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Editorial

So now is the time to say goodbye. It is with considerably mixed feelings that I sit in front of the computer to write this editorial. This will be the last time you have to read thoughts from a person who would like you all to play an active part in APCP.

Four and a half years seems a very long time in the life of a journal editor who works full time. To start with producing the journal was a very steep learning curve. To off set this I found a wealth of experience and friendship that were more than willing to help me along the way. I have enjoyed meeting and talking to each person who has crossed my path and consider myself very privileged to have had the honour of knowing and working with so many people.

The journal has developed like so many other things to do with paediatric physiotherapy. It has not been subject to an agenda for change or a national service framework but has become a very professional journal for very professional therapists. It has changed its format to sit nicely on the shelves with other journals, (even if it doesn't fit easily into your handbags anymore), the articles photocopy with ease for those temperamental machines that decide they don't like it if the size does not exactly match what is in their paper trays. APCP does not believe in reinventing the wheel but embraces an ethos of sharing and one way of doing this is to make the use of photocopying open and easier to all. Peer review

has also been a big step forward and I hope you will all agree raised the standard of the main journal articles to a level where they can be used by many to back evidence based practice and pieces of research, as well as just being interesting and useful. I suppose what I am saying is if you get the chance to become an active member of APCP take it with both hands, it will reward you in many ways.

I will be moving on taking up the position of chair of the national working group looking at possible inter-disciplinary UK guidelines for working with children with developmental co-ordination disorder. So rest assured I will still be begging for help from many of you – you can't escape that easily.

May I take this opportunity to wish my successor Terry Pountney the very best of luck as she takes up the editorial reigns and to thank her for her invaluable support on the editorial board, especially with the setting up of peer review. In fact to thank everybody who has worked on the editorial board with me during the last four and a half years. It couldn't be done without you. To you the membership of APCP, I just can't resist it – it is and always will be your journal, continue to contribute to it in every way you can. Use it to network with your colleagues.

My plans are for a long holiday. I will miss talking to you all but look forward to seeing as many of you as possible at congress in October – have you booked your place yet. It's not too late.

Sally Braithwaite

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Dear Sally

I am a paediatric physiotherapist working in an early intervention team in Limerick, Ireland. The local health board recently restructured our teams and ways of working. We have now amalgamated staff from voluntary organisations and health board to form team working in a transdisciplinary model as being used in a centre in New Zealand. I would like to hear from other physiotherapists who have worked this model and their experience with it

Thank you very much
Ursula Blake

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Physiotherapist

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Dear Sally,

We are a small paediatric team working for the acute hospital trust in Peterborough and would appreciate any help from the readers with 2 current issues:

Recently our department has received an increasing number of referrals for children with torticollis secondary to plagiocephaly. Unfortunately they have been above 6 months of age and so outcomes have been poor. One of our parents has taken her child privately to Medistox who run a service providing assessment and provision of helmets which gradually aim to correct the plagiocephaly. We would be interested to hear if any colleagues have had experience with this company or other types of orthotic helmets.

Secondly, we used to provide car seats on a short term loan basis to children who were placed in hip spica cast post hip surgery. Due to potential Risk and Litigation concerns we no longer provide this service and parents are expected to provide/purchase their own car seats. Does anybody else come across this issue and how do you deal with a situation when the family can't afford a car seat?

Please reply to us by e-mail.

Many thanks

Jo Campbell, Clinical Specialist Paediatrics
Nicola Forsdick, Senior Physiotherapist
Helen Jones, Junior Physiotherapist



Copy for the
DECEMBER 2005 JOURNAL

must be with the editor by

1st NOVEMBER 2005

The editorial board reserve the right to edit all material submitted



Terry Pountney – Your New Journal Editor

I have accepted the daunting task of taking over the editorship of this journal from Sally in January. Under Sally's stewardship the journal has made great progress both in the standard of its content and its shape and size. I hope together with the rest of the editorial board I can continue this progress.

I began my physiotherapy career in the mid -70s training at St Mary's Hospital in Paddington, London. My first passion was sports medicine but a move to my home city of Brighton by chance led me to a job at Chailey Heritage Clinical Services, a school and health organisation for children with disabilities. For several years I continued to practice Sports Medicine setting up a Sports Injury Clinic at the University of Sussex with a GP colleague. However motherhood meant I had to choose and I chose to concentrate on children.

I worked with the research team at Chailey developing assessment tools and equipment for children with complex disabilities for 7 years followed by a return to clinical work for 5 years. During this time I gained an MA in Health Promotion. The research bug had well and truly bitten me and so I returned to Chailey and under the guidance of the University of Brighton gained a PhD for a study on postural management and hip dislocation in cerebral palsy.

Currently I am working at Chailey as research lead and involved with a number of research studies, I am a visiting fellow at the University of Brighton and work part-time at the CSP as a Research Adviser. In my spare time, which I hope won't all be taken up editing the journal, among other things I enjoy exploring new places on my bike, running and gardening.

I look forward to working with you all and receiving your contributions to the journal.

Standing Frames for Children: An Evaluation of Postural Control Features

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Key Words: Standing Frames, postural support, evaluation

Introduction

Studies suggest that children with limited mobility can benefit from being supported in standing. For children with cerebral palsy, regular weight-bearing is believed to have physiological benefits such as improvements in bone mineral density (Chad 1999). Prevention of contractures and improved bowel and bladder control has also been reported (Beattie 2001). When used as part of a postural management programme, standing can also contribute to improvements in hip position (Pountney et al 2002). In addition, enabling a child to relate to peers at a comparable height whilst providing the opportunity to make eye contact can have positive psychological benefits including increased self-esteem (Shumway 1986).

Although standing frames are often used to provide the postural support required to achieve and maintain a standing position, little is known about the benefits and potential limitations of the numerous designs of frames available. Over ten years ago, Green et al (1993) described how the design of existing prone and upright standing frames were not meeting all the clinical needs of children who require this equipment. They reported that the postural control provided was unsuitable and the adjustability and usability of

these frames was inadequate. However, until now, no studies have evaluated standing frames. Therefore no guidance is currently available for purchasers on the suitability of individual product features for children with different clinical needs.

Numerous standing frames are available in the United Kingdom (UK) with a diversity of features across the range. Individual features can have an impact on ease of use, manoeuvrability and storage and more importantly they can determine the position a child can achieve, their comfort and personal acceptance of the equipment. Clear guidance is needed, therefore, if the most appropriate features and combination of features are to be chosen.

This article summarises key findings from a Department of Health (DoH) funded study (Daniels et al 2004) which evaluated the features of a representative sample of standing frames for eight to fourteen year olds. The aim of the study was to highlight the advantages and potential limitations of different features and product designs and to assess their impact on the ease of use and acceptability by users, therapists and carers. In this article we focus on three product features, namely, foot, knee and pelvic supports as these components can have a direct effect on the effectiveness of postural support provided in standing and can also impact on a child's level of comfort. Several other features which can impact on access, manoeuvrability, stability and weight bearing were also evaluated and these results are presented in the full report (Daniels et al 2004).

Method

Selection of Standing Frames

Manufacturer's literature, an internet search and the Hamilton Index were used to identify all standing frames available on the UK market. Consultation meetings were carried out with a convenience sample of health, education and social care professionals to identify areas of concern and priority for evaluation. Based on the outcome of these consultations, all prone and multi-positional standing frames suitable for 8 to 14 year olds were identified for evaluation. This group was selected as the frames available for this age range encompassed the majority of features available on the market. Frames were excluded if they had limited features or a limited size range for this age group. All frames were borrowed from manufacturers.

Recruitment and Selection of Participants

A convenience sample of twelve standing frame users aged eight to fourteen (seven boys, five girls) located in six schools across Derbyshire, Nottinghamshire and Staffordshire was recruited. Informed consent was gained from each child, their parents/carers and therapists. Ethical approval was obtained from the Local Research Ethics

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Committees.

Allocation of Standing Frames

Structured questionnaires were sent to the physiotherapist of each child to establish the child's height and mass, model and size of standing frame currently used and clinical needs. Each child was allocated two frames on the basis of anthropometric data and the clinical needs specified by the child's physiotherapist.

Trials

The children were asked to use each frame for 10 sessions or for a total of five hours. To maximise safe and optimal use, each frame was set up in accordance with the manufacturer's standard procedure when supplying to a purchaser. This usually involved the attendance of a sales representative and the child's physiotherapist. Two researchers also attended each set up session which was video recorded. A risk assessment was completed by a researcher and the physiotherapist and the manufacturer's product instructions were given to the physiotherapist for future reference.

Data Collection

Diaries were completed during each trial to record the frequency and duration of standing sessions and any comments made by the child, therapist or carer. Semi-structured interviews were carried out following completion of each trial with the child, their physiotherapist and any other staff member and/or carer involved in the use of the frame. Interviews identified therapist's satisfaction levels with the child's position and likes and dislikes of the frame identified by the child and their therapist. Interviews were recorded and transcribed. Both the diaries and interview transcripts were analysed by coding and identifying themes and sub themes relating to the features of standing frames.

Professional Appraisals

Three professionals, including two occupational therapists and an ergonomist with a physiotherapy background carried out a detailed professional appraisal of each frame. This appraisal considered compatibility of the device with other furniture, manoeuvrability, ease of use, aesthetics and accessibility. In addition, the content and clarity of manufacturer's literature was appraised and measurements of each device were taken using an anthropometer.

Results

Frames selected: Eighteen prone and multi-positional frames suitable for children between 8 and 14 were identified. Of these, seven were excluded from the evaluation because they had been

withdrawn from the market (n=1), were not available in an appropriate size (n=3), incorporated a limited range of features (n=2) or the manufacturers declined to participate (n=1). The final sample included eleven standing frames (table 1) with a variety of features and manufactured from different materials.

Trials completed: Twenty-three trials were completed by twelve children. Twenty were carried out at school and three at home. Ten children had a diagnosis of quadriplegic cerebral palsy, one had Developmental Motor Disorder and one child had Pelizeus Merzbacher disease. In 17 of the 23 trials, the minimum standing time of ten sessions or five hours was achieved. In the remaining six trials, children were not able to achieve the full standing time due to a change in physical needs (n=3), limited carer time (n=1) and practical difficulties at school such as holidays and timetable commitments (n=2).

Trials and Professional Appraisals: The results presented below include the findings derived from the equipment trials and the professional appraisals and feedback received from the children, their therapists and carers.

Foot Supports:

In 17 of the 23 trials, therapists were 'very satisfied' or 'satisfied' with the foot position achieved in the standing frame evaluated. Six different adjustments could be made to the foot supports of the frames evaluated and these included:

1. Height adjustment (independent or simultaneous)
2. Anterior/posterior adjustment
3. Lateral adjustment
4. Rotation
5. Inversion
6. Plantar/dorsi flexion

Table 1: Frames selected for evaluation

	Manufacturer/Supplier	Frame
PRONE		
P1	James Leckey Design	Woosh
P2	James Leckey Design	Pronestander
P3	Otto Bock UK Ltd	Charly
P4	Taylor Therapy*	Whirl
P5	G&S Smirthwaite Ltd	Lay Prone
P6	James Leckey Design	Lifting stander
P7	IPER Centre	Wheelie
MULTI-POSITIONAL		
MP1	R82 UK Ltd	Buffalo
MP2	R82 UK Ltd	Gazelle PS
MP3	Taylor Therapy*	Supro
MP4	Homecraft AbilityOne	Tristander

* now manufactured by G&S Smirthwaite Ltd

Three of the frames had foot supports which incorporated all six methods of adjustment (P1, P3, MP2). Two of the adjustments, independent height and plantar/dorsi flexion were reported to be

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advantageous as this enabled therapists to accommodate a child's leg length discrepancy and maximise foot contact with the support. Therapists who participated in the trials identified positive aspects of independent height adjustment:

"There's independent adjustment on the leg length so we didn't have to wedge a bit of foam or pads. He looks more secure as we were able to move the footplates independently."

