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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

Thank you for all your contributions to the journal over the past months. It has been encouraging that the number of submitted articles has risen and that they cover a wide range of topics. This journal features articles on gait analysis, service development to improve DCD referrals, and a review of Torticollis management. APCP Matters highlights some of the work being undertaken by APCP members on Competences and National Neonatal Forum. Please take time also to read the Treasurer's report and comment on the proposals within it.

The interactive CSP website is proving to be a popular resource for paediatric physiotherapists and discussion threads emphasise how much knowledge can be shared. Maybe some of these threads would be useful to provide material for journal articles particularly where there are differences in approaches and a lack of evidence.

In this journal we also remember two APCP members who have recently passed away, Carole Hurran and Sarah Prior. Both have contributed to APCP and paediatric physiotherapy and are a loss for both their families and our profession.

There are still places free for the Glasgow conference, the programme and application forms are reprinted in this issue.

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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 physiotherapists working in schools for children with Communication Impairments, high functioning autism, (Aspergers,) ADHD, and MLD.

We are hoping to meet two or three times a year and would like to open this up to other physiotherapists who work in this field.

Please write/email/telephone.

Yours sincerely

Jan Dodgson

Who Needs Gait Analysis?

Janet Rose, Clinical Specialist Physiotherapist, Child Health Team, Preston
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Introduction

Part of my role at Preston PCT is to support the Regional Botulinum Toxin Clinics at Lancashire Teaching Hospital. I assist with the clinical examination of the children, record their walking and produce an analytical report of the gait. Initially I undertook gait analysis training with the European Society for Movement Analysis (ESMAC) and have adapted their clinical assessment sheet for use at the clinic. I have attempted to follow gait analysis principles under the resource constraints placed upon the service – namely space, time and equipment.

I am constrained by the size of the ward where the gait analysis takes place. The ward has been marked with a path three metres long and one metre wide across the diagonal. Using a fixed path allows me to calculate parameters such as step length, cadence and average speed of walking. The path is quite short but it is the longest I can provide for the children and still give them chance to speed up, slow down and turn round. I feel that the distance is more limiting for the older children than the younger ones because of their greater stride length.

I have a digital camcorder available to me. I set the camera at approximately the level of the child's knee using a tripod stand, filming first in one corner of the ward and then another in order to capture movement in the sagittal and coronal planes. Children are filmed walking barefoot and in their orthoses allowing some estimate of the impact of the orthoses on gait. I have recently started taking the camera down to floor level to see if this gives me more detailed information about foot posture and floor clearance during gait. The videos are reviewed back at the office where I look at them in real-time on the television and then transfer them onto the laptop. On the laptop I can view a complete gait cycle frame by frame. The whole process is very time-consuming, making report writing a lengthy process.

In writing the report, I try to follow the structured assessment process learnt during the ESMAC training and link what is observed on the video with what is measured during clinical examination. I capture still images from the video footage to illustrate my observations in the report. Once the reports are prepared the videos are reviewed to decide on the need for injection therapy and the target muscles. This is a multi-disciplinary meeting involving myself, the paediatric neurologist and paediatric orthopaedic surgeon allowing an opportunity to participate in the decision process and reinforce

learning from different perspectives and experience.

The system is an evolving system with the next change being the intention to use some form of marker to identify important anatomical positions. I am aware of the limitations of the system that we have in use but I am trying to do the best that I can with what is available to me. I feel confident that I can justify the clinical decisions that are made with the evidence from our assessment process. However, I am aware that at specialist tertiary centres gait analysis technology is often used to support this decision-making process and this created a dilemma and a level of uncertainty in my mind.

The Dilemma

My dilemma is as follows - are the decisions that we are making without technical support compromising the potential benefits of the medical interventions we are applying? Would those decisions be any different or result in better outcomes if I had the support of gait analysis technology? After all, the Government directs us to provide a fair and equitable service for everyone based upon sound evidence (Department of Health, 1998). The National Service Frameworks for Children (2004) and Long Term Conditions (2005) outline the quality requirements for service delivery with the emphasis on a person centred service offering early specialist rehabilitation, prompt diagnosis and appropriate treatment to maximise potential. We have to do this whilst operating within the confinements of a resource bound environment.

In an attempt to ease my mind and resolve my dilemma I determined to look at the evidence base for the application of gait analysis to clinical practice and its role in clinical decision-making.

Searching The Evidence Base

I searched MEDLINE, CINAHL and AMED using a combination of keyword and MeSH terms (gait analysis; electromyography; diagnosis, computer-assisted; decision making), limiting the resultant list of articles to systematic reviews and clinical trials. I also found other articles of interest by hand searching significant Paediatric journals. A summary of the findings of these articles is given in Table I.

My intention with this article is to pass on some of the information that I have found. The article is structured as follows:

- Systems available to quantify gait
- Gait analysis in the clinical context
- Arguments for and against clinical gait analysis
- Finally I should like to share my thoughts about the relevance of a movement analysis approach to paediatric physiotherapy practice

Who Needs Gait Analysis?

Table I: Summary of research evidence, by year of publication, supporting the use of gait analysis in the clinical assessment process.

YEAR	AUTHOR	SUBJECTS/CLIENT GROUP	STUDY TYPE	GAIT ANALYSIS	CONCLUSION
1997	DeLuca et al	91 children with cerebral palsy and bilateral lower limb involvement	Prospective comparative analysis	3D joint kinematics and kinetics Dynamic EMG Biplanar video recording	Availability of gait analysis data alters clinical decision making in more than 50% cases leading to a reduction in surgery
2002	Fairburn et al	15 children with persistent poly-articular arthritis	Prospective open descriptive analysis	Biplanar visual vector system In-shoe plantar pressure system Force platform	Allows the identification of different patterns of gait disturbance which are not obvious on clinical examination alone.
2002	Fuller et al	36 adults with upper motor neuron syndrome	Non randomised repeated measures design	Kinetic and kinematic data Force platform Dynamic EMG	Alters surgical decision making and increases uniformity of decisions Reduces the risk of unnecessary surgery
2003	Cook et al	102 ambulant patients with cerebral palsy	Prospective comparative analysis	3D gait analysis 5 infrared cameras Force plate Real-time coronal and sagittal plane video recording	Gait analysis alters the level and type of surgical intervention
2003	Laliotis et al	25 diplegic children	Comparative analysis	4 infrared cameras Elite program Kinematic wave form analysis	Distinguishes between the need for surgical and non-surgical interventions
2004	Gough et al	24 ambulant children with spastic diplegia	Retrospective comparative analysis	3D kinematic and kinetic data EMG data	Using gait analysis to inform surgical decision making stabilises a child's gait pattern
2004	Schwartz et al	135 ambulatory children with spastic diplegia	Retrospective non randomised study	3D kinematics and kinetics Oxygen consumption	Decision making based upon gait analysis reduces the risk of iatrogenic deterioration in gait

Quantifying Gait

Gait analysis technology is used to quantify movement. The equipment used will differ depending upon what aspect of movement is being analysed. Systems can vary from biplanar video recording to three-dimensional data capture, EMG recording and ground force measurement interfaced to a central computer (Davis 2004). Research and academic institutions developed the technology in order to understand the complex mechanisms involved in normal human movement. Through this, clinicians now have a good understanding of normative gait parameters (Steinwender 2000) and the developmental maturation of walking (Sutherland 1988).

Two-dimensional video recording is important in clinical gait analysis because it provides information about the overall gait pattern and level of functional ability. Davis (2004, p. 90) argues that viewing the movement in real-time and slow-motion replay "significantly enhances the observer's ability to evaluate complex, multi-planar walking patterns". In addition to the qualitative analysis of movement there are ways of quantifying movement.

Kinematic analysis allows the quantification of body segments and joint rotations involved in movement. There are different ways of collecting this information including the use of electrogoniometers (Rowe et al 2001) or three-dimensional computerised systems such as Vicon (Kadaba et al 1990), Coda

Who Needs Gait Analysis?

(Maynard et al 2003) or Fastrack (Jordan et al 2000). In motion analysis systems, data cameras pick up data from markers the person is wearing. Technicians place markers at specific anatomical positions under strict protocols for measurement and placement. The controlling software analyses captured data and present it in graphical format. It provides details of spatial and temporal parameters (speed, step length, cadence) as well as Kinematics (dynamic joint range). When combined with a force-plate in the floor of the walkway, this system can produce images such as that shown in figure 1 as well as provide additional information about the Kinetics of movement (moments and powers acting at the joints).

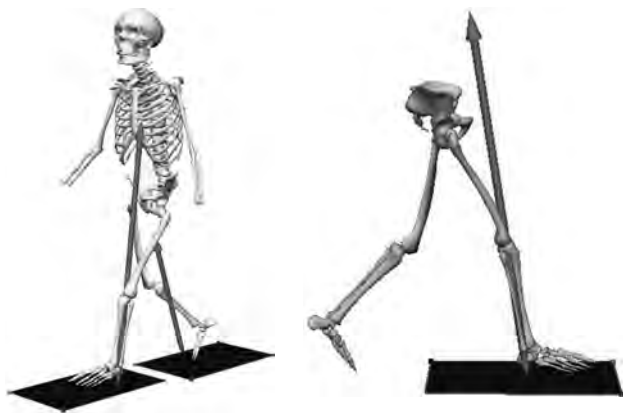


Fig. 1 Visual software can create animated skeletons to demonstrate recorded movement and superimpose the ground reaction vectors generated during the stance phases of gait. (Reproduced with the permission of Jim Richards, Professor of Biomechanics, University of Central Lancashire using Qualisys movement analysis system and C-motion Visual 3d software.)

Electromyography equipment and the use of surface electrodes or intramuscular fine wires record the switching on and off of muscular activity during gait. This is particularly important information when considering correcting gait through tendon transfers.

Recording heart rate and oxygen consumption can give some indication of the energy cost of walking. In a preliminary study at the ORLAU Movement Centre reported at the Clinical Movement Analysis Society of UK and Ireland (CMAS) annual meeting and AGM it was suggested that high energy consumption is an indicator of poorer long-term mobility (Butler et al 2006). CMAS was established in 2002. It developed out of the organisation Gait Labs UK. CMAS is a multi-disciplinary organisation, the majority of the members closely connected to clinical gait analysis laboratories. The main aim of the organisation is to provide "a coordinated approach

to movement analysis standards and professional matters" (CMAS 2004).

There is also increasing clinical use of plantar pressure systems (pedobarographs), which provide information about weight-bearing loads on the plantar surface of the foot. Alderson, Peters and Main (2006) report the use of the GAITRite® mat to study dynamic walking balance. The GAITRite® has been validated as a tool to measure step parameters (Webster et al 2004).

Gait Analysis in The Clinical Context

Within the clinical context, gait analysis is used as an adjunct to physical examination and observation in planning treatments and predicting functional behaviour following the intervention. "Combined with clinical information, the laboratory measurements of muscle function often provide the degree of detail and confidence necessary to optimise the rehabilitation interventions" (Esquenazi and Mayer 2004 page 21). James Gage in particular has been very influential in promoting the value of gait analysis in the treatment of pathological gait in children with cerebral palsy (2004). He states that not only is gait analysis an "essential tool in the treatment of cerebral palsy" but that it has "radically changed the treatment of cerebral palsy" (Gage 1993, p. 126) by allowing accurate pre and post operative assessment, critique of surgical procedures and identification of homogenous gait patterns.

Tomie and Hailey (1997) identify two main uses of modern gait analysis techniques in paediatric rehabilitation:

- Pre-treatment decision and/or post-treatment assessment purposes
- Descriptive or categorizing purposes

Laliotis et al (2003) used gait analysis to differentially treat children with either Botulinum toxin or surgical intramuscular lengthening by distinguishing between fixed contracture and dynamic contracture. DeLuca et al (1997) showed that surgeons alter their decisions when gait analysis data is available to them and gait analysis allows the adoption of a muscle specific approach to planning treatment in a way that is impossible by clinical judgement alone (Fuller et al 2002).

Fairburn et al (2002) were able to distinguish between adaptive gait patterns resulting from pain avoidance and those resulting from fixed deformity. They argue its use may help prevent the development of potentially damaging adaptive gait deviations. While the natural pattern in cerebral palsy is one of gait deterioration (Bell et al, 2002; Gough et al, 2004) Schwartz et al (2004) argue that it is possible to maintain, if not improve, children's functional abilities when computerized gait analysis is used to plan surgical interventions.

Who Needs Gait Analysis?

The Gait Analysis Debate

Tomie and Hailey (1997) state that while gait technologies successfully differentiate changes within subjects and differences between subjects, evidence of its beneficial effect on treatment outcome is sparse because of small patient numbers and absent or inadequate controls. A number of the research studies rely on the retrospective analysis of clinical records, which can lead to false conclusions because of the selection of the data to be included, failure to demonstrate causal link and potential for experimenter bias. However, Gage (2004) argues that by having a greater understanding of the "mechanisms by which pathological gait arises" it allows "a logical approach to treatment" (p. 238), providing person-centred planning (Fairburn et al 2002) and reduces the risk of inappropriate or damaging interventions (Gage 1994; Schwartz et al 2004).

Watts (1994) claims that scientists measure the things that are convenient to measure, not necessarily those that are most relevant. The biomechanical approach to gait analysis replaces descriptive accounts with graphical representations and mechanical outcomes where the focus of attention should be on function. Damiano and Abel (1996) have shown that clinical gait analysis is a valid indicator of motor function in CP and complements the use of GMFM in the functional assessment of the children. Indeed, walking cadence was a strong predictor of GMFM score. The Normalcy Index (NI) has been developed to provide an index of global gait pathology (Schutte et al 2000). It is based on quantitative gait data and provides a measure of "the deviation of a patient's gait from the average gait of subjects without pathology" (Novacheck and Schwartz 2004, p.410). Romei et al (2004) demonstrated that the Normalcy Index is easy to use, reliable and sensitive enough to distinguish between pathologies.

Whilst the human eye can only see 12 frames per second, the digital camera can capture data at the rate of 50 frames a second. This allows observation of gait in greater detail (Patrick, 2003). Movement can be slowed down to such an extent that frame-by-frame analysis is possible. "The advantage of gait analysis is that it allows a systematic appraisal not possible with the time constraints and equipment of clinics or physiotherapy treatment rooms" (Jones and Roberts 1998, p. 152). The video recording can be played over and over again to enable movement at each joint to be studied systematically. In addition, the ability to capture data in the transverse plane allows a true distinction between rotatory movement and movement in the coronal plane. This distinction is difficult to make with biplanar and observational assessment alone. When dynamic electromyography is combined with kinematic and

kinetic data there is a depth of information not only about movement but also about the recruitment of muscle activity, which is useful when considering tendon transfers.

