

ASSOCIATION OF  
PAEDIATRIC  
CHARTERED  
PHYSIOTHERAPISTS

JOURNAL



DECEMBER 2005

ISSUE  
NO. 117

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## Editorial

My first thoughts as I sit down to write my first editorial are to thank Sally for all her hard work and enthusiasm during her time as editor. She has changed the face of the journal and begun the process of introducing more peer review articles. I will endeavour to carry on her good work with the help of the editorial board.

APCP had a very successful day at the CSP congress in October; the invited speakers gave excellent presentations on Chronic Fatigue Syndrome and Pilates for children. Paediatric physiotherapists also featured highly in the paper presentation sessions indicating a growing evidence base for paediatric physiotherapy.

Wearing my various hats I am aware that paediatric physiotherapists are engaged in many activities such as guideline development, audit, research projects, thinking up innovative service delivery ideas, reading books and even treating children. The journal is here for you to share your thoughts and findings about these activities with your peers. In the journal this month there is "Writing for Physiotherapy" which outlines a variety of ways that you can contribute to the journal. Book, video/DVD and even useful website reviews are always welcome.

The Children's NSF is one year old and I wondered if any of you would like to share how you have implemented and/or audited these standards within your service. Have they helped you to improve and develop your service and increased awareness of children's services e.g. key working, information for children and families about services.

I am looking forward to the challenge of editing the journal and receiving your contributions for future journals.

TERRY POUNTNEY

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**MARCH 2006 JOURNAL**

must be with the editor by

**1st FEBRUARY 2006**

**The editorial board reserve the right to edit all material submitted**

## Letters

Ainslie Duncan  
Paediatric Physiotherapist  
New Zealand

Dear All

I am a paediatric physiotherapist and am currently employed by the NZ Ministry of Education. I am working with the most severely disabled children (the lowest 1% of the population). The majority of the children I am working with attend mainstream schools and are supported in the mainstream classes. I am interested in attending courses that are relevant to this work and would appreciate it if you could let me know what short courses workshops or seminars might be happening between April and July 2006 in paediatrics. I would also be interested in making contact with UK Physiotherapists who are working in Paediatrics and discussing the benefits and limitations of the different approaches to treatment/management of children with disabilities.

Please contact me at [Ainslie.Duncan@minedu.govt.nz](mailto:Ainslie.Duncan@minedu.govt.nz).

Yours sincerely,  
Ainslie Duncan

Susan Cleverley  
Membership Secretary

Dear All

### **Message from the Membership Secretary**

I would like to apologise to all the membership for the slow and sometimes erratic responses you have received from me over the last year. There have been a number of problems the first being a change in the process by which direct debits are collected, this required new soft ware being put onto the computer and new codes being allocated to each member, this did not go smoothly and we were unable to get through the security programme of the process. I then went on maternity leave and was unable to sort the problem effectively at the time. The computer also failed and we have not been able to get it up and running again.

We are now purchasing a new computer and will transfer the data across, hopefully the direct debit services will come out re-load the soft ware and actually ensure that the process works so that direct debits may be collected at the beginning of 2006.

The direct debit forms will be sent out as soon as I can access the addresses of members, this will I realise mean that the turn around for completion of the forms is very short, if you could bare with me on this I will endeavour to get the whole system up, running and up to date as soon as possible.

Hope you all have a good Christmas and New Year

Best wishes  
Susan Cleverley

## Congress Lecture

# Multidisciplinary Rehabilitation for Young People with Chronic Fatigue Syndrome (CFS/ME)

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**Keywords: Chronic fatigue syndrome, rehabilitation, adolescent**

While fatigue is a common symptom in young people today, chronic fatigue syndrome (CFS/ME) in young people is rare. CFS/ME is characterised by debilitating fatigue reducing function profoundly for at least 6 months with symptoms not explained by other medical or chronic psychiatric illnesses.<sup>1</sup> Unrefreshing sleep, muscle aches and pains, flu-like symptoms and severe headaches make previous levels of activity difficult to maintain. CFS/ME is often diagnosed soon after commencing secondary school. This is significant in terms of the syndrome being considered an illness of transition. It is striking that while UK prevalence is 50 to 100 per 100000 children, but there is a higher rate in adolescence. It is estimated that the prevalence in young people between the ages of 11 to 15 years is 0.2-0.6%. For young people suffering from CFS/ME, the impact on their lives can be dramatic and devastating as they are unable to attend school, lose contact with peers, and become generally less able to access their usual activities.

While little has been published on the management of CFS/ME in children and adolescents, evidence from studies in young people suggests that outpatient cognitive behavioural therapy (CBT) undertaken within the family<sup>2</sup>, activity/exercise programmes<sup>3,4</sup> or inpatient treatment<sup>5</sup> are helpful in about three quarters of young people. There is also a small amount of evidence supporting an outpatient rehabilitative approach inclusive of family work.<sup>3</sup> Great Ormond Street Hospital offers a multidisciplinary outpatient rehabilitation programme which includes a graded activity programme and family work, along side regular clinic appointments.

There has been much debate about the role of graded activity or exercise programmes in the management of CFS/ME. It is well known that inactivity leads to negative features such as poor

endurance, reduced fitness, poor quality sleep and muscle weakness. The adult literature has found people with CFS/ME to have these features<sup>6</sup>. Recent literature has started to explore the perceived exertion of people with CFS/ME as they undertake exercise. It has been noted that CFS/ME patients report higher effort on exercise testing than matched sedentary and depressed patients.<sup>7</sup> It would seem that regardless of the cause of CFS/ME it is likely that the provision of exercise or activity programmes would benefit young people with this syndrome.

The graded activities programme (GAP) aims to increase the amount of activity a young person does each day. The first step is to ascertain the baseline of activity. This is the amount of activity the young person completes every day with no exacerbation of symptoms. It is important to impress on the young person that this does not equate to a symptom free day. Other assessment tools include a strength assessment (number of sit-to-stands in one minute) and a sub maximal stationary bike test. If the young person has joint pain or muscle ache as a primary symptom range of motion is assessed to identify any hyper mobile joints and if found appropriate stabilising exercises are given.<sup>8</sup>

The young person always identifies the goals and content of the programme. However, sleep, activity/rest balance and school are core components of the management strategy. The aim is to establish a routine day from which increases can occur. The provision of a formal fitness programme is only considered once the young person can complete twenty minutes of walking and is in fact interested in this form of programme. School is a dominating feature in any young person's life and reintegration is a core feature of the programme offered. The young person sets the rate of progress; the emphasis is on small achievable goals.

Family work, when offered alongside a GAP, can both support goal setting as part of the activities programme, while paying attention to the social and emotional dimensions of living with CFS/ME. To look at the context in which the illness is occurring, as well as the context in which recovery is made possible, is its aim.

One of the first goals of family work is to understand the meaning that each family member attributes to CFS/ME. Exploring each person's motivation for rehabilitation is also important at this stage. Other aims of family work are: to identify factors maintaining illness; to challenge behaviours reinforcing illness; to help the family learn how to manage physical, psychological and social deconditioning; and to help the family put in place the goals which form part of re-conditioning. Paying attention to the way in which adolescence – and other life stages – are being negotiated within the

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family, can also be helpful in working towards recovery. Working with each family member's attitude towards recovery also forms an integral part of successful family work. As family work progresses and professionals are more certain of the family's commitment to rehabilitation, the family work can become more practically focussed. School reintegration often becomes a focus of work at this point.

When working with families where a member has CFS/ME, a variety of approaches can be used. Systemic work is a useful starting point with any family. This approach examines the illness located in the family, rather than in the individual diagnosed with CFS/ME. Other useful approaches include structural, strategic and CBT approaches. It is often helpful to be flexible regarding which approach to take as not all families respond as well to each technique, and different approaches may be needed when working with the same family at different stages of the recovery process.

Together GAP and family work can facilitate recovery in young people with CFS/ME. It is essential that all professionals working with this population provide enthusiasm and encouragement in order to confirm that recovery is possible.

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# Congress Lecture

## Paediatric Pilates and the Target Zone Hypothesis

### A Non-Prescriptive, Qualitative Approach to Exercise Therapy Theory / Practical Sessions

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**Keywords:** Exercise Therapy, Pilates, Paediatrics, Target Zone Training, Age Appropriate Explanations/Exercise Ideas

#### Summary

Exploring the scope of Pilates as a Clinical tool within Neurology, Orthopaedics, Surgery, and Respiratory Care. A qualitative discussion centred on adapting Pilates exercises to create an age/ability level appropriate clinical tool within varied areas of Paediatric Physiotherapy (incorporating consideration of the Target Zone Hypothesis).

This stems from evaluation of what has been learned from various training providers and from clinical practice. Examples are given from experience of the practicalities of Pilates as a clinical tool. Suggestions are offered on how the use of Pilates may enhance existing exercise therapy. The practical element of the presentation includes age appropriate exercises.

With safety in mind it is most important to bear in mind that none of the movements or exercises should cause pain, individuals should only move within their pain free range. Those in the first trimester of a pregnancy or in the acute phase of a new (undiagnosed) injury should not begin Pilates based exercises.

#### 1 Pilates – what is it?

“Pilates, is that a kind of vegetable?” “Pirates?” “Pie-lates?” The preceding are examples of the response in years gone by that this author has come across after mentioning the use of Pilates. Amazingly, the first response came from a consultant neurosurgeon.

In recent years, due to the increasing size and commercialisation of the UK Pilates industry, most

people do have some understanding of it being a method of exercise. However, in terms of endeavouring to increase awareness of the effectiveness of Pilates as a clinical tool amongst Physiotherapy colleagues and medical referrers, this increased commercialisation is perhaps a double edged sword: One feels slightly disappointed to think that the response from such professionals might easily be “ Oh yes, you can buy that in Marks and Sparks” or “Can’t patients save tokens from cereal packets to try that?”

Much is written about Joseph Pilates (1880 – 1967) and his original work in developing “Contrology” – the science of controlling movement – the method subsequently known as “Pilates”. It is very much the ‘stripped down’ versions of his ingenious original work, which are most relevant as a clinical tool.

2005 has seen major developments in the standardisation of the UK Pilates industry (with linkages to the Register of Exercise Professionals). However, due to the historical lack of standardisation within the UK Pilates industry, (which has been steadily growing over the last eight to ten years), there are many types of Pilates teachers.

As a clinician who has developed Pilates based treatment techniques within the niche area of Paediatrics, one has to perhaps question as to who will benefit most from the standardisation of the UK industry. There are clear benefits to the ‘benchmarked’ teachers who are at a commercial advantage to their less qualified counterparts. Standardisation will likely increase the chances of eligibility to NHS referrals for exercise on prescription and increase the likelihood of third party payers such as health insurers covering the cost of private sessions. Certainly adults without specific/significant pathologies should find it much more straightforward to judge the competence of a Pilates teacher on the basis of their ‘standardised’ credentials.

However, standardisation is possibly less helpful to those seeking Pilates as a clinical tool within niche areas such as Paediatrics: Critically, many ‘well qualified’ teachers may not be interested in working on such a remedial basis and may not have the transferable skills/experience to do so.

It is helpful to understand the various types of teachers in existence in order to access the most relevant resources for both therapists wishing to increase their own awareness of the method (an essential pre-requisite to using the exercises clinically) and to provide suggestions regarding appropriate resources for parents and patients to further their use of the method.



