
ASSOCIATION OF

PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS



NEWSLETTER

Association of Paediatric Chartered Physiotherapists

Newsletter No. 58

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EDITORIAL

Jenny McKinlay, Editor

We have started a very different kind of year with a rather different kind of Newsletter. It may not be to everyone's liking as there appears an imbalance of 'management' matters rather than clinical. Rest assured, this is atypical, and we expect to pursue again more fully our clinical interests in May.

The reasoning behind this newsletter is to let readers know that the National Committee attended a rigorous (but enjoyable) workshop weekend in November, where we debated at length such issues as 'Research', 'Outcome Measures', P.A.C.E., Running a Committee, marketing ourselves, and looking closely at our Constitution. On top of that, there was a typical quarterly committee meeting which took some five hours.

With the many changes which are about to be imposed on us as Health Service Providers, we are all keenly aware of the need for prudence in our evaluation of our clinical workloads. We have much to be proud of in developing and producing a quality service and need to be reassured that, even as we experience the wind of change, we remain highly valued members of our profession.

ANNUAL SUBSCRIPTION - £15.00

Send direct to Membership Secretary

Mrs. Jeanne Lamond
22 Whernside Rd., Cross Hill, Lancaster LA1 2TA

If you do not have an application form, write to the membership Sec. with name, address for correspondence, telephone no., place of work, CSP No. and APCP No. if you have one and a cheque made payable to the Association of Paediatric Chartered Physiotherapists.

Copy for the May 1991 Newsletter must be with the Editor by 1st April.

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

We wish to thank W.B. Saunders for granting the APCP permission to publish the following article, taken from 'Seminars in Orthopaedics' Vol.4, No.4 (December) 1989 pp220-228. Our thanks also go to Dr. Ian McKinlay who has written the review in such detail and at such length that we will split it into three parts in our Newsletters of February, May and August. If you cannot wait to see the remaining sections, you can of course approach your libraries to obtain the whole article.

While it may be viewed that the Editor has a biased opinion, it is surely appropriate to welcome this review from one of our Honorary Members who, over many years, has continued to provide support to many paediatric physiotherapists throughout the country. It is known that he would welcome your comments on the review. Dr. McKinlay can be contacted at the Agnew Unit, Royal Manchester Children's Hospital, Pendelbury, Nr. Manchester, M27 1HA

THERAPY FOR CEREBRAL PALSY

Dr. Ian McKinlay F.R.C.P.

A NUMBER of recent studies have shown that good-quality early childhood education can have lasting benefits for later learning and behaviour.^{1,3} Children from disadvantaged backgrounds have been shown to benefit most.⁴ The process enhances self-confidence⁵ and can be cost effective.⁶

There is evidence of early benefit from intervention programmes for children with mental retardation.^{7,8} Preschool intervention has been reviewed by Reader⁹ and Wedell et al,¹⁰ who discuss programmes for children with and without disabilities, as well as expansion of services and the effects of the British 1981 Education Act. Tingey et al¹¹ distinguish between parent support and direct child training; the former has been researched more because measurement is easier. Mitchell et al¹² discuss criteria for evaluating early intervention with a 50-item scale providing ratings on 14 parameters.

EARLY MOTOR PROGRAMMES

In 1973, Hughes¹³ reported infant motor programmes in which physiotherapists taught mothers to "work" with their children from the start, believing that parental management style is established during the first 3 months of a child's life and is hard to change later. Cowan and Brenton¹⁴ discussed early advice given by community health staff such as nursery nurses with special training.

INFANTS WITH CEREBRAL PALSY

So far as cerebral palsy is concerned, the diagnosis cannot be made with confidence in the first few months for most children, and even without treatment many children seem to "outgrow" cerebral palsy.¹⁵ Others show improvements which have more to do with maturation and growth than treatment.¹⁶ Prediction of high risk for cerebral palsies has improved for preterm neonates using ultrasound brain scanning¹⁷ or somatosensory evoked potentials.¹⁸ It would be worth considering trials of early therapy programmes for children whose neonatal neurological status and test results suggest such probability.

PARENTAL ATTACHMENT

These studies should take into account the effects of cerebral palsy on parents' attachment to their children,¹⁹ as well as cognitive and motor outcomes. Attachment patterns at the end of the first year have been shown to be predictive of later emotional and behavioural difficulties.²⁰ Hoare²¹ found no evidence of abnormal attachment between parents and children before the children developed epilepsy, yet a marked increase in dependency and anxiety followed the diagnosis. Similar mechanisms are likely to be at play for some families of children with cerebral palsy, which are to some extent concealed by the extended physical dependency of the children.

Kogan et al²² found that parents of children with cerebral palsy demonstrated less warmth to them than to children without disability. There is a known association between physical abuse and cerebral palsy; Diamond and Jandes²³ considered that about half the instances followed the diagnosis of cerebral palsy. The mechanisms whereby infants with cerebral palsy fail to thrive²⁴⁻²⁷ are not fully understood. However, a striking feature of mealtimes of infants without disability who fail to thrive is that there is a lack of rapport, communication, and organisation.²⁸ When feeding difficulty is the first reason for referral to therapists, the advice given should be more than mechanical, although practical advice is also necessary.^{29,32} The need to avoid splitting off psyche from soma in addressing childhood illness and disability was the main purpose of the authors in Apley and Ounsted's anthology,³³ yet this is widely ignored.

