment of Children with Special Educational Needs ..... (to be updated)
Guidelines for Calculating Caseloads ..... (to be updated)

*POST & PACKING COSTS (UK Only): Single copies: £0.50
2 - 5 copies: £1.00
6 -10 copies: £2.50

FOR MORE THAN 10 COPIES OR FOR POSTING TO OUTSIDE UK - POSTAGE UPON REQUEST PLEASE

TERMS: CASH WITH ORDER Cheques & postal orders made payable to "APCP Publications" & included with order.**

SEND ORDER WITH PAYMENT to:
Lorna Stybelska, Paediatric Physiotherapy Dept, Cumberland Infirmary, Carlisle, Cumbria, CA2 7HY.
Work tel: 01228 814739.
Home tel: 016974 72207. e-mail:stybelskal@aol.com

Name & Address ..... for delivery

.....

.....

HYDROTHERAPY TREATMENTS IN SCHOOL POOLS – THE REQUIREMENT FOR LIFEGUARDS

School swimming pools are frequently used for a variety of different sessions such as swimming lessons; exercise in water, and for Hydrotherapy treatment sessions. Local Education Authorities are increasingly requiring qualified lifeguards to be present during Hydrotherapy sessions, and this has become an area of concern to many Physiotherapists and Physiotherapy Assistants working in these facilities.

The Hydrotherapy Association of Chartered Physiotherapists (HACP) definition of Hydrotherapy is: -

" A therapy programme utilising the properties of water, designed by a suitably qualified Physiotherapist specifically for an individual to improve function, carried out by appropriately trained personnel, ideally in a purpose built, and suitably heated Hydrotherapy pool. "

(HACP 2002)

Hydrotherapy treatment sessions are therefore completely different to a swimming lesson or general exercise/"fun & games" sessions.

Physiotherapists are fully covered by their professional insurance to work in pools provided that Hydrotherapy is within their scope of practice. The HACP therefore feel that there need be no requirement for Physiotherapists or Physiotherapy Assistants to hold a lifeguard certificate, or for a lifeguard to be present in order to carry out Hydrotherapy treatments in school pools provided that: -

- The Physiotherapist has knowledge and training in Hydrotherapy that allows them to fulfil Rule One of the Chartered Society of Physiotherapy (CSP) Professional Code of Conduct while conducting these sessions. The CSP Professional Affairs Paper PA 39 "Guidance on Good Practice in Hydrotherapy" refers.
- The recommended minimum staffing level of one therapist in the water and one therapist or assistant poolside is strictly adhered to.
- All clients are checked for suitability to undergo Hydrotherapy as per the attached HACP Contraindications and Precautions list (November 2001)
- Properly tested evacuation procedures are in place, that allow safe, effective and rapid removal of a patient from the water in case of an emergency. These evacuation methods are to be practised at least twice annually under the direction of the Senior Physiotherapist in charge of Hydrotherapy. All carers or parents involved in these sessions should be familiar with the evacuation procedure. The HACP recommend the use of a water rescue board for this manoeuvre.
- The pool facility complies with the requirements of Chartered Society of Physiotherapy Core and Service Standards 2000, with regard to water temperature and quality.

References: -

CSP Core and Service Standards 2000

CSP Professional Affairs Paper PA 39 – "Guidance on Good Practice in Hydrotherapy"

CSP Industrial Relations Paper No 12 – Health & Safety in Hydrotherapy.

CONTRAINDICATIONS & PRECAUTIONS (HYDROTHERAPY)

Ratified by the HACP committee in November 2001

Absolute If the following are present hydrotherapy is not to be considered.

- Acute Vomiting or diarrhoea
- Medical instability following an acute episode (e.g. CVA, DVT, PE, Status Asthmaticus)
- Proven Chlorine/Bromine Allergy
- Resting Angina
- Shortness of breath at rest
- Uncontrolled Cardiac Failure/Paroxysmal Nocturnal Dyspnoea
- Weight in excess of the evacuation equipment limit

Relative If the following are present, hydrotherapy may be considered after a risk benefit analysis.

