
ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS



NEWSLETTER

READERS WRITE....

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EDITORIAL

It is sometimes a matter for conjecture how 'alive' an Association is, and when it was planned to have an edition of the Newsletter for members contributions, there was some concern what the response would be. As our readers will discover, we had no cause to worry, the members are very much 'alive' and anxious to participate. This has been particularly noticeable in the excellent response to our recent questionnaire about Conductive Education, about which there were some pertinent comments, which should be helpful when the information is collated. Thank you, all the people who were so helpful and returned the forms promptly.

This edition has a further survey, which again we hope you will complete, and help us to fight for better facilities in Child Development Centres. Statistics and facts being important when presenting evidence to Health Authorities and finance officers. The survey done in 1986 on provision and funding for equipment is now available, and the abstract of the findings is in the Newsletter. Our thanks to Miss Gill Riley in the South West, who did all the hard work. Whilst much of this paperwork may seem boring, it is a necessary part of finding out the problems paediatric physiotherapists are encountering, and trying to find ways to improve conditions and funding.

In November 1988 the Newsletter is to be about 'Problems in Practice', we hope you will continue to let us know what they are and be prepared to have them printed!

Best wishes for 1988 (your Editor has started the year well with a brand new grand-daughter) and the continuing progress of our thriving Association.

The last date for submission of material for the MAY 1988 Newsletter will be April 5th.

The subject will be 'Gait'.

The Editorial Board does not necessarily agree with opinions expressed in articles and correspondence, and reserves the right to edit material submitted.

SURGICAL TREATMENT OF C.T.E.V.

Mr. J. C. Dorgan, Consultant Orthopaedic Surgeon, Liverpool

The surgical treatment of C.T.E.V. can be classified under two headings - early surgery and late surgery. Early surgery is that carried out within the first year of life, in order to try and achieve full correction of the deformity. Late surgery is carried out in older children to correct either untreated deformities, or to correct deformities that have re-appeared with growth, in children who have had early correction.

1. Early Surgery

The principle deformity in C.T.E.V. is a medial displacement of the os calcis under the talus. There is also a fixed equinus deformity of the hindfoot and a varus deformity of the forefoot. The surgery is usually carried out when the child is between 3-6 months old depending upon the condition of the child.

a. Posterior Release

This procedure is used in those cases where the forefoot deformity has been corrected by serial strapping. The surgery is carried out under a general anaesthetic and a pneumatic tourniquet is used to give a bloodless field. A posterior incision is made and the tendo-achilles identified. The tendon is lengthened by a Z-plasty. A posterior capsulotomy of the ankle and subtalar joints is then carried out. The calcaneofibular ligament is released and the foot is then brought into a position of maximum dorsiflexion. If clawing of the hallux or toes is noted, then a Z-plasty of the F.H.L. and F.D.L. may also be required. The tourniquet is released before wound closure and full haemostasis is achieved. The wound is closed in layers and an intradermal suture is used to give a linear scar, and obviate the need for suture removal at a later date. A well padded full leg POP is applied with the knee flexed to 90° to prevent migration of the plaster.

Post operatively the child is kept in hospital for 48 hours so that the foot can be elevated and the POP split if necessary. A change of POP under general anaesthesia at 2 weeks post operation is usually carried out, and total time in POP is 6 weeks.

b. Posterio-Medial Release

This procedure is used in most cases where there is persistent varus of the forefoot and varus with equinus of the hindfoot. The procedure is similar to that already described for a posterior release but the skin incision is extended along the medial border of the foot. A posterior release is performed as described above. Attention is then turned to the medial side of the foot, and the navicular is identified. There is often so much displacement of the navicular that it ends up articulating with the medial malleolus. The tendon of tibialis posterior is identified and lengthened by Z-plasty. The capsule of the talonavicular joint is divided to allow replacement of the navicular in its correct alignment with the head of the talus. If necessary a K-wire is inserted to maintain the correction. Once a full release has been obtained, the tourniquet

is released and haemostasis achieved. By releasing the tourniquet, the Surgeon is able to assess the viability of the wound edges after skin closure. The foot is then immobilised in POP in such a position as to avoid undue torsion and avascularity of the wound edges. Full correction of the foot can be achieved at the change of POP under general anaesthesia 2 weeks later, when the wound has healed.

THE SCAPA GYM CLUB

Miss Emma McLeod MCSP

I am one of three physiotherapists working in Orkney - the group of islands between the North of Scotland and Shetland. As part of my remit I am responsible for paediatrics. Through this work I became aware that there was more than physio needed for these children and their families, but what...? The answer came whilst I was treating a young PE teacher. During his training, he told me that he had taken a trampoline session for cerebral palsy children, and how much they had enjoyed it. "That's it" I thought. I have the families, he has the school gym. Can we get the two together and get something going?

I talked with the CAMO and the GP's and got the go ahead. I then put the idea to the few families who were keen to give it a try. The gym teacher had also been doing his homework - the use of the gym hall for one and a half hours on a Saturday morning with no hire charges! Posters advertising the gym club were made by an art teacher, and put in the Health Centre. We were all ready to go. That was three years ago.

The SCAPA Club (named after Scapa Flow) stands for - Special Children Are Physically Able. I can only say it's a success. The numbers have grown. Referrals come from GP's, Health Visitors, Educational Psychologists and by word of mouth from other parents. The only stipulation I make is that the family's GP knows that they attend. Any handicap is acceptable be it physical, mental, long or short term. There is always a parent or guardian with the child and his or her siblings. We also have some additional helpers and often these are teenagers working for a Duke of Edinburgh award or a Guide/Scout badge.

The families pay £1 membership p.a. and 50p per family when they attend. This covers the insurance policy, and buys juice for the Saturday morning.

All the gym equipment is used, including the trampoline and in addition we have a ball pool, tunnel, 'physioball', slide and barrels. Nothing is structured, so the children can do things at their pace. There is no feeling of "I'm no good at that" or "I'm always the last to be chosen." For once the handicapped child is seen as an asset to the sibling. One boy was heard to remark "I'm glad my sister's got asthma, otherwise I couldn't come here." The parents exchange ideas and talk about problems relating to the children. One Mother told me with great joy, that since coming to the club (1 year) her child hadn't had an asthma attack. He is a 'ball of fire' and never stops going.

This club provides many assets to children and parents alike, but above all,

it gives a great deal of fun and laughter.

I would be interested to know if any other physiotherapists are involved with similar work as I would welcome an exchange of ideas.

THE BALLERINA SYNDROME

Noreen Hare

The "Ballerina" Syndrome is the title in fairly common use given to a group of children who persist in walking on their toes. Interest in them and the need to determine the cause in order for treatment to be appropriate, has promoted the following points for discussion.

The children who have been referred to Physiotherapy in Nottingham, are both male and female, aged from 14 months to eight years, i.e. just learning to walk or with established gait patterns. They are always accompanied by a concerned Mother and are usually sent from a neurological or orthopaedic clinic, or by a community paediatrician. They are agile, healthy active children with the one persistent and baffling phenomena that they insist on walking on their toes. The main problem concerning Mum, as they grow older, is the growth distortion of the foot and the difficulty in getting shoes to fit or that will stay on.

When analysing the problem three distinct categories emerge:

1. Neurological cause, perhaps a mild cerebral palsy such as spastic diplegia or hemiplegia. This problem is ruled out in the "ballerina" group as their physical and overall performance is so excellent. Movement and balance are quite normal, there is no evidence of asymetry or other functional involvement such as hand use. Moreover, there is no developmental history of delay.
2. Musculo skeletal, dystrophy, juvenile chronic arthritis: Boys of 3 and over with proximal or limb girdle dystrophies begin to walk on their toes in order to stabilise their hips and pelvis. Children with arthritis or joint pain tend to hobble rather than walk on their toes. Examination of both groups would reveal weakness, muscle atrophy and/or discomfort on examination. Again, the "ballerina" group are unique. They have always walked on their toes, there is no pain or discomfort although there may be some tightness of the tendon achilles, and hypertrophy of gluteal muscles in the older children.
3. Local Joint Problems: An undetected congenital deformity or dislocation of the hip may cause a child to adopt toe walking. Examination of the hip will soon reveal this difficulty if present. Similarly no examination of any child is complete without observation of the spine, shoulder and pelvic girdles in both horizontal and vertical positions. However, intimate and careful examination of joint ranges of the foot and ankle have revealed a possible cause of the "ballerina" syndrome.

We have found that all the children in the group currently being seen exhibit a limitation of within 5° of full dorsiflexion due to a "boney block" as opposed to muscle tightness or tension. With the child in long sitting, the calcaneum is grasped and the foot brought into dorsiflexion. In each case, as 90° is approached, the ankle swivels into eversion with a rotation at the Talo Calcaneon joint and resulting Valgus deformity.

This limitation to full dorsiflexion is confined to **one foot**. When the children stand and the heel is brought down, the foot becomes calcaneus and the valgus position is assumed.

The conclusion from this study is that the affected foot is quite unstable laterally on weight bearing, and swivels into a pronated position. To eliminate this problem, the child weight bears on his toes. To promote efficiency, he adopts the same posture with the unaffected foot.

What can be done to rectify The "Ballerina" Syndrome? It is necessary to take some action, as the Mother's fears are well founded. Growth, the abnormal weight bearing, and use, cause considerable distortion of the feet in shape and size.

First, if the symptoms described above are recognised, stretching of the tendon achilles in the young child and any attempt at muscle release in the older child would seem to be contra indicated.

Second, below knee walking plaster boots with the heel at 90° to the leg and the forefoot in mid position can produce dramatic results. But this will depend on the range of dorsiflexion and the degree of limitation.

Third, as a preparation for plaster boots a minimal raise under the affected heel has had encouraging results. This produces a heel toe gait on the unaffected foot, and allows weight bearing through the calcaneum on the affected side.

Finally, if a "boney block" to dorsiflexion is discovered examination by an orthopaedic surgeon with a view to further investigation of the joint problem is to be encouraged.

Feet have to last a lifetime, they grow and are moulded by use. The children exhibiting the "ballerina" syndrome are in no way incapacitated, but persistence in toe walking should be considered seriously and dealt with appropriately in order to prevent problems and discomfort in later life.

CONTROL OF HEAD POSITION IN SITTING FOR CHILDREN WITH MINIMAL OR NO ACTIVE HEAD CONTROL

Miss L. Swann, Snr. Physiotherapist, Dorchester

OBJECTIVE To find a suitable method of supporting the head of the child with minimal or no head control and which maintains a patent airway by preventing the head falling onto the chest during feeding and travelling. An appropriate support would need to be safe, cosmetically acceptable, and quick to make at low cost.

Materials

Plastic rivets to accompany plastazote
Plastazote 0.6 cms thick (for smaller children)
OR 1.2 cms thick (for larger children)
Polythene reinforcing material
Cotton strapping 2.5 cms wide and 2 D rings for each side
(Most of the time the 0.6 cms thickness of plastazote is adequate).

Indications/Contraindications

The support is not limited to use with children having lack of head control in cerebral palsy. It could be suitable for other conditions in which head control is diminished.