EFFECTIVENESS OF EARLY INTERVENTION

Reviewing early intervention programmes, McConachie³⁴ suggests that frequency of home visits should strike a balance between effectiveness and creating dependence. Sloper et al³⁵ found gains from intensive programmes to be short lived, and recommended that programmes should take account of their capacity to meet parental expectations. Sandow and Clarke³⁶ came to similar conclusions and advocated limited involvement to allow the parent to retain a role as a protagonist rather than a passive recipient of "expert" advice.

Several studies in recent years have shown that the improvements from intervention in early childhood are not sustained in later years, especially school age.³⁷⁻³⁹ The findings suggest that early intervention accelerates the initial learning rate of children with learning difficulties but that these children reach a plateau before those who have not experienced such special help. This is not to say that early intervention should be dismissed. Children's accelerated capacity to do things and to communicate reduces the frustration of early child rearing.⁴⁰ However, if early progress is not sustained it may be discouraging after false hopes have been raised.

EFFECTIVENESS OF THERAPY

The general effects of early intervention are relevant to consideration of therapy programmes because a third of children with cerebral palsies show mental retardation to some degree and a further third show patchy abilities, some of which fall below the normal range. A recent study⁴¹ appeared to show better results from a cognitive stimulation programme (Learninggames^{41a}) for 6 months and physiotherapy or 6 months than from physiotherapy alone for 12 months. This study is open to criticism,⁴² as the infants were not enrolled until they were more than 1 year of age, when the predictive value of developmental quotients is unreliable. As the 48 children with cerebral palsies were heterogenous, the findings could have been an artefact of randomisation or the result of management differences. The earlier

walking and better motor performance of the group who had the stimulation package are challenging findings nonetheless.

Harris⁴³ reviewed the evidence for effectiveness of early developmental therapy and lamented the dearth of well-controlled experimental studies. Sage⁴⁴ expressed similar concern. The difficulties in evaluating therapy are formidable, however comparable with a way of life.⁴⁵ Hinderer et al⁴⁶ have used a case study approach to compare the effects of "tone reducing" and standard splints on gait. This is an appropriate and under-used method for studying individual subjects.

EFFECTIVENESS OF REMEDIAL TEACHING

Remedial activity in general has not been supported by strong research evidence for effectiveness. Reviews concerning remedial teaching⁴⁷⁻⁴⁹ show little evidence for benefit in terms of sustained academic improvement. Yet it is commonly said that children receiving extra help become less anxious about school work and are more relaxed at home. In the follow-up of a cohort of children to the age of 17, Shaffer et al⁵⁰ found that the coexistence of clumsiness and anxiety at 7 years had high predictive value for later psychiatric difficulties compared with controls. However, only a minority of the children at risk went on to have disabling anxiety, depression, or withdrawal, and the authors speculate that schooling experience as well as parenting may have facilitated a good outcome.

DOCTORS' ATTITUDES

In a previous review,⁵¹ reference was made to the double standard many doctors apply to physiotherapy for cerebral palsy. They know that physiotherapy has not been shown to be beneficial,^{52,53} yet they refer children to therapists so that their parents will feel that something is being done. This is partly because many doctors have difficulty in recognising and coping with the processes of parents' grief: shock, denial, anger, and depression before acceptance.⁵⁴ They may prefer to pass on those aspects of the management in an acceptable way by referral for physical treatment. Therapists are often confronted by the emotional and behavioural consequences of the child's disability⁵⁵ within the permission given by the framework of a physical rehabilitation programme. Yet evaluation may be only in terms of joint angle or gait.

MAGICAL TREATMENT

Difficulty in specifying the true purpose of the referral for therapy allows the content of the movement education programme to matter less than the lessening of psychological distress in the family. That lays the way open to magical thinking⁵⁶ and enthusiasm for methods for which no evidence of specific effectiveness exists. If time and trouble involved in the pursuit of such treatment are not excessive, the programme may provide an acceptable framework within which the child can be cared for and managed with confidence. However, present evidence does not justify pursuit of detailed programmes which are bizarre, time consuming, or which require major family upheaval and expense. When families are anxious to sell their homes to go elsewhere for special treatment, to abandon their jobs to supervise a "total learning day" for their child, or to mount campaigns for voluntary societies and public authorities to invest large resources into fashionable programmes, it is time to address the process of grief.

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THE RUNNING OF A COMMITTEE

Mrs. P. Robinson, Director of Professional Affairs for C.S.P.

A. Purpose of the Committee:

- (i) Exchange of information
- (ii) Provide policies for the association
- (iii) Raise profile of the association - both between members, C.S.P. and general public.

B. Objective:

To achieve the purpose in the shortest possible time, as clearly as possible and with input from all members.

C. Members of the Committee:

(I) THE CHAIRMAN

Must be a good communicator, be able to control a group of people and must be the person in charge.

(N.B. Chairman is the correct term.)

Duties

Chairing meetings - including those of the Executive Committee (local or National) sub-committees, A.G.M. and other meetings.

Meetings may be highly structured or more informal but must have clear objectives.

The Chairman represents the Association locally or nationally to members, C.S.P and other bodies e.g. D.H.S.S. and the media in liaison with the P.R.O.

Chairing a Meeting

Check there is a quorum.

Provide an agenda (liaise with Hon. Sec.). May be useful to have a chairman's brief from secretary as well, giving objectives of each item.

Summarise the discussion - necessary for any action to take place and enables the secretary to take clear minutes.

Ensure there is an equal opportunity for each member to speak.

Keep order, or bring meeting to order when necessary.

Don't allow individual questions to be asked out of context - make a note to deal with it later.