The gait laboratory is an artificial setting for the child. Even the laboratory environment - temperature, lighting, noise levels, flooring may unwittingly alter the child's normal walking pattern. Clinicians working with cerebral palsy (CP) children know that they can respond differently from day to day and that it is more instructive to view the child over an extended period of time in a variety of settings to come to a full understanding of the child's true level of functioning (Watts 1994). Steinwender et al (2000) showed that there is indeed lower intrasubject between-day repeatability of kinematic gait data in CP children when compared to normal children although kinetic data showed better repeatability. They argued that marker placement error could account for some of this variability. Kirkpatrick et al (1994) suggest that the within-day variability of CP children could in part be explained by increased fatigue and the need to undergo more attempts to obtain clean contact with the force platform to acquire the data.

Within the gait analysis community, there are concerns about the variability and reliability of gait data. Institutions vary in their identification of problems and the treatments recommended, especially in bony procedures (Skaggs et al, 2000) although training, culture and experience may account for much of this variability. However, Noonan et al (2003) showed that different gait centres would recommend different treatment for the same patient because of variations in the raw data collected for evaluation. Variability of gait data arises because of marker placement errors, and definitions of specific points in the gait cycle and gait velocity (Gage 2003). This is of great concern to motion analysis laboratories. CMAS has an important role in addressing issues relating to variability in clinical gait laboratories in the UK and Ireland.

Discussion

Although in the primary care setting we have difficulty in matching the objectivity and precision of the gait laboratory it does not mean that we cannot apply the principles of the gait analysis approach to our own situations and clinical decision-making. After all, not all treatment options available to clinicians involve surgical intervention (Table II) yet they still can have a significant impact on a child's gait and level of functioning. How can we make treatment decisions relating to gait if we do not do some form of gait analysis to justify the choice and measure the impact of the intervention?

There are a variety of options available to clinicians not all of which involve surgical intervention but all

Who Needs Gait Analysis?

Table II: Management options for pathological gait in children with cerebral palsy.

Surgical	Medical	Physical
<ul style="list-style-type: none">• Derotational osteotomy• Selective muscle lengthening• Tendon transfers• Muscle recession• Selective dorsal rhizotomy	<ul style="list-style-type: none">• Baclofen• Botulinum Toxin A• Phenol	<ul style="list-style-type: none">• Orthoses• Appliances• Dynamic splinting• Walking aids• Exercise

of which can have a significant impact on the child's gait and level of functioning.

There appear to be six aspects of clinical gait analysis that can be adapted to the primary care setting to ensure that our clinical decision-making is based upon the right level of clinical evidence:

Use of technology

Mobile gait laboratories are available for hire and have been shown to be valuable when applied to orthotic provision (Stallard and Woollam 2003). Use of a digital camcorder really does enhance observation and gait assessment particularly when the movement is slowed right down to allow frame by frame analysis and the systematic study of body segments at each point in the gait cycle.

Comprehensive clinical examination

A comprehensive clinical assessment of range of movement, muscle strength and tone taken at one point in time provides the information that can be used to explain observations of gait deviations and guide therapy planning. Static clinical examination informs us about bony torsions, muscle shortening and joint contractures. Maintaining the discipline of assessing range of movement, tone and strength at all relevant joints means that you have the information available for the identification of possible contributors to a child's movement dysfunction. It helps us to identify muscle groups that need strengthening or stretching, bony torsions that contribute to intoeing or outtoeing and fixed contractures that require an orthopaedic opinion. If the profession could come to agreement over which measures are important in guiding treatment and how these measures should be taken then we will go some way towards reducing variability of paediatric practice.

Structured observation

Video recording should be taken in more than one plane to allow for observations of the movement in the appropriate anatomical plane. The temptation of making definitive comments about movement in

one plane whilst actually viewing movement in another plane should be avoided. There are tools available such as the Edinburgh Visual Gait Score (Read et al 2003) that have been developed to facilitate the structured observation of videoed gait and reduce the level of subjectivity inherent in observational gait assessment. Toro et al (2003) review the tools available to clinicians outside the movement laboratory setting.

Detailed understanding

Investing in time to attend basic gait analysis training such as ESMAC or read standard texts (Gage 1993, 2004) is worthwhile not only in increasing knowledge about normal gait patterns but also in raising awareness about the biomechanical forces acting the developing child and how our interventions can impact on those deforming forces. Without this knowledge at best our interventions will be ineffective at worst they may contribute to increasing the burden on the child and family (Gage 1994).

Linking clinical examination and function

An important part in the process is in linking the evidence from the static clinical examination with the dynamic observations. You need both if you are to provide a unique and specific child-centred programme which will optimise the effectiveness of the intervention and minimise the risk of any harmful consequences. Repeated regularly, perhaps at the child's annual review, it will help to chart the child's progress, provide evidence of the effectiveness of the intervention and help to guide future treatment planning. Not only that but it will highlight the individuality of the children's movement problems and their response to therapeutic intervention. Cognitive, behavioural, emotional and sociological factors also impact on the effectiveness of our treatments. Jones and Roberts (1998) discuss the importance of taking these factors into account when considering surgical intervention.

Multi-disciplinary working

Watelain et al (2003) demonstrated that clinicians from different backgrounds use different strategies when analysing gait but that these differences combined together actually enrich the assessment process. We can learn from each other. More experienced colleagues can help less experienced colleagues. Gait analysis improves with practice and in discussion over alternative interpretations of what is seen. Our observational skills become sharpened and our knowledge base increased.

Conclusion

The arguments for and against the use of gait analysis in the clinical context have been raging for the last 20 years. Instrumented gait analysis is an expensive commodity and yet if the cost of gait analysis were on a par with the cost of an MRI or CT scan (Gage 1994), it would not appear to be too exorbitant a cost. More therapists are becoming aware of the

Who Needs Gait Analysis?

advantages of applying a biomechanical model to the assessment of gait deviations and it is now possible to hire mobile gait laboratories for use in assessing children and tuning orthoses. Just as we have seen an increase in the number of imaging systems available in the Health Service so it is likely that we will see an increase in the use of motion analysis systems in the rehabilitation context. The paediatric physiotherapy profession needs the precision and detail of motion analysis to support clinical practice and provide a new clinical measure of functional change.

Although primary care physiotherapists do not have immediate access to instrumented gait analysis it is possible to apply gait analysis principles even where there are restrictions in time, operating environment, staffing and equipment. Ensuring that the right information is available for the decision process will maximise clinical effectiveness and reduce the risk of adverse reactions to interventions.

Can you imagine the wealth of information that would be available to us if once a year we provided

the children with a thorough biomechanical assessment and observational movement analysis according to nationally agreed protocols and procedures? Not only would it allow us to be specific in our treatment planning for each child, but also it would open up the possibility of collaborative longitudinal projects to establish optimum treatment processes and therapeutic care pathways. The deforming forces acting on a child with a static neurological condition continue throughout that child's life. We are not in a position to manage those forces effectively if we do not understand and apply biomechanical principles to our assessment processes and clinical reasoning. Combining the biomechanical model with our understanding of motor control and motor learning (Shumway-Cook and Woollacott 2001) will ensure that the motor performance potential of each child with gait dysfunction is reached.

But what of the children whose level of function and mobility does not allow gait assessment? Should they be excluded from observational assessment and thorough clinical examination? If the child is to be the centre of treatment planning and we are managing their care as effectively as possible then we have to develop our observation skills for movements other than walking. Movement analysis allows an individualised, person-centred approach

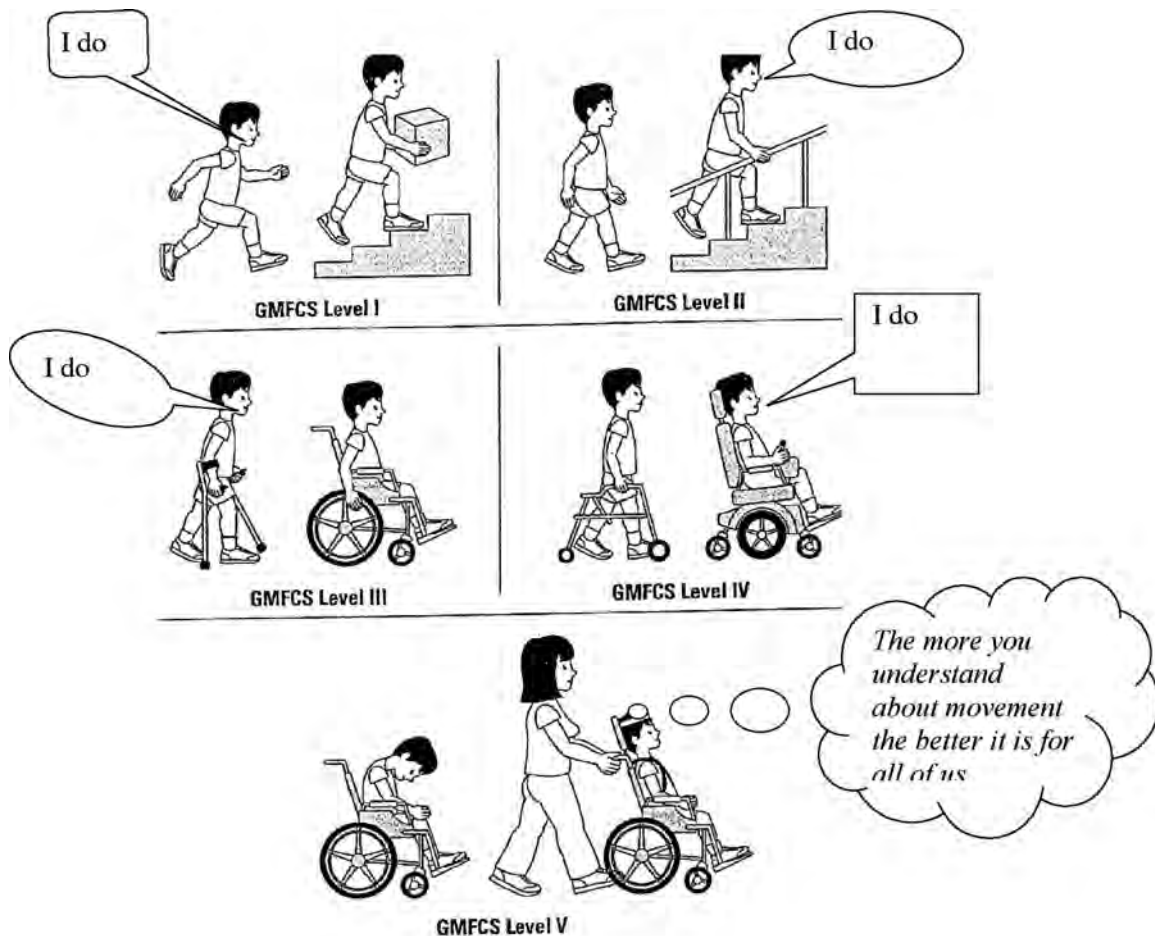


Figure 2: Children of all functional abilities will benefit from movement analysis, after Graham (2005). Reproduced with permission of the authors.

Who Needs Gait Analysis?

to treatment planning. It is of benefit in choosing effective treatments and predicting outcome following intervention.

Perhaps my question should not so much be "Who needs gait analysis?" but rather "**Who needs movement analysis?**" I shall let the children answer for themselves in Figure 2.

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Physiotherapy for Torticollis

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Key words:

Torticollis, differential diagnosis, congenital muscular torticollis, physiotherapy management.

Introduction

Torticollis is a descriptive term of abnormal posture, derived from the Latin *tortus* (twisted) *collis* (column), in which the head and neck are held in side flexion towards the affected side, with rotation of the head to the opposite side. Torticollis or wry neck is a common childhood complaint whose aetiology is diverse. Identifying the cause can be challenging. This paper will review the physiotherapy management of Congenital muscular torticollis (CMT) and Juvenile muscular torticollis.



Figure 1: A 5 year old boy with Down's syndrome who acquired a torticollis after a fall

Congenital muscular torticollis (CMT) is the most common manifestation of wry-neck posture but it is important to rule out other possible reasons for the unusual head tilt noted. Ballock and Song (1996) stated that in the literature there are more than 80 causes for torticollis. They suggested an algorithm to determine differential diagnoses, which can be summarized as thus:

- **Muscular:** contracture of the sternomastoid muscle on one side, noted in the early months of life. Although the cause may be undetermined it is thought that it may have been some sort of trauma during delivery.
- **Trauma:** fractures of the upper humerus, clavicle, C1-C2 subluxation. Minor trauma can lead to spontaneous C1-C2 subluxation. Children with bone dysplasia, Morquio's syndrome, spondyloepiphyseal dysplasia and Down's syndrome have a high incidence of C1-C2 instability.

- **Congenital (bony):** abnormal formation of the cervical spine resulting in bony deformity. Head tilt with rotatory deformity of the head and neck may well indicate a problem at C1 and C2. Head tilt alone indicates a more generalized bony problem in the cervical spine such as Klippel-Feil syndrome where 20% of patients have an associated torticollis (Hensinger et al 1974, Fielding and Hawkins 1977).
- **Inflammation:** Viral infections causing cervical adenitis or tonsillitis, retro-pharyngeal abscesses may cause local irritation leading to the adoption of a head tilt. Children with polyarticular juvenile idiopathic arthritis frequently develop involvement of the cervical joints with torticollis and limitation of cervical range of motion being the only clinical signs (Hensinger 2002).
- **Ocular problems:** squint, visual field defects
- **Neurological:** such as dystonia, posterior fossa tumours, Sandifer's syndrome in CP. Benign paroxysmal torticollis of infancy is due to many neurological causes, including drug intoxication (Hensinger 2002). Sudden posturing of the trunk and torticollis due to gastro-oesophageal reflux (Sandifer's syndrome) can be seen in a child with severe neurological impairment such as cerebral palsy. Space occupying lesions of the CNS, particularly posterior fossa or spinal cord, can cause a torticollis. Neurological signs may be subtle in the early stages but generally there will be findings such as long-tract signs or upper limb weakness (Gupta et al 1996).
- **Pain:** bone tumours such as osteoid osteoma, Ewings.
- **Idiopathic:** No obvious organic cause. Hysterical and psychogenic causes are uncommon in children but can exist. These should be considered only after other causes have been carefully excluded.

Congenital Muscular Torticollis

Congenital muscular torticollis (CMT) is a postural deformity, resulting from unilateral shortening and fibrosis of the sternocleidomastoid muscle (SCM) characterised in an infant or child as a persistent lateral flexion of the cervical spine to one side with rotation to the opposite side. The pathophysiology and aetiology of SCM impairment remains unproven although many theories abound from muscle trauma during delivery, soft tissue compression leading to compartment syndrome, breech deliveries and multiparity and intrauterine malposition (Fabian and Marshall 1984, Taylor and Stammos Norton 1997, Ho et al 1999). However CMT has occurred after otherwise normal deliveries and been reported in infants born by caesarian section

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(Hensinger 2002). CMT has also been historically linked to plagiocephaly due to persistent positioning of the head when prone or supine (Golden et al 1999).

