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**CHARTERED PHYSIOTHERAPISTS**

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**NEWSLETTER**

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# Association of Paediatric Chartered Physiotherapists

Newsletter No. 56

August 1990

## QUALITY OF LIFE - CONFERENCE EDITION

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## EDITORIAL

**Margaret Meagher, Chairman, Trent Region**

The 17th Annual Conference of the A.P.C.P. was held at Loughborough University with Trent Region acting as hosts to the 200 delegates. The theme was 'Quality of Life', and précis of some of the papers presented are enclosed within these pages for those unable to attend and will give some idea of the high standard of the speakers and topics. A new A.P.C.P. leaflet on 'Physiotherapy in Paediatrics' was launched during the Conference.

Each evening ended with a lively social event, skittles where inter-regional rivalries were battled out in the friendliest way - naturally! Our co-ordination skills were tested by the intricate steps of the various dances the following night. Whilst resting and catching our breath between the dances, it gave us a chance to look at the photographs of the Russian trip and hear the experiences of those lucky enough to go. These Conferences not only enrich and increase our knowledge of Paediatric matters, but are congenial settings where friendships are renewed and made.

At the A.G.M., three members of the National Committee retired from office - Maggie Diffey, Chris Young and Jill Brownson and Mary Clegg, Michell Lee and Lyn Weekes stepped into their shoes. We thank the outgoing officers for all their hard work, dedication and commitment to A.P.C.P. and welcome the new ones who have agreed to shoulder the responsibility of guiding us into the 'Nineties'.

Our thanks also go to the Trent Committee and their helpers for all their hard work in hosting the event and making everyone feel so welcome.

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Copy for the November issue must be with the Editor by 1st October.

The A.P.C.P. Annual subscription is due by 1st January annually. If members change either name or address, please notify the Membership Secretary. The subscription rate for 1991 will be published in the November issue.

Copies of the Newsletter (subject to availability) can be purchased from the Editor, price £2 incl. p. & p.

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

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# QUALITY OF LIFE

LOUGHBOROUGH UNIVERSITY, APRIL 1990

## LIFE IN A BURNS UNIT

**Fiona B. Bailie, FRCS, Consultant Plastic Surgeon, City Hospital, Nottingham.**

We have a nineteen bedded subregional Burns Unit in Nottingham which accepts both children and adults. The major number of cases are due to children with scalds, many of whom need skin grafting. The work of the Burns Unit Team consists of looking after both new Outpatients and Inpatients who require treatment of the acute burn injury, possible surgery and postoperative care.

Long term follow up may be needed to treat burns scarring - the mainstay of treatment being pressure garments and skin moisturisers, surgery only being carried out in cases of contracture formation, ulceration or instability of scars. However prevention is better than cure - for example smoke alarms and fire extinguishers in the home can help avoid house fires. A case of a two year old boy with severe facial and hands burns is presented to describe extensive reconstruction required after such a house fire.

**Miss J. Theakstone, MCSP, Sen. Physiotherapist, City Hospital, Nottingham.**

Children treated in Nottingham Burns Unit are provided with as welcoming and non-threatening environment as possible.

The Physiotherapist has an important contribution to make in the arrangement of a burn injured child and the main aims of treatment are outlined below:-

- 1) **Maintaining clear airways** - particularly after inhalation of smoke which can cause airway irritation, pulmonary odema, bronchospasm, and sooty sputum.
- 2) Preventing joint contracture by:-
  - a) **Exercise** - early active movement is particularly important in hand burns. Gortex bags, which incorporate a semi-permeable membrane allowing the exudate to evaporate and thus preventing skin maceration, are now used as a hand dressing on this Unit.

The importance of having adequate pain control was emphasised.

- b) **Positioning** - patients will often adopt the 'position of comfort' which is usually a flexed position which can lead to flexion contractures of underlying joints. This can be prevented by nursing the patient in a position opposite to that of potential contracture.
  - c) **Splintage** - if the joint range is not maintained by exercise or positioning then splintage may be necessary.

- 3) **Providing Psychological Support** - being aware of the psychological needs of paediatric patients and their relatives was emphasised. The Physiotherapist may need to spend a considerable amount of time in answering questions and providing support.
- 4) **Aiding functional independence** - the Physiotherapist has to help the patient become less dependent on the nursing staff by reinforcing functional activities, increasing their exercise tolerance and re-educating walking. Therefore increasing the patients confidence in preparation for discharge.
- 5) Reinforcing after care of grafted areas - particularly the need to regularly cream grafted area, the need to wear close fitting pressure garments for up to 18 months and the use of Silicone Gel sheets helping to prevent hypertrophic scarring was emphasised.

The role of the Physiotherapist on the Burns Unit is challenging but rewarding, requiring adaptability, flexibility and sensitivity to the childrens needs.

## **THE RED CROSS ENDORSEMENT: “TENDER LOVING CARE”**

**Mrs. D. Hessain, Expert in Cosmetic Camouflage, British Red Cross Society.**

The aim of the Cosmetic Camouflage Service is to improve the appearance and confidence of patients with any form of disfiguring scar. This has proved so successful, that Consultants now ask for this service, in order to help in the aid of patient recovery.

Camouflage creams used are able to conceal without being heavy; they also act as a sun bloc, and when applied as shown, are waterproof. When patients are used to these routines, the ‘Quality of Life’ is greatly enhanced.

If any problems arise in finding this service in hospitals, it may be found by contacting any British Red Cross Society Branch Office, or Headquarters at 9 Grosvenor Crescent, London SW1X 7EJ Telephone: 071-235-5454.

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## **MEASURING QUALITY OF LIFE**

**Dr. J. Moore, MB, FRCP, DCU, Consultant Paediatrician, Leicester.**

In the past attempts have been made to measure the success of therapy in terms of reduction in disability. In many children with long term developmental disorders this is an unrealistic expectation. It is much more likely that therapy will improve a patient’s quality of life if that could be measured. Published research indicates that this can be measured in the context of mental handicap (1) and a similar approach has been used to measure physical wellbeing in the paper by Mrs. Amos (see below).

- (1) Blunden R. Quality of life in persons with disabilities: issues in the development of services. In the Quality of Life for handicapped people  
Ed. Brown R.I., Croom Helm. 1988.

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## LIFE AFTER SCHOOL

**Mrs. Ann Amos, Senior Physiotherapist, Portland Training College.**

The Further Education Unit in Portland Training College provides a curriculum consisting predominantly of physiotherapy, independence training and alternative communication studies. The age range of the students is 16-19 years. A pilot project was set up in 1986 subsequent to a course conducted by Noreen Hare, on the Theory of the Human Sandwich (The understanding and evaluation of Movement Disorder). This resulted in the Portland Physiotherapy Programme.

Four students were chosen for the project - their common condition was cerebral palsy with athetosis. The students involved were Gary, who had additionally acquired contracted hamstrings; Jackie, who had additionally acquired a severe scoliosis; Julie, who had acquired a postural scoliosis and Sharon. The students were each assessed at the beginning of the programme and at six monthly intervals. The Physical Ability Chart (Hallett, Hare, Milner; Physiotherapy May 1987) was used to record their motor performance in lying, sitting and standing. Each assessment was filmed with video.

Treatment consisted of two one hour sessions per day ... when the students worked under the direction of a physiotherapist and with the assistance of two physiotherapy aids. Each programme was geared to individual need. Techniques included the use of gaiters on arms and legs to enhance the role of the trunk in movement and postural adjustment; and building up the supporting surface in order to correct the direction of fall and improve body/base contact. Exercises included weight shifting inter laterally and antero posteriorly in lying and sitting, rolling from supine to prone in both directions, sitting up from lying and rising from sitting to standing. The results of the project were as follows:-

- Gary: After one year could use a foot controlled wheelchair.  
After two years could use a hand-controlled wheelchair.  
Could co-operate in dressing himself.  
After three years he could access an expanded keyboard with his left hand.

- Jackie: By use of wrist attachments with improved arm control could:
- use a pointer for direct access to the keyboard of a touch talker
  - could drink from a beaker
  - could feed herself.
- Julie: No longer required a straw for drinking from a cup due to improvement in head control.  
Physical management had improved due to a decrease in severe extension spasm.  
Could access a keyboard with a head pointer.
- Sharon: Head control improved resulting in:
- improvement in feeding pattern
  - trunk efficiency improvement negated the need for a seat mould.

The results of this project are significant for the recorded improved physical performances of the individual students, and for the beneficial effects of the programme upon health, comfort, ease of management, well being and quality of life.