Adjourn if necessary. A 5 minute break may be helpful to allow tempers to cool.

Check and approve minutes before distribution.

Types of Meeting:-

1. A.G.M. - Very structured - no A.O.B. (can be discussed at a separate meeting afterwards with items listed.)
2. General meeting with guest speaker. Check guest has all they need and is welcomed properly - allocate someone to look after them. Introductions are easier if the speaker provides a concise, relevant C.V.
3. Extraordinary general meeting - stick only to the item for which the meeting has been called, no A.O.B.
4. Committee meetings - local and national, working parties etc.

The Chairman runs any meeting but can call on the secretary to give names etc. for elections. The Chairman is elected from the committee at a special meeting after the A.G.M.

(II) THE SECRETARY/MINUTES SECRETARY

Characteristics:	good organiser good memory ability to cope with people able to work closely with chairman
Requirements:	secretarial assistance (not everyone can type)

Duties:

General administration, maintain membership lists, relay information, act as communication link, arrange programme if necessary, assist at meetings to ensure smooth running, organise stationery.

At Meetings:

Notice must have been given of the meeting.

Agenda put together with assistance of chairman and circulated 2 weeks prior to meeting.

Produce minutes - send to chairman for checking, correct and distribute 2-4 weeks after meeting. This allows any required action to be taken by individuals.

A.G.M.:

carry out election procedures; give adequate notice and liaise with editor of newsletter.

Nominations - Provide form with names and C.V.s

Elections - decide on ballot or show of hands - organise tellers if necessary. Must note name of proposer and seconder and result of election in the minutes so that it is clear when up for re-election.

(III) TREASURER -

Characteristics: well organised, able to keep up with accounts. Needs to be a 'bully' at times to get people to pay up and avoid any extravagance.

Requirements: Link with membership secretary re. subs., also with book-keeper/accountant for advice on keeping accounts and efficient auditing. Maintain books and prepare accounts.

(IV) COMMITTEE MEMBERS

One month before the meeting check on action required in previous minutes.

Give secretary any written reports in advance to speed up process in meeting. Highlight main points.

2 weeks before meeting receive agenda and read it.

Send apologies if unable to attend, organise alternate and send any papers to her.

Discuss any pertinent items with regional colleagues (part of sharing and passing on of information)

At the meeting: attend on time. Indicate A.O.B. items to chairman and secretary ahead of time if possible. Anyone is entitled to write a paper for a committee meeting.

During the meeting:

1. Speak through the chairman. (put hand up to catch eye)
2. No anecdotes!
3. Keep to subject.
4. Understand requests for action (ask for clarification if necessary)
5. Propose or second action.
6. Understand voting procedure. Consensus round table may be judged acceptance of a proposal by chairman so formal vote not always needed.
7. Concentrate on the meeting.
8. Make notes on action.

Voting procedure:

1. A proposal must be seconded
2. The Proposal is then read out.
3. Anyone unhappy with wording can propose an amendment.
4. First amendment must be seconded and read out.
5. If no further amendments, first amendment is put to the vote.

6. If there is a second or subsequent amendment before voting each must be proposed and seconded. Each previous amendment 'falls away' if the new amendment is put to the vote and passed.

N.B. There should not be more than one proposal to vote on at once. Separate debates are necessary for each proposal. A flip chart is helpful re. wording.

Amendments must be minor alterations to wording only.

After the meeting:

Receive minutes, check - inform secretary if inaccuracies.

Check action. Report results. Report locally.

Start writing the report for the next meeting.

THE AGENDA

Useful to put number of meeting that year at top right hand corner, plus date.

e.g. A.P.C.P. (90) 1st Meeting 10.02.90

Any relevant papers attached should be given a figure by the agenda item on right hand side.

e.g. A.P.C.P.(90) 4.

This makes it easier to find information later.

Any agenda item must have reports sent 1 month before meeting to secretary.

Minutes can be more concise as reports are referred to by fig. nos.

e.g. P.R.O. report A.P.C.P.(91)3

THE MINUTES

For each item main points of discussion to be noted. Note various points raised (no names necessary), summary and decision.

Note action in action column on right + name of 'who to do.'

Minutes can be mixed style - tabulated or discursive.

Penny wound up her very useful and interesting talk by saying that it would not be necessary to be quite so formal in committee meetings at regional level!

* * * * *

MARKETING OURSELVES/IMPROVING OUR IMAGE

This was a very dynamic and thought provoking session by Claire Jackman who is marketing manager at the AMI Portland Hospital for women and children. It was not a matter of 'sitting back and listening' but rather 'getting up and doing!'

The definition of marketing (according to the Institute of Marketing) is that it is a management process responsible for identifying, anticipating and satisfying requirements profitably.

Whilst the language of marketing may sound alien to many physiotherapists the above definition seems to link in closely with the current and on-going changes in the N.H.S.

For this reason the session aimed to get us thinking about the need for and ways of marketing or promoting the APCP both at an individual level and as a national association.