A contra-indication would be if the support provoked a pattern of total flexion in a child with cerebral palsy. However with 2 children who have a problem with primitive flexor activity at the slightest provocation, the support has promoted some active neck extension when they have been positioned in suitable seating.

For an extremely “floppy” older child, the support is the solution to a problem. However, great care should be taken with a younger child or baby as it may provide unwanted sensory input which could encourage the development of patterns of flexion; therefore I have only used the support when absolutely necessary.

Points to Note

1. Main use is for feeding, travelling and during therapy sessions when needed to aid positioning. Also easily washed if the child vomits or dribbles.
2. Provides reasonably uniform pressure around the anterior aspect of neck so minimising pressure over trachea.
3. When the chin falls towards chest the shoulder pieces prevent the support slipping downwards.
4. Supportive yet flexible so if the child has fits it is safe.
5. Cosmetically acceptable and can be worn over a vest and under a T-shirt (also over a supportive corset worn for scoliosis) so the only visible part is under the patient’s chin.

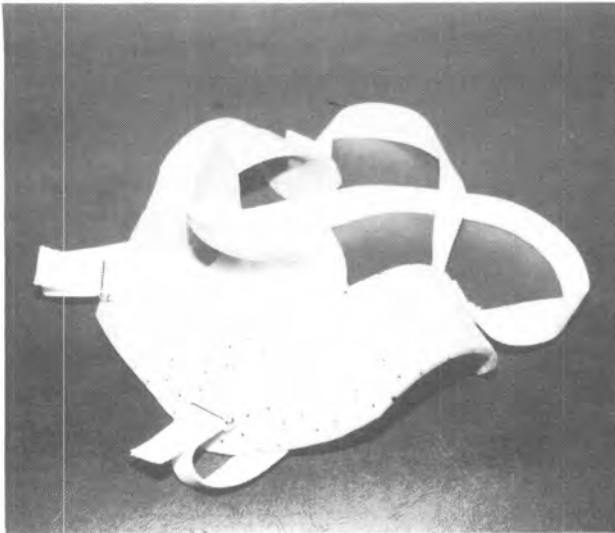
NB: A type of “helmet” support has been tried but the child’s head slips out. If there is a chin strap it causes pressure on the trachea in one place due to the weight of the head.

6. The head support usually lasts for 3-4 months but a small piece of polythene acting as a washer can be used behind the plastazote rivet for added strength.

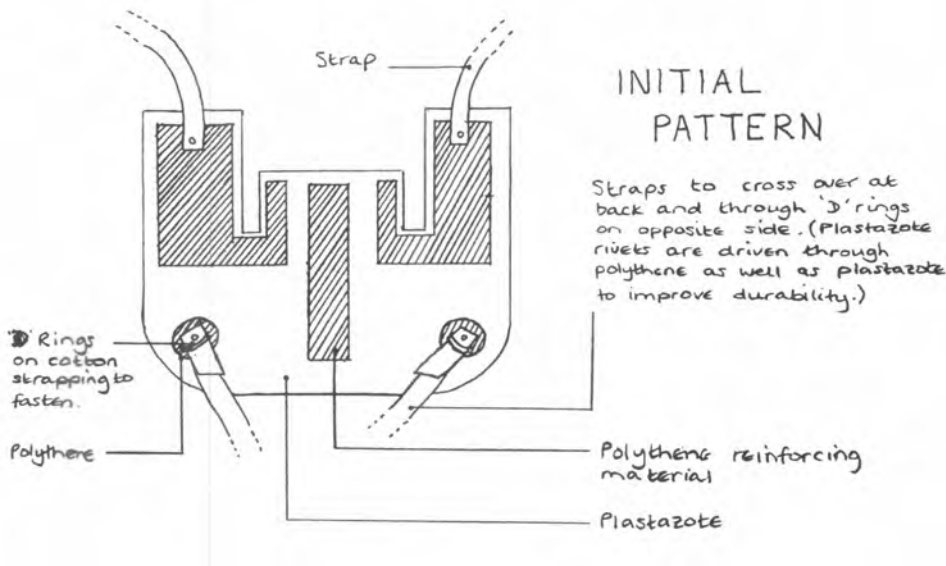
A padded "orthoplast" support has been tried as it is more hardwearing than plastazote but was found to be too rigid especially if the child has fits.



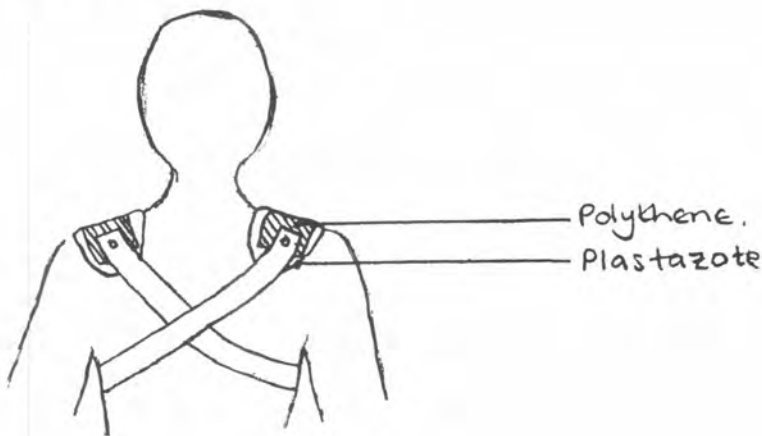
Child aged 3 wearing Neck Support.



Plastazote Neck Support.



POSTERIOR ASPECT



THE MANAGEMENT OF THE WHEELCHAIR CHILD

Mr. Owen McGhee, Senior Physiotherapist, Newham District

Lesions which cause a child to regularly use a wheelchair produce permanent, relatively untreatable effects. One of the main problems these children face is the transition from being cared for as a child to coping independently as an adult. Many parents fail to produce this transition in their own child because (i) they have developed a habit of looking after their disabled child, (ii) they do not necessarily know what the child may reasonably be expected to achieve and (iii) they do not know how to overcome the technical problems of living in a wheelchair. It is in the solving of the problems faced by the wheelchair user that the physiotherapist may legitimately apply herself and below are outlined some of the problems and solutions applicable to this child.

The vehicle

It is essential to understand from the outset that the wheelchair is a vehicle and like all vehicles is an item designed to produce mobility. Whilst it should be comfortable, its function as a seat is secondary to its function as a vehicle.

The user

1. The general user may stand or even walk with calipers for exercise but for general mobility they will use a wheelchair.
2. The second group are those who, although they walk indoors, find that it is too difficult, painful or slow to walk outdoors. They should use a wheelchair in the more hostile outdoor environment.
3. The third group are those who although they can walk cannot run. These people should use a wheelchair for sport.

There are two other specific groups of children who may be offered the use of a wheelchair. Muscular dystrophy children may begin to fall over in the playground at an early age. They may be offered the use of a SPORTS WHEELCHAIR for use during play and games. The chairs available from DHSS, at the moment, are entirely unsuitable for this child at this stage of the disease. The other group of children are those who suffer from diplegia. This child may walk indoors but may find walking outdoors impracticable. Providing that the child's hands are not too badly affected he may be able to use a chair independently outdoors. Unfortunately many diplegics cannot use a chair well enough to be totally independent.

The basic skill required for independent wheelchair use is the BACKWHEEL BALANCE. This will be used to ascend and descend 4 inch kerbs, to manage slopes and to negotiate flights of stairs. Every effort must be made to teach the child to backwheel balance for which reasonable hand control is necessary. Strength is not the issue, control is. If the hands are weak the chair can be altered to enable the child to accomplish the required skills.

Problems of hand control such as ataxia or spasticity require more complex solutions and total independence may not be achieved.

There are various designs of wheelchair, each with different handling characteristics. The most important feature is the position of the back wheel in relation to the backrest. If the back wheel is behind the backrest the chair will be very stable and therefore very difficult to tip onto its back wheels. This will make its use outdoors difficult and often dangerous. Unfortunately for many active wheelchair children the standard 8LC, because of its stability, is an excellent climbing frame but a poor outdoor kerb climbing vehicle. When we bear in mind that we start to train the wheelchair child to cross the road at the age of six or seven it is little wonder that we have to obtain funds to buy this child a private chair. The really horrifying possibility is that this child may fit into an 8LC until he is a teenager. Until now, private wheelchairs have cost between £500 and £1,000. Good quality 'High Performance' wheelchairs will shortly be available for around £200, placing these vehicles within the reach of every wheelchair child.

Whenever one introduces accessories or adaptations to a wheelchair one must bear in mind that these may alter the handling characteristics of the chair.

Back cushions profoundly alter the handling characteristics and can even render the chair useless as a mobility item. If a cushion is necessary one may have to move the pushing wheels forwards so that the chair can still be tipped by the user. It may be possible, as an alternative, to alter the back canvas to avoid the use of a back cushion.

Seat belts are an item which all children are compelled to wear whilst being carried in a motor vehicle. In respect of the independent wheelchair user it does not appear to be of value in any other circumstances. There is one occasion when a seat belt should never be worn by the active wheelchair child, that is in the vicinity of water. If the child has to be strapped into a chair because he is likely to fall out he should not be allowed near a pool or lake unaccompanied.

Armrests can obstruct access to the pushing wheels and many children are better without armrests.

Seat cushions will lift the child up, bringing him further away from the pushing wheels and this may cause him to lose contact with the pushing wheels.

Training

Mobility training for the wheelchair child begins at the age of six or seven. Training is given, in the gym, to enable the child to backwheel balance and this activity is encouraged as often as is possible. Once the child is competent in this skill he can begin to practice kerbs, first in the gym and eventually outdoors in conjunction with kerb drill and crossing the road.

The urban environment is considerably more hostile than home or school and the wheelchair child must be taught to become independent in this environment. The easiest way to achieve this is for the child to push himself around the streets first under supervision and eventually on his own. Parents and carers must be discouraged from pushing the chair unless absolutely

necessary and this will enable the child to build up his endurance. Eventually the child should be encouraged to take himself to and from school each day provided the distance is not too great.

School holidays are a good time to visit local areas with wheelchair children so that they can learn how to cope with shop doors, ramps, stairs etc. and for the child to learn to identify local facilities and their access. A spin off from this activity is often an increase in the child's confidence in addressing staff, asking questions and knowing when and how to ask for help. The child will also gain a better concept of his wider surroundings and of his local area and come into closer contact with the general public.

Use of public transport is encouraged during school holidays. We frequently take groups of children into the centre of London and elsewhere by public transport so that they can gain this experience.

The wheelchair child, because he is transported to most activities, needs encouragement to build up his endurance. This can best be done by the promotion of sports activities and the provision of regular long distance pushing. In our area we have strongly promoted road racing as a sport, going from one mile races at the age of eight to five kilometre races at ten and ten kilometre at twelve. Many children do half marathons at the age of fifteen and then enter the London Marathon at the age of eighteen.

