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

Editorial

In November I attended the European Academy of Childhood Disability in Monaco. It is always an excellent multi-disciplinary forum for networking and hearing about the latest research. On the last morning two presentations struck particular chords for me for our physiotherapy practice. They both raised the issue of doing what we know works. The question is how do we know what works? The answer is, of course, through documenting our clinical practice using robust assessment tools and outcome measures and through research i.e. by using our evidence base. It is easy to try the latest idea without proper evidence of its effectiveness to find it has become woven into our practice and it is too late to extricate it even when research suggests it is not effective. We have a responsibility to children and families to engage in interventions that work and avoid the latest gimmicks which are not evidence based either theoretically or practicality.

This journal reaches nearly 1700 paediatric physiotherapists in the UK and overseas and provides an excellent vehicle to report on and discuss clinical practice and research to ensure that we are providing the best possible treatment for children. It is your profession and your journal so please use these pages to share your knowledge.

The 2006 conference information appears in this journal. The programme includes a parallel study day on the Saturday run by the Neo-natal sub-group which is an exciting development for this year. There is also a call for papers and posters, an opportunity to disseminate the latest research and service developments.

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The editorial board reserve the right to edit all material submitted

Letters

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Dear All,

We are a group of paediatric Occupational and physiotherapists working in main stream and special schools in Derby.

We are currently looking at what written information parents receive, in the form of exercise programs, progress reports etc as a follow up to an audit. The audit identified discrepancies in the amount of information parents received. Subsequent meetings with the parents brought out their wishes for written information to be given on a more regular basis.

We are hoping to set up some local standards prior to re auditing and wondered if anybody already had local standards in place.

Many thanks
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Dear All,

Re East Anglia CF group

We are a small group of physiotherapists working with children who have cystic fibrosis.

The East Anglia CF group meet two or three times a year for a multidisciplinary meeting and study afternoon at Ravenswood Hotel near Bury St. Edmunds. The dates for 2006 are May 24th Wednesday and October 12th Thursday

The physiotherapists meet during the morning before lunch and the main meeting is in the afternoon.

We would like to invite any other physiotherapist working in or near to East Anglia to join us at our meetings. We are all members of the Association of Chartered Physiotherapist in Cystic Fibrosis (ACPCF), but would be delighted to include non-members.

My team are moving to a new building in a few months, so I have given two e-mail addresses, as these should stay the same!

Looking forward to meeting you all!

Best Wishes
Sue Whitby

The GAITRite® mat as a quantitative measure of dynamic walking balance in children with coordination problems

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Preliminary Results presented at 6th International
DCD Conference, May 2005 Trieste. "Dynamic
walking balance in children with coordination
problems: the usefulness of the 'GAITRite' mat"

Keywords: Gait Balance Measurement
Coordination Children DCD

Summary

Background and purpose: Poor postural control is a common feature of many developmental disorders e.g. Developmental Coordination Disorder (DCD), Dyslexia, Asperger's Syndrome, Benign Joint Hypermobility Syndrome (BJHS). In contrast to the number of studies of static balance in these conditions there are few on dynamic balance. 'GAITRite®' is a commercially available, portable, gait analysis system, which measures stride and step length, base of support, velocity and cadence, and gait cycle timings. The aims of the present study were (i) to determine whether the 'GAITRite®' system differentiates between children with and without dynamic balance problems and (ii) to explore the effect that increasing the task demand has on performance.

Methods: The participants comprised two groups of children: (i), a convenience sample of children aged seven to twelve years with coordination problems (putative DCD) referred to the outpatient physiotherapy department, of a large paediatric hospital, from various specialist clinics. Children with a known neurological diagnosis e.g. cerebral palsy or a degenerative neuromuscular condition

were excluded; (ii), an age-matched comparison group of typically developing children. All children were enrolled in mainstream education and none was identified as having learning disabilities. Children walked along the GAITRite® walkway at their preferred, fast and slow speeds. An additional obstacle task was then completed.

Results of Findings: Results suggest that children with movement difficulties, regardless of diagnosis, have more difficulty than controls adopting a range of speeds to meet different task requirements or altering gait parameters to cope with an obstacle.

Conclusion: It is suggested that GAITRite® provides a useful, transportable, quantitative tool for analysing locomotion in children with coordination problems.

Introduction

Poor postural control is a common feature of many developmental disorders for example Developmental Coordination Disorder (DCD), Dyslexia, Asperger's syndrome and hypermobility (Nicolson, Fawcett et al. 1995; Moe-Nilssen, Helbostad et al. 2003, Williams, Woollacott et al 1992). However in contrast to the many studies of static balance (Woollacott and Shumway-Cook 1990; Riach and Starkes 1994; Woollacott and Burter 1996), there are few dynamic balance studies particularly considering balance during gait. The GAITRite® is a commercially available gait analysis system, and consists of a 5.5m x 1m pressure sensitive carpeted walkway with computerised data acquisition. Temporal and Spatial (TS) measurements such as step and stride length and times are automatically computed along with cadence, velocity, base of support and duration of single and double support. Centre of Pressure (COP) data are also generated. The forces generated by the body to remain upright and to propel the body forward during gait are centred under the feet at the COP. The time trace of the COP can be considered as the outcome of the combined motion and muscle activity of all body segments that contribute to ambulation (Craik and Dutterer 1995).

Aims

To explore the usefulness of the GAITRite® walkway in:

1. Differentiating between typically developing children and children with movement difficulties affecting their balance.
2. Identifying characteristic features of particular individuals or groups of individuals.
3. Investigating the effect of increasing task demands on performance.

The GAITRite® mat as a quantitative measure of dynamic walking balance in children with coordination problems

Methods

The participants included in this exploratory study were twelve children with movement difficulties aged 7-11 years (two girls and ten boys). Inclusion criterion was a score at or below the 20th percentile on the Movement Assessment Battery for Children (M-ABC) (Henderson and Sudgen 1992). It was a heterogeneous DCD group with M-ABC score range from below the 5th percentile (n=6); between 5th-15th percentile (n=3), and between 15th -20th percentile with specific handwriting problems (n = 3). Twelve typically developing children (controls) matched by age and gender, were recruited from local mainstream schools and holiday play schemes. All children were enrolled in mainstream education and none was identified as having a learning disability.

Ethical approval was provided by the local ethics committee. Parents and participating children gave their informed consent.

Equipment

The GAITRite® walkway (CIR systems, NJ) is five and a half metres long with an active area of 61cm x 427cm (Figure 1 and 2). The active area of the mat is embedded with 16,128 sensors, set 1.27cm apart and activated by mechanical pressure. Data from the walkway is acquired via a computer software program (GAITRite® Version 3.4) that scans the walkway and records the position and on/off times of any active sensors, with a sampling frequency of 80Hz. The application software processes the information, reproduces the footprints and calculates the specific gait parameters listed above. This data can be printed off for medical records or can be exported as a text file for further analysis. The validity of the GAITRite® has been explored and the TS measurements compare favourably with both the Clinical Strides® Analyser, a portable device that detects step timings, and three dimensional clinical gait analysis (Bilney, Morris et al. 2003; Webster, Wittwer et al. 2005). The concurrent validity of COP measurements has also been supported (Alderson, Watson et al. 2005). The reliability of the walkway has been shown to be excellent for velocity in healthy adults (Batey, Rome et al. 2003) and recent studies have examined reliability in a paediatric population with low levels of measurement error and narrow limits of agreement for most measurements (Thorpe, Dusing et al. 2005). The toe angle and base of support measurements were reported to be the most variable measurements, and this is consistent with the results of adult studies.



Figure 1
The GAITRite® walkway

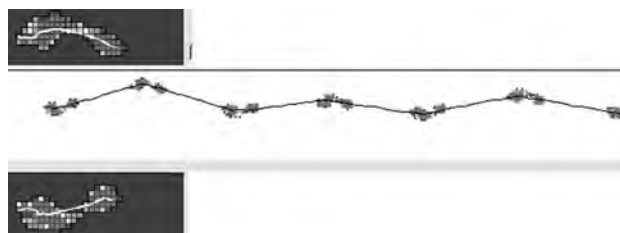


Figure 2
Gait pattern footprints with Centre of Pressure line for a normal adult

Procedure

Each child walked barefoot up and down the walkway for four experimental conditions: preferred, slow and fast speed, followed by an obstacle-crossing task. The trials all began two metres before the active area of the walkway and continued for two metres off the end of the mat to avoid unnecessary acceleration and deceleration. Before the experimental conditions commenced each child completed one practice walk. Each trial consisted of two passes of the mat. Trial one: The children were asked to walk at their self-selected preferred walking speed. Trials two and three were randomised as either a request for 'fast' speed or 'slow' speed. The preferred speed of walking was always completed first to help the younger children familiarise themselves with the procedure. Trial four: an obstacle task was introduced in the study. The obstacle consisted of a yellow cord supported by a jump stand at either side of the GAITRite® mat. The obstacle was positioned one third of the way down the walkway (1.2m). The cord was positioned at a height that equalled half the distance of the child's tibial plateau to ground. The child was instructed to walk up to the obstacle step over it, and keep on walking as in the previous trials.

Results

Temporal and spatial data

The data were grouped into the three different speed trials (slow, preferred, fast) and were analysed in SPSS 11.5 (Norussis 2003) using independent t-tests. No significant differences between matched groups were found in velocity, cadence, step and stride length and time, single and double support time and base of support and toe angle at slow or preferred

The GAITRite® mat as a quantitative measure of dynamic walking balance in children with coordination problems

Table 1. Results (mean values) for the fast Condition the typically developing children and children with coordination problems

	Controls (C)	DCD (D)	Difference between means	95% Confidence Intervals of the difference (C-D)	P Value
Velocity cm/s (sd)	168.6 (25.2)	201.9 (31.4)	-33.3	-58.4 to -8.2	*0.01
Normalised Velocity s ⁻¹ (sd)	2.6 (0.4)	3.2 (0.5)	-0.6	-1.0 to -0.2	*0.01
Cadence (steps/ min) (sd)	162.5 (20.5)	191.0 (25.1)	-28.5	-48.7 to -8.3	*0.01
Stride Length (cm) (sd)	127.2 (23.6)	126.8 (12.0)	0.4	-16.1 to 16.8	0.96
Step Length (cm) (sd)	63.0 (10.9)	63.1 (6.0)	-0.1	-7.8 to 7.6	0.98
Cycle Time (secs) (sd)	0.75 (0.09)	0.64 (0.08)	0.11	0.03 to 0.19	*0.01
Base of Support (cm) (sd)	8.0 (2.9)	6.9 (2.0)	1.1	-1.1 to 3.3	0.31
Toe angle (deg.) (sd)	10.0 (25.8)	12.6 (25.4)	-2.7	-25.6 to 20.2	0.81
Double support (% GC) (sd)	16.0 (3.1)	12.4 (5.6)	3.6	-0.3 to 7.5	0.07

* Indicates a significant t-test statistic
sd = standard deviation

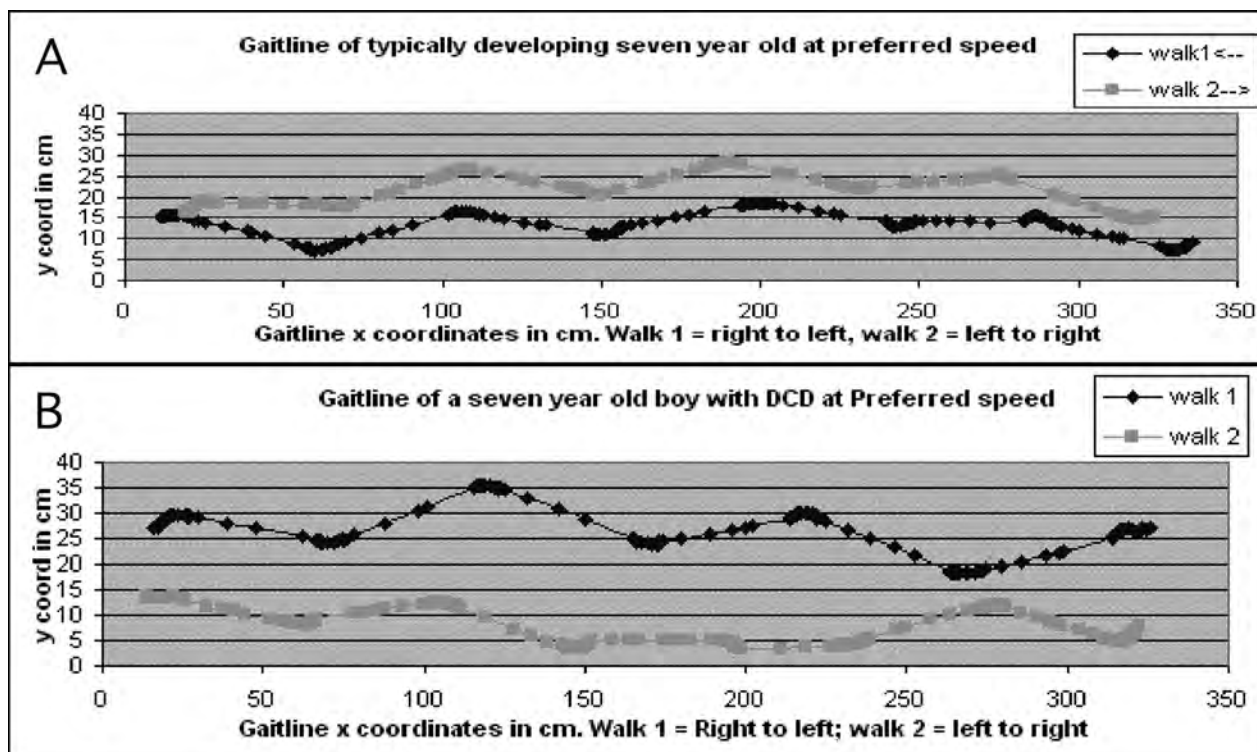


Figure 3
The walking patterns of (A) a typically developing seven-year old boy and (B) a seven-year old boy with coordination problems

The GAITRite® mat as a quantitative measure of dynamic walking balance in children with coordination problems

speeds. The fast speed showed significant difference for velocity (mean difference 33cm/s, Table 1) and cadence (mean difference 28 steps per minute, Table 1). The normalised velocity (velocity/leg length) was also significant (mean difference 0.6s⁻¹, Table 1). Normalised velocity allows children of different sizes to be compared. The wide confidence intervals associated with base of support and toe in/out angle reflects the normal variation of these measures in children. This has also been found in adult studies and suggests that these values should be interpreted with caution.