Before we could do this we needed to establish:-

- i) Who are our customers?
- ii) What are our customers requirements?
- iii) What is our (APCP) current image?
- iv) What would we like our image to be?
and finally ..
- v) How can we project our chosen image?
 - i) **Our Customers:** Amongst others include current and potential APCP members; CSP; health professionals including medical staff; parents and children; the general public.
 - ii) **Customer Requirements:** On this point assumptions should never be made. Customers need to be asked about their requirements by face to face contact, questionnaires etc. Once the information has been collected, what next? If we are not giving the customers what they want how can we satisfy their requirements e.g. altering working hours, making home visits.
 - iii) **Current Image of the APCP?** Has a reputation for professional good practise: a core of expertise; post registration training opportunities; within our profession the largest and leading special interest group. However, the Association is little known outside the profession and may be seen as a 'closed shop' by some.
 - iv) **Image for the Future?** One representing a professional, caring, information-sharing association which promotes a quality service in the field of paediatric physiotherapy and provides a range of post registration education opportunities. That the APCP should be a voice that is known to be the authority on paediatric physiotherapy both officially and therapeutically.

And ...

- v) **Projecting our Chosen Image:** Different avenues are open for this purpose, each offering different advantages and disadvantages. These include advertising (very

expensive), personal selling, sales promotion (e.g. free gifts - not very appropriate!), public relations (e.g. press releases, editorials, etc.), seminars and open days.

Of these the most appropriate seemed to be:-

Personal Selling - This a cheap form of image projection by face to face contact with customers but can be time consuming.

Public Relations - This is another cheap way of projecting our image and the public gives a high level of credibility to newspaper/magazine articles, for example. The disadvantage is that the individual or Association may not have ultimate control over what is contained in written articles, broadcasts etc.

Courses/training:- A good way of promoting the APCP image. Perhaps some time allocation for this should be arranged with employers. Other suggestions included strengthening APCP links with other professional and voluntary bodies; improving resources and information, and having a 'sales drive' to increase membership. It was felt that where there was a mutual interest in promoting the Association that the CSP should agree to share the costs incurred.

The session on marketing stimulated a great deal of interest within the group and it was proposed that a sub committee should be formed to look into "Raising the profile of the APCP". With her obvious depth of knowledge in this field, Claire Jackson kindly agreed to participate in such a committee. It is planned that this proposal will be further discussed at the National Committee Meeting in January, 1991.

Jenny Gill
26.11.90

* * * * *

THE WHITE ROOM -, MAES-Y-COED SCHOOL, BARRY, S. GLAMORGAN.

PENNINE AYRES - SENIOR PHYSIOTHERAPIST

Maes-Y-Coed is a school for children with severe learning difficulties, many of whom have additional handicaps affecting all the senses. A dark room was being established in the school when a reference was found to equipment suitable for use in a white room or white tower. The philosophy of a white room is a total multi-sensory approach based on the Philosophy of the Hartenburg Institute in Holland, the origins of which go back to 1975.

At this time targets for T.V.E.I. (Technical, Vocational Educational Initiative) were required to be identified. This funding is for projects run for and by children aged 11-19 years both in mainstreams and special schools.

With the knowledge that funding would be available from T.V.E.I., together with a donation from Children in Need and donations of materials and equipment from local firms, it was decided that the establishment of a White Room was to be a priority. Two members of the teaching staff were made particularly responsible and information was gathered and shared by all staff and therapists; a visit was made to St. Mary's Hospital, Carlshalton to see an already established room.

The room was then constructed utilizing space 5m x 2m in the corridor (room had then to be found for the wheelchairs!!). The building and electrical work were carried out by two School Governors and several members of the local community.

The room is completely padded, including the floor and covered with white vinyl with similarly covered wedges. It includes a water column with ascending bubbles which change colour, a mirror ball reflecting light around the walls, projectors which make gently swirling patterns on the walls and fibre optics which also change colour. Soft music is played through the session which normally lasts about 20 minutes. We also have a variety of switches by which the children can themselves control what happens, and are recently in receipt of a pressure pad switch which reacts to any slight movement of head or limbs.

This is a new project opened in October 1990 and careful note is being made of all the children's responses with continual monitoring and evaluation. There is close liaison with all other professions, physiotherapists, occupational therapists, speech therapists and ophthalmic specialists, checking vision. We also have a technician for day to day running of the equipment.

Although these are early days, we are already very pleased and surprised by the reaction we are getting from children with quite severe handicaps. It has a calming effect on those who tend to be over excitable, and has encouraged head movement and vocalisation in those children with very little movement.

Visitors are very welcome, if anyone is interested they are invited to contact Mrs. Milhuisen, Head Mistress on Barry (0446) 732755.

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SEATING FOR THE YOUNG CEREBRAL PALSIED CHILD

A letter sent by J.O. Simpson and reviewed by C. Dunn.

This letter describes the way in which a piece of research was designed as the result of the replies to a questionnaire on seating about three years ago. There was a subsequent wish to test the level of change of practice. The question is put to those who originally replied "how have things changed in three years?"

There was a perceived need to improve the design of available seating, and to convince Doctors of the need to recruit children into a study to ascertain the effects of using such seating from an early age, if severe motor delay was exhibited.

The hypothesis was that by ensuring that the children always sat in a reflex inhibiting posture, the severe skeletal deformities seen in older children would be prevented. The results proved that the greatest change was in developmental progress. The particular areas examined were hand/eye co ordination, feeding and drinking skills.

The results of the research are available for perusal housed at the Department of Orthopaedic Mechanics, Salford University. The outline of the results are described, with conclusions.

Without having read the whole Thesis, there remains a number of questions unanswered:

- * How were the groups of children selected?
- * Were the children Multiply handicapped?
- * Was the older group - who were mostly dependent at 38.3 months - more severely handicapped?

The children in the younger group were of an age where the skills being tested would only just be beginning to emerge, those in the older group were at a similar stage. The implication of this is that the older group might be more significantly handicapped.

The aiming of the seating Clinic set up was to bring down the age at which specialised seating was prescribed. This was achieved.