Two children who evaluated a frame with no height or plantar/dorsi flexion adjustment found it difficult to position their heels on the footplates. The therapists of these children found this lack of adjustability affected positioning and they commented that:

"Being able to adjust it to have a tilt would have been useful. If we had some adjustment in the footplates then I think we would have been able to adjust it better to suit her needs."

Three frames had foot supports which hinged to assist access (P2, P4, P5) and could be folded whilst the user was positioned in the frame. The foot supports of one of these frames (P5) folded on a double hinge (figure 1). During the equipment trials and professional appraisals it was found that when folded up these foot supports were not secure and could be lifted unintentionally (see figure 2).

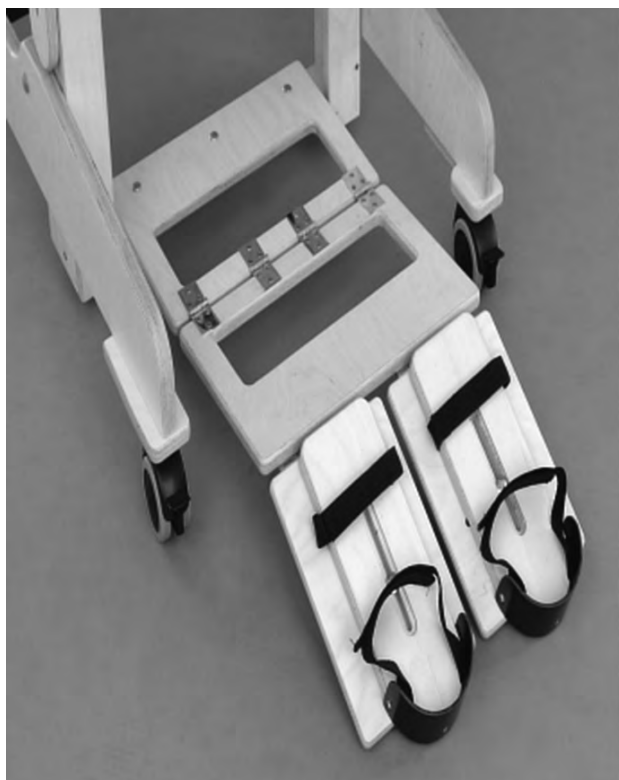


Figure 1: Double hinged foot support



Figure 2: Foot support which can be lifted by a child

"The plates rocked backwards and forwards and the footplates lifted up."

As this frame did not enable the height of the foot supports to be adjusted, lifting could be caused by a leg length discrepancy, lower limb flexion or spasm. One therapist was able to overcome the problem by tilting the frame away from vertical to increase the prone angle of the frame. However, movement away from vertical could affect the amount of weight-bearing achieved by a child. Additionally, professional appraisers found that foot supports attached to a frame with only one screw were not sufficiently secure to prevent movement.

Knee Supports

Knee pain or discomfort was reported by children in 11 of the 23 trials. Examples of comments made by children and therapists included:

"I like the standing frame, but after a while my knee hurts. I wanted to stay in the frame but needed to come out due to knee pressure."

Therapists ranked their satisfaction of the child's knee position as 'OK', 'dissatisfied' or 'very dissatisfied' in 7 of the 23 trials:

"I was dissatisfied with the position of his knees because of the limitations of the frame."

Six different adjustments could be made on the knee supports and these included:

1. Height adjustment (independent or simultaneous)
2. Vertical angle
3. Horizontal angle
4. Lateral
5. Anterior/posterior
6. Width

Two frames had knee supports that offered all six adjustments (frames MP1, MP2). One of these offered height adjustment of the knee supports as a pair only (MP1). A further three frames had five of the six adjustments including individual height

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adjustment (frames P1, P4, P6). These three frames did not allow the width of the knee support to be adjusted. Two therapists who evaluated these frames commented that the knee supports:

*"Held him well, gave him good support and he was comfortable.
It accommodated her knee position really well."*

Seven of the standing frames had knee supports which had anterior/posterior adjustment (P1, P3, P4, P6, P7, MP1, MP2). This feature was considered beneficial by therapists and the professional appraisers as it allowed for varying degrees of flexion in each knee and allowed knee extension to be increased gradually over time. Therapists of children who evaluated frames which did not have this adjustment commented on its absence, for example:

*"I think he could have got a bit straighter but there wasn't the accommodation for that.
There needs to be more flexibility in the knees...maybe anterior/posterior adjustment.
It would have allowed us to graduate and try to extend her legs a little bit."*

One therapist reported that she had to use padding under the child's knee to compensate for the absence of this feature.

Pelvic Supports

In 14 of the 23 trials, therapists were 'very satisfied' or 'satisfied' with the position of the child's hips and pelvis. Hip and pelvic control was offered by a combination of straps, sling supports, front and rear supports and lateral supports. Three styles of strap system were used to provide support to the hips and pelvis in a prone position on the frames evaluated. Three of the frames had an asymmetric strap (frames P1, P2, P5) as shown in figure 3. The asymmetric strap fastens around the child's pelvis before they are positioned in the frame. Two side straps then attach around the frame to position and secure the child. Professional appraisers noted that this style of strap should assist pelvic alignment as it allows independent control of each hip to be achieved via adjustment of the left and right straps.

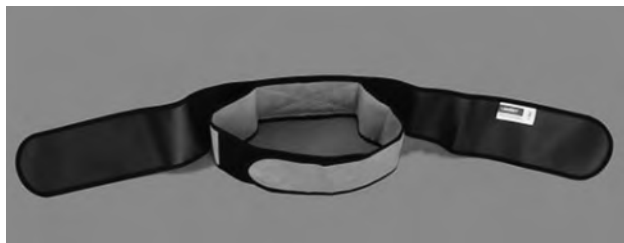


Figure 3: Example of an asymmetric strap

Two therapists acknowledged the advantages of this feature:

*"The pelvic band can adjust from side to side to accommodate the wind sweeping position which made him look very symmetrical.
It really did give her better control."*

One child also found this feature beneficial:

"They were easy to strap on because before I went in you had to pull one of the straps around me when I was out of it (the frame) and I found that a lot easier."

However, in two cases, it was reported that the pelvic strap was out of proportion. For these children, the straps which attached around the frame were too short whilst the straps which fastened around the pelvis were thought to be too long:

"I would prefer more flexibility or options on strap length."

In total, feedback was given in relation to the length and width of pelvic straps on five different frames. Therapists reported that more adjustability or strapping options was required to suit children's needs and to provide a secure position. Straps were considered to be too short to fasten around a child's hips or too long to be able to fasten securely. One therapist noted:

"Strap around pelvis seemed slightly short – could do with another strap over to give more security and reduce risk of another child loosening."

Seven of the standing frames evaluated had lateral supports to assist positioning of the hips and pelvis (P3, P4, P7, MP1, MP2, MP3, MP4). Six of these allowed the width of the pelvic lateral supports to be adjusted. Lack of width adjustment was considered to be a disadvantage by the therapist of one child who evaluated a frame without this feature (MP4):

*"I would want something that could wrap around the body more so that the lateral support was at his pelvis.
There was a big gap at either side that he could move around in. Once he lost his balance to that extent he couldn't bring himself back up again."*

Although a soft pelvic support was supplied with this frame, this did not provide enough support to compensate for the absence of lateral width adjustment.

Pelvic control in a prone position was provided via a solid rear support as shown in figure 4 on two of the frames evaluated (P3, MP2). This support was positioned from behind the child after they had

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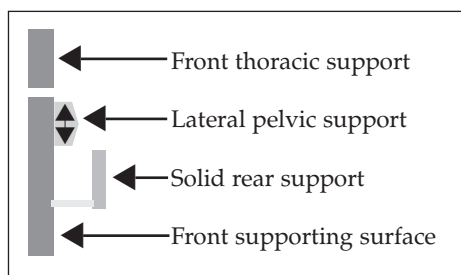


Figure 4: Side view of a prone standing frame with a rear pelvic support

transferred into the frame. The therapists of three children who evaluated these frames felt this was a positive feature. For one child, it was this particular feature that his therapist felt made a positive difference between the position he achieved in the frame evaluated and in his own frame. Therapists also commented that:

"It had an extra feeling of security. It gave a much better position for her pelvis and lumbar spine with less effort."

Three frames had a mechanism to assist hip abduction by moving the legs to which the foot supports are attached outwards at hip level (P3, MP2, MP3) as shown in figure 5. Two further frames offered an optional pommel to assist hip positioning (frames P7, MP1). A pommel was considered a positive feature as it made it easier for therapists to separate the child's knees. Two therapists who evaluated frames without a pommel or abduction feature commented for example:



Figure 5: Example of a hip abduction feature

"I would like to change the knee pieces to offer some abduction at the hips and keep the knees apart."

Some form of blocking system to allow separation of the knees would be useful."

One therapist reported using a conventional pillow to allow the child to gain a more symmetrical hip position as this could not be accommodated by the standing frame evaluated.

Discussion

During this evaluation, foot, knee and pelvic supports with multiple adjustments received positive feedback from therapists and professional appraisers. The limitations that were reported related to the lack of adjustability of components and recommendations were made to improve the flexibility of these supports. Placing a child in a frame that offers multi-adjustment will assist in achieving an optimal position to provide a child with the support required to maximise both their postural alignment and the clinical benefits derived from using a standing frame. Additionally, multi-adjustable components can accommodate fixed deformities or contractures if necessary.

The findings of this evaluation also show that multi-adjustable components could improve a child's comfort when positioned in a frame. In this evaluation, knee supports designed to allow anterior and posterior adjustment were reported to reduce pressure on the knees which could lead to improved comfort. Comfort levels can influence a child's personal acceptance of a standing frame as well as enabling them to maintain a standing position for the period of time required to meet therapeutic goals. It has been suggested that a standing frame should be used four or five times a week for 60 minutes to improve hip position (Stuberg 1992). Therefore, a standing frame must provide a child with the comfort required to tolerate this period of standing.

In the past, commercially available standing frames have been criticised for not being able to provide sufficient adjustability or postural control (Green et al 1993). Now, with the availability of over 70 standing frames on the UK market, there is a wider choice of feature variations available. As children who use standing frames have a broad range of clinical and environmental needs, no single style of standing frame will meet the requirements of all children, their therapists and their carers. However, an awareness of available features and their advantages and limitations can assist in the identification and selection of appropriate equipment. This information is also essential to manufacturers to ensure products offer the features required to meet individuals' needs.

Standing Frames for Children: An Evaluation of Postural Control Features

Conclusion

This article has presented key findings concerning the foot, knee and pelvic supports provided with standing frames for children aged 8 to 14. It is essential that a clear understanding of these features and their potential advantages and limitations is gained to enable frames which will provide effective postural support in standing to be selected. Findings also demonstrate the need for a range of adjustments on the components of standing frames to provide the flexibility required to accommodate the broad needs of children who use standing frames.

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Introduction

Children with physical disabilities are often advised to follow a postural management programme to prevent or reduce the progression of deformities, for example, hip subluxation/dislocation (Pountney et al 2002). This postural management may include support in standing. Supported standing is believed to have further clinical benefits such as assisting bone development (Chad 1999, Stuberger 1992), reducing the progression of contractures and improving bowel and bladder function (Beattie 2001). It also provides the opportunity for different visual and social experiences to be explored from those available in sitting or lying (Chia 2005).

Postural management programmes utilise equipment, for example standing frames, to enable children to maintain an effective position. Green and her colleagues (1993) advocate that standing support should be provided in a comfortable, controlled and symmetrical position. Additionally, it has been recommended that children with cerebral palsy should stand for a minimum of 60 minutes four or five times a week for bone development (Stuberger 1992).