Centre of Pressure data

The COP data can be analysed for each walk as a walking pattern, or for individual footprints. The walking pattern of the 12 typically developing

children showed consistencies between and within walks. The walking pattern of a seven-year old control at preferred speed demonstrates this consistency (Figure 3A). The walking pattern of the 12 children with movement problems was more varied. Greater within and between walk variation is shown in the walking pattern of a seven-year-old child with DCD, M-ABC < 5th percentile (Figure 3B).

The COP of the individual footprints was also compared. The children in the control group had a characteristic shape to their footprint patterns, a curved pattern joining the heel to the head of the 5th metatarsal and across to the toe (Figure 4A). In contrast, the footprint patterns of children with movement difficulties differed in shape and many had additional individual features. The footprint 'signature' of the seven-year-old boy with DCD has a more angular shape and greater movement in the frontal plane (medial and lateral direction). There is also an unusual cluster of points or swirl in the footprint pattern (Figure 4B). This represents a delay

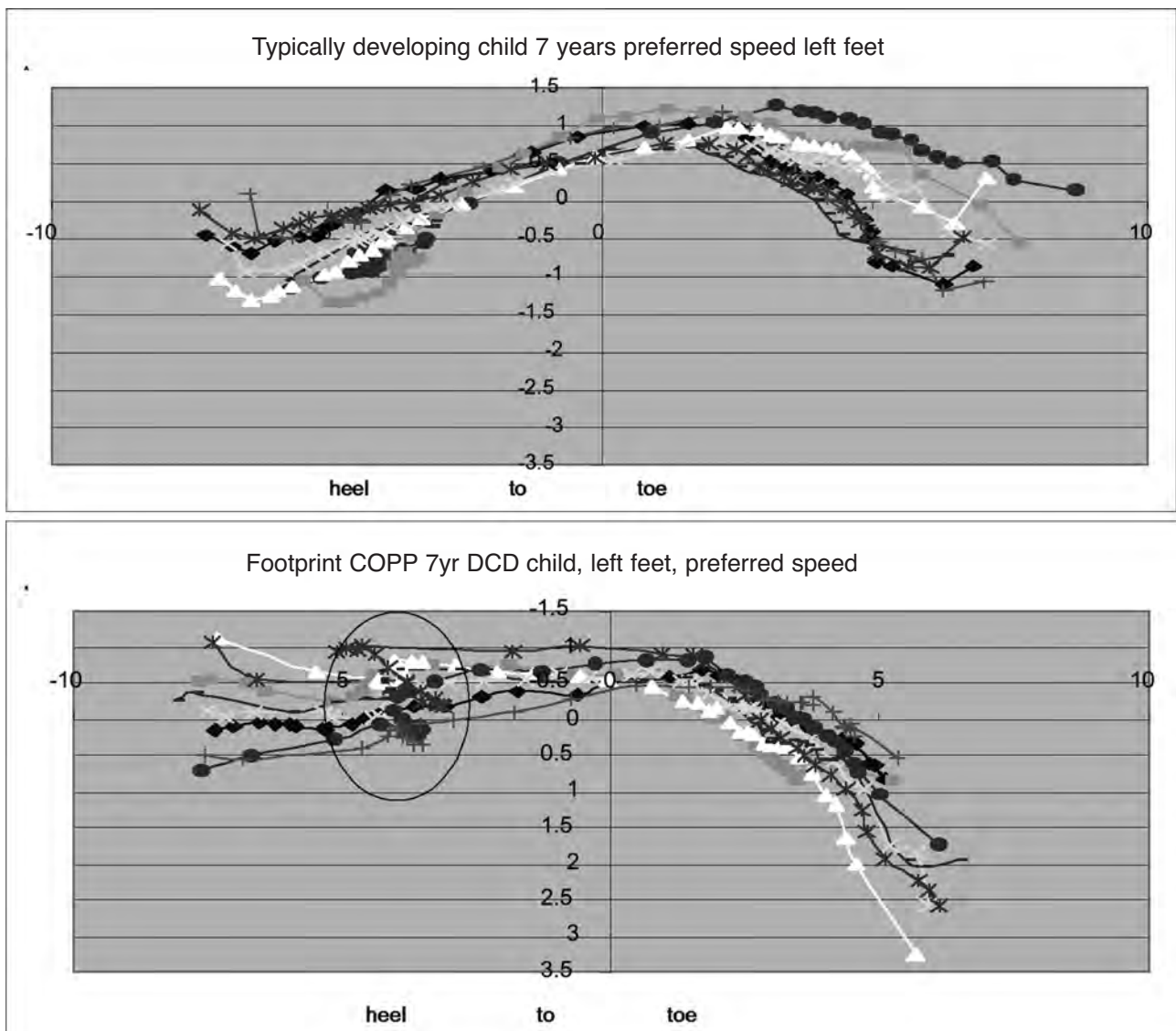


Figure 4
The GAITRite® footprint pattern of (A) a typically developing seven year old and (B) a seven-year old boy with coordination problems

The GAITRite® mat as a quantitative measure of dynamic walking balance in children with coordination problems

in forward progression during the period of weight acceptance. The level of variation observed in the footprint patterns of these two boys appears to be similar.

Obstacle trial

The obstacle trial was included to enhance the ability of the GAITRite® to discriminate between individuals and groups of individuals by adding an additional balance stressor to the assessment. All children tested were able to negotiate the obstacle safely when positioned at mid-tibial height (Figure 5). A few of the children with coordination problems paused in front of the obstacle and many slowed down to ensure a safe negotiation of the obstacle. This tentativeness was not observed to the same extent in typically developing children. Independent t-tests (SPSS) demonstrated the mean step length for the obstacle trial did not differ significantly from the preferred trial for the control group (mean difference 0.5cm, 95% CI: -1.6 to 2.7cm, $p = 0.62$), however the participants with coordination problems used shorter steps for the obstacle task (mean difference 1.4cm, 95% CI: 0.1 to 2.8cm, $p = 0.04$).

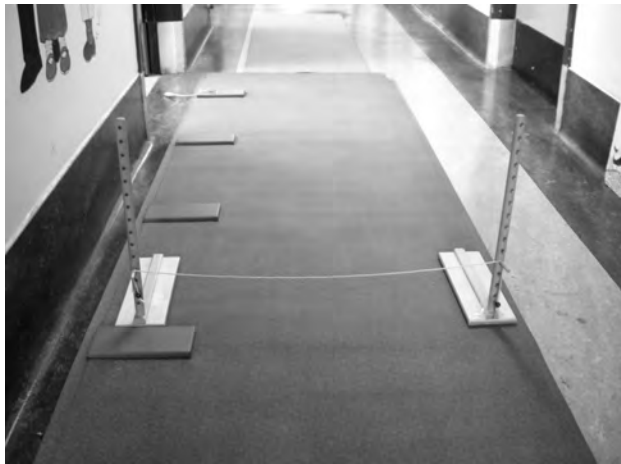


Figure 5
The Obstacle task setup

Typically developing children appeared to alter their step length from the start of their walk to ensure optimal placement of the feet before the obstacle without losing the rhythm of gait. Many of the children with coordination problems did not adjust their step length until the step immediately before the obstacle. Figure 6 demonstrates the lack of early preparation and the extremes of step length observed before and over the obstacle. In both groups the step length of the step over the obstacle was significantly greater than the step length before and after the obstacle (DCD: $p = 0.001$, Controls: $p = 0.017$). The mean change in step length over the obstacle was exaggerated in the DCD group (Figure 7), and post-hoc Bonferroni significance tests (adjusted p-values for multiple comparisons) indicated that there was more variation in step length in the DCD group.

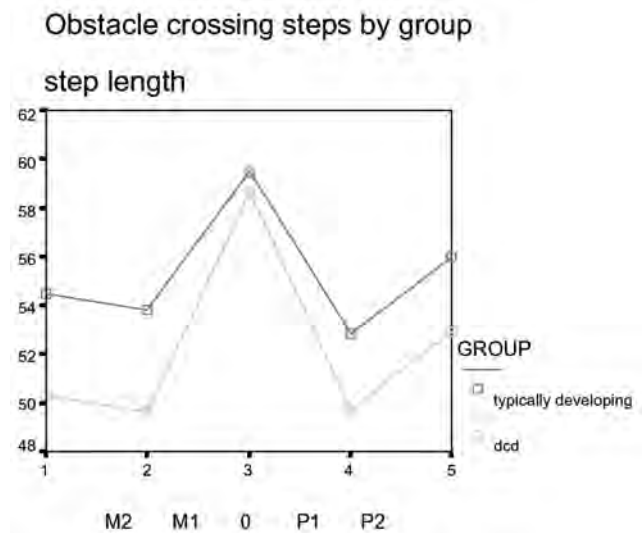


Figure 7
The mean step length selected by both groups of children before (M2, M1), over (0), and after (P1, P2) the obstacle.

Discussion

Temporal and spatial data

Temporal and spatial parameters such as velocity are widely used as a measure of functional ability and recovery after injury. However these measures are unlikely to identify subtle problems associated with walking or balance.

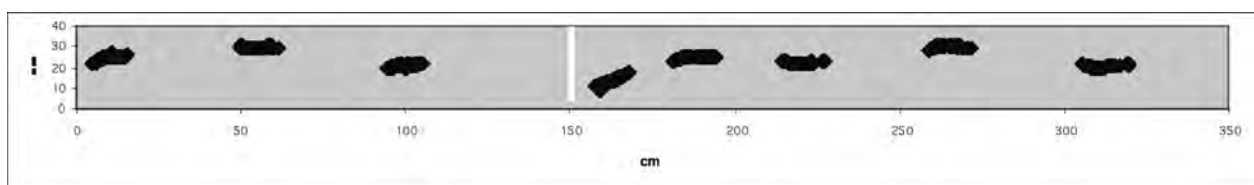


Figure 6
The obstacle trial of a seven-year old boy with coordination problems.

The GAITRite® mat as a quantitative measure of dynamic walking balance in children with coordination problems

This preliminary study compared twelve children with subtle movement and coordination difficulties (putative DCD) with a group of typically developing children of matched age and gender. This study showed that the preferred and slow walking condition was not able to identify group differences between children with (M-ABC <20%) and without balance difficulties. When children were asked to walk at three speeds (fast, slow and preferred) it was possible to discriminate between children with and without balance difficulties. This suggests that temporal and spatial measurements need to be recorded under at least three speed conditions to help capture a clearer picture of a child's walking profile.

Centre of Pressure (COP) data

The GAITRite® generates COP data as well as the temporal and spatial data. When presented in graphical format, these data appear to have the potential to describe the individual characteristics of children with walking balance problems. The COP walking pattern and footprint traces are less regular and demonstrate some additional abnormal features in the group of children with coordination problems. However it is not clear whether this relates to anthropomorphic issues such as flexibility (degrees of freedom in the system) or movement planning difficulty. Detailed analysis of these complex footprint curves using mathematical models may provide objective outcomes of COP in the future.

Obstacle task

The obstacle task helped to identify the children who have problems with motor planning, and also children who have difficulty controlling their balance when faced with a changing environment. This is a functionally relevant task for children who encounter many such challenges daily, for example stepping over pavements. Many of the children with coordination problems were unable to adapt their walking pattern from the start of the walk to accommodate an obstacle mid stride. The children with coordination problems used shorter steps that affected their speed. The step over the obstacle was much longer and the sudden change in step length appeared to alter the rhythm of their stepping. The children also altered their step width however this seemed to vary considerably between individuals. A number of strategies were observed. These included a wide base combined with step length changes, which offers greater stability but slows walking down considerably, and a narrow base combined

with step length changes, which requires much greater balance control but is much easier and quicker to recover from.

Preliminary analysis of the individual step lengths over the obstacle suggested that children with coordination patterns differ in their ability to smoothly modify walking to accommodate an obstacle. Further analysis was not attempted due to small sample size, and variation in strategies employed to safely cross the obstacle. This method has been used successfully in a study of children with Down syndrome and may be a useful way of looking at planning for movement (Virji-Babul and Brown 2004).

Conclusion

The GAITRite® provides general information about the effectiveness of the child's walking speed, stride length, and gait cycle timings. In addition the Centre of Pressure (COP) data revealed individual characteristics of walking and stepping pattern. The obstacle task adds an additional challenge and improves the ability to discriminate between children with different clinical presentations.

This preliminary study supports the use of the GAITRite® as a tool to help characterise the walking patterns of children with movement difficulties. The different types of data presented here may be useful objective tools in the process of identifying groups of children with different functional problems.

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Obese children: causes, consequences, challenges

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Jemma Mears describes how her team manages an increasing number of obese children presenting with non-alcoholic fatty liver disease, and suggests how GPs can assist in the prevention and treatment of childhood obesity.

Obesity is now considered to be a global epidemic.¹ It is one of the UK's largest health problems, and the prevalence of obesity across the nation has trebled in the past 20 years. The National Diet and Nutrition Survey found that one-quarter of men and one-fifth of women were obese² and the National Audit Office has estimated that by 2010 one in four of the adult population will be obese, and that the total cost to the NHS and the wider economy will be around £3.6 billion.³

With the incidence of obesity increasing across all age groups, there is an alarming proportion of children considered as overweight or obese.

The 2002 Health Survey reports that from 1995 to 2002, the prevalence of obesity almost doubled among boys aged 2-15 years (from 2.9% to 5.7%) and increased by more than a half among girls (from 4.9% to 7.8%). In total, in 2002, over a fifth of boys (21.8%) and over a quarter of girls (27.5%) were overweight or obese. Obesity prevalence in young adults aged 16-24 years was 9.2% for young men and 11.5% for young women with, overall, about a third of young men (32.2% in total) and young women (32.8% in total) were classified as overweight or obese. These figures may have surprised some, but for paediatric physiotherapists working in the UK, this unhappy picture is becoming all too familiar.