It was found that developmental progress was increased by the use of specialised seating, this being greater in the younger age group. The main recommendation of the study was that specialised seating should be prescribed to the Cerebral Palsied child between 9 and 12 months, and that three years was too late.

As research is increasingly needed in order to prove the need for certain aspects of practise and to bring about change, it is to be applauded that such detailed work is being carried out. The level of application and time taken for such a project is high and further research may be needed to monitor continued progress.

Should anyone require further details of this study, contact Jill Simpson, M.Sc., MCSP, 3 Park Ave., Swinton, Manchester M27.

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BOOK REVIEWS

KEYBOARD, GRAPHICS and HANDWRITING SKILLS HELPING PEOPLE WITH MOTOR DISABILITIES.

**By DOROTHY E. PENSO
THERAPY IN PRACTICE 15
CHAPMAN AND HALL**

This book is written by an Occupational Therapist who has a compelling interest in her special subject. The Author has had a long term interest in the care of children with developmental difficulties, which she now focusses on the Specific Learning difficulties which may be connected with the acquisition of handwriting and recording skills, and how these subjects may be helped.

The importance of a thorough assessment is shown, including motor perceptual and sensory abilities and disabilities. A description of the necessary gross and fine motor skills required is given. There is great detail on the choice of seating, surfaces, and materials required for writing, drawing and artwork. More information is given on typewriters, word processing and computers. There is also an extensive Bibliography.

This book is concise, informative and useful. The format is logical, showing problem solving and giving case histories. It would be a useful addition to the reading matter of Physiotherapists meeting these difficulties in patients of any age.

Caroline L. Dunn MCSP, SRP

From Acquaintance to FRIENDSHIP ISSUES FOR PEOPLE WITH LEARNING DISABILITIES

**HUGH FIRTH, MARK RAPLEY
B.I.M.H. PUBLICATIONS £14.75.**

This book is written by two psychologists who have now realised that the resettlement of people with learning disabilities has, in many instances broken apart friendships and relationships of long standing, that have formed in the large institutions which have been home to many of these people. They point out the importance of personal relationships, which can have an effect on the mental and physical health of individuals, and their aim in the book is to point ways forward for helping people with learning disabilities to widen their acquaintances and develop friendships in the community.

With a myriad of references, they have drawn widely from the literature appertaining to the subject, and have highlighted in different chapters such issues as, how friendships can develop, the role of leisure and social life, what help can be offered, including opportunities and activities, attitudes and personal attributes.

The point is made that responsibility lies with others to help those with profound disabilities to emphasise their own social value, but whilst most professionals will endeavour to do just this, one wonders about the world at large.

I feel that this is an endeavour to provide a source of reference and suggestions for dealing with a difficult subject, and as such will be useful on the bookshelf.

J.E. Lamond
APCP

SUMMARY OF THE MINUTES OF THE NATIONAL COMMITTEE MEETING HELD ON 1.11.90

The new booklet on Clumsy Children will be published in 1991 - the title is yet to be decided.

All booklets will be withdrawn as they are all out of date. Possible new titles will be considered in the future.

Pat Unsworth has resigned as Trent Representative and Jenny Gill has replaced her. Also Lyn Horrocks is standing in for Elizabeth Atter as the Wales Representative until further notice.

A.P.C.P. has given its support to the Bobath Cymru which is an organisation set up by parents in Wales to raise money for a Bobath Centre there.

The Post Registration Education committee reported that it had two meetings, one in July with Judy Mead from the C.S.P. to discuss the training of health care workers and explore the implications to Paediatric Physiotherapy. The second meeting was held with Sue Nayee from C.S.P. to discuss research issues.

The P.R.O., Caroline Dunn, reported that the Chairman, Treasurer and herself had attended the C.S.P. congress and that the motion put forward by A.P.C.P. was carried and will be discussed by Council.

Conference 1992 will be on "Forward into Europe" and will be held in the East Anglia region. It will be held from 26.03.92 to 28.03.92.

There will be two vacancies on the Committee in April and two members, Jenny McKinlay (Editor) and Viv Williams (Vice-Chairman) are due for re-election.

RESPONSIBILITIES OF A NATIONAL COMMITTEE MEMBER

To attend 4 committee meetings each year.

To participate in discussions on paediatric issues.

To be available to participate in one sub-committee group as appropriate.

To share expertise and help formulate A.P.C.P. policies.

To bring issues of concern to the attention of the National Committee and to communicate A.P.C.P. policy to relevant others.

To offer to review paediatric articles and books as necessary.

To be willing to represent APCP to various organisations and the media.

Finally - to have enthusiasm, a good sense of humour, to be able to work as a team member and to have boundless energy!

COURSES

Date: 7th - 9th February 1991.
Venue: Normanby College, King's College Hospital, London.
Subject: Sensory Intergrative Therapy - Level 1.

This three-day course is aimed at Physiotherapists, Occupational Therapists and Speech Therapists interested or working in the field of Sensory Integration. Levels 2 and 3 to follow. Participants should have had some previous experience in this field. Places are limited to 35 to ensure adequate supervision.

Fee: £90 includes lunch and refreshments.

Apply to: Marcus Bill, Physiotherapy Dept., Sheldon Children's Centre, St. Giles' Rd., London SE5 7RN.

CASTLE PRIORY COLLEGE

26/250 £165 18-20 February
VIDEO RECORDING TECHNIQUES

A practical course, using set projects on basic handling techniques.
Workshop equipment provided.