- Acute systemic illness/pyrexia
- Irradiated skin during course of radiotherapy
- Known aneurysm
- Open infected wounds
- Poorly controlled epilepsy
- Unstable diabetes

Precautions

- Fear of water
- Behavioural problems
- Incontinence of urine/faeces
- Gross Obesity
- Epilepsy
- Haemophilia
- Widespread MRSA
- Hypotension
- Renal failure
- Poor skin integrity/Open/Surgical wounds
- Pregnancy if water temperature exceeds 35 degrees Celsius

- Contact lenses
- Hearing aids/Grommets
- Impaired sensation/vision/hearing
- Invasive tubes in situ

HOT OFF THE PRESS

A booklet published by the Hypermobility Association, entitled –

'A guide to Living with Hypermobility Syndreme for Children and Teenagers' - One of the contributors is Nicola Tennant, a member of APCP based in Scotland

The booklet can be obtained from the Association:-

Website: www.hypermobility.org

E-mail info@hypermobility.org

PAEDIATRIC REHABILITATION EQUIPMENT AT BATH

Michael Hillman, Principal Engineer, Bath Institute of Medical Engineering,
Royal United Hospital, Bath BA1 3NG. Email: M.R.Hillman@bath.ac.uk
Julia Wright, Senior Paediatric Physiotherapist,
Children's Centre, Royal United Hospital, Bath, BA1 3NG.

The Bath Institute of Medical Engineering runs a paediatric engineering referral system for the Children's Centre at Bath's Royal United Hospital. Much of this work involves making modifications and adaptations to existing equipment. Sometimes new equipment is designed. Although much of the work is appropriate only for a particular child occasionally projects are undertaken which it is felt by both therapists and engineers would have a much wider usefulness.We would like to describe 3 such projects and would value comments from users if they feel they have clients who would benefit from similar equipment. The Institute is not able to produce one-off devices, but if there is sufficient interest, is able to produce a small batch of devices. We are also pleased to hear from manufacturers who would like to work in partnership wish us to make equipment commercially available.

Chariot for a child in a Swivel Walker

Children in "swivel walkers" or similar walking aids can be quite proficient at moving around their classrooms, but unable to move quickly from the classroom to another part of the school. This might be for toiletring, school lunch time or in an emergency, for example when the fire alarm sounds. In response to this requirement the Institute built a wheeled platform to allow a young boy with spina bifida who uses a Salford style Swivel Walker to be readily moved from classroom to toilet. He call it his "Chariot".

The base of the platform tilts down allowing the boy to walk onto it without any lifting being required by the staff. Braked wheels on the trolley stop it moving while he walks on. He has a cross bar to hold onto and a safety strap holds him in from behind. There are handles at the rear to facilitate pushing by staff, and it is collapsible when not in use.

The Learning Support Assistants in the mainstream school, which the boy attends, have been using this for the past year. They have reported that their lives and his have been much improved.

Grasp rail

The requirement was for a grasp rail for a boy with cerebral palsy to reach and grasp, in order to inhibit retraction of his arm. While there are such items available they are not suitable for attachment to a range of tables at home and school. Those with a sucker fastening can be unreliable on surfaces which aren't "mirror smooth" and others require fitting to modified tables. The solution developed was to clamp the bar to the table at the side of the child and then for the bar to bend round in front.

The child will now automatically reach for the rail with his right hand and this inhibits the associated reactions on that side and enables him to maintain body symmetry while using his left hand for unilateral fine motor skills and feeding.

The first prototype was sized specifically for the boy, but a subsequent version allowed adjustable reach and could be arranged for left or right hand use.