Childhood obesity is an important predictor of adult obesity.

Defining childhood obesity

Obesity in children is different from obesity in adults. The main difference is that all children and adolescents need to grow; during puberty, for example, a child's weight will double and their height will increase by 20%. This has implications for the diagnosis, prevention and treatment of childhood obesity. It is important to ensure that any dietary restrictions and/or increases in activity do not affect children's normal growth and development.



Measuring childhood obesity

The waters are still muddy regarding the best and most accurate way to measure obesity in children. The body mass index (BMI) tends not to be used in isolation; instead, it is expressed as a BMI percentile in relation to an age- and sex-matched population. However, while for the adult population there are agreed cut-off points to define obesity, those for children vary depending on which reference you consult.

Body mass index (BMI) = weight (kg)/height (m)²

Weight maintenance, rather than weight loss – allowing the child to grow into their weight – can be a suitable and achievable goal for some children.

Consequences of childhood obesity

In the past, obesity-related health problems have been associated with adult populations. However an increasing proportion of these illnesses are seen in children who are obese. These include:

- Coronary heart disease.
- Hypertension.
- Type 2 diabetes.
- Asthma.
- Sleep apnoea.
- Cancer.
- Fatty liver disease.



Obese children: causes, consequences, challenges

Other obesity-associated problems that can severely affect a child's quality of life are:

- Social and psychological problems.
- Joint and back pain.
- Stress incontinence.
- Breathlessness.

In most cases, it is these related problems that are treated rather than the underlying cause.

The imperative when tackling childhood obesity is to take a holistic, multidisciplinary approach, using physical activity and dietary and lifestyle changes.

Reasons for increasing obesity

What has caused this increase in obesity that we are seeing in our school-aged population? Obesity occurs when we take in more energy than we expend. Simply, we are eating more and exercising less than we did 20 or so years ago. Therefore we are in a long-term positive energy balance.

Dietary factors

For today's children, high-density foods are far more readily available than they were for previous generations. There is a frequent exposure to the advertising of junk food and a ready supply of fizzy drinks, crisps and chocolate in school vending machines. The number of fast-food outlets, offering "super-sized" meals and free toys, has increased exponentially and influences dietary choices.

Physical activity

Changed patterns of physical activity and the adoption of a more sedentary lifestyle are likely to be factors associated with obesity. For example:

- Fewer children are playing sport at school.
- Fewer children are cycling or walking to school.
- More children are being driven to school.
- Children's pastimes, such as computerbased activities and watching television, are more sedentary.

Meeting the challenge

As a paediatric physiotherapist working on a supra-regional liver unit, and specialising in liver disease, I have seen a definite rise in the number of children presenting with non-alcoholic fatty liver disease (NAFLD). Deposition of fat in the liver leads to varying degrees of inflammation and fibrosis, and it is not yet known whether some of these children will need liver transplantation in later life.

BOX 1

Exercise advice for overweight children

Beneficial "green light" exercises

- Cycling
- Running
- Swimming
- Football
- Dancing
- Playing games outside

Beneficial "amber light" exercises

- Walking to and from school
- Cleaning the house
- Washing the car
- Getting off the bus one stop earlier
- Taking the stairs instead of the lift

Exercise within the fat-burning zone:
50-60% of maximal heart rate

NAFLD is now recognised as an important childhood liver disease,⁵ and is thought to have direct links with childhood obesity. Treatment for NAFLD is weight reduction and regular exercise.⁵

Children referred to the liver unit are assessed by a multidisciplinary team, which comprises:

- Specialist doctor.
- Liaison nurse.
- Dietitian.
- Physiotherapist.
- Psychologist.

Children receive specialist advice from the team, including a plan of action and are reviewed regularly in follow-up clinics.

Supporting lifestyle change

The physiotherapy team provides much advice and encouragement on simple lifestyle changes and also educates the child and his or her parents on the best ways to exercise and combat the disease, giving advice on what types of exercise to take, how often and at what work intensity (Box 1).

BOX 2

Factors that contribute to successful treatment of childhood obesity

- Realistic goal setting
- Appropriate advice
- Support from the team
- Support from the family
- Targeting the whole family
- Regular follow-up
- One-to-one gym sessions

Obese children: causes, consequences, challenges

It is imperative that realistic goals are set with the families, so that they will see a change. The process of losing weight and increasing fitness is slow, and can be really difficult for these children, many of whom do not have access to decent exercise facilities (Box 2).

Some children are seen regularly in the physiotherapy gym at the hospital, where their progress is closely monitored. We have also engaged the help of the hospital youth worker, who has arranged locally based activities for the kids. Others are followed up more locally.

With an increasing number of obese children at the hospital, many paediatricians are trying to refer these children to my service and unfortunately due to funding issues I am unable to see them all. We are currently looking into the feasibility of providing a trust-wide service.

How GPs can help

The challenge to the GP is to encourage patients to incorporate physical activity into their daily life. Encourage 60 minutes of exercise per day. It can be in 20 minute sessions. The key concepts to get across are that it is important to minimise sedentary behaviour and that it doesn't matter what activity people get involved in as long as they are active!

GPs cannot be responsible for all aspects of treatment for an obese child. However, you can identify children who would benefit from input from other services and professional groups, and are ideally placed to promote prevention and treatment of obesity in children:

- Be proactive in identifying overweight children.
- Refer to the appropriate agencies early.
- Provide support and encouragement.
- Be aware of local facilities and incentives.

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Lycra Garments - A single case study

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Background

The Lycra garment has evolved from its original use in the 1940s as a treatment to reduce scar tissue formation after burns by compression although it continues to be used in this way. In 1989 by Jenny Ballantyne, an Australian Occupational Therapist working with burns victims altered the construction of garments provided to her patients. She began to make the garments more complex to meet the individual needs of her patients. Jenny then saw that the garment could have potential as a splinting medium in neurological conditions in place of immobilisation in rigid plastic to encourage active movement. The Second Skin garment was born and the use of the garments was extended to neurological conditions including Cerebral Palsy, Acquired Brain Injury and Multiple Sclerosis. The garment is constructed of panels of one or more layers of Lycra with the direction of stretch being applied in different directions according to the needs of the wearer. There is additional boning to give extra support to the trunk region with circumferential boning at intervals along the limbs.

During the 1990s other companies who made pressure garments for burns also began to see the potential for development into this area. The common element is the use of Lycra, which exerts axial pressure as well as directional pull over specific areas when worn. The garments are generally un-boned and sometimes utilise the directional stretch of the material. The main element of these garments is the compression which has also been used in lymphoedema. We know that biofeedback affects the nervous system and that the sensory and motor systems are intimately linked and it would appear that these garments affect the motor system via the sensory system as well as utilising biomechanics.

Suits are made of differing materials including Neoprene which is currently used by therapists to improve central stability by wrapping around the trunk (Hylton and Allen). (6) Suits can also contain boning for additional support or use the elastic straps to exert a directional pull.

Use of the suits has expanded over the last decade and evidence of their efficacy has been requested by fundholders in some areas in order to secure funding for ongoing provision.

Review of the literature

The studies' aims included the following objectives in children with altered tone to:

1. Increase proximal stability. (7)
2. Reduce involuntary movements.
3. Increase fluidity of movement.
4. Reduce spasticity.
5. Reduce limb swelling.
6. Increase range of movement in a normal limb.

There have been several published studies where the manufacturer of the garment on test has often been the sponsor which may have introduced bias into the study. The studies generally have small samples sizes with 1 – 40 participants with a mean of 13. They also had a wide age range of 12 months of age to adult with the majority of studies looking at children. The studies tend to be of short duration (2 days – 16 weeks) and therefore the long term outcomes cannot be reported (Gracies & Marosszey; Knox 2003) (3,7).

Postural stability and fine motor control

In most studies measurable objective improvements have been noted (Blair et al 1995; Cheung & Chan 2003; Gracies et al 1997; Nicholson et al 2001; Rennie et al 2000; Edmundson et al 1999; U. of Birmingham 2002 and Rosenbaum & Josman 2003). Improved postural stability was improved in 89% but it was the subjective elements that showed the most change e.g. increased confidence (Blair et al 1995). Set against the improvement in postural stability is the resistance from the material to voluntary movement which may delay the development of motor skills. There is no recorded increase in abdominal strength ((Blair et al 1995)) but improvements in sitting ability have been noted (Scott -Tatum 2003). Some assumptions have been made about the improvement in distal control as a result of improving postural stability. A recent study of 47 children looking at this relationship concludes that the two systems of postural control and fine motor control are separate but related. It seems that although the two systems work together they do not correlate with each other (Rosenbaum & Josman 2003). It is not clear whether one system is dependent on the other but experience with children would suggest a strong relationship.

Walking ability is improved in one study (Scott -Tatum 2003) but not in another (Rennie et al 2000). Fine motor control was evaluated in two studies and showed an increase in joint ranges of the fingers. This may have been due to the splinting effect of the garment preventing unwanted range rather than improved voluntary control (Rosenbaum & Josman 2003; Gracies et al 1997 and Knox 2003).

Lycra Garments - A single case study

Sensory Issues

Another important element is the screening out of tactile input (Hylton & Allen 1997) which decreases distraction caused by movement of clothing, light touch etc. therefore improving concentration and self-esteem.

There is also a strong indication that the suits are uncomfortable to wear for some wearers while others are happy to wear them for 8-13 hours (Blair et al 1995). A small study in Hong Kong felt that although the functional outcomes were encouraging the climate is humid and not suited to this type of garment which caused skin problems in the subjects (Cheung & Chan 2003). Some subjects have request further suits, particularly those with ataxia, athetosis and hypotonia. (Edmundon et al 1999).

Not all improvements can be interpreted as a result of the garment as the subjects may also have had other interventions such as increased therapy, botulinum toxin injections or specific programmes to concentrate on certain skills (Knox 2003).

It is evident that not only is the fit of the suit important but also the way it is put on and maintained with carer training being necessary to maximise the outcomes (Gracies et al 1997).

Attitudes to the garments change over the length of the studies. Some found the garments easier to put on and take off over time with comfort also improving, while others have found the difficulty handling the garment for dressing a disincentive to continue with it (Rennie et al 2000). Some of the garments were perceived as being less attractive at the end of the study (Scott-Tatum 2003). Some companies do try to make the garments attractive to children, taking into account the personal preference of the child and including decorations.

Those children who chose to continue with the suit after the trial were those with low or fluctuating tone. (Gracies et al 1997) suggested that suits should be used before joint contractures have developed. There is some evidence of carryover after the garment is removed.

There is currently a shortage of objective information about this type of orthotic.

None of the studies are Randomised Controlled Trials and this type of study cannot be blinded. There is also the lack of homogeneity of participants. The distribution of altered muscle tone in children with Cerebral Palsy is unique in each child. There are similarities but the individual differences make

matching subjects as controls difficult. (Knox 2003 & Rennie et al 2000). Matching children for functional ability and muscle tone is difficult but also matching their social circumstances and emotional disposition would be equally hard. The largest previous study with 32 subjects has just 8 matched controls that illustrate the difficulty matching subjects for a large trial.

This affects the hierarchy of the evidence and may have an effect on decision-making when service providers consider whether to make this available as a treatment modality. Funding is currently refused on the basis of the limited evidence. The provision is therefore patchy across England. It is therefore important to add to the body of evidence.

Case study

This case study followed a subject over a long period of time (6 months) to map the changes in motor skills alongside the emotional and compliance issues. It is hoped to gain a better understanding of the attitudes of subject and carers as the treatment progresses and the child matures.

As adherence is a major issue, an objective was to include this aspect into the study.

The subject was selected by the physiotherapist and identified by Second Skin as a suitable candidate both in terms of distribution of tone, functional ability and family support. The subject was a teenager with cerebral palsy with a right hemiplegia. She had not had any other intervention e.g. botulinum toxin or surgery which might affect the outcome of this study. She was educated in a mainstream school but had some learning difficulties. She had constant dystonic shoulder and arm movements and therefore found it difficult to keep her arm still. The function of the affected hand was very limited and she used her unaffected hand for all activities with the affected hand assisting. The aim of garment was to reduce involuntary movements around the shoulder and facilitate a more normal arm and hand posture.

The subject was assessed using the GMFM and Bruininks Oseretsky test of motor proficiency. A video was taken of these two tests before the garment was introduced and six months afterwards. Monthly taped interviews were taken with the subject and her mother and a daily diary was kept to measure qualitative data.

Approval for the study was granted by the local ethics committee and permission was given by the subject and parent.

Lycra Garments - A single case study

Suit Design

The suit was a short bodice that enclosed the affected arm with a short sleeve to the elbow on the unaffected side. The dorsal aspect of the bodice was boned and further boning at intervals round the arms. There was an additional glove to promote finger extension. It was provided by Second Skin. (see figures 1 and 2)



Figure 1 Lycra bodice front view



Figure 2 Lycra bodice back view

Aims

1. To measure changes in functional ability.
2. To test compliance.

Objectives

1. To assess pre and post-trial motor ability.
2. To record changes in attitude of the subject and parent toward the orthosis during the period of the trial.

Method

This was a single case study design using the following outcome measures:

- Gross Motor Function Measure
- Bruininks Oseretsky
- **Video** The subject was videoed completing the GMFM, Bruininks Oseretsky tests and during dressing and eating skills within the same environment before receiving the suit and at the end of the six month trial. The videos were watched by the physiotherapist and OT and compared.
- Questionnaire
- **Diary** The diary was set out with 7 daily questions. It was designed to be easy and quick to complete. Questions 3,4&5 had the following visual scale of happy to sad faces.



Questions

1. How long did the suit take to put on?
2. How long did you wear it?
3. How comfortable was it?
4. Did you enjoy wearing it?
5. How did you feel when you took it off?
6. Has it been washed?
7. If yes, was it dry to wear the next day?