26/256 £145 22-24 February
BEYOND THE BASIC MOTOR PATTERN

A special weekend for experience staff, led by Ester Cotton.

26/275 £39 7 March
THE SHERBORNE MOVEMENT METHOD

A workshop for teachers, therapists and workers with children with special needs.

All enquiries from Castle Priory College,
Wallington, Oxfordshire OX10 0HE.

INTERNATIONAL CONFERENCE ON ORTHOTICS

Dundee, Scotland 16-20 September 1991

Organised by the Dept. of Orthopaedic and Trauma Surgery, University of Dundee.

This conference is intended for physicians, surgeons, orthotists, therapists, engineers and other professionals involved in the prescription, design and supply of orthoses.

Send for information on DUNDEE '91 from The Secretariat, Dundee '91, Dundee Limb Fitting Centre, 133 Queen St., Broughton Ferry, Dundee DD5 1AG, Scotland.

LETTER TO THE EDITOR

Dear Editor,

I am enquiring if any members have experience in treatment of Arthrogyrosis in the neonatal period onward.

There have recently been two such babes referred and I would be very grateful if any member had any experience of information to share on this subject.

Cathy White, Sr. Paed. Physiotherapist,
Southampton General Hospital, Shirley, Southampton SO9 4XY.

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BERTA AND KAREL BOBATH

We are very sorry to hear of the recent deaths of Dr. and Mrs. Bobath. The Bobaths have been known world wide for their unique teaching and treatment, and have dedicated their lives to that approach.

For so many physiotherapists in both the paediatric and adult field, this is a sad time, and we, as an Association, wish to extend our sympathies both to the Bobath family and to the team who continue the work at the Centre.

It is understood that there is to be a memorial service in the summer, the date to be confirmed.

Editor.

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The Membership Secretary would like to thank all members who have paid their subscriptions promptly.

HERE AND THERE

Wendy Turner reports on the Welsh Region Study Day held in Swansea in October entitled:

Prevention and Intervention in the Orthopaedic Management of Cerebral Palsy.

The day was led by Mr. P. Witherow, Consultant Paediatric Orthopaedic Surgeon at the Bristow Children's Hospital. Mr. Witherow opened with an in-depth presentation of gait analysis stressing the importance of this assessment. Jane Pyman MCSP followed on the analysis of efficiency which measures the effort used by the children. An essential factor in the decision - 'prevention and intervention'. More specifically were discussed hemiplegia, diplegia and quadriplegia. Preventative management was always foremost, use of correctly fitting AFO's, and close working relationships with the orthotist were stressed as essential. Casting for these was a specialised technique - each child being individual in their corrective need.

INTERVENTION - "When?" was the obvious question - if possible never before 7/8 years. Growth rate must be carefully considered as is the continued functional ability of the child. Mr. Witherow's percutaneous procedures with hemi and diplegia have very little blood loss or scarring. Children are up and weight bearing in 48 hours and neurodevelopmental physiotherapy commences immediately.

Prevention of hip dislocation in quadriplegia was greatly discussed as were possible ways of prevention. The dystonic child being of the greatest concern, sleeping shells were used with some children as a preventative measure.

ON SURGICAL INTERVENTION. Hip spicas are removed after 4 weeks, with the child kept as an in-patient. Daily pool therapy helps reduce flexor spasm, and sleeping in bivalved shells should be continued for at least 3 months, or indefinitely if the child will tolerate them.

MULTIPLY INCREMENTAL LENGTHENING - this is a subject much in discussion.

As part of the assessment prior to surgery, alcohol blocks and, more recently, botulinus, are injected into individual muscles at the motor point. These provide a good indication of the expected post-operative effects of surgery and the child's abilities to overcome their problems.

Post operative physiotherapy is intensive and essential - 6 weeks as in-patients with twice daily treatment sessions.

The afternoon closed with the assessment of three children by Mr. Witherow and Jane Pyman.

More than 50 people attended, coming from as far afield as Oxford, Aberyswyth and Haverfordwest. Disciplines present includes an orthopaedic sister, a bio-engineer, clinical medical officers, paediatricians and physiotherapists.

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MRS. DELIA CURRY, SR. PHYSIOTHERAPIST AT ST. MARY'S HOSPITAL, PORTSMOUTH, REPORTS ON A STUDY DAY HELD IN NOVEMBER.

"The South West Region hosted a study day on 10th November on Cystic Fibrosis."

The day started with Dr. E. Neville, Consultant Physician at St. Mary's Hospital, Portsmouth, speaking on 'C.F. - the problems of adolescence.' This was a very lively presentation and underlined the tremendous pressures the CF adolescent is under at what is generally a fairly difficult stage of development for the normal young person.

After coffee, Dr. Margaret Lamont, Medical Officer in Genetics at the Wessex Regional Genetic Counselling Service, spoke about 'Genetic Counselling in CF Families.' This proved to be a very enjoyable in-depth talk and certainly speaking for myself, helped to clarify the genetic pattern of inheritance in carriers of the CF gene plus giving up-to-the-minute information on advances in research and the implications for the future.

In the afternoon, we had delightful talks by Christine Ireland, Superintendent Paediatric Physiotherapist from Southampton General Hospital on 'Physio in CF', and Karen Williams, Paediatric Dietician at St. Mary's Hospital, Portsmouth on 'Nutrition in CF - meeting the need'.

The day was brought to a close by tea and discussion with Sharon Andrews, an adult CF sufferer who recently received a heart/lung transplant. This proved to be a very positive and enlightening close to the day.