CMT may not be noticed initially but often, within the first few weeks of life, the parent may notice a lump in the muscle (sternomastoid tumour), level with the angle of the jaw, which is apparent when the baby cries. It is generally a non-tender lump that is mobile under the skin but located in the SCM. It attains maximum size in the first month of life and then gradually regresses. More commonly, by the age of 4-6 months, there is no lump apparent but the parents are concerned that the baby tends to keep his or her head turned persistently in one direction and seek advice at this stage. There will frequently be accompanying plagiocephaly and, on assessment, it is obvious that there is restriction of movement at the neck on that side. If untreated there will be progressive deformities of the face and skull, apparent within the first year – flattening of the face on the side of the affected muscle may result in considerable cosmetic deformity, with the level of the eyes and ears becoming more asymmetrical during the years of growth up to skeletal maturity. Cheng et al (2000) stated that 90% of children with torticollis would present with positional plagiocephaly. If left untreated the resulting clinical signs may be restricted neck movement, persistent head tilt, facial and skull deformities, scoliosis and delayed motor development (Cheng et al 2001, Hylton 1997). Golden et al (1999) found that three quarters of babies with plagiocephaly in their study had some degree of SCM imbalance or CMT. Fabian and Marshall (1984) counselled that treatment of plagiocephaly be incorporated in the treatment of torticollis, as it is an early result of the condition. Because of the persistent head tilt, untreated torticollis may eventually lead to a high thoracic scoliosis (Tachdjian 1967).

There is a strong association between CMT and congenital developmental dysplasia of the hip with figures of up to 20% quoted by some authors (Hensinger 2002, Tien et al 2001, Walsh and Morrissy 1998, Staheli 1994). Check with the parents that the hips have been screened but as part of an assessment undress a baby and check the hips, looking for asymmetrical range of hip abduction, discrepancy in leg and/or thigh length. If in doubt ask for a further opinion.

Physiotherapy Management

After diagnosis a baby may be referred for physiotherapy. Prior to treatment other causes of congeni-

tal and acquired torticollis – such as those resulting from vertebral anomalies, infection or inflammation of adjacent structures should be ruled out (Cheng et al 2001, Ballock and Song 1996).

Conservative treatment involves:

- Passive stretches to the affected SCM
- Active stretching exercises of the affected SCM (appropriate stimulation to encourage head turning)
- Head reshaping (positioning to prevent development of plagiocephaly or to ameliorate the effects of plagiocephaly as well as to improve facial and skull symmetry)

Passive stretching:

A regimen of stretching exercises is the most common form of treatment with positive outcomes for over 90% of identified cases before one year of age (Morrison and MacEwen 1982, Luther 2002). It is important to also include positioning and handling advice, as well as activities to encourage active stretch and strengthening exercises into the programme (Emery 1994, Cheng et al 2001). Frequent, short 'tummy time' periods when the child is awake are also recommended (Cheng et al 2001).

If the SCM is very tight stretches are highly recommended immediately after diagnosis (Emery 1994, Cheng et al 2001). Traditionally physiotherapy has consisted of passive stretches to the neck usually carried out by one or two people, stabilising the shoulder girdle, whilst stretching the neck by exerting traction, using a baby's head. Most of the literature available on CMT does not investigate the effectiveness of conservative management even though it is seen as the first line of treatment recommended after diagnosis. Physiotherapy techniques are generally referred to as passive stretching but rarely described or explained. Although it is generally agreed that muscle stretching should not be painful, the literature seems to have little consensus in the frequency or the number of stretches needed (Emery 1994, Staheli 1998, Taylor and Stamos Norton 1997, Cheng et al 2000, Cheng et al 2001). Two basic stretches are often described (neck rotation to the same side, side flexion to the opposite side) but few authors describe the positions used. In some cases the two movements are combined and may be incorporated with neck flexion or extension.

Emery (1994) reviewed the outcomes of conservative treatment of 100 children diagnosed with CMT before the age of two years with a mean age of 4 months (range 0.5-15.5 months). The parents were taught a stretching programme to increase an infant's range of neck rotation to the affected side and side flexion to the opposite side. She recommended that two people were required to carry out the stretches—one to secure the shoulders and stabi-

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lize the clavicle, the second person to carry out the stretches. Emery is unusual in that she describes the technique to carry out each stretch (hand placement, stretching technique, frequency and duration of stretch) advising stretches being held for 10 seconds, repeated five times each, twice a day. The stretching programme was discontinued when there was full passive range of motion with no resistance at the end of range. Each child was reviewed one month after the cessation of the stretching programme to ensure that the range of motion had been maintained. In addition parents were shown positioning and handling skills to promote active neck movements to stretch the affected SCM and to strengthen the SCM on the opposite side. Management may be supplemented after the age of 4½ months with the use of a tubular orthosis for torticollis (TOT) for persistent head tilt, worn during the day, when awake, as an active correction device. Emery recognized that early implementation of treatment was important as it becomes more difficult to carry out stretches as a child becomes older and stronger. Regardless of severity of restriction a mean of 6.9 months treatment was needed for children with a SCM tumour, who tended to present earlier for treatment than those without a mass (4.7 months, range 1-36 months). Those requiring a TOT took longer to achieve full range of neck motion. Complete recovery (full passive range of motion) was achieved in all but one of the children in the sample.

Fabian and Marshall's (1984) literature review on the conservative (and surgical) management of CMT described the differing stretching programmes carried out at several centres, with session recommended to be carried out from 2-6 times a day, with the number of repetitions of each stretch ranging from 10 to 20 times and hold varying from 5-20 seconds. Whilst all seem to have agreed that the stretch should not be painful Shepherd (1974) suggested that the duration of a stretch should be gradually increased to 5 minutes, as tolerated, but must not proceed to the point the infant where the infant is screaming and becoming cyanosed!

The family of a baby is therefore taught the stretches (depending on the local protocol) and advised to carry out them out several times a day, such as at every nappy change. The physiotherapist then goes about her daily work leaving the family to carry out the stretches in between appointments. The baby quickly learns that being placed on their back may spell trouble, the hands come down from above and the baby tenses and cries as soon as they are touched, leaving the family fraught and exhausted by the time of their next appointment.

Celayir (2000) described the intensive home treat-

ment programme to babies of under one year of age with CMT in his centre. Parents were required to perform the passive neck stretches every three hours, repeating each stretch Citing a 100% success rate he stated that CMT, if diagnosed early could be successfully treated conservatively using an intensive protocol of passive stretching exercises. The mean age of the participants in his study was 38.6 days (range 15-120 days). However he did acknowledge the importance of good parental cooperation with the programme as the key to such a pleasing outcome. Compared to treatments such as that described by Emery the mean treatment duration was found to be 3.2 months +/-1.3 months.

Taylor and Stamos Norton (1997) found stretching programmes were poorly tolerated as evidenced by crying and strong resistance when being stretched. Many physiotherapists involved in the management of babies with torticollis, have ceased passive stretches in this fashion and use positioning to improve the head position and muscle length, as well as encouraging active movement to address the muscle imbalance, and are finding similar success in a more 'gentle approach'. Parents are encouraged to be creative during their therapy sessions with their baby and therefore feel empowered in their baby's recovery. Strengthening the overstretched muscles on the other side of the neck can be achieved through the use of postural reactions as a baby gains head control. Holding, carrying and playing with the infant in positions that will encourage the desired active and passive movements. Taylor and Stamos Norton (1997) assessed the outcome of this approach and found that good to excellent outcomes were achieved in 96% of their study group (n =23) and importantly registered a high degree of parental satisfaction.

Most authors agree that the stretching programme should be weaned gradually once full range of motion is restored. Most recommend that the child is reviewed periodically, until walking to ensure that the range of motion is maintained, with some suggesting that a child is monitored for several years (Fabian and Marshall 1984).

Active stretching

Methods to encourage active stretching include positioning the crib to provide stimulation to encourage head turning to the affected side, carrying, handling and feeding the infant in such a way as to get them to turn their head in the desired direction. Tummy time for play should also be encouraged. Shepherd (1974) believes that exercises to achieve active stretch is more effective than passive stretch to the SCM.

Botulinum toxin injections are beginning to be used by some practitioners to relax the tight muscle (Luther 2002).

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Torticollis at a young age usually resolves without long-term effects. Surgical release may be necessary if there is restriction of movement by more than 20° by the age of one year (Noordeen 2005).

Juvenile Muscular Torticollis:

It is uncertain whether juvenile torticollis has been present but not recognized since infancy or if onset has occurred during late infancy or early childhood. Careful assessment is needed to exclude significant pathologies and a child should be referred back if there are any concerns that this is not a muscular torticollis. A child may have developed facial asymmetry and review of family photographs will show that a child's head may have always been tilted to one side. Both heads of the muscle will be contracted and require surgical release. Physiotherapy cannot overcome this contracture.

Physiotherapy following surgical release

Following surgical release of the sternomastoid muscle there will be the need to carry out passive stretches to maintain the length achieved during the operation. Timing of post-operative physiotherapy is usually dependent on surgeon's preference but may begin as early as 24 hours. In any case it is advisable to teach the parents how to do the stretches before a child goes for surgery.

No physiotherapy should be carried out without analgesia given in good time to be effective before stretching is started. A child may also have been given a soft collar to wear for support and comfort and should only be removed for physiotherapy, washing and meals in the first few weeks.

Stretches to the neck need to be carried out with a child lying supine, the shoulder girdle stabilised, so that the neck can be moved throughout as full a range of side flexion to the opposite side, rotation to the same side as well as full extension. Gentle traction should be applied throughout and released slowly at the end of the stretch. There appears to be little in the literature about post-operative physiotherapy but generally parents seem to be advised to carry out the stretches twice a day, each stretch 5 times with a hold of 10-20 seconds (Emery 1994).

Active exercise is important to address the muscle imbalance resulting not only because the tight muscle is now longer and needs strengthening, but also to address the 'over-long' muscle on the opposite side. It is important to use mirror work as a child may have no concept of having his or her head in a central position and will need visual prompts to correct the head position between each exercise. There

may also be some short term visual disturbance until the eyes accommodate to the improved head position. Advice regarding positioning to encourage head turning, when watching TV or looking at the blackboard, may be needed before the child goes home. Therapy supervision should continue until the child is habitually holding their head in the corrected position.

Conclusion

According to the literature CMT can be successfully treated if conservative treatment is started early, usually consisting of a programme of passive stretches alongside advice regarding positioning and appropriate stimulation to encourage active stretch and to prevent or improve accompanying plagiocephaly. It is advisable to monitor children with resolved CMT to ensure that range of neck movement is maintained. Surgery is indicated for those infants and children over the age of one year, where conservative treatment has failed or for cases that have been diagnosed late.

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To develop a more co-ordinated approach to the identification, assessment and management of children experiencing motor coordination difficulties, across Education and Health services in Knowsley.

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Motor co-ordination difficulties, referral, education.

Summary

This a service development report summarising a change in referral procedure for children with motor co-ordination difficulties allowing direct access from education, in particular Special Educational Need Co-ordinators to Occupational Therapy and Physiotherapy services. This included networking with other agencies and delivery of a training package to a cross section of education staff.

Our conclusions included:

1. A lack of knowledge and understanding regarding these difficulties was evident within education.
2. Other agencies were looking to network to improve the child centred approach.
3. The time lapse between identification of concern and intervention was reduced by allowing education staff direct access.
4. Further analysis and education is required to ensure appropriate referrals.

Introduction

Historically, children in St. Helens and Knowsley suspected of having problems with the development of fine and gross motor skills and motor coordination skills, could only be referred for assessment through a Medical Practitioner to the Paediatric Therapy Services at Whiston Hospital. The Therapy service in the St. Helens and Knowsley area is a joint service consisting of Occupational Therapists and Physiotherapists. Over a number of years the service to children with motor co-

ordination difficulties developed to include Occupational Therapists, Physiotherapists, and a Technical Instructor.

In early 2003, the Therapists became concerned about the delay between identification of concerns and the child and family receiving advice/intervention. After assessment, if appropriate, the advice regarding strategies and activities to encourage and was being provided to parents and schools. In a large number of cases advice to education staff had to be given several times, not only across the range of schools, but also within the same school. The Therapists therefore developed a questionnaire, which was sent out to all primary schools in St. Helens and Knowsley, asking for staff views on their training needs in respect of children with motor co-ordination difficulties. An excellent response was received indicating a high level of demand for training.

The Therapists decided that it was necessary to establish closer links with colleagues from other disciplines to ensure accurate and timely communication in line with National Service Framework for Children. This included those agencies whose assessments of children contributed to the identification and management of motor coordination difficulties, and could be interested in working jointly. This would allow sharing of information and to consider how to achieve alternative referral pathways. In July 2003, a group from Paediatric Therapy made contact with the Schools Psychology Services in St. Helens and Knowsley, which are separate LEAs, but served by the one Health Trust. Knowsley Child Guidance (KCG), a team of Child Guidance Social Workers and Educational Psychologists, responded to the suggestion to develop a joint working approach to the assessment of children with motor co-ordination difficulties. At that time St. Helens Schools Psychology Service provided their own training to schools regarding motor co-ordination difficulties.

Inter Disciplinary Teamwork

An initial liaison meeting between the Therapists and the Knowsley Child Guidance Service took place in October 2003, when participants explained their working practices and how they contribute to the processes of identifying and managing children with motor co-ordination difficulties. It was decided to set up a joint working party to consider the possibility of offering a training programme for staff in Knowsley Schools, the focus being to improve their basic knowledge and understanding, to identify children with motor co-ordination difficulties and to make appropriate direct referrals. The Therapists had already developed a PowerPoint presentation on motor co-ordination difficulties, which was an overview of the condition focusing on: what parents and teachers may report, the role of

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therapy staff, and the subsequent pathway through therapy. This had been primarily intended for training of other health professionals, but had also been delivered in some educational settings. It was agreed that this training should be given in December 2003 to the working party members and to other invited representatives from the educational services and Child & Adult Mental Health Service (CAMHS). The Principal and Senior Orthoptists, who have worked with Knowsley pupils who have dyslexia, were also invited to attend.

Following this training session, which was very well attended, it was decided to broaden the working party to include those outreach teachers from the three geographical areas of Knowsley responsible for Special Educational Needs Co-ordinator (SENCO) in-service training sessions, a secondary school SENCO and representatives from Therapy, KCG and Orthoptic Services. It was subsequently agreed that the PowerPoint presentation already developed by the Therapists, could be adapted for training school staff and the programmes for the three training sessions for primary schools and one for secondary schools were planned. As motor co-ordination difficulties have implications for involvement of other professionals in identification and management of the condition, it was decided that the training sessions should include brief contributions from a speech and language therapist, behaviour support staff, a secondary special school PE coordinator, child guidance social workers, educational psychologists and school nurses. More substantial participation was provided by the Orthoptist, who discussed the implications that motor coordination difficulties have for visual processing difficulties.