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## Pilates teachers in the UK – a general guide

**Type A** *teachers who have served a traditional apprenticeship in classical pilates; may have a background in dance or sport; may themselves go on to teach on modular training courses for Pilates teachers.*

**Type B** *teachers who have completed a modular course from a 'universal' training organisation; that is to say a training organisation which accepts candidates from all types of backgrounds; thus some will be health professionals or fitness teachers but equally, people who have been in completely unrelated fields with no experience of working with bodies. It is important to note that historically the quality and structure of such courses has varied greatly; some correspondence based, some without any supervised teaching.*

**Type C** *health professionals who have completed a modular course from a clinical training provider; that is to say a provider who works exclusively with health professionals and does not train members of the general public.*

**Type D** *general exercise teachers; may have completed a brief "one off" training course in Pilates and historically have incorporated Pilates into other forms of exercise e.g. Pilates type keep fit classes/'tums and bums'.*

In terms of what one might expect from the above subgroups of Pilates teachers, the following might be helpful to be aware of:

**Types A & B** should hopefully be using the Pilates principles in combination with the Pilates exercises/movements (i.e. using it as a complete method). This may be less the case with type B due a historical lack of standardisation. Critically, they may lack the transferable skills and or interest to apply the method in a remedial/Paediatric setting.

**Type D** likely to offer sessions in the lowest price bracket due to less investment in training and higher numbers of participants in a group. They may well use the Pilates exercises/movements WITHOUT the underlying principles – this is where injury is perhaps most likely to occur.

**Type C** this group should have the transferable skills to be able to use the exercises and principles together as a complete method (probably in a very modified way) AND/OR use the Pilates principles to enhance existing exercises/treatments.

Considering the above it is therefore perhaps sensible for Physiotherapists to experience a particular teacher for themselves (preferably without making it clear that they are investigating the possibility of referring parents/patients) before referring/suggesting patients or parents use a particular teacher.

## 2 Basic principles

Central to Joseph Pilates' original method is the application of a key set of principles, which underpin the movements/exercises. Over time, in the hands of various training providers these have been adapted and expanded/contracted to suit the particular requirements of each 'strain' of Pilates which has developed. From experience, I have found the four most relevant, key principles needed to underpin Paediatric Pilates are: Relaxation; Alignment; Breathing; Centring. Issues, which, should link in naturally as the patient progresses include: Concentration; Flow of movement; Co-ordination; Stamina/strength.

Within 'general' Pilates (aimed at adults) many teachers will aim to incorporate all of the above at once – imagine that this is like learning to drive or learning to speak a language and you can see why for the purposes of clinical work, especially within Paediatrics it is necessary to break it down further.

Each of the four key principles listed above will now be dealt with individually:

**Relaxation:** relates to the release/lengthening of unwanted muscle work/tension. In many patients this is especially evident axially in superficial musculature as well as in other superficial muscle such as the erector spinae in the cervical and lumbar areas.

**Alignment:** delving back into memories of Physiotherapy training in terms of adapting the idea of a line of gravity or 'plumb line' to aid assessment/awareness of postural alignment. I have adapted the idea of using a 'plumb-line' and tend to take an instant photo in profile of the patient which, when a straight edge such as a pencil is placed vertically across it, clearly demonstrates where the 'plumb-line' or line of gravity falls.

It is interesting to note that the majority of patients (and therapists) have their plumb-line/line of gravity falling way forwards of its' ideal resting point (slightly anterior to the lateral malleolus) due to an unstable trunk/pelvis.

Using building blocks is another excellent way to illustrate segmental alignment against gravity: think of the body as having four segments; head, thorax, pelvis and lower limb. Clearly, in order to counter-balance and stay up against gravity, a displacement of one block leads to them all being out of alignment

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– thus creating: Greater mechanical strain through spine, and other joint complexes; Altered biomechanics of gait; Altered muscle function/length; Alteration of ‘normal’ spinal curves.

A useful way to summarise the relevance of Pilates to a patient’s overall postural alignment and muscle balance is to consider the following equation:

**GRAVITY + BODYWEIGHT (+/-PATHOLOGIES)  
-VERSUS-  
MUSCLE BALANCE + MOVEMENT PATTERNS  
= FUNCTIONAL POSTURAL CONTROL  
/PHYSICAL ABILITY**

If, as Physiotherapists we do not influence/re-educate the latter, the former will dominate creating a sub optimal level of functional postural control and potentially, further pathologies as a result of this. We may be able to offer relief from the acute symptoms of e.g. soft tissue damage as a result of the predominance of gravity/bodyweight /pathologies. However, we must take a dynamic role in the management of muscle balance and movement patterns if we are to afford the patient long-term relief and maximum potential.

**Breathing** can be described as either apical, lateral costal or abdominal/diaphragmatic. For the purposes of Pilates, lateral costal breathing is the most desirable. This is because it allows basal ventilation (think of lung surface markings), does not encourage tension/activity in the upper accessory muscles or the shoulder girdle generally and it allows the abdominal muscles (specifically transversus abdominus) to maintain a stabilising function. (Abdominal breathing generally results in the ‘overstretch’ of transversus abdominus as the abdominal wall expands, thus reducing its’ capacity to remain a competent stabiliser.)

‘**Centering** is one of many interchangeable terms used to describe the engagement of the core postural stabilising muscles. Other examples include: “engage your centre” “scoop back your tummy” “navel to spine” “switch on your core”. The relevant muscles to the above phrases are generally thought of as transversus abdominus and pelvic floor. Other relevant muscles (not an exhaustive list) include: Anterior sub-occipitals, lower fibres of trapezius, serratus anterior, multifidus, transversus abdominus, internal obliques, gluteus medius, hip adductors, vastus medialis, soleus, lumbricals & interossei.

From a practical point of view it is helpful to

consider transversus abdominus as the principle core stabiliser. In addition to its’ attachment to the thoraco-lumbar fascia (helpful for ‘co-contraction’ or ‘overflow’ of e.g. multifidus) it shares an area of attachment with the anterior portion of the pelvic floor (thus again useful for ‘co-contraction’ or ‘overflow’).

### 3 Muscle fibre types – anatomically versus functionally

As we as therapists are aware, skeletal muscles comprise of both fast twitch and slow twitch fibres. Clearly both types of fibre may co-exist in one given muscle. However, each muscle tends to function more towards being either a mobiliser (fast twitch) or stabiliser (slow twitch). Therefore, in the interests of clarity and in order to make the understanding of muscle function more user friendly for parents and children, I think functionally and describe muscles as mobilisers or stabilisers.

Using the analogy of ‘Sprinters’ (mobilisers) and ‘Marathon runners’ (stabilisers) is, I have found of even greater relevance; it affords further clarity of the key issues which the parents and patients need to comprehend in order to carry out the exercises effectively.

In clinical practice I have found the following information to be of assistance in facilitating the necessary understanding on the part of the parent and patient. Sprinters are described as having the following properties: work only when needed, work at high effort levels, sit on the body’s surface as long thin straps which make movements of joints happen, the fibres only run in one direction and fatigue/tire very easily. A useful example to site is rectus abdominus.

In contrast, Marathon runners are described as: working all the time in the background at a low effort level, deeper inside the body and short/broad in shape, fibres run in many directions and do not fatigue/tire easily. A useful example to site is transversus abdominus.

#### 3.1 Distorsion of ‘marathon runners’ and ‘sprinters’

Often noted both clinically and in our own bodies, due to a dysfunction in muscle balance and movement patterns (for varied reasons), the roles of the sprinters and marathon runners are particularly prone to distortion.

An upper limb example would be the upper trapezius over working to compensate for weakness in the lower trapezius. A practical example of this clinically would be the patient (potentially with a diagnosis of Dyspraxia/DCD) who is unable to maintain control of their pencil in order to write across the page they are working on. Accompanied

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by this functional difficulty is often a complaint of pain/discomfort in the upper trapezius or upper limb generally.

A lower limb example would be the hamstrings over working/tightening to compensate for an unstable pelvis (weak gluteus medius, transversus abdominus etc.) Tight hamstrings are, in my experience often a symptom of an unstable pelvis (the hamstring acting as a 'guide rope' on a tent would to try and anchor the pelvis and accommodate/prevent further anterior drifting of the pelvis and the resultant 'drifting' of the ischial tuberosities in postero-superior direction.

To summarise the practical benefits of the clinical application of Pilates, it is useful to consider that: By facilitating the release of unwanted tension in the superficial mobilisers and engaging the deeper stabilising muscles, we can re-balance the body and its' movement patterns.

### **3.2 Levels of postural control**

When dysfunctional, the 'marathon runners' work only on a very conscious level and are likely to fatigue and switch off during an exercise if too much is asked of them. A practical example would be if one tries to sit or stand with erect posture but is only able to maintain the position for a short time and finds that the effort of maintaining the posture is associated with discomfort/aching. Once the erect posture is released and one is 'slumped' or slouching again, any discomfort associated with the erect posture disappears. This is symptomatic of dysfunctional postural control and represents the fact that the 'sprinters' were primarily producing the erect posture, rather than the 'marathon runners'.

When functioning subconsciously, the 'marathon runners' work when we consciously ask them to and then continue working for a little while afterwards in an unconscious way. Feedback from patients/parents may be that they notice a temporary improvement in postural alignment/function for a period of time after the exercises have been practised.

When the 'marathon runners' are functioning automatically, working all the time without the need for conscious control, the level of activity in them will vary according to the activity being done and patients notice increased stamina and function. Observers might comment that the patient looks taller/slimmer/straighter.

The length of time taken to progress from dysfunctional to automatic functioning will vary from patient to patient but in general, if exercises are practised at least three times a week, I have found that they are functioning subconsciously, if not automatically, within weeks rather than months.

For adults once this level of automatic functioning has been achieved, in most cases they are able to significantly reduce the frequency/intensity of practice of their exercises whilst maintaining their improved function/symptom control. In the paediatric population, growth spurts may necessitate further intense periods of exercise performance in order to regain the muscle balance, which might be degraded due to the change in biomechanics which accompanies increased bone length.

It is still feasible, I feel, despite potential issues of growth spurts to promote the Pilates approach to exercise therapy as a short term investment (of relatively intense practice and concentration) for a long term gain (i.e. they won't need to work so intensively 'for ever' in order to maintain their improvements).

### **4 Golden Rules**

In order to achieve optimal results from the use of Pilates as a Clinical Tool, the following 'golden rules' are suggested to patients: Don't try too hard – 25% effort is the aim; don't move into pain – it is there for a reason (i.e. a mal-alignment, overstretch on the nerve tissue, added to which movement into pain is counter-productive as it will trigger protective spasm/guarding in the sprinters); this is more exercise for your brain than your body; QUALITY not quantity.

### **5 The Target Zone Hypothesis for Exercise Therapy**

In order to achieve the desired core postural muscle activity during exercises the degree of difficulty of the exercise prescribed should be such that the patient is able to perform it through recruitment of muscle activity at the appropriate level of effort/contraction (given here as 25%).

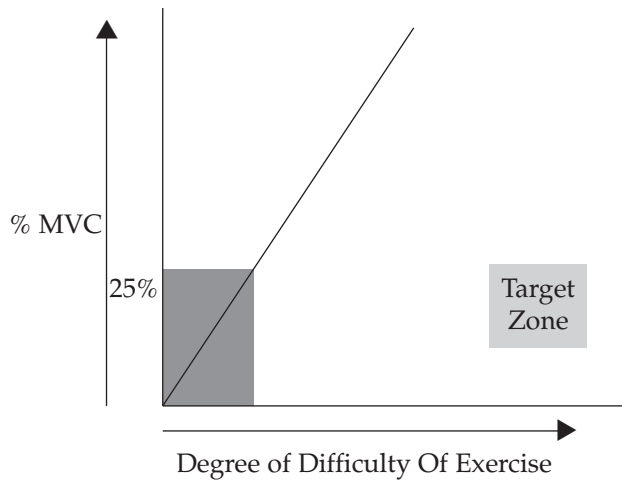
Should the degree of difficulty of the exercises prescribed be too great, the patient will 'over recruit' muscle activity and (unless the patient already has functional postural muscle as below) the resultant recruitment of (mobilising) 'sprinter' muscle fibres will coincide with the disengagement of the (postural) 'marathon runner' muscle fibres.