Another means of training we use to enable our wheelchair children to become independent is to take them on 'Training Camps'. The camp gives the child the freedom on the one hand and pressure on the other to enable him to develop his skills in many areas. The terrain round the camping area is on the whole entirely unsuitable for wheelchair use and the child has to learn to manage this 'obstacle course' successfully. Children have to do a greater variety of activities than they will normally have to cope with at home such as cooking and washing up and managing their own medical and toileting problems. When children realise that they can cope with the difficult circumstances likely to be found at the training camps their self confidence is much increased. They soon realise that being handicapped or being in a wheelchair does not mean that they are helpless and in need of care and protection for the rest of their lives.

FIRST IMPRESSIONS

**Mrs. M. Lee, Supt. Physio, A.M.I. Portland Hospital for Women
and Children**

Beginning a new position, especially a promotional one is always a somewhat nerving experience. Time is needed in order to find ones feet and learn the ropes. When I began at the A.M.I. Portland Hospital for Women and Children, 7 weeks ago, I arrived with a great deal of enthusiasm and an intense curiosity on how different, working in the private sector would be.

The Portland Hospital specialises in Obstetrics, Gynaecology and Paediatrics. It offers a wide and extensive service in these specialities, both in out- and in- patient care and is the only one of its kind in the United Kingdom. It is licensed for 88 beds and has a SCBU and ITU and can cater for all paediatric conditions except major cardiac surgery.

From a physiotherapy point of view the experience is extensive. In obstetrics, we offer a wide range of classes, from ante-natal classes to keep-fit and swimming fitness classes and in the post-natal period, general exercises, keep-fit classes for post surgical patients and we have particular expertise in treating incontinence and pelvic floor problems.

The paediatric services are wide and continually growing. There is a Child Development Team, Learning Disabilities Clinic and we offer treatment for all conditions. Treatments are generally carried out at the hospital, but we often do home and school visits as well. We are presently expanding our services with a Mother and Toddler Group, an Asthmatic Clinic, Hydrotherapy sessions and a Toy Library.

Beginning my position at the Portland Hospital it soon became clear that there were a number of advantages working in the private sector, but that it also had many similarities. I was immediately struck by the continued helpfulness and friendliness that everybody (from the cleaners, to the porters, to other Departmental Heads) showed to me, which no doubt accounts for the smooth running of the hospital. Managerial decisions can be taken quickly, resolving virtually any problems with satisfying speed.

The largest difference I feel is your ability to spend time and in my view therefore, offer the best possible treatment for a patient. The frustrations of being too busy to see children as regularly as I would like are now thankfully over. From a paediatric point of view, patients frequently come daily for intensive treatment. There is a striking degree of motivation in our group of parents and patients. The family as a whole appear to work much more as a team, so treatment and management is carried over in the home. This often leads to a surprising rate of progress.

The patients we have are varied. A large proportion are from England, but we do have a number from abroad, who come for assessment and treatment programmes. These latter patients often have a limited time in this country, consequently programmes and necessary equipment must be organised quickly. It is amazing how quickly firms can dispatch equipment if you ask nicely!

There is far more knowledge needed in business skills than I ever imagined. I am responsible for a budget, which includes revenue, expenses, staff salaries and national insurance etc, of which I had had very limited prior experience. Physiotherapy becomes more than just a treatment, it becomes a commodity, which needs to be effective, efficient and attractive. It needs to be administered by highly proficient therapists so that consultants, patients and their families recognise your skill and are satisfied with your service. The department must in fact become a centre of excellence in its expertise and facilities. My attitude to my patients must therefore follow on from this. First impressions play an important role especially for the patient. An inviting, well prepared room in nice surroundings with a welcoming member of staff is

important. The Paediatric Physiotherapist must be flexible enough to treat and have specialist knowledge in all paediatric conditions. The facilities and equipment needed for assessment and treatment are important and it is refreshing to find that this is easily accessible and possible in the department.

The work at the hospital is hard and there are long hours, though many other Physiotherapists and other professionals in similar managerial positions work just as hard, but the work is very rewarding. Patients do perhaps object and criticise more freely if they are dissatisfied, but these hopefully should be small in number and will always guide you to know how your department is viewed by others, so that changes can occur.

The hospital is small and the staff know each other and work well together as a team to make patient care the best possible. The Physiotherapy Department continues to grow. There will shortly be three full timers and five part-timers. There are bank staff for week-end work. Thus co-ordination of staff together with continuity of work and treatment must always be maintained. It is not always an easy task.

All the patients have the right to be offered the best possible treatment and service, no matter which type of hospital they go to. Money is always talked about in both sectors - the cuts in the N.H.S. and the affluence in the private sector. We certainly do have the ability to buy new equipment and whatever is necessary for the best patient care, but at the same time we are and have to be, efficient in our resources and management as after all we are running a business.

On reflection the two sectors have the opportunities of being very similar. They can both learn from each other and perhaps should have the opportunity to liaise more closely. One must remember that the ultimate goal is the same for both sectors, namely "Excellent Patient Care and Treatment".

DEVELOPMENTAL PAEDIATRICS AT POOLE

Mrs. M. Holmes, Senior Paediatric Physiotherapist

The Child Development Centre at Poole has been open for just over three years, although the Team has been in existence since 1969, the work previously being carried out in the main hospital. This had its problems, as not only were the members of the Team situated on three floors in various Departments, but the physio/occupational therapy treatment room was a converted changing room with small windows at ceiling height.

It was not until we moved, into the new light and airy, purpose-built Unit, that we realised how claustrophobic the old room had been, and this fact was mentioned by several parents.

The development team consists of a Consultant in Developmental Paediatrics, a Community Paediatric Consultant, Senior Clinical Medical Officer, Health Visitor, Remedial Teacher, Social Worker, two Speech Therapists - who each come in for one day a week, Play Therapist/Assistant, three full-time Physiotherapists and, at the moment of writing, only one full-time Occupational Therapist - where there should be three.

An Audiology Clinic is held at the Centre, as is an Orthopaedic and Premature Baby Clinic. Close contact is kept with the Eye Department in the main hospital, and an Orthoptist makes regular visits to the Centre.

Now that we are all under one roof, communication is much easier, and parents are often introduced to us before their first appointment so that, hopefully, they will feel more at ease when treatment is started.

Referrals to the Centre come from G.P.'s, Clinic and School Doctors, and from other Consultants. All children have a full assessment from one of the Paediatricians before being referred onto the appropriate Team members. They are reviewed regularly, with a progress report being put in by whoever has been seeing them for treatment.

An Educational Psychologist comes into the Centre to observe any under school age children who are being statemented, seeing them in at least one treatment session, and also in their own home setting.

Regular meetings are held involving all members of the Team, including the Educational Psychologist and three community physiotherapists, when on-going treatment plans for various children are discussed.

Close links are kept with the Premature Baby Unit, where many of the children who are now being seen in the Centre have spent the first weeks of their lives. Every baby born in the Maternity Unit is checked for CDH on the first or second day, by a paediatric physiotherapist from the main hospital, or from one of us at the Centre, as part of a hip screening programme. In some cases, impending neurological problems have come to light as a result of general observation, at the same time as the hip check, and this has been a useful spin-off.

The parents have formed a Support Group and hold coffee mornings - also evening meetings - mostly in members' homes; but occasionally in the Centre. It has taken some time to become a viable group, but this now seems to be flourishing, which is pleasing - after all, the parents are the most important members of the Team.

DANIEL'S CHAIR

Miss Pam Ebdon, Snr. Community Paed. Physiotherapist, Ilford

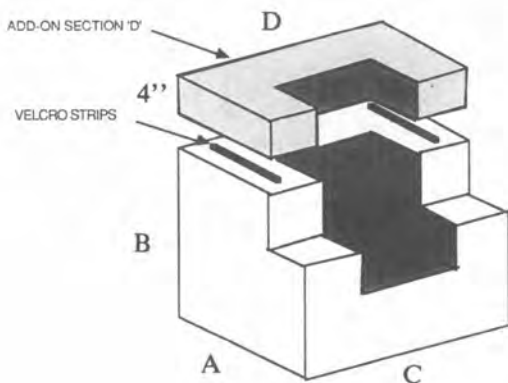
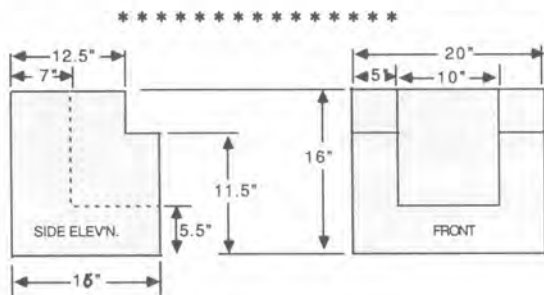
This chair and table was designed and made-to-measure for Daniel, a 15 month old baby with spastic quadriplegia and severe visual impairment, whose seating needs I was finding difficult to accommodate within the readily available range of baby equipment. The chair was cut by a local foam rubber supplier from high density, flame retardent foam blocks, sealed with flame retardent PVA type adhesive. The flame retardent vinyl covering was fitted by a tailor, working for a local community project. The playtray was constructed by a friend, a carpentry enthusiast, and made from white formica faced chipboard, with a 1" lip surround, mounted on four legs of appropriate height for the chair,

In an attempt to minimise the volume of equipment Daniel needed to allow him alternative positioning whilst in the confined space of a holiday cottage, a number of possibilities came to light. By using the chair as illustrated on side A, Daniel can sit with knees flexed, feet plantigrade. By using the chair on side B, with extension D secured by adhesive velcro, he can long sit in gaiters. Still with the chair based on side B, the tray placed adjacent to side C, Daniel can low kneel, his arms supported on side C, enabling him to play at the table. By inverting the chair, a wedge is formed suitable for postural drainage. As yet, happily, this alternative has not been necessary. In the sitting positions, Daniel wears a Mothercare nylon harness, secured at the back of the chair by a crepe bandage.

Grateful thanks to Jim Hayes, Essex Foam, Terry Escort, 627 Fashions, Seven Kings, and to Peter Jarrett, who gave their time and effort free of charge.

Also to Daniel's mum, Fiona, for the original sketches, and of course to Daniel, for being so patient during measuring and fitting!

The total cost of the chair and table was £27, being the cost only of the materials used. Time taken from design to completion was 2 weeks.



DANIEL'S CHAIR

Material :-
 flame retardent foam slabs
 covered with flame proof vinyl.

A DAY IN THE LIFE OF A PAEDIATRIC PHYSIO - RECOGNISE IT??

by Angela Glyn-Davies

7.45 Dring! Dring! 'Mum it's for you' - Hello Angela - it's Claire - could you get me some feeding tubes for James from the Children's Ward when you're at the hospital. He's a bit chesty today - perhaps you could have a look at him at the Opportunity Group this afternoon? Of course I will - see you later. And I've not even set off for work yet!

Driving to work - what am I doing today? Quick glance at the diary while stopped in a traffic queue - every day is different and my middle-aged memory does not retain details! Next exercise - can I get past the reception desk without being seen and landed with a heap of messages and letters before I have got my brain in gear. 'Angela - Mrs. Bevan rang - she's worried about her babies splint and Anne Hebbage Health Visitor wants you to ring back before 9.30 about a little girl with delayed development and here are your letters!' You guessed - I was seen!