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## **ACTION VERSUS APATHY**

**Barbara Sears and Renate Hallett, Sr. Physiotherapists, S. Notts. College of F.E.**

We work at a college for further education in Nottingham. The college has provision for students, age between sixteen and twenty years, who have special educational needs. There are students with physical disabilities, those with severe and moderate learning difficulties, and also hearing impaired students.

As therapists we have concerns over the mix of disabilities in our department. We find that behaviour patterns exhibited by students with learning difficulties make the adult atmosphere and environment impossible for those students with physical disability to work towards independence.

Further integration into mainstream courses is planned, but we know that this will only succeed if there is sufficient support for each individual student, regarding both their mobility and health, together with support for their specific educational problems.

Through each young person's life much effort and goodwill has been expended by many professionals in what we all hoped was in the best interests of the individual young person, at each stage of his or her life. In spite of much action we still meet apathy.

We investigated why so many of our students, especially the academically brighter ones, appeared to be more apathetic than their able-bodied peers, and came up with several conclusions and suggestions.

Problems experienced by our young people seem to originate from lack of identity and independence, lack of choice and no role in life. We identified three areas of concern (see model), and suggest that action, not just CRISIS, has to be taken in these areas if our young people are to achieve greater independence and an improved quality of life.

## **1. INSUFFICIENT PHYSICAL ABILITY**

We could identify three components that had effect on the progress in the disabled persons' life:

### **PHYSIOTHERAPY**

Availability of this service for people 16+.

Ongoing assessment to monitor the physical state.

Links between paediatric and adult physiotherapy service to share information and ideas.

Change of emphasis and education on physiotherapy, with hand-over of responsibility to the young adult for their health, fitness and maintenance of physical ability.

### **SURGERY**

Pressure for surgery as the answer for all problems.

Greater emphasis on recording physical ability.

Recognition of the short and long-term effects that surgery may have on these ability levels.

### **PRESSURE TO WALK**

Pressure from society to be upright, and get walking, regardless of efficiency. Shortcuts are often taken, and levels of movement abilities necessary for independence are overlooked.

Improved awareness and understanding of potential skills of each individual could cut down on some of the handicaps and deformities often seen in the young adult.

The second area effecting progress or regression is:

## **2. EMOTIONAL PROBLEMS**

Splits in the family, financial problems, lack of respite care, lack of information and consultation, acceptance of diagnosis, lack of self image, self care and hygiene, lack of choice in clothes and financial affairs, emotional weaning (both carer and student), lack of role in society.

We feel a realistic future plan must be discussed by all parties with sufficient counselling, honesty and encouragement to overcome social attitudes.

The third area we looked into:

## **3. UNSUITABLE PHYSICAL ENVIRONMENT**

### **EQUIPMENT**

Improvement in this area is also vital: efficient, suitable and speedy provision of equipment and wheelchairs. Access to a functional indoor and outdoor electric wheelchair, which must be ergonomically efficient and up to date.

Importance of the individual being involved, and having a choice in this area.



## HOUSING

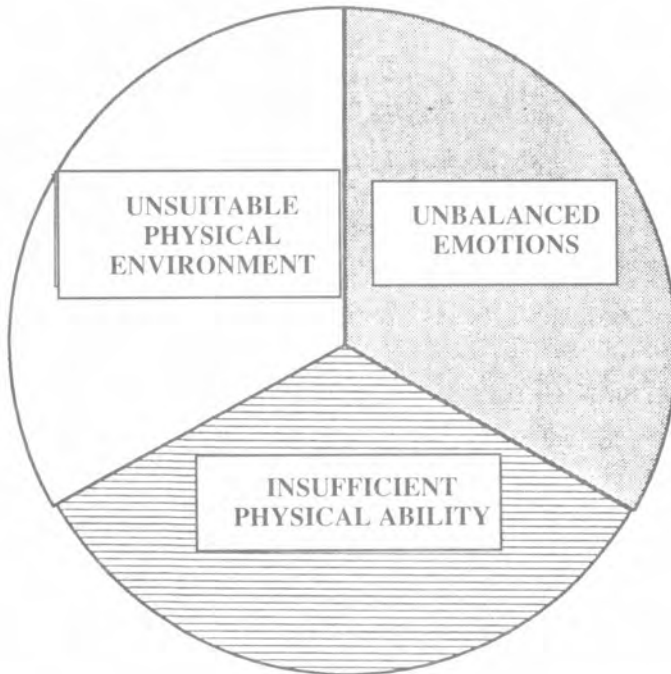
Improvement in the provision of and in choice and range of different housing types, independent, sheltered, supported etc.

## PUBLIC AMENITIES

It should be the right of all disabled persons to have access to pavements, houses and transport by ramps and lifts, and suitable toilet facilities in shops, recreation areas and in the work place.

It is essential that each person is seen as a whole; that professionals and carers communicate effectively and give practical advice, information and counselling at all stages to allow each young person, on their own behalf, to choose a way to fulfilment and to achieve their potential.

To SUCCEED against APATHY is the aim.



This model is adaptable, and proportions will vary with each individual.

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## LIFE WITH AND AFTER ORGAN TRANSPLANTATION

**Margaret E. Hodson, MD, MSc., FRCP, DA, Director of Dept. of Cystic Fibrosis, Brompton Hospital, London.**

I am a respiratory physician and therefore will confine my remarks to lung transplantation.

Lung transplantation has only been possible in the 1980's. This came about due to the improvement in surgical techniques and the use of cyclosporin. Cyclosporin is a drug which prevents the recipient rejecting the donor organ.

For lung transplantation the following techniques can be used:- single lung, double lung and heart/lung transplantation. The technique used depends upon the available donor organ material and the disease of the recipient. In the UK the most commonly transplanted pulmonary disease is cystic fibrosis (CF) and over 80 patients have so far been transplanted. The first successful patients with CF were transplanted in 1985. Other lung diseases which have been successfully treated by transplantation include fibrosing alveolitis, emphysema, sarcoidosis and alveolar cell carcinoma.

Survival for heart/lung transplantation for CF is currently 70% to one year and 68% to two years. It is important to remember that not all patients are suitable for transplantation and all patients need very careful medical and psychosocial assessment before being put on a transplant waiting list. They all need very careful medical, psychosocial and spiritual preparation for what is a very major surgical procedure. Part of the preparation should include meeting patients who have already undergone the procedure and talking through with senior members of staff exactly what is involved and what it will be like after the operation. They must understand that life-long follow-up will be necessary. Not all patients would wish to be considered for transplantation when they know exactly what it involves. A patient who is suitable for transplantation and wishes to proceed is placed on the waiting list. The waiting time for a suitable donor organ to become available may be a few days or many months. Patients are matched for blood group, size and CMV status. At the time of transplantation patients are given large doses of immunosuppressive drugs; cyclosporin, methylprednisolone and azathioprine. They will continue to take cyclosporin and azathioprine twice daily for the rest of their lives. Approximately one quarter of the patients do not survive surgery and the immediate post-operative period. The patients who do well may be out of the Intensive Care Unit within one week and discharged from hospital 4-6 weeks later. They will then have to return to hospital very frequently for regular follow-up.

Lung function gradually improves and may well be within 70% of predicted three months after a transplant operation. Patients are subject to episodes of infection and rejection which have to be treated promptly. They monitor their lung function daily at home.

Before transplantation many patients are extremely breathless and often can only walk a few yards. Many are on continuous oxygen. After transplantation the patients who do well soon develop a near normal exercise tolerance, they are able to undertake education or employment. Many transplanted patients have been on overseas holidays and some have married. The quality of life after transplantation has been assessed in detail using the Nottingham Health Profile, and patients show marked improvement in ability to work, perform home tasks, the quality of their social and sex life, hobbies, and holidays. There

is also a significant reduction in the amount of time they spend in hospital and at out-patients compared with their pretransplant hospitalisation.

There are still many challenges involved in lung transplantation. There is a shortage of donor material and it is an expensive form of treatment. The patients will require life-long follow-up. Many patients need considerable help to adjust to their new lifestyle which enables them to do many things which they were too disabled to do before transplantation.