To achieve this, equipment must be both comfortable and personally acceptable whilst offering adequate support to meet therapeutic goals. For a child, acceptance may be related to factors such as the aesthetics of a frame whilst for carers and therapists it may be influenced by practical issues that affect ease of use, adjustability, access and manoeuvrability (Daniels et al 2004).

A study carried out on behalf of the Medicines and Healthcare products Regulatory Agency (MHRA) (Daniels et al 2004) identified that over 70 standing frames are available on the market in the United Kingdom (UK), many of which can be used by children. This product group incorporates a wide range of features that can impact on positioning, comfort, manoeuvrability, accessibility and safety. This study investigated the advantages and potential limitations of different product features through trials and professional appraisals. Children and their therapists were asked to provide detailed feedback and to compare characteristics and usability of the frames evaluated with the frame they normally use. This article summarises the observations and findings expressed by children and their therapists during this study and discusses the implications of these findings in relation to the selection and provision of standing frames.

Method

Selection of Standing Frames

Manufacturer's literature, an internet search and the Hamilton Index were used to identify all standing frames available on the UK market. Consultation meetings were carried out with a convenience sample of health, education and social care professionals to identify areas of concern and priority for evaluation. Based on the outcome of these consultations, all prone and multi-positional standing frames suitable for 8 to 14 year olds were identified for inclusion in the evaluation. This group was selected as the frames available for this age range encompassed the majority of features available on the market. Frames were excluded if they had limited features or a limited size range for this age group. All frames were borrowed from manufacturers.

Recruitment and Selection of Participants

A convenience sample of twelve standing frame users aged eight to fourteen (seven boys, five girls) located in six schools across Derbyshire, Nottinghamshire and Staffordshire was recruited. Informed consent was gained from each child, their parents/carers and therapists. Ethical approval was obtained from the Local Research Ethics Committees.

Allocation of Standing Frames

Structured questionnaires were sent to the physiotherapist of each child to obtain the child's height and mass, model and size of standing frame

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currently used and a list of their clinical needs. Each child was allocated two frames on the basis of anthropometric data and the clinical needs specified by the child's physiotherapist.

Trials

The children were asked to use each frame for 10 sessions or for a total of five hours. To maximise safe and optimal use, each frame was set up in accordance with the manufacturer's standard procedure when supplying to a purchaser. This usually involved the attendance of a sales representative and the child's physiotherapist. Two researchers also attended each set up session which was video recorded. A risk assessment was completed by a researcher and the physiotherapist and the manufacturer's product instructions were given to the physiotherapist for future reference.

Data Collection

Diaries were completed during each trial to record the frequency and duration of standing sessions and any comments made by the child, therapist or carer. Semi-structured interviews were carried out following completion of each trial with the child, their physiotherapist and any other staff member and/or carer involved in the use of the frame. Interviews identified therapist's satisfaction levels with the child's position and likes and dislikes of the frame identified by the child and their therapist. Interviews were recorded and transcribed. Both the diaries and interview transcripts were analysed by coding and identifying themes and sub themes relating to the features of standing frames.

Results

Part One: Standing Frames Used Prior to the Study
This section presents the findings relating to each child's own standing frame and the standing programme they follow.

Participants: Twelve children (table 1) and their physiotherapists (n=6) participated in this evaluation. Ten children had a diagnosis of quadriplegic cerebral palsy, one had Developmental Motor Disorder and one child had Pelizaeus Merzbacher disease.

Table 1: Participant information

	Mean	Range
Age of children	11 years	9 to 14 years
Number of years using a standing frame	6 years	1 to 11 years
Age when started using a standing frame	5 years	3 to 10 years

Standing frames currently used: Figures 1 and 2 show the reported frequency and duration of standing sessions by the sample of children. Six children (50%) were reported to use their own frames four to five times per week and nine children (75%) stand on average for 60 minutes or more.

Figure 1: Average frequency of standing sessions

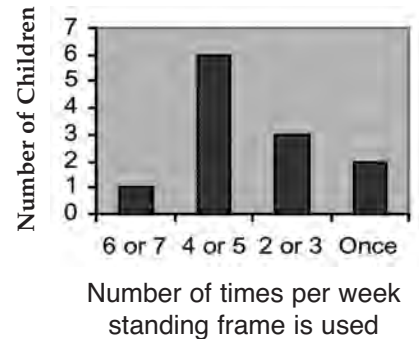
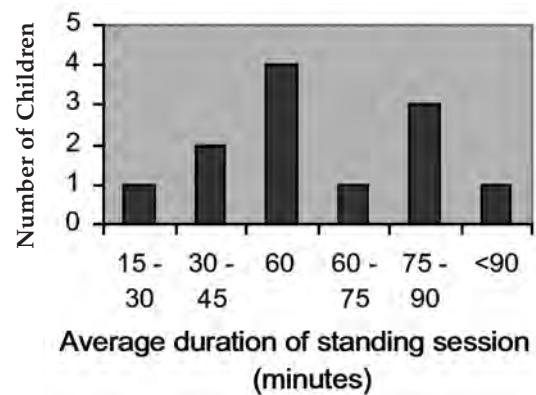


Figure 2: Average duration of standing sessions



Eleven of the twelve children used a standing frame at school. Two also had access to a frame at home during the school holidays (n=1) or on a permanent basis (n=1). Eleven of the twelve children did their schoolwork and nine used a computer whilst positioned in their standing frames. The child who permanently had access to a frame at home did his homework, watched television and ate meals whilst positioned in a frame.

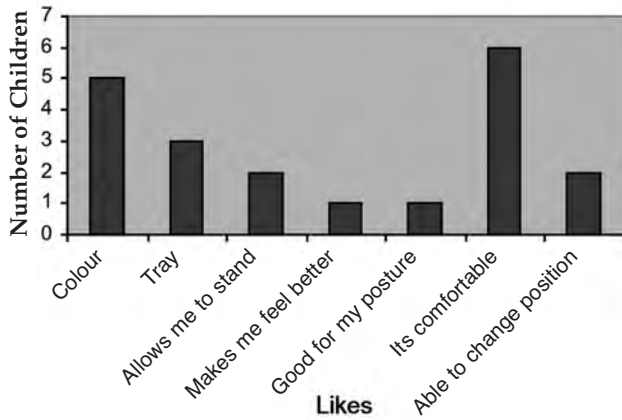
All of the children (n=12) enjoyed standing and ten commented that they enjoyed using their current frame. The two children who did not enjoy using their standing frame attributed this to knee pain (child 4) and general discomfort (child 6).

Figure 3 shows that five children liked their own frame because of its colour and six liked it because it was comfortable. Figure 4 illustrates the changes that the children reported they would like to make to their own frames. Six children (50%) stated that they would like to be able to move about when using their frame and four children (33%) would like to improve the comfort of their own frame.

The physiotherapist's satisfaction with individual characteristics related to the children's standing

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Figure 3: Reason(s) why children liked their own standing frames



frames is summarised in figure 5. For all of these factors, the physiotherapists of at least half of the children (n=6) were satisfied. Physiotherapists were dissatisfied with the standing posture of four children (child 2,4,9 and 12).

Part Two: Standing Frames Used During the Study

This section presents the findings which relate to the equipment evaluated as part of this study and comparisons made with the children's own standing frames

Summary of standing frames selected for trials:

Eleven standing frames were selected to represent the range of features available on standing frames on the current UK market. Feature variations included adjustability of components, types of straps and support systems, angle of adjustment and construction. Additionally, one frame had large self propelling wheels which enabled a child to manoeuvre the frame independently. Two frames had a power unit to control the angle of the frame using a hand set. One frame had a facility to assist a child from a sitting to standing position.

Figure 4: Changes children reported they would like to make to their own frames

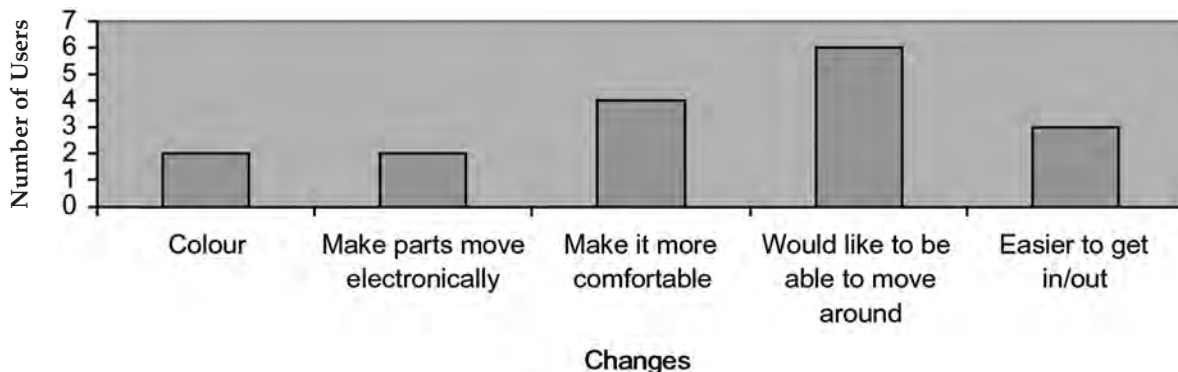
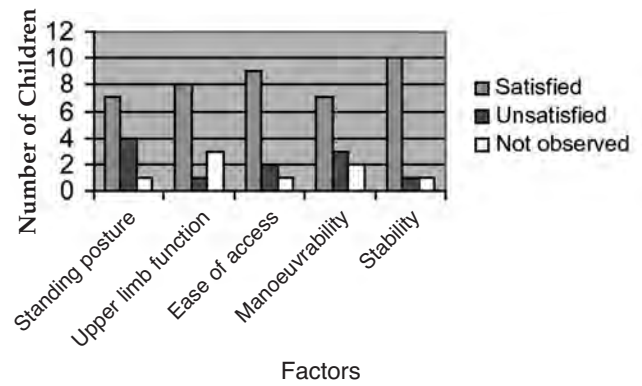


Figure 5: Satisfaction ratings given by physiotherapists

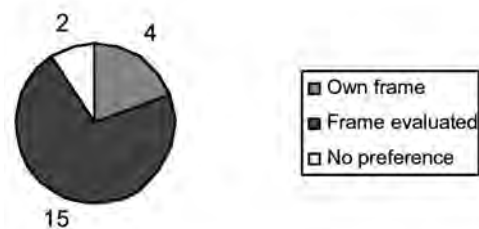


Trials Completed: A total of twenty-three trials were completed by twelve children. Twenty trials were carried out at school and three at home during school holidays. Mean standing time was six hours. In five trials the children were not able to complete the minimum evaluation period of five hours or ten standing sessions. Two children withdrew from the study as the frame was unsuitable for their clinical needs. A further three children reported time restrictions at home or school however, they felt they had used the frames for a sufficient time to provide feedback. Interviews with children were carried out following 21 trials and with therapists after all 23 trials.

Children's Responses

Figure 6 shows that following 15 of the trials, the children preferred the frame they had evaluated above their own frame. Table 2 shows the reasons given for this preference. In eleven of the fifteen trials the reason for this preference was improved comfort. Children reported improved comfort at their knees (n=2) and at their feet (n=2).

Figure 6: Did you prefer the frame you tried for us or the frame you use normally? (n=21)



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Table 2: Reasons why children preferred the frame evaluated to the frame they use normally (n=21)

Reasons given	No. of trials
More comfortable than my own frame	11
Colour/material	4
I can operate it myself	4
Easier to get in/out	2
Like the straps	2
Able to change position/angle	2
Stable	1

Physiotherapists' Responses

Figure 7 shows that in 16 of the 23 trials, physiotherapists preferred the frame evaluated to the frame used normally. The reasons given for this preference are listed in table 3.

