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SEPTEMBER 2003

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The Editorial Board does not necessarily agree with opinions expressed in articles and correspondence, and does not necessarily endorse courses advertised.
EDITORIAL

Since the formation of the Health Professions Council continuing professional development for physiotherapists and for our colleagues in other therapy-related areas is becoming an issue that we can no longer avoid. Very soon, documented evidence of the work we do to support our life-long learning, and that of those working with us, is not going to be an option. In order to re-register and continue our professional practice we will need to prove that we have undertaken relevant activities that will underpin the practical therapy we offer to the children and families that we work with each day.

We all have to undertake mandatory training in issues relating around child protection, health and safety, resuscitation and many subjects that are obvious to promote good and safe practice. Many therapists undertake to regularly read and even contribute to journal articles. Very often we have excellent in-service training packages set up in the places that we work, with many contributing to these and the ongoing education of those they work with. Some therapists have the knowledge to be speakers at courses and conferences which they can share with a wider audience.

It is becoming increasingly difficult for many therapists to access external courses. In a busy working day, where there are never enough physiotherapists to complete a heavy workload and financial support from trusts is not as good as it might be, the justification for having one or more study days to attend for such a course needs to be high, with proof that such training is not available somewhere in-house. It is rarely considered that the opportunities for information exchange and networking when a therapist attends a course away from the work place are of any particular importance and if an in-house course is attended it is possible to ‘get hold’ of individuals should something crop up; training time does not seem to be sacrosanct and sections of the training are often sacrificed for other urgent matters of a clinical nature. Both doctors and nurses seem to have a training budget which proportionally is very much higher than those of therapists and the time for them to undertake training towards their professional development is protected. With the rapidly approaching need for us to show just exactly how we are progressing our careers, therapists need the same type of support from their trusts or other employing authorities and it is up to each of us to insist that this is what we need too.

On a slightly different but complementary note, APCP helps support the professional development needs of all its members with conferences and courses at regional and national level and in part through this journal. As many of you are aware, the editorial board are always looking for ways in which we can enhance your opportunities to gain knowledge and share ideas. A short while ago we asked for volunteers with the skills to peer review some of our articles. We were fortunate to have heard from several therapists who were willing to take on this role and we would like to extend our thanks to them. However, to make peer review really work, we still need more of you to come forward. Remember, the idea is not to provide review for all contributions but to provide a core of articles and papers that have a strong base to disseminate research and that will provide a firm knowledge base for those of you who may wish to use them as a starting point for your own practice. If you feel you have the expertise to offer yourself as a reviewer please do not hesitate to contact me with a brief outline of your area of interest and curriculum vitae at – sally.braithwaite@btinternet.com

Sally Braithwaite
Dear Sally

We are currently reviewing our methods of screening "at risk" infants in our area, especially the use of assessment tools.
I would be very grateful for opinions of the different models available, from physiotherapists working in this field.
I would be especially interested if you run a multidisciplinary screening service. For example, do you all keep individual notes or jointly record your findings using one assessment tool?
Yours sincerely
Kathie Drinan

Dear Sally

Re: Management of a child with Sickle Cell Disease and Severe Physical Disability

We have a three-year-old boy who suffered severe anoxic damage at age two and a half. He now has minimal active movement and is totally dependent on his carers for carrying out his stretching/mobility programmes.
We have recently introduced a more active mobilisation programme to try to increase the blood flow through his limb joints to try to decrease the build up of sickle cells.
Has anyone else any experience with similar children and whether physiotherapy can help reduce the incidence of sickle cell crises?
Yours faithfully
Jill Mildner and Stella King
Sr Physiotherapist

Dear Editor

As a group of paediatric physiotherapists in the Lothian & Borders Hospital Trust we are looking at guidelines, good practice and clinical effectiveness in the treatment of children with Down's Syndrome.
In order to evaluate physiotherapy intervention we would be interested to hear from anyone who has used or formulated guidelines, questionnaires, audit or research material for this group of children and their families.
We would be delighted to share information and liaise with other therapists who have an interest in the physiotherapy management of babies and children with Down's Syndrome. If anyone would like further details of our group, or a copy of the finished work, please contact me at the above address.
Yours sincerely
Cathleen Hunter
Dear Sally

Strength Training for Children with Cerebral Palsy

I was delighted to read and hear Margaret Mayston’s presentation at our Conference 2003. As a Director of the Bobath Centre she has shown courage in exploring some fundamental issues of the Bobath approach and now reviews studies showing that strength training is not contra-indicated.

She is justified in saying that any “strengthening should not be applied unless functional gain will be obtained” as I have found this so after long clinical experience. I vouch for this view based on applying selected methods from experts such as Phelps, Knott, Rood and Vojta which could be used for motor function. However, strengthening methods need to take account of functions at different motor developmental stages. In my book, “Treatment of Cerebral Palsy and Motor Delay” in all its editions since 1977 strengthening includes the use of appropriate manual resistance and joint compression for holding functional postures (isometric training and weight-bearing with added load). In addition, selected arm and leg movements against resistance from Proprioceptive Neuromuscular Facilitation (PNF) are used at different developmental stages and used within functions such as gait, rolling, crawling and various arm reaching actions. There is observation that there is association increased activation for counterpoising (postural adjustment) during voluntary movement against resistance.

In my forthcoming Fourth Edition (2003) I have taken this work further in relation to studies in motor learning and my experience that children need to achieve strength whilst carrying out motor functions which have meaning and purpose for them. It is therefore best, whenever possible, that we give priority to motor functions that they have chosen to enjoy. There is then an activation and engagement of the whole child or adolescent. The whole includes sensory input as well as the cues provided by resistance, giving a child understanding of where and how to move and balance. There is promotion of attention to body parts and the important emotional satisfaction of a child or adolescent overcoming resistance. All this assists learning of motor control. However, children accustomed to being facilitated by handling need to be taught how to function against resistance and that they can do so! Clearly, active muscle work needs assessment so that it can be detected and challenged by appropriate resistance for each individual.

I would be interested to hear whether other clinicians have similar experiences to mine. Clinical observations are stimulants for useful research studies.

Yours sincerely

Sophie Levitt
Dear Sally

Re: Sleep Systems and Lycra Splinting

On behalf of the North West Paediatric Managers we are interested to know if any national guidelines are proposed regarding these two items of paediatric care.

A small survey within the North West has resulted in many differences in the provision and different areas providing local guidelines. It really is a lottery as to what is available to whom and by whom, depending on where you live. We are sure that if this happens in this area, it will be equally different nationwide. We are interested to know if guidelines could be proposed if they are not already planned.

Thank you for your help.

Yours sincerely
Wendy Gray

Dear Editor

I would welcome up-to-date thinking on the management of toe-walkers who have no apparent pathology behind the toe-walking.

Having worked for many years in Paediatrics, these toe-walkers until recently were treated with first stretching exercises, followed by active exercises, with boots advised for footwear as they made toe-walking more difficult.

If this made little difference, and especially if there was some limitation of dorsiflexion with a straight knee, bilateral below knee-walking plaster casts were applied, to be kept on for around 6 weeks, if necessary changing the plasters during the 6 weeks to gain a better stretch [serial plasters].

The benefit of this treatment being:
1. Stretch of the Achilles tendon
2. Inhibition of toe-walking

This treatment is not undertaken so readily in our area now, although, I found some success.

I would welcome new ideas on these little people who habitually toe-walk.

Fam Wilkie
Community Paediatric Physiotherapy

Dear Sally

I wonder if you would be kind enough to include the following in the next edition of the journal:

We are having increasing difficulty in obtaining funding for Second Skin Lycra suits. It has therefore become necessary for us to develop a protocol to assist in justifying our recommendation for suits particularly the Second Skin product. I am sure we are not alone and wonder whether anyone has an example of a protocol that they use in their area.

Gill Wildon
Dear Sally,

I hope you will not mind me imposing on your time to ask for your help in a piece of research I am carrying out.

I have recently joined The Pasque Charity in Luton, Bedfordshire, to carry out a piece of research into the needs of young people with life-limiting and life-threatening conditions. The Pasque Charity operated Keech Cottage Children’s Hospice and the Pasque Adult Hospice Service but have come to recognise the lack of service provision for the 18-30 age group. The children’s hospice is geared very much towards young children, whereas the adult hospice usually caters for cancer patients most of whom are over the age of 70. There is, therefore, a real lack of appropriate provision for young people whose holistic needs cannot be met in these settings. The charity has begun to see more and more young people who were expected to die in childhood continuing to need services into their 20’s due to advances in medical technology. Pasque now want to address this need.

I am remaining very open-minded as to what services we may provide and want to explore all possibilities, including a physiotherapy service. I recently read a piece of research by King’s College, London which identifies physiotherapy as a resource that is lacking for children with life-limiting incurable disorders. Their parents and carers report taking on much of this role and identify it as a contributor to stress.

I am trying to ascertain whether this is also an issue for young people and their carers, particularly because they will no longer be receiving physiotherapy at school. I would be really interested to hear your views and those of your colleagues on this matter; whether you think it would be a worthwhile service to provide, improving quality of life, and whether physiotherapy can be tailored to meet the different needs of this age group.

I have 6 months in which to complete this research so I would really appreciate it if you can give any feedback as soon as possible.

Thank you for your help.

Yours sincerely

Joanne Goode
MANAGEMENT OF HIP DISLOCATION WITH POSTURAL MANAGEMENT

Teresa Pountney MA MCSP, Anne Mandy PhD, Elizabeth Green MD FRCPCH BAHons,
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Abstract

Hip dislocation in children with cerebral palsy has a well documented history and morbidity. This paper will present a retrospective study of children with bilateral cerebral palsy who had various postural management and surgical interventions and its effect on hip deformity. The most widely accepted theoretical model of hip subluxation/dislocation is that an imbalance of muscle length and strength around the hip leads to acetabular dysplasia and consequent hip subluxation. Maintenance of muscle length and strength and, loadbearing is therefore a logical prevention. Research on normal infants’ postures has provided biomechanical data to form the theoretical basis of 24 hour postural management equipment.