In the case of patients who already show functional core postural muscle/ideal muscle balance, exercises requiring over 25% effort will result in the recruitment of 'sprinters' BUT with the continued functioning of 'marathon runners' in the background.

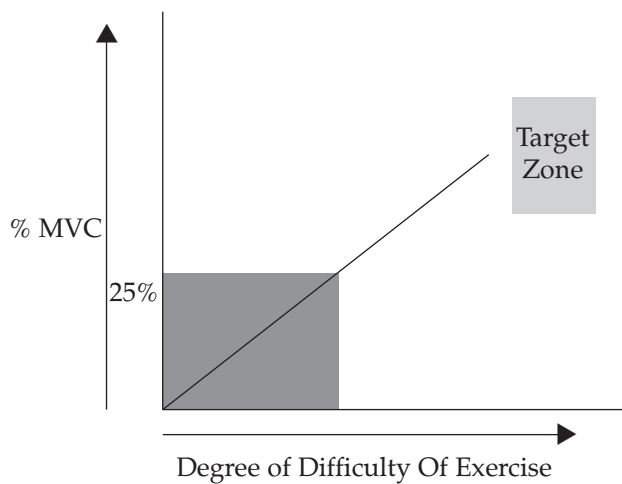
# Paediatric Pilates and the Target Zone Hypothesis A Non-Prescriptive, Qualitative Approach to Exercise Therapy Theory / Practical Sessions

## 5.1 Graphs to illustrate the Target Zone Hypothesis for Exercise Therapy

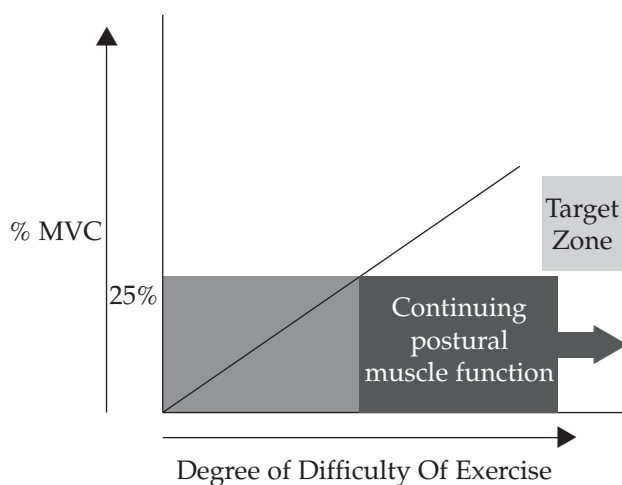
Grade 1 - Dysfunctional Postural Muscle



Grade 2 - Improving Postural Muscle



Grade 3 - Functional Postural Muscle



## 6 Examples from Clinical Work

The following examples involve patients with diverse diagnoses and are a sample of the many interesting results observed over the past five years. They cover a cross section of NHS and private patients, all of whom were treated on an individual basis (although one [6.3] later progressed to join adult group classes).

### 6.1 Dyspraxia

A seven-year-old boy, diagnosed Dyspraxic and under the care of a Consultant Paediatric Neurologist had a previous diagnoses of right LMN facial palsy (aged 4) and Otitis media (five times at the age of 2) both of which had resolved and there were no significant presenting factors related to either condition. He presented with ligamentous laxity and was on the waiting list for a course of sensory integration. His attention span was limited.

Developmentally he had displayed some delay, walking at nineteen months and climbing the stairs from the age of three. He still, however aged 7 needed to use a handrail to climb the stairs. At the outset of treatment he was unable to kick a moving ball, unable to run and throw at the same time and had very poor ball catching skills. In terms of fine motor function he was reluctant to write, wrote with heavy pressure and tense pencil grip and whilst his pencil control had been described as 'reasonable' his writing was slow and laborious. He tired very easily and complained of discomfort in the arm.

Posturally, he was very winged with an accentuated thoracic kyphosis. His lumbar spine was quite flattened, as were his gluteals. His abdomen was prominent and low toned.

The intervention consisted of four basic Pilates exercises, focusing mainly on scapular stability (he was not able to comprehend/perform any of the pelvic work initially). The exercise programme was carried out with his mothers' supervision three times a week.

He was first reviewed three weeks into his home exercise programme. It was noted that in the previous week (two weeks into the programme) the patient, his mother and teacher had all noticed and commented upon a marked improvement in the speed and quality of his handwriting. Significantly, during this first three-week period, he had also started using the stairs without the handrail. This was especially interesting as it indicated an 'overflow' or 'co-contraction' from the scapular stabilisers to the pelvic/trunkal stabilisers (which had not been specifically targeted in the exercises thus far). It was also noted that he was less winged at the scapulae.

At the second review, six weeks into his home

## **Paediatric Pilates and the Target Zone Hypothesis A Non-Prescriptive, Qualitative Approach to Exercise Therapy Theory / Practical Sessions**

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exercise programme (which by then consisted of five exercises) he managed to consciously isolate the contraction of transversus abdominus in co-ordination with exhalation. Again his posture was improved (less winged in particular) and he was delighted to have scored a goal at football. (This was a first for him.) His ball skills (throw/catch) were significantly improved when combined with the Pilates principles. One further exercise was added (six in total) and others were refined/progressed.

The next review was delayed until 15 weeks after the inception of his programme, due to his mother having been acutely ill. It seemed that little (perhaps no) practice had been done as a result of the difficult home circumstances in the interim (nine weeks). However, all the functional/postural improvements were maintained and, possibly slightly improved although not as quantifiably as at the first and second reviews.

At this point his schoolteacher was keen to know how she could help implement the programme in P.E. and so the Pilates principles were to be applied to ball skills work in the P.E. setting. The home exercises were further refined and cut down to two in number.

A second boy (aged 11) with a diagnosis of Dyspraxia (along with diagnoses of; dyslexia, ADHD, Aspergers syndrome, growth hormone deficiency and a difficult family/social history) was seen for treatment during a time when he received no other therapy or educational input whatsoever. (He had been withdrawn from school by his main carer as it was an inappropriate placement and had not received home tutoring.)

Along with marked instability, (which caused problems with gross and fine motor function) his concentration span/ability to focus on tasks was a major problem. Just prior to my involvement, he had been assessed by a behavioural optometrist who had provided special glasses with prismatic lenses in order to improve his concentration/focusing skills. The patient had been instructed to gradually phase in use of the glasses and given a six-month review date.

At the six-month review, the optometrist was delighted with the objective improvements (functionally the patient had started to spontaneously read or colour in, which was a new phenomenon and his concentration span was increased).

What the patient and his carer did not tell the optometrist was that the prismatic glasses had been lost (never to be found) shortly after they were provided and thus he had only worn them briefly on a couple of occasions. In the interim, the only other variable was the fact that we had been working (fortnightly-monthly) on his treatment programme. Additionally, the patient showed improvements in his posture and ball skills.

### **6.2 Non-specific (undiagnosed) postural and fine motor dysfunction**

A ten-year-old boy presented for treatment having been referred via a Consultant Paediatric Rheumatologist. He had complained of general aching associated quite possibly with muscle tension/soft tissue strain due to a grossly rounded posture. There was nil else of note in his history.

His main difficulty was in handwriting, which was so slow and laborious that he was having to do homework to keep up at school (none of his peers had homework). He demonstrated poor letter formation and a very rounded posture as he sat/wrote. He was notably winged at the scapulae and had an accentuated thoracic kyphosis.

In general terms he was very shy, lacked confidence and would never play outside.

A small set of several exercises aimed at improving scapular stability were performed daily with his fathers assistance/supervision. He was reviewed fortnightly for a period of six weeks.

Initially he was aware of the contraction of transversus abdominus but unable to co-ordinate this with his breathing pattern. At the first review (two weeks in to his programme) he showed a significant improvement in the speed, fluidity and quality of his handwriting. Indeed he had started to write in script, which he had previously been unable to do.

Within approximately four to six weeks, his handwriting speed had improved to the point where he no longer needed to do homework to keep up with his peers. His sitting posture was noticeably improved and his scapulae much less winged. Significant in terms of his general development, he became (in his fathers' words) "a different child" within the 4 to 6 week timeframe. He had begun to play outside, play football, became much more confident and had to be called in for meal times.

### **6.3 Severe Scoliosis**

An eight-year-old girl presented for treatment with a history of severe scoliosis (diagnosed as an infant), which had been treated since the age of six months with either a POP jacket or, latterly a thermoplastic jacket, which was worn 23 hours per day. It was

## Paediatric Pilates and the Target Zone Hypothesis A Non-Prescriptive, Qualitative Approach to Exercise Therapy Theory / Practical Sessions

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acknowledged by her consultant that she would need surgery to correct the scoliosis once she was in her teens.

Her consultant reviewed and re-x-rayed her every four months – without fail the curve progressed at each review. Her mother (who had experience of Pilates in her own body and felt that some form of exercise programme was important for her daughter in preparation for her future surgery) had requested a physiotherapy referral whilst in clinic. Although the consultant did make the referral, the physiotherapy offered was a one off assessment and advice session.

We began working together (always with the jacket off) shortly after she had been for a regular review at clinic. The focus of the sessions was to implement a small number of Pilates exercises, focusing on body awareness release of muscle tension, pelvic and spinal/trunkal stability and segmental movement, along with scapular stability. At the next clinic review (three months into her programme) it was noted that there had been no further progression of her curve. To date (approaching 3 years) this has remained the case. She is now reviewed six monthly by her consultant and approximately six monthly/annually by myself. The home exercise programme has been gradually refined and progressed.

Potentially the inception of this treatment programme co-incided with the closure of lumbar growth plates and so there is no concrete way to know if the treatment was a relevant factor in the stabilisation of her scoliosis. It is very interesting to note, none the less. This issue aside, her increased core stability, muscle balance and body awareness will surely be an advantage when she does come to have her surgery (and beyond).

### 7 Photographic case study

A young man of 16 with a background of ADHD (treated with Ritalin) presented (via his GP) with symptoms in the lumbar and thoracic areas relating to an excessive lordosis/swayback posture. He was a very serious sportsman, training six or seven days a week, mostly rugby and basketball.

From the initial photograph it is clear to see his postural alignment is a major issue. His stance was wide, with hips abducted and externally rotated, to accommodate his centre of gravity being shifted so far forwards.



Photograph One



Photograph Two

Specifically, the distance between the xiphisternum and pubic bone was exaggerated thus transversus abdominus was compromised by virtue of being over lengthened.

Treatments to establish the home exercise programme (carried out 3 times a week plus) were carried out weekly/fortnightly/monthly over an eight to ten week period to bring the patient to the point where the second photograph is taken. Within the first week, the patient noticed an improvement in his overall stamina and strength, describing that he simply felt stronger and more flexible. After approximately six weeks the patient and his mother noted a change in his postural alignment.

The second photograph shows not only the altered (improved) spinal alignment but also the more neutral position of the lower limb. It is also clear to see that the xiphisternum to pubic bone distance is reduced and the holding tone in transversus abdominus is increased.

### 8 Clinical Applications

The following conditions are either ones which have been addressed personally using this approach, or those which colleagues who have attended SMP&P Ltd clinical courses have reported back as having responded well to treatment.