As figure 5 shows, the physiotherapists of four children were dissatisfied with the standing posture they achieved in their own frame. The preference

Figure 7: Did you prefer the frame evaluated or the child's own frame? (n=23)

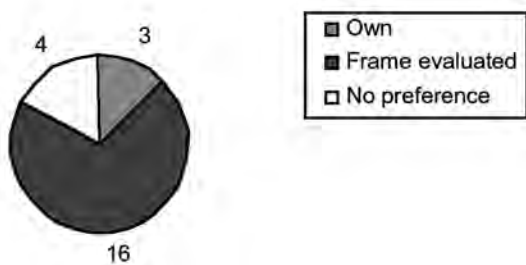
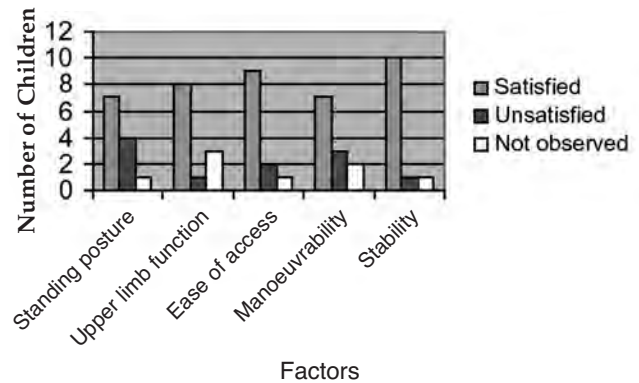


Table 3: Reasons for preferring evaluated frame over the child's own frame (n=16)

Reasons given	No. of trials
Improved posture/position	8
Easier to assist user in/out	4
Easier to position	2
Improved support	2
Increased standing time	2
More adjustability	2
Improved aesthetics	2
Participant could control their own position	1
More transportable	1

Figure 5: Satisfaction ratings given by physiotherapists



expressed by the physiotherapists of these four children between the frame evaluated and the child's own frame is presented in table 4. The reason given for this preference is also shown.

The therapists of five children reported that the frame they normally used was 'inherited' or provided from an existing stock. The

Table 4: Preferences expressed by therapists of children whose standing posture was unsatisfactory in their own frame

Child	Trial 1		Trial 2	
	Preference	Reason	Preference	Reason
2	Frame evaluated	Improved position	Frame evaluated	Improved position
4	Frame evaluated	Improved position	Frame evaluated	Improved posture
9	Frame evaluated	Improved position	Frame evaluated	Own frame is easier to use
12	Frame evaluated	Improved hip and pelvic control	Frame evaluated	Improved posture

Table 5: Preferences expressed by the therapist of children whose frame was supplied from existing stock

Child	Source	Trial 1		Trial 2	
		Preference	Reason	Preference	Reason
5	Existing stock	Frame evaluated	Easier to assist user in/out	Frame evaluated	Aesthetics
9	Existing stock	Frame evaluated	Better position	Own	Easier to use
10	Inherited frame	Frame evaluated	Easier to assist user in/out	Frame evaluated	Improved thoracic support
11	Existing stock	Frame evaluated	More comfortable (knees)	Frame evaluated	More transportable around school
12	Inherited frame	Frame evaluated	Improved hip and pelvis control	Frame evaluated	Easier to assist user in/out, better posture

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physiotherapists of seven users did not identify the source of the child's own frame. Table 5 shows the preference expressed by the physiotherapists of these five children between the frames evaluated and their own frame.

These five children reported that they preferred the trial frames in 9 out of 10 trials.

Discussion

This study presents findings from trials that gave children the opportunity to use alternative standing frames. In a high proportion of trials, both the children and their physiotherapists expressed a preference for the frame they used during this study above their own frame. In the majority of trials, therapists attributed this preference to the ability of the child to gain improvement in posture whereas the children associated this with being more comfortable. Reports of improved comfort, posture and acceptance are likely to be linked to the different features and adjustability of components available on the frames evaluated.

Therefore, consideration by therapists of the available features could influence the clinical benefits of this intervention. The effects of improved comfort, for example, could include reducing the distraction caused by discomfort to enable a child to participate more fully in activities and may also encourage a child to remain in their frame for a longer period of time, contributing to a potential increase in the physiological benefits of this intervention.

However, for many standing frame users, it may not always be possible to ensure that the features of the frame they use are optimal for their needs. As these findings show, physiotherapists are dissatisfied with the standing posture a child can achieve in their own frame yet posture can be improved greatly if a more appropriate frame is used. This could be attributed to the many barriers which interfere with the successful use of assistive technology (Copley and Ziviani 2004). Barriers may include factors such as limited resources and personal acceptability which could specifically affect the ability of therapists to ensure the provision of optimal equipment. The effect of these factors in relation to standing frame provision and strategies to overcome these are discussed below.

1. Limited Resources

The sourcing, assessment and purchasing of appropriate equipment requires professional time, knowledge of the market place and adequate funding. These resources may not always be readily

available to physiotherapists. Therefore, limited resources could result in the provision of equipment that may be restricted in its ability to fully meet the needs of a child.

i) Time Restrictions The availability of a large number of standing frames on the UK market makes researching this product group a time consuming task with therapists relying on the marketing strategies of manufacturers rather than having the resources available to investigate the products available in depth. Additionally, it is not always possible to try a frame over an extended period and in environments where the child participates in functional activities. This prevents the child and their therapist from adequately assessing the ability of the frame to fully meet their needs. This may be overcome through the use of resources such as a recent evaluation of the features of standing frames (Daniels et al 2004) and through the use of a web based searchable database of standing frames soon to be made available by the MHRA.

The needs of children who use standing frames can change on a regular basis. Continual assessment is required to ensure the components of a frame are accommodating their needs and the position is acceptable for the child. The time and availability of staff to ensure continuous assessment, if limited, could affect positioning, comfort levels and opinion of a frame. Therapists can influence this through education of support staff and encouraging a child to communicate issues such as areas of discomfort through diaries or body charts.

ii) Financial Restrictions Budgetary constraints may necessitate sharing of standing frames by children or the provision of a frame already in school stock rather than enabling a therapist to source a frame from the open market. This may prevent children from being supplied with a frame with optimal features for their needs, especially if stock is limited. This is reflected in the findings of this study. Both the children who had a standing frame that was 'inherited' or supplied from existing stock and their physiotherapists preferred the frame they evaluated over their own frame in nine out of ten trials. To overcome this, physiotherapists are challenged to find objective methods of demonstrating the clinical needs of a child to funding bodies.

2. Acceptance by the Child

When selecting a frame, consideration should be given to other features in addition to position and comfort that may influence a child's acceptance of a frame and therefore affect frequency and duration of use. Children who participated in this study indicated that features such as colour and ability to move around in a frame were important to them. Half of the children would have liked to be able to move themselves around in their own standing

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frame, demonstrating a desire to have control of their environment and be independent rather than confined to one position. This can be compared to the independence that can be gained from a self-propelling or powered wheelchair offering the opportunity to mobilise around a classroom. This can be maximised by involving a child in frame selection.

3. Novelty Factor

These findings could be attributed to the 'novelty' factor of new equipment. However, although new and alternative features may have influenced the children, the physiotherapists who participated in this study based their preferences on clinical reasoning and assessment skills and knowledge of the child's clinical needs.

Limitations of Study

This study included a small number of participants from a small geographical area where the provision of equipment may be affected by local regulations and funding and therefore may not reflect national activity. However, therapists can consider the findings of this study in relation to their local service when reviewing standing frame provision and adopt similar methodology to establish if optimal equipment is being provided.

Conclusion

Children and their physiotherapists expressed preference of alternative standing frames above their own frame due to improved posture and comfort. Provision of equipment which optimises these factors could contribute to maximising the clinical benefits of a standing programme for an individual child. Assessment for this equipment should also take into consideration additional factors that are of importance to a child. However, limited resources may prevent the provision of this equipment. The challenge to physiotherapists is how to determine that the frame a child is using is providing maximum benefit and how to access the resources to ensure this is achieved.

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The North Star Clinical Network for Paediatric Neuromuscular Disease Management

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Introduction

The North Star Clinical Network consists of participating paediatric neuromuscular centres whose overall aim is to optimise patient care by achieving and practicing consensus on best clinical management, with agreed assessment and treatment protocols. To date 17 centres from across the UK who specialise in the treatment and management of this condition have been involved with the project.

The key objectives for the North Star Project are as follows:

1. To set up a UK wide clinical network of paediatric neuromuscular centres, optimising patient care by achieving and practicing consensus on best management, with agreed assessment and treatment protocols. The network currently consists of lead consultants and senior physiotherapists from specialist centres across the UK. Groups of staff meet on a regular basis to discuss best management and to formulate guidelines for professionals and information for families. Examples of work produced to date include a consensus statement on the current role of glucocorticoid corticosteroids in Duchenne muscular dystrophy, advice for families on the role of these steroids, and dietary advice for children with neuromuscular disease (the last two are both available via the Muscular Dystrophy Campaign website - www.muscular-dystrophy.org) To develop a nationally agreed, standardised clinical assessment protocol to monitor the disease in patients with Duchenne muscular dystrophy (DMD).

2. To develop a national database of information from these parameters of disease activity in a large cohort of patients with DMD. Collating information from many different centres about this rare but devastating condition will give a larger body of information to assist clinical decision-making. The database will therefore facilitate the process of audit and review which is necessary to ensure optimal treatment and management. The initial intent is to formally monitor the effects of steroid treatment in

children who are still walking. However it is envisaged that the database will expand to collect information from children who are no longer walking, therefore helping to optimise treatment for this group as well.

3. The initial focus is on optimising and standardising steroid therapy in ambulant children with DMD throughout the UK. A recent Cochrane Report¹ reviewing the use of glucocorticoid corticosteroids for children with DMD outlined the potential benefits of this therapy. However in clinical practice there still remain questions regarding the optimal dose to maximize function whilst minimizing possible side-effects. To this end newly diagnosed children and those due to start steroid treatment will be assessed using the North Star assessment protocol, and recruited to the national database.

4. This article will concentrate upon the work to date of the Physiotherapy Assessment and Evaluation Group of the North Star project in developing the assessment protocol.

Development of the neuromuscular assessment protocol

Measurement theory has been described as the 'conceptual foundation of all scientific decisions'². There is therefore a need for clinical measures to be based upon the principles which underpin quality measurement. Measures should be valid, reliable, appropriately responsive for their specified purpose and feasible for the setting in which they are to be used. Paediatric physiotherapists, with their specialist assessment and analytical skills, play a key role in the measurement and evaluation process for this patient group.

Identification of measures

The starting point for any investigation is a clear question – why is this data being collected, what information is needed from it. Consideration needs to be given at an early stage to how data are to be analysed and what questions it may be possible to answer from that data. In the case of the North Star project there are two clear aims – the first a documenting of the physical status and disease progression in ambulant children with DMD, the second an investigation of the effects of glucocorticoid corticosteroid therapy for these children.

Possible measures for the project were identified from a variety of sources:

- A review of those currently in use in specialist muscle centres across the UK
- A literature review based upon Medline and CINAHL databases
- Recommendations from the international ENMC workshop on management of DMD³

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A paradigmatic approach was applied to rationalise possible choices of measurement options for this project. Table 1 outlines this reasoning process.