The notes and X-rays of 59 children with bilateral cerebral palsy from East and West Sussex and Oxfordshire, were examined and measured to determine whether a relationship existed between postural management and the level of hip subluxation/dislocation. X-rays were measured using Reimers’ hip migration percentage.

Postural management support was divided into 3 groups for analysis. Category 1: use of a 24 hour postural management approach using Chailey Adjustable Postural Support (CAPS) system lying, sitting and standing; Category 2: 2 items of CAPS (either lying/sitting or sitting/standing supports); Category 3: use of the CAPS seat only and/or any other postural supports. Hip status was recorded for analysis as both hips safe (under 33% migrated), one hip safe or neither hip safe.

Children using “All CAPS” prior to hip subluxation maintained significantly more hip integrity than other groups ($\chi^2$ p = 0.001).

Postural management interventions have an important role in prevention of hip dysplasia.

Keywords: Cerebral palsy, postural management, hip dislocation, paediatric, deformity

Introduction

Hip subluxation and dislocation in children with cerebral palsy has a well documented history and morbidity but as yet successful conservative management of this problem has not been achieved. Numerous methods of controlling this deformity have been tried over the years with varying amounts of success including bony and soft tissue surgery, orthotic devices, seating and standing supports. The heterogeneity of children with bilateral cerebral palsy and the variety of surgical interventions available has resulted in very few rigorous studies of the long term outcome of many of these interventions, particularly in the area of conservative management of hips. This paper will present the findings of a retrospective study of 59 children with bilateral cerebral palsy who had a mixture of postural management and surgical interventions to control hip deformity.

The most widely accepted theoretical model of hip subluxation and dislocation of the hip is that an imbalance of muscle length and strength around the hip joint disrupts the femoral head contact with the acetabulum causing acetabular dysplasia and consequent hip subluxation. Muscle spasticity, particularly of the hip flexors
and adductors has often been cited as the initiator of this process. Current knowledge of musculoskeletal plasticity, however, suggests that apparent spasticity has a greater component of muscle and connective tissue shortening than neurological hypexitectability. These theories suggest that the imbalance of muscle length and strength between opposing muscle groups and the consequent impact on body development should be preventable. The effects of muscle imbalance around the hip are present from the earliest stages of development in children with bilateral cerebral palsy. A normally developing infant achieves symmetry of posture at about 3 months of age, persisting asymmetry beyond this age can insidiously lead to the long term gross asymmetry of posture seen in older children with bilateral cerebral palsy. Early changes in the acetabulum and proximal femur have been documented in previous studies. Children with bilateral cerebral palsy at 18 months had hip X-rays, which were different from the normally developing child and at 30 months a prediction of hip status at five years could be made. Maintenance of muscle length and strength along with loadbearing to provide joint compression would be a logical solution to this problem.

At Chailey Heritage Clinical Services a 24 hour approach to postural management has been researched and developed over the past 15 years. The approach was developed out of a need to prevent musculoskeletal deformities whilst improving the ability of children with low motor abilities to participate more actively in life with the use of powered mobility and communication aids. The approach combines postural control in the positions of lying, sitting and standing with hands on therapy, active exercise programmes such as cycling, hoistering and swimming and is supported by education programmes for parents and professionals. The postures simulate a higher level of physical ability by changing the loadbearing surface and positioning the head, shoulder girdle, trunk, pelvis and legs. The postures that the children adopt within the equipment are based on a scheme of assessment, the Chailey Levels of Ability. The levels detail the position of the head, shoulder and pelvic girdle and limbs and the loadbearing pattern of infants from birth through lying and sitting to achieving independent standing. This research provided a wealth of biomechanical data on infants’ postures, which has formed the theoretical basis of our equipment. The equipment provides a starting position for movement and encourages movement within limited boundaries. Each item of equipment allows a range of movement within which the child can move and recover balance. With a stable base the child’s use of their head, arms and legs can be more controlled. Control of the hip, pelvis and spine is achieved by applying corrective forces via the supporting surface, lateral thoracic and pelvic control and kneeblocks (Scrutton, 1978, Nelham, 1981). Figures 1-4 illustrate the items of equipment.

The main aim of this paper is to present the findings of a retrospective study of children using a variety of postural management interventions to determine how effective they have been in controlling deformities of the hip and spine.

**Methods**

The records of children attending Chailey Heritage School row or in the recent past; the Chailey Heritage Clinical Services Posture Clinic; children from East and West Sussex Health Authority areas; and the Oxfordshire Wheelchair Service were reviewed. Children included in the study had bilateral cerebral palsy with no other condition likely to affect their musculoskeletal development, had used postural management equipment for a minimum of two years and had sufficient data available for analysis.

The history of each child’s progress was documented using information from each child’s medical, physiotherapy and rehabilitation engineering notes. The information collected from these notes included the child’s Chailey Levels of Ability in lying, sitting and standing, the type of positioning equipment used and the age of provision. Use of equipment was recorded only if the child was using the equipment on a regular basis as recommended.
MANAGEMENT OF HIP DISLOCATION WITH POSTURAL MANAGEMENT

The information collected was rationalised in suitable time periods and the positioning equipment were categorised according to type in order to ease analysis of the data.

The child's hip radiographs were measured and the data recorded. The hip measurements were taken using the method of measuring migration percentage described by and modified by Scrutton (personal communication) using a parallel arm drafting machine, tracing paper and fine pencil lines. A reliability study on the modified measurement method was undertaken and found standard errors of measurement of ±4.4% the accuracy of which is sufficient to monitor annual migration rates (submitted to Physiotherapy).

The acetabular index was measured on X-rays in children under 8 years of age. In children over 8 years of age it was not measured as it is considered to be unreliable.

Results

The records of 59 children were reviewed. The minimum age at which the first entry in the records was documented was 5 months and the maximum 9.8 years. The minimum age for the final entry was 3.2 years, maximum 18.4 years. The length of the review period was between 1.2 years and 16.9 years (mean review period 7 years). At the first data entry 93% of the children were at Chailey Level of Ability 2 or below in sitting indicating that they were unable to sit independently. At the final measure this had decreased to 60%. A total of 533 X-rays (430 hip and 103 spinal) were measured by the author whose standard error of measurement was ±3.2. The number of invalid X-rays which could not be measured were discarded was 11%.

Postural Management

For the purposes of statistical analysis the types of postural management used were collapsed into three categories. The variety of postural supports was numerous and would not allow statistical analysis on an individual basis. The three categories were divided according to the degree of postural control provided by the equipment. Category 1 was use of all Chailey Adjustable Support (CAPS) systems in lying sitting and standing. Category 2 was use of two items of CAPS and Category 3 was use of the CAPS seat only and or any other postural supports. The prolonged time period and retrospective approach meant that complete accuracy on equipment use was not possible. Children were categorised according to the category of postural management most consistently used. In the case of the All CAPS category children consistently slept in their lying supports.

The use of "All CAPS" and "2 CAPS" was restricted to Chailey Heritage Clinical Services and East and West Sussex. The Oxfordshire wheelchair service had a 15% use of the CAPS seating system as their main seat but did not use either the lying or standing supports.

Hip measures

The desired outcome for each child was to have both hips safe (<33% migrated). Changes in single hip status were not considered significant if the opposite hip remained subluxed or dislocated. The outcome measures used were therefore both hips safe (both under 33%), 1 hip safe or neither safe. Hips were considered subluxed over 33% migrated and dislocated at over 80% migrated.
Discussion

This study suggests that conservative management using the 24 Chailey postural approach prior to the development of hip subluxation can reduce hip dislocation in children with bilateral cerebral palsy. This approach offers more than traditional splinting and bracing programmes. The equipment positions children at higher ability levels which allow movement from a position of symmetry to encourage changes in neuronal selection and the possibility of developing improved patterns of movement which will in turn have a beneficial impact on muscle and bony development around the acetabulum and proximal femur. Many authors have theorised about the impact that the effects of delayed motor development and abnormal patterns of movement lead to dysplasia. The exact mechanism of how this occurs has not been established but many authors suggest that asymmetrical activity of the muscles surrounding the hip and their effect on bony development are the main cause of dislocation. Others suggest that lack of ambulation and the consequent failure of the hip to loadbear is the most significant factor in hip development. The consequence of asymmetrical muscle pull and failure to loadbear can be seen in the development of the acetabulum and the proximal end of the femur. Children with bilateral cerebral palsy have increased femoral anteversion compared to the normal population and this is associated with dislocation of the hip. Coxa valga may be persistent in children with cerebral palsy when muscle imbalance around the hip joint prevents the hip abductors functioning normally and consequently disrupts the contact of the femoral head with the acetabulum. If these theories are correct the introduction of a programme of postural management which maintains muscle length, encourages normal movement patterns and provides joint compression should interrupt the current mechanism of hip dysplasia seen in this group of children.

It is necessary to identify the group of children at risk of hip subluxation early in their development to ensure that the process is arrested early. Greiter’s work (1988) indicates that the group of children born very preterm may begin to experience muscle and bony changes around the hip joint during the neonatal period which can compromise their later development. The Chailey Levels of Ability are a scheme which can be used to identify children with persisting asymmetry beyond the normal age.