- Specific tasks

Results

GMFM scores before fitting of the suit were 96.8%. Scores taken again after wearing the suit for 6 months were 97.6 %. There was no significant change on application of a sign test. This is consistent with other studies (Rennie et 2000).

Bruininks-Oseretsky was administered in the domains of fine motor skills: response speed, visual-motor control and upper limb speed and dexterity. There was no change in the score although there were some changes in the execution of the tests.

Video Involuntary movements of the shoulder appeared to decrease with an improvement in shoulder position during the first few weeks of

Lycra Garments - A single case study

wearing the suit but were still enough to interfere with function.

Fine motor control showed the most change with a reduction in supination. Reaching from a distance with the affected hand was more accurate particularly when the elbow was straight. Stabilisation and manipulation of paper in the affected hand to allow cutting with scissors by the other hand was improved whilst wearing the suit and there was a reduction in wrist flexion during tasks. She was able to hold a lace in the affected hand in order to thread a block onto it. In the pre-suit tests she was unable to hold a lace and used the unaffected hand alone to complete the task. One of the outcomes requested by the subject was that she wanted to be able to hold a bottle on the affected hand and drink from it. Unfortunately the quality of this activity did not improve.

Diary and questionnaire

The suit took between 2 and 5 minutes to put on. It was worn for periods between 2 and 8 hours during and day after the initial weaning in period of two weeks when wear was gradually built up. Generally the suit was worn on weekdays but not when the subject was ill or on holiday. Early problems with skin reactions around the axilla were soon resolved. Comfort was variable with a frequent comment that it was a relief when it came off. The garment was dry ready to wear the next day as long as it was washed soon after returning home from school and placed in the airing cupboard. The suit was generally better tolerated when she was in the school day routine.

Interviews

These took place on a monthly basis during the period that the suit was being worn. They took place in the subject's home with the subject and one or both parents present. They were recorded and then transcribed.

To begin with they reflect the emotional adjustments to the garment and a positive attitude to the changes seen in reduced involuntary movements and improved thumb and finger position that persisted throughout the period of the trial. The subject remained mainly positive in her reports about the suit until the late Spring when the weather improved, when she began to find the suit more uncomfortable and was concerned that it could be seen beneath a short-sleeved school blouse. At this time compliance began to decline as the subject felt increasingly uncomfortable as the Summer continued. It was difficult for the subject to appreciate the possible benefits of long-term use.

Interview 2 weeks after starting to wear the suit

I. Interviewer. S. Subject

- I. "What about the position of your thumb?"
S. "It brings it out"
I. "Out to the side?"
S. "Yes"
I. "What about the shoulder?"
S. "Sometimes"
I. "Sometimes, it varies then, day to day?"
S. "Yes"
I. "OK and what about the involuntary movements that you don't want, is that the same?"
S. "Less I think"
I. "So are you enjoying wearing it?"
S. "When it's not rubbing.....and it's been, my fingers have come out a bit more"
I. "OK so your hand's a bit straighter?"
S. "Yes"
I. "Have you had any problems with it?" (the suit)
S. "No, apart from sweatiness"

Interview 7 weeks into trial

- I. "How do you feel when you take it off?"
S. "It's a big relief when it comes off"
I. "Do you notice any difference after you've taken it off?"
S. "My arm feels looser when it comes off, for the rest of the day"

Interview 5 months into the trial (May)

- Mum "I think the difficulty coming up to the Summer, it's not only it being hot but actually how it looks because she's going to want to wear short sleeves"
S. "I'd rather not wear it in the summer"
Mum "Well we've discussed this already and decided anyway haven't we, that you've got to try which you've agreed to do"
S. "I've found it really difficult before but recently when I've been trying to open doors, pulling the handle down, I can do it"

At end of trial

- Mum "Its been, on a morning, arguing to get it (the suit) on and then once it's on and she's at school..... I think it's worked out a bit better"
S. "I have to wear my jumper all day...because people will see it"

Discussion

Although Gross Motor Function Measure did not detect any change in function the video evidence suggested that there were some areas where functional ability had improved e.g. improved ability to use affected hand to clean teeth, improved

Lycra Garments - A single case study

thumb abduction increasing the usefulness of the hand in bilateral tasks.

The qualitative data from the interviews suggest that the subject felt she gained some benefit from the suit but found it uncomfortable in warmer weather. There were issues regarding the aesthetic aspects of the suit i.e. visibility under clothing.

The findings of this case study reflect previously reported studies in that there appears to be some improved motor function but it has been difficult to quantify. The issue of compliance with use was also highlighted as described in previous studies.

Conclusions

Taking into account the results from this study and the outcomes of previous studies it would seem that the suit seems to be particularly appropriate for children with dystonia and athetosis (Blair et al 1995 & Nicholson et al 2001). Dystonic shoulder movements were reported to have reduced after a short time of wearing the garment and accuracy of fine motor skills was improved on re-test of Bruininks Oseretski but not sufficient to affect the scores.

This study adds to the existing literature on this intervention but has identified similar findings. No definitive evidence of the effectiveness of lycra suits is available and further research is needed.

Recommendations when considering this type of intervention to maximise its effect needs to include:

- Careful selection of the child, taking into account the child/parent relationship and the support of the school/ nursery staff as the garment may need to be removed i.e. for PE, toileting.
- The level of learning difficulties.
- The attitude to current orthotics, motivation and adherence.
- Ability of parents and carers to adhere to the intervention protocol.
- A second garment would ease the pressure on washing and drying the garment but this would also have a significant effect on cost.
- Flexibility of use during hot weather.
- Use of robust outcome measures when providing suits to demonstrate effectiveness.

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Report on Kidz Up North Event

On 24th November APCP was present as an exhibitor at Kidz Up North, the only UK exhibition totally dedicated to children with disabilities. The event took place at the Reebok Stadium and APCP North West Regional Treasurer Sue Booth and regional committee member Siobhan Goldstraw manned the stand on behalf of the national APCP.

The opportunity to be a part of the event arose when the North West regional treasurer noted the longstanding involvement of NAPOT at the event and felt it would be useful if APCP could have a similar presence. In the event the two organisations were sited alongside each other in the exhibition hall and this provided good opportunities for sharing information and networking. The organisers welcomed the involvement of APCP and look to cement the relationship in the future, by inviting APCP to supply ideas for lecture topics and/or speakers to attend the event and be part of the exciting lecture/seminar/round table format.

The event proved to be very busy with hundreds attending, including existing and lapsed APCP members, parents, trade manufacturers, enthusiastic first year physiotherapy students, other professionals and even the Chief Executive of a PCT!

The topics of conversation varied widely, e.g. professionals expressing general discontent about bandings on Agenda For Change, notably Senior I being banded at 6 and Managers being banded at 7. Meanwhile parents related sad and disturbing tales about the withdrawal or reduction of physiotherapy, including one who had received less therapy after the administration of botox than before it. The predictable sequelae to this were the frequent request for private physiotherapy.

There were some requests made for courses on topics including GMFM, Northstar Project, ABC outcome measures. Also some requests were made regarding the publications, e.g. if the manual handling booklet was being updated in the near future; and why the Move approach did not appear in the Outcome Measures Pack; some felt the price of the publications was too high. Altogether 38 membership forms were taken and 45 publications sheets.

Overall the event proved a valuable opportunity to network and promote the existence and work of the APCP amongst professionals of all kinds and in related areas like trade. It is hoped many new members will have been recruited as a result and that lapsed members will rejoin.

Sue Booth would like to publicly thank Gill Holmes for assisting in the provision of the display boards and Siobhan Goldstraw for spending time on the stand.

Sue Booth
APCP North West Treasurer



Evidence Based Review of Assisted Standing

In 2004 Sue and Nikki formed a network of therapists with an interest in assisted standing. Through their active research, they recognised the lack of conclusive published literature to support this intervention. This was resulting in therapists finding it difficult to demonstrate the evidence base for the use of assisted standing.

The Standing Network has provided a central resource to record research or audit activity in this field. This included pooling the reference lists of researchers and making it available to therapists who requested it. However, this only signposts clinicians to the resources and relies on them having the time and skills to synthesise this information.

It has become obvious that we now need to work towards forming a robust evidence base and clinical guidelines to support the continued use of assisted standing. This will involve bringing together the knowledge and skills of researchers and clinicians with experience in this field.

Current Issues:

Five papers have been found that study children in standing frames. Two of these are masters theses, one an abstract from the proceedings of a scientific meeting. Of the two remaining studies, one examines hand function and is equivocal about the results. The other looks at bone mineral density and shows that doubling standing times increases vertebral bone mineral density but not tibial bone mineral density.

The paper by Stuberg, which is widely quoted, suggests standing times, 30 minutes twice a day to provide adequate muscle stretch and 1 hour four to five times a week to improve bone density. This is based on studies from animal research but he does not discuss how he arrived at the figures. Evidence needs to be examined further so we can confidently accept or reject these timings and provide an evidence base on which clinicians can prescribe standing programmes.

We plan to produce:

1. a comprehensive literature review of published and unpublished literature
2. use of this literature review to produce clinical guidelines
3. recommendations for future research based on gaps in current research
4. advice on how we should move forward to establish an evidence base

1. Literature Review

Members of the Standing Network have already carried out and published research in this field. Therefore, much, if not all of the published literature has previously been reviewed. This task would involve pooling together these reviews to support therapists by providing a document to which they can easily refer. To ensure all literature has been accessed, relevant electronic databases such as Medline, Pubmed, Cinahl will be searched using search terms/key words from the goals and conditions listed below. The reference lists of published papers will be used to source publications not identified by the electronic search and authors contacted to identify any unpublished work. A critical appraisal of all studies will be carried out.

All goals of standing would be addressed:

- Maintain/increase bone mineral density
- Maintenance of soft tissue length including muscle stretch
- Improvement of hip integrity
- Experience of upright position in good alignment
- Improved function – head control, hand function, communication, feeding and drinking
- Improved bladder and bowel function
- Improved respiratory function
- Psychological and social benefits

This will include children with the following conditions who are perceived as benefiting from standing:

- Cerebral palsy
- Muscular atrophy

APCP Matters

- Arthrogryphosis
- Spina Bifida
- Osteogenesis imperfecta
- Spinal cord injury
- Acute brain injury
- Paediatric stroke

2. Clinical Guidelines

Guidelines based on the reviewed literature of all goals as outlined above. Guidance on frequency and duration, equipment etc will be addressed.

To complete this work funding has been applied for to support the personnel who will be involved in this project. A small number of people with clinical, academic and research experience have expressed an interest in being involved in the working group. Funding has been applied for, for:

1. a room for collaborative meetings
2. fares for collaborators for joint meetings
3. publication of final documents
4. support and approval from APCP to ensure national acceptance

Critical appraisal training will be offered to those working on the literature review and guidelines.

If you would be interested in joining the group working on the literature review and guidelines please contact: Sue Bush: suebush2001@yahoo.com or telephone : 020 8965 3723.

Sue Bush MSc, MCSP and Nikki Daniels BSc(Hons)

Committee Matters

National committee met on Friday 13th January at CSP in London with new faces and new roles for existing committee members. It was the first meeting for Terry Pountney as Editor, Lindsay Rae as PRO and Sue Coombe as CIG liaison/Diversity officer.

Sarah Crombie attended a further meeting of the Downs syndrome working party and circulated a developmental checklist compiled by the group for comment by the committee. The checklist will be piloted and APCP will receive 5 copies to comment on in collaboration with families. Lorna Stybelska continues to represent APCP on the Skills for Health Competencies group.

Lesley Smith and Peta Smith attended a further meeting at the RCPCH in November seeking to establish links with the college and with the paediatric clinical interest groups of allied health professions including Occupational therapy, Speech and Language therapy and Dietetics'.

A questionnaire has been circulated by the DCD guideline group and work is proceeding. Sally Braithwaite will inform the committee of progress. The Botulinum toxin guideline group met on 12th January to review the questionnaire responses and literature search. The group are following the SIGN guideline process which is lengthy but robust. Sue Bush gave a short presentation to committee highlighting the research on Standing being carried out with Nikki Daniels. The Standing group hope to develop standing guidelines and are seeking the support of APCP.

The working weekend will take place March 23-25th in Belfast. The programme includes Competencies for Paediatric physiotherapists, the profile of APCP, the Constitution and developing the links between national committee and the affiliated Groups (Neonatal Care, Critical Care and Neuromuscular Interest). Planning for Conference in Glasgow, November 06 continues and there are initial plans for conference in 2007 to be hosted by South East region.

The regional representatives bring to committee a variety of issues raised by members. Their contact details are published in this journal if you have any issues for the March national committee meeting.

Laura Wiggins, Secretary

Research and Education

Research Officer's Report

I know it's spring but first of all a belated Happy New Year to you all. These best wishes come with an apology for the lack of a report from me in the last Journal. Do you ever have times when there is so much to do that everything is last minute? Life in October 2005 was hectic, to say the least, what with leaving Great Ormond Street (along with a whole rain forest of articles and essential bits and pieces that might come in handy, but the reality is that the pile I had at GOSH is still the same large pile but relocated to my study at home) as well as getting ready for another trip to Afghanistan. As this trip was no longer reliant on annual NHS leave I was away for 5 weeks and you were left in the very capable hands of Sarah Crombie, who would have dealt with your enquiries with great efficiency during the time I was away – if only the report had made it to the editor! Some gremlin in my new e-mail server had other ideas and the report never made it. Thank you Sarah for holding the fort and my apologies to those of you who may have had queries and thought I was ignoring you!

Research Bursaries:

I know there are several people out there anxiously waiting for news of the next round of research bursaries. The timing of the next round of bursary applications was discussed at the National Committee meeting in October and I am pleased to inform you that applications will be considered in July 2006. If you would like to apply for funding please do contact me for guidelines to help with your application and as well as an application form. The closing date for applications will be 30th June 2006.

Please note the change of e-mail address: jeannahartley@hotmail.co.uk or ring me 020 8883 5641.