Table 1 Schematic illustration of a paradigmatic approach to measurement in DMD (after Krebs 1987)

THEORY	CONCEPT	CONSTRUCT
What ideas and physiological evidence relate to DMD?	What variables should I measure?	How should I measure them? Possible examples:
Progressive strength disease of skeletal muscle	Muscle wasting Functional abilities	<ul style="list-style-type: none"> • Manual muscle testing • Quantitative muscle testing – e.g. myometry • Hammersmith Motor Ability Scale • Brookes UL and LL scales • Timed functional tests • ADL scales e.g. EK scale, WeeFIM, Barthel • Upper limb functional tests • Goal attainment scales
Distinct pattern of proximal muscle wasting in early stages of disease	Muscle strength Gait analysis Use of compensatory strategies	<ul style="list-style-type: none"> • MMT/QMT • Observational, gait lab • Kinesiology
Progressive deterioration in respiratory capacity	Respiratory abilities Incidence of chest infections Features of nocturnal hypoventilation	<ul style="list-style-type: none"> • Lung function tests • Hospital admissions/ GP interventions • Subjective assessment/questionnaire • Overnight oximetry
Risk of contractures due to muscle imbalance and deteriorating mobility	Joint range of movement	<ul style="list-style-type: none"> • Goniometry

A critique of key identified measures was then undertaken, addressing aspects of validity, reliability, responsiveness and feasibility. A report was produced from these sources and circulated to the North Star project groups for comment. This report also served as the basis for the physiotherapy consensus meeting, which was convened to identify and prioritise key measures for use in clinical practice.

A group of senior physiotherapists specialising in neuromuscular disorders met and a nominal group consensus technique⁴ was used to first identify key measures for monitoring disease progression in ambulant children with DMD, then to assess the level of agreement between therapists in the use of the measures. This consensus technique gives a format for structured discussion and prioritisation of measures. The results from the consensus do not necessarily give the 'correct' answer to a question, but rather offer a means of identifying current opinion and areas of disagreement. Interpretation of the results within the context of the overall aim of the North Star project, and with regard to the concepts of measurement theory to ensure measurement validity was therefore still important.

Discussion identified twelve core measures (shown in Table 2). These included functional scales, timed functional activities, muscle strength, respiratory capacity and contractures. Group members privately ranked each measure on a Likert scale of 1-9, where 1 was 'of no importance' and 9 was deemed 'very important'. The degree of importance therapists gave to the individual measures (median score), and the level of agreement between the group members (range) were analysed. The range of scores gives an idea of consensus among the group. Range was split into the following categories:

- 1-3 = unimportant
- 4-6 = fairly important
- 7-9 = very important

Agreement was considered as strict where the range of scores fell within any one of the above categories and as 'relaxed' where they fell across two. Where scores were spread across the whole scale no agreement was gained. The results from this round of scoring were fed back to the group and further discussed before results were finalised.

Seven items scored medians of 8 or 9, reflecting a high level of importance. All other items scored in the mid range, indicating an equivocal response from the group. Strict agreement was found for seven items (four of these showed one 'outlying' score but a high median). The five other items showed relaxed or no agreement. Measures which were designated 'high importance' and a 'strict' level of agreement were recommended for incorporation within the assessment protocol.

From the clinical and literature review relating to measurement in DMD and the consensus process, the following measures were therefore taken forward as those offering comprehensive monitoring of the disease process in ambulant children:

1. Hammersmith Motor Ability Scale⁵
2. 10m timed walk

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Table 2: Identified measures and consensus findings

Measure	Median	Range	Comments
HAMA*	9	9	High importance, strict agreement
Timed walk 10m	9	7-9	High importance, strict agreement
Timed walk 30m	6	3-9	Medium importance, no agreement
Timed Gowers	9	6-9	High importance, strict agreement (x1 outlier)
Timed stairs	5	3-9	Medium importance, no agreement
MMT	8	5-9	High importance, strict agreement (x1 outlier)
Myometry	8	5-9	High importance, strict agreement (x1 outlier)
Lung function	9	8-9	High importance, strict agreement
Contractures	9	6-9	High importance, strict agreement (x1 outlier)
Brookes functional	7	4-8	Medium importance, relaxed agreement
Spinal posture	6	3-9	Medium importance, no agreement
Observational gait	7	4-8	Medium importance, relaxed agreement

*HAMA = Hammersmith Motor Assessment Scale

3. Timed rise from the floor
4. Manual muscle testing
5. Myometry
6. Measurement of contractures
7. Lung function (FVC)

Development of test detail

Each of these test options was then reviewed in detail by the project coordinator and a small group of physiotherapists expert in the treatment of children with neuromuscular disorders. From this process test detail was defined for all measures and a draft 'User Manual' produced. The standardisation of test detail is ultimately of importance so that when data are being analysed from so many centres the differences that are seen are due to treatment interventions and not merely to differences in test method.

A new functional scale was defined from the framework of the Hammersmith Motor Ability Scale, the 'North Star Ambulatory Assessment'. The need for changes was driven by a number of factors relating to the young patient group who will be assessed for the project – newly diagnosed boys, or those due to start steroid treatment. There have been

anecdotal reports of children treated with steroids gaining a maximum score when assessed using the Hammersmith Scale, i.e. that there is a ceiling effect. Before steroid treatment was an option this was not an issue. The content has therefore been developed to include some more difficult aspects of gross motor function, with detailed grading of each activity to address perceived issues with the sensitivity of the scale.

Workshops were then held at different venues across the country to ensure standardisation of the test procedure and to gain an input from the larger project group. A total of 35 physiotherapists attended one of the seven workshops. The User Manual was again modified and circulated to all following this process. Proforma assessment sheets have also been developed. These include forms for all the formal tests and supplementary information regarding management of joint range, descriptive gait analysis, seating equipment, parent and child perceptions of health and general wellbeing and the monitoring of spinal posture.

Myometers and spirometers for the project were identified and purchased for participating centres. A practical session in the use of the myometer has been attended by key senior staff from all centres, as the use of hand-held myometers was a new technique for the majority of physiotherapists.

It is recognised that not all regional centres have the same level of resources for assessing these children. Where resources in terms of physiotherapy time are limited it has been recommended that functional, timed tests, assessment of joint range and FVC measures are undertaken as a basic requirement for standardised monitoring.

We are currently in the process of piloting the assessment process and undertaking reliability exercises on the tests, prior to starting formal data collection.

Work is also underway to define TELER indicators⁶ for the monitoring of key functional milestones.

Summary:

- The overall aim of the North Star Project is to optimise the care of patients with neuromuscular disease by achieving and practicing consensus on best clinical management, with agreed assessment and treatment protocols
- The initial priority of the network is in the management of children with DMD
- A comprehensive review of existing practice and of the literature relating to measurement in DMD has identified key measures to monitor disease progression.
- A nominal group consensus technique was used to identify and gain expert agreement in the use of seven key measures.

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- These key measures have been refined and standardised to provide the basis of the North Star assessment protocol.
- All staff collecting assessment information for the project have attended workshops to standardise test method.
- All measures are currently being piloted prior to the start of formal data collection.

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Appendix

North Star' Centres

The following is a list of the clinical centres who have been involved with the development of the assessment protocol and the work of the project to date:

Paediatric Department, Heartlands Hospital, Birmingham
Frenchay Children's Centre, Frenchay Hospital, Bristol
Department of Child Health, University Hospital, Cardiff
Armistead Child Development Centre, Broughty Ferry, Dundee
Fraser of Allender Neurosciences Unit, Royal Hospital for Sick Children, Glasgow
Child Therapy, Leeds General Infirmary
Physiotherapy Department, Ashfield School, Leicester General Infirmary
Child Development Centre, Royal Liverpool Children's Hospital, Alder Hey
Newcomen Centre, Guy's Hospital, London. From October 2005 this service will transfer to the Paediatric Neuromuscular Clinic, the Evelina Children's Hospital, St Thomas Hospital
Physiotherapy Department, Hammersmith Hospital, London
Physiotherapy Department, Great Ormond Street Hospital, London
Physiotherapy Department, Royal Manchester Children's Hospital
Newcastle Muscle Centre, International Centre for Life
Paediatric Neuromuscular Clinic, Queen's Medical centre, Nottingham
The Muscle Clinic, Robert Jones and Agnes Hunt Orthopaedic and District Hospital, Oswestry
John Radcliffe Hospital, Oxford
Neuromuscular Clinic, Ryegate Centre, Sheffield
Physiotherapy Department, Southampton General Hospital
Muscle Clinic, Morriston Hospital, Swansea
Northern Ireland Muscle Clinic, Belfast City Hospital

Committee Matters

The national committee meeting, which should have been held at CSP, Bedford Row on 8th July, was cancelled following the events in London the day before. There will be a smaller meeting of the executive committee and other committee members in September. The next full committee meeting is on 6th October 2005, in Birmingham. Contact your regional representative with any issues you wish to be discussed

Laura Wiggins

ASSOCIATION OF PAEDIATRIC
CHARTERED PHYSIOTHERAPISTS

Annual General Meeting



**The 32nd Annual General Meeting will be held on
Friday 7th October at CSP congress, Birmingham,
beginning at 3pm.**

All paid up members of the Association are entitled to attend.

**Voting will be restricted to full members of the Association
and a current membership card will be required.**

**Minutes of the last AGM are available from the Secretary
on receipt of a SAE or by email to laura.wiggins@ntlworld.com**

**Nominations are invited for 4 committee vacancies.
Nominations should be sent to the Secretary the calendar month
prior to the AGM together with a proposer and seconder who
should be fully paid up members of the Association.**

Botulinum Toxin A, Paediatric Physiotherapy guideline

The Botulinum toxin A guideline group are looking for your knowledge and experience.

On Monday 26th September there will be a meeting held at CSP, London titled The Role of the Paediatric Physiotherapist in the use of Botulinum Toxin A – a Reflection of Current Practice. The provisional agenda includes

- Introduction and Aims for the day
- The Specialist Centre, Leeds
- The community Experience – Brookfield House
- Acute head injury – TBC
- Chronic disability, contracture, pain management – Tadworth court
- Multi Level Approach – Belgium
- Upper Limb – Guys Hospital
- APCP guidelines, link to spasticity forum, Injectors course, Coventry University.

Those applying will be asked to complete a questionnaire related to current physiotherapy practice and the cost for the day is £25.

For more information contact Laura Wiggins, laura.wiggins@ntlworld.com

For application forms and to receive your questionnaire, contact Jane Horner, The White House, Tollerton, York YO61 1PS

With Sympathy

It is with great sadness that APCP learnt of the death of Ann Grimley. Ann, who was one of the founder members of APCP died on 17 April 2005. She had a long and distinguished career working with children, and will be remembered by many for her specific dedication to working with 'clumsy' children and by many of you who worked at or had association with the Royal Manchester Children's Hospital. Ann who trained in Salford also worked in the USA and completed her career as a district physiotherapist in Preston. She retired in 1992 and was made a Fellow of the Chartered Society of Physiotherapy in 1995 for contribution to the profession as a whole but specifically for her work with children.

May we in APCP take this opportunity to extend our deepest sympathy to Ann's family and closest friends.

**ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS
National Account
Balance Sheet as at 31 December 2004**

	2004		2003	
	£	£	£	£
FIXED ASSETS				
Computer Equipment (see notes to accounts)		1,638		2,988
CURRENT ASSETS				
Cash at Bank	95,750		105,500	
Congress Debtor - 2004	4,774		0	
Conference Debtor - 2005	2,400		0	
	102,924		105,500	
CURRENT LIABILITIES				
Creditors	0		4,145	
	0		4,145	
		102,924		101,355
		104,562		104,343
ACCUMULATED FUND				
Balance brought forward at 01/01/2004		104,343		98,269
Add Surplus for the year		219		6,074
		104,562		104,343

Income and Expenditure Account for the Year Ended 31 December 2004

	2004		2003	
	£	£	£	£
INCOME				
Courses	10,940		19,140	
Capitation Fees	3,788		144	
Subscriptions	41,940		47,108	
Publications	2,395		3,090	
Bank Interest Received	1,997		2,179	
Sundry	25		16	
Received from Conference	4,774		6,779	
Advertising	3,100		1,300	
Congress 2002	0		412	
		68,959		80,168

APCP Matters

EXPENDITURE

Catering & Accommodation	8,182	1,934
Committee Travel & Subsistence	12,332	12,749
Honorarium	1,650	1,650
Postage, Stationery & Telephone	5,669	6,934
Accountancy Fees	1,616	1,586
Course Fees	10,546	17,062
Publications	13,906	15,473
Computer Expenses	0	249
Gifts	231	187
Conference & AGM Expenses	1,035	5,210
Depreciation of Computer Expenses	1,350	1,077
Critical Group – Donation	1,000	0
Neonatal Group – Donation	0	1,000
APCP SW – Conference 2003	0	2,704
Research Bursaries	11,223	6,279
	<hr/>	<hr/>
	68,740	74,094
	<hr/>	<hr/>
Surplus for the year	219	6,074
	<hr/>	<hr/>

Notes to the Accounts December 31 2004

Fixed Assets

	Computer Equipment
	£
Cost	
01-Jan-04	5,399
Additions	0
	<hr/>
31-Dec-04	5,399
	<hr/>
Depreciation	
01-Jan-04	2,411
Charge for year	1,350
	<hr/>
31-Dec-04	3,761
	<hr/>
Net book amount	
31-Dec-04	1,638
	<hr/>
31-Dec-03	2,988
	<hr/>

**ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS
REGIONAL AND AFFILIATED GROUP ACCOUNT SUMMARIES
31 DECEMBER 2004**

	£		£		£
Birmingham Region		Scottish Region		Northern Ireland Region	
Balance brought forward 31/12/03	3,647	Balance brought forward 31/12/03	3,690	Balance brought forward 31/12/03	158
Plus: Surplus for the Year	1,138	Plus: Surplus for the Year	896	Plus: Surplus for the Year	287
Balance 31/12/04	<u>4,785</u>	Balance 31/12/04	<u>4,586</u>	Balance 31/12/04	<u>445</u>
East Anglia Region		South East Region		Neonatal Group	
Balance brought forward 31/12/03	1,193	Balance brought forward 31/12/03	1,683	Balance brought forward 31/12/03	2,195
Plus: Surplus for the Year	494	Plus: Surplus for the Year	2,433	Less: Deficit for the Year	-282
Balance 31/12/04	<u>1,687</u>	Balance 31/12/04	<u>4,116</u>	Balance 31/12/04	<u>1,913</u>
London Region		South West Region		Critical Care Group	
Balance brought forward 31/12/03	1,241	Balance brought forward 31/12/03	4,007	Balance brought forward 31/12/03	0
Less: Deficit for the Year	-31	Less: Deficit for the Year	2,561	Plus: Surplus for the Year	1,211
Balance 31/12/04	<u>1,210</u>	Balance 31/12/04	<u>1,446</u>	Balance 31/12/04	<u>1,211</u>
North East Region		Trent Region			
Balance brought forward 31/12/03	646	Balance brought forward 31/12/03	1,162		
Plus: Surplus for the Year	579	Less: Deficit for the Year	-84		
Balance 31/12/04	<u>1,225</u>	Balance 31/12/04	<u>1,078</u>		
North West Region		Welsh Region			
Balance brought forward 31/12/03	1,146	Balance brought forward 31/12/03	2,576		
Plus: Surplus for the Year	731	Less: Deficit for the Year	-920		
Balance 31/12/04	<u>1,877</u>	Balance 31/12/04	<u>1,656</u>		

Research and Education

Research Report

Many apologies for this being a short report but I have been sick and looked very much like missing the copy date for this Journal. Phlegm and me don't mix – that's why I do orthopaedics – so the last couple of weeks have been a bit of a trial. Picture me coughing as I drag myself from my sick bed to write this report – fingers trembling from weakness as I type, with the odd cough wracking my weakened body! (The truth is that the antibiotics worked so I am now back at work trying madly to get this done before Sally gets in touch!)

Research Group Meeting June 2005:

The meeting in June was a success as we got a new member! Unfortunately the usual crowd had problems that day with sickness, family matters or horror of horrors urgent clinical calls so poor Sue – the new girl - was the sole attendee, along with Debbie Jackson from GOSH who very kindly stood in for me. Thanks to Lucy Alderson, a research physio at GOSH had agreed to take us through critical appraisal of a couple of articles. Importantly Sue had a chance to discuss her research ideas and I think found it a useful.

The next meeting will be on **Thursday September 22nd at Great Ormond Street Hospital at 2pm**. Please note the change of venue but hopefully we will make it to Queen Mary's some other time. If you remember from the last Journal the discussion will be on how to do research and work fulltime. Please do come – it is a nice group and hopefully will grow, albeit slowly. It would be very useful if you could ring (020 7405 9200 ext 5144) or e-mail me to let me know you're coming so that I can send you maps etc and also let you know where to find us – if enough of you respond then I can then book an appropriate sized room and cancel the booking for the broom cupboard.

Research Help Register:

I am delighted to report that since my appeal for more people to register as willing to help others one person has volunteered. A big hand for Northern Ireland! It does seem to me – in my short time as Research Officer – that requests for names of those willing to be sent questionnaires etc peaks in the autumn (probably that's when students begin their projects) so you will not be inundated with paperwork. Many times I am asked for people only in Wales or the South East so you may never be asked BUT please remember how difficult it can be

to collect data as a researcher and how good it is to know that there are people out there you can access via APCP. If we want to encourage the youngsters into paediatrics a little help at their undergrad project stage may get them to think kindly on paediatrics as a potential career choice.

I am now anticipating that I will be inundated with offers – please do help!

Child Health and Paediatrics Specialist Library:

I found this whilst browsing through iCSP and thought it would be worth sharing – sorry to those of you who already know!

This site has a wide range of topics related to the health and welfare of children and is aimed at professionals seeking information on a wide variety of aspects of child health. Certain aspects of the library are restricted to Athens users so if you don't have an Athens account I would take your boss out to the pub and then ask!

I found lots of NSF info as well as stuff on

Asthma,
Autism,
CAMHS standards,
Chronic fatigue/ ME
Disabled child standard
Ill child standard

And loads more – it's alphabetical as you can see.

Centre for Evidence Based Child Health:

This centre is part of the national network of centres for Evidence Based Health Care (EBHC) and was established in 1995, based in the centre for paediatric epidemiology and biostatistics at the Institute of Child Health, 30 Guilford Street, London WC1N 1EH. The overall aim of the centre is to increase the provision of effective and efficient child health care.

To achieve these aims the centre runs educational programmes to help health practitioners acquire the necessary skills to integrate critical analysis of evidence to day to day decisions. Courses and workshops are run in Evidence Based Health Care, as well as tutor training, teaching resources, how to set up evidence based courses as well as MSc modules EBCH. I attended one of their courses several years ago on How to Practice EBCH – it was fantastic.

If you are interested try:

[http://www.ich.ucl.ac.uk/ich/html/academic
units/paedepid/ebm.html](http://www.ich.ucl.ac.uk/ich/html/academic_units/paedepid/ebm.html)

That's all. Hope you all had great summer hols.

Jeanne Hartley

Regional and Sub-Group Reports

SCOTLAND

The Study Day on Friday 17th June 2005 was a success and well attended by APCP members in Scotland. Dr Terry Pountney's presentations gave us comprehensive view of postural management from assessment using the Chailey levels of functional ability, through the biomechanical approach to the prescription of postural equipment and the evidence base for changing management of the hip. The handout provided gave members useful information for future reference and a contact point for those who required more information.

We held the Regional Annual General Meeting at the end of the day. The members were very supportive and we did not have to lock any doors to ensure that we had the required quorum to hold the meeting.

APCP Conference 2006 – after much discussion the final title will be Moving Forward – Challenging Expectations. Unfortunately due to cancellation of the National Committee Meeting in July, I have not had the opportunity to discuss the progress we are making with plans for the Conference. However we have a Regional Committee Planning Meeting on 9th September and further progress and ideas can be fed back at the National Committee Meeting before CSP Congress in Birmingham in October.

ALISON GILMOUR

NORTH EAST

At our last committee meeting in June, we were delighted to welcome new co-opted members Heather Cooper and Lyn Swan from the Hartlepool area of the region. We could still do with more new members to replace those of us who are retiring from the committee so if you feel that you could give a little of your precious spare time, you will certainly gain from your involvement, professionally and socially!!

As mentioned in my last report and hopefully you will have received a flyer by now, our next study day, 'Multi-disciplinary Approach to the Management of DCD', will be on Wednesday 9th November 2005. However there has been a change of venue to St George's Centre, Middleton, South Leeds. An application form can be downloaded from documents section of paed network ICSP and details for the day can be found in the events section.

The committee are currently planning study days etc for the following year and once finalised will be advertised. If any of you are able to host a day in your region or have a burning desire to hear about a specific topic, do get in touch...it is not too late.

Finally, it is with some sadness that I write my last report for the NE after 8 years as your representative. It has been an honour and a pleasure to be involved with my colleagues in the NE and nationally. Your new representative following the National AGM in October will be Heather Angilly, whom I wish all the best in her new role. I thank you all for your support over the years and can say that I have met some wonderful colleagues, many of whom are now good friends. Here is to APCP onwards and upwards!!

MARY HARRISON

SOUTH EAST

Life is rather quiet here in the South-East region at the moment BUT preparations for the Study Evening and AGM at Bluewater on 15th September are just about complete. You will have received a flyer in July and, hopefully, lots of you will have booked a place. It promises to be an interesting session about Childhood Pain – and there's always the opportunity to shop or dine after the cocktails!

We are looking for new members for the Committee – 2 members have had to step down – so please consider joining us. You won't have to make a huge commitment of time but the meetings are always lively and a wonderful way to feel part of a network of paediatric physiotherapists. THINK ABOUT IT!!

Do remember that, if you have any business which you would like raised at the AGM, you will need to contact Jill Larkins, Secretary, at least two weeks before the AGM.

We are already hard at work starting to plan for APCP Conference in 2007 which we will be hosting. There are many aspects which need to be considered such as entertainment, speakers, graphics, printing etc. If you have any ideas about people who would be 'ideal' for these, or any other activities, do let me know. We'd like to 'tap into' all your local knowledge so please, get your thinking caps on and send your ideas flooding in. We'd like to make this a conference that YOU would like to attend – and we would welcome all your ideas/ suggestions/ advice/assistance.

Finally, don't forget the APCP day at CSP Congress in Birmingham on Friday 8th October – it promises to be an interesting day.

ANN MARTIN

Regional and Sub-Group Reports

EAST ANGLIA

I hope everyone had a good summer. Our committee have been very busy organising a very comprehensive programme for our two day course in November on 'Managing Children with Complex Needs'. The venue will be St Albans, on the 17th and 18th November. Please see the separate announcement in this journal. We are offering a bursary for one place on the two day course, so please write to me if you are interested.

We are also proposing to run a one day course early in September in Cambridge, which could combine with our AGM. If this is successful, a separate notification will be posted to all members – please pencil the 24th September in your diary as the most likely date. Two possible subjects for which speakers have been suggested, are 'orthotic intervention for plagiocephaly', and 'an alternative approach to treating dyspraxia, dyslexia, and ADD'. If we are unable to arrange this in September, these two topics could then be covered next spring, and we will instead hold our AGM in November during the two day course in St. Albans.

I am also pleased to report that, following a request from members, we have been able to book a very popular course on use of the gymball in paediatrics 'Get on the Ball' with Joanne Elphinstone. – this will take place in February 2006, in Peterborough or Ely – more details will follow later this year.