Conclusion

This retrospective study gives a clear indication that conservative management of hip deformity can be successful if implemented prior to the development of hip subluxation. Postural management over the 24 hour period is essential to help direct movement patterns towards ensure maintenance of muscle length and joint range. Interventions need to be acceptable for the child and family and easily integrated into their lifestyles. Postural control in lying at night can provide a long period of stretch at a time when muscle activity does not counteract gentle stretch. Standing support which allows some movement at the hip joint aids the compression needed for hip joint development. Currently there is a prospective study underway to assess the effectiveness of introducing a 24 hour postural management programme in a longitudinal cohort of children under the age of 18 months of age. This will provide greater insight into the length of time positioning is required to be effective in controlling deformity.

The lack of service frameworks for the integrated provision of postural management equipment to children makes provision of this equipment dependent on local expertise and resources (Audit Commission 2000). There is potentially a positive cost benefit in providing 24 hour postural management compared to the long term care required for individuals who develop severe deformities and require multiple surgical interventions.

The study also indicated that children receiving surgical interventions may not always be successful in achieving long term stability of the hip.
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NHS and social services in England and Wales.


MANAGEMENT OF HIP DISLOCATION WITH POSTURAL MANAGEMENT


The Use of Lyera Socks in Peripheral Sensory Deficit

Sarah contracted meningitis at the age of ten. She recovered but had residual reduction in hearing and peripheral sensory deficit. This deficit is particularly poor in the feet but also affects the knees and lower legs and to a lesser extent the trunk, hips and thighs. This results in difficulty recognising lower limb joint position, altered balance ability and a change in gait pattern. With the severe hearing deficit it is not possible to use auditory clues to compensate for the poverty of proprioceptive feedback and it is necessary to rely upon visual prompts and the remaining poor sensory mechanisms to achieve functionally independent mobility.

During the acute stage of her illness, Sarah received minimal therapy intervention consisting of chest care, and initially it seemed that from a physical point of view, with the exception of her hearing, she was going to make a good recovery. She returned to her mainstream primary school where the supportive ethos allowed her to continue her education where she had left it. Unfortunately, as youngsters of her age do, Sarah entered a massive growth spurt; this seemed to affect her balance and general mobility along with her general independent functional ability. It was at this stage that she was referred to the community paediatric physiotherapy service. She began a daily management programme of passive and active stretches and an exercise programme which was aimed at enhancing her balance reactions and postural awareness as the means to improving gait pattern, and functional ability along with reducing fatigue and trying to combat the painful muscle cramps.

Even with a full assessment it was difficult to tell exactly why she was experiencing a deterioration in her mobility, an increase in levels of fatigue and some muscle pain due to cramp-like symptoms. True, she was growing and unfortunately also true, her hearing deficit also seemed to be increasing. It was felt that per her hearing difficulties, however, were not a contributing factor to her balance problems. Sarah transferred to a secondary school which was primarily geared up to support her hearing difficulties. It was on three levels and had vast numbers of stairs to be negotiated every day and it was necessary to walk long distances just to complete a day's timetable.

Sarah was really beginning to struggle from a mobility point of view and strategies were negotiated with the school to reduce the amount of walking and stair climbing she had to do in a day. Unfortunately, her levels of fatigue and pain continued to increase along with the number of falls she was having and it was also noticed that along with worsening balance reactions, foot posture was starting to deteriorate and the tendo-achilles were becoming tighter. She showed high arched feet with subtalar joint (STJ) instability resulting in calcaneal valgum. For this she was prescribed ½ length, UCBL style, made-to-measure heelpads covered with chamois. The heelpads contained the STJ and improved foot stability and we felt they might be contributing towards improving her proprioceptive feedback. Asking ourselves why this was posed a major question. It is certainly easier to balance on a stable foot and any proprioceptive feedback possible would be consistent and thus more easily interpreted but this fact did not really give us an answer.

Finding sport difficult following her illness, Sarah had taken up horse riding and discovered to her delight that she was rather good at it. She started to acquire all the kit associated with her new-found passion and often commented to her mother that when she wears her chaps and body protector for riding she felt much more stable and seemed to have a better idea about where her body was in space and what her posture was doing. These comments did not go unnoticed and inspired us to try dynamic Lyera socks although we had no idea how effective, if at all, they were going to be.
**SINGLE CASE STUDY**

Lycra garments have been used for children with cerebral palsy since the 1990s. Clinical experience suggests that the garments decrease tone in spastic and dystonic muscles, decrease involuntary movement, and improve axial tone in children with postural hypotonia. The garments seem to improve proprioceptive feedback through pressure and can modify tone. Was a variation of this hypothesis going to help Sarah?

A pair of Dynamic Lycra socks were made to be worn 6-8 hours a day. The aim was to improve proprioceptive feedback with consistent circumferential pressure and hopefully to improve her gait, her spatial awareness of the position of her feet when sitting as well as standing and reduce fatigue and pain. She had commented that people would trip over her feet when sitting, because she did not realise that her feet were in the way. This often resulted in embarrassment and bruised ankles for herself.

The socks are felted knitted and provide even compression all over, but do not adversely effect circulation, unlike surgical stockings.

Initially, Sarah had to be convinced that it was to her advantage that she should try dynamic lycra garments by her parents and ourselves; she was worried about potential bullying at school, and such socks were just ‘not cool’ and did nothing for ‘street cred’. However, they did not show underneath her school trousers and socks and she wears them everyday, because she finds a great improvement in her stability. We were surprised to learn that they could only be washed on Saturday because she insisted that they were laid out each evening with her clothes for the next day exactly where she knew where to find them. It was clearly necessary to provide a second pair, especially as summer approached.

In terms of concrete clinical evidence to support the effectiveness of the use of lycra socks to provide improved proprioceptive feedback and physical function for Sarah, validated indicators are currently of limited use. From a qualitative point of view, she is falling less, pain seems to be more controlled or at least not lasting so long and the gait pattern is just starting to change. However, the foot posture has not improved and the fatigue levels currently remain unaltered. It should be possible to develop some quantitative measures which would support the use of lycra socks in this way but there is still a lot of work to be done before it is possible to say whether or not this is an isolated success, or just exactly what level of success we may have. However, over a year later Sarah says that she could not function at the level she does if she did not have her lycra socks.

We would very much like to hear from anyone who may have been using lycra garments in the same way as ourselves and is willing to share their ideas and experiences.

**Bibliography**


*My thanks are extend to The Magazine For The British Association Of Prosthetists And Orthotists for their kind permission to print a modification of an article that they first published in Issue 2 2002 of their journal.*
This case study was written as part of the APCP Introduction to Paediatrics Course held in Wales in November 2001. It was felt good enough for inclusion in this journal, but I would be grateful if its author could contact me for recognition – Editor.

The child that has been chosen for this case study is a boy aged 2 years and 10 months. In order to maintain his confidentiality he will be referred to hereafter as Jimmy.

In this account a brief description will be given of Jimmy's medical history, diagnosis and social history and the findings from subjective and objective assessment. The goals and aims of physiotherapy intervention, treatment carried out and overall management of the child will be discussed as well as the clinical reasoning for the modalities chosen. Outcome measures and measurements used during this episode of care will be outlined. Finally, personal reflections will be discussed on the treatment given, the decision-making processes used and what has been gained from this experience.

Jimmy was referred to see a Consultant at the age of 22 months due to his parents' concerns that he was "toe-walking" and reluctant to put weight on his right leg. On medical examination he was reported to have increased tone in both lower limbs, equinus deformity of his right ankle and mild flexion contractures of both knees. A Magnetic Resonance Imaging scan revealed "left sided change". A diagnosis was given of spastic diplegic cerebral palsy. The physiotherapist working in the clinic alongside the consultant was involved in assessing Jimmy and offering initial advice to the parents. He was then referred to the community paediatric physiotherapy service at which point my involvement began.

The World Commission for Cerebral Palsy described cerebral palsy as a "persistent but not unchanging disorder of posture and movement, caused by damage to the developing nervous system, before or during birth or in the early months of infancy". Hare, Durham and Green (1998) state that cerebral palsy is "an umbrella term encompassing a wide range of different causative factors and describing an evolving disorder of motor function secondary to a non-progressive pathology of the immature brain". They classify children with diplegic cerebral palsy as those who "have use of their arms, readily acquire sitting balance, and have most difficulty with standing and walking".

Physiotherapy assessment

Jimmy's mum reported that Jimmy was born at full term by normal delivery with Ventouse. He was a lively active little boy, who was able to crawl and had walked independently at 18 months. He was an only child, living with both parents and was otherwise healthy, with no other medical problems. He was on no medication.

Objective assessment revealed the following problems:

- mild increase in tone in his lower limbs, especially his calf musculature and his hamstring muscles.
- reduced range of movement at his ankle joints i.e. dorsiflexion of 90±0 degrees on the left side (i.e. planatar grade less 20 degrees),
- reduced range of movement at his knee joints i.e. flexion contracture of 10 degrees bilaterally,
- unable to make heel contact with the floor during the stance phase of walking on either foot. This led to Jimmy's toe walking,
- reduced weight bearing on the right leg as compared with the left,
- flexed posture of hips and knees in standing and walking.
Jimmy demonstrated a “flexed/adducted/internally rotated gait” characteristic of diplegic cerebral palsy. In order to effectively treat any child, it is essential to assess thoroughly his/her abilities and difficulties. Assessment is an ongoing process, carried out often over many treatment sessions as the therapist gets to know the individual child. In this way it is possible to observe changes as they occur, so that treatment goals and methods can be modified and progressed as and when appropriate.

Physiotherapy aims of treatment decided upon after initial assessments were as follows:

- to prevent further contractures of the lower limbs
- to increase the ranges of movement at his ankles and knees
- to facilitate more symmetrical weight bearing
- to re-education his gait pattern and achieve heel weight bearing
- to promote his physical development and acquisition of gross and fine motor skills.