- Dyspraxia/DCD
- General postural problems
- Scoliosis
- Adolescent back/neck pain
- Acute hemiplegia
- Cerebral Palsy
- CFS/ME
- Psychiatry/ Eating disorders
- Cystic Fibrosis
- Asthma
- Muscular Dystrophy

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- Hip/knee pain
- Post line insertion/removal

### **9 The Basic Principles In Practice**

In this session the issues of lateral breathing, pelvic floor and transversus abdominus recruitment were worked through practically.

Key issues to assist lateral breathing include; using the hands/a stretch band to increase proprioceptive awareness, use of the automatic inhalation reflex to open up the lateral costal area naturally, blowing out (to distinguish between the in and out breath), being aware of keeping the lower rib to ASIS distance constant.

Important points to consider in the recruitment of pelvic floor include; imagery for the pelvic floor, selective recruitment of front versus back pelvic floor and slow twitch versus fast twitch fibres, and the link between pelvic floor (thumb sucking) and transversus abdominus.

Also discussed were recent 'edicts' within the Pilates industry, which insist on recruitment of pelvic floor before recruitment of transversus (so as not to increase the intra-abdominal pressure and therefore potentially compromise the pelvic floor integrity). The conclusion drawn was that the evidence this assertion was based on related to top-level female athletes performing extreme abdominal work. In light of the fact that clinically we are aiming for very gentle, physiological activity within transversus abdominus and pelvic floor, experience from clinical practice suggests that there is co-contraction/overflow between the two. Indeed in some cases where (with adults) pelvic floor dysfunction is the main reason for treatment, there is an inability initially to recruit pelvic floor consciously. However, within a one to two week period of very gentle work with transversus abdominus, the conscious control (and function) of the pelvic floor begins to return.

The engagement of transversus abdominus was focussed on in terms of its gentle physiological role in expiration. It was stressed that over recruiting would result in de-stabilisation and have a compounding effect on existing muscle imbalance.

### **10 The use of Massage Balls**

Massage balls (semi soft, inflated 9cm "prickle stimulation balls") were used in various ways; to effect soft tissue release (using the wall to roll the ball across problem areas), to enhance/facilitate

pelvic awareness and movements, especially those which release/re-align the lumbar-pelvic region, for desensitisation of skin (especially hands and feet), to aid general relaxation and body awareness (via lying on two balls, one under the occiput, one under the sacrum) and to promote balance and co-ordination via foot massage, especially useful pre-exercise/sports.

### **11 Fun and Functional Exercises For Children**

Blowing bubbles or blowing cotton wool along via a drinking straw are both fun and useful with pre-school/younger patients as a way to increase awareness of the natural recruitment of transversus abdominus on expiration. These activities can be done in sitting standing or four point kneeling.

Several scapular stability exercises, which are best addressed from the sitting position, are easily adaptable to being child friendly. For example the "Genie" where the shoulders are taken from neutral to external rotation and back to neutral (whilst the elbows remain flexed to 90 degrees and in contact with/very close to the lateral ribcage). Think of a genie granting wishes.

A further example is "Angel Wings/Super Hero Cape". Here one arm is abducted from the shoulder, keeping the hand in the peripheral vision and leading with the thumb (as the anatomical position). The movement is halted before any elevation of the shoulder girdle takes place. The other hand is placed over the upper trapezius of the moving arm to increase awareness of any 'sprinter' activity.

For all the scapular stability exercises, the scapulae are gently depressed towards the waistline/back trouser pockets prior to physical movement of the limb in either direction.

"Rainmaker" biofeedback props can be utilised to demonstrate a way to increase awareness of pelvic/trunkal movement in selected exercises. The process of applying the Pilates principles to ball skills is relatively straightforward. Although it seems a protracted way to play throw and catch, clinical experience has shown that patients do not mind this because of the dramatic improvement in performance which results.

### **12 'Low Maintenance' Routes to Co-contraction**

With some patients/in certain practical settings it is useful to be able to 'cue' the correct postural muscle work in a functional (weight bearing) setting, possibly as an adjunct to the traditional clinical floor work.

Some nice images/ways to encourage improvements in global alignment/stability include; thinking of pointing the 'pointy' bit of your 'elf ears' up towards the ceiling, thinking of a piece

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of string from the crown of the head attached to helium balloons, pushing/pressing through points of contact with the BOS rather than 'passively' accepting support from the base, and 'separating' body parts i.e. draw the head away from the shoulders, ribs away from the pelvis etc.

### **13 Summary of Practical Advice for the Clinical Application of Pilates**

It should always be remembered that it is the QUALITY of exercise, not the quantity that is important. Therefore avoid giving numbers of repetitions to do and keep the number of exercises prescribed to an absolute minimum.

You cannot explain too much – it is imperative that the patient and parent understand WHY the exercises have to be done so precisely. This is not conventional exercise and in order to use it clinically it is much more work for the brain than the body. A patient will feel victimised/a failure if they are constantly corrected – explaining about the 'sprinters' and 'marathon runners' will avoid this and ensure that they take the correct approach.

Historically I have tended to limit assessment to the bare minimum. The reasons are twofold: firstly by getting pretty much straight into the exercises, you capitalise on the enthusiasm which the patient and parent are likely to have for a new interaction. Thus you also move them more quickly towards the functional improvements, which will then help to maintain their motivation. Secondly, whilst a battery of standardised testing tells us there is a problem, the patient and parent tend to already know that. The testing doesn't often actually tell us/them WHY the problem is there. Additionally it can become quite a negative focus i.e. this is how bad you are; this is what you can't do.

Therefore I find it useful to have assessment consisting of a postural photo, (video if possible of) markers such as two/one leg standing with/without eyes open, handwriting samples, and ball skills ability. Crucially important is the SUBJECTIVE history FROM THE CHILD as to what they want to change/improve. The child is much more likely to comply with the treatment programme if it is orientated towards something which motivates them. Often the perceptions of the parent and child as to the main 'problem' can vary hugely.

Remember the potential overflow/co-contraction which occurs, this means that exercises which you

thought it at first impossible for the patient to comprehend/perform are quite possibly very feasible within a relatively short space of time. An OPEN MIND is all-important.

It is vital that the therapist experiences the exercises prescribed in their own bodies FIRST. Otherwise they will lack the understanding and skills to preempt/correct the patient when they 'cheat' (as they inevitably will) and use their sprinters instead of their marathon runners, or perform 'trick' movements.

Finally it is vital that we do not prescribe either the terms of reference for describing engaging the core stabilisers or the names of the exercises. It is of paramount importance that the patient performs the exercises accurately (remembering the target zone hypothesis) and this cannot happen if they do not have a relevant description/illustration of them in their own terms. Therefore, the patient should be allowed to describe the process of centring in their own way, and to note/illustrate their own home programme in whichever way they feel appropriate. This lends 'ownership' of their treatment programme and encourages a positive, proactive approach which is all-important.

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# Postural Management For Children With Cerebral Palsy: the Implementation And Evidence Base

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The purpose of 24 hour postural management (PM) with children with cerebral palsy is thought to; decrease the need for surgery, minimize developmental deformity and increase participation and satisfaction levels.

**But when we position a child with cerebral palsy do we know if we are actually achieving those aims?**

Under the aegis of the MacKeith meetings, (multidisciplinary meetings held with the purpose of increasing the knowledge and experience of those in the field of neurodisability), a meeting was held at the Royal Society of Medicine in early May, entitled '24 hour postural management for children with cerebral palsy: for limiting deformity and promoting participation'.

The participants included a paediatric neurologist; physiologist; paediatricians; physiotherapists; occupational therapists; a head teacher from a special school; clinical engineers; orthopaedic surgeons and an orthotist, all with considerable experience in postural management and the prevention of deformity in children.

Limiting deformity and promoting participation in children with cerebral palsy requires a multimodal approach, possibly involving individual therapy, surgery, orthotics, pain management, botulinum and positioning. The key aims of this meeting however were to

1. Confirm our understanding of what are the mechanisms that underlie deformity in Cerebral Palsy.
2. Consider what evidence base there is for 24 hour management over less total postural management (PM) programmes.
3. Highlight the contra-indications? Where are the problems? In terms of muscle strength, practicality, organisation, adherence, funding, attitude etc.

The key issues arising from the meeting will be presented here.

With regard to underlying mechanisms, we need to distinguish between positional and postural deformity;

- Postural deformities are caused and may be fixed by active abnormal muscle tone.
- Positional deformities instead are caused by the forces of gravity and growth that influence the position that the child is placed or nursed in. Failure to adequately vary those positions leads to a limited selection of postures.

The position of the foetus in utero encourages an asymmetrical posture which in turn influences preferred lying position after birth in the infant with cerebral palsy.

Additionally an association was found between preferred lying posture in supine during infancy and direction of subsequent deformity. Suggesting we need to think about supine lying position very early on in the child with a neurological disorder, in order to broaden the child's range of positions.

In children with Gross Motor Function Classification System (GMFCS) level V and 1V focus should be on postural support during daytime and night-time activities. However as the likely level of neurological disorder is not clear during the first half year of life, it is suggested postural activity also needs to be incorporated into postural management.

In children with GMFCS levels 1-111 a balance needs to be found between postural activity and postural support. With the appropriate degree of support, adaptive movement should be an integral part of the approach used to delay deformities.

We need to be mindful that there may be a risk of providing support and control at the expense of function, strength and participation.

Mention was made of the problems of transition into adult services for youngsters with cerebral palsy and the need to be aware of the biomechanics associated with the progression of postural deformities even after the individual has stopped growing. This management situation may be further exacerbated when the youngster is cared for by aging parents. The orthopaedic surgeons emphasized the need for a close understanding between therapist and surgeon to inform decision-making. The problems of informed consent were discussed and critically, the lack of adequate outcome measures that can be used longitudinally to support timely intervention with this client group was highlighted.

It was recommended that a medical assessment was needed for a child where a sleep system is being considered in order to avoid medical complications, such as hypoxia, This would include taking a sleep history, perhaps using drawings to illustrate the child's sleeping postures.

## Postural Management For Children With Cerebral Palsy: the Implementation And Evidence Base

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There is evidence that postural management equipment can improve the participation of children with a severe disability, in terms of social interaction, communication, eating, drinking, and upper limb function, as well as physiological functioning (pulmonary and urinary tract) The 'how' and 'when' and for 'whom' of PM however needs further evidence. For example with regard to standing there is no evidence that provides guidance on the most effective posture that should be achieved within supported standing, nor consideration for the opportunities for movement within the support and how this may impact on function and development.

The same can be said for orthotics, where there is evidence that function may be improved but to date, the effects on deformity are not well supported by research.

*The need for reliable and valid measurement tools combined with rigorous research methodology was recommended in order to provide objective evidence for postural management.*

However even without a designated research study, very useful data can be collected clinically from pooled single cases, provided common criteria and outcome measures are used. These measures should quantify functional and quality of life issues, consider the satisfaction of child, carer and professional, as well as measure posture and deformity.

A data base to support this audit could be modelled on ReTIS (rehabilitation technology information service) designed for Scottish needs.

A key point that emerged was that by using the ICF framework ( WHO, 2001) intervention can be individually tailored to the context of the child and family rather than the focus being on postural management and deformities. For PM to work in schools, a common shared aim of the entire team involved with the child is needed, as is parental involvement from an early stage. Postural care pathways provide this structure and facilitate proactive and consistent implementation of PM. A mother at the meeting who has an 11 year old son with severe CP, described her experiences of surgery and postural management, emphasizing how essential comprehensive carer support and training is in order for PM to be feasible.

The financial and resource implications associated with PM for children were addressed by Sandy Clarke from the DoH (ICES/CSIP). She quoted from

recent legislation and government initiatives concerned with the provision of equipment for children, in particular the National Service Frameworks for Children, Young People and Maternity Services (2004) and for those with a Long-Term Conditions (2005). National standards state that following best practice, children should have timely access to the equipment they need, when and where they need it. Clinically, however, the story is of fragmented services, too few therapists and unreliable and insufficient funding. Her key recommendations echo those already highlighted. In addition she focussed on the need for there to be integrated LA/ LEA provision to make better use of limited resources, to pool budgets, and quantify unmet need.