The other two topics which we had been planning to run study days on this year – Chronic Fatigue, and Pilates for Children – will actually form the APCP's one-day programme at the CSP's annual Congress in Birmingham on 7th October. In view of this, our committee are offering two bursaries for that day to East Anglia members. If you would like to apply, please write to me (address in this journal) – places will be offered on a first come first served basis, with a maximum of four members sharing the two bursaries.

A number of our committee are coming to the end of their term of office. Sue Chillingworth, our secretary, and Lynn Edmondson will be resigning from the committee, and I will be standing down as chair and regional representative at the next AGM, as I have now served my full term on the committee. We therefore really do need some new members to join the committee – I can guarantee that you will find it a friendly, informal and welcoming committee, and a wonderful opportunity to meet a wide variety of colleagues from around the region, while making a valuable contribution to your CPD.

I look forward to seeing you all at our AGM, and will post details of this to all East Anglia members separately as soon as we have finalised the date.

SUE COOMBE

WALES

Conference seems a long time ago now and even on another planet. However we are still receiving expressions of congratulations from delegates and have now had analysis of the returned evaluation forms which show an excellent scoring for all lecturers and the facilities at the Taliesin theatre. We even managed to make a profit on the whole Conference to our great delight!

Not to rest on any laurels (would we?!) I have news of something a little less strenuous. Jennie Carroll (Director of Therapy at Bobath Cymru) has kindly agreed to facilitate a problem-sharing day for those treating children and babies with Cerebral Palsy. This will take place on 3rd November at the Hollies School in Pentwyn, Cardiff, 9.30am until 4.00pm. The cost will be approximately £25 for members and £30 for non-members including tea & coffee. There will be spaces for 15 people only on a first-come first-served basis so watch for fliers coming to your workplaces and apply to me as soon as possible if you are interested.

Finally, and on a really high note, Viv Williams (one of the founding members of the APCP Wales and a very well known figure in the Physiotherapy world) has been honoured by the CSP and awarded a Fellowship for her work in the development of physiotherapy services for the children of South Wales and Bulgaria. This follows on from her recent award of an honourable fellowship of the University of Wales College of Medicine. We congratulate Viv most heartily and hope that many will travel to Birmingham in October for the CSP Conference where she will receive her award.

I look forward to seeing many of you on the APCP day at the CSP Conference.

JILL WILLIAMS

NORTH WEST

It seems such a long time since I last spoke to you as I managed to miss the copy deadline for the last journal. Sorry! This year has flown by, so I'll try and give a quick recap on what's happened in the region this year.

Our AGM was held on 4th March and we looked at the work of the HPC and issues around registration and CPD. It was very thought provoking and has

Regional and Sub-Group Reports

certainly kick-started me into looking at my portfolio.

In June we held a very successful 2 day course on Muscle Strengthening in Cerebral Palsy at Alder Hey. The course proved very popular and was oversubscribed, it evaluated very well. I'd like to give a special word of thanks to Nicola Henderson who organised the event.

For the future we are hoping to host a study day on Development Orthopaedics later in the year. To date we have some speakers confirmed but the final programme isn't complete yet, look out for details on interactive CSP and we'll be sending fliers out ASAP. We are also considering follow up days to the hydrotherapy days we did last year.

As a committee we continue to meet regularly, so feel free to contact us with any concerns or ideas. Please remember we are working on behalf of the membership of the region and we rely on your feedback and ideas to ensure that we are getting it right. Don't forget we have a number of bursaries available to assist towards study and attendance at courses/conferences. If you are interested please apply in writing giving a brief outline of the purpose for the request and we will give it every consideration.

The Kidz up North exhibition will be held again this year at the Reebok Stadium on 24th November. This year we are planning to have an APCP stand at the event and we are looking for some volunteers to kindly give up an hour or two of your time to help man the stand. If you are interested could you please contact Sue Booth at Birtenshaw Hall School on 01204 304230. Sue is co-coordinating this event on behalf of APCP.

ELAINE LLOYD

NEONATAL SPECIAL INTEREST GROUP (Affiliated to the APCP)

BLISS BOOKLETS – "Handle me with care" and "Look at me I'm talking to you" have been well received and are proving to be useful to many physiotherapists working on neonatal units throughout the UK. Parents are also giving favourable feedback about them and finding their layout and presentation to be just what they want whilst their babies are on the unit and also the information for early discharge ie equipment and early development. We will continue to encourage as many physiotherapists to use and recommend them for continued feedback.

STUDY DAY AND AGM – Our next study day is planned for Wednesday 19th October in Bristol. The title is "Reducing Risk & Optimising Outcome". We will hold our AGM on that day as well. The Neonatal Committee will meet on Tuesday 18th in the afternoon. This will be our first full committee meeting since Edinburgh Last October as most of our contact has been via e-mail apart from the table top meeting in December at Nottingham to look at the competences.

APCP CONFERENCE – GLASGOW 2006 – We hope to have more ideas re speakers after our meeting in October.

BABY WALKERS – At our recent Northern Region Neonatal Day this topic was raised again as some staff were reporting that they were still dealing with young babies pre and full term, being placed in baby walkers by their parents / carers. Peta Smith has recently had a request from Aberdeen City Council, for the National Homes and Leisure Committee to support a ban on baby walkers throughout the UK. This was brought to the committee for consideration from the Scottish Home Safety Office Group. As a result of this the committee voted to request a Europe wide ban. Members of the baby product association were in attendance, so now a plan of agreed action needs to be drawn up. Interestingly it was raised that in the new Fairy advert there is a baby in a door bouncer. Would it be appropriate for us to contact them and highlight the detrimental effect of their use on babies development. Especially if Fairy / Pampers will be sponsoring further booklets!

BARBARA HAEDERLE

APPLICATION FORM FOR A.P.C.P. PUBLICATIONS

2005	
Paediatric Outcome Measurement	£20.00
2003	
Special Educational Needs	
Code of Practice 2001	
Guidance for Paediatric Physiotherapists	£10.00
2002	
Paediatric Physiotherapy Guidance for Good Practice	£5.00
Obstetric Brachial Plexus Palsy	
A guide to physiotherapy management	£10.00
Hip Dislocation in Children with Cerebral Palsy	
A guide to physiotherapy management	£7.50
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
Baby Massage	£1.50
The Children Act 1989 “A synopsis for Physiotherapists”	£1.00

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CUMBERLAND INFIRMARY, CARLISLE, CUMBRIA CA2 7HY.
WORK TEL: 01228 814739
e-mail: stybelskal@aol.com**

Name and Address for Delivery:

.....

.....

Here and There

Summary of: Education (Additional Support for Learning) (Scotland) Act 2004

The Education (Additional Support for Learning) (Scotland) Act 2004 (ASL Act) introduces a new framework to support all children and young people who face barriers to learning (Additional Support Needs). This includes those with disability or health needs, social and emotional needs and those in need of care and protection.

It will be underpinned by a Code of Practice which sets out local authority and other agency responsibilities and parental rights within a new additional support needs framework. This will be published in its final form in July 2005. It can be viewed in its draft form at www.scotland.gov.uk/publications/2005/05/09154617.

The Act comes into force within Scotland on 14th November 2005.

The main provisions of the Act are:

- Concept of additional support needs
- New duties on Educational Authorities and other agencies (including health)
- Rights for parents
- Planning to meet the needs of all children and young people
- Resolving differences for families and authorities, mediation, dispute resolution, tribunals

A multi agency training package is currently being developed by the Scottish Executive to help with implementation of the act for all managers and practitioners.

The act provides both opportunities and challenges for Allied Health Professionals.

The focus is on developing strong multi-agency working both at assessment, planning and delivery of service.

Implementation requires our services to look at new ways of working, redesign, effective use of all staff including support workers, clinical effectiveness and partnership working. This is being done both at a local and national level. £3 million for two years has been given to health from education. All local areas are in the process of rolling out the work identified for use of their allotted share of this money.

There is an AHP Development officer – Morag Dorward - who is seconded to the Executive for 12 months to help implement the act from an AHP perspective. She is based in the Additional Support Needs Division of the Education Department.

Each area has an identified AHP lead for the ASL Act. They sit on a national AHP Action group chaired by Morag Dorward. Other representation includes a Child Health Commissioner, and social work and teacher developments officers. Close links have also been established with college professional officers who are involved with many of the agreed actions. The group are doing some targeted work around implementation. The actions planned include

- looking at demand management and triage systems for occupational therapy, physiotherapy and speech and language therapy
- development of support worker roles including a scoping exercise to establish current use of support workers in child health services for occupational therapy, physiotherapy and speech and language therapy
- national information sharing mechanisms on AHP services for parents, education and other professionals.

Further information can be obtained from your local AHP lead or from the AHP Development Officer at morag.dorward@scotland.gsi.gov.uk :

Notes written by:

Morag Dorward
AHP Development Officer
3B(N)
Additional Support Needs Division,
Victoria Quay
Edinburgh
morag.dorward@scotland.gsi.gov.uk
Tel: 0131 244 7849

Please contact me if you wish any clarification of expansion of any of the above.

Course Feedback

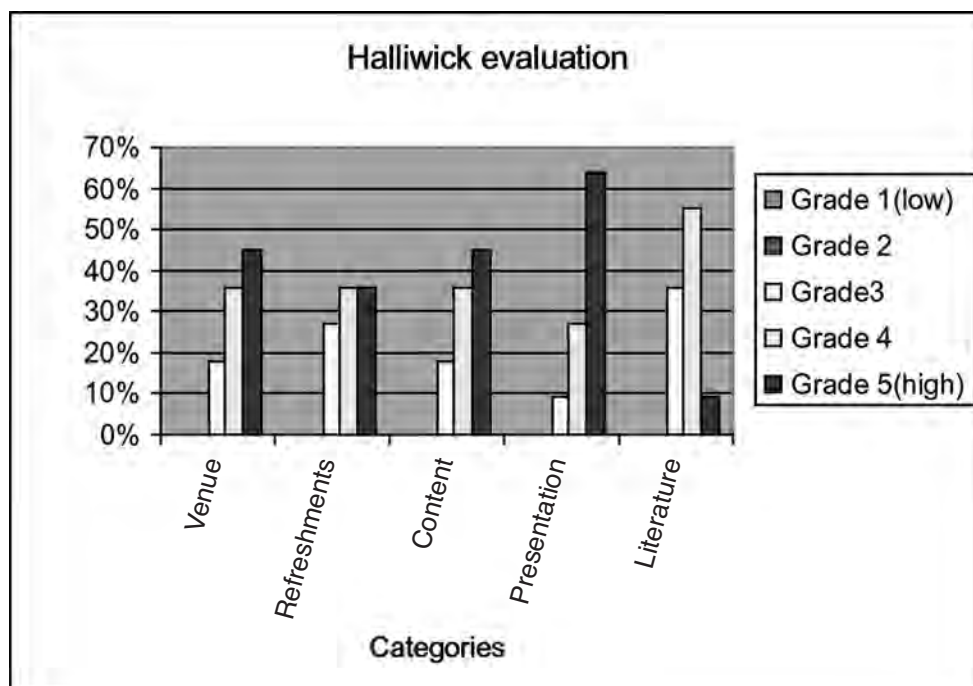
Introduction to Halliwick Course – APCP SW Region

On the 17th May I organised an 'Introduction to Halliwick' course at the prestigious venue of the Quays in Southampton – 'home' of Pete Waterfield.

As I am giving up the APCP South West Region Treasurer post this year after 3 years of service, I thought it would be a nice way to bump up the funds.

It has taken me a little while to revise my Excel skills for which I apologise, but now that I have managed to format the chart below I am happy to report back on a most enjoyable day.

Colin Stevens (my personal 'Bobath' hero!) was the chief lecturer on the day aided and abetted by my colleague Jane Stewart-Parry. I think that most candidates appreciated his added dose of humour to the day!