A glance through the mail reveals several reports on children that I treat, a new referral from a school doctor, a letter from the Chartered Society of Physiotherapy which has to be photocopied and distributed round the district (I am the District Union Steward as well) a postcard from the family of one of 'my' children (isn't that nice of them?) and a catalogue of special equipment for handicapped children.

I'd better go and ring that Health Visitor before she goes out - Yes Anne - of course we will look at her - not sitting up properly yet and almost a year old - not weight bearing either. Can you get the Doctor to write? Thanks. Angela - phone for you - orthopaedic clinic need you over there - some of your children about to be seen. O.K. - rush over to the clinic.

Charles (Hemiplegia) walking much better but needs new boots 1cm raise on bad side and continue with exercises. Right - Charles you go round to my room I'll be with you in a minute.

Elizabeth (Severe cerebral palsy) - hips not so good but there is no point in operating as she will never walk - but try and do something to improve the position in the wheelchair. Right I will see to it (write that down Angela - remember the middle-aged memory!)

Sheila (baby with dislocated hips) - hips much more stable now but needs a bigger size Van Rosen Splint. Right - we'll fit that now.

Rupert (baby with Bilateral Talipes) - slight improvement but feet still rather tight - keep up the strapping. We had better go and restrap the feet too.

A bit of a queue outside my room! Measure the feet and do a form for new boots. Write down about the wheelchair in the 'Action' book - see her at special school. Fit a new Van Rosen splint and restrap the babies feet. (Pooff! I will smell of Tinc Benz for the rest of the day - it gets all over my hands when I spray it on the babies feet).

Oops! Time for meeting with my two paediatric colleagues to sort out this weeks problems and plan next weeks work. Quick slurp of the coffee and (Oh dear!) the inevitable knock on the door - Angela - telephone call for you. The usual glare from my colleagues (we never manage this meeting without

interruption) but phone call sorted out as quickly as possible and back to the meeting.

'Toot! Toot! - is it that time already? Peter, who has muscular dystrophy, has arrived in his own car but cannot get out. So nip out - wheelchair out of the boot - heave him out of the car seat into it, and inside, another heave from the chair to the bed and he's ready for treatment. Scout round other parts of the department for pulley ropes and slings (there are never enough - NHS cuts - heard of them??!!) and Peter is soon swinging away. Angela - I would like to join a Disabled Sports Club - do you know who to contact? I'm pleased to hear it Peter - I will look into it and let you know next time you come for treatment.'

Oh dear - it's 1 o'clock - we should be at the Opportunity Group. Collect colleagues, jump in the car and drive the 3 miles to the school. Must remember to check James chest, put him on wedge to drain. The Advisory Teacher is here today - could you do a report Angela, for Tina's statement (Oh hell!) - Yes of course! Hang on and I will find the gaiters for Patrick's legs and then we will put him on his prone board to paint. Could someone throw me a cloth - Philip (Spina Bifida) has been sick (Must be the thought of all that hard work from the nasty Physio!) Hey! (Polite way of addressing ones colleague) - do you think Catherine has got a Scoliosis? Hey! (other colleague) do you think you could persuade Nellie to stop screaming - can't hear myself think! Fit Sammy (Athetoid Spastic) in suitable position in special chair so he can try and drink by himself. Assist helper with James who also has feeding and swallowing problems. Two hours have gone before you know it - must get back to the department - it's clumsy class in the gym and soon the place will be invaded by nine little darlings (not to mention their mothers and sisters as well).

Whoosh! The gym door opens and in they rush, piles of clothes everywhere. Miss - watch me hop - Miss can I go on the bike - Miss - I played football today. Right you lot - let's get started. Walking, stamping, shouting, singing, running, stopping, rolling, stretching, balancing, crawling, kneeling, squiggling on the floor, standing, jumping, hopping, balancing on the form. One hour later we are **all** exhausted! Get dressed now children, your Mums are here. Where's my trainers, someones taken my T-Shirt, Miss can you tie my shoes up etc! Off they go.

Peace - but statistics (bloody statistics) to do - write up the cards, fill in the numbers and Oh! - Surprise! It's time to go home.

Driving home and stuck in the traffic queue - thinks - Oh hell - what on earth will I make for supper! Key in the front door - Mum - what's for supper and can we have it straight away because we are going out at 7.00. That's my other job!!

THE WEDDING

The Bride was radiant, the Bridegroom handsome, and the fully choral ceremony was progressing nicely, when down the aisle came a fashionable young lady in a pink dress with broderie anglais top, white tights and neat patent shoes. Carefully negotiating round the bridesmaids, she sat down quietly behind the happy pair and listened to what was happening, occasionally nodding her agreement.

During the signing of the register she moved over to observe at close quarters the lady soloist - always taking care not to be in the way. Retrieved by her mother after the ceremony, she went on to the reception, and using her own special form of locomotion, feet and hands on the floor, legs straight, bottom well in the air - she inspected the guests, smiling widely at everyone. When the Jazz band started, she partnered her Father in the opening dance, before deciding enough was enough, and falling fast asleep on her tummy by the side of the dance floor.

Guess who upstaged the Bride? You're right! The 18 months old, happy little Downs Syndrome daughter of the Best Man.

Thoughts of a Disabled Person

Blessed are you who take time to listen to difficult speech, for you help us to know that if we persevere, we can be understood.

Blessed are you who walk with us in public places and ignore the stares of strangers, for in your companionship we find havens of relaxation.

Blessed are you who never bid us to 'hurry up' and, more blessed, you who do not snatch our tasks from us, for often we need time rather than help.

Blessed are you who stand beside us when we enter new and untried ventures, for our failure will be outweighed by the times when we surprise ourselves and you.

Blessed are you who ask for help, for our greatest need is to be needed.

Rejoice and be exceedingly glad, for you deal with us as God has dealt with all his children.

For permission to reprint these beatitudes we are indebted to the "John Grooms Association for the Disabled, 10 Gloucester Drive, Finsbury Park, London.

The National APCP committee has formed a working party to formulate guidelines for good practice in paediatric physiotherapy. The initial structure of these guidelines is set out below with an introduction and keypoints - each of which will be expanded into a small 'chapter'. The guidelines are aimed at physiotherapists and other Health Service professionals, managers and associates. Your comments on the introduction and keypoints at this stage, would be greatly valued by the working party. Non communication from APCP members will be assumed to signify agreement with the proposed structure. Ideas and suggestions please to one of the following by March 31st 1988.

Mrs. Caroline Dunne MCSP - Primary Care Unit, Smallwood Health Centre, Redditch, Worcs.

Mrs. Viv Williams MCSP - Children's Centre, University Hospital of Wales, Heath Park Cardiff.

Chris Young MCSP, Royal Alexandra Children's Hospital, Dyke Road, Brighton, Sussex.

GUIDELINES FOR GOOD PRACTICE IN PAEDIATRIC PHYSIOTHERAPY

Good practice depends primarily upon the competence of the physiotherapist. This competence is based on the integration of sound theoretical knowledge and training in specialist practical skills and philosophies which have been broadened and refined with experience. It is dependent upon a continuation of the learning process and will be enhanced by sound and sympathetic management.

Client Group Definition

Children between 0-19 who have a general or specific developmental delay, disorder of movement, disability or illness which may be improved, controlled or alleviated by physiotherapeutic skills and the possible use of specific equipment.

Qualities Required of a Paediatric Therapist

Professional Ability

1. A sound generic base on which to develop specialist expertise through training and continuing education.
2. A sound specialist base on which to develop further practical skills.
3. A thorough understanding of theories, philosophies, sciences and treatment modalities in the management of disorders within paediatrics.
4. The application of knowledge appropriately, practically and with insight.
5. The accurate assessment of children including skilled interpretation of verbal and non-verbal signals and environmental factors.

6. Ability to identify, analyse and prioritise problems and record findings precisely.
7. Ability to plan and progress treatment including appropriate goal setting.
8. The writing of informative reports for other professionals.
9. The teaching of skills to others (children/parents/carers/professionals).
10. Ability to continue learning through one's own experience and that of others.
11. A knowledge and understanding of research skills.
12. A knowledge and understanding of management structure and procedures.

Inter-Personal Skills

1. Communication and liaison skills.
2. The ability to make child and family or carer (guardian) feel at ease - and individuals of value.
3. The ability to work within a multi-professional team.
4. The ability to listen actively with empathy.
5. Patience, tact, enthusiasm, humour and perspicacity.
6. Flexibility and tolerance together with broad understanding and sensitivity.
7. The use of counselling skills with parent/carer/child to facilitate, through insight, a positive attitude.
8. A keen, open and enquiring mind.
9. Professional integrity and objectivity.

Keypoints

1. Knowledge of
 - (i) major stages of child development - and deviations from the normal.
 - (ii) Paediatric pathology and appropriate management.
 - (iii) Environmental and cultural variables which influence family structure, dynamics and motivation.
 - (iv) Child psychology.
2. Accurate assessment and recording of findings; goal setting and treatment/management planning; review and treatment/management progression - within the context of daily life.
3. Communication and team work with other professionals, parents and carers involved in the management of the child, including counselling skills.
4. Knowledge of current and developing legislation relating to the rights, care, education and management of the child.
5. Knowledge of statutory and voluntary support groups and organisations involved in child care and family/carer support.
6. Training requirements and appropriate management structures in paediatric physiotherapy.

POST REGISTRATION EDUCATION REPORT

Mrs. P. M. Eckersley, Post Registration Education Advisor

The Education Reform Bill at present before parliament has a number of implications for children with special educational needs! It has been stated in the media that the proposed bill and The 1981 Education Act are incompatible. As physiotherapists we need to be aware of the possible consequences of this legislation.

The Bill has four major components:-

1. A National Curriculum and Testing

There will be a curriculum of ten specified subjects for all primary and secondary schools. This will include core subjects of English, Maths and Science and foundation subjects such as history, technology art and P.E. It will be the duty of every governing body, head teacher and L.E.A. to secure that the school curriculum satisfies these requirements. Originally 80-90% of time was to be spent on these subjects, this may be reduced to 70%.

Attainment targets will be set in each subject in the curriculum and children will be tested at the ages of 7, 11, 14 and 16.

There is a possibility that "statemented" children may be excluded from all the provisions of the national curriculum and testing. However there is concern that the 18% of children who have special educational needs at some time during their school career might have failure imposed on them at an early age.

2. School admissions

The principle of open admission will apply and L.E.A.'s will lose the power to set ceilings on admissions. This will mean that every school will have to take pupils until its "standard number" (number admitted in September 1979) has been reached. This may have implications where schools with lower numbers have been able to set rooms aside for activities such as mother and toddler groups, individual tutorial rooms and resource bases. These may have to revert to classrooms.

3. Financial control to governors

At present decisions on school spending are shared between local councils and headteachers. Changes will mean that in schools with more than 200 pupils financial decisions will devolve to governors. This devolution will also include the delegated power to appoint and dismiss staff and spending on books and equipment.