In reality there are many practical problems in implementing effective 24 hour postural management including time limitations, delays in acquiring equipment, and parental resistance. The organization of 24 hour postural management needs to be co-ordinated well, possibly highlighted as a specific part of a job description.

The meeting concluded that while the theoretical principles of 24 hour postural management are accepted, more objective evidence is needed as to practice. Specifically, how early does PM need to be introduced, which procedures and /or equipment are effective in promoting postural control and preventing deformities, and for whom. With common criteria, practical guidelines and defined outcome measures we could pool our clinical findings, which would add weight to the evidence base and in so doing improve provision for children with neurological disabilities.

A consensus statement and recommendations will be published as a result of the meeting.

Palisano et al (1997) Gross motor Function Classification System for Cerebral Palsy, *Dev. Med. Child Neurol.*; 39; 214-223  
<http://www-fhs.mcmaster.ca/canchild/>

Disabled Child - National Service Framework for Children, Young People and Maternity Services (2004) page 18.  
<http://www.dh.gov.uk>

This report was first published in NAPOT Journal, Vol 9 no.2 Summer 2005 p17 - 19 has been reprinted with kind permission of NAPOT.

# Survey of Musculoskeletal Disorders in Physiotherapists and Physiotherapy Assistants

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Musculoskeletal disorders (MSDs) are one of the most common causes of severe long-term pain and physical disability and are considered one of the biggest health problems facing workers today. But how are physiotherapists and physiotherapy assistants affected by work-related MSDs?

In a new report, the extent of work-related musculoskeletal disorders in CSP members is revealed. Based on a survey of 3,661 physiotherapists, physiotherapy assistants and physiotherapy students on clinical placement, the report discusses the results of what is the largest health and safety study the CSP has ever undertaken.

According to our study, 68% of physiotherapists, physiotherapy assistants and physiotherapy students on clinical placement reported a work-related musculoskeletal disorder (MSD). The low back is the area of greatest concern for CSP members, with 48% having experienced work-related low back pain. Forty per cent (40%) have experienced work-related hand, wrist or thumb problems: a finding that worries the CSP as a physiotherapist's hands are the tools of their trade.

Of further concern to the CSP is the finding that 44% have not had a risk assessment in their current post, suggesting that many employers may be failing in their duty of care (risk assessment is a legal obligation on employers, forming part of the Management of Health and Safety at Work Regulations 1999). The Society is calling on NHS and private sector employers to ensure risk assessments are carried out promptly and thoroughly, and in accordance with legal obligations.

Another major finding from our survey is the significant under-reporting of injury. This is an issue because under-reporting of injuries undermines official action: if a problem is 'invisible', how do you know it's there and how can you solve it? One way of trying to establish the extent of the work-related musculoskeletal problem in your workplace is to

encourage reporting of injuries. There are many reasons why CSP members are reluctant to report injury: fear of being viewed as a 'bad' physio and a reluctance to have a work-related injury 'on-the-record' are just two examples. Yet reporting of injuries should be encouraged and barriers to official reporting identified. Introducing 'pain prompts' and body mapping at the end of shifts or the working day may prove useful tools in encouraging CSP members to log and report symptoms. Getting a handle on the scale of the problem can help early diagnosis and help identify where timely action can minimise cumulative injury and absence, and prevent possible injury claims at a later juncture. One other barrier to official reporting is the daunting size and nature of the workplace accident form. Focus groups held with CSP members to discuss the survey results revealed a strong desire for workplace injury forms to be redesigned, preferably with physio-input to help make the form more user-friendly and useful to the 90% of injured CSP members who would not consider filling one in currently.

A third main finding from our study is the increased risk of injury to newly qualified graduates.

As a result of this study the CSP is calling for all physiotherapy departments to be given the right resources to put in place effective strategies to prevent work-related musculoskeletal injury.

The CSP also wants the Department of Health and NHS Employers to fund an ergonomic research study into the design of physiotherapy departments, aimed at identifying 'best practice' design features and eliminating those poor working environments that contribute to bad posture.

The CSP is also calling for:

- More resources and assistance for physiotherapy departments to put in place effective preventive strategies to reduce risks and prevent injury
- Employers to review training needs, paying particular attention to rotations where risk factors may vary, induction programmes and mentoring schemes (younger physiotherapists and newly qualified graduates are most at risk of injury)
- A review of electronic booking-in systems to give physios the flexibility to balance appointments for 'light duty' patients with those requiring a greater degree of manual therapy techniques, to help reduce the risk of repetitive strain injury
- Workplace accident forms to be made more user-friendly, to encourage reporting of injuries
- Physiotherapy and other Occupational Health services to be available on-site

## Survey of Musculoskeletal Disorders in Physiotherapists and Physiotherapy Assistants

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The findings and conclusions contained in the report are relevant to arguably all strands of the physiotherapy profession. We are urging all physiotherapy departments to invest in a copy of the report, which can be used as a reference document or training tool.

Tackling work-related musculoskeletal disorders is a challenge for all of us. Musculoskeletal damage resulting from the practice of physiotherapy is not inevitable, and musculoskeletal injury is not a quid pro quo of the job. But physiotherapists and assistants continue to get injured at work despite their specialist knowledge.

Work-related musculoskeletal disorders affecting members of the Chartered Society of Physiotherapy costs £10 (members); £12.50 (non-members). Copies can be ordered from the Enquiry Handling Unit (EHU), CSP, 14 Bedford Row, London WC1R 4ED. Telephone +44 2 07 306 6666; email enquiries@csp.org.uk. An extract from the report was first published in *Physiotherapy*, Volume 91, Number 3, September 2005 pages 138-147. Contained in the report:

- Injury statistics of CSP members (over 40 tables)
- What type of injury matters most to physiotherapists
- Career stage where most injuries occur
- Injuries by clinical setting
- Use of mobilisation techniques and thumb injury
- Job risk factors CSP members implicate in their injury
- Physiotherapists' responses to injury
- Preventive strategies adopted to avoid reinjury
- Case studies

The report also compares the prevalence of work-related MSDs in CSP members to that found in physical therapists in Australia, Canada, Kuwait, Slovenia, Turkey and the USA.

The report considers the challenges faced by the profession if the relatively high levels of work-related musculoskeletal injury are to be tackled effectively. These include:

- Information rich, practice poor? Implications for clinical educators and training
- Inducted into illness? Why we need a fresh look at induction programmes, rotations, mentoring and more supervision in the early years
- The culture of physiotherapy: why the profession needs to work towards a new paradigm of physiotherapy practice
- Individual action: six steps to better workplace health
- Taken to task: addressing the workplace environment

The CSP's research study was conducted in part in response to a motion at the 1999 Annual Representative Conference that called on the CSP to investigate and raise awareness of the extent of MSDs in physiotherapists. The information gathered from the study and included in the report provides the CSP, for the first time, with baseline data on the prevalence of work-related musculoskeletal disorders amongst members and adds to the growing body of survey evidence on MSDs and physiotherapists.

## Minutes of the 32nd Annual General Meeting held on Friday 7th October at Birmingham

The Chairman, Lesley Smith reminded those present that this meeting was for members only

### 1. Apologies

Apologies were received from Adare Brady Julia Graham Jeanne Hartley, Ruth Davies Linda Fisher Lorna Stybelska, Felicity Dickson Rachael Hufton

### 2. Minutes

The minutes of the 31st Annual General Meeting held at the Crown plaza hotel, Liverpool were available for members to read.

**Proposed: Christine Shaw**

**Seconded: Sally Braithwaite**

### 3. Matters arising

No matters raised

### 4. Chairman's Report, 2004-2005 Lesley Smith

Welcome to the 32nd Annual general meeting of the National Association of Paediatric Physiotherapists. My predecessor Adare Brady chaired the last AGM in Liverpool on 1st May 2004 some 17 months ago. The alteration to an autumn date is the conclusion of considerable work, planning and changes to the constitution to allow conference to coincide to an autumn date compatible with the full CSP conference. Our plans are potentially to join the full conference every third year.

However such is the length of the planning cycle that the 2005 conference plan was already well in hand and as such took place in Wales at Swansea University at the beginning of April. Our thanks go to Jill Williams, and the Welsh committee for hosting a most successful and profitable event.

Affiliated Groups have been a leading component in the shape of APCP development. Following the success of the Neonatal Group, The Critical Care/Respiratory Group is now affiliated with identified office bearers and a liaison representative who will attend APCP meetings.

More recently the 3rd affiliate group has emerged. The Neuromuscular Group held their inaugural meeting at the CSP on 27 May they also have identified their committee and have extremely exciting plans in place.

Although not an affiliated group as such Spasticity Management is obviously a clinical area of much interest for paediatric physiotherapists, Lesley Katchbrian has been coordinating meeting for approx the last year re Botulinum Toxin. Approx 70

interested parties attended a study day on 26 Sept entitled Reflection on Current Practice. Work to date and future plans will be made available through ICSP.

The much planned DCD Scoping meeting has now taken place. Sally Braithwaite is chairing this National Working Group and I am pleased that Gill Brown, of NAPOT is part of this group who will be looking at possible inter disciplinary UK guidelines for working with children with developmental coordination disorder.

Website development was high on the agenda many months ago and progress to date has been disappointingly extremely slow. Rob Ledger at CSP's main commitment has required to be in developing the CSP website with APCP's link following in the wake. I am happy to report that the basic APCP website has been reregistered and has been launched as of this conference.

Particular note should be made of the major Publication of 2005 the much-awaited Outcome Measures Pack, which was launched at Swansea. Our thanks particularly go to Adele Leake for the huge amount of work undertaken and also to the PPIMS group chaired by Carol McKay, in proof reading this document to bring to publication standard.

I wish to congratulate Sally Braithwaite on yet again pulling together our very excellent and informative journal over the past 17 months. A task which she will be handing over to Dr Terry Pountney with Decembers issue. I am sure this much enjoyed and looked forward to aspect of APCP life is moving into Terry's very capable hands. Thank you Sally for all your editorial expertise and work with the printers.

Plagiocephely Peta Smith is working with Prahb Salaman PRO at CSP regarding producing a "Tummy Time" leaflet and APCP have representatives invited to various DOH committees and meetings including NSF, Skills for Health, and Downs Syndrome Working Party.

The committee is conscious of the ever increasing requests of time, and commitment from our CIG to participate in significant pieces of work and we will therefore be writing to DOH to urge support/time off. (this being in line with recommendations made by Leonie Dawson CSP)

The Royal College of Paediatrics and Child Health invited representatives from APCP on the evening of 6 July I attended with Laura Wiggins. This was a scoping meeting with other AHP colleagues invited from Speech and Language, Occupational Therapy and Dietetics. Our agreed shared aim is to work to improve the health and wellbeing of children. The next meeting planned for 9 November 2005.

## **APCP Matters**

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The apparent convenience of the meeting at the Royal College on evening of 6 July coinciding with APCP meetings of 7th and 8th July was short lived as the events on the following morning required rapid cancellation of the various meetings, which were to take place on Thursday in preparation for the full meeting on Friday 8 July 2005. Thankfully no one was directly involved with the bombings and I wish to thank all who helped with communication and information over this difficult time. Subsequent to this cancellation the Exec reconvened Monday 12 September and the National Committee meeting took place to catch up yesterday.