The first treatment intervention at this time was to apply bilateral below knee soft cast plaster with a delta cast back slab. The aim of this technique was to give a sustained stretch to the gastrocnemius and soleus muscles in order to reduce soft tissue shortening and increase the range of movement at the ankle joints. A study carried out by Tardieu et al. (1988) demonstrated that the soleus muscle must be stretched for six hours a day to prevent contracture. It was therefore felt that the most effective way to maintain a stretched position of Jimmy’s ankles for this amount of time was in a non-removable splint. This cast was kept on for a week, after which the range of movement at Jimmy’s ankles had improved, with dorsiflexion of 90+5 degrees bilaterally.

Once this extra range of movement had been achieved it was important to maintain the improvements and so Jimmy was referred to the Orthotist with a view to providing an ankle foot orthosis. Jimmy was found to have mildly pronated feet in a weight bearing position. It was decided to supply him with a D.A.F.O. (dynamic ankle foot orthosis). This is a very thin flexible supramalleolar orthosis with a plantar flexion stop, and is said to have inhibitory or tone-reducing qualities. It is reported that the prolonged stretch and pressure on the Triceps surae muscle and toe flexors causes a decrease in spasticity (Radika et al. 1997). The footplate is custom made to provide support and stability to the arches of the foot and to position the mid-tarsal and subtalar joints in a neutral position. Also the footplate is designed to reduce abnormal muscle activity and to effect biomechanical changes, including decreased excessive plantar flexion and improved movements of the lower limb, pelvis and trunk during standing and gait (Radika et al. 1997).

Physiotherapy treatment was commenced whilst the soft casts were on, making full use of the improved alignment of his ankle joints, with his ankle plantarflexors in a stretched position.

Once the soft casts were removed, it was observed that Jimmy’s active control of inner range knee extension and hip extension was reduced. These extensor muscle groups were weakened through longstanding lack of normal use during standing and walking. This weakness from disuse was therefore a secondary problem thought to be a result of the primary problem of decreased range of movement in the lower limbs. Therefore an extra goal was added to the list of physiotherapy goals of treatment as follows:

- weakness of hip extensors and knee extensors.

Treatment was carried out on a weekly basis to address the problems identified above. The approach taken was an eclectic approach where elements of different treatment methods and systems are combined as appropriate to suit the individual needs of the child. The eclectic approach is described and advocated by Sophie Levitt (1982).

One of the main approaches used was the Bobath concept of assessing and treating neurological conditions. The Bobath approach stresses the importance of assessment of movement patterns, tone, posture and quality of movement. Treatment aims to influence tone through handling and positioning and to facilitate more
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normal movement patterns, performed in a smooth, efficient and co-ordinated manner, to achieve a functional goal.

For example, the sequence of movements involved in moving from high kneeling to standing was assessed and it was found that Jimmy only used his left foot to push up with and when asked to use the right leg, he pushed up from his toes using the spasticity in his calf muscles. Therefore during treatment sessions, Jimmy was facilitated to stand up using his right foot, but with assistance to weight bear through his heel and use hip and knee extensors more selectively to push himself up.

Another functional activity used was squatting, picking toys up from the floor with support from therapist to maintain dorsiflexion at his ankles and heel weight bearing. In this way Jimmy was using his own muscle activity to control his movement patterns.

From an orthopaedic viewpoint, simple passive and active stretches were used to increase ranges of movement in Jimmy's ankles, knees and hips, performed during play, during bathing and dressing etc. by both therapist and parents.

Repetitions of sit to stand were used to strengthen quadriceps and gluteal muscles.

However, whilst performing these exercises and stretches, consideration was given to the quality of the movement and the influence on Jimmy's tone. Therefore for this activity the ankles were held in a "good" position (i.e. one of heel weight bearing, made possible by the increase in range of dorsiflexion gained from the soft casts and stretches). In this way, strengthening work was being carried out but on the basis of normal movement.

Bridging activities were used as part of Jimmy's treatment to mobilise his ankles and to encourage weight bearing through his heels. In this position he was facilitating the activity of his ankle dorsiflexors, hip extensors and knee extensors.

The position of high kneeling was used to facilitate pelvic tilt and pelvic control in both antero-posterior and lateral directions. In addition isolated gluteal muscle activity could be worked on. From this position Jimmy was facilitated to move into half-kneeling and then into standing, thus giving the activity a functional purpose. It was important at the same time to explain to Jimmy's Mum, as his main carer, as to the reasons for changing the way that he was moving from kneeling to standing and also how to assist him in carrying this over into every day use. In this way treatment and re-education of Jimmy's movements were not just carried out for an hour or two a week, only in a treatment session, but frequently through his normal daily activities and play.

In standing, to encourage weight transference and balance reactions, reaching games were played using bubbles and toys and activities such as throwing, catching and hitting a ball were used.

Long sitting was a position Jimmy was encouraged to play in, in order to stretch his hamstring muscles. This was a readily accepted position to be in and was easily implemented at home on a frequent basis.

Another approach used in the treatment of cerebral palsy is the Hare approach. This describes a "system for the analysis of posture and movement within the context of gravity and the supporting surface ("the human sandwich factor"). Assessment is made in positions of lying, sitting and standing, with particular attention to the trunk-body part-supporting surface relationship in each position... Treatment techniques include the use of arm and leg gaiters." (Hare et al. 1998).

Leg gaiters were incorporated into Jimmy's treatment programme. In standing, leg gaiters were worn to help maintain knee extension, controlling the threat of deformity, making handling and moving easier and improving the quality of physical performance. These factors are among those named by Hare as successful outcomes. Using gaiters in standing also encouraged a more normal pattern of weight bearing through extension rather than flexion. With Jimmy's knees supported the therapist was then able to give support, facilitation or guidance to Jimmy's hips for example or to concentrate on his foot position.

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Gaiters were also a valuable piece of equipment from Jimmy’s mum’s point of view, to enable her to play with him in standing, knowing that his legs were being maintained in a better position. Without the gaiters this would have required two people. In terms of selecting treatment techniques and following different approaches, consideration had to be given to the number of people required to carry out the treatment, as well as the ease of application. In this particular situation, treatment was generally carried out in Jimmy’s home where equipment and space were limited. Also, it was important that his mum could carry out exercises and activities when she was on her own in the absence of “another pair of hands” or therapist assistance.

Jimmy’s gait pattern as described earlier as one of lower limb flexion/adduction/external rotation could only be re-educated once the causes were identified and changed. In other words, as he gained more range of movement (e.g., to gain knee extension) and more extensor muscle activity (e.g., hip and knee extensors) Jimmy was able to walk with a more extended gait pattern. Thus, gait re-education was very much a part of the treatment programme discussed and was not a separate entity.

Hydrotherapy was another treatment technique chosen in conjunction with all those already discussed. There were several reasons for this choice. Firstly, the water proved to be a beneficial environment in which to mobilise Jimmy’s lower limbs and pelvis and, secondly, the water provided resistance in order to strengthen his hip and knee extensor muscles. A third aim was to promote his general confidence in the water and his ability to control the position of his body in the water.

In addition, a programme of daily home exercises and stretches was introduced to include:
- active and passive ankle movements
- long sitting to maintain length of hamstring muscles
- bridging exercises
- sit to stand activities, with his parents encouraging weight onto his right leg
- activities to promote weight transference in standing.

All of the above were incorporated into play and fun activities to ensure Jimmy was motivated to participate in his exercise programme. His mum, as the main carer while his dad was at work, was very much part of the team involved in Jimmy’s care. Her views of his problems, his progress and his response to treatment were always taken into account and it was important at every stage that she was informed and involved in his treatment. Educating his parents as to the nature of abnormal tone and how this affected his ability to move normally was an important part of the therapist’s role. Their understanding and participation in his overall management was essential to ensure compliance and carry over.

Several months after Jimmy’s referral to physiotherapy, he was referred to an orthopaedic centre for assessment with a view to injections of Botulinum toxin into his spastic muscles.

One of the main reasons for this was that the original gains in the range of his ankle dorsi flexion had not been maintained fully. Botulinum toxin, one of the most potent biological agents, may be injected directly into muscle to produce a dose-dependent and reversible weakness paralysis; it works by blocking the release of acetylcholine at the neuromuscular junction. (Flett et al., 1999). Jimmy’s passive dorsi flexion was greater than his active range and during gait he did not utilise the available range. Evans et al. (1999) reported that there was a greater response after injection in those with a dynamic component of spasticity.

After being assessed, Jimmy received injections of Botulinum toxin A into his medial and lateral gastrocnemius muscles and medial hamstring muscles bilaterally. Immediately afterwards he was put into bilateral below knee plaster casts which stayed on for two weeks to maintain a stretch to the gastrocnemius muscles.

After the plasters were removed it was found that Jimmy’s range of ankle dorsi flexion had improved to 90+5 degrees (i.e., 5 degrees of dorsi flexion past plantar grade).
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It was essential following the injections to continue with the goals identified above and treatment continued. It was also important to ensure that the increased range of movement available was used actively and the muscle control in that range improved.

In order to evaluate the success of physiotherapy interventions and treatment techniques it was necessary to be able to measure any changes that occurred. In addition goals that are set need to be measurable in some way, in order to know if and when they have been achieved.

Before, during and after Jimmy’s treatment measures were taken of his ranges of movement using a goniometer. Although there is a degree of subjectivity and error using this instrument, reliability was maximised by using the same person to test each time. The tester followed written guidelines on the methods and positions to use for each test. These measurements were the main ones used in Jimmy’s case and were a quick and easy way to obtain the information required.

Also used were our department’s gait assessment charts. These charts break down each of the phases of the gait cycle, stating what should occur at each phase and asking for comments on what is actually observed. An example would be the amount of hip extension during mid-stance, or the position of the knee and ankle (in terms of joint range) at initial contact of the foot with the floor. The use of these charts made assessing his gait more objective and specific and small or large changes could be detected and recorded more methodically and consistently.