Some concern has been expressed that some schools may decide to allocate a greater amount of finance to books, science equipment, and other curricular areas covered by The National Curriculum, and allocate very little to special needs students. The publication of the test results may also have an effect on the ethos of the school and willingness to integrate special needs pupils.

4. Grant maintained schools

Any county or voluntary secondary school or a primary school with more than 300 pupils will be able to apply for grant maintained status. If this is approved by the Education Secretary the new grant-maintained school will take over the premises from the L.E.A. which will no longer have any responsibility to maintain it. These schools will then receive their funding directly from government.

This could mean that a school which has been adapted for barrier free access ie: disabled toilets, ramps, lifts, equipment for sensory handicaps, is lost from L.E.A. control. The position is uncertain with regard to the provision of peripatetic teaching services, and special equipment which would previously be L.E.A. supplied. If these services had to be "bought in" by the school there would be no guarantee that they would have budget priority.

Other points are contained in the Bill but the above appear to be of major importance. I would be grateful to receive any comments or queries.

From the National Bureau of Handicapped Students:-

PRESS RELEASE

GCSE: Arrangements for Candidates with a Disability

Comprehensive guidance notes which explain arrangements for candidates whose disability is likely to handicap them in GCSE examinations, have been prepared by the six GCSE Examining Groups. The Guidance Notes were welcomed today by Richard Stowel, Director of the National Bureau for Handicapped Students (NBHS) who described them as "practical and reassuring". A working party co-ordinated by NBHS has been working closely with representatives of the Examining Groups following serious concern amongst staff, students and parents when details of special arrangements for GCSE were first announced last year; NBHS played a vital role in collecting information on current good practice which has been included in the Guidance Notes.

The Guidance Notes have been recommended to all the Examining Groups by the Joint Council for GCSE and will be included in documents published by Examining Groups. The Guidance Notes will be available to all colleges, schools and examination centres and will offer information to staff preparing candidates with special educational needs for the new GCSE, as well as students themselves.

The purpose of special examination arrangements is to compensate for the limitations imposed by the handicap, but not otherwise to advantage the student. Issues covered include: the principles on which Examining Groups will base special arrangements; and the information which they will need about individual candidates to provide appropriate arrangements; choice of syllabus, time allowances, and the effect of fatigue of candidates with physical handicaps, with visual or hearing losses and those with learning dysfunction, including specific learning difficulties (dyslexia) and minimal brain damage.

The Joint Council has also approved a recommendation from the Examining Group Secretaries for the setting up of an Advisory Committee comprising staff representatives of the Examining Groups and professionals with experience of the

needs of disabled students who are handicapped in examinations. The Committee, will meet this Autumn, and thereafter, at least once a year in the Autumn term.

The Advisory Committee will provide an informed view on the introduction of GCSE as it affects students with special educational needs, and will bring to the attention of the Examining Groups information on technological and other developments, which affect the study and communication methods of candidates with disabilities, will analyse reports from Examining Groups on the implementation of the new Guidelines, and make recommendations about any necessary revisions to Joint Council policy in this area. The Advisory Committee will also maintain close links with specialist organisations in the field of disability and the teaching profession. The Advisory Committee can be contacted via the Secretary to the Joint Council for the GCSE.

Mr. Dennis Hatfield, Chairman of the Joint Council for the GCSE has commented: "by establishing an Advisory Committee, the Joint Council has demonstrated its commitment to ensuring that GCSE developments will enable all students regardless of the level of their disability to show the skills and knowledge they have acquired".

ENDS:

Further information from: Ms. Sylvia Simmons - NBHS, Development Officer.
01-274-0565

ABSTRACTS

Early Physical Therapy Effects on the High Risk Infant - A Randomised Controlled Trial

Authors: Martha C. Piper Ph. D., V. Ildiko Kunos MD, Diana M. Willis MD, Barbara L. Mazer BSc, Maria Ramsay DPs, Kenneth M. Silver MD. From the School of Physical and Occupational Therapy, Jewish General Hospital, Royal Victoria Hospital and Montreal Childrens Hospital, McGill University, Montreal.

Paediatrics Vol. 78 No. 2 August 1986

A controlled trial was conducted in a group of 134 babies born in two Montreal hospitals, to evaluate the value of physiotherapy on infants at risk neurologically, and to assess whether such early intervention would prevent or minimise the development of future handicap.

Each baby was assessed by a neonatologist within two weeks of birth and assessed to be at risk - they were then assigned to one of two groups, the experimental or control groups. Those on the control group received conventional follow up care, whereas those in the experimental group received physiotherapy treatment every week for the first three months of life, and then once every two weeks for nine months. Treatment was based on neurodevelopment lines and each

child was always seen by the same physiotherapist. Each treatment session lasted an hour, the time being spent on individual handling, individual programme writing and careful parent instruction. These parents were issued with notebooks to record their own daily treatment.

All the babies were reassessed at their corrected ages of twelve months. No significant difference was found between the two groups, but the babies weighing less than 750 grammes at birth demonstrated significant delays in growth and development compared with those heavier.

The article ends by suggesting physiotherapists should view these findings as a challenge to search for and develop new treatment approaches, for these young babies, and evaluate through careful, scientific investigation.

Body Part Identification in 1-4 year old Children

Authors: Kathryn MacWhinney - Previous OT graduate student - Boston Univ.
Sharon A. Germark OTR, FAOTA Assoc. Professor of OT Boston University.
Anne Fisher OTR, FAOTA, Asst. Professor of OT Boston University.

American Journal of Occupational Therapy. July 1987. Vol. 41 No. 7

The purpose of this study was to examine the sequence in which parts of the body are learned and identified by very young children. There have been studies on this subject but the results have generally not been presented very clearly.

A group of 101 non-disabled children were drawn up from four age groups - 1 year olds, 2 year olds, 3 year olds and 4 year olds, there being approximately 24 children in each group - the ratio of boy and girl being roughly equal in each group. A well known form of doll was used being nineteen inches in size, and each child was asked to point to 20 parts of the body.

The majority of 1 year old children were unable to point to any specified part of the body, although half the parents reported correctly the children knew eyes and nose. However in the 2 year old age group there was a substantial increase in the recognition of body parts, 11 or more being correctly identified by 75% of the children. The children of the two older age groups were able to identify all but one or two body parts. Facial parts appear to be learned first with a significant increase in body awareness between the ages of one and two years - the girls scoring slightly more than the boys.

The study was not easy to carry out and it is suggested the knowledge learned would be useful in order to establish ages of which the ability to identify parts of the body and the progression in which they are learned.

BOOK REVIEW

Basic Attainments Programme for Young Mentally Handicapped Children.

Bill Gilham.

Published by Croom Helm. £8.95 paperback.

In the current climate of integration of handicapped children into normal schools, many start disadvantaged because their basic skills have been slower to develop than those of their contemporaries. This new book in the Special Education series is therefore a welcome aid not only for parents, but also for those professionals who are involved in teaching young mentally handicapped children.

Divided in to five sections - Fine Hand Control, Drawing, Number, Writing and Reading, each section gives a variety of programme, preceded by a 'ceiling objective' which is what it is hoped the child will achieve at the end of that programme, then continues with an outline summary of objectives, general teaching rules and background teaching activities.

Clearly set out with numerous illustrations and carefully detailed progressions which are easy to follow, the programmes are excellent for communicating ideas and stimulating the imagination of young children. Because of the variety of the programmes it is possible to change the topic, if achievement in one area comes to a temporary halt, thus giving the child a fresh challenge.

This book will be a valuable addition not only to the bookshelves of Special Schools but also in many homes.

ABSTRACT OF RESULTS OF QUESTIONNAIRE INTO THE PROVISION AND FUNDING OF EQUIPMENT FOR CHILDREN WITH SPECIAL NEEDS, APRIL 1987

Over the past few years the Association of Paediatric Chartered Physiotherapists has been aware of increasing confusion and concern within the membership in the matter of the provision and funding of specialised equipment for children with special needs. As these requests for clarification have been increasing especially since the recent managerial changes and with the deteriorating financial climate it was felt useful to try and pinpoint the main difficulties.

Hence this questionnaire was drawn up by three senior paediatric physiotherapists each holding responsibilities in differing areas, e.g., in the community, in an independent "special school" and in a hospital based unit.

The equipment was divided into three main categories:-

- a) that used by physiotherapists for treatment purposes.
- b) that used as aid for medical treatments (National Health Service Act 1977).
- c) that used as "aids to daily living" (Chronically Sick and Disabled Persons Act 1970).

It was decided to make the questionnaire cover as wide a span as possible so questions involving toy libraries and electronic equipment were included.

The questionnaire was divided into six main sections, each section being divided into several sub sections. The main divisions involved the structure of funding for

paediatric physiotherapy treatment equipment, levels of satisfaction with wheel chairs and equipment supplied by A.L.A.C., the provision of static seating, equipment for home use, toy libraries and electronic equipment.

Copies of the questionnaire were sent out to the A.P.C.P. membership through the Regional Representatives and to a cross section of District Physiotherapists throughout mainland Britain during Spring 1986.

The response was lively with good representation from each region of A.P.C.P. Over half the District physiotherapists enlisted the help of their paediatric physiotherapists. The completed questionnaires were difficult to collate and read because of the diffuse comments written round the sides as though those completing them could hardly contain themselves. These were a feature of the completed questionnaire and emphasized the interest, concern and feelings of the physiotherapists involved with children. These were included in the complete report.

The main problem areas were identified as follows:-

- a) The necessity of having to supplement budgets for physiotherapy treatment equipment. Over 83% of those replying found it necessary to supplement either through charities, or involve themselves in personal fundraising in order to cover the costs of necessary equipment.
- b) Physiotherapists having to be involved with many different budgets and multiple sources of funding. 54% of those responding had to order equipment from various sources, some ordering equipment from as many as four to five differing budgets.
- c) Levels of dissatisfaction with A.L.A.C. 48% were not satisfied with the models of wheel chairs and buggies as supplied by A.L.A.C. Reasons are tabulated in complete report.
- d) Levels of dissatisfaction with moulded seating.
- e) Increasing difficulties with funding all types of seating.
- f) High cost of equipment and repairs.

It is hoped the information gathered from the questionnaire will be both helpful and useful - several people commented they found merely completing the questionnaire to be educational. The problems high-lighted may not be possible to solve but it is hoped guidelines may be able to be developed eventually.

D. G. Riley,
Superintendent Paediatric Physiotherapist,
Odstock Hospital,
Salisbury.

Copies of the complete report may be obtained from the above address. (A S.A.E. or a small donation to cover postage would be appreciated?)

ACTIVITY DAYS FOR CLUMSY CHILDREN

Judy Dalton, Supt. Physiotherapist, Newman School

In the Rotherham area there are approximately thirty children presenting fine-gross motor and learning difficulties that places them within the so called classification of being clumsy. Referrals from clinical medical officers, educational psychologists and mainstream schools have increased, to the present numbers, and are anticipated to rise further. With our current staffing levels, it is difficult to do more than an initial assessment, and treatment sessions once every four to six weeks, along with advice and treatment programmes offered to teachers and families.