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Information sought

Does anyone know if MAROUSHKA are still in business? They were at Riverside, Totnes, Devon, TQ9 5JB. We advertised their musical instrument - the cimbala - some time ago. The cimbala is strung with piano wire, and sets of music provided make immediate tunes available for children with some fine motor movement. If anyone knows where the company has gone, or if indeed, it is still in existence, please let the Editor know.

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The National Curriculum really is 'A CURRICULUM FOR ALL'

This is a video presentation of the attempt one special school has made to address the issues of National Curriculum.

Norfolk Park is a Sheffield school for children with severe and complex learning difficulties. The programme shows the different approaches to National Curriculum used in the school, sensory, exploratory play, topic based and experiential.

Copies of 'A Curriculum for All' are available from the Head Teacher, Norfolk Park School, Park Grange Rd., Sheffield. Price, including P&P £9.99 (Cheques to Norfolk Park School Fund).

THE DYSPRAXIA TRUST

Developmental Dyspraxia Explained

Other names are 'Clumsy Child Syndrome', 'Perceptuo-motor Dysfunction', 'Minimal Brain Dysfunction', 'Motor Learning Difficulty'.

Dyspraxia is an impairment or immaturity of the organisation of movement. Associated with this there are problems of language, perception and thought. Gross and fine motor skills are hard to learn, difficult to retain and generalise, and hesitant and awkward in performance. Articulation may be immature or even unintelligible in early years. Language may be late to develop also. There is poor understanding of the messages that the senses convey and difficulty in relating those messages to action. Dyspraxic children of normal intelligence may have great difficulty in planning and organising thoughts. Those with moderate learning difficulties have such problems to a greater extent.

For most children, there is no known cause, although it is thought to be an immaturity of neurone development in the brain rather than brain damage. Dyspraxic children have no clinical neurological abnormality to explain their condition.

The Dyspraxia Trust, formed in 1987 by two mothers of dyspraxic sons, aims to:

put parents and children in contact locally and nationally

arrange regular meetings for members

produce a newsletter containing articles from parents and professionals, ideas, shared problems and information

promote better diagnostic and treatment facilities for dyspraxic children

encourage a wider understanding of the condition and its implications by professionals in the health and education fields and by the general public.

Enquiries to The Dyspraxia Trust, P.O. Box 1270, Gerrards Cross, Bucks SL9 0SF.

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JENX LTD. are pleased to announce that there is a new size 3 Prone-angle chair, suitable for older children and young teenagers. For more details and prices, contact them at 74 Hoyland Rd., Sheffield S3 8AB Tel: 0742 756312.

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CSIE - The Centre for Studies on Intergration in Education - have a comprehensive publications list on topics such as 'Integration - Educating all children in ordinary schools', '1981 Education Act - CSIE Summary', and 'Guiding the Professionals'. For more details, contact CSIE, 4th Floor, 415 Edgware Rd., London NW2 6NB Tel: 071 452 8642.

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BOBATH CYMRU APPEAL

The provision of an intensive physiotherapy service in Wales is the main priority of the Bobath Cymru Appeal. The initial aim is to secure premises in which a start can be made, to employ therapists on a limited scale and to provide a service as soon as possible. Secondly, it is aimed to construct a building specially designed to expand Bobath therapy services and to include full support and information for the families of handicapped children in Wales. The London Bobath Centre has pledged full support to these initiatives and is co operating with them to establish the necessary legal, financial and professional framework within which it will operate. Full backing has been received from Mr. George Thomas (Viscount Tonypandy), who has agreed to be the President of the Bobath Cymru Appeal.

Be a big help and send a donation to the following address or telephone 0222 493104.
Bobath Cymru Big Help Appeal, 39 Axminster Rd., Cardiff CF2 5AR.

DON'T FORGET YOUR APPLICATION TO THE INTERNATIONAL PAEDIATRIC PHYSIOTHERAPY CONFERENCE



CARDIFF - AUG. 2 - 4

For programme & Application form contact:

Lyn Horrocks
The Children's Centre or
University Hospital of Wales
Heath Park
Cardiff CF4 4XW

Jane Millar
Physiotherapy Dept.
Cardiff Royal Infirmary
Newport Rd.
Cardiff CF2 1SZ

See the November Newsletter

*- centre pages -
for lots of details.*



REGIONAL REPORTS

Trent Miss Jenny Gill, Child Development Centre, City Hospital, Bucknall Road, Nottingham MG5 1PB.

Thanks to Pat Unsworth for her stint (albeit brief!) as Trent Regional Rep. Congratulations are also in order following her recent marriage!

All but one member of the committee (and very valuable she is too!) are novices. We are gradually finding our feet and trying to make plans for a 1991 programme.

The AGM will be held on Wed. 13th March at the School of Physiotherapy, Nottingham City Hospital. This year we will begin at 6.00 p.m. with the buffet - kindly supplied by Gilbert and Mellish. The AGM will follow at 6.30. Then at 7.00 there will be a talk given by Dr. Leon Polnay, Sen. Lecturer in Child Health, entitled: 'Doctors do it in corridors', Should be interesting!

It is planned to hold a study day in Nottingham on Sat. 20th April - 'Children and the Human Sandwich', by Noreen Hare. For further details, please contact Miss Kath Hickman, Deputy Supt. Paediatric Physiotherapist, Paediatric Rehab. Department, D. Floor, Queen's Medical Centre, Nottingham. Tel: (0602) 42142, Ext. 42776.