Attempting to analyse the gait cycle of a lively, active two-year-old is not easy, so to solve this problem video recordings were made of Jimmy’s walking. These recordings were found to be very valuable in observing changes and the quality of Jimmy’s gait.

Another measurement tool that could have been used was the Gross Motor Function Measure (GMFM). This is a standardised, validated test to measure change in gross motor function over time in children with cerebral palsy. Movements in different positions are scored and totalled to give an overall score. This measure can be extremely useful in demonstrating change and possibly next time it would be used. In Jimmy’s case the “standing” and “walking, running and jumping” sections would have been the most appropriate parts of the assessment.

Although Jimmy’s cerebral palsy mainly affects his lower limbs it is also important to consider the indirect, secondary consequences of his condition. For example, the deficiencies in his lower limbs caused his balance to be compromised. Therefore in standing, his upper limbs were being overused as part of his balance mechanism. His arms, being used as stabilisers, were therefore less free to move and develop ball skills for example. Jimmy’s overall acquisition of gross and fine motor skills is an important aspect of his growth and development and needs to be borne in mind during his physiotherapy episode of care. Jimmy will need to be monitored at various stages in his childhood and growth. According to Hare, Durham and Green (1998) increasing postural deformity during rapid growth is probably the most important factor determining the loss of physical ability in many children.

In recent months, Jimmy has started at playgroup two mornings a week. To ensure that this went smoothly, preparations were made to address any special needs that he may have or any obstacles there may be to his integration into playgroup. Contact was made by the physiotherapist with his playgroup leader to provide them with a report of his abilities and any difficulties he may have. The worker assigned to care for Jimmy during his playgroup mornings was then instructed regarding his balance difficulties, his D.A.F.O.s, and asked to encourage him to sit in long sitting when on the floor. Physiotherapy goals were also able to be incorporated into his general activities and play in the playgroup setting.

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Personal reflections and conclusions

Being relatively new to paediatrics, I relied heavily on my experience of using the Bobath concept with adults with neurological disabilities. One major difference I was aware of was the fact that children with cerebral palsy have not even developed their motor skills and so normal development is further impeded. Jimmy has never experienced “normal” standing, walking and running. Treating his signs and symptoms has to be carried out within the context of his development and growth. Pathology affecting predominantly his lower limbs could also have a tremendous impact on the abilities of his upper limbs, his ability to relate to his environment and his emotional and social development. In Jimmy’s case he was able to relate to people, play and move around his environment as much as he wanted. However, as he grows older, the potential is there for further problems to become evident. I believe Jimmy’s physiotherapy intervention was successful in changing his ranges of movement, muscle control and gait pattern. More importantly, his functional abilities were improved and his movement made easier and more efficient, requiring less effort and compensatory strategies. In addition, further complications have been avoided, such as painful contractures, and his general development has been facilitated and encouraged.

The importance of identifying the problems, considering the needs of the whole child within their social setting and setting clear, measurable goals has been apparent to myself from treating this child. My involvement with Jimmy has been a valuable learning experience but also a pleasant and satisfying one.

References

A questionnaire was sent to all the paediatric physiotherapy managers by Emma Day, Senior II Paediatric Physiotherapist at Queen's medical centre in Nottingham. Emma felt that she would like to share its collected results with members of APCP.

Out of the 57 questionnaires sent out 28 were returned - this is a 48% return rate. Below is how they were divided.

For the rest of the results the responses from GOS (tertiary hospital) will be in those from the hospital-based departments.

The number of toe-walkers currently under review varied greatly between departments, ranging from 1-100. The mode average was 10.

11 questionnaires stated that the number had increased, 12 thought it had stayed the same and 1 thought it had decreased. The reasons given for these changes were: more cosmetic awareness of parents, increased awareness of Health Visitors (HV) and GPs and more use of botox and the use of physiotherapy pre and post injection.

Referral sources
I collated and presented this information based on the type of department.

Hospital based
71% of departments stated that orthopaedic surgeons were the most frequent referrers, GPs, hospital paediatricians, neurologists, community paediatricians and HVs followed (in order).

Community based
The most frequent referral source again were orthopaedic surgeons with 38% of departments quoting them as their most frequent referrer, community paediatricians appeared the next most popular, followed by GPs, HVs, hospital paediatricians.

Joint trust
Again, there was a difference in frequency of each referral source. In order, the most came from GPs (57%), followed by hospital paediatricians, orthopaedic surgeons, community paediatricians, HVs and neurologists.

Treatment modalities
Each department used a different combination. By far the most frequently used were stretches, which were either the first or second choice of 93% of departments. This was followed by exercise programmes, which
HABITUAL TOE-WALKER QUESTIONNAIRE RESULTS

were often stated to be taught in conjunction with stretches. Casting, pedros, splints (night, day) and boots then followed in order of popularity.

Gaiters appeared to be rarely used.

Bottox was often mentioned and used either after the above had been tried or used alongside the above. Normally, the decision to inject was made after a discussion between the orthopaedic surgeon and physiotherapist.

12 trusts stated they used their own protocol.

The frequency with which these children were seen differed slightly between departments.

The departments that indicated that the frequency varied dependent on the child often stated that the reviews were initially frequent and as they felt that the child was becoming more competent in carrying out the exercises etc. the frequency tailed off.

Which physiotherapists treat these children (results from those that answered this question)

_Hospital trust_ - In 3 the work was split between the orthopaedic and neurology PTs
   - In 1 the neurology team saw them
   - In 1 the orthopaedic team saw them.

_Community_ - In 11 the community physiotherapists saw them.
   - In 3 departments both orthopaedic and neurology PTs saw them.
   - In 1 the orthopaedic PTs treated them.

_Joint trusts_ - In 3 the community team reviewed them
   - In stated the work was split between the community and orthopaedic team
   - In 1 the orthopaedic team treated them.

* The majority of these children were seen on an individual basis only, except two departments who stated that they saw them both in groups and individually.
* For the majority of the departments there was no maximal length of time that these children were seen for. Two departments saw them for between 2-3 months and 1 gave them an open appointment.
* The responses for the outcome measures used and the discharge criteria have been grouped together as the answers given overlapped greatly. The following were used - PROM / AROM, gait analysis, Oxford scale, balance, TALER and video analysis. These determined discharge and treatment progression.
MOVING AND HANDLING

Members may be aware of increased publicity of individuals taking action under the Human Rights Act and Disability Discrimination Act regarding issues around moving and handling; as well as reports in the media of a ruling, earlier this year, overturning local authority “no lifting bans” following a High Court ruling against East Sussex County Council (Therapy Weekly Feb 27 2003 Vol, 29 no. 33).

I would like to take this opportunity of reminding members that even with minimal lifting policies a risk assessment is still a legal requirement if the task you are carrying out involves a hazardous handling procedure which can not be avoided. (MiFOrd 1992) There is a need to balance the potential benefits to the child of carrying out the task and the risk involved.

Assessment must be made of the level of risk involved in the handling task to the individual child, the carer and any professional working with that child.

Wherever possible risk should be minimised and controlled – this may be by training, use of equipment or may mean that goals of therapy have to be re-assessed and treatment plan adjusted.

The CSP support physiotherapists in their day to day work which may well involve manual lifting (therapeutic handling) as part of the rehabilitation programme of patients, but members must remember that documentation is the only tangible evidence of that can be produced in a Court of Law if legal action is taken against them, to show that a risk assessment of the task has been carried out and that control measures have been implemented so that risks have been reduced as far as is possible.

We must also be aware that this age of evidence based practice we must be able to clinically justify our own actions should they ever be questioned.

Members need to be conscious of their own posture during treatment sessions and avoid, at all costs, time spent with their spine in static postures, e.g. forward flexion combined with rotation.

We must remember that we are "health professionals" and it would be hypocritical to put at risk the health of the children with whom we work, the carers whom we train to carry out therapy programmes and just as importantly, our own health or that of our colleagues.

Julia Graham
Clinical Specialist
Paediatric Physiotherapy

Are your membership details correct?

I have been going through the membership database and have come across a number of people who appear to be in the wrong regional group. There may well be good reasons for this, such as where you are working or the journal going to parents’ addresses.

If you have changed job or grade please let me know. If I have spelt your name or address wrong then this is the chance to have them corrected.

Please would you check your details and let me know if they need amending, or if you think your work details might need updating, Your regional group is the letters after your membership number e.g. EA = East Anglia, NW = North West etc.

My e-mail is susan.rideout@bcl.nhs.uk and my address is at the front of the journal.

Thank you very much.

Susan Rideout
Membership Secretary.
Dear APCP Members

As a result of previous correspondence, both to myself and the Journal, I wish to inform the membership that APCP has been in discussion with OCPA about producing a joint statement for physiotherapists working across the NHS and Private Sector (or in some cases, both) to promote better communication, collaboration and cooperation. It is important that all physiotherapists work together to produce the best outcomes for children in our care.

Until this work is started (and 2003) APCP members should refer to the document produced by APCC in collaboration with others, in September 1998, "Guidance for Parents and Professionals Working with Children with Motor Impairments - Communication, Collaboration and Cooperation".

Adare Brady
Chair APCP

**Guidance for Parents\(^1\) and Professionals Working with Children with Motor Impairments**

**Introduction**

The aim of this document is to improve communication, collaboration and cooperation between parents and agencies involved in working with children with motor impairments.

It is the result of consultation between various National bodies (Appendix 1). The guidance is built on principles of good practice and communication and aims to provide a benchmark for local partnerships.

It is hoped that by encouraging greater interagency collaboration, the parents, children and professionals involved will be aware of choices available. This should be based upon accurate and up-to-date information to allow for the provision of appropriate, consistent and clear advice.