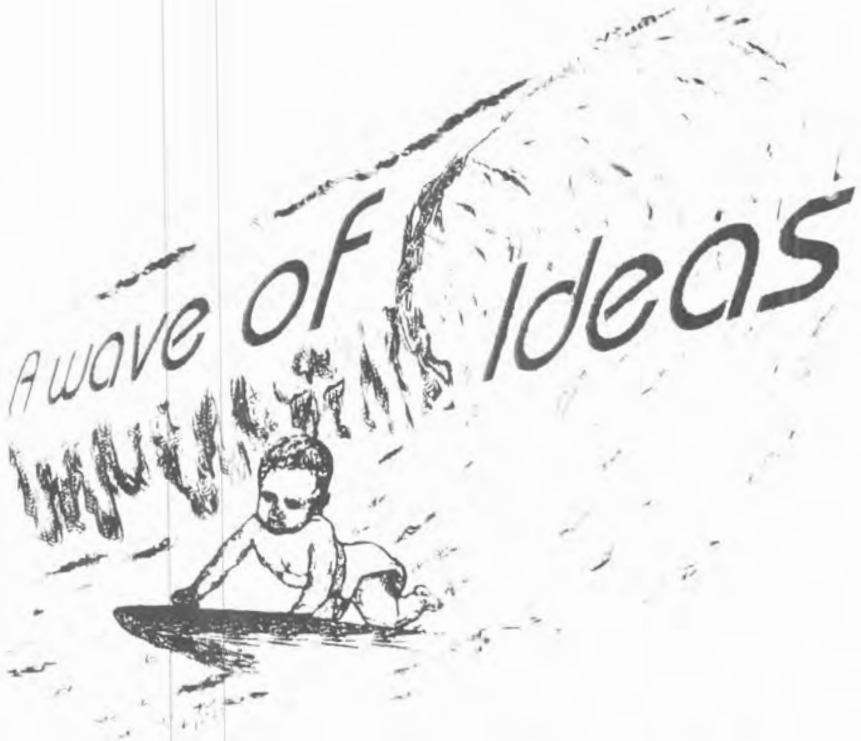
Weighted walker

Although some disabled children find it difficult to walk unaided they can often manage to move across a room with the help of something stable to hold on to. Walkers are available for this purpose, but often they are too light to provide much resistance when being pushed by the child. To solve this problem the weighted walker was developed to incorporate a bay that can hold a plastic container. Weight can be added by filling the container with water, or it can be removed altogether leaving space for other objects to be carried. The advantage of using water as a means of weighing the walker down is that it negates the need for a heavy block. This in turn makes the storage and transporting easier.

ASSOCIATION OF CHARTERED PHYSIOTHERAPISTS

ANNUAL CONFERENCE 2003

A WAVE OF IDEAS



To be held at Marsham Court Hotel, Bournemouth

on 2nd – 4th April 2003

APCP CONFERENCE

At

THE MARSHAM COURT HOTEL, BOURNEMOUTH

THURSDAY 3RD – SATURDAY 5TH APRIL 2003

PROGRAMME

Thursday 3 April

13.30 – 13.45	Opening
13.45 – 14.45	Making the right start Helen Robinson, Neonatal Physiotherapist, Taunton
14.45 – 15.00	tea
15.00 – 16.00	Outcomes of pathology Dr Rebecca Mann, Consultant Paediatrician, Taunton
16.00 – 16.30	free paper session

Friday 4 April

09.00 – 10.00	Adolescent knee pain Sue Close, Paediatric Physiotherapist
10.00 – 11.00	Management of the long term ventilated child in the community Barbara Boosfeld, Clinical Site Practitioner
11.00 – 11.30	coffee
11.30 – 12.30	National AGM
12.30 – 12.45	Jenx Award
12.45 – 14.00	lunch
14.00 – 15.15	workshop 1
15.15 – 15.45	tea
15.45 – 17.00	workshop 2
17.00 – 17.30	SW Region AGM

Saturday 5 April

09.00 – 10.00	Dealing with adolescent children with JIA Dr Jackie Clinch, Consultant Paediatric Rheumatologist, Bristol
10.00 – 11.30	Strength training in CP Dr Margaret Mayston, Clinical Director Bobath Centre
11.30 – 11.45	closing speech
11.45	coffee in bar

WORKSHOPS

Aromatherapy	**Pam Buckley**
Posture management	**John and Liz Goldsmith**
Serial casting	**Shelley Cox**
Craniosacral therapy	**Anneli Hulkkonen**

CONFERENCE PACKAGE

NAME:	**member**	**non member**
COMPLETE PACKAGE Hotel accommodation All daytime catering and Thurs pm dinner Entry to conference sessions Overnight B&B based on two sharing	**£250**	**£300**
(PLEASE INDICATE WITH WHOM YOU WISH TO SHARE IF KNOWN)		
SINGLE ROOM SUPPLEMENT DAILY	**£20**	**£20**
FRIDAY Full day lectures Lunch, tea, coffee	**£100**	**£120**
THURS OR FRIDAY NIGHT ACCOM Per night including breakfast	**£75**	**£75**
THURSDAY PM LECTURES Including tea	**£50**	**£60**
SATURDAY AM LECTURES Including coffee	**£50**	**£60**
CONFERENCE DINNER Friday evening Those delegates not wishing to attend must make their own arrangements for this evening	**£25**	**£25**