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## **THE SUTHERLAND ASSESSMENT SPLINT**

**Mrs. Mysie Sutherland, Physiotherapist, Rutland House School, Nottingham.**

The need for an assessment splint grew out of several factors:-

1. The setting up of a nursery attached to Rutland House School meant that for the first time in the school's history, we were being given very small cerebrally palsied children to educate. These young children came from many different Health Authorities; some with very good back up from their home management team: some with little or no help. These children mostly have a paediatrician, but may have irregular and sparse physiotherapy and teaching. So often these children have no conceptual knowledge of sitting or standing.
2. However their statutory services function, some children are not firmly in the system; some have been overlooked, some have been assessed as being too frail for much effort on their part, or on the part of their teacher/physiotherapist and were therefore destined more for a "care" situation rather than a "learning" or educational system.
3. Thus the nursery sessions tend to have some multiply handicapped children with any equation of C.P. plus visual/auditory problems, epilepsy, nutritional and respiratory problems. Apart from geographical diversity, the severe and complex nature of these children's needs makes it difficult to decide "what" help is needed "where".
4. Parents and professionals alike do want a method of determining where splinting might help this particular child to become upright for:-
  - a) Feeding,
  - b) Toileting,
  - c) Seeing,
  - d) Heating,
  - e) Sitting,
  - f) Standing,
  - g) Walking.

### **Summary of the uses of the Assessment Splint:-**

1. It is immediately adjustable to the child's size and shape.
2. It will operate in safe planes of movement for all the leg joints.
3. It would enable the operator to pinpoint the need for custom made splints should this be necessary.

4. It makes less of a drama for children and parents alike in seeing the comfort and logic of splinting, which could be a psychological benefit now, and in the future.
5. The Sutherland splint is instantly available to the physiotherapist in the home, classroom, or treatment centre. It should therefore be considered as a tool for the physiotherapist, rather than another splint for the child however much the short or long term use of the splint may prove beneficial to a particular child.

**Conclusion:**

This splint could have applications, not just for small C.P. children in this country, but in developing countries where orthotists and splints are not readily available.

I would like to record my grateful thanks to the Rolls Royce apprentices who developed this splint for me, and to Mike Wilkinson of OMEX MEDICAL who is willing to manufacture the splint for all of us.

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## **FOUND AT CONFERENCE - LOUGHBOROUGH**

1. Pale woollen scarf
2. 1 black glove
3. 1 Hot water bottle and cover
4. 1 Roll type neck pillow.

If owners could contact Margaret Meagher -  
she would be happy to send them on to them -

9 Oak Road, Thulston, Derby DE7 3EW.

The following are handouts relevant to the Lecture 'After Intergration'  
given by Mrs. Ann Markee.

## PAEDIATRIC PHYSIOTHERAPIST

<b>P</b>	<b>PROFESSION</b> 'Allied to Medicine' or complementary to others - many non-medical who are endeavouring to help 'Handicapped Families', Must encourage 'blurring' of professional boundaries, leading to overlap of professional expertise.
<b>H</b>	<b>HANDLING.</b> Physical handling must be de-mystified and taught to all who come into contact with the child by either parents or therapist. We must neither take for granted nor underestimate these skills but share them.
<b>Y</b>	<b>WHY</b> are children assessed or treated by physiotherapists? Because they have delayed or deviant development of posture or movement in some form either gross-motor or fine hand skills.
<b>S</b>	<b>SUPPORT</b> for children and families must be general: social, emotional and practical - by showing treatment and handling (parents as co-therapists) and by making time to discuss problems and aspirations.
<b>I</b>	<b>INTERCOMMUNICATION</b> and co-ordination with other involved agencies leads to more effective input and breaks down barriers and defences. Realistic goal setting and shared aims could limit the number of workers and cut down confusion in families.
<b>O</b>	<b>OBSERVATION.</b> Apart from 'hands', observation is the physiotherapists most valuable tool for its leads to the interpretation of 'Body Talk'. Professionals and Parents must also observe each other and learn.
<b>T</b>	<b>TREATMENT:</b> Proposed at Case Conference or earlier if obviously necessary. Eclectic approach, combining many different systems, is ideal. Mostly in the child's own home leading to involvement of the whole family on own ground leads to a child more relaxed.
<b>H</b>	<b>HOME-HABITAT:</b> Don't take in too much ready made equipment - 'washing up bowl' therapy encourages families to think up their own 'aids' and ideas from the home leading to greater relaxation and exchange.
<b>E</b>	<b>EDUCATION:</b> Physiotherapy should be available in any school setting - but since the 1981 Ed. Act, advice and support for teachers in an ordinary setting will become doubly important if success is to be achieved.
<b>R</b>	<b>REFERRAL</b> can come from anyone, but treatment must always be approved by a doctor. Referral should happen as early as possible for most effective intervention - as early as birth for some children.
<b>A</b>	<b>ASSESSMENT:</b> Usually at C.D.C. but could be in the home for best results. Always based on fundamental knowledge of normal development. Should be positive ability NOT disability, and understanding on our part leads to real partnership.
<b>P</b>	<b>PARTNERSHIP:</b> Our work would be valueless without the help of parents who care for the child 24 hours per day. We must teach them our skills and learn from them. Humility and understanding on our part leads to real partnership.
<b>I</b>	<b>INFORMATION:</b> Parents should have access to all relevant information and should be encouraged to ask for it to be explained to them if necessary. Thus they can hope to make more enlightened decisions.
<b>S</b>	<b>SEATING</b> and positioning in general at home and in school is vital for maximum concentration and function, and most efficient eye and hand skills. Physiotherapists have the 'know how'.
<b>T</b>	<b>TRANSPORT:</b> Correct wheelchairs etc. are important, but we should be careful not to 'over-motorise'. Disabled children need to keep fit for it aids such things as bowel and bladder function and circulation.

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<b>Teachers skills</b> →		<b>when there is a child with a disability</b>
<b>Observation</b>	}	Builds complete picture of child from as many sources as possible. Parents first, also Health, Psychology, social services etc. Diagnosis alone is not enough - all children are different!
<b>Assessment</b>		A set of symptoms may handicap one child but not another. These skills may need to be more precise when a child has Special Educational Needs.
<b>Adaptation</b>	}	Adaptation of the way activities or information are presented so that the child has the best possible opportunity to participate. Adaptation of the environment suitability of seating and equipment, height of work surface etc.
<b>Flexibility</b>		Access to rooms, toilets etc need checking. Ask for help if you're not sure. Flexibility to arrange things differently if necessary eg. accommodate onlookers, advisers, etc.
<b>Communication Liason</b>		With others involved needs to be regular and ongoing if much advice is needed. Communication of information to the child may need to be more careful if, for example there are associated learning difficulties or perceptual problems.
<b>Motivation</b>		Often depends on success, which may depend on motivation is usually enhanced for children with movement difficulties by the challenge of being with "normal movers". Motivation to enjoy movement.
<b>Task Goal</b> } <b>Setting</b>		Activities or learning material may need breaking down to reachable goals - simplified so that participation, achievement, success is possible.
<b>Teamwork</b>		Breaks down professional and other barriers - "demystifies" (especially medical matters) dispenses with "jargon" all working for same aim.
<b>Imagination</b>		and knowledge means understanding of the child's disability and situation - ability to anticipate needs. Makes explanation to other children possible - "Disability Awareness".
<b>Patience</b>		No Comment!
<b>EXTRA Needs?</b>		<b>BENEFITS?</b>
<ul style="list-style-type: none"> <li>• Non-teaching classroom help</li> <li>• Adaptation of environment special equipment etc/</li> <li>• More information - specialist help and advice.</li> <li>• More detailed knowledge and advice about possibilities of P.E.'s movement.</li> </ul>		<ul style="list-style-type: none"> <li>• May make more careful plans - set more realistic goals for all.</li> <li>• assessment's observation skills maybe enhanced in an area which is less known.</li> <li>• other children may stretch powers invention, co-operation and understanding.</li> <li>• whole lesson may become more interesting - shared learning for all.</li> </ul>

# Physiotherapists and Intergration

- There must be regular meetings in school for all those directly involved with the 'special' child, including parents, to assess progress, plan goals and share aims.
- Physiotherapists must be prepared to teach special skills in handling and in management of the child with a disability to all those involved remembering always that others may be unsure of touching and holding and may need frequent encouragement and reassurance.
- Physiotherapists could involve themselves in planning disability awareness programmes in schools, thus furthering the 'demystification' of disability.
- Participation in the appointment of classroom helpers suited to a child's particular special needs and subsequent close co-operation with them could mean the creation of another co-therapist and increase the likelihood of correct physical management throughout the day.
- The example of internal and close partnership with parents acquired during pre-school years of shared treatment could overlap into schools and break down barriers of communication.
- Participation in interdisciplinary courses is vital if professionals are to share knowledge and expertise. Physiotherapists might promote greater understanding of movement disorders.
- Where formal therapy is not indicated, but some training in mobility or co-ordination, or understanding of body image is desirable, physiotherapists might work through P.E. or music and movement lessons offering useful and structured motor and perceptual experiences to groups of children with and without movement difficulty. Preparation of practical information and leaflets is also useful.
- Finally, physiotherapists must regularly assess the need for their involvement and recognise when it is important to stand back and advise, co-ordinate, or just observe.