This multi-disciplinary approach promoted school staff awareness about other issues, for which training may be beneficial. It was decided that referrals should come from those with specialist knowledge namely the SENCO. In addition it was considered important for front line staff dealing with children on a daily basis such as learning assistants, and teachers should attend the sessions to gain increased awareness of the condition and coping strategies. An adapted referral form (see Appendix 1) was developed from the existing community referral form to include SENCO name, permission from parents, school concerns. Some information on the original referral form the SENCO would not have, for example Birth/Medical History and Investigation Results was removed. Primary

and secondary school check-lists, to assist teachers in the identification of motor coordination difficulties, were devised by the Therapists. This information was then divided into age appropriate skills, taking into account variations of norms. Teacher and parent booklets were further developed from existing information leaflets prepared by previous Therapy students for both primary and secondary pupils and included coping strategies for school and home. These were to be given out to the participants, in a training pack which was provided to attendees of the training.

Delivery of Training

The training venues were selected, in each of the three geographical areas of Knowsley for primary schools and one in the central area for secondary schools. The training was given as twilight sessions and free of charge, to encourage high levels of participation as there would be no implications for school budgets with regard to course fees or supply staff. The primary training sessions were targeted at all primary school SENCOs, PE co-ordinators, nursery teachers, learning support assistants and any other interested staff. The three primary school training sessions took place during September and October 2004. The secondary working party then took over and planned the secondary school training session for January 2005. This was targeted at SENCOs, PE staff, Learning Mentors and Learning Assistants. All the training sessions were well attended. Approximately 350 SENCOs, Teaching Staff, Learning Assistants, Learning Mentors and PE co-ordinators attended in total. The three primary and one secondary school working party representatives took turns in acting as the Co-ordinator for each venue, chairing the training sessions and arranging the resources required and refreshments. All the site managers were very helpful. Prior to the training taking place the Child Guidance Service had publicised the sessions via e-mail and was responsible for preparing the training packs, which were distributed to all participants at the sessions. Additionally, flyers and application forms were despatched to all primary schools through the area Co-ordinators for the training and by internal mail to all secondary schools. The Therapists delivered the training and sent follow-up packs to all SENCOs who had attended, facilitating the use of the new referral procedures to the service.

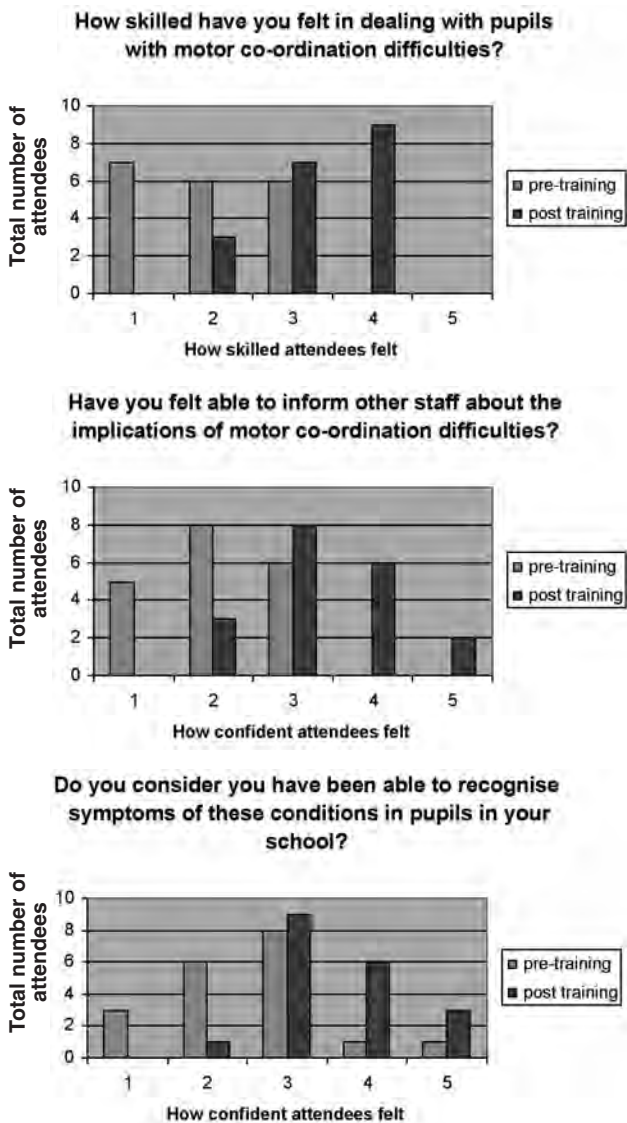
Conclusion

Following the training sessions, a new core working party was set up, consisting of four representatives from the Paediatric Therapy Service and two from the KCG. The aims were to ensure that the work which had been carried out should be publicised, that the value of the training to participants should be evaluated, that the alternative referral route to the Paediatric Therapy Service should be assessed for its viability and to ensure that all who had made the training sessions were recognised and thanked.

To develop a more coordinated approach to the identification, assessment and management of children experiencing motor coordination difficulties, across Education and Health services in Knowsley.

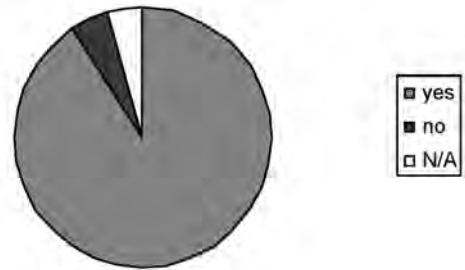
SENCOs who attended the training reported improved confidence in dealing with different aspects of their work, used the Advice for Teacher and Parent booklets effectively, understood therapy reports and were aware that poor speech articulation can be part of the DCD and would like specific training in visual processing problems. Figures 1-4 illustrate other findings from the Post-training questionnaire Results for SENCOs.

Figures 1-4 Post-training Questionnaire Results for SENCOs



From October 2004 all Primary SENCOs and from January 2005 all Secondary SENCOs who had attended the training were able to directly refer to the Paediatric Therapy Service which reduced the

Has the Teachers' checklist proved helpful in identifying the possibility of motor co-ordination difficulties in your pupils?



total waiting time from identification to intervention by a therapist.

Knowsley Paediatric Therapy Service is now in the process of evaluating and auditing the appropriateness of referrals and the effect on waiting times to fulfil NHS targets. Retrospectively, the therapy staff involved in the pilot feel that the training provided to SENCOs needs to be a rolling programme to account for staff turnover as some schools are now unable to directly refer to the Occupational Therapy and Physiotherapy service as those trained have now left. Some amendments need to also be made to the checklist provided to SENCOs as some have not been completed correctly or passed to parents to complete. It is also felt by staff that this package of training and direct referral should be offered to those schools within the St. Helens area as the Occupational Therapy and Physiotherapy service covers both Knowsley and St. Helens and we are therefore offering a different service dependent on where the child goes to school.

Books used to compile the school checklists

Lee, M (1996). Setting up a Dyspraxic Physiotherapy Service, Blair House, Denham Green Lane, Denham.
 Meggitt, C and Sunderland, G (2000). Child Development An Illustrated Guide, Heinemann, Oxford.
 Sheridan, M.D. (1997). From Birth to Five Years, Routledge, London.
 Woolfson, R.C. (2003). Bright Start, Hamlyn, London.

Acknowledgements

Irene Fatimilehin, Educational Psychologist, Knowsley Department of Education and Lifelong Learning

Jenny Jones, Educational Social Worker, Knowsley Department of Education and Lifelong Learning.

Members of the Southern and Northern Area Support Teams.

KNOWSLEY PRIMARY CARE TRUST

Whiston Hospital, Prescott, Merseyside. L35 5DR

PAEDIATRIC OCCUPATIONAL THERAPY/PHYSIOTHERAPY SERVICES

REFERRAL FOR MOTOR CO-ORDINATION ASSESSMENT

Please print clearly

CHILD'S NAME	D.O.B.
Address (Street/Road)	Next of Kin
Town	Relationship to Child
Post Code	Home Tel. No.
School: SENCO: Class Teacher:	G.P. Name and Address: Tel. No.:

Do parents understand the reason for referral to Therapy Services? []

Permission obtained []

Available Medical Information:

Details of Child's/Parent's concerns:

Details of School's concerns:

Current Medication (if known):

Family History and Social Circumstances:

Other Agencies involved:- (Please give name and contact number)

Educational Psychologist:

Speech Therapist:

Orthoptist:

Other:

Signature:.....School:.....

Please also print name:Tel. No.:.....

Date:

Please ensure all sections are completed and legible. Lack of relevant information will result in a delay in a child being seen.

Thank you.

Profile

Chris Sneade
New Membership Secretary



As I take over the role of membership secretary I would like to thank Susan Cleverly for her hard work and commitment in serving the members since 2002. She leaves this post for an equally important one of motherhood with her second child. I'm sure the skills she has developed as secretary of time management, prioritisation and organisation will be used to their full during this impending busy and exciting time

I qualified as a physiotherapist in 1983 from The Royal Orthopaedic Hospital, Birmingham, and had my first post at Queen's Medical Centre, Nottingham. I then spent 2 years working at The Duchess of Kent Children's Hospital in Hong Kong, predominantly in the orthopaedic management of children with CP. My "gap year" lasted longer than anticipated, but during my time in Australia I worked at Parramatta Hospital, Sydney, and at the Royal Children's Hospital in Melbourne. Upon my return to the UK I spent 15 years working in St Helen's and Knowsley in both special schools and the community, with a specific interest in pre-school children.

I am currently employed by the Royal Liverpool Children's Hospital, Alder Hey as a Clinical Specialist in Neurodisability. My role covers two areas of practice: with local pre-school children in the CDC and as part of the tertiary multi-disciplinary team in the management of spasticity. New initiatives include the development of physiotherapy-led clinics and extending the scope of the physiotherapist within these clinics. A key component of this role is to give expert physiotherapy opinion within the speciality and to represent the views and concerns of community colleagues throughout the North West.

I have been North West Rep for BABTT, and Conference Secretary when APCP came to Liverpool in April 2004. I have been a member of National Committee since October 2005.

Susan oversaw some changes during her time as secretary in which membership fees are processed through the introduction of a direct debit system. As the membership approaches 1800 in number, the process will continue to be reviewed so that the renewal process and the recruitment of new members can be dealt with in a timely and efficient way. I look forward to having contact with the membership, and know that I will be supported in this role by the other members of the National Committee.

Treasurer's Annual Report 2005 / 2006

PROPOSAL TO INCREASE SUBSCRIPTION RATES

Full Membership:

£25.00 increasing to £40.00

Associate Membership (Students, Physiotherapy Assistants, Retired):

£12.50 increasing to £20.00

APCP subscription rates were last raised in 1998 and for several years following this rise, APCP showed significant annual profits.

In 2003, members may re-call that National Committee decided that it would benefit its members and the profession to utilise a portion of this accumulated fund to support research into paediatric clinical practice. Since this time, four research projects have been supported to the tune of approximately £30,000 - these projects are still ongoing.

However, in general the ongoing basic costs of running the Association have been gradually increasing. In part this can be attributed to inflationary factors relating to committee expenses, costs of printing and postage etc. The annual cost of printing and distributing the APCP Journal is now approximately £12,000.

National Committee has also expanded to include representation from the new Affiliated Groups. Quarterly National Committee meetings now involve on average 26 Committee Members / Representatives from Regional and Affiliated Groups, and cost an estimated £6,000 per meeting in travel and subsistence. This cost rises to £10,000 - £12,000 for a working weekend.

£5.00 of the proposed subscription rise has therefore been identified to cover these increasing costs and to enable APCP to provide financial support for the new Affiliated Groups.

However, a further £10.00 rise is being proposed at this time to enable APCP to employ a full-time Administrator. It is proposed that this Administrator will act as the interface between the Association and its members, as well as supporting the work of Committee Members.

The APCP Executive Committee is currently investigating how best to implement this proposal and considering in detail the proposed job description. The Executive Committee would strongly recommend that members support this proposal.

The proposal to raise subscription rates from January 2007 will be open to a membership vote at the Annual General Meeting on Saturday, 11th November 2006 at The Crown Plaza Hotel, Glasgow.

Following are the National Accounts 2005 Balance sheet and Income/Expenditure account.

I would be happy to answer any queries relating to this proposal, or to receive your comments. Please email fiona.down@btinternet.com

Fiona Down

APCP National Treasurer

ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS

NATIONAL ACCOUNT

Balance Sheet as at 31 December 2005

	2005 (£)	2004 (£)
Fixed Assets		
Computer Equipment	1,003	1,638
Current Assets		
Cash at Bank	77,334	95,750
Conference Debtor - 2004	0	4,774
Conference Debtor - 2005	0	2,400
Conference Debtor - 2006	104	0
	<hr/>	<hr/>
	77,438	102,924
Current Liabilities		
Creditors	4,145	4,145
Corporation Tax	0	0
	<hr/>	<hr/>
	4,145	4,145
	<hr/>	<hr/>
	73,293	98,779
	<hr/>	<hr/>
	74,296	100,417
Accumulated Fund		
Balance brought forward at 1.1.2005	100,417	104,343
Add (Deficit)/Surplus for the year	-26,121	-3,926
	<hr/>	<hr/>
Balance carried forward at 31.12.2005	74,296	100,417

ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS

NATIONAL ACCOUNT

Income and Expenditure Account for the Year Ended

	2005 (£)	2004 (£)
INCOME		
Courses	1,325	10,940
Capitation Fees	2,331	3,788
Subscriptions	43,850	41,940
Publications	1,835	2,395
Bank Interest Received	2,200	1,997
Sundry	31	25
Received from Conference	2,711	4,774
Advertising	600	3,100
Santander Dividend	21	0
Transfer from Deposit Account	20,000	0
	74,904	68,959
EXPENDITURE		
Catering & Accommodation	15,285	8,714
Committee Travel & Subsistence	10,108	12,332
Subscriptions	3,038	0
Postage, Stationery & Telephone	5,838	5,636
Accountancy Fees	1,645	1,616
Course Fees	1,421	10,546
Publications	16,020	17,519
Computer Expenses	0	0
Gifts	0	114
Conference & AGM Expenses	22,899	0
Depreciation of Computer Equipment	1,588	1,350
Critical Care - Donation	0	1,000
Cash Advance	5,000	0
Research Bursaries	15,530	11,223
Committee Other	2,383	2,835
Misc.	270	0
	101,025	72,885
	-26,121	-3,926
Corporation Tax	0	0
(Deficit)/Surplus for the Year	-26,121	-3,926

Feedback from Competence Framework Working Group APCP

A working party made up of 8 members of the National Committee including a member of Paediatric Physiotherapists in Management (PPIMs) have started to look at development of a Competence Framework for paediatric physiotherapists lead by Peta Smith Vice Chair APCP.

Peta initially met with Mairead O'Siochru CPD Adviser of The Chartered Society of Physiotherapy in January 2006 to discuss this project. This was then moved forward at the national committee working weekend in Belfast in March 2006.

The use of Competences by healthcare workers has been identified as being important to the commissioners of health services. By developing our own professional competence framework we will ensure that we, as providers, meet the standards required not only under the statutory frameworks as described below, but also the standards set by the Chartered Society of Physiotherapy and APCP to ensure a consistent high quality standards of care by our members.

APCP is committed to supporting the professional development of its members and sees the development of a Competence Framework for Paediatric physiotherapists as an essential tool to help members identify their own personal development needs, and to reflect on their knowledge and skills in order to identify, plan and evaluate areas for development. This continuing professional development CPD is an essential requirement to the Health Professions Council.