Other Sources of Research Funding:

I find the information from the research domain on interactive CSP to be very useful and I would suggest that those of you looking for funding sources should sign up – if you haven't already of course! What often happens is I look on the site just before I write this report, there are often a few possible things to tell you about but the deadline is always sometime between the time I write the report and you getting the Journal – so do look. Don't forget to look in Frontline too – my last copy had info on funding for courses, including Masters level.

The Nancy Finnie Charitable Trust Research Award: This trust distributes funds in the range of £25 - £30 each year and are inviting applications from suitably qualified therapists to undertake research in the area of treatment/rehabilitation of the child with cerebral palsy. They are particularly keen on multi-disciplinary projects.

Application form and guidelines, enclosing a large SAE from:

The Nancy Finnie Charitable Trust 18 Nassau Road London SW13 9QE.

Applicants are encouraged to send a synopsis of the proposed work in the first instance.

Applications must be there no later than 30th April 2006.

National Physiotherapy Research Network:

The NPRN was launched in June 2005 and was established to support research development and its implementation. It was also designed to provide access to the knowledge base for the physiotherapy profession and like-minded researchers. It also aims to support the implementation of the knowledge base within physiotherapy practice and foster supportive and collaborative links with other disciplines and networks. There are no formal membership requirements.

Seventeen regional hubs have been formed as well as a CIG hub. If you want to find out more or want to become involved in your region or CIG contact:

London: Dr Caroline Alexander
c.Alexander@ucl.ac.uk

Edinburgh: Dr Gill Baer
gbaer@qmuc.ac.uk

Keele: Dr Maggie Bailey
m.j.bailey@physio.keele.ac.uk

Hertfordshire: Dr Mindy Cairns
m.cairns@herts.ac.uk

Bristol: Dr Fiona Cramp
fiona.cramp@uwe.ac.uk

South East: Dr Angela Glynn
a.glynn@bton.ac.uk

Dublin: Dr Diedre Hurley-Osing
deidre.hurleyosing@ucd.ie

Southampton: Dr Paula Kersten
p.kersten@soton.ac.uk

Midlands: Dr Sallie Lamb
s.lamb@warwci.ac.uk

Aberdeen: Dr Alasdair MacSween
a.macsween@rgu.ac.uk

Sheffield: Dr Sue Mawson
s.j.mawson@shu.ac.uk

Northern Ireland: Dr Sheila Lennon
s.lennon@ulster.ac.uk

West of Scotland: Dr Lorna Paul
l.paul@gcal.ac.uk

Central Lancashire: Dr James Selfe
jselfe@uclan.ac.uk

Research and Education

Leeds: Ms Charikleis Sinani

c.sinani@leedsmet.ac.uk

Greater Manchester: Dr Sarah Tyson

s.tyson@salford.ac.uk

Wales: Dr Robert Van Deursen

vandeursen@cardiff.ac.uk

CIG Reps:

Dr Caroline Alexander c.Alexander@ucl.ac.uk

Dr Ann Bruton ab7@soton.ac.uk

Dr Mary Cramp m.c.cramp@uel.ac.uk

Mr Stephen May s.may@shu.ac.uk

Professor Tim Watson t.watson@herts.ac.uk

Dr Karen Barker (PRS Rep)

karen.barker@noc.anglox.nhs.uk

Ms Carol McCrum (Consultant Rep)

carol.mccrum@esht.nhs.uk

Mr Andy Sweeney (OCCP Rep)

andysweeney@physiocentre.demon.co.uk

And on a much smaller scale!!

London Area Research Group:

Still staggering on! If you live anywhere near London and would like to join us please do come along to one of our meetings. Very friendly, relaxed and informal – a good chance to discuss any aspect of research you may be struggling with, or perhaps a chance to tell us about things that went well. We can all learn from each other and to do this in such an affable environment is really nice!

Having said enough to persuade you to come, I hope, that we will see you at a meeting in the spring – dates and venues still to be confirmed. Please contact me if you would like to come.

For those of you who live too far away to join us in London how about lobbying your local APPCP branch to start a group area? I will be more than happy to help, if you need it.

RESEARCH INTEREST REGISTER:

I am sure you all read your Journal from cover to cover. However not many of you seem to notice the last page where you can register your research interests! The list I have is a little sparse and I know there is a lot of you involved in research who haven't registered – me included – hence the resolution! If I do it – please will you? I would love to be inundated with information so please fill in the form and stuff it in an envelope and send it off to me. Cut to fantasy of George Clooney look-alike postman, heavy sack full of APCP forms on his back,

staggering up my garden path, Jeanne standing with her nose pressed against the window longing to hear from you etc, etc..... GO ON - YOU CAN DO IT!

Another appeal! To those of you who have finished studies please do consider writing up your findings and sharing the information with us. We can learn so much from each other.

HOT OFF THE PRESS!!

This has literally just arrived, just as I was about to push the button to send this report off!

Second Colloquium of Qualitative Research in Allied Health Professions

04.05.2006-05.05.200-06

Venue: University of East Anglia, Norwich

Course ref: 0605a

Open to: AHP (numbers will be limited)

Course fee: £95.00 for the two days (including lunch, coffee and refreshments)

Lead by Dr Barbara Richardson, Reader in Physiotherapy, School of Allied Health Professions, with facilitators from AHP Faculty and past PhD students. The course aims to help researchers of all experience to join with European colleagues in peer review of their own and others' projects. Projects may be in development, in progress or in the process of submitting for publication.

For further information contact:

Annette Wood, School of Allied Health Professions, UEA, Norwich NR4 7TJ 01603 593098

Email: shortcourse.ahp@uea.ac.uk

So now you know!

In the meantime may all your research proposals, ethics applications, research studies etc go well for you.

Jeanne Hartley

Education Report

Course accreditation system – Ensuring quality of learning opportunities

The kite marking of courses by the APCP is now underway. This involves awarding accreditation to courses which meet the quality standards set by the APCP. An accreditation panel assesses each course applying for kite marking on the following criteria; clarity and appropriateness of learning outcomes, suitability for the target audience, teaching and learning methods promote active engagement and deep learning, costing is in line with APCP guidance, relevance of speaker's experience and use of course evaluation. It is anticipated that APCP kite marking will help members to make decisions around which courses to spend their hard earned money on. Similarly, the kite mark may offer additional weight when seeking trust funding. Only courses approved by the accreditation panel will be able to use the APCP name or logo on their course materials.

If you are running a course which you would like to be accredited by the APCP please email a.c.leake@shu.ac.uk to receive an application form for accreditation.

(Please note that this accreditation system applied to courses lasting more than 1 day.)

Student issues – Raising the profile of APCP

The education committee has been investigating the support that APCP offers to students and feels that we offer a good standard of service to students. However, it may be that students are not aware of the APCP and we need to raise our profile. If you are taking student physiotherapists on clinical placement it might be helpful to them to mention the APCP's student support mechanisms. We offer; a database of paediatric Physiotherapists who have volunteered to take part in student research projects, reduced rate membership, student places on appropriate APCP courses, advice and help for specific questions through iCSP (the CSP's interactive web site), publications of good practice guidelines and evidence based summaries to help develop best practice. If we help to foster these links we will be able to develop the paediatric Physiotherapists of the future.

Therapy Assistant development - HELP NEEDED

We all agree that our assistants are vital to the effectiveness of our therapy. Up to now, the APCP have focused on developing learning opportunities for qualified Physiotherapists and students. However, we would like now to spend some time developing a portfolio of learning and development for assistants working in paediatrics. This is an exciting and challenging new development that we want our whole membership to be involved in. To start the process we need to undertake an audit of current learning needs and ideas for good practice. Please take the time to fill in the questionnaire on the following pages, you will need to ask an assistant to fill in section 2, then return it to me within 2 weeks. If you prefer to have an electronic copy, email me and I'll send you one. Once we have a baseline of current needs and practice, we can then develop some learning tools (national/local courses or local learning materials) that will help to assist the development these key members of our paediatric teams.

Adele Leake

Therapy Assistant Development Questionnaire

Section 1; for completion by Physiotherapist.

1/ Do you have a therapy assistant working with you currently? (Circle most appropriate) Yes/No

2/ What sort of work does the assistant undertake? (Tick as many as appropriate)

- Hydrotherapy
- Moving and handling
- Administrative duties
- Equipment provision eg, wheelchairs, standing frames, walking aids
- Note writing
- Play/distraction
- Screening for therapy input
- Waiting list management
- Routine Interventions eg, exercise/activity programs
- Skilled handling as part of a team
- Resource gathering eg, making videos
- Other (please state)
-

3/ What sort of training and development do you currently offer? (Tick as many as appropriate)

- Inservice training
- Self development log/portfolio
- One to One instruction
- Reading lists/ WWW resources
- Information videos
- CDrom
- Courses designed for assistants
- Other (please state)
-

4/ Which 3 training and development opportunities you think the APCP should look to develop?

- (Tick 3 only)
- None
 - Inservice training packages for local staff to use
 - Self development log/portfolio for assistants to use
 - Reading lists/ WWW resources
 - Information videos
 - CDrom
 - Courses designed for assistants
 - Other (please state)
 -

Thank you, if you have any materials you would be willing to share with us please put your email address here for us to contact you in future.....

Research and Education

Please pass the section 2 to an assistant for completion.

Section 2 for completion by Therapy assistant

5/ What sort of training and development do you currently use? (Tick as many as appropriate)

Inservice training

Self development log/portfolio

One to One instruction

Reading lists/ WWW resources

Information videos

CDrom

Courses designed for assistants

Other (please state)

.....

6/ What sort of learning opportunities do you think you would most enjoy? (Tick as many as appropriate)

Inservice training

Self development log/portfolio

One to One instruction

Reading lists/ WWW resources

Information videos

CDrom

Courses designed for assistants

Other (please state)

.....

7/ How easy would it be to get time away to attend a short course? (Circle the appropriate answer)

A one day course - Hard/ Fairly hard/ Fairly easy/ Easy

A two day course - Hard/ Fairly hard/ Fairly easy/ Easy

8/ What sort of things do you need to learn more about just now? (Tick as many as appropriate)

Hydrotherapy

Equipment provision eg, wheelchairs, standing frames, walking aids

Play/distraction

Routine Interventions eg, exercise/activity programs

Skilled handling as part of a team

Resource gathering eg, making videos

Searching the internet for resources

Legal issues in paediatrics

Normal Development, motor, social, language and play

Other (please state)

.....

*Thank you for your help. Please return the form to
Adele Leake, Senior Lecturer in Physiotherapy, Faculty of Health and Wellbeing,
Sheffield Hallam University, 11-15 Broomhall Road, Sheffield S10 2BP*

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SOUTH WEST

Apologies for the lack of information from the region in the last journal. Hard IT lesson learnt - all letters in an e-mail address are important!!

The planning for a Sensory Integration course in the SW region has finally come to fruition in Yeovil on 20th March. Many thanks to Ruth Jacklin for organising this one. The programme looks both informative and interesting.

The integrating disability into PE courses are still in the planning phase for both Dorchester and Devon. Suitable venues to host these are still being sought. Any offers?

The region is hosting the APCP's Advanced Cerebral Palsy on March 13th and 14th in Gloucester. Further details can be found on iCSP events site.

We are currently looking to boost the representation on the SW committee from the south and west of our region, most notably from the Devon, Cornwall, Somerset and Bristol areas. Anyone interested please contact for further details. You may even enjoy it!

LYNDA NEW

SCOTLAND

The Regional Committee for Scotland has been working hard to put together a varied and interesting programme for the Annual Conference to be held in Glasgow at the Crown Plaza Hotel from 10th-12th November. A draft programme is outlined in this issue of the journal. The full programme and registration details will be included in the June journal. We would recommend that members planning to attend should take advantage of the "early bird" rate. Please note that this will be the only discount available. The next committee meeting is at the Craighalbert Centre for Conductive Education in Cumbernauld on Friday 24th February. A study day is planned for Friday 17th March at Braidburn School in Edinburgh at which Mary Ann Houghton will give a presentation on the place of Pilates in paediatric physiotherapy. The afternoon session will be a practical session. Due to the problems associated with the transfer of direct debit payment of membership subscriptions, there has been a delay in the production of an up to date address list from the national membership secretary. In order not to miss out on application details for this study day, please contact me with your name

and address on 0131 337 4203. The answer machine is well trained.

ALISON M GILMOUR

NORTH EAST

Our next study day is imminent. If you have not yet booked there is still time to do so.

The subject is **Muscle Strengthening in CP** and the course tutor is **Jan Morton** from Glasgow.

The day will begin with the AGM. This is your opportunity to find out what happens within APCP at local and national levels and to give your opinions. There will also be a discussion about research and we hope to be able to offer practical help for those considering embarking on research but are frightened by the prospect! As usual a tasty lunch is included in the cost, so book soon by calling 01429 522 810 or via www.interactivecsp.org.uk

We are busy planning our courses for 2006/7 and hope to be able to reveal our exciting plans before too long!

We have two new committee members in the region representing the northern reaches. We welcome any other members who would like to contribute to the valuable role of organising particularly from the East of the region, which is not represented.

Would members please check their bank statements carefully as problems with the computer system and direct debits may mean that you will need to pay by cheque this year while new mandates are set up again.

Membership renewal forms will be available at the AGM.

Thank you to all on the NE committee who cover huge distances to be at meetings and put together attractive study days with such great food!

HEATHER ANGILLEY

LONDON

London Committee had a very productive first meeting of the year. We agreed a new programme of evening lectures but need to confirm dates with lecturers. We hope they interest a wide range of our members. The next 2 evening lectures will be advertised.

The topics will be:

April - The role of Physiotherapy in the management of Children with Downs Syndrome
June - Theratog garments - What are they and how can they be used in PT practise.

Regional and Sub-Group Reports

Your support last year means that our funds allow us to offer one London branch member a free place at the Paediatric Conference in Glasgow, 10 - 12th November 2006. Attendance fees for the whole conference will be paid (You will have to pay travel and your accommodation). The programme looks excellent. There is no competition we would just ask you to confirm you are a member of APCP with your membership number and contact details, please ensure you will be able to attend if you win. Apply by email to Christina Rafter rafterc@gosh.nhs.uk. Closing date for application is 30th April, the place will be drawn at the next committee meeting 3rd May. The winner will be notified immediately after the meeting. If you are thinking you stand no chance please note we offered a place last year but no one applied, so no place was given.