Conference After Dinner Entertainment  
*Left-Right - Ann Grimley, Caroline Aston, Margaret Meagher, Maggie Diffey, Dr. J. Moore, Noreen Hare.*



# CHAIRMANS REPORT A.P.C.P. - MARCH 1990

Maggie Diffey

As we enjoy together this our 17th annual conference, it is time again to consider the past 12 months since we met together at Guildford. The past 12 months have sped by and the APCP has been steadily growing in membership numbers which now stand at about 1100.

The news letter which has covered a variety of topics is sent out to our large membership quarterly and I would like to second my thanks to Jenny McKinley our editor, for her continuing direction of the editorial board and the newsletter. The newsletter continues to grow, indeed, much material has been collected for future editions. The editorial board met in the autumn and will meet again in May in order to plan subject matter into 1991. It is hoped that it is recognised that this is just a part of the work of the association, but a very important part which acts as our voice, but also as an opportunity for its members to express their views.

The small sub committee for Good Practice Guidelines have met on several occasions and the culmination of their deliberations has resulted in the very excellent document, which every paid up member should receive.

The publication of this document is timely and may assist those who are planning services to nudge their managers in the right direction. It has taken many hours of work and we must be proud to read the final version. Further copies are available at the price of £1.00 (£1.25 including postage) and it is hoped that members will purchase copies to either sell or give to their managers.

I should like to thank the sub committee for all their hours of work which went into the production.

During the year, our P R O, Caroline Dunn, managed to open the filing cabinet sent to her crammed full of papers. She also received the notice board from Elma Bell. In order to keep abreast of current matters, she is trying to keep the board as flexible as possible, introducing new material constantly.

New header panels have been introduced in dark blue, which is a good display colour, in the same material as the main panels and will take velcro mountings. A leaflet holder has also been added. Good photographs are expensive to purchase and we thank people who have donated photographs on show this weekend.

National physiotherapy week has encouraged Paediatric physiotherapists in many areas to carry out some enterprising events. These range from displays of publicity material in city centre shopping precincts, Libraries and clinics, to job swaps, open days, presentation of scrolls to "children of courage", mini naidex and articles in professional journals. We are very much hoping to receive written accounts and will hope to pass them on to you.

The new publicity leaflet owes a great deal to the Blue one, written by Noreen Hare a few years ago. This one is much more a progression than a new leaflet. We feel it is important that this is publicly launched so that all members know of its existence and can therefore use it.

Caroline also leads the regional reps meeting, which usually takes place prior to our full committee meetings. These meetings are invaluable and have proved to be of great benefit to APCP.

Thank you, Caroline, for your continuing work as PRO.

My thanks to the regional reps for their continuing and valuable work as liaison between the national committee and the members in the regions. Efficient communications to members at grass roots are the hallmark of an effective and caring association. All regional reps have a great deal to do to turn round the newsletter and get them out to members along with relevant local notices.

The post reg education subcommittee chaired by Mary Clegg, who is also an association vice chairman, has been very active. The interest shown by members for the validated "Introduction to paediatric physiotherapy", continues and exciting new developments are being discussed at the moment, which will lead to greater recognition of the post registration certificate.

We have had our four full committee meetings this year, with wide ranging discussions on a variety of topics. The agenda is lengthy and there are many issues to be debated.

Last Autumn, the national committee held a weekend workshop in Tonbridge. It was led by Jenny French and Sandra Holt and we investigated statistics and medical audit. We had lectures by a charming statistician who made statistics sound easy.

Penny Robinson led a session on legal matters as paediatric physios are increasingly being called upon to make assessments on handicapped children or court settlement cases.

At this point, I would like to give a vote of thanks to our excellent treasurer, who has so ably looked after our financial affairs. Jill also has the knack of making figures sound so easy and knows the technical terms when speaking to our auditors. This is her last conference as treasurer and we thank her for all the hard work she has put into the post.

We are also losing our secretary Chris Young, who has decided to stand down from the post. I would like to record my thanks for all the excellent work she has put in during the past twelve months. There is an enormous amount of correspondence, which has to be dealt with and circulated to all the members of the committee. Although she is leaving as secretary, we are fortunate to have her moving to the editorial board, where she will continue to serve the association.

I would like also to record thanks to two members of the team, who are unable to be present this weekend.

Michelle Lee, who is publications officer and looks after the remaining booklets we have on sale.

The other person is Jeanne Lamond, who is membership secretary, and does such a lot to keep our ever-growing membership list up to date. Could I ask you to help her, by renewing your membership by January 1st each year and sending her the correct amount of money and your correct name and address.

If you change your name during the course of the year, could you remember to let her know in order to bring the computer records up to date.

My thanks to all members of the committee, who faithfully support all the meetings, workshops and make up our range of subcommittees. I am always grateful for their support and the amount of voluntary work that goes into managing the largest of the C.I.G.s.

These days, with the new legislation, everybody is very stretched in the amount of work to be done in our own hospitals and departments and I know that being part of the National Committee increases the commitment by a considerable amount. However, there is never any difficulty in finding members who would be willing to form a subcommittee and take on an even greater work load.

As many of you know, a small group have recently returned from the first ever paediatric physiotherapy visit to Russia. This was an exciting venture, or maybe I use the word adventure, as there were many difficulties we encountered on the way. Nevertheless it proved to be a fascinating insight into another culture and we have forged links with several people interested in paediatrics whilst there. Many of us would like to return to continue where we left off on our final visit, which was the long awaited visit to a cerebral palsy unit.

Finally I would like to thank all of you for your love, fellowship and support during my term of office as your chairman.

It has been a great privilege to hold this office and I can only say thank you.

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• The European Academy of Childhood Disability will hold its second meeting in Durham in September. this is an opportunity to meet with many disciplines from all over Europe and to greatly enhance our knowledge and understanding of current issues.

To see if any places remain, contact Olivia Plunkett, Administrative Secretary, Medical Education and Information Unit, The Wolfson Centre, Meckenburgh Square, London WC1N 2AP. Tel: 071 - 833 - 2017.

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## TREASURER'S REPORT - APRIL 1990

Jill Brownson

The Treasurer referred members to the Balance sheet which is a Consolidated Account of all the Regional Accounts, the Publications Account, the 1989 Conference Account and the National Account.

The top Left-hand section of the Accounts looks at Income and shows an overall increase of £15,331 being £47,312 as opposed to £31,981 in the previous year.

The Income from Courses and Conference was increased by £5,548. Book sales were increased by £337, but of course this leaves less in stock and therefore an asset reduced by £172.

Subscriptions were increased by £5,369 - largely of course due to the increase in Membership fee.

Increases in Interest rates means that more Interest is earned on monies held in interest paying accounts - reflected in an increased Interest income of £486.

Shirt sales refers to the Sweatshirts sold on behalf of the 1989 Conference - and represents a profit of £615.

Abbey National shares issue refers to the bonus 100 shares issued to Abbey national account holders at the flotation of the Building Society. The Scottish region of the A.P.C.P. hold such an Account and disposed of the shares at a profit of £131.

The National Account is also held in the Abbey National Building Society and 100 shares are held in the name of A.P.C.P. - they should be listed as an asset but their value of course is variable - currently they are worth £190.

The 1989 Conference, hosted by the London Region made a profit of £1,239 (this figure includes the profit made from the sale of sweatshirts already mentioned).

The Expenses shown in the top Right-hand section are similarly increased.

The increase of £5,881 paid out as Lecture fees and Accommodation slightly outweighs the increase in revenue from Courses. Newsletters cost £500 more to produce last year.

Committee Expenses were increased by only £147 (this refers to Regional and National Committees), Administration costs were increased by £2,290.

Administration costs relate to both Regional and National Committees but the increase is specifically related to increased National costs. Postage costs, in particular, rose by £400. - Members will have noticed that they receive their Membership cards upon renewal far more quickly now - because they are sent out individually rather than being given to the Regional reps. for distribution with the Newsletters.