The Need for a Competence Framework....background information

The National Service Framework (NSF) for Children, Young People and Maternity Services is a joint project between the Department of Health and the Department of Education and Skills. It necessitates good Partnership working through the statutory frameworks required by the **Children's Act 2004**. It forms part of the NHS 'developmental standards' - standards that NHS organisations must work towards and will therefore be taken into account in the Healthcare Commission's work.

The Children's National Service Framework is a ten-year programme, aimed at everyone who comes into contact with, or delivers services to children and young people, intended to stimulate long term and sustained improvement in children's health. It aims to ensure fair, high quality and integrated health and social care from pregnancy, right through to adulthood. It will help to deliver the five outcomes of the Every Child Matters: Change for Children Programme. Implementing the NSF standards in partnership locally, will deliver a large part of the 'be healthy' outcome and contribute to the other outcomes, especially 'stay safe.'

It consist of 11 standards which are linked to the central themes of the NSF, for early identification and prevention, access to age-appropriate services and provision of high-quality, coordinated services.

Standard 8 Disabled Children and Young People and those with Complex Health Needs states that disabled children and young people who require ongoing health interventions, have access to high quality, evidence-based care, delivered by staff who have the appropriate skills for diagnosis, assessment, treatment, ongoing care and support. It also states that all Local Authorities and PCTs must ensure therapeutic interventions for disabled children are agreed and overseen by specialist paediatric therapists who are competent in the core of skills, knowledge and competencies set out under **Standard 3. Child, Young Person and Family-Centred Services**.

Standard 3 of the Children's NSF refers to the core competences for all people working with children at every level. It states that all agencies must ensure high quality services through effective clinical governance and quality assurance. Increasingly skills and competences will shape job design as a means of developing the best services. Standard 3 states that as children and young people's needs differ from those of adults, the knowledge and skills required by staff working with them requires specialist training and that all staff should be well-led, supported and competent in knowing what actions to take to keep children safe.

It suggests training programmes must be set up to support the core competency areas. This training should be based on the **Skills for Health National Competence Framework for Children's Services** (which was developed to be applicable to a range of settings and professions) and the **DfES Common Core Prospectus**.

The Department of Education and Skills (DfES) are developing a workforce reform strategy to improve the skills required. Primary Care Trusts and Local Authorities will need to develop staff training programmes to ensure that staff at all levels within organizations have a common core of skills, knowledge and competences which are appropriate to their responsibilities and degree of contact with children, young people and families. We, therefore, as a professional body, hope to be able to demonstrate to the Commissioners of Children's Services across the UK that by the development of a competence framework, specifically for paediatric physiotherapists, we will be able to provide a guide to the range of knowledge and skills a paediatric physiotherapist needs in order to work at a safe, effective, professional standard and which we hope members will be able to use to plan and monitor their professional development throughout their career.

The Common Core of Skills and Knowledge for the Children's Workforce, work on which began in 2002, was completed and published in April 2005 alongside the **Children's Workforce Strategy**. It sets out the areas of expertise that everyone working with children, young people and families should have.

The essential skills and knowledge are described under six areas:

- Effective Communication and Engagement with children, young people and families
- Child and young person development
- Safeguarding and promoting the welfare of the child
- Supporting transitions
- Multi-agency working
- Sharing information

Skills for Health (SfH) is the Sector Skills Council for Health and has been licensed by the DfES to develop the health workforce across the UK (NHS, independent and voluntary).

It works with employers to identify the skills needed to deliver high quality competent healthcare. SfH is running a number of projects aimed at developing competence frameworks in specific areas and occupational sectors within the health service. (Competences and Competence Frameworks: Skills for Health and the Competence Agenda CSP June 2006)

The ones which affect paediatric physiotherapists are

- **The Children's National Workforce Competences**, including those involved in the delivery of services to children, young people and their families
- **SfH's Competence-Based career management Framework for Allied Health Professions** project will have significant implications for all physiotherapists who work within the Health sector. The plan is to identify existing competences that cover the functions carried out by AHPs at all levels and to develop new competences where gaps exist. The competences will then be incorporated into a competence framework linked to the Career Framework for Health and the KSF. (SfH)

APCP representatives have been working with SfH in the production, field testing and development of the Children's Competence frameworks in relation to paediatric physiotherapy and continue to do so.

The framework provides generic competences for people who work with children as well as more specific competences including the competences needed to care for:

- the acutely ill child
- children at risk of significant harm.
- Maternity and care of the newborn (covering the competences needed to care for pregnant women, their families and newborn babies)
- Public Health Practice National Workforce Competence Framework for Children's Services

Work has begun looking at condition specific competences for use in children's services to support the implementation of the common core.

APCP Matters

These individual competences cover the work activity which needs to be carried out to achieve a particular purpose, the quality standards to which these activities need to be performed and the knowledge and skills people need to be able to carry out those activities.

It will enable multi-disciplinary teams to work together effectively in the interests of a child and forms the foundation of a qualifications framework that will allow people to progress to more senior positions and other parts of the workforce.

SfH's Competence-Based career management Framework for Allied Health Professions project

This framework will develop shared competences that will cover a number of AHP groups but specific competences for the different professions will also be identified and developed.

Julie O'Sullivan from the CSP is working closely on this project with SfH to address the 9 'levels' of the career framework within AHP roles. Each level of working will be described by the competences required, the academic awards and qualifications. These levels will be based on the competences within the framework. It is hoped that this project will be completed by 2007 and will be rolled out nationally across the UK. They are to be piloted at 9 physiotherapy based pilot sites across the UK. We will also then be able to map these into our framework. These levels may not necessarily relate to the Agenda for Change bandings.

APCP also plan to encourage PPIMS and other Managers of Paediatric Physiotherapy staff to use the APCP competence framework, which we hope eventually to map against the AHP Competence framework, to ensure skill mix of their teams, ensuring that their workforce meet the competences for the proposed 'levels' and in future be able to reference them against the KSF outlines for jobs.

APCP Competence Framework

The main aim of this framework will be to guide the practice of physiotherapists in the field of paediatrics.

It is expected that the finished document will be a working document which will change as new knowledge, skills and innovations emerge.

The competence framework will link to the NHS Knowledge and Skills Framework KSF. The SfH competences are already mapped against this framework with each competence being linked to a relevant KSF dimension and level.

Using the framework will help physiotherapists to:

- deliver consistently high standards of care,
- identify your level of practice and plan your career in a more structured way
- pinpoint education and development needs to help you realise your potential more effectively
- seize opportunities to influence the direction of physiotherapy practice

Definition of Competence

"General, overall capacity, holistic, rests on a consensus view of what forms good practice" Competence and Capability CSP June 2005

What it is and what it's not!

- Competence involves;
 - o thinking, critical analysis and learning
 - o assimilation of new learning with previous learning
 - o integration of new knowledge, skills and abilities with previous knowledge etc.
 - o application of new learning in practice
- Competence is not;
 - o just about knowledge, skills and abilities
 - o just about demonstrating technical skill
 - o just about doing or completing task (CSP Physiotherapy Competence and Capability resource pack 2005)

APCP Matters

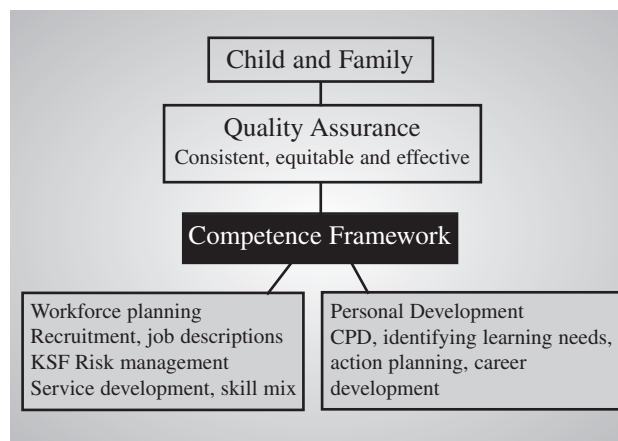
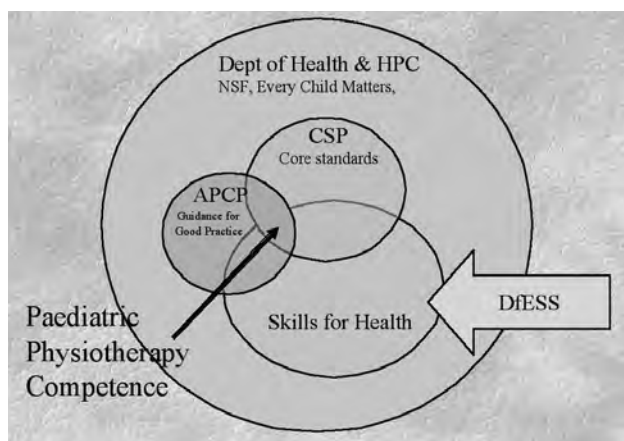
How a competence framework differs from competency ?

- Not looking at competencies that are formally assessed and passed!
- We are working toward providing a guide to the range of knowledge and skills a paediatric physiotherapist needs in order to work at a safe, effective, professional standard.

Benefits

Benefits are not only for paediatric physiotherapy but also for their employers, patients and the public.

- The framework will give employers;
 - a model to ensure consistently high standards of care
 - clearer insight into the expertise and competence of staff
- Children and their families will benefit from the framework because it will ensure;
 - consistently high standards of patient care
 - increased effectiveness to service provision
 - improved access and choice for care provision



The APCP plan

What have the working party done so far?

- Thrashed out issues around what a competence framework is!!!
- Become familiar with the existing competence frameworks
- Considered the value and method of using the skills for health web tool
- Agreed the way forward

Over the next year

- To ensure consistent use of the term "Competence framework" and not to talk about 'competencies'
- To agree generic core competences relevant to Paediatric physiotherapy from the National Workforce Competence Framework (NWCF) relating them specifically to paediatric physiotherapy and adding any relevant competences that are not included
- Update the Paediatric guidance for good practice and eventually link these to the developed APCP competence framework, also ensure these are linked to CSP Core Standards of Physiotherapy Practice, HPC Standards of proficiency for physiotherapists
- To arrange further meetings with the other CIG/OGs & CSP who have already developed a Competence Framework and learn from their experience (e.g. Association of Chartered Physiotherapists in Cardiac Rehabilitation)
- Develop a tool for paediatric physiotherapists to evaluate their competence
- Create a profile for a paediatric physiotherapist,
 - Competent, Proficient, Expert (Assistant?)
 - I= involved, A= accountable, K= knowledge of
- Disseminate the work for consultation
- Disseminate the framework to individual members, to employers, regulatory organisations, and management groups
- Role out to affiliated groups

APCP Matters

References

ACPICR Competences for the exercise Component of Phase III Cardiac rehabilitation 2005

Children Act 2004; www.opsi.gov.uk/acts/acts2004/20040031.htm

Childrens Workforce Strategy;
www.everychildmatters.gov.uk/deliveringservices/workforcereform/childrensworkforcestrategy

Common Core of Skills and Knowledge for the Children's Workforce. Every Child Matters Change for Children. HM Government Non-statutory Guidance,2005 www.everychildmatters.gov.uk ref DfES/1189/2005

Competences and Frameworks Skills for Health and the Competence Agenda CSP Guidance Paper (June 2006)

Core Standards of Physiotherapy Practice CSP 2005

Every Child Matters website (www.everychildmatters.gov.uk)

Skills for Health website: www.skillsforhealth.org.uk

The NHS Knowledge and Skills Framework (NHS KSF) and the development review process October 2004 DoH publications 40440

National Service Framework for Children, Young People and Maternity Services. Core Standards. 2004 40493

NSF Standard 3 Child, Young Person and Family-centred Services 2004 DH Publications 40493

NSF Standard 8 Disabled Children and Young People and those with Complex needs 2004 DH Publications 40494

Physiotherapy Competence and Capability CSP Resource Pack June 2005

Standards of Proficiency Physiotherapists. hpc 2005 www.hpc-uk.org 1005/SOP/PH/A5 October 2005

Peta Smith
Vice Chair APCP July 2006

APCP Representation on the Forum for Maternity and the Newborn at the Royal Society of Medicine

The Neonatal Group APCP was asked to consider providing representation on the Forum for Maternity and the Newborn at the Royal Society of Medicine (RSM). I was contacted by Avril Hillyard, the women's health physiotherapy representative on the group (and also the membership secretary of the Forum) so I attended one of the Forum meetings in London on Monday 15th May 2006 to find out what it was all about.

The RSM has 55 dedicated Sections, including Paediatrics and Child Health, and Maternity and the Newborn, which organise over 300 meetings annually almost all of which have CPD accreditation. The role of a committee member on the Forum would be to help organise one of the 4 to 6 meetings per year on subjects related to pregnancy, birth, and care of the newborn. As well as the organisation of the CPD meetings, the neonatal physiotherapy representative would be expected to attend 4 to 5 committee meetings per year at the RSM in London. To be on the Forum, you must apply to become an associate member of the RSM which costs £120 per annum (approx) and your eligibility will be assessed.

The evening meeting was chaired by Dr Elvidina Adamson-Macedo (President of the Forum and a perinatal health psychologist) - the incoming President is Gillian Aston (midwife). The representation on the group

APCP Matters

includes neonatal nursing, a retired GP, midwifery, NCT, women's health physiotherapy, obstetrics and gynaecology (medicine), research psychology. The agenda items were around planning of meetings for CPD for the incoming year and proposed topics included domestic violence, child protection, home births and neonatal rescue.

Previous meeting topics included "Medicines in maternal and neonatal care", an all day joint meeting with the Section of Pharmaceutical Medicine and Research (April 2006), "Osteopathy- its application in neonatal and maternity care" (this was in fact cancelled due to lack of support in May 2006), and "Female Genital Mutilation: an outmoded practice?" (June 2006).

I was made very welcome at the meeting and the Forum members are very keen to have a neonatal physiotherapy representative on the group. The next stage of the process will be for the Neonatal Group committee and APCP National Committee to discuss the benefits of membership of the Forum and the financial costs to APCP (as these were considerable for my travel and accommodation). The APCP membership will be kept informed of the decision.

If anyone is interested in finding out more information about the Royal Society of Medicine and the Forum on Maternity and the Newborn the web site address is <http://www.rsm.ac.uk>

Adare Brady
Chair Neonatal Group

Paediatric Physiotherapists in Management Support (PPIMS)

This group was formed in 1997 to provide a forum where paediatric physiotherapy managers would meet to discuss and share common areas of practice, problems and ideas.