There are plans for APCP to run the 'Introduction to Paediatric Physiotherapy' course in November 2006. This will hopefully be in central London and details will be advertised as soon as they become available. There is already a list of interested people. If you want your name to be added please email Christina or me.

Please use this report to pass on regional news. I will happily include information forwarded to me.

STEPHANIE CAWKER

TRENT

As your new National Committee representative I would like to take this opportunity to say "hello" to all Trent region A.P.C.P. members and to say a big "thank you" to Clare Hill for her commitment to this role from which she is now standing down. As your regional representative I am able to take your views and queries to the National Committee so feel free to contact me if you have anything to say. I would also like to encourage you to join our regional meetings. Our next meeting will be held in The Children's Therapy Department at Loughborough Hospital at 16.00 on 11 April. We are looking at changing the format of our meetings so that we can be of greater benefit to our members and we are open to suggestions. I think that there is sometimes a danger of existing purely for the purpose of existing but what we want to do is to offer opportunities for net working and skill sharing locally and so the bigger we are the more effective we are likely to be. We are also considering inviting speakers along and this is obviously of greater benefit if we are a larger group. We organized a couple of very well received courses last year and hope to do the same again this year starting with a course in Lincoln on 27 April on Dysphagia including the effects of posture on

respiration. At our autumn meeting concerns were expressed regarding the management of torticollis and competencies around this and I took these concerns to the National meeting in January which generated some interesting discussion. As a result of this we await the publication of guidance to be published in the journal at a later date. Attending local meetings is also an opportunity to hear what is happening at National level. I look forward to meeting some new members at our future meetings.

SUZANNE LAWRENCE

WEST MIDLANDS

I recently took over the role of W. Mids Rep from Lindsay Rae, who I would like to thank on behalf of the committee for her hard work as both the Regional Rep and Chairperson.

We have had a restructure of the committee recently and can send out a list of committee members if anyone is interested. Our aim is to represent the variety of specialities within paediatrics on the committee, so if you are interested in joining please contact me.

A course is being held on 8th May "Plagiocephaly and Torticollis" with a lecture on Cranio-Sacral Therapy. There will be lectures from leading experts in this field, for more details contact Catherine.kear@sbpct.nhs.uk or look on iCSP.

There is a bursary available for any interested Physiotherapist, so contact me for more information.

I am looking for ideas to improve links from the West Midlands Committee to the APCP members in the West Mids. We will be sending out a questionnaire to canvas opinion about the best way forward and for ideas on courses you would like us to run, so please contact me with any thoughts or wait for the questionnaire - your comments are very important.

HELEN BAYLISS

SOUTH EAST

Once again I sit in front of my computer and wonder what on earth to write! Which nuggets of information will be of interest? What information do I need to impart and, finally, won't someone else please come and write this for me?????

For the last few months your local S.E. Region committee ... (wouldn't you like to join the party?) have been combining planning for courses in 2006 with work for National Conference in 2007. The beginning of February, however, heralds the start of the new Conference Committee for 2007, with an inaugural meeting at the Grand Hotel in Brighton (are you sure that you wouldn't like to join??) From

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then on the 2 committees will run as separate events. Several members - Peta Smith, Vice Chair of National Committee, Lucy Erasmus, Treasurer, Jill Larkins, Secretary, and I will sit on both committees. In this way the S.E.Region committee can remain up-to-date with National Conference plans for 2007 but can concentrate on plans for the South East Region for 2006/7 Conference Committee will also be joined by several other physio's from the South East who have 'volunteered' to add their knowledge and ideas (not to mention time and effort) into making 2007 a conference to remember. As I have said in my previous reports - if anyone has any ideas/contacts for speakers, entertainment, publicity, advertising etc please, please do get in touch.

The first Study Day which the S.E Region committee is running this year is titled "London 2012 – Are You Ready?" and will be held on 27th April – venue still to be finalised. We have gathered together a variety of people with knowledge and experience of sporting opportunities and achievements for children and young people with disability. The speakers include Mike Bishop, who is Kent Disability Sports Officer; a physiotherapist with a particular interest in working with young people with disability in Gyms/Fitness Centres and a young wheelchair athlete from Kent who has competed nationally in tennis. It promises to be an extremely interesting and stimulating day.

Look out for information on iCSP and through the S.E.Region e-mail circulation list. If you would like to add your name to the e-mail list please contact me (address at the back of the Journal) and I will forward the information to Jill Larkins. Do remember that you can use your £5.00 off voucher from the AGM/Study Day to reduce the cost.

National Committee, meanwhile, are planning to run a working week-end in Belfast looking at issues such as Competencies, Profiles and Constitution & Affiliation. I am assured that 'working week-end' does exactly what it says on the tin – ie more work than weekend! It will, as always be good to work with a band of enthusiastic and motivated physio's who are committed to the development not only of our professions but also to the service which we provide to children with special needs and their families.

Other matters from National Committee include plans for running an Introduction to Paediatrics Course in the South East. If anyone has a brilliant idea (even a good idea would help!) for a venue or would like to speak on the course then do get in touch and I will forward your ideas to the

organisers. The other item of interest is the progress of the Standing Network, looking at/researching the evidence for the use of standing frames. The article in ACPJ Journal, March 2005 pp10-11 includes information about this group and Sue Bush, Senior Physiotherapist, will be publishing more up-to-date information in the Journal. Many of us use standing frames on a daily basis where's the evidence? Get in touch with the Standing Network and find out.

A Happy Easter to you all

ANN MARTIN

WALES

To all ACPJ Members in the Welsh Region – Greetings!

Can I introduce myself as the new representative for Wales on the ACPJ National Committee. My name is Diane Rogers and I have been a paediatric physiotherapist for the past 25 years, currently working as Head of Children's Physiotherapy Services for Cardiff and Vale NHS Trust. I know many of you already, from my role as the Clinical Specialist in Paediatric Cystic Fibrosis however I look forward to meeting everyone sometime in the New Year. Please do not hesitate to contact me if you need any information or if you want me to relay something to the National Committee.

Here is a brief update about things that are happening in Wales.

The Children's NSF was officially launched in October 2005 – the final document is now available on the Welsh Assembly Government website, or you can telephone and ask for hard copies. This is a very positive move by the Welsh Assembly Government and we are expecting some good things to come from it. If anyone has any questions regarding these, please do not hesitate to contact me, either via e-mail or telephone.

The Children's and Young People's Specialist Services (CYPSS) are currently developing standards of care for a number of paediatric specialities, please look out for the draft copies of these so that we can all pass our comments back through the appropriate channels and make any changes that we feel are necessary.

Viv Williams received her Fellowship of the Chartered Society of Physiotherapy at the recent CSP Congress in Birmingham. A number of colleagues who have worked with over the years were present to cheer her on and can we say many congratulations again to her on this award.

In the New Year the ACPJ in Wales are planning a programme of study days to be held throughout the region and members will be informed of dates,

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times, venues and topics as they are organised. We have provisionally booked a "Foundation Wheelchair Assessment" course for 27th April 06 (15 places only); details will be circulated after our December committee meeting. Please also remember that our AGM will be held on March 15th at the Quality Hotel in Cardiff and flyers for this will be coming out shortly.

I look forward to representing the members in Wales over the next 2 years, but I am aware that I have a very hard act to follow in Jill Williams. Can I just take this opportunity to say, thank you very much to Jill for all the hard work that she has undertaken on behalf of APCP members in Wales during her term of office, and I am very pleased that she is still in the Cardiff area because I am sure I am going to need to ask her about lots of queries.

DIANE ROGERS

NORTH WEST

Happy New Year to all the members in the region, hope everything is going well for you all. Our membership numbers for the region mean that we are one of the largest groups but we always have room for more – so I would ask that you encourage colleagues who aren't already members on the benefit of joining. Membership forms can be found on iCSP or by applying directly to the membership secretary.

Following on from that can I please ask members who have queries about membership or want to change their address etc to contact the membership secretary directly as she holds the data base on her computer not your regional rep. That way you can ensure that it is done directly. I receive a number of these requests and while I endeavour to ensure Susan gets the details this means there is always the extra stage for things to get lost. Susan Cleverley's details are in the front of the journal.

The local committee last met in December and although we have recently lost some committee members we have had interest from others. This however doesn't mean that we don't need your support because we do, so as I've said before if you would like to become involved get in touch. Just another quick reminder, the AGM for 2006 will now be in October to keep us in line with National AGM set for November.

Our next study day is on March 17th on Orthopaedics to include torticollis/plagiocephaly, Ilizarov, the spine in CP and NMD etc. It is being held at Manchester Children's Hospital and details

can be found on iCSP or directly from me on 0161 9185177. We are also in the process of finalising further courses for later in the year and details will be circulated at a later date. At present we have quite a list of suggestions we are considering, looking at feasibility etc. Committee meets again in early March to do further work on this.

That is all for now folks! Speak to you again in June.

ELAINE LLOYD

NORTHERN IRELAND

The committee would like to thank Alison Mountstephen and Tina Weston for all their hard work as Chair person and Secretary over the last few years. We would also like to congratulate Alison on the birth of her baby daughter Anna.

It was great to see a good turnout for our first meeting of the year. We enjoyed an informative presentation from Kimberley Wroblewski on Applied Behavioural Approach.

Due to the low turn out at evening meetings in the past, we decided to change the format. We are running a multi-disciplinary workshop for "Children with low tone pelvic instability" on 10th February at Scabo Children's Centre.

There will be a Postural Management Course by Terry Pountney on 18th and 19th May. All members should have received information and an application form for the course. The committee are trying to increase our membership and will be in contact with all paediatric departments in the area. If you have any colleagues who would like to become a member you can contact myself on 028 79301170 or Deidre Martin on 028 44513721 for a membership application form.

If you have any thoughts, on subjects for study days or courses for next year we would be glad to hear from you.

GEMMA LIPSCOMB

NEONATAL SPECIAL INTEREST GROUP

Since the last journal another change has occurred on the committee which is that our secretary Nicky McNarry has stepped down and the post is now filled by Sian Howells as Membership Secretary and Hilary Cruickshank as Secretary. Hilary is also our PRO and Publications Officer.

We thank Nicky for all her hard work since the inauguration of the group just over 3 years ago and wish her and her young family all the best for the future. Just as a quick reminder, that all members are

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required to renew their membership with our new Membership Secretary in January so if you have forgotten or wish to become new members then please contact Sian on sian.howells@cardiffandvale.wales.nhs.uk

Other news to report is that we are holding a 3 day study day in Belfast in June, flier is included in this Journal and on iCSP. This promises to be a high quality course covering neonatal care from respiratory care through to developmental and neurological follow up. This is planned to be a roving course which will run in various regions after Belfast.

Then later in the year we are joining the National APCP conference in Glasgow in November and are running a satellite course for neonates, again the flier is in this Journal and will be posted on iCSP.

The BLISS booklets have been so popular that they have almost run out and a reprint of the booklet has been approved with plans to review for alterations as required prior to the next reprint.

BARBARA HAEDERLE

NEUROMUSCULAR GROUP

The inaugural meeting of the APCP Neuromuscular Physiotherapy Group took place on 29th May 2005 at CSP Headquarters in London. The group was formed through an increasing need for physiotherapists working with these rare conditions, to share expertise and information, in an area which is rapidly changing.

Over the last ten years, ground-breaking research undertaken by Professor Kate Busby and Dr. Michelle Eagle at the Newcastle Centre has led to a change in how we view the mortality of patients with Duchenne Muscular Dystrophy. The advent of non-invasive ventilation has added approximately ten years to the lives of these young men and has provided physiotherapists with a new challenge. Healthcare professionals are now searching for ways of enabling these young men and their families to enjoy their added years with the best possible quality of life. This emerging population requires physiotherapists to rise to the challenge of respiratory care, 24hr postural management, contracture management, orthoses and maintenance of function to name but a few of the key areas.

The Muscular Dystrophy Campaign and Parent Project UK are two major charities who are working in partnership with the NHS and are continuing to fund research into steroid therapy, which is believed

to slow the rate of progression of muscle wasting and the exciting new field of exon skipping, a potential cure for DMD. In light of these changes, physiotherapists are requiring to improve their assessment and review techniques of DMD and work more proactively with their paediatric case loads in order to empower these young men and their families with better physiotherapeutic management to take them into this new era. This group is also unique in the fact that active participation from adult therapists working through the transition stages is also encouraged in order to facilitate a better understanding of the emerging difficulties that many of these young men and their families will face.

This APCP affiliation will provide therapists with a medium to work together to develop current management programmes. It will be a forum where ideas can be discussed and research can be supported. During the inaugural meeting, areas for development included a national care pathway for DMD, investigation into the management of the neuromuscular foot and how to facilitate gait in the limb girdle muscular dystrophies.

The members of this group are proactive therapists in their own right and have developed areas of expertise all around the country. As newly elected chairperson, I look forward to participating in this positive and developing field with a group of therapists who are poised to push forward their skills in the evolving field of neuromuscular disorders. For further information on joining this group and forthcoming study days, please contact Elaine Scott, Research Physiotherapist Secretary, Tel: 07795 227170 Email: E_scott@btopenworld.com or Marina Morrow, Chairperson, Tel: 0141 774 3428 Email marina.m@ntlworld.com

MARINA MORROW

CRITICAL CARE SPECIAL INTEREST GROUP

Paediatric physiotherapists throughout the UK, whose primary interest is working within Paediatric Critical Care have joined forces for the first time to form an official interest group affiliated to the APCP. Through the APCP we hope to raise our profile nationally and provide stronger links with the CSP.

We have an established committee who are working hard to meet the needs of our membership, this being training and education, peer support, information exchange, developing/sharing evidence based practice and linking with other professional groups.