West Midlands Mrs. Carol Foster, Physiotherapy Dept., The Childrens Hospital, Ladywood Middleway, Ladywood, Birmingham B16 8ET.

Wales Mrs. Lyn Horrocks, 9 Garth Close, Rudry, Nr. Caerphilly, Mid Glamorgan.

After a very short 'innings', Elizabeth Atter has had to resign as Regional Rep. due to heavy work and maternity leave at Christmas time. I am standing in at the moment, but would welcome nominations for a new Rep. as soon as possible.

Preparations are moving ahead for the 1991 International Conference together with the ACPRC. We have already had applications from UK and abroad.

The study day on 'Prevention and Intervention in the Orthopaedic Management of Cerebral Palsy' held in Swansea in October was so successful, a full report had been written by Wendy Turner, one of the organisers (see 'Here and There').

On 20th October, a study day was held at Morrision Hospital, West Glamorgan, and was very well attended and stimulating for all.

North West Miss Lyn Wakely, 2 Ash Bank, Pipers Ash, Chester CH3 7EH.

North East Miss Judith Baigent, 75 Main St., Seamer, Scarborough, N. Yorks. YO12 4RF.

Unfortunately, our planned study day on Legal Issues in November had to be cancelled because of illness. We now hope to hold it in March - more

details will be available with this newsletter.

At the time of going to press, we have no other study days arranged. Suggestions for subjects would be gratefully accepted.

A happy 1991 to everyone.

South West

Mrs. Caroline Hurran, 23 Bayswater Ave., Westbury Park, Bristol BS6 7NU.

Chamwell School in Gloucester have started a structured motor programme with the help of two Hungarian conductors working with a nursery and an infant group. So far staff are very happy with the way things are going.

Meetings on Sensory Integration are being held in Gloucestershire at different schools. The next one will be at St. Rose's at Stroud on 14th February, at 7.30. All are welcome to attend but contact Linden Clark at Chamwell for more details.

Plans are going ahead for Conference 1993 to be held in S.W. Region. It seems a long way off, but booking for the venue at Bath University have to be made by the end of this year.

South East

Miss Terri Fearn, 38 Woodlands Close, Peacehaven, E. Sussex BN10 7SF.

During 1990 we held a workshop on 'Measurement of Windswept Hip Deformity' and Study Days on 'Gait Analysis' and 'Spina Bifida'. These were all well attended.

This year, we plan to hold a day on 'Arthrogyrosis plus advances in Orthopaedics' on March 16th. Also, a day on 'Behaviour Modification' in June, and one on Conductive Education later in the year. Details of these will be advertised nearer the time.

We hope to see lots of members at the International Conference in Cardiff in August.

We are always pleased to hear your views, and do discuss things seriously at Committee Meetings. We are also keen to have a flow of new committee members, as that keeps the society fresh with new ideas.

London

Miss Karen Burchett, 6 Willersley Ave., Orpington, Kent BR6 9RS.

E. Anglia

Mrs. Jackie Reynolds, Church Farm House, Ormsby, St. Michael NR29 3LN.

An interesting afternoon was spent at Addenbooke's Hospital, Cambridge in October listening to Penny Robinson speaking on Legal Affairs. She made particular reference to Paediatric measures and those present found it very useful and helpful.

Our next Study Day is planned for March 6th at Watford General Hospital when John Patnell and Vicky Draycott from Oswestry will discuss Gait Analysis.

Your local committee is hard at work planning the 1992 National Conference and the programme will shortly be presented to the National Committee for approval.

I sent a short questionnaire out with the November Newsletter and have had three replies only. Surely the East Anglia members can do better than that! The National Committee hopes for information back from APCP members as well as disseminating it to them. Have a look for your questionnaire and please return the completed slip to me.

Scotland

Mrs. Ann Harden, 56 Juntly Court, Langside, Glasgow G41 2DH.

N. Ireland

Miss Ruth Graham, 75 Ravenhill Gdns., Belfast BT6 8EQ.

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THE CHALLENGE OF CHANGE

A STUDY DAY IS BEING ARRANGED FOR 13TH APRIL AT THE INSTITUTE OF CHILD HEALTH, DURING WHICH IT IS HOPED TO PROMOTE USEFUL DISCUSSION ON THE CHALLENGE OF CHANGE IN THE MANAGEMENT OF CEREBRAL PALSY.

Amongst speakers will be Jenny Bryce from The Bobath Centre.

Places are limited to 244, so apply soon, using the enclosed application form and further details of the day. The A.G.M. will be held at lunch time.

ANNUAL GENERAL MEETING
OF THE ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS
SATURDAY 13TH APRIL 1991
AT THE KENNEDY LECTURE THEATRE,
INSTITUTE OF CHILD HEALTH,
UNIVERSITY OF LONDON
30 GOWER STREET,
LONDON WC1N 1EH.

The Constitution of the Association of Paediatric Chartered Physiotherapists will be reviewed at the above meeting. Copies will be available.

At the National Committee Workshop in Worthing in November 1990, the main points for discussion regarding the constitution were as follows:

1. THE ELECTION PROCEDURES FOR THE EXECUTIVE OFFICERS INCLUDING THE CHAIRMAN AND VICE-CHAIRMAN.
2. THE TIMING OF REGIONAL AGM'S.
3. THE AUDITING ARRANGEMENTS.

The resultant changes suggested at this workshop will be submitted to the membership at the AGM on 13th April for their approval.

Once agreed by the membership attending the AGM, the Constitution will be circulated to National and Regional Committees and so be available to any member.

