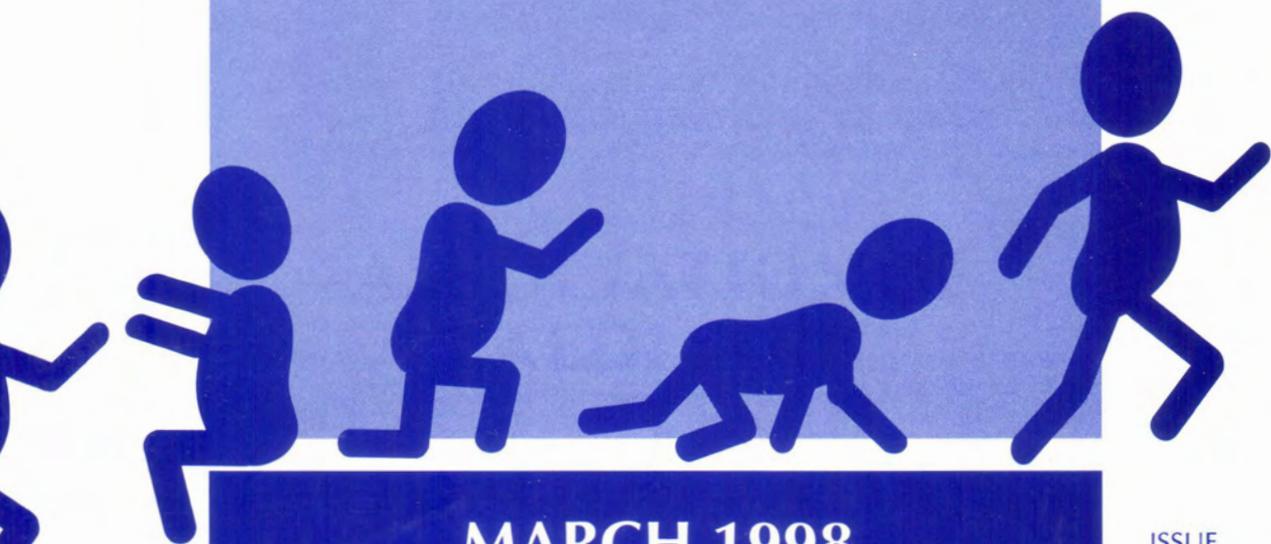


**ASSOCIATION OF  
PAEDIATRIC  
CHARTERED  
PHYSIOTHERAPISTS**

**JOURNAL**



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

### JILL BROWNSON

Editorial Board  
Past APCP Chairman

Clinical Effectiveness is a broad heading encompassing clinical audit, health and safety, research and development, and quality. Audit departments across the country will be using the term Clinical Effectiveness to describe their work and hopefully involve more people enthusiastically into a world where audit is not seen as a potential constraining task but as a chance to review all aspects of Clinical Practice. Our aim should be for effective practice to be demonstrated to purchasers and less effective practice to be identified and reviewed. Clinicians and their managers will be able to link these findings to their training needs and utilise benchmarking, national guidelines and clinical guidelines within their day to day practice. These tools, together with standards and protocols can be used alongside standardised measurement to identify health gains.

Managers need to have a clear idea of how Clinical Effectiveness can improve their services and empower clinicians to make decisions about prioritising their caseloads and their time.

It remains vital to the profession that clinicians both become and remain active and involved in 'reflective practice'. Dr Ann Moore MCSP wrote in the May 1997 *Physiotherapy Journal* of the balance needed between academic and clinical environments for a commitment to quality patient care. She speaks of the objectives all physiotherapists should have to achieve the best effect and recommends that 'The physiotherapy profession will stand a better chance of achieving all these objectives if clinicians and academics collaborate.'

So we should not be reliant solely upon those physiotherapists involved in Master's degrees developing their evaluative and critical reasoning skills to determine clinical effectiveness and contribute to evidence based practice.