THURSDAY NIGHT DINNER Available in the hotel	**£20**	**£20**

WELCOME RECEPTION PRIOR TO THURS PM DINNER
Please indicate whether you wish to attend *yes / no*

Please send completed forms to

Ms Gill Smith / Mr Rob Shaw, Physiotherapy, CDC, Poole Hospital NHS Trust, Longfleet Rd, Poole, Dorset BH15 2JB.

Cheques should be made payable to: APCP SW Region Conference 2003

Closing Date for applications will be 28 Feb 2003

Cancellations will be refunded up until the closing date but subject to a £20 fee. However substitute delegates are welcomed at no extra charge.

FINAL CALL FOR PAPERS!

Should you wish to present any research or critical reviews of literature in a ten-minute slot, we welcome your application. Please supply your abstract.

APPLICATION FORM

NAME: .....

ADDRESS: .....

.....

.....

POST CODE: .....

TEL NO: .....

EMAIL: .....

FAX: .....

PLACE OF WORK: .....

APCP NO. AND REGION: .....

NATIONAL COMMITTEE MEMBER: YES / NO

DO YOU HAVE ANY DIETARY OR SPECIAL REQUIREMENTS? PLEASE DETAIL -

.....

.....

WORKSHOPS

NAME: .....

Delegates have the opportunity to attend two workshop sessions
Please indicate your preference in order 1 – 4

A) Aromatherapy

B) Craniosacral therapy

C) Serial splinting

D) Postural management

SIXTH ANNUAL COURSE IN PHYSIOTHERAPY FOR CHILDREN WITH MOTOR LEARNING DIFFICULTIES INCLUDING DYSPRAXIA

This course is designed for physiotherapists working in paediatrics with some knowledge of Neuro-Developmental Therapy.

It gives an overview of motor learning difficulties including Dyspraxia and covers assessment and treatment planning. The course offers a mix of theory, practical and video observation. Sally's work combines knowledge of Sensory Integration with Neurodevelopment Treatment.

This course would appeal to experienced clinicians and those developing their skills in this area.

Tutor:	**Sally Wright MCSP**
Dates:	**12th – 16th May 2003**
Venue:	**Chelsea & Westminster Hospital**
Fee:	**£350.00 payable to Chelsea & Westminster Healthcare NHS Trust Charity**
Closing date:	**18th April 2003**

For further information please contact Jenny Bassford, Physiotherapy Department, Chelsea & Westminster Hospital, 369 Fulham Road, London SW10 9NH. Tel. 020 8846 1608

TRENT REGION

Sleep Systems and 24-hour Postural Management *By Terry Poutney*
20th March 2003 10 – 2 pm
Sheffield Children's Hospital
To include AGM and late lunch
For further information contact Claire Hill/Sally Vardy on 01142 717227

APCP EAST ANGLIA STUDY DAY – PAEDIATRIC RHEUMATOLOGY

Venue:	Addenbrookes, Cambridge
Date:	Friday 20th June
Speakers:	Clive Ryder – Consultant Paediatric Rheumatologist
	Janine Hacket – Senior Occupational Therapist
	Jan Scott – Senior Paediatric Physiotherapist from the Birmingham Children's Hospital Rheumatology Dept.
Programme:	Differential Diagnosis
	Surgical Management
	Disease Education
	Physical Management
Cost:	£30 members, £60 non-members (to include lunch)
Contact:	Maaike VanVarick, Tel. 01702 221044
	E-mail: maaikevanvarick@hotmail.com

The Portland Hospital

The Portland Hospital for Women and Children is one of the top private hospitals in London providing a service unique, in the private sector, as the only hospital dedicated solely to the care of women and children.

The Physiotherapy Department is a well-established and busy department that provides a wide range of in and outpatient paediatric and women's health services.