The cancellation of the scheduled meetings in July brings home the considerable work that is undertaken by the various officers on APCP behalf and I wish to acknowledge The contribution by CIG liaison, Diversity, Editorial, Education, Membership, PRO, Publication's Research, Treasurer and All Regional Reps. Work required in all areas increases year on year and the need to support these offices with small teams or individuals or functioning in a shadowing capacity has become the way we as a committee see these varied and complex aspects of our structure developing.

I wish to acknowledge the sad loss earlier this year of Ann Grimley and share with you a little about her from an appreciation written by Dr John McKinlay. Ann Grimley was obviously a team player as he records. Her determination to promote team work across disciplines was a hallmark of her successful clinical career in Salford. S & L therapists, OT's, Orthotist's, Wheelchair engineers and all sorts of doctors were made most welcome in her department, and combined clinics there became frequent. The setting was bright and spacious. Families and children were encouraged to enjoy their visits. As a clinician Ann was beloved by children and families. Trainees and students had outstanding learning opportunities. In service post graduate education of a high standard was one of her passions and when paediatric physiotherapy was a tender plant in the CSP's allotment Ann was one of a group of remarkable gardeners bringing it to maturity and confidence. They established APCP conference, The Journal and procedures within The Chartered Society. Ann Grimley a great founder of APCP.

### **Adoption of the Chairman's report**

**Proposed: Mary Harrison**

**Seconded: Alison Gilmour**

### **5. Treasurer's Report 2005 Fiona Down**

The treasurer's report was published in the September APCP journal

#### **Adoption of the Treasurers report**

**Proposed: Sally Braithwaite**

**Seconded: Sue Coombe**

### **6. Adoption of the Auditors.**

The Nicklin Partnership was formally adopted

**Proposed: Fiona Down**

**Seconded: Sue Coombe**

### **7. PRO's Report Gill Holmes**

As APCP Chair Di Coggins had the vision of an APCP website and set up the original site. This proved to be popular with paediatric physiotherapists, patients, parents and other healthcare professionals. Unfortunately the structure was not sufficiently sophisticated to meet all the demands of a well used website and was extremely difficult to update and therefore discussions took place with the CSP about developing a new interactive web site. This has been undertaken by Rob Ledger and his team from the CSP who have built and developed iCSP and who was in a good position to guide us through the process of creating a new APCP website which would meet the demands of an increasingly IT literate profession. It is therefore with great pleasure and relief that I can now say that the website is ready to be launched. The site is still under construction and therefore will not be in its final form for some time to come, but hopefully it is something which will grow with the Association, changing to meet the demands of our profession. I would like to thank Rob and his team for their support and advice. Training of the team of moderators led by the incoming PRO will be arranged shortly.

As PRO I am asked for promotional literature as is Lorna Stybelska Publications Officer – all of which are now out of date, and so a group met to discuss and create new leaflets. The plan is that there will be two leaflets one aimed at professionals explaining the role of paediatric physiotherapy, the other for children. Lorna and I decided that we would create a publicity pack for therapists which will consist of large posters, A4 posters, copies of the new leaflets, APCP pens and APCP balloons. Pens and balloons have been printed with the APCP logo and are available from the stand. The final format of the leaflets will be decided at the working week-end in March 2006. I would like to thank Linda Whittaker a member of the Liverpool Conference Committee for her help with the purchase of the pens and balloons.

APCP has been involved in supporting the setting up of a Neuromuscular Disease Clinical Interest Group which will exist as a specialist sub group of

## APCP Matters

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APCP with close links and support from the Muscular Dystrophy Campaign Group. An inaugural meeting took place at the CSP Headquarters in May 2005 and there are more than 60 physiotherapists who are interested in becoming members. A second study day on the Neuromuscular Foot has been organised for 28th November at Alder Hey Children's Hospital and is aimed at paediatric physiotherapists and orthotists. The group aim to take part in APCP Conference in Glasgow 2006.

Finally as this is my final meeting as PRO I would like to wish Lyndsay Rae all the best in her new role as APCP PRO.

### 8. Research Officer's Report Jeanne Hartley

First of all my apologies for not being here to present this report in person today.

I have now been Research Officer for APCP for nearly 18 months and have been fascinated, intrigued, amazed and awed by some of the enquiries and discussions I have had with members, whether by e-mail or over the phone. It is wonderful to think that so many of you are involved in research, want to discuss ideas or appropriate methodologies and for me, as someone who feels passionately that the best outcome of any intervention is the patient/client's opinion, an increasing interest in and commitment to qualitative research. I can now imagine lots of you muttering 'Qualitative research doesn't count!' but once you hear, as I did this week, an orthopaedic surgeon saying how important it was to look at functional outcomes rather than measuring results on a X-ray, things are surely changing. I picked myself up off the ground (tried not to hug him!) and enthusiastically agreed to help with his proposed study!

Finding the time for research, in amongst your busy clinical commitments, is an ongoing issue as we push increasing large piles of paper around our desks and chase targets. Developing sound evidence based practice is vital – not only so that we do not waste our time, as well as that of the children and families, in pursuing ineffective treatments that have been used from time immemorial or the new but suspect 'in thing', because all this has to be funded. Purchasers are now looking for value for money! They will soon start looking at what physiotherapy is all about and we need to be ready! I do try to keep you all up to date with funding opportunities etc in the Journal – you would be surprised how many calls for applications for funding have such short notice that there is no chance of getting it into the Journal – but ring me up or e-mail me – as I may have information available

that's just right for you. Once the new APCP website is up and running this information should be more easily available to you.

Many of you have registered your research interests. Thank you. For those of you who haven't done so please do think about it. It is a good way of making contact with people with similar research interests, especially as a forum for sharing ideas, peer support etc as well as perhaps combining with other centres to increase population numbers and therefore the power of the study.

During the autumn I am very busy with enquiries from students wanting help with their undergraduate projects, mostly with questionnaires but occasionally telephone interviews and discussion groups. Again many thanks to all of you who so kindly help and I know the students do appreciate it as they tell me so. Please do contact me if you would like to help – either fill in the form that appears from time to time in the Journal or contact me. You never know – your help may be the thing that gets them interested in paediatrics in the long term. I am delighted to report that one student, Fiona-Jayne Simpson, received such help, won the student prize and has a poster on display at Conference! No mean achievement.

It was hoped that small APCP research groups would grow like mushrooms around the regions but despite best efforts little has happened. I will be chasing the local regions to encourage them to organise regular research meetings over the next few months. There is small informal group in London, which hopefully will continue to flourish. I have found it useful to be in an informal environment where I feel relaxed in confessing my fear of statistical analysis, find others feel the same or with luck one of the group will tell you of an easier way to look at the data. Look for information about the London meetings in the Journal and ring or just turn up – you'll be very welcome. Finding friendly support when you are in the middle of a research proposal is so useful - if there is no group in your area please consider forming one. So far suggestions of a national forum/study day on research topics or to disseminate research findings has been met with apathy so perhaps local groups will have to suffice for the moment. Those of you involved in MSc projects etc please remember you are obliged to tell others of what you found, even if you think it isn't significant. You may feel that standing up at a conference a little daunting but consider publishing your study findings. The Journal is always keen for such items. (Memo to Jeanne – *stop* the prevarication and practice what you preach!)

Research Bursaries: Last year three people applied for research bursaries and I am pleased to report that one person was successful in obtaining funding. This study will look at the effect of different angles

of tilt-in-space wheelchairs on the posture and function of children with cerebral palsy. A fascinating study, the findings of which will be important to those of you who work in this field. It was decided that further funding would not be available until 2005 and I hope that, after discussion at the National Committee meeting yesterday, an announcement will be made in the next Journal inviting applicants. I know there have been a few enquiries so it is great to see such interest from members.

### **9. Education Liaison Officer's Report. Adele Leake**

#### **10. Election of Committee Members.**

A notice of committee vacancies was published in the September 2005 APCP journal and in Frontline. The secretary received nominations who were elected to the committee unopposed. The members are

Christine Sneade: proposed by Helen Hollet and seconded by Sue Walmsley

Terry Pountney: proposed by Christine Shaw and seconded by Peta Smith

Lindsay Rae: proposed by Sally Braithwaite and seconded by Claire Hill

Sue Coombe: proposed by Ruth Vaughan and seconded by Debra Chaney

#### **11 AOCB**

No further issues discussed

#### **14. Date, time and place of next AGM**

The next AGM will be held in November 2006, Glasgow the date and time to be confirmed and published in the APCP journal.

The meeting closed at 4.06pm

## **Chairs report from Neo-natal Group APCP AGM Bristol October 2005**

Three years! How time has flown. It gives me such great pleasure to welcome you all to the third AGM of the Neonatal Group APCP here in Bristol. It is good to see many familiar faces and, encouragingly, new ones, gathered together giving us the opportunity to network, share information, or just catch up with all the gossip!

2004/5 has posed new challenges for paediatric physiotherapists across the country with the publication of 'Every Child Matters', the Children Act and the NSF for Children Young People and Maternity Services and Fitness for Purpose.

Every child matters-the Change for Children programme paves the way for more multi-agency services delivering a range of early intervention and preventive work and challenges us to work more closely and collaboratively with all colleagues.

The aims of Every Child Matters, Change for Children, for children to be healthy, stay safe, to enjoy and achieve, make positive contributions and achieve economic wellbeing are at the heart of the Children Act 2004.

This Act, along with the standards described in the NSF for Children and Young People ensures we must all make these aims top priorities for all children and young people, and will guide us to achieve these outcomes on behalf of all children and families.

Neonatal Care requires team work in order to provide consistent, safe and effective models of care aimed at promoting positive outcomes for the vulnerable infants who are admitted to our NICU's. The field of neonatology continues to attract physiotherapists, occupational therapists and speech and language therapists, and our expertise and knowledge of infant development and respiratory care is being increasingly acknowledged and sought after within our own specialist areas by our neonatal Team colleagues if not by our physiotherapy service managers.

The Neonatal Physiotherapy group has been contacted frequently throughout the year for advice from physiotherapists across the country who are hoping to develop services into Neonatal Intensive Care Units. This is either by an 'in-reach' model from the Community services into the acute setting, or as an 'out-reach model' from the acute setting into the community. Either way these models of care promote continuity of care for the families we work with, and hopefully establish strong communication links between the two providers promoting family centred care which will benefit the children and their families



## APCP Matters

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It is an uncertain time for those of us working within the NHS for children's services as yet again System Reform and Organisational Design is upon us through Fitness for Purpose - Commissioning a patient led NHS. Who knows who will be the providers or commissioners of Children's community services?

In the future much of the current commissioning function of existing PCT's will be devolved to GP practices and so the relationships between PCT's and acute NHS trusts will change due to patient choice and an increase in the number of providers. Will GP clusters want to commission our services? Will they be aligned by vertical integration into the Acute Foundation Trusts, or devolved to Children's Trusts or Healthcare trusts or Commercial Mutuals. The debate rages on.

The development for Children's Trusts is required under the Children Act, and so adds another factor to the equation. Lets hope despite all this the valuable clinical input we provide for neonates is not lost or forgotten in the melee.

In the past year the Neonatal Group has continued its close affiliation with APCP and I am pleased to report that two other specialist groups have followed our lead into becoming affiliated to APCP, the Critical Care group, and more recently the neuro-muscular group. APCP's support and advice is invaluable to the continued success of the Group and they have agreed to give financial support to specific pieces of work that we may want to undertake to advance, promote or ensure the standard of neonatal physiotherapy. APCP has just launched its new website at CSP Congress 2 weeks ago. [www.apcp.org.uk](http://www.apcp.org.uk)

There has been a delay in the development of the site as there have been problems rolling out the national icsp site, which is being developed at the same time through the CSP. Further development of the APCP site is on-going. This site is open to the public but also has a secure site for the membership only. It is envisaged that the neonatal group will have its own page on the secure site for us to use as we wish, but could include interactive communication, information sharing and exchange, posting of fliers and details of who we are and what we are up to. This is very exciting and I hope that eventually it will become a useful and valuable tool and an effective method of information exchange and sharing and communication.