£300 more was spent on Printing and Stationary - this includes Headed notepaper, Photo-copies of Minutes etc.

There were further costs involved in transferring Membership details to a different

Computer, and in order to maintain a more Professional approach in dealing with the membership we now pay the Membership Secretary for hours worked on behalf of the Association.

Other increased costs were incurred by holding a workshop for National Committee members and Regional Reps. in October.

In 1989 the Regions spent £762 more than in 1988.

The National Committee spent more on Travel expenses for 1989 - more sub-committee meetings were held (for example Good Practice Guidelines committee), similarly postage, stationary and telephone expenses were higher.

However there was a surplus of Income over Expenditure for 1989 of £4,474.

This surplus is taken to the bottom Right-hand section where it is added to the Balance brought forward from the previous year and a creditors figure to make a total asset of £25,047 as compared to £20,639 in the previous year.

This asset figure is analysed in the bottom Left-hand section. Of the total cash asset of £21,186, the National Account held £12,688 the remainder being held in the Regions and Publications Account in the previous year £11,368 was held in the National Account and £6,642 in the Regions.

Thus at 1st December 1989, despite an increased revenue from the increase in subscription rates of £5,369, the National account held an excess of only £1,320 over the previous year. The Regions collectively held £2,057 more than in the previous year.

Already this year it has cost an extra £2,000 to print and distribute the Good Practice Guidelines to all members, and it is right of course that Capital should be used to fund projects such as this.

The Treasurer recommended that the membership fee be raised to take effect from January 1991, rather than waiting another year by which time the Association might be running at a loss and a greater increase would be necessary.

Now that more money is held in the Regions, members have more say over how their profit from Study days etc. is spent. The running of the Association is achieved solely by the Membership fee and the Conference Profit with much less reliance on the latter.

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# POST REGISTRATION EDUCATION REPORT

## SUB-COMMITTEE

Mrs. Mary Clegg

This has been a year of consolidation and planning for the Post Registration Education Committee. The membership - S. Holt, V. Williams, J. French and myself felt the need to establish our existence with the drawing up of a constitutional framework, which has duly been approved by the National Committee.

During the year there have been three meetings with the fourth due this month.

In October, Sandra and I attended the third Annual Standing Conference of Post-Registration Tutors, Clinical Supervisors and External Assessors at the C.S.P., when we were introduced to new members of staff within the Societies' Education Departments, including Alan Walker, Director of Education. The purpose of this Conference is to exchange information and ideas on how Post Registration Education should develop.

Eileen Thornton - Chairman, outlined developments relating to the master Plan which has included the setting up of a working party whose remit is to devise ideas for making the plan work.

She said that after much discussion four stages of education had been identified by the Education Committee -

1. Pre Registration.
2. Post qualification and in service experience.
3. Courses.
4. Research.

She then urged us to look at wider developments in education and stated that validated courses should be linked to academic institutions, thus having joint validation by the profession and the institutions.

Your own Committee has three main topics under discussion at the present time.

We are aware of the need to have a National Profile of Services. There are several reasons for this including the determining of staffing levels and grading to help answer the many questions arising regarding the availability of Paediatric Physiotherapists. It will also provide us with information on what each region has to offer, regarding post qualification experience and perhaps the development of Training Exchange Schemes.

This is a huge task and will, I fear, involve another questionnaire. I hope you will appreciate the value of this and co-operate with us, as you always have done in the past, when we put it into action.

Requests are beginning to come to the A.P.C.P. for help with research projects. We need to develop some guidelines from which to work, as to whether we give approval or sponsorship to such projects. This is a complicated issue and Jenny French is forming a working party to look into this.

We have updated the Course Validation Document. This has gone up for re-validation and approval at the April meeting of the Education Committee of the C.S.P.

Alterations have included an extended time scale with more contact hours. The plan is to run the course again with a dual venue in London and Wolverhampton late in this year going into 1991. Early in March, I had a meeting with the Head of Department of Health Sciences at Birmingham Polytechnic to discuss the possibility of the Polytechnic validating the course as a C.A.T.S. Unit. They are very interested, as it has long been the ambition of the Department and Faculty to expand the range of courses open to the Health Care Profession. A course development group involving ourselves, the C.S.P. and the Polytechnic should be set up during this summer, with the strong possibility that the course will have conjoint academic validation by the autumn and the first intake after Easter 1991. Another first for the A.P.C.P.

If this occurs then we will, of course, re-think any proposed plans for a re-run along the present lines this coming winter.

My thanks to Post Registration Education Committee, to Pam Eckersley for external advice, the National Committee and the continuing support from the C.S.P.

The following letter comes from the C.S.P. in response to a recent meeting there between Mary and the Post-Registration Officer. Please read it carefully - these are important issues regarding our future progress as a profession.

**Letter from Mrs. J. Carey, Post-Registration Officer at the C.S.P.**

2nd May, 1990.

"We are delighted that your negotiations with Birmingham Polytechnic are progressing. This is exactly the kind of development we hope will happen with all post-registration courses which include an evaluation of practice since, unlike the CSP, such higher education institutions are able to offer the necessary academic awards, either at first degree, post-graduate diploma or Masters degree level, and also the necessary resources and facilities for teaching and study at this higher level.

As we explained, the Society is not in a position to give academic credit to courses at this level, i.e. CATS Level III and above, independently, but would wish to be involved in the institution's validation process by sending a representative from its Post-Registration Accreditation Panel to take part in the institution's internal validation of the course once it was prepared, thus ensuring its professional as well as academic validation.

As we also explained, the Society is no longer validating any post-registration courses. This is not a reflection of the Society's opinion of the course but is due to the fact that the Society is instituting a new system of accreditation and recognition as outlined to you. We are therefore in the process of discussing with individual course teams how they wish their course(s) in the future. Some will naturally fit into the Society's new system of accreditation whilst others will wish to seek links with higher education institutions for their courses, as you have done. However, we do not envisage that these courses will be taken on without some changes, in particular the elements of evaluation of practice. As discussed with you, we do not feel the current title of your course truly reflects its content and would therefore advise you to decide which elements of it could be developed as introductory modules in centres of excellence around the country and which elements could be developed using more evaluative methods of learning and assessment.

If you would like further advice from us as you plan the new course with the polytechnic, please do not hesitate to get in touch. It is certainly an exciting development.

# PUBLIC RELATIONS REPORT

Caroline Dunn

The last report was written before the Annual Conference at Loughborough University. I would like to offer words of appreciation and many thanks, on behalf of the Regional Representatives and myself, to the Loughborough Committee for all their hard work and hospitality. The atmosphere remained friendly throughout, both during the business and leisure pursuits.

Members are encouraged to continue to communicate with APCP either through their Regional Representative, or directly, matters of interest, both good and difficult. Many developments in Services are taking place, with Department Manuals being written leading to service contracts. Health Service Trusts are being set up. Much of this is in the hands of management, but it would be interesting and useful to hear from around the regions to what extent members are involved in these matters.

For information: the remaining stocks of APCP booklets (there are no plans for reprinting these) are held by:

Mrs. C. Foster, MCSP, Supt. Physiotherapist, Children's Hospital, Ladywood Middleway, Ladywood, Birmingham.

'Guidelines for Good Practice' are available from Mrs. J. Lamond, 22 Whernside Road, Cross Hill, Lancaster LA1 2TA, price £1 plus p.&p.

'Physiotherapy in Paediatrics', a publicity leaflet, is available from Mrs. C. Dunn, and from Regional Reps.

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## APOLOGIES

We regret the printing error in the May issue of the Newsletter regarding Multiple Incremental Lengthening (page 10).

Under the 'Outcome' series the only child to change category from Non-functional to walker, R.G., was credited with the paragraph that should have been under N.D. i.e. 'Ambulant around the house on Carter's city elbow support trolley' etc.



## ABSTRACTS

### Report from Hong Kong on the six week International Course at the Peto Andreas State Institute for Conductive Education of the Motor Disabled and Conductors College, Budapest.

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In 1987 a group of professionals from Hong Kong including Occupational Therapists, Physiotherapists, Teachers, a lecturer and a nurse attended a six week course at the Peto Institute in Budapest.

They have produced a comprehensive report of all they saw and learnt combined with their personal assessments of Conductive Education, and its potential for use within their own rehabilitation service.

Included in the report is a compilation of notes taken from lectures by Dr.Hari, plus the handouts from the course, which provide some useful theoretical background to Conductive Education.