Due to this situation we decided to look at the possibility of seeing these patients in groups. We looked carefully at venues, and after a couple of 'Activity Days' held in the local special school hall, we were fortunate enough to have the use of the rehabilitation hospital at Firbeck, Rotherham. Set in beautiful grounds, we have the gymnasium, another room and a hydrotherapy pool.

Initially a letter with a detachable return slip is sent to all patients who have been assessed as being suitable for the 'activity day'. The letter advises parents of the date and times, and requests that the children bring a P.E. kit and packed lunches. The slip should then be attached, stating whether or not they will be able to attend, require transport, together with the names and numbers of parents and children. Some parents bring siblings, who may join in with the groups, unless there is a large number, in which case we run a 'creche' facility.

The children and parents arrive at 10.00 a.m. We divide the children into three groups of five each, according to age and ability. The children then change into their P.E. kit, stressing that parental help should be kept to a minimum. The O.T.'s oversee this section, and offer help and advice to those who are struggling. We then have a general warm up period, incorporating running, jumping, hopping, directional activities and stopping and starting, with staff joining in and aiding anyone whose concentration is lapsing, or unable to perform any of the activities.

At 10.30, the groups are then divided up, one to occupational therapy, one to the pool, and one remains in the gym. The groups are then rotated after one hour, to the next, and after lunch, again rotated to the remaining activity. At some time during the day we have a parent discussion group. This has been very valuable, allowing parents to 'compare notes', and to voice their fears and worries. Nearly all have commented on the fact that previously they were classed as neurotic mothers, and all have said they hadn't realised that there were other children with similar difficulties, and how helpful it was to talk about them. Other topics for discussion were the sociability of the children, their schoolwork and 'clumsiness'. We also led the discussions to cover parental over-protectiveness, explanation of the condition, others attitudes to the children and how altered items of clothing may help the children in dressing situations, e.g. elasticated waists and roomy clothes.

The pool sessions are valuable as the children often experience fear of the water, and poor co-ordination in the water. We aim to improve their confidence and help them to learn to swim in a one-to-one situation.

The physiotherapy session looks at different skills required, using basic exercise

programmes followed by body skills, spacial awareness and co-ordination exercises. We usually finish with a fun game or activity.

The occupational therapists look at fine motor skills, incorporating drawing, copying and cutting out, with a finished piece of work to take home.

The activity days take place every term, and now we also run an over 11 group, which looks at activities in secondary schools, including ball skills and slightly more advanced motor requirements.

Twelve activity days have now been held and the results of a questionnaire handed to parents on the last one indicated that they felt their children benefitted greatly from the day and enjoyed coming. In conclusion, we feel that although it takes quite a lot of organisation and staff, overall having an activity day for clumsy children is an effective way of treating this group with good results.

HAPPENINGS

On Thursday November 19th, the Welsh region had an SOS call from BBC Radio Wales, to answer enquiries about Baby Walkers, following the press release by APCP and CSP on the dangers and problems associated with them.

VIV WILLIAMS, Supt. Physiotherapist for Childrens Services and a National Committee member of APCP went to BBC Radio Wales to give a short interview, outlining some of the hazards and difficulties aggravated by excessive use of baby-walkers. This was an opportunity to explain some of the reasons why Paediatric physiotherapists advise against use of baby-walkers, especially for children with any movement problems. This radio interview was another first for Paediatric Physios in Wales.

MRS. J. BRECKON'S article in our November issue which roused so much interest from all sides on the safety of baby-walkers, has also prompted several firms to research further into the safety and design of these pieces of equipment. Well done Mrs. Breckon.

MISS NOREEN HARE and **PENNY ROBINSON** (CSP Professional Advisor) were interviewed on Oxford Radio in the autumn, prior to the CSP Congress.

R. HALLETT, **NOREEN HARE** and **A. MILNER** are involved in a research project entitled - Evaluation of the Quality of Life of the Multiply Handicapped before and after surgery for Spinal Correction.

MRS. J. LAMOND was invited to write the Christian Comment for the local press in Lancaster. This she did and based it on the theme of the use we make of our hands.

ARTICLES OF INTEREST - NOVEMBER 1987

Robson P.

Lower Limb Deformity and prevention of scoliosis in cerebral palsy.

Arch Dis Child 1987 June; 62 (6): 547-8

Ward J., Center Y.

Attitudes to the Integration of disabled children into regular classes: a factor analysis of functional characteristics.

Br J. Educ. Psychol. 1987 June; 57 (2): 221-4

Rockey J.

BJOT: occupational therapy with children (Historical)

Br J. Occup Ther. 1987 October; 50 (10): 341-2

Strauss GD et al

Variable weight training in cystic fibrosis.

Chest 1987 August; 92 (2): 273-6

Douglas J., Ryan M.

A preschool severely disabled boy and his powered wheelchair: a case study.

Child Health Care Dev 1987 September-October; 13 (5): 303-9

Everts J. F.

Developing the high school's guidance network to cater for students with special needs.

Except Child (Queensland) 1987 July; 34 (2): 107-15

Gregory J. F. et al

Orthopaedically handicapped students in public and private high schools.

Except Child (Queensland) 1987 July; 24 (2): 85-92

Feeney R. J.

Designing for disabled people.

Int Disabil Stud 1987; 9 (2): 92-5

Hanley J., McAndrew L.

A survey of the younger chronic sick and disabled living in the community in Lothian Region.

Int Disabil Stud 1987; 9 (2): 74-7

Kniel A.

Choosing a preschool for handicapped children: factors in parents decision making.

(Brief research report)

Int J. Rehabil Res. 1987; 10 (2): 210-4

Odwin O., Yule W.

Augmentative communication modes taught to cerebral palsied children: findings from a longitudinal study.

(Brief research report)

Int J. Rehabil Res. 1987; 10 (2): 202-6

Hanson R. R., Graves M. R.

Current concepts: care and habilitation of the child with myelomeningocele - a multidisciplinary approach I. Neurological complications of myelomeningocele.

J. Miss State Med. Assoc. 1987 June; 28 (6): 145-50

Kaufman J., Hardy-Ribakow D.

Home care: a model of a comprehensive approach for technology-assisted chronically ill children.

J. Paediatr Nurs. August; 2 (4): 244-9

Herndon W. A. et al

Effects of neurodevelopmental treatment on movement patterns of children with cerebral palsy.

J. Paediatr Orthop 1987 July-August; 7 (4): 395-400

Products for the handicapped child.

Midwife Health Visit Community Nurse 1987 March; 23 (3): 90-1

Hari M.

Conference interview: treating the whole child, not the disability. (Interview by Pat Scowen).

Midwife Health Visit Community Nurse 1987 May; 23 (5): 184-5

Sutton A.

Conductive education: hope for the motor-disordered.

Midwife Health Visit Community Nurse 1987 March; 23 (3): 84-8

Cannon S. E. et al

Head-erect behaviour among three preschool-aged children with cerebral palsy.

Phys. Ther. 1987 August; 67 (8): 1198-204

Butler P. B., Major M.

The Para Walker: a rational approach to the provision of reciprocal ambulation for paraplegic patients.

Physiotherapy 1987 August; 73 (8): 393-7

Canny G. J., Levison H.

Exercise response and rehabilitation in cystic fibrosis.

Sports Med. 1987 March-April; 4 (2): 143-52

Copies of the above articles can be ordered from:-

Mr. Martin Saunders,
Assistant Librarian,
National Demonstration Centre,
Pinderfields General Hospital,
Wakefield,
West Yorkshire,
WF1 4DG.

Please quote the bulletin date, and full details of the citation. You will be invoiced at 9p per sheet. Do not send money with order.

FORTHCOMING COURSES

The Selection and Use of Self Propelled Wheelchairs.

Tuesday February 23rd

Venue: Elizabeth Fry School, Suffolk Rd., London E.13

Information and application forms: Mrs. S. Holt, Newham Child Development Centre, 84 West Ham Lane, London E.15 4Pt. Tel. 01 519 1150

The Assessment and Management of Multi-Handicapped Children.

February 29 - March 4

Venue: The Institute of Child Health, Univ. of London.

Information: The Departmental Secretary, Department of Developmental Paediatrics. The Wolfson Centre, Mecklenburgh Square, London WC1N 2AP. Cost £160.

The Chailey Adaptaseat - Its Philosophy and Use.

Friday March 11th

Venue: The William Merritt Disabled Living Centre, Leeds. A Study Day for professionals concerned with seating children. The Chailey team will demonstrate this seating system which can be assembled without workshop facilities. The course will include assessment procedures, prescription criteria and demonstrations.

Details: Monica Callin, Snr. Physiotherapist, The William Merritt Disabled Living Centre, St. Mary's Hospital, Green Hill Road, Armley, Leeds. LS12 3QE. Tel. 0532 793140.

APCP ANNUAL CONFERENCE "Paediatrics towards 2000".

April 15-17

Venue: The University of Warwick.

Information: Miss H. Wotherspoon MCSP, 34 Westminster Rd., Selly Oak, Birmingham B29 7RS.

Fifth International Conference of the International Academy of Paediatric Transdisciplinary Education.

May 3-7.

Venue: Town Hall, Royal Borough of Kensington, London.

Information and copies of preliminary programme: TFC Conference Secretariat, Congress House, 65 West Drive, Sutton, Surrey.

Sports and Recreational Activities for the Disabled.

Saturday/Sunday May 7-8.

Venue: St. Michaels Physical Handicap Unit, Throne Road, Rowley Regis, West Midlands.

Includes talks on B.S.A.D. Games and P.E. Outdoor Pursuits, Riding, Judo, Gymnastics and Trampolining, Personal achievements.

Fee: £35 inc. lunches, tea and coffee.

Details: Judy Hemming-Allen, Supt. Physiotherapist, Physiotherapy Dept. Firs School, Coopers Lane, Smethwick, Warley, West Midlands. Tel. 021 558 8222.

Dressing Matters.

June 2 or 3 - July 7 or 8.

Venue: Disabled Living Foundation, 380/384 Harrow Rd., London W9 2HU.

Fee: £25 inc. coffee, buffet lunch and afternoon tea.

Seating and Mobility for Children.

July 14 or 15.

Venue: Disabled Living Foundation, 380/384 Harrow Rd., London W9 2HU.

Fee: £25 inc. coffee, buffet lunch and afternoon tea.

Both the above courses - number limited to 35 per day.

For application ring Disabled Living Foundation: 01 289 6111

The following courses all relate to Visual Handicap and usually run from 10 a.m. - 4 p.m.

Applications to: Administrator, RNIB Education Courses, Marlborough House, Holly Walk, Leamington Spa CV32 4XP. Tel: 0926 452 868.

Course No. 79

Special Needs and Learning Difficulties of the Young Child.

Wednesday February 24th.

Venue: Post. Graduate Medical Centre, Ipswich Hospital, Ipswich.