On behalf of you all my thanks go to the National Committee of APCP for the encouragement help and support they have given our Group over the past year.

Our own Committee has worked hard throughout the year to help us move forward in achieving our original objectives.

One of our major achievements this year was the publication and launch of the 'Handle Me with Care, supporting your premature baby's development' booklet compiled and produced in a collaborative working partnership with Bliss, the premature baby charity. These booklets are available to parents free of charge from Bliss and professionals, or Units can order them for the price of package and postage. I must express my very sincere thanks to the members of the working party who successfully saw this project through to completion, Sue Angus, Katrina Blenkinsopp, Christine Brown, Allie Carter, Pat Dulson and Helen Robinson. From Bliss, Shanit Marshall, Janice Pepperell, Maria Porter and Farrah Pradhan, the parents and specialist physiotherapists, occupational therapists and neonatal staff for their input and advice and feedback. Special thanks go to the babies and parents St Thomas's Hospital, NICU London, and the East Kent NICU of William Harvey Hospital Ashford and also to Barbara Lucas, a neonatal physiotherapist of North Shore Hospital Sydney on who's original idea this booklet was based.

We are at present hoping to produce a joint poster based on the booklet with Bliss, which should be available later this year. Feedback from parents, physiotherapists and our medical and nursing colleagues around the country has been positive and encouraging. I hope you have all managed to collect your free copies of the booklet along with the 'Look at Me I'm Talking to You' booklet which should be read in conjunction with the Handle Me with Care booklet.

In December last year members of the committee met in Nottingham to field test 5 of the competences from the Children's National Workforce Competence Framework, Maternity and Care of the New born. These national occupational standards, developed by the health workforce, led by Skills for Health, describe good practice. The standards have been developed to guide practice, improve the capacity and capability of the public health workforce. They are designed to set out what practitioners need to be able to do, and what they need to know in order to offer services to the public. Each competence includes both performance criteria and knowledge and understanding criteria, and is developed to encapsulate best practice in the area. The Maternity and Care of the newborn framework is the product of work carried out over the past 2-3 years in which a large number of organisations, teams and individuals have been involved. I was very happy to represent the NNG APCP at these meetings and pleased that we were able to contribute our thoughts, opinions and ideas to the competences. We hope to be able to advise

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paediatric Physiotherapy Service managers and Heads of Service of the importance of the Workforce Competence framework when developing services and posts for specialist neonatal physiotherapists within the NICU's, also when developing KSF outlines for such posts. They will help to define the responsibilities of the post holder, the job description and importantly be useful within the appraisal process. Further information on the Skills for Health national Workforce Competences are available on their website [www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk)

The Group continues to strive towards establishing high standards of safe, effective, evidenced based practice nationally and to develop clear guidelines for service provision.

Competence to practice in this specialist field, which requires skills and knowledge beyond the scope of standard paediatric physiotherapists, therefore continues to be high on the Agenda for 2006. We are planning to use the Skills for Health competences to establish clear guidelines for neonatal physiotherapy practice, and a working party of neonatal physiotherapists has been set up to identify and make recommendations for the competencies required by physiotherapists working in this field, to ensure that standards for good practice within the profession are maintained. APCP is also working towards identifying competences for paediatric physiotherapist throughout the UK and the working party will be working closely with them to achieve this aim.

The Skills for Healthy Competences can also be used to develop and provide APCP/CSP accredited courses and Fiona Price, Education Officer will outline these to you in her report.

The National Committee's committed efforts to raise our profile and recognition continues to pay off, we still jump up and down and shout about our presence to all and sundry. As a result more people begin to acknowledge Neonatal Group APCP and invite us to have representation contributing our expertise, advanced knowledge and skill to various projects.

In May 2005 I was contacted by the Scottish Home Safety group asking to support a motion, being placed before the National Home and Leisure Committee of RoSPA, calling for a ban on baby walkers throughout the UK.

A report was compiled and sent to them report outlining our position on the matter and supporting the motion. In June I received a letter from Sarah Colles, Home Safety Advisor at RoSPA thanking us very much for our support and informing us that the

Committee had voted to request a Europe wide ban on baby walkers. Members of the Baby products association were in attendance at that meeting. She reports that they have not yet decided on a plan of action to achieve this but was pleased to let us know they had crossed the first hurdle. So watch this space!

In June we were invited to comment on a Consultation document from the Nuffield Council on Bioethics on The Ethics of Prolonging Life in Foetuses and the Newborn. This foundation was formed in 1991 to identify, examine and report on the ethical questions raised by recent advances in biological and medical research. In September 2004 the Council established a working party to consider the ethical, social, legal and economic issues involved in saving the lives of fetuses and the newborn. The public consultation period closed on June 25th 2005 and the Working Party is now considering the issues that they raise. The responses will be available to download from it's website after the Working Party has published its Report, which is expected to be towards the end of 2006. Website [www.nuffieldbioethics.org](http://www.nuffieldbioethics.org)

The tummy time and plagiocephally leaflets project is still on-going and I must admit it is mainly the pressure of work commitments by myself, and Jeanne Hartley Research Officer APCP that has delayed this project, along with awaiting the production of an APCP photography consent form. It is planned that we will endeavour to complete this project in the following year with the leaflets being distributed at primary care level. Prabh Salaman from PR office at the CSP is supporting the project and she is looking into sponsorship to cover printing costs with babyproduct companies.

The Committee has also identified a piece of work needed to develop evidenced based care pathways and guidance for the treatment or should I say non-treatment of positional talipes. This project is not a priority objective for this year but if anyone is interested in being involved in this project please contact any member of the committee.

So we have continued to grow and develop. I am pleased to announce two members of the national committee have taken neonatal interests to the ultimate research level by producing off- spring of their own over the past 12 months! Congratulations go to Anna Mayhew on the birth of her son Finn who is one year old today and Nicky McNarry on the arrival of Max.

I also had a welcome email from Emma Cameron nee Sinnamon from Dubai in May announcing the proud arrival of her daughter Niamh. She reports that her research findings up until the 4 month result should be published this year in Pediatric Physiotherapy but as yet she doesn't know which

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edition. Term age comparisons between FT and PT items of motor development has also been sent to Pediatric PT for publication consideration. She continues to carry out her research in the field of neonates and has just completed a study in Dubai looking at pain responses and handling procedures in NICU, which she will be writing up in due course.

I am happy to report that next year the neonatal group has been invited by the Scottish Organising Committee, to hold our own satellite Conference at the APCP National Conference in Glasgow which we have accepted. The Conference will take place in November. The theme of the Conference is 'Moving Forward- Challenging Expectations'. The Neonatal satellite programme will take place on Saturday November 11th and will include next years AGM.

Laila de Groot has kindly accepted our invitation to speak on this day. Many of you will know she is a physiotherapist from the Netherlands who is internationally acclaimed for her research with preterm infants. She continues to work in the Neonatology division of University of Amsterdam. Her main field of interest and research has been in infant development particularly prematurely born infants and their follow-up. Should be exciting so please join us there! She has also been invited by the main APCP conference to give a keynote lecture on the Saturday morning.

My sincere thanks go to all the members of the committee for their hard work and support throughout this past year. It is not easy committing time and effort whilst trying to hold down your job, be a full time wife, mother or partner even if it is for an organisation that you so strongly believe and care about. A lot of the hard work is compensated for by the friendships formed, the peer support and enthusiasm. We have managed to conduct most of our business via email which is quick convenient and less costly in time and expenses than meeting regularly across the UK. The APCP NNG webpages will also, hopefully, make dissemination of information quicker and easier to the membership allowing you all to have the chance to express your views and opinions and share your expertise when we, as a Group are asked to contribute, consider and comment on specific projects or concerns.

If any members are interested in joining the committee I can assure you that it is not as daunting as you may think, and that many of you out there will have a lot to offer. If you are interested please contact the any member of the Committee.

Finally it is with much regret that I have to announce Nicky McNarry has decided to stand down as Secretary to the group and I personally would like to

thank her for all her effort and commitment in the Group's early development. She has endlessly dealt with enquiries, membership and compiled and updated the database of expertise and organised us for our meetings. She continued on throughout her pregnancy and Max's arrival. Many thanks Nicky. She has agreed to stay on the national committee.

I also have to tell you that I have decided to stand down as Chair of the Group. Next year I take on the role of Chair of APCP National Committee and feel that I will not be able to devote the time and commitment to the neonatal group that it deserves. New blood is always a good thing for any organisation and it is also time that someone else takes hold of the reins and guides us through the next few years, I am therefore very happy to report to you that at yesterday's committee meeting Adare Brady was voted in as the new Chair. I plan to remain on the Committee for the next few years and to continue to offer my support.

I will of course not forget my real roots and will strive to continue to promote the role of the paediatric neonatal physiotherapy in my time as Chair of APCP at every opportunity!

Thank you

Peta Smith  
Chair Neonatal Group APCP  
October 2005

## Research and Education

**The Nancie Finnie Charitable Trust**  
**(Registered Charity No.1082707)**

The Trustees of the Nancie Finnie Charitable Trust invite applications from suitably qualified therapists wishing to undertake research in the area of treatment / rehabilitation of the child with cerebral palsy. Multidisciplinary projects are encouraged. The Trust is small providing for an annual distribution of funds in the range of £25K- £30K.

Application form and guidelines may be obtained by writing to the Trust's principal office at 18 Nassau Road, Barnes, London, SW13 9QE, enclosing a large stamped self-addressed envelope. Applicants are encouraged to send a synopsis of the proposed work in the first instance. Applications must be received no later than **30 April, 2006**.

# Regional and Sub-Group Reports

## SCOTLAND

Janet Parkinson our training officer and Ann Kendal our treasurer joined me at CSP Congress at the International Conference Centre in Birmingham. This was the first time I had attended CSP Congress, an enjoyable and interesting experience. I particularly enjoyed attending the Awards Ceremony to see Viv Williams receive her Fellowship for her work in the development of physiotherapy services for children in South Wales and Bulgaria.

Ann, Janet and I particularly enjoyed the APCP Programme within Congress. The Paediatric Pilates Sessions by Mary Anne Houghton, Director of South Manchester Physiotherapy and Pilvcatcs Ltd were excellent and Janet is going to contact her in the hope of setting up a Study Day in Scotland in the Spring 2006. The memory of a room full of paediatric physiotherapists doing weird and wonderful things with small spiky balls will do much to de-stress the three of us as we work towards completing the organisation of APCP Conference Glasgow 2006!

The next regional committee meeting for Scotland is on Friday 18th November in the Crown Plaza Hotel in Glasgow, the venue for the APCP Conference 2006. The hotel is being refurbished at the moment and our visit will give all the organising committee an opportunity to familiarise themselves with conference venue and to clarify any issues which may arise.

The National Committee have decided that each year one of the affiliated special interest groups will have the opportunity to hold a study day and AGM within the National APCP Conference. In 2006 the Neo Natal Group are planning a study day and AGM for Saturday 11th November. The clinical interests of the Critical Care Group and the Neuron Muscular Group will be reflected through the speakers in the main conference programme. The APCP Conference in Glasgow in November 2006 will be the first APCP Conference in which the clinical interests of the Affiliated Groups will be specifically included in the programme. We hope that by making the programme inclusive of these affiliated groups, it will meet the interest of a wide range of APCP members across the whole country and we will attract Conference delegates from "au the airts" translated as from all parts of Britain.