The most detailed section of the report contains information about every department within the Institute including a) a general description, background information, composition and aims of the group; b) a detailed description of the group at work, including timetables, programmes and room plans; c) comments and assessments on all aspect of the groups that were observed.

How much experience of Conductive Education each member of the team had was unclear from the report. However, it is clear that they were all impressed by the way the groups were organized, the way the Conductors divided the work so that the programmes ran effectively and smoothly, and how they motivated and kept the interest of the children, although they felt unable to comment or evaluate the educational objectives as they were there for such a short period of time.

At the end of six weeks each delegate in his assessment reflected the debate which has continued since Conductive Education was introduced into this country more than two decades ago:

Should Conductive Education be introduced into our established system? . . . . . How can we adapt it to improve our own existing system?

This is an interesting and informative document which I would recommend to all those wanting to learn about Conductive Education and how it fits into the Welfare, Health and Educational system in Hungary.

(Copies available from Mrs. Anita Tatlow, 3 Felix Villas, 61 Mount Davis Road, Hong Kong. Cost approx. \$50 H.K.)

Margaret Adams, MCSP, Ridge Hill Stowbridge, W. Midlands.

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**Title:** Back Pain In Children

**Author:** P. G. Turner FRCS. J. H. Green McNorth, C.S.B. Galasko, MSc, ChM, FRCS. Royal Manchester Childrens Hospital, England.

**Source:** Spine Vol. 14 No. 8 1989

Two school based studies have shown that backache is very common in childhood and adolescence, yet the vast majority do not seek specialist medical advice. Those cases seen within the orthopaedic clinic are few but are considered highly significant with serious underlying pathology, diagnosis often being difficult and delayed.

This study was carried out to detect the incidence of back pain in such clinics, the cause of the presenting symptoms the clinical findings and the most efficient investigations.

61 cases of children with back pain were seen in the years 1978 - 1984 - less than 2% in the child - adolescent age range, 30% of these being 14-15 years of age. 50% had serious spinal diseases, the two most common being Schevermann's disease and spondylosis.

The most useful investigation was radiography of the spine, along with simple hematological tests. In cases of non specific physical signs, myelography was an effective diagnostic aid but was expensive and unpleasant. Scintigraphy was found to be as useful and more acceptable.

In the absence of neurological signs and when the spine was mobile, a 'wait and see' policy was justified, accompanied with symptomatic treatment by physiotherapy analgesics and perhaps a simple spine orthosis.

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**Title:** Surgery of Children with Juvenile Chronic Arthritis

**Author:** C. J. McCullough M.A. FRCS, Northwick Park Hospital, Middlesex.

**Source:** Current Orthopaedics (1990) 4 - 121 - 124

The article summarises surgical intervention in cases of Juvenile Chronic Arthritis under the age of 16 years. The author feels these children should come under the umbrella of a paediatric rheumatology service which should include a paediatric orthopaedic surgeon - with this combined approach the previous picture of children with severe deformities fixed to a wheelchair should be a thing of the past.

Surgical pathology is outlined and some of the difficulties of anaesthesia described.

The most usual surgical procedures are then summarised for each joint, mainly concentrating on the lower limb.

The hips are considered the most important joint as far as surgical intervention is concerned - the more common procedures being soft tissue release and total hip replacement.

In the knee soft tissue release, epiphyseal stapling, supracondylar osteotomy and occasionally total knee replacement are the most usual procedures but all these can lead to post operative complications.

The foot and ankle joint problems are mostly corrected by triple fusion or dorsal wedge osteotomies - many problems are helped by intro-articular injections of a short acting steroid.

In the upper limb, surgical procedures are much less frequently indicated - the use of intra articular steroid injections and suitable splinting is more commonly advocated.

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- Title:** The Gross Motor Function Measure - a means to evaluate the effects of physical therapy.
- Author:** Dianne J. Russel, Peter L. Rosenbaum, David T. Cadman, Carolyn Gowland, Susan Hardy, Sheila Jarvis. Hamilton, Ontario.
- Source:** Developmental Medicine and Child Neurology 1989  
Vol. 31 pp 341 = 352

Methodological approaches to the evaluation of changes in function in children with Cerebral Palsy are now attracting attention compared to those studies which compare changes between groups of similar cases.

The paper describes a study designed to develop and validate an evaluative measure of motor function to see its accuracy to the changes in gross motor function in children with Cerebral palsy.

111 children with C.P., 25 with head injury and 34 non disabled pre school children were evaluated on two occasions, the second evaluation taking place after an interval of 4-6 months. Parents and therapists independently scored the children's activities within two weeks of each assessment and a couple of these were 'video-taped' for evaluation.

85 activities were selected based on literature review and the clinical experience of those taking part in the trial. (paediatricians/experienced therapists). Most activities could be accomplished by normal five year olds. The activities were categorised in sub headings, i.e. those performed in supine, prone four point kneeling, sitting, kneeling, standing, walking and climbing. Each activity was scored on a four point scale, based on independence.

Hypothesis on the validity of the responsiveness to this scoring are discussed at length throughout the article.

Correlations between scores, and the judgements concerning the alteration in function by parents and therapists over a period supported the hypothesis that this type of gross motor function measure would show both positive and negative changes and could be a useful factor in measuring the effectiveness of physical therapy.

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## LETTERS TO THE EDITOR

Dear Colleagues,

I have recently been referred a seven week old baby girl with 'Cri du Chat' syndrome. I have only managed to obtain scanty information on this syndrome and would be keen to hear from other therapists who have treated children with this condition.

Sincerely,

Finola Beattie, BSc, MCSP SRP

The Royal Belfast Hospital for Sick children, Belfast BT12 6BE

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Dear Editor,

I should like to comment on the articles published in the May Newsletter entitled 'Rushin' Round the U.S.S.R.' and say how much I enjoyed reading them as my experience has been similar.

Recently I travelled with my husband, who is involved in a joint-venture, to Kiev in the Ukraine. I was fortunate enough to be given a tour here of the Minski District Clinic Hospital for children - No. 1. This is a new, 600 bed children's hospital providing care for all childhood conditions and admitting patients since November 1989. It serves a population of 300,000 in the district, 75,000 children.

I was met at the main entrance by the hospital administrator and the Chief Doctor, Dr. Svetlana Yakushava who appeared delighted at the British interest in her hospital. At my request I was immediately shown the physiotherapy department and met a charming young lady in charge who had trained for 7 years to become a 'Doctor of Physiotherapy' and a further 5 months to specialise in paediatrics. The department was organised around a very large rectangular open-plan waiting area; bright and airy with a few paintings on the walls, apparently applied by mothers while waiting. Numerous treatment rooms led off this area.

I too found electrotherapy very much in evidence, including nasal U.V.R. probes, ultrasound self-administered to the neck, faradism to the affected limbs of a hemiplegic 8 year old boy. Electrotherapy is also used for stomach, kidney, throat and gland conditions. In another room I was shown a row of steam inhalation machines for chest conditions; a baby being massaged in another; hot packs in another. The hydrotherapy department consisted of a large pool for children, a smaller, shallower one for babies and another room housed a row of individual baths, where one child was immersed in oxygenated water. The large gym was not complete - 2 wall bars, a few hoops, 1 exercise bike, 2 forms and 2 medium sized soft balls and a treadmill.

Duly gowned, masked and booted I was then escorted to the 'Department of Pathology of the Newborn'. All the babies were lying in oval cream coloured plastic cots, head end elevated. There were some incubators, but I was told no baby was ill enough to need one. The Nursing Sister was very proud of all their equipment - mainly from Hungary and Switzerland with a resuscitation pack from France. The digital electronic weighing scales were especially demonstrated for my approval!

When I asked about the babies' diagnoses the reply was often 'Encephalopathy' or 'infection'. Working through an interpreter is not easy, although I was told that one baby had sustained brain damage through a forceps delivery. I was not too sure about another having an infusion through an I.V. Catheter. 'Medicine' I was told, not antibiotics, not plasma - but green! The lowest weight baby I was shown weighed 2.3 Kgs. All the babies were swaddled. All children spend alot longer in hospital than in the U.K. Antibiotics are not used much, if at all, while herbal remedies are.

I thoroughly enjoyed my visit and over coffee and liqueurs, having been joined by a neurologist, we exchanged views. I was bombarded with questions about the paediatric physiotherapist's role in the U.K. and the concept of home visits using my own car caused much amazement. In the U.S.S.R. women do not drive cars! I too found it difficult to justify my existence in common with one author in your May newsletter! Bobath brought a glimmer of recognition, Conductive Education/Peto none; and the fact that I had not used mustard plasters caused great hilarity.