Sharing skills, knowledge and understanding is essential to ensure safe and effective care of the child and family. Practitioners from different approaches are encouraged to share experiences and observe others' practice as well as discussing aims and objectives.

**Parental choice**

Parents and children have a choice and whilst receiving intervention from one source may turn to another approach. Families are encouraged to discuss with the other agencies involved any additional intervention they are receiving, to enable the best plan for their child to be negotiated and agreed.

Practitioners should respect the choice of intervention made by parents and their child, and all services should remain accessible to them, whichever approach they select. Communication between the parents, child and practitioners involved will enable the child to access a coordinated service which can be responsive to needs and priorities over a period of time.

**Complementary Approaches**

It is very important that those involved with the child's care, communicate regularly with each other. Where possible, practitioners should agree on similar aims and objectives to allow the child to receive the maximum benefit. Good working practices between practitioners will allow complementary approaches to be developed alongside each other and statements of criticism about different interventions must be avoided.

It is recommended that parents and practitioners record and share information, which should be disseminated to those concerned.

\(^1\) For ease of reading, 'parent' refers to parent or carer throughout the document.
Appendix 1
This document has been created by the following organisations.
Each organisation produces its own publications/standards of practice; individual organisations should be contacted for further information.

The Association of Paediatric Chartered Physiotherapists
c/o the Chartered Society of Physiotherapy, 14 Bedford Row, London WC1R 4ED.
The Association of Paediatric Chartered Physiotherapists is a clinical interest group concerned with all aspects of physiotherapy related to the needs, care and well being of the sick, injured and developing child and family/carers.

The British Association of Bobath Trained Therapists
The Bobath Centre, 250 East End Road, London N2 8AU.
The British Association of Bobath Trained Therapists consists of Physiotherapists, Occupational Therapists, Speech and Language Therapists and Doctors who have completed the inter-disciplinary post-registration course on the Bobath (NDT) approach to the treatment of Cerebral Palsy and allied neurological conditions.

The Chartered Society of Physiotherapy
14 Bedford Row, London WC1R 4ED.
The Chartered Society of Physiotherapy is the professional association, educational body and trade union for the UK’s 34,000 chartered physiotherapists, physiotherapy assistants and students.

Conductors’ Employers’ Group
c/o Andrew Sutton, The National Institute,
Cannon Hill House, Russell Road, Moseley, Birmingham B13 8RD

The National Association of Conductors (NAC)
Liz Zsargo, NAC Secretary, 32 Larchwood, Keele University, Keele,
Staffordshire ST5 5BB.
The National Association of Conductors is an association of Peto qualified conductors working in the UK, which aims to promote the interests and standards of conductors in the UK and to play a prominent role in the development of Conductive Education in the UK.

Royal College of Paediatrics and Child Health
50 Hallam Street, London W1N 6DE
The Royal College of Paediatrics and Child Health is the Professional Body for Paediatricians.

Speech and Language Therapists UK Special Interest Group in Cerebral Palsy
c/o The Royal College of Speech and Language Therapists,
7 Bath Place, Riverview Street, London EC2A 3DR.
This Special Interest Group represents The Royal College of Speech and Language Therapists.

UK Federation for Conductive Education
c/o Horton Lodge School, Rudyard, Leek, Staffordshire ST13 8RB
A membership organisation of users, parents, professionals and interested supporters, committed to the quality development of conductive education in the United Kingdom.
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UPDATE ON APPLICATIONS FOR ETHICAL APPROVAL FOR RESEARCH PROJECTS
Useful website: www.corec.org.uk
If you are planning a research project in the near future or are considering applying for funding, the above website will be useful, as there have been some changes to the way applications for ethical approval are now being managed. COREC who are the Central Office for Research Ethics Committees, co-ordinate the development of operational systems for local and multi-centre research ethics committees (LREC's and MREC's) on behalf of the NHS in England. They are currently piloting a standard NHS research ethics committee form in an electronic format, which they hope to be universally used by October 2003. The form looks scarcely enormous, but I am assured that it is not too difficult to complete!
There have been changes to Health Authority areas, which are now larger and may affect the Local Research Ethics Committee (LREC) you need to apply to. You can check which is your LREC on the website. If you need to carry out your project in two different parts of a Health Authority, if it is passed by one LREC in the H.A, it will be sufficient to cover the whole of that H.A. for NHS research ethics review of your protocol. Another big change is that before you apply for ethical approval for your project, you will need to have had funding agreed to, at least in principle. This is different from before, as previously you needed to go through the ethics procedure and have approval prior to applying for funding.

RESEARCH CONFERENCES
APCP research study day, September 5 2003
This has been organised at the Institute of Child Health, London. Methodologies workshop in the morning, with free papers in the afternoon.
Physiotherapy Research Society conference, Thursday 27 November 2003
Nuffield Orthopaedic Centre, Oxford

USEFUL WEB PAGES FOR INFORMATION ON STATISTICS
I have found the following websites useful for help with statistics — both for information and for analysis:
http://www.bmj.com/collections/statsbk/index.shtml
This is a free online introductory statistics textbook which can be found on this BMJ page. It is quite useful and user friendly.

Other free online textbooks:
http://www.psychstat.smsu.edu/introbook/sbk00.htm
http://www.statsoft.com/textbook/statihome.html
Statistical software for health research that can be used free on a trial basis, but is cheap to buy:
http://www.camcode.com/updates.htm
To perform statistical functions and online information on statistics:
http://www.members.aol.com/johnp71/javastat.html
http://www.coe.ilstu.edu/plk/class/eya509/tutor.htm
These have online statistics books, tutorials and downloadable software.

A user’s guide to evidence based practice may be found at:
http://www.cche.net/principles/content_all.asp

Sarah Cremin
Research officer APCP
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A.P.C.P. JOURNAL 29 SEPTEMBER 2003
REGионаl Reports

North East

Unfortunately our last study day at the beginning of June had to be cancelled due to lack of sufficient support. This meant that once again our rearranged AGM from March did not take place. If anyone would like to have copies of the Chairperson, Treasurer and NE Rep’s annual reports please send a S.A.E. to Karen Roach, Secretary, 7 Kielder Road, Elwick Grange, Hartlepool, TS26 0QF.

Hopefully, many of you will have applied for our study day on Thursday 18th September on Legal Issues and Caseload Weighting in Leeds (flyer sent out to all local APCP members in July).

Topics for Study Days are chosen from requests of our members. Your local committee are interested to hear of any other requests for topics not recently covered but do ask for your support at these study days. They take a lot of time and effort to arrange and done by the committee on a voluntary basis.

Hope that you have enjoyed this lovely summer weather and had great holidays for those of you fortunate enough to have got away!!

Mary Harrison

Scotland

The Scottish committee met in May to start to plan the programme for our Study Day in November 2003. Since then our Course Organiser Janet Parkinson has been very busy contacting and checking the availability of suggested speakers. The committee will meet again in September to finalise details and arrangements.

The proposed programme for the Study Day on Friday 14th November at The Engine Shed, 19, St Leonard’s Lane, Edinburgh, is as follows.

Morning Programme

Dr Barry Meadows from the Southern General Hospital in Glasgow, has agreed to start the day by giving a presentation on his work on the application of biomechanics in neurological impairment in children.

This will be followed by a presentation by Mr Jamie McLean from Dundee, on neurological impairment in children from an orthopaedic perspective.

The morning programme will close with a short insight session given by Leanne Forshaw, senior pupil at Graysmill School in Edinburgh on her experiences of life with an intrathecal baclofen pump. Leanne will give her views assisted by her Vanguard communication system. Ann Bruce Senior Speech and Language Therapist, will be on hand for moral support.

After lunch the Study Day will continue with Dr Paul Elson, consultant paediatric neurologist, and Mrs Valerie Kennedy, senior paediatric physiotherapist, who both work at the Sick Children’s Hospital in Edinburgh. Dr Elson will explain the theoretical background to the use of intrathecal baclofen. Val Kennedy will discuss the physiotherapy management of children undergoing this treatment and give a short case presentation to illustrate this work.

Study Days at the Engine Shed have always been very popular and we hope to see as many of the 160 APCP Scottish members as possible there on 14th November.

Alison Gilmour

West Midlands

I have now taken over as regional representative from Susan Rideout and would like to wish her good luck in her new role as membership secretary. If anyone has anything they would like to be fed back to the National Committee they can contact me at the Birmingham Children’s Hospital.

We ran a two day course in June, which I am pleased to say, went well. At present we are planning our programme for next year and ideas include Paediatric Orthopaedics and Pilates for Children. We will let you know when the details are confirmed. If anyone has any other suggestions or would like some support to run a course please contact a member of the committee.

Lindsay Rae
SOUTH EAST

On Wednesday, June 24th a very successful workshop was held at Charlton Special School, Greenwich entitled “School Physio” facilitated by Anne Martin, Clinical Specialist Physiotherapist.

This was attended by many therapists working both in the mainstream setting and special schools. It was so over subscribed that there is a plan to hold a similar day in July for the members who had to be placed on a waiting list. Participants brought along any protocols, guidelines and research papers pertaining to all aspects of physiotherapy carried out in the school setting for discussion and information sharing.

It was an extremely interesting and thought provoking day with plenty of information sharing. The IT support at the school meant that every member went home with a floppy disc containing all the references, protocols and criteria already being used by services across the region. A plan was made to meet again in October to formulate a SE standard of criteria for such intervention as hydrotherapy, activity programmes, caseloads, and equipment provision and manual handling to be used consistently throughout the region. A very good day!

Plans are also being made for Pilla Pickles to come to talk to us in November for a day which we intend to open up to colleagues from the Local Education Authority, such as Teachers, SENCOs and LSAs as well as other AHPs on ‘Collaborative Working.’ Pilla is an extremely entertaining and interesting speaker with many years experience of teaching children with Special Educational Needs. Please look out for further information and application details in Frontline CIG section, and Paediatric section of www.interactivecsp.org.uk.