ALISON GILMOUR

## NORTH EAST

This is my first report as regional rep and first of all I would like to thank Mary Harrison on your behalf for the thoroughly brilliant job she has done in this post during her term in office. Here's hoping for a slightly more restful retirement! I hope to keep you as well informed as she did.

As well as being your regional rep I am also a moderator for the newly launched iCSP website and the link moderator between iCSP and APCP. Please make good use of the site after re-registering. I think you will find it easier to navigate than previously.

By the time you read this we will have held our autumn course on DCD and looking forward to 29th March when we will hold a course on muscle strengthening in CP. It will be held in N Tyneside and the speaker is Jan Morton from Glasgow. The AGM will be held on the same day together with a discussion about research. Please come prepared to contribute to this discussion.

Please also remember to renew your membership of APCP. Taking out a direct debit eases the list of things to remember at this time of year leaving you free to enjoy Christmas more fully!!

If you would like to serve on our friendly committee please contact us for an informal chat.

HEATHER ANGILLEY

## LONDON

As the end of the year is fast approaching London region goes from strength to strength. We have a full committee and have welcomed 2 new committee members; Zoe Humphrey-Gaskin and Merete Olsen. London membership has equalled previous years and new members have joined each month. If you don't subscribe by direct debit please don't forget to renew your membership ASAP to receive journals on time and to benefit course offers for the whole year. Please encourage new members as there are lots of benefits.

London region also says a big thank you to Sally Braithwaite as she steps down as Journal editor for everything she has done to give us the new and improved Journal. We welcome to Terry Pountney who takes over.

Support for the evening lectures on HIV and Postural management was excellent. The feedback has been very positive and new ideas have come in thick and fast. We now have suggestions to keep us busy for the next 2 years. Now comes the task of finding speakers foolish enough to come out on evenings when, no matter what time of year, it always seem to be raining!

## **Regional and Sub-Group Reports**

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The cost of training and lack of training budgets are always in our thoughts when we put lectures together. We have had a number of members request more detailed training for a full day. We are considering the viability of this, and which topics would have widespread appeal. If you want to feed back your ideas please email Christina or me.

A couple of reminders:

If you haven't sent back the questionnaire on sleep systems from the last journal, please do send the form back even if you don't have experience with using them.

If you haven't returned your Botulinum toxin questionnaire again please do. More copies can be obtained from Lesley Katchburian at [katchl@gosh.nhs.uk](mailto:katchl@gosh.nhs.uk)

I wish you a very happy new year and look forward to a lively and inspiring 2006.

STEPHANIE CAWKER

### **SOUTH EAST**

Since I wrote the last report we have organised a very successful Study Day and AGM. The attendance was much better than last year so perhaps those questionnaires which many of you completed (thanks to everyone who did take the time to fill them in and post them back) and which we collated achieved their aims. We chose a subject, Management of Pain in Children, a venue, Bluewater, and a day, Thursday, which appealed to many more of you ... maybe the cocktails and canapés helped too??? We're already making plans for 2006 so put 28th September in your diary and join us again at Bluewater!

The second APCP Conference of 2005 took place Birmingham in October – the only time when there will be 2 Conferences in one year – with some excellent speakers and interesting exhibitions. If you have never been to Conference you really should consider a trip to Glasgow in November 2006 – it's a great opportunity to catch up with all the latest happenings in paediatrics.

As I wrote in my previous report, we are already 'planning hard' for October 2007 when we will be hosting Conference in Brighton. Peta Smith (Vice Chair of National Committee and a member of our SE Region Committee) and I spent a very enjoyable day in Brighton visiting some of the nicest hotels on the sea front (gosh, it's hard work being on committee!) We now have to look for speakers and entertainment .... more hard work!

At our recent committee meeting we were delighted to welcome Rachel Naunton from Croydon as a new committee member. New faces and new voices are always a welcome addition as they help to bring in new ideas to stimulate discussion and innovation - would you like to join us too?

Finally, our next course will be in March 2006 but we still have to confirm the venue and the speaker. Watch out for the flyers and application forms and book early – perhaps you could use the £5.00 voucher from the AGM to reduce the cost?

Best wishes for a Happy Christmas and a good year in 2006.

ANN MARTIN

### **NORTH WEST**

There hasn't been a committee meeting since my last report and things have been generally very quiet in the region so this will be a brief report. As a committee we are meeting again in December and hope to have finalised the details of the orthopaedic study day to be held in March 2006.

We are looking ahead to next year and we have some thoughts on the kind of study days that we could organise but are always open to new ideas, so please feel free to contact the committee. In order to keep in line with the National AGM being at the latter end of the year we have also decided to move our regional AGM and Study Day to October time so please look out for details nearer the time.

Another point I've made before is not to forget that we have a number of bursaries available to assist towards study and attendance at courses/conferences. Apply in writing if interested and attach a brief outline of the purpose for the request and we will give it every consideration.

As I said this is only a brief report and all that is left for me to say is thank you for your continued support and being that time of year to wish you a very Merry Christmas and a Happy New Year.

ELAINE LLOYD

### **NEONATAL SPECIAL INTEREST GROUP (Affiliated to the APCP)**

Once again I find myself having returned from our study day and AGM at Bristol, where we were fortunate to hear an extremely interesting and informative lecture from Professor Peter Fleming on sleeping positions in preterm infants and the greatly increased incidence of SIDS. The research he was presenting is published on line and is available for down loading. It goes without saying that this will have significant implications for all of us working not only with preterm and low birth weight babies

## Regional and Sub-Group Reports

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but all babies under the age of 1 year. The details are [adc.bmjournals.com](http://adc.bmjournals.com) 'Sudden Infant Death Syndrome and sleeping position in pre-term and low birth weight infants: An opportunity for targeted intervention'.

The research highlights that preterm babies are more vulnerable in their sleeping positions, whether that be on the neonatal unit or once they are discharged home. We as health professions need to be clear about the message that we are giving our parents as they are more likely to remember what we 'do' than what we 'say'. The message that we heard loud and clear is that babies are no longer to be put to sleep on their sides. This may have an impact on how we advise parents of babies with conditions such as Torticollis and Plagiocephally but may also change the onus and place the responsibility with parents to actively interact with their babies during the day for play and developmental positioning.

The afternoon session commenced with an informative talk on nutrition in preterm infants by Dr Pamela Cairns, Consultant Paediatrician, Bristol. Pamela highlighted the fact that nutrition is important for longterm outcome and that boys who have been growth retarded are most at risk for longterm problems. Ongoing studies are looking at the link between fetal undernutrition in middle and late gestation and heart disease in later life.

The second speaker of the afternoon was Chrissie Israel, Clinical Trials Manager for the Preterm Infant Parenting Study (The PIP Study). Full details of the study can be found at [www.neonatalneurology.org.uk/PIP.htm](http://www.neonatalneurology.org.uk/PIP.htm)

Chrissie also discussed the Neurobehavioural Assessment of the Preterm Infant (NAPI assessment) which is used at 35 weeks post menstrual age -it has 7 neurobehavioural sections, 41 test items and 30 summary ratings. Chrissie can be contacted on [chrissie.israel@bristol.ac.uk](mailto:chrissie.israel@bristol.ac.uk)

BARBARA HAEDERLE

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# APCP Membership Application/Renewal 2006

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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 2006 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.

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**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, 36 Cascade Avenue, Muswell Hill, London, N10 3PU**. This information will be used to inform you of reseach study days and help us to learn more about our members' research interest.

Name

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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.*

# Writing for the APCP Journal

The aim of the APCP Journal is a forum to disseminate original research, facilitate continuing education for paediatric physiotherapists and provide an opportunity to debate all controversial issues.

Most articles should be no longer than 3,000 words excluding references and abstract. The types of article identified to achieve these aims include:

## Peer reviewed articles

Papers submitted under this section are all reviewed blind.

- *Research Report*

A report which permits examination of the method, argument and analysis of research using any method or design (quantitative, qualitative, single case study or single case design etc).

- *Scholarly paper*

A paper sharing ideas and experience or reviews in a specific area of practice.

- *Audit Report*

A report which contains examination of the method, results, analysis, conclusions and service developments of audit relating to children and physiotherapy, using any method or design.

- *Review Paper*

A critical appraisal of primary source material on a specific topic related to children.

- *Treatment Report/Case Studies*

A report of the treatment of a child or series of children which provides a base line description of established treatments, or a new insight into the techniques or treatment of children with a specific problem.

Case reports should be no longer than 2,000 words.

- *Technical Evaluation*

A description of a mechanical or technical device used in assessment, treatment, management or education to include specifications and summary evaluation.

- *Service Development Report*

A report of changes in service delivery aimed at improving quality.

## Other types of Editorial Material

- *Abstracts of Theses and Dissertations*

Abstracts from research projects, including those from undergraduate or higher degrees, audits or presentations. They should be up to 300 words and where possible the conventional format: introduction, purpose, method, results, discussion, conclusion.

- *Letters and replies to APCP*

These can be about any issue pertinent to paediatric physiotherapy or APCP. They may relate to material published in the previous issue(s) of the APCP journal. Copies of replies to editor.

- *Book reviews – up to 500 words*

## Preparation of Editorial Material

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

The first page should give:

- The title of the article
- The names of the author(s)
- A complete name and address for correspondence
- Up to three relevant professional and academic qualifications for all authors and their current positions
- Any source of funds supporting the work
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## All Peer-reviewed Articles

The title page should give:

- The title of the paper
- Up to five key words.
- A structured summary of no more than 300 words explaining the purpose and summarising the key points and conclusions. For research reports this should be under the headings of:
  - Background and Purpose
  - Methods
  - Results of Findings
  - Conclusion

Copy should be:

- typed or printed
- double spaced
- on one-sided A4 paper with at least a 1" margin all round
- Consecutively numbered
- include the name, qualifications, current position, and contact address of the author(s).

The text should be well organised and written in simple and correct English under appropriate headings. The positions of tables and figures should be indicated.

## References

References should be in the Harvard style:

In text, cite only the author(s) surname(s) followed by the date of publication, eg (Robinson, 1994) or Robinson (1994). Use a, b, etc, to indicate more than one publication by the same author(s) in the same year (eg 1992a, b). For three or more authors of a cited paper, name the first followed by et al, eg (Smith et al, 1990).

In the reference list, include articles in journals and books alphabetically by author. For citations from journals, give the names and initials of all authors (year of publication), title of the article, full name of the journal, volume number, issue number and first and last page numbers, eg **Brown, A, Green, B and Gold, C (2001)**. 'The value of exercise', *Physiotherapy*, **87**, 1, 77-79.

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number or the page number of the citation or both, eg **Gardner, M (2001)**. *The Annotated Alice*, Penguin Books, Harmondsworth, Chap 10, page 210.

## Tables

Give them an appropriate title and number them consecutively as they are referred to in the text. Use only horizontal lines. Explain all abbreviations in a footnote. Place tables on a separate sheet after the references.

## Figures and photographic images

Number them consecutively as they are referred to in the text and place on separate sheets after the tables. List all captions (legends) on a separate sheet.

## Permissions and Ethical Certification

Protection of subjects: Written permission from children, parents or guardians to publish photographs of recognisable individuals must be enclosed with the material, or obscure facial features. For reports of research involving people written confirmation of informed consent is required.

Any paper based on a study of children, families or staff, submitted to the APCP journal, must have received ethical approval and state by which REC committee. If for any reason your study is exempt, you must make a statement with the covering letter explaining why it is not applicable.

The use of names for children is encouraged in case studies for clarity and humanity, but they should not be their real names.

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**Paediatric Pilates and the Target Zone Hypothesis A Non-Prescriptive, Qualitative Approach to Exercise Therapy Theory / Practical Sessions**

**Postural Management for Children with Cerebral Palsy: the Implementation and Evidence Base**

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