Fee: £20 inc. lunch.

Course No. 72 b

The Enhancement of Residual Vision with Profoundly Handicapped Children.

Saturday February 27th.

Venue: Rutland House School, Nottingham.

Fee: £20 inc. lunch.

Course No. 80

Exhibition of Toys, Equipment and Adaptations (Pre-School and Primary).

Tuesday March 1st.

Venue: Benefactors Hall, University of Warwick.

Fee: £3.

Course No. 83

Developing Daily Living Skills with Adolescents.

March 8th.

Venue: Royal School for the Blind, Wavertree, Liverpool.

Fee: £20.

Course No. 85

Assessing and Enhancing Vision of the Pre-School Child.

March 16th.

Venue: Goldney House, University of Bristol.

Fee: £20.

BOOKS

Child Sexual Abuse within the Family.

Compiled by a working party of Dr's, Social Workers and Police.

CIBA Foundation £5.95

The Secret Life of the Unborn Child.

Dr. Thomas Verny with John Kelly.

£3.95

Both the above books available from: Gale Centre, Freepost, Loughton, Essex
IG10 1BR. Tel. 01 508 9344.

In Tune with Each Other.

Documentary Film/Video about a group of Mothers and babies (3-6 months)
meeting to sing and play rhythm games.

From: Pace Productions, 12 The Green, Newport, Pagnell, Buck MK16 OJW.
Tel. 0908 618767 VHS/Beta £14.50 inc. VAT and postage.

HAVE YOU HEARD???

★ The Dyslexia Institute with Headquarters in Staines, Middlesex, launched an appeal in October for £1.5 million to train more teachers, in the hope that more children with dyslexia will be able to have the special tuition which they need.

★ The Royal United Hospital in Bath have announced a £70,000 two year research programme into cot death syndrome.

★ Parents of girls with Retts Syndrome held a two day conference in Leicester recently, to discuss ways of easing the burden on families. This recently discovered syndrome, which affects only girls, only becomes apparent after the children have developed normally for 12-18 months. Following this, their skills gradually deteriorate, their intelligence is destroyed and their emotional connections severed, leaving them with the skills of one year olds for the rest of their lives. Most are exceptionally good looking children. The UK Association currently has 160 families on its books.

★ Sir Hugh Casson has been impressed by the genius of a 13 year old autistic boy, whose personal form of communication is expressed in drawing. He prefers detailed architectural subjects which he reproduces faithfully. An exhibition of his drawings has been on show at the RIAS Gallery in Edinburgh.

★ The figures given below by the Child Poverty Action Group for 1987 make sad reading.

150,000 will have experienced their parents divorce.

79,000 children were in local authority care.

85,000 children disappeared from home.

★ An information pack containing 10 Commandments to protect children against molesters has been produced by Childwatch. Parents are urged to ensure their children know them by heart. Available from: Childwatch, 60 Beck Rd., Everthorpe, South Cave, Brough, East Yorkshire.

★ A new survey - Literacy, Numeracy and Adults - suggests that a stammering child or the late talker may continue to feel the effects of their problems into adulthood. Available from: ALBSU Kingsbourne House, 229/231 High Holborn, London WC1.

ERRATA

It was with horror that we found 'Varus' mis-spelt 'Vareus' in the title of Anne Raffle's article in November, but hope that all our readers will appreciate it was a misprint.

Mrs. Raffle is the Paediatric Supt. of the Royal Liverpool Childrens Hospital, City and Alder Hey Branches. Mrs. Rene Adams is the Community Paediatric Superintendent. We apologise for the confusion.

EQUIPMENT

MedicLoo 'Dryad'

Warm Washer/Dryer BIDEET facility, adapts to existing or new W.C. pans.

When no longer needed the special seat assembly can be replaced by a standard seat, and the Module utilised elsewhere.

Choice of duration of Douche and Air Dryer facilities.

Wide adjustment for angle of jets.

Anti-fouling renewable Protectors for Jets.

Controls may be Module or Wall Mounted and are fingertip operated. Also operable by any limb extremity or orally.

The Module may be fitted on either side of the w.c. pedestal.

Extra strong seat attachments are provided, also adjustable lateral fittings ensure rigidity of seat onto the pedestal.

Price - Basic £602.00

Medic Bath Limited, P.O. Box, Ashfield Works, Hulme Hall Lane, Manchester, M10 8AB. Tel. 061 205 7495/6.

Warley Chairbed

Powered by a 240 volt linear actuator you plug it in to any 13 amp socket. Operated by means of a two button hand control, the chairbed is raised from the laying position to the sitting position with the utmost ease. As you can stop the chairbed at any time a full range of positions can be achieved.

Available from SML Aids Limited, Bath Place, High Street, Barnet, Herts, EN5 5XE.

The Easibath Range

Easibath Domestic - fixed height. Static height bath with one folding side, enamelled lock rail, standard adjustable backrest, bath mat, head pillow* 1½" waste fittings. Mounted on stand with one side panel and one end panel and provision for height adjustment on installation.

Price £970.00 complete.

Thermostatic mixer/shower unit for end of bath or wall mounting.

Easibath Hi-Lift. Variable height bath with one folding side, stainless steel locking rail, standard adjustable backrest, bath mat, head pillow* 1½" waste fitting, trap and 1 metre flexible connection. Mounted on hydraulically operated variable height stand.

Price £1,590.00 complete.

Available from: Kingkraft Limited, Roebuck Place, Chapel-en-le-Frith, Stockport, Cheshire, SK12 6ER. Tel. 0298 812528.

Centromed

When fitted to almost any single bed, either domestic or hospital the Mattress Variator transforms it into an efficient hand controlled automatic system for raising and lowering the bedhead into variable positions, through fully prone to

sitting upright simply at the press of a button. So easy and yet so effective the device consists of the Mattress Variator, Hand Controller, Control Unit, air hose and instructions.

Price £230.00 for MV/1 (Single Bed). Available from: Centromed Limited, Brookfield Industrial Estate, Leacon Road, Ashford, Kent. Tel. 0233 28018.

The Incare Faecal Collector

The InCare Drainable Faecal Collector is a totally new concept. It simplifies procedures, avoids the problem of soiled patients, helps reduce the risk of skin soreness and saves valuable nursing time.

*InCare Medical Products, a division of Hollister Incorporated, 43 Castle Street, Reading, Berks, RG1 7SN.

TOYS

Hals Pals

Dolls with cheerful clothes and big smiles, to help children come to terms with disabilities. Hal now has four pals - Party Pal who comes with crutches, Ballerina Pal who wears a hearing aid, Outdoor Pal who has a guide dog, and Winning Pal wearing a tracksuit, and with his own wheelchair. All from Nottingham Rehab.

Webster the Spider

Bobs up and down as it is pulled along on its eight legs, suitable for one to four year olds. Manufactured by Kiddicraft.

Power Workshop

Sounds lethal with its battery powered drill, screwdriver and saw but is well designed and harmless. Three to seven year olds. Fisher Price.

Video Smarts

Designed for 3 years and upward. Uses a computer console plugged into V.H.S. and Colour T.V. The first cassette included with the Video smarts computer console teaches the child number concept. The 30 minute cassette also features cartoon characters, puppets and music. Six further educational tapes will be available.

Video Smarts including computer console and first video cassette from Argos, Zodiac and other U.K. stores. Cost around £50. Tapes can be ordered from: Action GT, Abingdon Industrial Park, Abingdon, Oxon OX14 1AU. £8.99 plus £1 p & p.

THE WORK OF THE NATIONAL COMMITTEE

There have been 4 committee meetings over the past year one of which was as part of a weekend workshop when we were looking at 'job descriptions'. The format of meetings is always very similar and they tend to take place in London, on a Friday or Saturday, lasting from 11 a.m. to 4.30 p.m.

Following on from apologies for absence and matters arising from the minutes we have a correspondence slot when replies to various letters are discussed. The postbag yields various enquiries, examples of those received this year include a query as to whether or not physiotherapists working in schools should be employed on the same basis as educational staff, many letters from parents/relatives asking for information and advice, and a large number of letters on Conductive Education. We also received regular information and requests for information from various agencies dealing with children.

At every committee meeting we have 'reports' from the Treasurer, Editorial Board, Post Registration Education sub-committee, Public Relations Officer and all Regional Representatives report on what is happening in their region. We also have an update at each meeting as to how the Conference arrangements are proceeding.

Other Agenda items over the past year have included Criteria for Funding Towards Courses, Funding for Tutor Training and Aids and Equipment Survey.

Two sub-committees are due to report at the next meeting on 'Code of Good Practice for Paediatric Physiotherapy Management' and 'the Relationship between the Role and Function of Paediatric Physiotherapy and Conductive Education.'

A new venture this year was a one day meeting of Regional Treasurers with the National Treasurer, a representative from the Finance Department at CSP and an accountant from the firm we employ to audit the accounts. This was a very useful day and there are plans to make this a regular annual event.

In future editions of the Newsletter we are intending to give a short outline of the previous committee meeting. Any comments, requests for further information or suggestions should be sent to the Secretary or to your Regional Representative.

COMMITTEE VACANCIES

There are two vacancies for the National Committee, nominations together with the name and membership number of the proposer and seconder should be sent to the Secretary Mrs. S. Holt, 43 Westwood Park, London by March 14th 1988.

Now is your chance to have a say in how your Association is run!

REGIONAL PROFILES

LONDON

Although the smallest in area, London region has the highest concentration of paediatric services in the country. The current membership of 125 is probably only half the number of paediatric physiotherapists working in the Capital, in 31 health districts. Two of these, the Great Ormond St. Group of hospitals and the Hammersmith Group, are designated "Special Health Districts".

Several of the famous specialist hospitals e.g. The Brompton Hospital, have childrens units, and there are seven private hospitals where children are treated. Many centres are world renowned, adding to our heavy caseload. Here APCP has a lot of competition for members from other paediatric and specialist interest groups. Meetings clash, travelling can be difficult and budgets for study are tight. For these reasons we produce our own Newsletter and try to represent APCP as many other groups as possible.

As with many other parts of the country, there is an increasing shift of work from the hospital into the community and the majority of members work in this area. Although many areas serve schools which cater for children with differing special needs, few of them, perhaps surprisingly are residential.

London, our Capital, with its wealth of expertise, its variety of services and its interesting cultural and ethnic mixes, suffers from many problems which directly or indirectly, affect us as physiotherapists. More than the usual shortages of cash, as so many hospitals are fighting for money. More than the usual inner city decay, causing poverty, homelessness and hardship for many of the families we see. More than the usual delays in travelling from place to place (and then having to find somewhere to park when we get there)!

Hard work? Definitely. Challenging? Certainly. Stimulating? WE think so.

Marion Main Physiotherapist

SOUTH WEST

The South West region of APCP covers a large area, extending westward from Basingstoke, Alton and Portsmouth (this includes the Isle of Wight, Cornwall and the Scilly Isles). The northern boundary extends from Swindon, Gloucester and Cheltenham. One member lives in the Channel Isles. This widespread region has many sparsely populated areas with few major towns. Teams of Paediatric physiotherapists are based from the following towns:— Truro, Plymouth, Exeter, Yeovil, Taunton, Bristol, Bath, Swindon, Cheltenham, Gloucester, Southampton, Dorchester, Poole, Basingstoke, Salisbury and Winchester.