To date PPIMS has addressed various issues including:

- Criteria for paediatric Clinical Specialist posts
- Caseload weighting (Nottingham demand measurement system has been piloted regionally and has been posted on iCSP)
- Guidance to members on SEN act
- Mapping of Assistants and Technical Instructors working in paediatrics
- Outcome Measures (A guide to paediatric outcome measures has been produced as a result of collaborative working between PPIMS, APCP, ACPM and CSP. This is available for purchase through APCP)
- National Service Framework for Children (PPIMS members have been actively involved in influencing this work)
- Consent. (A guide to good practice for obtaining consent in paediatrics is nearing completion, and will be distributed to PPIMS members)
- AfC and KSF. PPIMS members have provided peer support by sharing knowledge and experience
- Clinical Supervision. Following a successful study morning, led by Alison Somek, a further study day is to be arranged.
- Work has been started to produce a document for managers which will provide a consensus guideline in relation to the essential, desirable and extended scope of clinical services, governance, quality and knowledge and skills of staff. This should help inform business plans and service profiles relevant to commissioners.

PPIMS membership is open to CSP members who are responsible for the strategic planning and implementation of paediatric physiotherapy services. Members are expected to contribute to this interactive group by sharing good practice and by producing reports on issues raised by the group.

A membership mapping exercise was carried out in May 05, which indicated that at that time we had 66 members, distributed in the following regions:

- South England (incl. Avon, Gloucestershire and Wiltshire) 10 members
- Midlands (incl. Trent, Shropshire, Staffordshire and Essex) 13 members

APCP Matters

- N. England (incl. South Yorkshire, North West, Cheshire and Merseyside) 23 members.
- London 10 members
- Ireland (North and South) 5 members
- Scotland 1 member
- Wales 4 members

We have recently sought to strengthen our links with APCP and ACPM with the aim of providing improved channels of communication and effective working interfaces. This should facilitate collaborative working for response to Government initiatives, and in the development of policies and protocols of common interest. Currently a member of PPIMS committee attends APCP national committee meetings.

Thanks to the dynamic support of members, PPIMS has gone from strength to strength in its aims of leading, promoting and influencing paediatric physiotherapy management, and of improving services for children across the country.

Our next meeting is on 27th November 2006, at Mile End Hospital, London, with guest speaker Robert Jones (Head of Therapy Services, East Sussex Hospitals NHS Trust), who will speak on change management for AHPs.

For details regarding joining PPIMS please contact our membership secretary Nicky Boag at nicky.boag@northpct.manchester.nwest.nhs.uk

Carol McKay

Research and Education

Education Liaison Officer Report

Aiding Physiotherapy assistant CPD

As you may remember in the last journal I asked you to fill out a questionnaire to help the APCP education committee to determine training needs and strategies for helping to support Physiotherapy assistants. Since assistants are a key element of our work force in Paediatric Physiotherapy it seems important to help to support and encourage their ongoing learning as part of the Physiotherapy team.

Many of you returned questionnaires, (thank you) and this meant that we were able to analyse the results and come up with a primary strategy for supporting assistant learning. A brief summary of the results is as follows.

Current role of assistants - Physiotherapists reported that many assistants (90%) undertake a very full and varied role within their department including, hydrotherapy, moving and handling, administrative tasks, equipment provision, note writing, play activities, routine exercise and activities, skilled handling as part of the team and resource gathering. Fewer undertook roles of screening for input (20%), waiting list management (4%), equipment ordering (10%) and liaison with other agencies (10%).

Current training for assistants - Physiotherapists felt that assistants were encouraged to participate in current training activities including In-service training (100%), Portfolio building (75%), one to one supervision (90%). 50 percent of assistants were involved with some assistant training courses either within the physiotherapy department or within the trust general training programmes. A minority of assistants were engaged in reading or internet based activities (20%), using video resources (25%), or CDRoms (10%). Other activities listed by some respondents included NVQ training, reading Frontline and the APCP journal, Open College Network training and paediatric courses as appropriate. When the same question was asked of assistants the results echoed the feelings of the Physiotherapists. Many were engaged in in-service training, portfolio building, one to one supervision, and courses. Much fewer were reading, internet searching, using CDRoms, or video as tools to enhance learning.

How can APCP help with assistant training - When asked which type of resources the Physiotherapists would most prefer to help support their assistants' learning, a large majority indicated that local in-service training materials (75%) and specific paediatric physiotherapy courses (95%) would be most helpful. Assistants reported that they enjoyed participating in activities which were face to face exchanges, e.g. In-service training (80%), one-to-one supervision (95%), courses (100%). Other activities

were enjoyed by much fewer respondents; video (50%), portfolio, reading, internet searching, CDRoms, all being enjoyed by only 15-20% of respondents.

Assistants reported that they would be able to gain time to study away from their workplace but that this would be subject to funding available at the time.

What specific learning needs have been identified - There are many diverse learning needs reported by assistants in the questionnaire. However, the majority identified; up-to-date knowledge of equipment, Normal development, routine interventions for common conditions and skilled handling techniques, as key parts of their ongoing learning in the near future.

The way forward - Having considered the results the APCP education committee have agreed that there seems to be a need and enthusiasm for a one day course for physiotherapy assistants. This will meet the need for face to face learning opportunities, based around normal development and management of common conditions seen by assistants. The first course for assistants will focus on neurodevelopmental problems and common treatment strategies for these children, as the majority of assistants tend to work within the community or within child development centres. In order to allow easier access for assistants in England and Wales the course will initially be run in the Birmingham area. However, if this course is successful, it will then be rolled out to other areas of the UK, including Scotland and Ireland as we are aware that travelling large distances for one day courses is unfeasible.

APCP training for assistants working with children with Neurodevelopmental problems - A one day course to be held in Birmingham in February 2007 (for initial info contact me on a.c.leake@shu.ac.uk)

Introduction to Paediatric course

This course has usually been delivered as a 4 or 5 day event over one week, however due to changes in funding for CPD and in order to facilitate the CPD of unemployed graduate physiotherapists we have decided to run the next Introduction to Paediatric course as a series of one day courses. The course will be based in the London area and will be open to Physiotherapists and unemployed graduate Physiotherapists. The course will be available on a daily rate or as a whole package. Watch out for the advert coming soon.

Concerns re. quality assurance of private practitioners treating children

Several reports have come to the national committee regarding the professional standard of private practitioners treating children as part of a much

Research and Education

broader adult case load. These reports tend to focus on a lack of good communication with other agencies and worries surrounding the skill level of practitioners who only treat children intermittently as part of a large adult practice. In order to raise awareness of the multifaceted nature of Paediatric practice and the competencies expected of a professional working with children, the APCP is working with PhysioFirst to deliver a one day awareness raising programme at their national conference in April in Nottingham. In addition APCP will be working on materials which APCP members can use to demonstrate their commitment to working with children and suggest a range of evidence that private practitioners could use to demonstrate their range of experience and CPD in Paediatric Physiotherapy.

(If members experience significant concerns regarding a private practitioner then they are reminded to discuss these directly with the Physiotherapist involved and if necessary seek advice from the CSP).

Adele Leake, Education Liaison Officer

Research Officer's Report

First of all, profound apologies for the lack of a report in the last Journal. My sons will tell you that my I.T. skills are pretty basic. The family joke is the only thing that I can use with a plug attached, without calling for help, is a hairdryer (ha ha!). BUT I did write a report, full of lots of news (now out of date so I can't recycle it) only I have no idea why it didn't get to where it was meant to be. I am hoping my e-mail gremlin(s) have disappeared and that this will appear in the September Journal. If it doesn't then you won't be reading this and I'll be beating up the laptop yet again. Sorry to ramble but bear with me.

Research Bursaries:

Applicants for research bursaries were considered at the beginning of July. It was so pleasing to see such good applications and really interesting projects. I can confirm that APCP will be helping to support a study entitled: 'Modified constraint induced movement therapy with young children with congenital hemiplegic cerebral palsy – a randomised controlled trial'. Two other applicants will also hopefully be supported once a few issues have been sorted out and I will let you know about them next time.

On the issue of research I am indebted to Sarah Crombie for the following information about the National Institute for Health Research which was launched in April 2006. (<http://www.nihr.ac.uk>) I have had a look and there's lots of interesting stuff

there as well as a link to the central office for research ethics committees (COREC) for those of you battling with the form. queries@corec.org.uk has help for applicants. When I saw the COREC form when it first came out I was pretty relieved I had just got ethics before it became national but the site seems to be fairly user friendly if you need advice.

Research Help Register:

Sorry to keep banging on about this list – and thank you to the three (yes only three) of you who have volunteered help this year. More help would be lovely – particularly from areas like the North-East and Yorkshire where volunteers are thin on the ground. Last week I sent out 100 questionnaires, for a postgrad student, which meant that there were not many people on the list who got left out. As I sat there writing 100 envelopes I became aware that this was the list I inherited from Sarah and may need updating as some of you may have moved on, stopped working for a while or even given up all together! So in the next few months I will contact those of you who have given e-mail addresses to make sure you are still where you said where and also to find out a little more about your special interests, so that I can target you more appropriately if there are questionnaires to be sent.

For those of you not on the register (yet!) please do consider helping. Remember we hope that today's students will want to work in paediatrics and its little things like having help from APCP that might swing it! Those of you working towards post-grad degrees may also find help and advice from others in your field of interest from the register. I am now on it – that means there were really only 2 volunteers as I was setting an example!

A word, though, to students and their supervisors. Please do try and plan ahead as far as possible so that there are no problems. Remember that I do take holidays and may be away for other reasons. On my way to Heathrow and then Afghanistan in March I called into the Post Office to pick up a parcel that the postman had tried to deliver at the weekend. I was hoping that the parcel would be the final lot of medical equipment I was to take with me. Imagine my horror to find it contained 50 student questionnaires! I spent most of the journey trying desperately to remember addresses that I could send the questionnaire to and managed to send 15 from the airport. The remainder had to wait until I got back! It transpired that the parcel had taken nearly 2 weeks to reach me so you have to build into your plans the vagaries of the postal service as well as me being out of the country!

Well, that's about it for this time. It's holiday time so I do hope you all have great hols, fantastic weather and a well earned rest from ethics committees, literature searches, statistics and everything else to do with research!

Jeanne Hartley

Regional and Affiliated Groups' Reports

SOUTH WEST

The next planned Study day in the region is the AGM planned for the 14th November at Salisbury District Hospital. Ginny Humphreys from Vranth House School and Centre, Exeter is leading the study day entitled "24 hour Postural Management, How to get it going".

Ginny will be outlining

- current evidence for 24 hour postural management
- local integrated care pathways
- training for carers.

Further details will be available on iCSP.

The AGM is your opportunity to find out how the regional APCP committee runs your group locally, express your ideas and maybe even join the committee. At this year's AGM we have available only 2 vacancies for regional committee members. Please contact me prior to the AGM if you would like to join us on the committee and would like further details.

The region is planning to run a course in North Devon on Integrating Children with Disabilities into PE. This is planned before the end of this year with further details published on iCSP when a date and venue have been confirmed. Many thanks to Robbie Shaw for organising this one. For those who missed out on this course when it was held 2 years ago in Gloucester, Alton and Salisbury, this is a must. Early booking is advised as places were snapped up very quickly last time.

Please take a few moments to think about joining us on the local committee. The time commitment isn't huge, you get to meet lots of interesting people and get to extend your professional network, plus of course it will look good in your CPD folder!.. not to mention the fun element. My contact details are at the back of this Journal, and I look forward to receiving you emails.

LYNDA NEW

SCOTLAND

The planning and organisation of Conference 2006 in Glasgow is going well.

I hope members studied all the conference information in the June Journal and will take the opportunity to support APCP by not only attending, but also contributing papers and poster presentation.

Applications are coming steadily. Paediatric physiotherapy service managers, regional representatives, and the chairs of the affiliated groups have all been sent a conference information pack and Lindsay Rae our Public Relations Officer is also going to post all the conference information on our web site.

Take advantage of the early bird rates and send off your application form before you go off on your summer holidays.

See you in Glasgow.

ALISON GILMOUR

NORTH EAST

I trust you all enjoyed the summer and are now ready for the busiest term of the year!

Welcome to those who are new to the region.

By the time you read this the APCP's own website will be up and running. This site will have a public area and an area for members only. It will not be "interactive" in the same way as iCSP but will display information relevant to paediatric physiotherapy including the special interest groups.

I am pleased to tell you the details of our next course, which will be held on **Wednesday 29th November at Pontefract General Infirmary**. It will be on the subject of **Sensory Integration** aimed specifically at Key Stage 1 and 2 (Infants and Juniors for the older ones of us!) this being the most widely treated age range. Places will be limited to 30 as there is a practical element to the day. Please book early to avoid disappointment. The cost will be £25 for APCP members and £35 for non-members. This includes our usual offer of a delicious lunch. Application forms are downloadable from the paediatric "documents" section of iCSP.

Our last study day on Muscle Strengthening was well received and the feedback forms have given us ideas for future courses.

Can I encourage you to consider submitting articles for this journal, particularly about current practice, single-case studies. We want to encourage sharing of practice and it's also good for CPD!

Remember the national APCP conference is approaching. You will find the programme and application form in the June edition.

Just a reminder, videos are available to hire. We will try to make these available at the next course.

We would like to see representation from a wider area of our huge region. Please do contact me if you have some time and ideas to spare!

HEATHER ANGILLEY

Regional and Affiliated Groups' Reports

LONDON STEPHANIE CAWKER

TRENT SUZANNE LAWRENCE

WEST MIDLANDS HELEN BAYLISS

SOUTH EAST ANN MARTIN

EAST ANGLIA

WALES

My apologies for the lack of a report from Wales in the last edition of the journal, I have had to take some personal time and so didn't submit a report in time for publication. However I can report that the last few months have been quite busy for the local committee. We held our AGM at the end of March and were lucky enough to fill all the vacant committee posts with eager volunteers. Many thanks to Gwyn Owen from the Department of Physiotherapy Education in Cardiff for her presentation on CPD before the AGM, it was very well received by everyone present. The Wales region have also been busy organizing a Foundation Wheelchair Course which was held in conjunction with the ALAS, Cardiff in April and with a further course hopefully planned for the autumn.

In addition, in liaison with the All Wales Paediatric Physiotherapy Managers and Lead Clinicians Network we have contributed to a Staffing Ratio Tool being formulated within Wales and helped to develop a questionnaire which will look at the demographics of Paediatric Physiotherapy Services in Wales.

On a more personal note, one of our local community physiotherapists Liz Atter has appeared in a regional newspaper extolling the virtues of exercise for children and young people and Sian Howells (Neonatal Physiotherapist) and Vicky Huett (Team Lead for the Vale) have been interviewed by BBC Wales during "Physiotherapy Prevention Week".

I have circulated the APCP conference details to all committee members, network members and Paediatric physiotherapy departments so please have a look and apply.

DIANE ROGERS

NORTH WEST

I must start by apologising for my absence from these pages in the last journal – I'd been away and missed the deadline. Sorry!

It has been relatively quiet in terms of visible activity this year in the region but as a committee we have been very busy in the background planning future study days etc. The committee has met on three occasions so far this year and the courses we are planning include follow ups to our very successful muscle strengthening and hydrotherapy days. Other suggestions we are considering are non invasive ventilation in neuromuscular disease and all this entails. As always we welcome ideas from the membership.