Finally, with very good wishes to all our 'Doctors' in the U.K. I was duly escorted to my car, Dr. Yakushava waving enthusiastically from the hospital steps as we drove away.

Mrs. Delia Curry, B.A. Grad Dip. Phys. MCSP., P.T. Community Physiotherapist, St. Mary's Hospital, Portsmouth. P. T. Private Practitioner.

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## COURSES

**Title:** **Stimulating the Multiply Handicapped Child.**

**Venue:** Bleasdale House School

**Date:** Saturday 12th October 1990

**Course Organisers:** APCP N. West Region

Further information and Application form from Mrs. E. Walters, Pineleigh, Silverdale Rd., Arnsdale, Via Carnforth, Lancashire LA5 9EH. Tel: 0524 761720.

**Title:** **Prevention and Intervention in Orthopaedic Management of Cerebral palsy**

**Date:** 20th October 1990

**Time:** 10.00 - 4.00 (9.30 registration)

**Venue:** Postgraduate Centre, Morrision Hospital, Swansea.

**Speakers:** Mr. P. Wutheroe, FRCS, Bristol Children's Hospital  
Mrs. J. Pyman, Supt., Physiotherapist, Bristol Hosp. for Sick Children.

**Cost:** £5.00 APCP Members, £6.00 non Members.

Coffee provided. Lunch can be purchased in hospital canteen.

**Applications to:** Mrs. J. Harvey, 20 Pen-yr-Heol, Skewen, Neath, W. Glamorgan.  
Further details can be provided on request.

### APCP SOUTH EAST REGION:

**Title:** **The Management of Spina Bifida**

**Date:** Saturday 17th November, 1990.

**Time:** 9.00 - 4.00 Registration 9.00 a.m.

**Venue:** Queen Mary's Hospital for Children, Carshalton, Surrey.

**Fees:** £12 APCP Members, £15 non-members.

Includes coffee, lunch and tea.

The study day is designed to give an overall view of the general management of spina bifida, including surgical treatment, associated problems of hydrocephalus and orthotics.

Fees to be sent with application cheques made payable to 'A.P.C.P.' to: Ms. Ginny Wisbey, MCSP, Physiotherapy Dept., Queen Mary's Hospital for Children, Carshalton, Surrey SM5 4NR. (Tel: 081 643 3300 Extn. 343).

## CASTLE PRIORY COLLEGE

For more details, contact Castle Priory College, Wallingford, Oxfordshire, OX10 0HE.  
(Tel: 1491 37551/26350).

**The Hand as a guide to learning** 26/102  
14th - 16th September  
£169 Tutor - Ester Cotton

**The Sherborne Movement Method** 26/114  
29th September  
£39

**Basic Counselling Skills** 26/125  
9th - 12th October  
£199

**Halliwick Swimming Method** 26/134  
22nd - 23rd October  
£95

**Perception - a hidden handicap?** 26/148  
7th - 9th November 1990  
£165

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See Regional Reports for some other courses - contact regional reps. for details.

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*A.P.C.P. Publicity Board on display at Conference*





# INTERNATIONAL PAEDIATRIC PHYSIOTHERAPY CONFERENCE



CARDIFF

# 1991

AUG. 2nd - 4th

<b>Friday Afternoon</b>		<b>August 2nd</b>
JOINT SESSION		
Genetics Neo - Natology		
<b>Saturday All Day</b>		<b>August 3rd</b>
A.P.C.P.	A.C.P.R.C.	
Paediatric Muscle Conditions Handling the Floppy Baby Living with Muscular Dystrophy - The Practical Aspects Muscular Dystrophy - - - Now	Cystic Fibrosis Paediatric Asthma  The Neo-Natal Chest Paediatric Cardo - Thoracics -	
<b>Sunday Morning</b>		<b>August 4th</b>
JOINT SESSION		
<p>"Exploring the Wider Issues"</p> <p>Leading into Discussion Workshops . . . . . Topics to include:</p> <p>'Taking Home Your Special Baby'</p> <p>'Adolescents Facing The Future'</p> <p>'The Unexpected Handicap . . . . Helping Parents'</p>		

*Full social programme available for delegates, their families and friends.*

For application forms and full programme please contact:

Lyn Horrocks  
Childrens Centre,  
University Hospital of Wales  
Cardiff. CF4 4XW.  
Tel: 0222/755944 Ext. 3585



## HERE AND THERE

- **Developmental Movement for Children**

Cambridge University Press

by Veronica Sherborne

This book shows how developmental movement can contribute to the well being of children with learning difficulties, profound disabilities and children who are emotionally and behaviorally disturbed. It covers how to set about a planned programme of activities, tailored to the needs of specific groups.

ISBN 0 521 37006 X Hard Covers £12.95 net.

ISBN 0 521 37903 2 Paperback £6.95 net

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- **Developmental Medicine and Child Neurology** is now available monthly.

\* \* \* \* \*

- **'Which?'** the consumer magazine, in its May 1990 issue, takes a close look at pushchairs.

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- **WELCOME TO WRITE AWAY - THE ONLY PENFRIEND CLUB FOR YOUNG PEOPLE WITH SPECIAL NEEDS**

Write Away is a registered charity which has recently been developed by two people with a wide range of experience with children with special needs. Nicolle is a teacher of children with special needs, Hilary is a music therapist.

Write Away is a penfriend club for young people with special needs, and since we recognise that their siblings have their own special needs, Write Away has also been set up with them very much in mind.

One of the greatest problems for young people with special needs is the sense of isolation they can feel. The opportunity to make friends through sending drawings or writing letters encourages communication in a natural and exciting way.

**DAVID BLUNKETT, MP, Write Away patron, writes:**

"For young people with a learning difficulty or with a disability, isolation and being cut off from the community and the society around them can be a very real problem. One contribution to helping people build confidence, social skills and friendship can be through the development of a penfriend."

Young people are encouraged to correspond with their peers using their OWN CHOSEN MEANS OF COMMUNICATION: conventional pen and paper, braille or electronic communicators.

For those who find written information difficult, audio cassettes will be provided. In addition, if members prefer drawing a picture, then this too would be welcomed.

To join, children (and adult helpers) fill in a registration form. Upon receipt of a token £1 membership fee, penfriends are matched according to the criteria stated on the form, and are sent their new penfriend's name in a lovely Write Away folder which contains a pen, paper and envelopes.

In addition, the first 500 children who register with us will be given a £2 book of "smile" stamps!

Write Away is presently open to all young people with special needs and their brothers and sisters in London and the South East, and will be expanding to include the whole of the U.K. from January 1991.

Future plans are regular newsletters and special Write Away events at which members will have the opportunity to get together and further develop relationships.

For more information and registration forms, please contact

Nicolle Levine or Hilary Wainer:  
Write Away  
PO Box 175  
New Ash Green  
Dartford  
Kent DA3 8PQ  
Phone: 081 - 452 - 3330

## • THE SPECIAL NEEDS COMPANY

We would like to draw all paediatric physiotherapists' attention to the emergence of our new company - SNC/Playring Ltd.

I am a Speech Therapist and having worked for nine years cobbling together toys and specialized equipment for use during therapy, I finally decided to return to college to learn about design. Consequently this company has been set up with the aim to produce toys and equipment with a bias towards special needs but producing results which ALL children want to play with. The Playring system received the medic Design Award in 1989 and has been well received by many physiotherapists. It crosses well the barrier of special needs versus 'normal'. It is a play environment which offers postural support while encouraging exploration with its many holes, squeakes, pockets, beads etc. There are several different shapes which can be interchanged.

If you would like to receive our free brochure, please ring 071 794 9497 or write to:  
Playring Ltd/SNC, 53 Westbere Road, West Hampstead, London NW2 3SP.

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## REGIONAL REPORTS

### N. WEST

**Reg. Rep. Miss L. Wakely, 2 Ash Bank, Pipers Ash, Chester CH3 7EH.**

On behalf of APCP NW, in May the Staff at Alder Hey Hospital organised an exceptionally good 'Study Day' entitled 'Update on Cystic Fibrosis'.

Our next venture is a three day course on Sensory Intergration, 5 - 8th July, in Chester.

The final Study Day of 1990 will be at Bleasdale School, Arnside, Lancashire entitled 'Stimulating the Multiple Handicapped Child'.

Plans are well advanced for next year's AGM in March when David Scrutton has kindly accepted our invitation to come and talk to the members on 'Hips'.