I think the chart above demonstrates the overall satisfaction with the day although the diving pool was a little cold for some of us chillier mortals – it is normally quite hot!

I think that the course wetted the appetite for a more in depth visit to Halliwick and the South West Region of APCP are hoping to organise a basic course in the near future – possibly in Salisbury.

I was, however, disappointed with the attendance at the course – we had space for 24 candidates but only managed to attract 11 – perhaps the more comprehensive course will meet needs better. It was lovely to see some of our education colleagues on the course with us.

A profit of approximately £140 was raised mainly due to the willingness of the Quays staff to keep costs low which was a great relief to me.

So it's goodbye from me but I'll keep in touch with all the friends I have made over the years in such a valuable and forward thinking organisation.

Clare Olsen



APCP at CSP CONGRESS 2005

Come and join us on
FRIDAY 7th OCTOBER
at the International Conference Centre
in Birmingham

APCP's day at Congress will include talks on
Chronic Fatigue Syndrome and Pilates for Children.

As well as networking and catching up
with old friends there will also be the
opportunity to attend APCP's AGM.

Please look in Frontline for further information.

Tickets for day attendance are available.

OUTLINE PROGRAMME – CONGRESS 2005

FRIDAY 7TH OCTOBER – APCP

08:00 Registration opens

09:30 APCP SESSION:

Management of children with chronic fatigue syndrome/ myalgic encephalomyelitis

Robyn Hudson BSc App Phys,
Physiotherapy Clinical Specialist
Great Ormond Street Hospital

Anna Gregorowski BSc (Nursing)
Adv Dip Child Dev PG Cert MA,
Nurse Consultant
Great Ormond Street Hospital for Children

11.00 BREAK ; EXHIBITION OPEN

11.30 AWARDS CEREMONY

12:15 LUNCH

13.15 CSP KEYNOTE SPEAKER

14:00 APCP SESSION

Paediatric Pilates – Session 1 Theory

Mary-Anne Houghton BSc (Hons)
MCSP HPC RPT, Director of South
Manchester Physiotherapy & Pilates Ltd

15:00 BREAK

15:30 APCP AGM
Jenx Award

Paediatric Pilates – Session 2 Practical

Mary-Anne Houghton

17:30 WELCOME RECEPTION

19:00 EXHIBITION CLOSE

20:00 CSP ANNUAL DINNER

Congress Speaker Biographies

Mary-Anne Houghton

Mary-Anne Houghton is a Chartered Physiotherapist, registered with the Health Professions Council, a Registered Physical Therapist in the USA [Michigan], a member of the ACP, OCPPP and the Body Control Pilates® Association. In her ten years since qualifying from Liverpool University, she has a broad range of clinical experience within paediatrics and adult medicine, having worked in the NHS and private sector in the UK and in the USA. In her role as director of South Manchester Physiotherapy & Pilates Limited, she provides exercise therapy based treatments and Pilates classes. She develops and runs courses for Physiotherapists/Occupational therapists and Therapy Assistants in the clinical application of Pilates and was the first to offer a specific Paediatric Pilates course. She has produced a Paediatric Pilates Manual for therapists, hand-book for patients and guide for parents to complement the clinical work and courses she offers. Her clinical courses have been running since 2001 throughout the UK and she has been invited to teach internationally.

Anna Gregorowski

Anna has been part of the Adolescent Medicine Team at Great Ormond Street Hospital since it was formed 8 years ago. She was appointed to the post of Nurse Consultant from September 2004, and now leads an outpatient Chronic Fatigue Service for children and young people. She is particularly interested in chronic illness in adolescence, meeting the needs of adolescents in hospital, and is a keen advocate for effective transition to adult care.

Robyn Hudson

Robyn Hudson is presently working as the Clinical Specialist in Physiotherapy at Great Ormond Street Hospital in London. She has previous experience in managing adolescents with CFS/ME at Monash Medical Centre in Melbourne Australia. Where they provided the only rehabilitation outpatient programme for young people with CFS/ME in Victoria.

NEONATAL CARE GROUP

'REDUCING THE RISK AND OPTIMISING OUTCOME'

A study day open to all who are involved in the care of
preterm and fragile infants



WEDNESDAY 19TH OCTOBER 2005

9.30. AM – 4.00. PM

St Michaels Hospital Bristol

Draft programme

- | | |
|---------------|--|
| 9.30 | Registration and Coffee |
| 10.00 – 10.45 | Sleeping positions in preterm and low birthweight infants and the risk of SIDS – an opportunity for targeted prevention
Professor Peter Flemming, Professor of Infant Development |
| 10.45 – 11.30 | Limits of Viability – Should we aim higher or lower?
Dr James Tooley, Consultant Neonatologist |
| 1.30 – 11.45 | Coffee |
| 11.45 – 12.45 | AGM and Trade Stands |
| 12.45 – 1.45 | Lunch |
| 1.45 – 2.30 | Growth and Development
Dr Pamela Cairns, Consultant Neonatologist |
| 2.30 – 3.30 | Positive Parenting the Preterm Infant
Chrissie Isreal |

Applications to
Sean Howells
Children's centre
Llandough Hospital
Penlan Road
CARDIFF CF64 2XX

Estimated cost at time of going to print
£50.00 SIG and APCP members
£60.00 non-members
to include lunch, tea and coffee

Email sian.howells@cardiffvale.wales.nhs.uk

APCP EAST ANGLIA
**MANAGING CHILDREN WITH
COMPLEX NEEDS**

17TH & 18TH NOVEMBER
THE CHILDREN'S CENTRE, ST ALBANS

**COMPREHENSIVE TWO-DAY
PROGRAMME:**

- EARLY SUPPORT
- CONSENT
- ORTHOPAEDIC MANAGEMENT AND THE ROLE OF BOTULINUM TOXIN INJECTIONS
- 24 HOUR POSTURAL MANAGEMENT
- PLAY
- SAFE THERAPEUTIC HANDLING
- ORTHOTIC MANAGEMENT AND THE ROLE OF LYCRA
- MANAGING FEEDING AND SWALLOWING PROBLEMS
- THE ROLE OF THE HOSPICE

Cost: £80 for APCP Members, £120 for non-members. Colleagues from other disciplines welcome, but as places are strictly limited, priority will be given to paediatric physiotherapists who are APCP members.

A **bursary** is being offered for one place on this course to APCP members. For further details, including application form, please contact:

Sue Coombe, Jenny Lind Physiotherapy Dept., Norfolk & Norwich Hospital, Colney, Norwich NR4 6QH
Or email: sue.coombe@nnuh.nhs.uk



Queen Margaret University College
EDINBURGH



Paediatric Physiotherapy and Occupational Therapy:

A critical approach to advancing specialist knowledge and practice

Run as part of the MSc Physiotherapy programme

This block attendance module will run from September 2005 – May 2006 for part time students only

The module critically analyses the issues relevant to clinical effectiveness and explores and evaluates:

- the principles of good communication in various settings with children, families and other professionals
- how psycho-social issues influence interventions with children
- the legal & ethical issues in relation to working with children

This module has been developed in association with the Association of Paediatric Chartered Physiotherapists

For further details contact: Gill Baer (gbaer@qmuc.ac.uk) or
Fiona Coutts (fcoutts@qmuc.ac.uk)

Details of the full MSc programme can be obtained at
[http://healthsciences.qmuc.ac.uk/
LEARNING-RESOURCES/postmsc/home.htm](http://healthsciences.qmuc.ac.uk/LEARNING-RESOURCES/postmsc/home.htm)



Kidz up North 2005 is a two day event



Venue: Reebok Stadium, Bolton

Wed. 23rd Nov ★ 9am-5pm ★ Moving Kidz A Multi Disciplinary Approach

Speakers from:

National Association for Paediatric Occupational Therapists
Chartered Society for Physiotherapists > Royal College of Nursing

Covering:

Different aspects of Paediatric Moving & Handling > Practical Workshops
Exhibition of new Paediatric Moving & Handling equipment
Disabled Living, Manchester will present the prototype of their "Bubbles Clothing"
Cost: £98.50 plus VAT **Contact:** Norma Richardson on **0870 777 4714**

Thur. 24th Nov ★ 9.30am-5pm ★ The only uk exhibition *TOTALLY* dedicated to disabled children

Seminars include:

Disability Equality improving the life chances of disabled people
Every Child Matters – The Challenges & Opportunities > Community Care Law >
Play Talks - Scope > Controlling Your Wheelchair - AWC > Alternative Therapies >
Problem solving when moving and handling children > Planning for the future-legal matters
Exhibition: Over 70 stands plus lots more fun and features ...
Cost: **FREE (booking on the day essential)** **Contact:** Disabled Living on **0870 777 4714**

For updates visit www.disabledliving.co.uk or email kidzupnorth@disabledliving.co.uk

APCP Membership Application/Renewal 2006

TO BE COMPLETED BY ALL NEW MEMBERS AND EXISTING MEMBERS NOT USING THE DIRECT DEBIT SCHEME

N.B Any member who has arranged to pay by direct debit and then duplicates their subscription with a cheque will be refunded on request. They will, however, incur a £3.00 penalty to cover administrative costs.

- 1) **Annual subscription for 2005 is £25.00**, and runs from the 1st January to 31st December.
- 2) Ordinary Membership is open annually subscribing members of the Chartered Society of Physiotherapy.
- 3) Associate membership is open to professional people with an interest in Paediatrics, subject to approval of the National Committee.
- 4) Associate Membership is open to Physiotherapy Students and Physiotherapy Assistants at half the total annual subscription. Students are not eligible to pay by Direct Debit.
- 5) Retired members are only required to pay half the total annual subscriptions.

All cheques should be made payable to 'APCP'

I wish to *apply for/renew my membership of the Association of Paediatric Chartered Physiotherapists

* delete as applicable.

PLEASE USE CAPITALS ON THIS FORM

Title (Mrs, Ms, Miss, Mr, Dr, Other)

First Name Surname

CSP Number APCP number

Profession Grade

Address for correspondence

.....

.....

.....Post code

Telephone number

Place of work

.....Post code.....

Telephone number.....



Please complete if you are a new member

About your work place:

What type of facility is it?.....

Is your work place a regional or famous centre? Yes / No

If 'yes' what speciality?.....

About you and your work:

Your speciality in paediatrics

Do you have a sub-speciality?

Would you be willing to lecture/teach in your speciality subject? Yes / No

Are you willing to have visitors? Yes / No

If 'yes' give contact person and address

.....

.....

Would you be able to take students on an elective placement? Yes / No

If 'yes' who should be contacted?

Name

Address

.....

Subscriptions are due by the 1st January.

Journals will NOT be sent until membership is renewed. Members who are late reviewing their membership forfeit the right to back issues and will only receive them subject to availability.

Please notify the Membership Secretary of any change in address.

Currently we are not permitting commercial mail shots to be sent to members. Should there be a change in this current policy, and you should not wish to receive such communications, please indicate by ticking this box.

**Please complete and return, with your cheque (APCP) to:
Susan Cleverley,
Physiotherapy Department, Orchard House, 9 College Road, Chichester PO19 6PQ.**

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 **Jeanne Hartley, Research Officer, Physiotherapy Department, Great Ormond Street, London, WC1N 3 JH**. This information will be used to inform you of reseach 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.



DON'T FORGET
TO BOOK YOUR PLACE
AT CONGRESS FOR
7TH OCTOBER

- REMEMBER THIS IS
PAEDIATRIC DAY



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CONFERENCE EDITION

In this issue :

**Standing Frames for Children: An Evaluation
of Postural Control Features**

**An Evaluation of Standing Frames
Designed for Children:
Preferences of Users and Therapists**

**The North Star Clinical Network
for Paediatric Neuromuscular
Disease Management**