Following my mention in previous reports about the availability of bursaries we have had several requests from members and are pleased to announce we have been able to grant four to the successful applicants.

Our last study day was held in March and was an Orthopaedic Day. We had several excellent presentations and as usual received positive feedback; it's just unfortunate that more members were not able to attend. It seems that in the present climate March is not the best month to hold a study day, so close to the end of the financial year when people have maybe already used up their study leave quota for the year. What we hear more and more nationally is that managers are really limiting the amount of time staff can have for study leave and that if granted it needs to be very specific to the post held.

Finally I need to announce the AGM. It will be held on Saturday, October 14th, starting at 9.30am at the Postgraduate Centre, Warrington District General Hospital, Lovely Lane, Warrington. As usual this will be followed by a study morning, speaker to be confirmed but we will be sending out fliers. We will, again, be able to offer the study event for free to members.

I hope you have all had an enjoyable summer and I hope to see as many of you as possible at our AGM.

ELAINE LLOYD

NORTHERN IRELAND GEMMA LIPSCOMB

NEONATAL SPECIAL INTEREST GROUP

Since the last report we have run our first neonatal course in Belfast. This was an extremely well received course and one of the course participants has kindly done a report on this. The feedback was not only pleasing but more than reflected how much hard work had gone into the preparation by the lecturers. Well done and thank you to all those who put in so much effort! The plan is for the course to run again in other areas. The committee are due to meet

Regional and Affiliated Groups' Reports

in October to identify objectives for the group in the next 1 - 2 years. This will include further courses along the lines of Belfast.

However before that is the National Conference in Glasgow, 10th - 12th November where we are holding a satellite day. Remember to check out the details and come and join in with what is guaranteed to be a fantastic and worth while experience.

As the group is now coming up to it's 4th year since inauguration we are due to re-new some roles. If anyone is interested in becoming involved at committee level and to be co-opted into a role then please contact myself or Adare Brady via e mail on petenbop@tesco.net or aabrady@talk21.com

BARBARA HAEDERLE

CRITICAL CARE SPECIAL INTEREST GROUP

Our last study day was held at Sheffield Children's Hospital on Tuesday 20th June, it was well attended. The main topic was 'Haematological Considerations for the Acute Respiratory Patient'. Our group held the AGM during this study day, 15 APCP members were in attendance. The Critical Care Group Constitution was voted in with no objections, please contact Dave Morgan (Chairman) at dave.morgan@cmmc.nhs.uk if you would like a copy of the constitution. The Chairman delivered the annual report, thanked the members of the committee for their hard work and the members of the group for attending the study days. Future training days, the APCP conference and next year's conference in Brighton were discussed. We are keen to develop peer support over the coming year and improve our national coverage, especially in Scotland. If you know any colleagues who are not members please encourage them to join. We are looking to form working groups to develop guidelines e.g Mucolytics/saline and non-invasive ventilation. If anyone is interested in joining these groups please contact me at rachael.hufton@cmmc.nhs.uk. A financial report was given by Sarah Hines (Treasurer) our accounts are being audited by an accountant and are said to be healthy. A formal report cannot be given until the audit is complete.

RACHAEL HUFTON

NEUROMUSCULAR SPECIAL INTEREST GROUP

ELAINE SCOTT

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

2005	
Paediatric Outcome Measurement	£20.00
2003	
Special Educational Needs	
Code of Practice 2001	
Guidance for Paediatric Physiotherapists	£10.00
2002	
Paediatric Physiotherapy Guidance for Good Practice	£5.00
Obstetric Brachial Plexus Palsy	
A guide to physiotherapy management	£10.00
Hip Dislocation in Children with Cerebral Palsy	
A guide to physiotherapy management	£7.50
Evidence Based Practice	
• Management of Obstetric Brachial Plexus Palsy	£3.00
• Hip Subluxation and Dislocation in Children with Cerebral Palsy	£3.00
OR	£5.00 for the pair
Paediatric Manual Handling – Guidelines for Paediatric Physiotherapists	£10.00
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Book and DVD Reviews

Down's Syndrome Play, Move and Grow by Anne Jobling and Naznin Viriji-Babul

Overall the book was not that easy to read, it was quite wordy and Americanised. There were some nice sections on advice and information on how to keep a child or adult active, these are mainly common sense but could be useful for parents or carers to pursue and develop motor skills. We are not totally convinced that it meets its stated aims that it is a book on motor development but it does cover the reasons for being active and some of the problems faced for people with Down's syndrome. For physiotherapists it would be easier read in sections as a reference book, where further reading could be gathered but really of limited value.

Chapter 1

This provides a good basic background of associated medical problems, and may be useful for new staff or students. The section on Hypotonia is incorrect and very misleading and the research included under the topic of motor control is inappropriately placed in reference to what is being discussed (Karst and Hasan).

Generally the language throughout is wordy and difficult to read and understand. It moves around theories and never really draws you to any satisfactory conclusions, the GMFM is mentioned but not referenced.

Chapter 2

This contains a nice aspect on joint attention but this could have been expanded, and may have been better placed at the start of the book as it is much easier to read and understand. It offers a range of strategies for parents and carers working with children with Down's Syndrome.

Inclusion of the Ulrich and colleagues study was inappropriate, especially if this is targeted at parents and carers, as the results need to be interpreted with caution.

Chapter 3

This chapter offers practical suggestions and useful advice for parents regarding the environment and play and keeping away from structured regimes. Interesting comments on the long term implications for the development of balance and postural control. The picture of the child riding his bike with no helmet or shoes was not to be recommended.

Chapter 4

Although with an American slant, this chapter offered some nice common sense ideas for keeping fit and active. In several instances figures are referenced to text but do not materialise.

Chapter 5

Again an Americanised slant and we were unsure what is meant by speech movements as this is not explained.

Chapter 6

This section was not comprehensive or broad enough for all professionals. Again due to the American slant it is not correct for the UK and could be misleading in terms of therapy services and education in the UK. What standardised assessments are psychologists using that look at movement and planning for appropriate aids in the classroom?

Chapter 7

An interesting and informative chapter for a new member of staff, carer or student.

General

This book about the life of a child with Down's Syndrome is not fully related to motor development and has some incorrect and misleading references, it is more focussed on keeping fit and active rather than a progression of motor development as therapists would see it. It is not really relevant to physiotherapy but provides a useful source for references. This book has tried to cover too broad a spectrum and has not really covered anything well.

Barbara Headerle and Felicity Dickson

Book and DVD Reviews

Practical Approach to Paediatric Intensive Care

Edited by Parveen Khilnani.

Hodder Arnold, 2005, £69.00 (hardback)

ISBN 0340905824

Parveen Khilnani and an impressive authorship from across India and the USA set out to produce a text emphasising the practical aspects of paediatric intensive care. It has been described as “the first comprehensive Indian textbook on paediatric intensive care” but whether it is applicable to a wider audience and an aid to European and North American paediatric intensive care clinicians, is another matter.

The book is systematic and has 12 clearly defined sections, opening with a chapter on basic practical issues. My initial impression was that the layout, content, tables and diagrams etc appear to be very user friendly. However, almost immediately it is evident that the text is plagued with spelling mistakes and quite fundamental factual errors. For example there are multiple tables advising on how to calculate ETT size, stating that the appropriate size for a 4 year child is a size 16 rather than the correct size 5. Paediatric intensive care colleagues have also commented on significant discrepancies in resuscitation guidelines and significant oversights in relevant clinical information, for example limiting information pertaining to cardiogenic shock to just neonatal disease.

Whilst there is a lot to admire about the book, there are occasions where it seems to lack focus and in some chapters becomes rather repetitive. The chapter on ventilation was an example of this where principles, modes and equipment were talked about repeatedly having the potential to become quite confusing and, at times, unnecessary. In addition, some of the information around this topic has already become outdated.

It is widely accepted that within the UK, current practices in paediatric intensive care exhibit and encourage multi-disciplinary working. Unfortunately this book only has a superficial chapter on nursing issues which fails to emphasize many of the evolving roles. For example, nurse delivered weaning and extubation. In addition, there was only limited information and discussion as to the role of chest physiotherapy. A potential concern regarding this is in centres where physiotherapy intervention is minimal or non-existent. If using this text as guidance, clinicians would scarcely be able to recognise the need or indications for respiratory physiotherapy let alone encourage or develop physiotherapy involvement. Whilst I appreciate that this is a generalised text, with limited scope for detail in all areas, there was an obvious lack of involvement or consultation with other disciplines when producing this aspect of the text.

I feel that it should be acknowledged that Parveen Khilnani and her co-authors embarked upon an enormous undertaking when deciding to produce this text and an incredible amount of work has been invested in producing a book which, in parts, could be very useful especially to trainees embarking upon an attachment in the PICU. The emphasis on physiology that runs throughout the text is commendable. In addition, I have been informed that some sections are very useful particularly those on managing the airway, difficult intubations and guidelines on transport of the critically ill child.

However, when reviewing this text I repeatedly referred back to the original claim and asked: “does this book achieve what it set out to?” which was to emphasize the practical aspects of paediatric intensive care. Unfortunately, in my opinion, the short answer is No. I feel that if you had the time to locate the useful and factually correct information you could learn an awful lot. However, at times, there is too little focus and too many errors to allow this book to become widely accepted and regularly utilized in clinical practice.

Melanie Lindley

Book and DVD Reviews

Daniel Can Do

Available from
Professor S E Henderson
4 Manor View
Huntingdon, Cambs PE29 1WD
Cost : £15 + £2 p&p

This is a combined package comprising a DVD and CD.

The DVD is a 20 minute film and commentary featuring Daniel, his parents and his physiotherapist Ann Markee. The presentation is described in the accompanying literature as "one possible solution to the practical problems faced by families and professionals concerned with children with DCD." It demonstrates the use of normal school and leisure activities in improving self-esteem, developing peer relationships and achieving goals without an improvement in objective measures such as the Movement ABC. The activities included were timed functional activities such as dressing, playing computer games, Kung Fu, rugby and playing a musical instrument. It is a useful reminder that resources both in and outside of the school environment can motivate children and remove therapy from a clinical setting

The CD contains a PowerPoint presentation given at the 6th International conference of DCD in Trieste, 2005. It gives some information and statistics for average referral and waiting times for therapy, explores the links between DCD and other co-morbidities and presents the Cognitive Motor Approach outlined by Henderson & Sugden in 1992 and which was used to treat Daniel.

The role of Occupational Therapy is included in the CD but not in the DVD.

The DVD and CD would be of use to parents and as training material for therapists new to the field.

Helen Bayliss, Senior Physiotherapist
Juliet Sweeney, Senior OT
Heather Angilley, Senior Physiotherapist

THE APCP RESEARCH GROUP REGISTER

If you would like to be a member of the APCP research group, please fill in the form below and return it to **Jeanne Hartley, Research Officer, Physiotherapy Department, Great Ormond Street Hospital, London WC1N 3JH**. This information will be used to inform you of research study days and help us to learn more about our members' research interest.

Name

Contact
Address

Post Code

Tel. No.

Fax No.

E-Mail:

What are your research interests?

Are you undertaking any type of research project large or small? **YES?NO**

If yes 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.

Tributes

A Tribute to Carole Anne Hurran (nee Vaughan) (12th October 1944 – 22nd June 2006)

Carole trained at the Middlesex Hospital. Once qualified, she worked for a year at the Whittington Hospital in London. She moved to the General Hospital in Cheltenham from 1967 – 1971, where after rotations she specialised in Paediatrics and Adult Neurology. Her next move was to Bristol to the Royal Hospital for Sick Children, where she continued her lifelong interest in paediatrics. Following the birth of her children she worked part time in Day Nurseries treating children with multiple disabilities and developmental delay. Her next full time post was at St Monica's Home of Rest where she ran a small department for nearly four years, treating people over the age of sixty with physical disabilities including neurological conditions. In 1982 Carole took up a post at Claremont Special School in Bristol. In 1989 she became superintendent physiotherapist in charge of the team of paediatric physiotherapists based at Claremont School, working in the community in North West Bristol. She remained in this post until she retired in April 2006.



Carole had an ongoing interest in continuing education, both for herself and other physiotherapists. She trained in Bobath therapy in 1969 and completed an Open University Bachelor of Arts degree in Biological, Social and Educational Sciences in 1980. She did the six week training in Budapest in 1988 in Conductive Education at the Peto Insitute. In 1991 she gained the Advanced Certificate in Paediatric Physiotherapy. As part of her CPD she attended and ran an eclectic variety of short courses. More recently Carole assisted in European research in selective head cooling to improve neurodevelopmental outcome in newborn infants with neonatal encephalopathy.

An honorary member of APCP, Carole had an impressive record of contributing to the association and journal. Her first reports as South West regional rep appeared in 1991, and in 1994 she and her committee were responsible for organising the annual APCP conference at Bath. Carole moved on to become the Post-registration Education Spokesman, and her vision and hard work in this role within APCP became central to modernising the approach to paediatric physiotherapy through CPD. This was achieved via publications on Statutory Assessment for Children with Special Educational Needs, the Outcome Measures pack, Guidance for Good Practice in Manual Handling and by forging links with universities to provide CPD opportunities for paediatric physiotherapists. During her years on the APCP national committee her marvellous sense of humour lightened many meetings and her presence at annual conferences will be greatly missed. The APCP today sees many ripples spreading from the work Carole nurtured in the 90's.



Always at the forefront of change in the paediatric field she was keen to ensure that paediatric physiotherapists continued in their professional development. She had a particular interest in the growth of integration and inclusion for children with special needs and was instrumental in projects within Avon, leading on policy and the logistics of integration.

Colleagues will remember Carole for her leadership, innovation and supportive management style. She helped encourage teamwork in a special school setting where the physiotherapy team was stable over a number of years, a testament to the happy working environment she created. Carole was a great friend and mentor and encouraged and helped many colleagues, both in Bristol and in APCP, to gain confidence and knowledge. She gave willingly of her time

Tributes

and supported her team tirelessly through many NHS and Education Department changes, as evidenced recently by her refusal to retire until she had seen all her staff through Agenda for Change.

Carole will also be remembered for her acting and singing ability in student reviews and light opera and later at Claremont School's annual pantomimes and at APCP conferences. She was a member of the Bristol Phoenix Choir for over 20 years. In her leisure time she enjoyed walking, gardening, international travel, book club membership, her family and friends, and holding memorable parties. Carole never lacked enthusiasm and energy for anything in life and seemed to manage to fit more into each day than any other person around her. When she was ill with cancer Carole continued to live as full a life as possible, even working on writing KSFs when she was not fit enough to treat patients.

Carole will be remembered for her influence on many physiotherapists and members of the multi-disciplinary team who worked with her. She was wise and caring in her very modest way and for us personally was very special, quietly leading us on to follow in her twin roles in APCP education and in community paediatric physiotherapy management in the North Bristol NHS Trust. She dedicated her life to nurturing generations of children with disability, their families, and the staff who worked with them.

Carole will be a great loss not only to her family, colleagues and friends but also to paediatric physiotherapy. Through her husband Jeff, daughter Nicky and son Pete her indomitable spirit will continue.