APCP National Committee have asked the membership if any of the regions are interested in hosting and organizing ‘The Introduction to Paediatric Physiotherapy Course’ next year.

Please let me know if anyone is interested.

PETA SMITH

EAST ANGLIA

Since the last Journal, we have held our study day on Paediatric Rheumatology in Cambridge. This was very well received, despite some last minute hitches with the technology on the day. However, were disappointed with the low number of applicants, which left us with a last minute dilemma as to whether to cancel the study day. As a result, we have decided to set a closing date for future study days, so that everyone has plenty of notice if a course does not have enough support to be viable.

By the time this edition of the Journal has reached you, the study day on Legal Aspects of Note Writing will be almost upon us. This is being held on Friday 12th September in St Albans. Notification of the study day will have been sent to all areas, and details have been put on our website (apcp-eastanglia.org.uk).

We are also running a follow up to the extremely popular Paediatric Gait Analysis course which we held last June with Elaine Owen. This is probably more relevant to those who have already attended one of Elaine’s courses. Places are limited to 30. It will be held on 31st October and 1st November, and the closing date for applications is 7th October. Full details are in a separate announcement in this Journal.

Further study days planned for next year will include Targeted Training, with Dr. Penny Butler, and Strength Training with Dr. Margaret Mayston. Other topics we are looking into are Sensory Integration, DCD, OBPL and Talipes.

We look forward to seeing you at our future study days.

SUE COOMBE

LONDON

After all the moans about poor turn out you excelled yourself for Sue Molland’s talk on Benign Hypermobility Syndrome. The Gym at GOSH was packed out! Our branch extends through Bucks and into Oxfordshire and the great thing was that we got to meet some of you from those areas. Sue’s talk was excellent so for those of you who were disappointed Sue has very kindly agreed to do it again on December 9th in the Gym at GOSH (6pm for 6.30 start) Cost as
before: i.e £5.00. Please ring me if you want to come
(020 7405 9200 Bleep 690).

We have had to turn the Autumn programme around
a little so the talk on Strengthening and Treadmill
Training in CP will now be held at Great Ormond
Street Children’s Hospital on 23rd September 2003
at 6.15 for 6.30 start. The speakers will be Kate
Beattie, Senior Physiotherapist at the Bobath Centre,
whose MSc dissertation was on treadmill training
and Lucy Alderson Senior Physiotherapist in
Neurosurgery at GOSH. There will be a small charge
of £5.00. Tea and coffee will be provided. Contact
Lucy Alderson in the Physio Department at GOSH to
book a place. Please book early as our gym can only
hold 50-60 people maximum! Fliters will be sent to
your CDCs etc soon.

We hope that the study day planned on Paediatric Pain
will now take in November, it will probably be at the
Wolfson Centre but the date as yet has not be
confirmed. Again fliters will be sent out once
arrangements have been made so look out for them.

Well that’s about all except to wish you all great
holidays and look forward to meeting masses of you
at the meetings planned for the autumn!

JEANNE HARTLEY

WALES

First of all, we have some good news!

The Bobath Liaison Sub-Committee of A.P.C.P. Wales
is very proud to announce that the eight-week Bobath
Introductory Course will be held at Bobath Cymru in
Cardiff during the summer of 2004. The course will
start in July and places are limited to 25 persons.
Further details will be available soon.

Our second piece of good news is that Mrs Viv
Williams, former Superintendent Physiotherapist at
UHW Children's Centre until her retirement, has been
honoured by the University of Wales College of
Medicine with an Honorary Fellowship. This has been
awarded to Viv in recognition of her work to improve
the support to parents and children with special needs
in Wales. She is also honoured for her work in setting
up treatment centres for children with cerebral palsy
in Bulgaria, which are now used as models of
excellence in other areas of Eastern Europe. A fuller
account of the award and ceremony are published
debels elsewhere in this Journal. As you can imagine, we
are all very proud of Viv.

A.P.C.P. Wales “Consent” subgroup have met several
times and are at present looking for funding to produce
a guidelines booklet.

We had excellent feedback from delegates attending
the two-day Respiratory Course that we ran in April
at St David’s Children’s Centre. We hope now to hold
the third Respiratory Course possibly in 2005 which
will concentrate on increasing our practical skills.

Arrangements for Conference 2005 to be held in
Wales are in hand, and a subgroup has been set up to
research suitable venues and communication
possibilities. They will report to the Committee at our
next meeting on September 10th. We hope that
conference will be held in Swansea and would
welcome suggestions for speakers from the
membership.

As you can see A.P.C.P. Wales continues to be
extremely active on your behalf and are working to
provide a range of stimulating and innovative study
days for your delectation!

Further courses are as follows:

1. Manual Handling versus Therapeutic Handling –
The Risks. Run by Wendy Williams – to be held in
the Newport area closest to M4, sometime in
November. Flyers with all details will be circulating
in September, but we do know that the cost will be
£30 for members and £15 for non-members.

2. Elaine Owen will be holding a two-day course on
Gait Analysis on January 19th/20th 2004. Again,
further details to be announced in September.

By the time that you read this, the CSPPhysiotherapy
Week at the National Eisteddfod will have taken place
and I hope will have generated a lot of interest in the
profession and a greater appreciation of the expertise
available to the public within the NHS and in the
private sector. Tuesday 5th August was Paediatric Day
and I am sure that I will be able to report to you, with
accompanying photographs, on a most successful day
in the next Journal.

JILL WILLIAMS
NEONATAL CLINICAL INTEREST GROUP
(Affiliated to the APCP)

Our first study day since the inaugural meeting in November was held on the 27th of June at Rotherham and organised by The Transpennine Group.

I think I speak for everyone who attended that we were fortunate to have taken part in such an incredible day. The organisation was faultless and the topics covered by the speakers were not only extremely interesting but also presented in such a way as to be totally inspirational.

Dr Alan Gibson, Consultant Neonatologist from the Jessop Wing in Sheffield gave a clear and thoroughly enjoyable presentation on Pathology, scanning, imaging and predicting outcome.

Anna Simpson MCSP, Research Fellow presented the results of her 5-year PhD study on “Predicting outcome in pre-term infants.”

Always an excellent speaker, Anna took us through step by step how she embarked on her research and all the stages of ensuring that the results would be without fault or bias. The results were enlightening and certainly do her, and all those who have helped her, credit.

Following Dr Gibson’s talk in the morning all regions presented feedback of the meetings which had taken place since the meeting in November.

Also, Peta Smith Chair of the NNCIG presented minutes of the committee meeting held the previous evening. The main message was that there have been several links established and forged with very influential bodies dealing with the care of pre-term babies.

- Bonnie Green – Head of professional and public affairs at BLISS, Allie Carter, Vice Chair, had met with BLISS who are very supportive and able to work with us and provide sponsorship for courses, as well as assisting with the development of leaflets. Anna will write a report for the October newsletter on our role.

- Rachel Haynes – Head of public affairs at CSP had asked for assistance with a submission to the House of Commons Health Select Committee inquiry into the provision of Maternity services.

- The 4th report published by the above committee on 18.06.03. had shown recognition of the role of the Neonatal Physiotherapist as an advanced sub-speciality within Paediatric Physiotherapy.

Networking at Lunchtime
NEONATAL CLINICAL INTEREST GROUP
(Affiliated to the APCP)

- Information regarding the group – NNCIG (APCP) – have been posted on the interactive CSP site.
- A Report of the Neonatal Intensive Care Services Review Group published in April 2003, “A strategy for improvement”, recommended best practice and suggests units to be staffed by nurses with the right competencies and correct staffing levels. The report only mentions nursing and medical staff whilst neonatal physiotherapists are not included at all. Peta recommended that we as a group should write to the chair of this committee. Peta will inform them of our existence and also highlight to them the objectives of our group, with special regard to the development of a high standard of care, and the need to ensure adequate training in order for physiotherapists working in this field to develop competency to practice safely and effectively.
- The Maternity and Neonatal Workforce Group MNWG was set up in February 2001 and feeds into the NSF. Again, many child-related organisations are represented, with no mention of Physiotherapy. Similarly, Peta suggests that we as a group should inform them of our existence and objectives, and will take this on.
- Further links include BAPM Neonatologists, who have already given positive feedback, and PPIMS who may benefit from our input if planning to develop the role of the neonatal Physiotherapist.

The next study day is planned for November 7th in Bristol and to be organised by The Southwest Group.
For further information regarding the study day contact Nicky McNarry on nicola.mcnarry@mail.qmctraction.trent.nhs.uk

Fifty members attended this successful meeting.
APPLICATIONS FORM FOR APCP PUBLICATIONS - 2003

New Publication:
2003  Special Educational Needs
      Code of Practice 2001
      Guidance for Paediatric Physiotherapists ........................................... £10.00

2002  Paediatric Physiotherapy
      Guidance for Good Practice ................................................................. £5.00

2002  Obstetric Brachial Plexus Palsy
      A Guide to physiotherapy management .................................................. £10.00

2002  Hip Dislocation in Children with Cerebral Palsy
      A guide to physiotherapy management ................................................... £7.50

Evidence Based Practice
- 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 J Foley .............. £5.00
Tests and Measures Resources Pack (2nd Edition) .......................................... £3.50
Baby Massage .................................................................................................. £1.50
The Children Act 1989 “A synopsis for Physiotherapists” ................................ £1.00
Guidelines for Calculating Caseloads (not available at present, in process of being updated)

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A.P.C.P. JOURNAL 35  SEPTEMBER 2003
CONGRATULATIONS

Vivienne Williams
was recently awarded an
Honorary Fellowship of the
University of Wales
College of Medicine

It appears that Viv Williams was no ordinary paediatric physiotherapist. Her long and somewhat distinguished career began in the 1950s as a student at the Cardiff School of Physiotherapy. Viv qualified in 1950 and went to work at Cardiff Royal Infirmary to gain experience in all the general areas of physiotherapy. However, she was soon to move into paediatrics and was eventually in the 1970s to become the first Paediatric Superintendent Physiotherapist in Cardiff and used this lofty position to develop children's services in South Glamorgan from then on. As a real advocate for parents and children with disabilities she became a pioneer for under-developed children's services.