For some of us it will be possible and indeed advantageous to participate in the research projects that they undertake. So often when we are approached to assist in research we are put off by the amount of time that might be involved. The recommendation from now on must be that we should embrace more enthusiastically the opportunities for both research and clinical audit on behalf of our patient groups. We should aim for both the purchasers and users of our services to be assured of all the components of an effective service.

I also recommend to you all that after reading this issue of the APCP *Journal* you hunt out your *Physiotherapy Journals* from last year and re-read or even read the article based on the Founders Lecture entitled 'Physiotherapy for best effect' January 1997 and also the scholarly paper

## EDITORIAL

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entitled 'Research, the Collaborative approach: Clinicians and academics.' May 1997.

Failing that - at least take from the paper the definition attributed to Kettering (1961).

Research is a high hat word that scares a lot of people - it needn't . . . It is nothing but a state of mind, a friendly welcoming attitude towards change . . . it is the tomorrow mind instead of the yesterday mind'.

**Copy for the JUNE 1998 Journal**

**must be with the editor by**

**1st MAY 1998**

**The Editorial Board reserves the right to edit material submitted**

## LETTERS TO THE EDITOR

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Mrs Sue Whitby  
Primrose Lane  
Huntingdon  
Cambridgeshire  
PE18 6SE

Dear Lin

1. Have you or any readers of APCP journal had any experience of children with a congenitally absent platelets amegakaryocytopenia. There are approximately 20 cases in the world. The immediate problem is how to protect the baby as he starts to be mobile, so that he will not damage himself. Hopefully a bone marrow transplant will be possible soon. If anyone has any advice, please contact me.

2. I have recently tried to buy the latest and revised 3rd edition of "Handling the Young Cerebral Palsied Child at Home" by Nancie Finnie. Unfortunately, I am told it is already out of print and a reprint is apparently not likely. Has anyone any ideas about where to get one?

Please contact me on the above telephone number.

Yours sincerely,

Sue Whitby.

3 Manor Way  
Hail Weston  
Huntingdon  
Cambridgeshire  
PE19 4LG

Dear Lin

Please publish this letter to all readers of your Journal.

I often get asked for photos of children having physiotherapy. We have a small collection, which have been used in various displays. I am involved in collecting photos for a paediatric physio display board for my Trust. I would like to use some of the photos to start a bigger collection for APCP. Please could any of you let me have photos for the collection? Don't forget to ask for written permission for the use of the photos for display etc. Many of you will have friendly Medical Photography departments who will take the photos for you. The CSP were having a photo shooting session (in December 97), to produce a modern range of photos, to show the wide range of patients who benefit from physiotherapy. They want to be able to go to more exhibitions etc. to show the broad, seamless spectrum of physiotherapy and the huge range of patients. I have been lent a few photos from their existing collection.

I continue to be asked about 'backache in children'. The CSP was asked to comment on a press release by a group of 'trained masseuse', who have started a campaign called 'Body Action' - about problems caused by the use of I.T. by children in school causing problems, because of poor posture. Did anyone see it or does anyone know anything about it? Is anyone involved in work with children who have back problems? This could be due to posture, lifting and carrying large school bags, sports injury, overuse etc. If you have produced any leaflets, games or have other ideas please share them with me.

Best wishes

Mrs Sue Whitby

## LETTERS TO THE EDITOR

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Cerebral Palsy Clinic

Chris Hani Baragwanath  
Hospital,  
P. O. Bertsham, 2013,  
South Africa

Dear Lin

The Cerebral Palsy Clinic at Chris Hani Baragwanath Hospital is the only out-patient facility providing therapy to children with cerebral palsy and other neurological conditions living in Soweto, South Africa. Soweto is a huge sprawling urbanized township, home to over 3 million people. It is a disadvantaged and under-resourced area, characterized by poverty, unemployment, violence and crime.