APCP would like to thank Jeff Hurran, Lyn Jenkins, Terry Pountney and Lyn Campbell for this tribute to Carole.

A Tribute to Sarah Prior

(13th August 1957 – 20th July 2006)

Sarah died on 20th July after a courageous 18-month battle against cancer. Growing up as the daughter of an Anglican minister she learned how to relate to all kinds of people and her practice was enriched by her empathy and kindness to the children and parents that she worked with.

Sarah trained at Manchester Royal Infirmary School of Physiotherapy (1975 –1978) and made lasting friendships there.

Sarah's career in paediatrics began at Great Ormond Street Hospital and continued working in the community, close to home, in Brent from 1990-2002. Towards the end of this period she arranged to update her respiratory skills at St Mary's hospital and began doing weekends and on calls there. In 2002 she joined the staff at St. Mary's as an extended scope practitioner in paediatric orthopaedics. She enjoyed the challenge of establishing herself in this post but realised that neurodevelopmental physiotherapy was what she loved best and went to Ealing hospital as a Clinical Specialist in 2004.

Sarah became a member of the APCP London branch committee in 1999 serving as PRO and then Treasurer. She attended National Committee meetings as stand in for the London representative on a number of occasions. She was an enthusiastic and lively committee member, always calm and well organised and eager to take her share of the work, often taking on extra tasks to help others. She was great fun to be with and brought wit as well as wisdom to meetings.

All who worked with Sarah can testify to the thoroughness and attention to detail with which she approached everything she did. Many of her colleagues became her friends, responding to her care and concern for them. She found breaking the news of her cancer very hard because she hated to see her friends upset. All who visited her came away feeling that she had been ministering to them more than they to her. Her Christian faith meant that she was sure of her destination and her concerns were for those she was leaving behind. Our sympathies go to Adrian, Alice, Lucie and Thomas in their great loss.

Sarah will not be forgotten for she was too great a friend and colleague to so many, and her courage and strength a lesson to us all. She will be sadly missed.

Sue Bush



**APCP CONFERENCE
GLASGOW
10th - 12th November**

MOVING FORWARD – Challenging Expectations

FRIDAY

1.00	CONFERENCE OPENING & WELCOME	<i>Alison Gilmour (Chair APCP Scotland)</i>
1.20	KEYNOTE SPEAKER Moving Forward to a Healthier Future	<i>Professor Phil Hanlon</i>
2.00	Intrathecal Baclofen	<i>Dr Paul Eunson</i>
2.45	Visual Problems following premature birth	<i>Professor Gordon Dutton</i>
3.30	TEA	
4.00	Current Issues in PICU Physiotherapy	<i>Elaine Dhouieb</i>
4.45	Paediatric Intensive Care and Physiotherapy	<i>Dr Ulf Theiland</i>
5.30	OPENING of EXHIBITION & 'A Taste of Scotland'	
6.15-7.00	Workshops • Neuro-biomechanical aspects to gait problems • Kids & Physios having a Ball (Swiss Ball)	<i>Dr Barry Meadows Joanne Elphinstone</i>

SATURDAY

9.00	CHAIR	<i>Kendryck Lloyd Jones (CSP Policy Officer Scotland)</i>
9.05	KEYNOTE SPEAKER Moving Forward – Chaos or Development?	<i>Dr Laila de Grout</i>
9.45	Movement for Learning & Life (MOVE)	<i>Christine Shaw</i>
10.15	COFFEE	
	CHAIR	<i>Katie Kinch</i>
10.45	The Changing Panorama of Neurological Physiotherapy	<i>Dr Margaret Mayston</i>
11.50	ANNUAL GENERAL MEETING	
12.45	LUNCH	
	CHAIR	<i>Laura Wiggins</i>
1.45	Balance, Education & Movement – getting BEAM into the curriculum	<i>Anne Finlayson/Dianne Rickard</i>
2.30	Physiotherapy in Neuromuscular Disorders	<i>Marina Morrow</i>
3.00	Genetic Implications in Neuromuscular Disorders	<i>Dr Douglas Wilcox</i>
3.30	TEA	
4.00	FREE PAPERS	
5.00	Guidelines for Essential Medical Surveillance for Children with Downs Syndrome	<i>Dr Patricia Jackson</i>
5.30-6.00	'Spot the Differences' in service provision around the UK	<i>Linda Fisher & Team</i>

SUNDAY

	CHAIR	<i>Dr Eva Bower</i>
9.00	Paediatric Rheumatology	<i>Dr Janet Gardner Medwin</i>
9.45	The Evolution of NIV in Acute Paediatrics	<i>Melanie Lindley</i>
10.30	COFFEE	
11.00	Advances in Spinal Surgery in Children	<i>Mr Ian Harding</i>
12.00	CONFERENCE CLOSE	

**NNG Conference Day in Association with APCP
Saturday November 11th
The Crowne Plaza Hotel, Glasgow**

- 9.00 Main APCP Conference opening**
- 9.05 Keynote Speaker Main APCP Conference Laila De Groot
'Moving forward, Chaos or Development'**
- 9.45 Main APCP conference**
- 10.15 COFFEE**
- 10.45 NNG Laila de Groot - Early intervention**
- 11.50 Main APCP Conference AGM**
- 12.45 - 1.40 LUNCH**
- 1.45 Jean Pierre Lin - 'Neuro-anatomy and physiology of
dystonia/dyskinesia and basal ganglia dysfunction -
lessons of deep brain stimulation in children'**
- 3.00 AGM NNG**
- 3.30 TEA**
- 4.00 NNG Laila de Groot**
- 5.00 CLOSE**



APCP CONFERENCE
GLASGOW 2006
10th - 12th November

(including Neonatal Group Conference
Saturday 11th November)

DELEGATE NAME		
Title:	First Name:	Surname:

If you are attending the NEONATAL GROUP CONFERENCE on Saturday 11th please tick the following box & complete the relevant boxes from Packages 1, 2 or 3

The following are the 3 individual packages you may choose from -
Please ✓ appropriate

PACKAGE 1 - RESIDENTIAL
This is the FULL conference package & includes: shared accommodation on Friday & Saturday nights at the Crowne Plaza Hotel, all daytime catering, plus 'Taste of Scotland' on Friday between 1730 - 1900, entry to all lectures and your selected workshop session on Friday
(Overnight B&B is based on 2 sharing accommodation. Single rooms are available at a £37.50 supplement per night)
Please see over for workshop list and indicate your choice

	Early Bird before 01/09/06		Booking after 01/09/06		Amount to Pay
	Member	Non-Member	Member	Non-Member	
Twin en suite (per person)	£265 <input type="checkbox"/>	£285 <input type="checkbox"/>	£280 <input type="checkbox"/>	£300 <input type="checkbox"/>	£
Please give name of person with whom you will share:					
Please allocate me a delegate with whom I will share: <input type="checkbox"/>					
Single en suite	£340 <input type="checkbox"/>	£360 <input type="checkbox"/>	£355 <input type="checkbox"/>	£375 <input type="checkbox"/>	£

OR

PACKAGE 2 - NON RESIDENTIAL
This includes entry to all lectures, all daytime catering plus 'Taste of Scotland' on Friday from 1730 - 1900, but NO overnight accommodation
Please see over for workshop list and indicate your choice

	Early Bird before 01/09/06		Booking after 01/09/06		Amount to Pay
	Member	Non-Member	Member	Non-Member	
Attending Full Conference	£160 <input type="checkbox"/>	£180 <input type="checkbox"/>	£175 <input type="checkbox"/>	£195 <input type="checkbox"/>	£

OR

PACKAGE 3 - DAY & HALF DAY RATES (Non Residential)
Please see over for workshop list and indicate your choices if applicable

	Early Bird before 01/09/06		Booking after 01/09/06		Amount to Pay
	Member	Non-Member	Member	Non-Member	
Friday PM - includes entry to lectures, workshop, refreshments & 'Taste of Scotland'	£50 <input type="checkbox"/>	£60 <input type="checkbox"/>	£60 <input type="checkbox"/>	£70 <input type="checkbox"/>	£
Saturday All Day - includes entry to lectures, lunch & refreshments	£80 <input type="checkbox"/>	£90 <input type="checkbox"/>	£90 <input type="checkbox"/>	£100 <input type="checkbox"/>	
Sunday AM - includes entry to lectures & refreshments	£45 <input type="checkbox"/>	£55 <input type="checkbox"/>	£55 <input type="checkbox"/>	£65 <input type="checkbox"/>	

Please to indicate your preferred workshop
(Limited number of places available)

Friday Workshops 6.15 - 7.00pm		
Neuro-biomechanical approach to gait problems	Dr Barry Meadows	<input type="checkbox"/>
'Kids and Physios having a ball' (Swiss Ball)	Joanne Elphinstone	<input type="checkbox"/>

Please to indicate if you wish to attend

OPTIONAL EXTRAS		
Saturday evening Conference Dinner & Ceilidh <i>After dinner speaker - Muriel Gray</i>	£25.00	<input type="checkbox"/>
		Amount to Pay
		£
Would Honorary members please tick the following box if they wish to attend the Conference Dinner <input type="checkbox"/>		

POSTAL ADDRESS for Correspondence (receipt, pre-conference info etc)	
Email:	Tel:
Place of Work (to appear on conference badge):	
National Committee Member: Yes/No	APCP No & Region:
Organising Committee Member: Yes/No	
Please tell us if you have any special requirements? (diet, mobility etc):	

Payment:
CHEQUES should be sent with application and made payable to: 'APCP Conference Fund'
Please write your name and address on the back of the cheque.

TOTAL AMOUNT - to include either Package 1,2 or 3 plus Conference Dinner (if applicable)	TOTAL AMOUNT TO PAY
	£

<p>Please submit your registration form (as early as possible to receive the discount) to:</p> <p style="text-align: center;">Lyn Campbell (APCP Conference) 16 Cammo Walk Edinburgh EH4 8AN 0131 539 0619</p> <p>Home email: campbell.l@blueyonder.co.uk Work Email: lyn@craighalbert.org.uk</p> <p>Please ensure your payment is sent with your application and enclose a <u>SELF ADDRESSED A5 STAMPED ENVELOPE</u> for pre-conference information</p> <p>RESIDENTIAL Registration Forms must be received by 9th October 2006 NON RESIDENTIAL Registration Forms must be received by 27th October 2006</p> <p>Cancellations will be refunded up until the closing date of the 27/10/06 but are subject to a £25 administration fee, however substitute delegates are welcome at no extra cost</p>

<p>For information on booking alternative accommodation please contact: www.visitscotland.com or telephone: 0141 204 4400 or adjacent to the Crowne Plaza is the City Inn at www.cityinn.com</p>
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APCP CONFERENCE GLASGOW

NOVEMBER 10th – 12th 2006

CALL FOR ABSTRACTS

If you are interested in submitting an abstract for a Poster or Oral Presentation
please contact:

Arlene Smillie at Camelon Health Centre, 1, Baird Street, Camelon, Falkirk
On 01324 679 129 or by email at arlene.smille@fvah.scot.nhs.uk

NOTICE

The 33rd Annual General Meeting
of the
Association of Paediatric Chartered Physiotherapists
will be held on
Saturday 11th November
at
The Crowne Plaza Hotel, Glasgow
beginning at 11.50 am

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

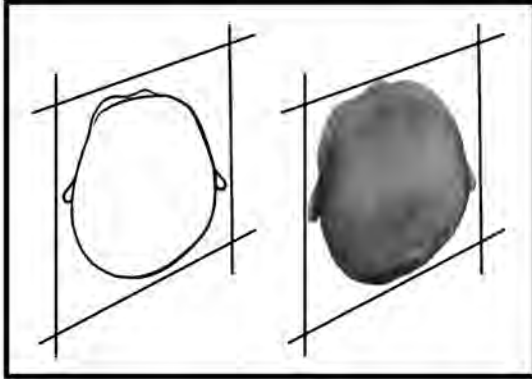
Minutes of the last AGM are available from the Secretary by email or on
receipt of a S.A.E.

Notification of committee vacancies:

There will be one vacancy. The retiring member is Lesley Smith.
Nominations should be sent to the secretary by the end of September 2006 together
with names of a proposer and seconder who must be members of the Association.

Plagiocephaly

Guidelines for Diagnosis and Treatment



If you work in paediatrics and are interested in learning more about the causes, prevention and treatment of positional plagiocephaly, you are invited to attend our half-day CPD course.

This course will help you:

- * Understand the characteristics of the three common head shapes we see resulting from positional flattening.
- * Recognize infants at higher risk for developing positional plagiocephaly.
- * Understand the relationship between torticollis, SCM imbalance and positional plagiocephaly.
- * Provide parents with simple and effective strategies to prevent positional flattening and reverse early flattening in appropriate timeframes.

You will be provided with:

- * Free handouts and resources we have available for you to share with parents and colleagues.
- * A certificate of attendance as proof for CPD requirements.
- * Access to our plagiocephaly research library.

Schedule your course today!

Courses can be held for groups of up to 10 people and are held on the last Friday of every month from 1 PM - 4PM. There is no charge for this course.

To book, please contact us at: 020 7935 5844



Provided by Cranial Technologies Europe, Ltd.

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Ground Floor Suite
76 Wimpole Street
London, W1G 9RT

020-7935-5844

www.cranialtech.co.uk



**Bayley Scales of Infant and Toddler Development™
(Bayley III)**

**One-Day Training Workshop
9.30am – 4.30pm**

**Trainer: Betty Hutchon
Course fee: £80**

Monday 16th October 2006, @ the Royal Free Hospital, London

This one day workshop will introduce course participants to the Bayley-III.

It will include an overview of the subtests, a broad look at the changes from BSID II, research design, psychometric properties, and special group studies. The Cognitive Scale, Language Scale, Motor Scale, Social-Emotional and Adaptive Behaviour Scales will all be discussed.

Administration and scoring procedures will be described and interpretative considerations discussed.

The workshop is aimed at Paediatric Therapists, Psychologists, Paediatricians and others responsible for assessing child development, who meet the criteria for a CL2 registration code with Harcourt Assessment.

A certificate will be issued on completion of the training day.

For information and application form, please contact:

Marilyn Dowdye
Administrator
Child Health Department
Royal Free Hampstead NHS Trust
Pond Street
London NW3 2QG
Tel: 0207 472 6270
Fax: 0207 830 2003
Email: marilyn.dowdye@royalfree.nhs.uk

Advertising in the APCP Journal

The APCP journal offers a unique opportunity for individuals and organisations to advertise their job vacancies, courses and products directly to paediatric physiotherapists.

Products		Vacancies		Courses	
Full page	£500	Full page	£300	APCP courses	Free
Half page	£300	Half page	£175	Full page	£300
Quarter page	£200	Quarter page	£125	Half page	£175
				Quarter page	£125

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In this issue :

Who Needs Gait Analysis?

Physiotherapy for Torticollis

**To develop a more coordinated approach
to the identification, assessment and
management of children experiencing
motor coordination difficulties,
across Education and Health services
in Knowsley.**