To date we have run 3 successful study days, the October Study day hosted by Birmingham Children's hospital was our most successful yet. Topics covered were, Splinting and Positioning in

Regional and Sub-Group Reports

the Acute Setting, Management of Plastic Bronchitis, Ventilation Strategies for the Acute Cardiac Patient, Management of Head Injuries and Mucolytic and ETT instillation. Sarah Hines at Great Ormond Street Hospital has completed a national audit on Mucolytic and ETT instillation and we hope as a group that we may be able to develop some guidelines from this in the future. The next study day will be hosted by Sheffield Children's hospital on Tuesday June 20th 2006. The clinical theme for the day will be Paediatric Haematology and Oncology. For further details please contact Mel Lindley at melanie.lindley@sch.nhs.uk. Please contact me if you have any ideas for future study days or courses at rachaelhufton@yahoo.com. We look forward to writing a webpage for the APCP website where we can keep you up to date with current information about our group and any future study days.

A priority for the group is to ensure that membership is easy to access and open to all, be it Critical Care that you work in all the time, some of the time or you simply have an interest. Our aim is to have representation from all Paediatric Critical Care Units throughout the UK and to build a database of Physiotherapists, their areas of personal interest and specialism. If you would like to become a member of our group please contact Mel Lindley at melanie.lindley@sch.nhs.uk for a membership form.

Many thanks for taking the time to read this, myself and the committee are looking forward to hearing from you soon.

RACHAEL HUFTON

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Here and There

School physio day - January 2005 at Charlton School Activity group

This report is the long-promised summary of one of the discussions which took place during the School Physio study days which were organised at Charlton School in South East London between 2003 and 2005. These study days were designed to bring together physiotherapists working in educational settings, both mainstream and special schools. The format for all the study days was workshops on selected topics – Activity Programmes, Caseloads, Equipment, Hydrotherapy, Moving & Handling and Multi-Disciplinary Working – with ‘guided questions’ to stimulate discussion (Not that much stimulation was required!) and facilitators to keep the discussions ‘on track’.

The format proved so successful that it was followed for the final study day when local experts were invited to facilitate discussions based on the findings of the previous study days. The hope/plan was that this would be a way to bring together the knowledge and experience of all the course participants which could then be formalised into a document which could be used to inform future practice.

As so often happens, when ‘collected wisdom’ is written down the result can appear to be a statement of the obvious which makes the reader think “I knew that”. However, collected wisdom often isn’t written down. This article seeks to remedy that situation.

The conclusions from the Equipment Group have already been written up in this Journal by Nikki Daniels, who was at that time Research Therapist with MHRA. [APCP Journal March 2005 pp 10-11]

This article focuses on the discussions about Activity Programmes. The final articles about Hydrotherapy and Moving & Handling are in preparation.

I am grateful for the assistance given by Dianne Rickard, Senior Physiotherapist with Maidstone Weald PCT, who read several draft versions of this article and added invaluable comments and information. As they say in all the best papers – any errors are mine.

Activity programmes group

(To avoid clumsy word splits e.g. child/ren I have chosen to use the singular ‘child’ throughout this article – with the understanding that the comments may apply to an individual child or to groups of children)

The discussion group for Activity Programmes was

facilitated by Dianne Rickard, one of the founders of BEAM, an activity programme for use in schools with children with Developmental Co-Ordination Difficulties.

The focus of the group was to look specifically at the provision of School-Based Activity Programmes for children with special needs who attend mainstream schools. Specific activities/exercises were not discussed as the focus was on HOW intervention could be provided in school.

Who does what?

For the provision of School-Based Activity Programmes the child will usually be assessed by the physiotherapist who is providing the school-based activity programme. The programme will be delivered by a member of the education staff at the child’s school. In this situation the physiotherapist acts as a ‘Consultant’ to the school staff – using their physiotherapeutic skills and expertise to identify the child’s movement difficulties and to plan a programme for remediation. Making use of expert physiotherapy skills in this way may act to relieve the stress of feeling like a ‘lone worker’ and impact directly on waiting lists by increasing the number of children who can be seen for assessment and advice.

The School-based Activity Programmes may be devised to be carried out on an individual basis with one particular child or may be used for a group of children in a school. One of the benefits of School-Based Activity Programmes is that these are usually practised with much more regularity than home-based programmes. Another advantage is that activities can be generalised into other school situations as the child’s competencies improve and school staff gain an increased awareness of the child’s abilities.

Assessments for children in school make use of the usual assessment tools available to paediatric physiotherapists such as Movement ABC, GMFM (Gross Motor Function Measure) Chailey Levels of Ability, Bruininks Oseretsky. [see end of article]

For ideas about activities to include in the programmes the group members had accessed a wide range of resources such as the HemipHelp information packs, Scope, Movement MOT and Top Start. London Council also provides packs of alternative games which can be played by children with special needs in mainstream schools. Physio Tools can also be a useful tool for the provision of activity programmes – programmes with writing AND pictures are always well received.

Where do they do it?

There was much discussion about the indicators for providing School-Based Activity Programmes. Perhaps the major consideration is where it would be most appropriate to see the children. When

Here and There

children are in full time education a large part of their waking hours are spent in school. Working hours for physiotherapists often match school hours. Where children would benefit from a daily management programme school is often the most appropriate place for this to take place. Schools can also provide a useful forum and opportunity for multi-agency working for the benefit of the child.

There are, however, some situations when school-based work is not appropriate. These may include issues around privacy for the child or family, suitable space/equipment at school and the competencies of school staff. Some therapeutic interventions – such as hydrotherapy – are unlikely to be accessible at school. There may also be times when the child does require ‘hands-on’ physiotherapy – perhaps post-surgery or with provision of specialist equipment.

For School-Based Activity Programmes it essential to consider the space available to carry out the programme. Storage of equipment is another important issue – bean bags and balance beams may be needed for the same group. These need to be safe and secure when not in use but easily accessible when needed. Space and accessibility are particularly important if the programmes are to be carried out on a daily basis. Although schools have responsibility for moving & handling training & for maintenance of their equipment the physiotherapist must risk assess the particular activity & named staff competence to carry out programme.

Why do they do it?

When education staff are to be involved in School-Based Activity Programmes there needs to be real commitment from the school which will be providing time, space and staff. Head Teachers and SENCO’s often say that their staff are “not physiotherapists”. However, the group felt very strongly that it is essential to ‘sell’ the programme to schools. It may be possible to explain to staff and parents that the physiotherapist may be the “expert” in their child’s condition but that staff and parents are the “experts” in the child. It can also be useful to explain the benefits to education in that children may be more easily able to access the National Curriculum. Educational tasks can also be included in therapeutic activities – e.g. counting when walking. The book by Pilla Pickles [2004] is an excellent source of ideas.

The Special Needs Toolkit is also a very useful source of support (pages 25 – 28) as is the Special Needs Code of practice (pages 135 – 142). The DfES publication ‘Targeting Support’ (0201/2003) describes the 3 Waves of Intervention. Under Wave

3 it lists “Individual support from visiting specialists & Specialist structured programmes. Wave 3 paves the way for daily (or intensive) 1 to 1 support for the “out of step” child. The programme should in some way be connected with the work of the rest of the class & intervention can take place outside the classroom. DfES have devised documentation supporting the work of Speech & Language Therapists (SALT) but, interestingly, not Physiotherapists or Occupational Therapists. Maths difficulties & alternative recording only mention SALT intervention! The Document “Removing Barriers to Achievement” (DfES/0117/2004) Chapter 4 – Delivering Improvements in Partnership 4.28 Page 87 talks about therapy staff supporting & training teachers & LSA’s to “deliver programmes within the child’s school & in line with strategies agreed with teachers to support the child’s learning”.

How do they do it?

Training for education staff is, obviously, an important consideration. Usually the physiotherapist will undertake this on an individual basis. However, it may be more effective to consider group or ‘cluster’ training – perhaps the physiotherapy department can develop a ‘rolling programme’ of training for education? In the early years of the use of the BEAM programme the physiotherapists involved provided regular training for school staff who would be implementing the programme.

Changes in education staff with each academic year are often inevitable unless the education staff are working on a 1:1 basis and move through the school with the individual child. Training programmes for schools can mitigate the effects of educational staff changes and may have beneficial ‘spin offs’ in terms of improved liaison and good working relations.

Competencies which can be used with education staff had been developed by some physiotherapists in the discussion group. These can be used to identify training needs for education staff and then to confirm that they are competent to carry out agreed programmes. Signatures from physiotherapist, head teacher/SENCO and trained staff formalise the arrangement.

Moving and Handling and Risk Assessment are essential aspects of any work with children. Usually it is the responsibility of the education team to ensure that these are carried out but it is within the scope of practice for physiotherapists to give advice about specific situations. As always documentation is critical.

Sharing information, monitoring progress and reviewing programmes can all pose problems when using School-Based Activity Programmes. Information from the group participants included

Here and There

Visit Appointment Letters and Visit Forms, both in triplicate, which can be used for each school visit to provide information before and after the appointment to parents, school and for physiotherapy records.

Experience within the group suggested that to ensure maximum adherence to a School-Based Activity Programme it was best to demonstrate the activities and provide visual instructions at the time of the assessment. It was also thought important to include clear information about relevant expectations and activity progression. Contact details for problems and follow-up plans are also essential. The view of the group was that "Long, posted programmes or reports tend to get filed and not acted upon".

Physiotherapy reviews can often be linked to the Annual Review process for children with Statements, where the aim can be for the physiotherapist to attend the review or provide a report. (These reports usually are read and included in the summary).

Problems:

Although this final discussion group was planned to look at solutions for the many problems identified in the previous study days it was almost inevitable that some problems areas would remain ... obviously the most difficult problems to resolve!

Time remains a crucial issue – not only in the limited availability of physiotherapy time in many departments but the limited time available in schools when competing with the demands of the school timetable and the National Curriculum. School-Based Activity Programmes are considered to be one way of addressing both these issues. However, they may not always be easy to implement. Many of the group felt 'bullied' by Head Teachers, SENCO's and, sometimes, more senior physiotherapists in to providing a "hands on" physiotherapy service – they did not feel autonomous. It may be easier to deal with these pressures if there is an obvious structure for provision in schools. Some departments have developed a 'pyramid service' which include school programmes with no follow-up, through supervised School-Based Activity Programmes to 'hands on' for a very few, acute conditions.

Changes in staff – more usually in education than physiotherapy – and changes in class/school for the child are also issues which can impact of continuity of care. Group training for education may be one way of addressing this. Although maintaining a full programme of school staff training may also place

massive, possibly unachievable, demands on a physiotherapy service.

Liaison with all the parties involved in School-Based Activity Programmes can prove difficult, particularly involving parents in the ongoing care of their children. However, improving links with families and schools can facilitate this and the time for a 'phone call is, usually, less than the time for a treatment session. "It is worth the time to make sure that the school sees you as part of their team" was the consensus of the group.

Final thoughts:

Throughout the group discussions about the provision of School-Based Activity Programmes it was obvious that high levels of co-operation and adaptability, from both physiotherapists and education staff, are essential to 'make it work'. Working indirectly (through education staff) in someone else's space (school) requires high level skills of negotiation and explanation and security on the part of the physiotherapist – in addition to their physiotherapeutic skills! The better this is done the better the outcomes for the children.

Despite the difficulties all the group remain committed to, and even enthusiastic about, working with School-Based Activity Programmes.

- During the discussions some of the group made mention of competencies which they had developed for work with Education Staff. If any of these are available for 'sharing' please either send them to me for circulation, send them to the Journal or post them on iCSP. Thanks.

For information:

Assessment tools: the APCP Outcome Measure Pack (2005) is an excellent resource for information about paediatric assessment tools. [See current Journal for details]

BEAM – further information is available from Dianne Rickard on dianne.rickard@nhs.net. Information packs, including CD ROM and leaflets are available from 01622 749545

Discussion groups: further information about the discussions and a full transcript of each group are available from annmartin2@nhs.net

Pickles Pilla A.C. *Inclusive Teaching. Inclusive Learning: Managing the Curriculum for Children with Severe Motor Learning Difficulties.* London. David Fulton. ISBN - 1843121751

Resources:

www.hemihelp.org.uk, www.scope.org.uk, www.youthsporttrust.org.

The Movement MOT Operates out of St. Mary's Hospital, London

Ann Martin

South East Regional Representative

Book Review

Health Care and the Autism Spectrum: A Guide for Health Professionals, Parents and Carers

Alison Morton-Cooper, Jessica Kingsley Publishers, London, 2004, 128 pages, £13.95, ISBN 1-85302-963-7

The author of this book is a parent of a teenager with autism. She is also a nurse with experience in journalism and health education.

The book is intended for parents, professionals and carers, and covers different aspects of health care provision. The style of writing is easy to read and the text is well presented, although the book is quite short at just over 100 pages. The contents cover visits to the general practitioner and hospital, both planned and emergency visits, and issues involving consent, hygiene, eating difficulties and bereavement. It gives insight into a variety of reactions that can be encountered when providing health care to this group of people.

The book offers practical advice on preparing for clinical interventions and how to avoid conflict while accommodating the rigid structures that are part of the condition, i.e. maintaining structure, being aware of sensory difficulties, clear and careful communication, and adequate supervision.

Useful references for further reading are provided with a limited list of fact sheets, journals and websites that will be useful to readers who are not familiar with the management of autism.

While generally suitable for its intended audience, the language is sometimes too professional. It lacks a section relating to dentistry, where sensory issues are crucial and specialist help may be needed. Some suggestions are unrealistic in the typical National Health Service environment, e.g. It recommends separate quiet waiting areas, longer consultations and extra supervision during procedures, all of which have resource implications.

The text would be most useful as an introduction to the needs of the autistic person and as a reference book for a library. For professionals involved in the care of this group of patients, the book would be useful to raise awareness of the factors that may affect treatment approaches in both the adult and the child with autism and its associated diagnoses. However, the contents would not provide any new insights to those experience in this field.

Heather Angilley

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Aberford Road, Wakefield WF2 4DG, UK
Tel: +44 1924 213783
E-mail address: hangilley@aol.com

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

Contact
Address

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Tel. No.

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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.



ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS



APCP CONFERENCE GLASGOW 2006



CROWNE PLAZA HOTEL
10th–12th November



APCP CONFERENCE, SCOTLAND PROGRAMME

The programme for the conference includes a wide and varied range of topics of interest to paediatric physiotherapists. There is specific content to interest the Neuromuscular and Critical Care Affiliated Groups. The Neonatal Care Group will run a study day in parallel within the main meeting on Saturday 11th November. International speakers and speakers from around the United Kingdom have been invited to contribute and an outline is as follows. The programme will include a session of free papers and posters will be on display during the meeting. **Offers of papers and posters are invited.** There will be a comprehensive trade and book exhibition and social events are planned to allow delegates to meet and socialise. Please note that the full conference programme, "early bird" application form and all conference information will be available on APCP web site in May and in the June Journal.

FRIDAY 10th NOVEMBER 2006

1.30 pm

Opening Keynote Speaker - Professor Hanlon, Professor of Public Health, University of Glasgow, followed by contributions from **Dr Paul Eunson**, Consultant Paediatric Neurologist, The Royal Hospital for Sick Children in Edinburgh and **Professor Gordon Dutton**, Professor of Paediatric Ophthalmology, The Royal Hospital for Sick Children, Glasgow. The afternoon session continues after the tea break with contributions from Elaine Dhouieb, Senior Respiratory Physiotherapist and Dr Ulf Theiland, The Critical Care Team, The Royal Hospital for Sick Children, Edinburgh. This session concludes with the official opening of the Trade Exhibition and "A taste of Scotland." Two workshops are available.

SATURDAY 11TH NOVEMBER 2006

9 am

Opening Keynote Speaker Laila de Groot, Paediatric Physiotherapist, Vrije University Medical Centre, Netherlands. The Neonatal Group will attend the first part of their Study Day following the Keynote Speech and will return for the AGM. The main meeting will continue with Contributions from Christine Shaw, MOVE Education Co ordinator, Scotland and Dr Margaret Mayston from Bobath.

**11.50-12.45pm AGM of APCP,
Lesley Smith, The National Chair.**

1.30 pm

"All The Bits In Place" Led by Linda Fisher, Senior Physiotherapist, Special Education Needs and Pupil Support Services, Basildon Essex. Next Marina Morrow Clinical Specialist Physiotherapist in Neuromuscular disorders, Ashcraig School, Glasgow and Dr Wilcox, Geneticist, University of Glasgow will give a joint presentation. The free papers session will follow the tea break and this afternoon session concludes with a contribution by Dr Patricia Jackson, Consultant Community Paediatrician, The Royal Hospital for Sick Children, Edinburgh. In the evening the Regional committee will host the Conference Dinner and we hope that all delegates will join our guests for an entertaining and convivial evening.

SUNDAY 13th NOVEMBER 2006

9 am

Key Note Speaker Dr Janet Gardner- Medwin, Consultant Rheumatologist, The Royal Hospital for Sick Children, Glasgow. Speakers for the next slot are still to be confirmed. We hope to have contributions from clinical specialist from physiotherapy and nursing. After coffee, Mr Ian Harding, Consultant Spinal Surgeon, in Bristol will give the final presentation to conference. The Conference 2006 will close at 12.30 pm.

ALISON M GILMOUR



TRENT REGION A.P.C.P. STUDY DAY

THURSDAY 27TH APRIL 2006

10.00am - 4.00pm

At St Francis School, Lincoln

Dysphagia and Respiratory Management

am:

Hard to swallow

Presented by: Helen Burchnall

Physiotherapist, Special Interest Post in Dysphagia

Short AGM

LUNCH INCLUDED

pm:

Effects of posture on respiration.

Theory and Practice

Speaker to be confirmed

Cost: members £25, non-members £30

Closing date: 7th April 2006

Name APCP membership number

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Please send cheques made payable to APCP for the correct amount to:
FAO. Pam Pastor/Hilary Heritage. Physiotherapy Dept. St Francis School.

Wickenby Crescent. Lincoln. LN1 3TJ. Tel: 01522 523430

- map and programme will be sent with receipt

The role of therapists in neonatal care



Run by:
Neonatal Interest Group
Association of Paediatric
Chartered Physiotherapists

Wednesday 14th,
Thursday 15th and
Friday 16th June 2006

Antrim Hospital Site,
Antrim, Northern Ireland

Cost:
1 day £70 (APCP members)
£ 80 (non-members)

2 days £140 (APCP mem-
bers) £160 (non-members)

3 days £180 (APCP mem-
bers) £220 (non-members)

Course content:
Respiratory care
Prematurity and
pathology
Concepts of care
Neurodevelopmental
assessment and
intervention

20 places
Application forms and
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fiona.price@sth.nhs.uk
www.interactivecsp.org.uk
Fiona Price, Physiotherapist,
Neonatal unit, Level 2,
Jessop Wing,
Tree Root Walk,
Sheffield, S10 2SF



Association of Paediatric Chartered Physiotherapists

Advanced Course on Cerebral Palsy

13th and 14th March 2006

At The Milestone School, Longford Lane
Gloucester, GL2 9EU

This course is designed to enhance the clinical reasoning and problem solving strategies of experienced clinicians working with children with Cerebral Palsy. The course is based around interactive learning with lecture/seminars, group work, video analysis and appraisal of literature.

The speakers and delegates will analyse the evidence and theory underpinning assessment and treatment approaches for this client group.

By the end of the 2 days delegates will have been assisted to develop holistic and critical approaches to management of this patient group.

Further information and an application form can be obtained from Lynda New, Quedgeley Clinic, St James, Quedgeley, Glos GL2 4WD
Tel. 01452 891414.



COMING SOON
APCP CRITICAL CARE GROUP
STUDY DAY
20th June 2006

Update and Current Management of
Oncology / Haematology Patients
in Paediatric Critical Care

***SHEFFIELD CHILDREN'S HOSPITAL
NHS TRUST***

For more information and
date please contact
Mel Lindley at:
Melanie.lindley@sch.nhs.uk



EVIDENCE BASED CPD Courses

PAEDIATRIC RESPIRATORY & MUSCULOSKELETAL WORKSHOP

(tutors Peter Beirne MCSP & Paul Ritson MCSP)

April 29 to 30 – Uxbridge, Middx, June 17 to 18 – Paisley, Scotland, Sept 2 to 3 – Newcastle, Oct 21 to 22 - Cardiff

Cost £189 (includes refreshments, course handbook and CPD certificates - 14hrs)

Presenters: Paul Ritson graduated from Royal Liverpool Hospital College School of Physiotherapy in 1988. He has worked at the Royal Liverpool Children's NHS Trust (Alder Hey) since 1990, specialising in the respiratory speciality of Paediatric Intensive Care since 1993 having completed the Brompton Hospital Validated Respiratory Course. Since 2000, Paul has worked as a Clinical Specialist Physiotherapist on the Paediatric Intensive Care Unit at Alder Hey. For the last 10 years Paul has co-organised and lectured on *Paediatric Respiratory Care* on the Mersey Region On Call Course for newly qualified Physiotherapists. He has also delivered the Paediatric respiratory module at the University of Liverpool for the past 7 years and at the University of Salford in Manchester for the last 5 years. In October 2003, he was co-organiser of the APCP Introduction to Paediatrics course – an annual course lasting 1 week, validated by the APCP. He has been an invited speaker at national conferences, including ACPRC Conference, Advanced ITU courses at University College and Great Ormond Street Hospital, London. At present, he is part of a group of Physiotherapists starting a Paediatric Intensive Care Physiotherapist Interest Group, which will be affiliated to the APCP. In March 2004, an 'On Call Physiotherapist Survival Guide' was published, to which Paul wrote one chapter and co-authored a second.

Peter Beirne graduated from Royal Liverpool Hospital College School of Physiotherapy in 1991. In 1996 he began to develop the Paediatric Orthopaedic Service within the Trust and also became involved with the English and Welsh Athletics Teams. Following promotion to Superintendent at Alder Hey in 1996, he continued to develop the inpatient and outpatient Orthopaedic service and worked closely in setting up the Paediatric Ilizarov service. During this time he was also heavily involved in the Haemophilia service and setting up National guidelines into the treatment of paediatric conditions. He became a member of the British Athletic Team and attended numerous international meetings as athletic team Physiotherapist, culminating in 1998 when he was part of the Medical Team supporting the English Team at the Commonwealth games in Kuala Lumpur. Since 1996, he has also been employed as Physiotherapist to the Everton Football Academy. His work encompasses the full time and academy players as well as setting up a musculoskeletal screening programme and assisting in the audit of injuries and musculoskeletal research. Becoming a Clinical Specialist in 1998 he set up the adolescent knee pain clinic and the Ponsetti method clinic with the Orthopaedic surgeons to treat babies with Talipes deformities. For the past several years he has presented the Paediatric Orthopaedic Modules at Liverpool and Salford Universities at undergraduate level. As well as lecturing locally and nationally on Orthopaedics and children in sport, the most recent being at the APCP introduction To Paediatrics Course in Liverpool, 2003.

Course Description: This exciting course focuses on 2 specific areas of Paediatric therapy – respiratory and orthopaedics. The course has 2 theme specific days, and comprises a mix of theory and practical workshops. The delegate will gain insight into the assessment, management and problem solving in this challenging client group. Practical skills will also be taught in the workshops, including CXR interpretation in respiratory and orthopaedic patients. Therapists carrying out on call duties involving children may find the respiratory component of this course particularly useful. Throughout, this course will be led in an open style, encouraging delegate participation and exchange of ideas and information.

PRACTICAL PODIATRIC BIOMECHANICS (tutor Paul Harradine, MSc, BSc (Hons), SRCh, Cert Ed, Podiatrist)

March 18 to 19 – Winchester, April 22 to 23 – Tidworth, Wiltshire, May 6 - 7 – Taunton, Somerset, June 17 to 18 – Redruth, Cornwall,

July 15 to 16 – Uxbridge, Middx, Sept 16 to 17 – Harrogate, Sept 30 to Oct 1 - Guernsey, Nov 11 - 12 - Hemel Hempstead, Herts

Cost £189 (includes refreshments, course handbook and CPD certificates - 14hrs)

Presenter: Paul Harradine graduated from the Northampton School of Podiatry in 1994. He is currently the Company Director of The Podiatry & Chiropody Centre, Portsmouth, as well as running a number of private podiatric clinics in Portsmouth and Southampton. He was the Clinical Lead Specialist in podiatric biomechanics within Portsmouth HealthCare NHS Trust between 2000 – 2004. Paul also has a Masters of Science in Sports Injury and Therapy, Certificate in Professional Studies 'Sports Podiatry', Post Graduate Certificate in Sports Science from Manchester Metropolitan University and a Certificate in Education. Paul has regularly taught podiatric workshops to podiatrists, physiotherapists and Naval Medical personnel over the past 6 years and lectures on podiatric biomechanics at Southampton University School of Health Professions and Rehabilitation Sciences. He is also a member of the Southampton University School of Health Professions and Rehabilitation Sciences school board.

Course Description: This intensive 2 day theoretical and practical course is based on extensive clinical experience in assessment and treatment of lower limb and gait dysfunction, as well as extensive reference to research publications. A number of pathologies will be presented together with appropriate assessment and treatment techniques. The evidence supporting the use of the assessment and treatment procedures will also be presented. Participants completing this course will gain a greater understanding of the anatomy, biomechanics, assessment and evidence-based treatment of this interesting and complicated subject.

ANTERIOR KNEE PAIN: DIFFERENTIAL DIAGNOSIS & TREATMENT

(tutor Lee Herrington MSc, MCSP, CSCS)

March 18 to 19 – Taunton, April 22 to 23 – Dublin, May 13 to 14 – Cardiff, July 15 to 16 – Reading, Sept 16 to 17 - Peterborough, Nov 16 - 17 - Chichester, W.Sussex

Cost £189 (includes refreshments, course handbook and CPD certificates - 14hrs)

Presenter: Lee qualified as a Chartered Physiotherapist in 1990 from Manchester University, having previously completed a degree in Human Biology from Loughborough University. In 1996 he was awarded an MSc in Sports Injury and Therapy from Manchester Metropolitan University. He has also been certified by the National Strength & Conditioning Association (of America) as a strength and conditioning specialist. Currently, Clinical Specialist Physiotherapist, Cheshire Physiotherapy Centre; Lecturer in Sports Rehabilitation, University of Salford; Honorary Lecturer in Sports Physiotherapy, Manchester Metropolitan University and Prince Faisal Sports Medicine Hospital, Riyadh, Saudi Arabia; Member of the International advisory board to the journal Physical Therapy in Sport. Lee has worked with elite sportspeople for the last twelve years including time with Great Britain Rugby League and Wigan Warriors Rugby League Club. Also, consultative work for a number of professional football clubs and individual elite level sportspeople from a multitude of sports including archery, athletics, swimming, triathlon, sailing, boxing and martial arts. Specialist areas of clinical interest are the treatment and rehabilitation of sports injuries, specifically Patellofemoral joint pain and rehabilitation following knee surgery (principally ACL & PCL reconstruction). Current research interests include: assessment and treatment of lower limb motion control (proprioceptive) deficits; assessment and treatment of Patellofemoral joint pain; lower limb pathoneurodynamics and muscle injury. Lee has presented research and lectured on the topics of patellofemoral pain syndrome, exercise rehabilitation and assessment of movement dysfunction both nationally and internationally.

Course Description: The course is delivered through a series of lectures, practical demonstrations, and practical tutorials. A course handbook will be available to support all materials presented. Day 1 investigates the many and varied causes of anterior knee pain, looking at the features of each of these individual pathologies which allow for differential diagnosis of these conditions. The second part of the first day is dedicated to assessment of anterior knee pain, this section is very interactive with frequent opportunities to practice the assessment techniques demonstrated. Day 2 involves the presentation of treatment strategies for the treatment of the three commonest causes of anterior knee pain; patellofemoral pain, patella tendonosis and fat pad syndrome. Treatment techniques included are taping techniques, joint mobilisations and exercise rehabilitation procedures, this section is very interactive with frequent opportunities to practice.

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*Warren Glover, Research & Policy Officer
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