Physiotherapy Manager

We require an enthusiastic and innovative therapist, with a proven managerial track record, to lead the physiotherapy team. In this challenging and exciting post you will be required to:

- Provide an effcient and flexible service for both in and outpatients
- Facilitate the review and development of new services
- Motivate and lead your team
- Take responsibility for your departmental budget
- Work alongside the marketing team to actively market the physiotherapy service
- Liaise effectively with other departments within the hospital
- Carry a small clinical load

As part of HCA we are committed to ongoing clinical development initiatives to provide excellent standards of care and services to meet the needs of all our patients and users. Continuing education and staff development are high on our list of priorities. **Quote ref: 003/5300/DMA.**

Senior I Physiotherapist - Paediatrics

This post provides the opportunity to demonstrate and develop skills in all areas of acute and outpatient paediatrics. Working alongside an experienced Senior I Physiotherapist you will be required to:

- Assess and treat a wide range of paediatric inpatients including cover of SCBU, PICU and NICU
- Assess and treat a wide variety of paediatric outpatients including those with neurological, respiratory and orthopaedic conditions
- Have input into orthopaedic clinic
- Have APCP membership

You should ideally be Bobath trained although postgraduate education is actively encouraged. **Quote ref: 003/5300/S1P/2.**

For an informal visit or discussion on either post, please contact Stephanie Hudson, Deputy Physiotherapy Manager on 020 7580 4400.

These posts are exempt from the Rehabilitation of Offenders Act 1974 and the successful candidates will therefore be required to apply for a standard or enhanced disclosure.

HCA is committed to equal opportunities in employment

For an application pack, please contact The Recruitment Office on 020 7616 4969 (24 hours) or visit our web site www.HCAInternational.com

Please quote the appropriate reference.

Closing date: 4 April 2003.

HCA
www.HCAInternational.com

London Bridge Hospital • The Wellington Hospital • The Princess Grace Hospital
The Lister Hospital • The Harley Street Clinic • The Portland Hospital

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THE APCP RESEARCH GROUP REGISTER

If you would like to be a member of the APCP research group, please fill in the form below and return it to Sarah Crombie, Research Officer, 10a Record Road, Emsworth, PO10 7NS.
This information will be used to inform you of research study days and help us to learn more about our members' research interest.

Name

Contact
Address

Post Code

Tel. No.

Fax No.

E-Mail:

What are your research interests?

Are you undertaking any type of research project small or large? **YES/NO**
If so please give a brief summary . . .

Would you be happy for other physiotherapists with similar research interests to be put in touch with you? **YES/NO**

Thank you for completing this form.

Association of Paediatric Chartered Physiotherapists

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Please return completed form to : APCP Secretary, Mrs. Christine Shaw, 42 Cammo Grove, Edinburgh EH4 8EX to arrive no later than 4 weeks prior to the A.G.M.

Notes for Contributors

The Editorial Board welcomes research material; referenced articles and evaluations of physiotherapy practice; informal articles.

Manuscripts should be sent to Mrs Sally Braithwaite, 531 Church Road, Yardley, Birmingham, B33 8PG.

Copy to be submitted should be typed on one side of the paper, double spaced and with ample margins. All pages should be numbered consecutively.

Manuscripts should provide the title of the article and the author(s) name(s) and full postal address for correspondence.

References should be given in the Harvard System.

In text — Author(s) name and initials followed by the date of publication. Use a,b, to indicate more than one publication in the same year. Where there are 3 or more authors use first name followed by et al.

For books — Laszlo, J. & Bairstow, P. (1985) *Perpetual Motor Behaviour* (Rinehart and Winston)

For chapters within books

Morley, T.R. (1992) Spinal deformity in the physically handicapped child, in : G.T. McCarthy (Ed). *Physical Disability in Childhood* (Churchill Livingstone)

For articles — Scott O.M., Hyde S.A., Goddard C.M., Dubowitz V., (1981a) Prevention of deformity in Duchenne muscular dystrophy. *Physiotherapy* 67(6), 177-80.

Tables and Figures

The approximate position of the tables and figures should be indicated in the manuscript.

Keys to symbols should be included.

Tables should be numbered by Roman numerals and figures by Arabic numerals.

Figures should be supplied in a finished form, suitable for reproduction. Figures will not normally be redrawn.

Proofs will be sent to authors if major alterations have been made to the text.

The Editorial Board reserves the right to edit material submitted for publication.

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