### W. MIDLANDS

**Reg. Rep. Carol Forster, Supt. Physiotherapist, The Children's Hospital, Ladywood Middleway, Ladywood, Birmingham B16 8ET.**

The new committee have been busy drawing up a programme of events for the coming year, so far three study days have been organised:

1. 13th October, 1990 - Birmingham University Dept. of Psychology - Jane Riddoch on 'Single Case Study Research Methodology' - the final programme will be circulated to all members.

2. January 1991 - Respiratory Day Course to be held at Solihull Hospital - further details to follow.

3. 'Down's Day' - venue to be confirmed later. This is the second attempt to present this day, the first being cancelled due to lack of support!

4. A surprise event in May - watch this space!

The rest of the region is, I presume, quiet. Is anything of interest going on out there? Do you have any areas of concern? Do you have anything of which the National Committee should be made aware? Please let me know.

### SCOTLAND

**Reg. Rep. Miss A. Harden, Physiotherapy Dept., Royal Hospital for Sick Children, Yorkhill, Glasgow G3 8SJ.**

Following the great amount of interest shown by Scottish members, the full eight week Bobath Course will be held in Scotland in 1993. The Committee will be holding meetings to discuss time of year, venue, etc.

The next Study Day will be held in October, the topic being Cystic Fibrosis. The day will cover latest trends in research and treatment of Cystic Fibrosis with lectures including physiotherapy, genetics, bacteriology and heart-lung transplants.

We look forward to meeting many of you again. Please keep us informed as to topics you would like to Study Days.

## S. WEST

**Reg. Rep. Mrs. Carole Hurran, Supt. Physiotherapist, Claremont School, Henleaze Park, Bristol BS9.**

We had a successful study day in Bristol in May on Conductive Education attended by about 80 people, including many teachers, nursery nurses as well as therapists. Our A.G.M. was held during the day, attended by 26 members.

Gill Riley stood down as Regional Representative after several years of hard work whipping the committee into shape, producing those regional newsletters and keeping everyone up to date with what is going on nationally in ACP. Our grateful thanks to Gill who will be staying on the committee to help keep the momentum going!

I will be the new regional rep. (no other nominations being received), but Gills' is a hard act to follow. I work in Southmead Health District with responsibility for the Education Physiotherapy Service which is based at Claremont School. I am a member of BABTT and have attended a 6 week international course at the Peto Institute (This combination need not produce schizophrenia!). Judith Lott is our new treasurer and our thanks go to Ann Hyland for all her hard work in this post previously.

Courses planned in the future include Cystic Fibrosis on 10th November at Portsmouth, and Gait Analysis at Poole in the Spring of 1991.

## E. ANGLIA

**Reg. Rep. Mrs. Jackie Reynolds, Physiotherapy Department, James Paget Hosp., Gorleston, Gt. Yarmouth NR31 6LA.**

On June 23rd a study day was held at James Paget Hospital which was attended by 31 people. Speakers included Dr. Peter Weller from Birmingham Childrens' Hospital, Barbara Webber, from Brompton and Joyce Gemmell from Mansfield. The question of change in management was the theme for the day and all the speakers contributed towards a successful day, even if we did have some musical accompaniment from a wedding party next door!

Our next meeting will be on October 11th, at Addenbrookes Hospital, Cambridge when Penny Robinson will talk about Legal Aspects of Paediatric Physiotherapy. This will be at 2.00 p.m. A further study day is planned for next March. Your committee would like to hear from you with ideas for further courses next year.

## LONDON

**Reg. Rep. Karen Burchett, Squirrel's Leap, 6 Willersley Ave., Orpington, Kent BR6 9RS.**

The good news - London Newsletter is back in production, a new A5 format and lots of copy, but more required. Keep it coming. Our famous sweatshirts are now available in red and navy - send s.a.e. for order form to any London Committee members.

The programme planned for the next two years is outlined:-  
15 Sept. 1990 - Research (made simple?), London Hospital  
Nov. 6th & 7th - Perception, Pat Kennedy, O.T. at G.O.S.  
The bad news is that 'Counselling for Paediatric Physiotherapists' on  
June 23rd had to be cancelled due to lack of support. We hope the rest  
of the programme fares better, or we will begin to feel London Region  
is grinding to a halt.

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## RECENT NEWS!

At the National Committee Meeting on 17th July, Viv Williams was elected as Vice  
Chairman. Congratulations Viv - sorry you are not on page 1 this time, but you will be for  
the November issue!

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The A.P.C.P. usually hold its A.G.M. during National Conference, but, as you know,  
our National Conference in 1991 will take place in August - in Cardiff.

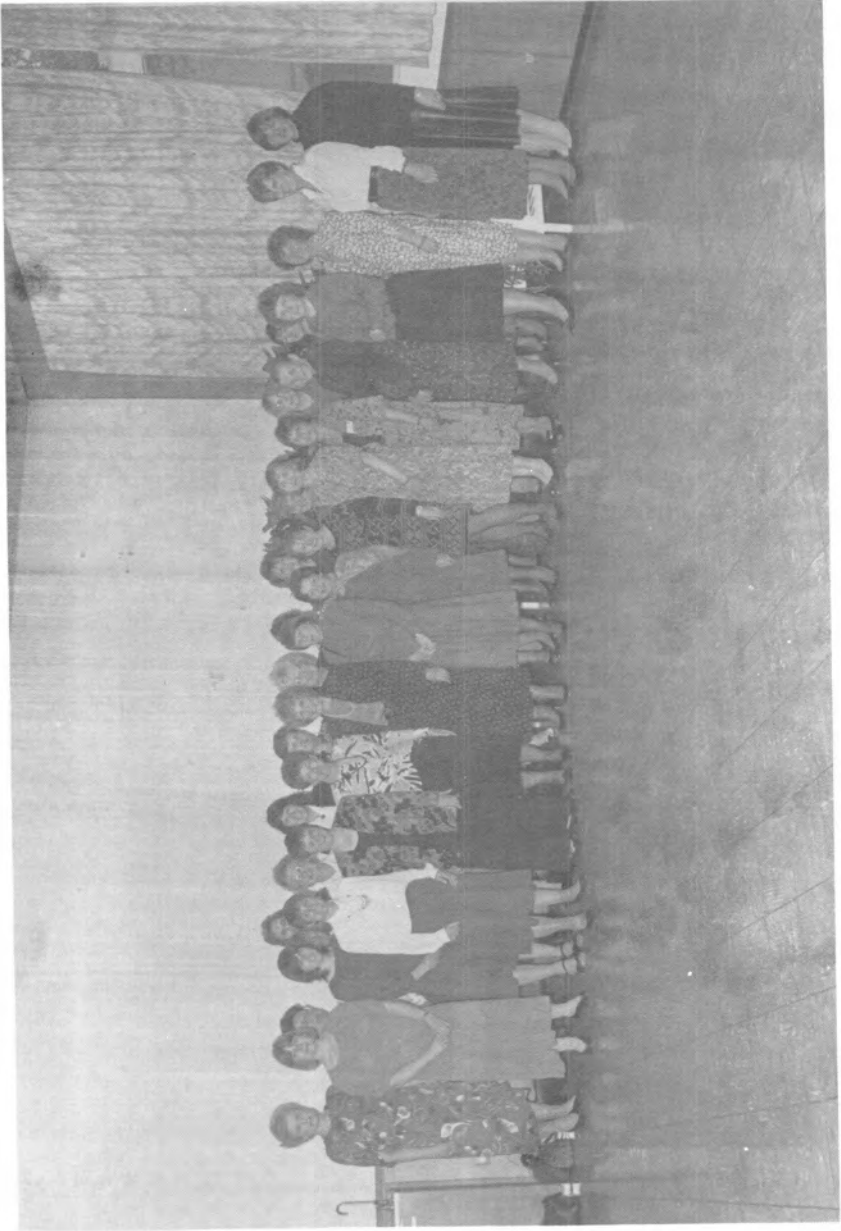
It is a requirement that the Association of Paediatric Chartered Physiotherapists hold  
its Annual General Meeting in April, and so, notice is hereby given that next years' A.G.M.  
will take place in London on Saturday April 13th.

The venue is yet to be finalised, but hopefully it will be at the Chartered Society of  
Physiotherapy.

Plans are being formulated for the day to hold an open forum at which members can ask  
pertinent questions such as 'Where does our membership money go?'

Further details will be found in the Newsletter, but please **BOOK THE DATE NOW.**

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*National Committee with Trent Regional Committee*