Viv continued her professional development by attending the eight-week Bobath Course in London in 1984 and went on to put in place introductory courses for therapists back in Wales between 1985 and 2000. In 1988 she became the first chairperson of the British Association of Bobath Trained Therapists. She was instrumental in organising the first eight-week Bobath Course taking place in Cardiff in 1990. Viv's ability to work with a wide range of people led her to be a facilitator on the working party that resulted in the opening of the Welsh Bobath Centre for the treatment of children with cerebral palsy.

She was involved with charity groups such as Riding for the Disabled and various Halliwick Swimming groups. Her particular clinical expertise was developed through links with the Special Care Baby Unit at the University Hospital of Wales and the continued care of these children in the community. Viv taught as a visiting lecturer at the University of Wales from 1989 until her retirement in 1996.

Sponsored by the British Council, Viv lectured in Calcutta, India on early intervention for special needs. In 1995, after being approached by the Bulgarian Ambassador, she advised on the setting up of a centre for children with cerebral palsy in Varna. She continues to help support and develop this centre even since her retirement, organizing exchange visits with government officials, social services and educational staff and even the Welsh Assembly Government.

Viv is a Fellow of the Chartered Society of Physiotherapy and has offered professional contributions with consultancy advice for setting up a service for children with learning difficulties for Gwent Healthcare NHS Trust in Czerphilly. She has published papers and given tremendous support to all her colleagues. In 1997 she was invited to a Royal Garden Party, in recognition of her contribution to the community.
Viv has improved the quality of life for many children and their families both at home and abroad. Her commitment to pass on her knowledge, skills and caring nature to undergraduates, qualified staff, families, in fact anyone who wanted to listen, has improved the standards of paediatric care locally, nationally and internationally.

Viv wishes to extend her thanks to all her friends and colleagues in the APCP, saying that they have all helped towards this very special award by being there and providing support throughout her long career.

CREATIVE THERAPY IDEAS
FOR USING DYCEM NON-SLIP

There was a serious purpose behind the Dyce "How do you use yours?" competition which ran at the recent Naidex Show. It brought forward a number of innovative and creative ways to use the popular non-slip material which highlighted and re-emphasised Dyce's position not only as an essential Occupational Therapy "tool of the trade" but as an important facilitator for a range of therapies.

The competition, run in conjunction with Homecraft - who are supplying £250 worth of Dyce products to the winner - was judged by Homecraft's Clinical Product Specialist, Alison Attenborough. Alison selected an entry from Karen Al Khina, Occupational Therapist at Bower Grove School in Kent. Karen creates different shapes and colours using Dyce reel material to use as "stepping stones" during a motor skills group. This helps with colour and shape matching, eye/hand/foot co-ordination and balance control - and the children have great fun at the same time!

Alison commented "I especially liked this entry as many people use bean bags or paper for this type of motor skills activity, but Dyce provides strong tactile and visual stimulation/differentiation. The important message is that Dyce is so versatile in therapy. Those who only think about Dyce in terms of "kitchen/dining" use are missing out."

Chris Hobbs, Business Manager, for Dyce Non-Slip said that the competition had been very successful in raising awareness of the many uses in therapy.

For more information on Dyce Non-Slip range, please call Sandrine Jones on 0117 955 9921 or email us at nsenquiry@dyce.com

Looking for a tutor to run Paediatric Hydrotherapy Courses?

In 1995, I organised and delivered the first week-long Paediatric Hydrotherapy course in the UK. I receive regular requests to run courses and there appears to be a paucity of paediatric hydrotherapy tutors (except Halliwick). I am therefore developing a new service for paediatric physiotherapists who would like to run hydrotherapy courses in their own locality.

For further details or to request an information pack, please contact Heather Epps MSc MCSP HT SRP Grad Dip Phys
Clinical Specialist Paediatric and Adolescent Physiotherapist
13 Fairfield Drive, Dorking, Surrey RH4 1JQ.
Tel. 01306 880 693 Mob. 07930 318 477 or email info@childrensphysio.co.uk
COME TO CONFERENCE 2004

EVIDENCE INTO PRACTICE

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APCP

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Indicative content:
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• Biomechanics
• Bone and muscle change
• Theories of motor control
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e.g. pain, pharmacology, vision, communication

"Touchbase" Conference Centre, Mansfield, Derbyshire, November 11th and 12th 2003
Cost - £120 including lunch

For details contact Fiona Down,
5 Home Farm Close, Hilton, Huntingdon,
Cambridgeshire, PE28 9QW
Tel. 01480 830614 email: fiona_down@hotmail.com
APCP EAST ANGLIA STUDY DAY
PAEDIATRIC GAIT ANALYSIS AND ORTHOTIC MANAGEMENT

Venue: Fulbourn, Cambridge
Date: Friday 31st October and Saturday 1st November
Tutor: Elaine Owen, MCSP, Dip Lower Limb Orthotic Biomechanics, Dip Clinical Gait Analysis
Programme: This is a two day follow up and refresher to the course which we held in June 2002. There will be some revision of the theory, with a large practical element, including analysis of videos, and patient demonstrations. There will also be an updated manual.
Cost: £80 members, £120 non-members (to include lunch)
Contact: Priya Jackson, Tel: 01702 221044
Email: Priya.Jackson@southend.nhs.uk
Closing Date: 7th October 2003

Paediatric Hydrotherapy Course
Borders General Hospital
Melrose
31st OCTOBER and 1st NOVEMBER - 9am - 5pm
Cost £140
Tutor: JACKIE PATTMAN MCSP SRP HT

This course is open to physiotherapy assistants and educational staff working with children with special needs.

For application form apply to:
PAT USHER
HYDROTHERAPY DEPARTMENT
BORDERS GENERAL HOSPITAL
MELROSE
SCOTTISH BORDERS TD9 6BS
Tel No.01896 826547
PAEDIATRIC CONSENT DAY

A study day for senior therapists in Occupational Therapy, Physiotherapy and Speech and Language Therapy.

Venue: Celebration Suite, Burragge Centre, James Paget Hospital, Gorleston, Great Yarmouth, Norfolk NR31 6LA

Date: Friday 24th October 2003

Time: Registration 9.30 a.m.
10 a.m. - 4 p.m.

Speaker: Kate Hill – is an experienced advocate at the Westminster firm where she practises. She regularly represents Trusts at Inquests. She has been involved in emergency applications involving consent issues in Obstetric intervention cases, those involving children and patients with learning difficulties.

Content: Problem-solving, interactive day with active participation using clinical scenarios. Prior to the event you will be expected to submit clinical scenarios concerning issues and challenges of consent when working with children and their families.

Cost: £120 to include tea, coffee and lunch

To book a place and for an application form, please contact:
Eleanor Coates, The Children’s Centre, Lowestoft Road, Gorleston, NR31 6SQ.
Tel: 01493 442232 Fax: 01493 440885 Email: eleanor.coates@jpaget.nhs.uk
University College London Hospitals NHS Trust
Physiotherapy Department

Physiotherapist – Paediatrics
Senior 1: £26,769 - £31,233 p.a. inc.
Ref: CS/372/ES

Are you looking for a new challenge or a Senior II with a strong background in acute Paediatrics?

Are you keen to work at a three star rated central London Teaching Hospital in a dynamic and friendly Therapy Department?

This exciting role would be appropriate for a well-motivated and dynamic Physiotherapist wanting to develop their skills in the field of acute Paediatrics.

You would be responsible for a diverse case-mix, which includes respiratory, orthopaedics, haematology and oncology, as well as being a key member of the NICU and SCBU multi-disciplinary teams.

You will join the Paediatric and Adolescent Unit Physiotherapy Team, covering both UCH and the Middlesex sites. A Clinical Specialist leads the team.

As the lead for the Paediatric service there are opportunities to further develop the service linking closely with community paediatric teams to ensure the most appropriate physiotherapy management programme on discharge from the acute setting.

Our Therapy department runs a broad range of in-service training, from a rolling CPD and research programme, to specifically developed training for Senior IIs and Clinical Specialists, tailored to their managerial and clinical needs.

For further information or to arrange an informal visit, please contact Mandy Tottman, Head of Therapies on 020 7380 9137.

HOW TO APPLY:
• Print an application pack from www.uclh.org/jobs or
• Telephone 0870 442 4529 weekdays 8am-7pm or Saturdays 9am-2pm quoting the reference number.
• All our vacancies can be viewed on our website at www.uclh.org/jobs

Closing date: 26 September 2003

UCLH is an employer committed to equal opportunities and improving working life for all our staff.
All our jobs are open to job share, with or without a partner.
VACANCIES

BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST

Royal Alexandra Hospital for Sick Children  -  Brighton

Senior 1  15 hours /week  Maternity Leave Cover

We have the above vacancy until March 2004.

We are looking for a Paediatric Physiotherapist with neurology experience to help cover a mixed case load of children with Developmental/ Global Delay and Cerebral Palsy.

For more information please contact :

Chris Young  -  Anne Walker
Superintendent Physiotherapists

Tel:  01273 328145 ext 2155
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.*
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

G.T. McCarthy (Ed). Physical Disability in Childhood (Churchill Livingstone)

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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