Most of these teams have a heavy community commitment and are made up of a large number of part time staff. There are also a few teams of paediatric physiotherapists based in small country towns. Another feature of the SW region is the presence of well established 'Private' schools, such as the Lord Mayor Treloar College at Alton Hants, Dame Hannah Rogers at Ivybridge, and Princess Margaret School in Taunton. The Honeylands project in Exeter, founded in the 1960's was a pioneer in the team approach to the treatment of the handicapped child.

The last five years have been turbulent with both the implementation of the 1981 Education Act and the implementation of Griffiths. There have been major shake-ups in well established regimes but now a much clearer picture is beginning to emerge. A number of new paediatric consultant posts have been created, including a regional paediatric neurologist based in Southampton; this has meant corresponding expansion in new paediatric physiotherapy posts. Also, a number of Senior I physiotherapists have been upgraded to Supt. III, as departments have been reorganised and co-ordinated. As this region has always, and continues to be underfunded, the ratio of physiotherapists to children is low. When one also bears in mind the distances to be covered, paediatric physiotherapists remain under considerable pressure.

Because of the financial restraints and lack of educational funding, groups are tending now to meet regularly on a more local basis. However, the membership remains eager to get together annually, and the regional committee is in the process of being reorganised to enable this to happen.

Integration into mainstream schools is a major factor in the region and is advancing rapidly. With the small, elderly village schools common to the region, this is proving to be a challenge to many members. There is little formal research taking place within the SW region at present. Southampton University run the well established MSc. course and paediatric physiotherapy has benefited from some of the research projects from this. Southampton H. A. also employ a paediatric physiotherapist with a part time commitment to research into asthma.

The Child Development Centre in Dorchester have for some time been evaluating the physiotherapy treatment of premature and low weight babies. Bristol Childrens Hospital is a regional centre for orthopaedic surgery on Cerebral Palsy. Saxon Wood Hospital in Basingstoke have recently evolved a new seating system, and Lord Mayor Treloar College are at present evaluating Conductive Education. But with the low population figures, it can be difficult to do formal research projects.

There has always been considerable enthusiasm and interest amongst the members of APCP, and despite the problems of communication (6 hours plus from Basingstoke to Cornwall, and many small country roads) plus lack of funding, members continue to be eager to meet and learn from one another.

Study Days are well attended and always lively. It is hoped to be able to expand these on a more regional basis. Membership presently stands at 96.

Gillian Riley. Supt. Paediatric Physiotherapist

REGIONAL REPORTS

London **Reg. Rep. Miss V. Read, 62 Madeley Rd, Ealing, London W5 2LU.**

On Wednesday, March 2nd at 6.30 p.m., we are holding our AGM in the lecture theatre at the Hospital for Sick Children, Gt. Ormond St. It will be followed at 7 pm by a lecture on 'Neonatology' and a Cheese and Wine Buffet.

Members £3. Non-members £3.50. Please apply in writing, with the fee and enclosing a s.a.e. to: Marion Main, 36 Gladstone Court, Anson Rd, London NW2.

Any suggestions for future topics on Study Days or evenings, will be welcome.

S. East

Reg. Rep. Miss C. Young, Royal Alexandra Childrens Hospital, Brighton.

Surprisingly few people applied for the two funded places to the APCP Annual Conference in Warwick, in April 1988. This was possibly due to the typing error in the November S.E. Report which stated that we were hoping to "find" (instead of "fund") two people to attend the Conference. The two members who will be funded following the draw made on 3.12.87 are Isabelle Johnson from Canterbury (Chairperson of S.E. Region) and Anne Walker from Brighton. We are planning a Study Day on June 18th at Chailey Heritage, on 'Seating' Details will be in the March Physiotherapy Journal.

We are looking for at least one more committee member for the S.E. Committee. Nominations please to S.E. Rep. before the AGM on 5.3.88.

North East

Reg. Rep. Liz Barron, 5 Sandy Lane, Ripon N. Yorks. HG42PD.

Our evening meeting in December was well attended. Everybody was fascinated by the films shown by Dr. Woods of a group of Cerebral Palsy children. These were taken in 1959 and 1962 and showed very good results were obtained without any present day techniques but lots of dedication. We are planning an evening talk on Muscular Dystrophy in February and a Day Course which will include the A.G.M. in March. Further particulars of these will be sent nearer the date.

South West

Reg. Rep. Miss G. Riley, Meadows, Bowerchalke, Nr. Salisbury.

A Course on Visual Handicap will be held at the Child Development Unit, Poole General Hospital on one of two Fridays in March details will be published in the Regional Newsletter.

It is hoped to run a course on 'Counselling for Parents with Young Handicapped Children', over four evenings at Odstock Hospital, Salisbury in April/May 1988. Numbers for this will be limited.

There have been a number of meetings to discuss the pros and cons of Conductive Education, throughout the region during the Autumn. Considerable interest has been aroused in this subject, and members have made good use of the opportunities available to further their knowledge.

East Anglia

Reg. Rep. Lyn Weekes, 37 The Cedars, Milton Rd, Harpenden, Herts.

We held a most stimulating workshop at the RNIB School, Rushton Hall, on October 5th, when Sophie Levitt spoke on 'The Management of the Multi-Handicapped Blind Child'. The day began by people putting forward the questions to which they would like answers. As the day progressed, under Sophie's expert guidance, we pooled our knowledge and experiences. She left us with a

firm directive to, look for the positive, and then devise therapy to build on the positive basis.

A further Study Day is being held on January 22nd 1988. Application forms were enclosed with the last Newsletter. On what promises to be an informative day, the speakers will include: Dr. Pat Sonksen, Wolfson Centre, Institute of Child Health, Dr. Jean Cooper, Principal of the College of Speech Sciences, Mrs Jean O'Halleran, Snr. Paediatric OT at the Nissan Centre, Sussex, Mrs. Christine Long, RNIB Educational Advisor, Dianne Sandler, play specialist, will give advice about the toys on display during the lunch break.

Our AGM will be held on March 17th 1988 at Basildon Hospital Essex, in conjunction with a Study Day on 'Special Care Baby Units'. Application forms enclosed with this Newsletter.

Plans are in hand for an Autumn meeting in High Wycombe, and a summer meeting in Kings Lynn. If we haven't had a meeting in your area yet - try inviting us!

Wales

Reg. Rep. Lyn Horrocks, 9 Garth Close, Rudry, Caerphilly CF8 3EN.

Chailey Heritage Seating Day - Thursday 3rd December.

We had a very successful study day at the University Hospital of Wales on December 3rd when we welcomed the Research Team from Chailey Heritage in Sussex: Roy Nelham, Research Director, Catey Mulcahey, Research Occupational Therapist, Terri Poultney Research Physiotherapist.

They gave an excellent presentation of their assessment procedure and the development of the Chailey Adaptaseat. This was a very stimulating day, and we hope to incorporate many of their philosophies and techniques into our own Regional Special Seating Service for children.

Halliwick Swimming Course, November 21/22nd.

A very active and successful week-end was organised in conjunction with the Sports Council for Wales. The facilities at the National Sports Centre in Cardiff were excellent, and the course was very well attended by Paediatric Physiotherapists, Special Education Teachers, Occupational Therapists, Nursery Nurses and Physiotherapy 'Helpers. Many thanks to Dinah Cadogan and Jill Pepper all for their lectures and demonstrations. This partnership of APCP and the Sports Council for Wales worked well, and we hope to arrange further courses together.

Advance Notice: A three day Bobath Course - An Introduction to the Treatment of the Multi-Handicapped Cerebral Palsied Child - is to be held on Tuesday 1st/Wed 2nd/Thurs 3rd March 1988 at the Combined Training Institute at the University Hospital of Wales, Cardiff.

BITS AND PIECES

★ Speaking at the Conference "Together for Children" to be held in London in May (see Courses) will be our Chairman Mrs. M. D. Diffey, our P.R.O. Miss E. Bell and the S.E. Reg. Rep. Miss Chris Young. Also speaking will be Mrs. E. Cotton.

★ Have you heard of SEQUAL? - Special Aids and Equipment for living - an independant non-manufacturing National Charity which aims to assist severely physically disabled people to buy electronic/electrical equipment.

Information - SEQUAL, Ddol Hir, Glyn Ceiriog, Llangollen Clwyd LL20 7NP. Tel: 0691 72331.

★ A group of parents is getting together to form a British Action for Childrens T.V. For information contact: Philip Simpson, British Film Institute, 81 Dean Street, London.

★ A new hip scanner developed in Northern Ireland may dramatically reduce cases of missed C.D.H. in small babies. Created by Professor Rob Mollen of Queens University, Belfast, the machine is said to be more sensitive than the human hand, and can tell the difference between the clunks and clicks in the joint.

★ New regulations now govern the sale of bunk beds for children up to six years. Gaps in the structure of the bed must be less than 3".

★ A number of Toy Libraries and Nurseries have benefited from the Children in Need Appeal.

★ A new booklet "The Physical Treatment of Cystic Fibrosis" by Diana Gaskell M.B.E., F.C.S.P. and Barbara Webber M.C.S.P. of the London Brompton Hospital is now available for copies, contact: Mrs. S. Kennedy, P.R.O. Cystic Fibrosis Research Trust, Alexandra House, 5 Blyth Road, Bromley, Kent. Tel: 01 464 7211.

★ At a meeting of scientists in Cambridge earlier this month, Dr. Eric Hoffman of the Harvard Medical School, said that though "gene therapy" was ethically and technically difficult - the treatment of Duchenne Muscular Dystrophy through the technique was under consideration. Dr. Hoffman was the author of a paper announcing the discovery of dystrophin, a protein lost through the gene defect characteristic of the disease.

★ The Fisher-Price Advisory Service will advise on choosing Toys. For free information pack send 40p in stamps to: Fisher-Price Advisory Service, 30 Farringdon Street, London EC4A 4EA.

★ Winganna who made natural fleeces for babies now make push chair liners. From: Winganna Natural Products, St. Ishmaels, Haverfordwest, Dyfed SA62 3DL.

★ Heart Cord Ltd. - an arm of the British Heart Foundation produce a "Panda Calculator", 4" long with a Panda Face and eight digit display. It will add, subtract, multiply and divide. When the Panda Face is moved up it also sings! Uses two G.10 batteries (not supplied) from Heart Cards, P.O. Box 45, Burton-on-Trent, DE14 3LQ. £5.99, p. & p. £2.25.

★ New two-way baby car seat by Britax, can be used facing backwards in either front or back seat, and also adjusted for forward facing in back seat. Harness and crutch straps are adjustable. Washable reversible cover. From £50.55. For nearest stockist contact: Britax Excelsior Ltd., Chertsey Road, Byfleet, Surrey KT14 7AW. Tel: 09323 411121.