The Clinic treats over 300 children a month. Owing to the large numbers and a lack of resources (especially staff!), it is only possible to see the children once a month. Thus home management is essential and for this equipment and appliances are necessary. This is where we have enormous problems as the only equipment we have available are pushchairs and rollators. We see many children who have, or who are developing terrible contractures and deformities and the parents are desperate for any form of assistance. Most of the children do not have access to any form of schooling, and having no community resources, social services or respite care available, the burden of care on the mothers is high.

On behalf of the staff and the children at the Clinic, I am appealing to the readers of your Journal for any help they may be able to provide in the form of equipment that is no longer being used in their departments. There is especially a need for standing frames (like the flexi-stand), prone standers, adaptive seating and Pedro boots (especially small sizes).

If there is anyone who might be able to assist us, I would be grateful if they would kindly contact Mrs Sue Middleton, Flat 2, 40 Chestnut Road, West Norwood, London SE27 9LF. Tel. no. 0181 761 0182. We would love to hear from you.

Your sincerely

Gillian Anderson

## DELIVERING AN EFFECTIVE PHYSIOTHERAPY

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In 1997 CSP invited APCP to host and chair a session at Congress at Heriot Watt University, Edinburgh.

The theme for the session was 'Delivering an Effective Physiotherapy Service to Children'. Mary Goy, APCP Secretary, chaired the session and short presentations were given by Fiona Corkhill, Jill Brownson and Maureen Grant.

The following three articles are the transcripts of the presentations.



**Speakers and Chairman:** (left to right) Maureen Grant, Jill Brownson, Mary Goy and Fiona Corkhill

### FIONA CORKHILL

Grad. Dip. Phys.,  
MCSP, DMS

There is a drive nationally for Trusts to develop a strategy for clinical risk management which is mandatory and linked to a strict timetable for implementation. It is an integral component of the Clinical Negligence Scheme for Trusts which has set standards to provide a framework which will ensure trusts develop an effective Risk Management strategy. Trusts pay an annual premium to insure against clinical incidents which is calculated against the level of clinical risk they are considered likely to incur. Achievement of the standards will provide an opportunity for both a financial return on investment in a Clinical Risk management programme and increased discounts for insurance premiums.

A structured Clinical Risk Management programme should enable a clear improvement in patient care to be identified. The programme will enable Trusts to monitor all incidents both clinical and non clinical thereby

highlighting areas which may require a review of standards and procedures of Clinical Risk to all staff and have a direct impact on Clinical Effectiveness.

The broad heading of Clinical Effectiveness encompasses clinical audit, health and safety, research and development and quality. Trusts are required to nominate an executive director of the board to carry responsibility for Clinical Effectiveness and this person may be the Medical Director. Clear lines of accountability can then be drawn up and down the management structure. In a Trust whose structure has a directorate model of management the Clinical Director or Service Manager would be accountable for clinical effectiveness in their area. The management of Clinical Risk will then filter down to front line staff.

This is an example of one of the standards :

**A comprehensive system for the completion, use, storage and retrieval of medical records is in place. Record-keeping standards are monitored through the clinical audit process.**

The rationale behind this is that **complete and timely records allow a clear picture of events to be obtained which is imperative for managing complaints and litigation.**

Examples of some of the criteria against which this standard is measured state :

**There is clear evidence of clinical audit of record keeping standards for all professional groups in risk specialities.**

**An author of an entry in a medical record is clearly and easily identifiable.**

Anyone working in an operational management situation will understand the importance of maintaining high standards of documentation particularly in the increasingly litigious environment in which we work. A focus on this area will impact on other aspects of clinical practice through the process of regular case note audit.

A Clinical Effectiveness strategy appropriately implemented will provide a focus for the review of all aspects of clinical practice. It is a huge agenda but through improved incident reporting areas of potential risk will be identified.

It will give clinical staff a forum to enable clinical practice to be scrutinised within a multi-disciplinary framework and establish evidence based

practice and clinical guidelines as an accepted process in the delivery of health care. It will enable effective interventions to be demonstrated to purchasers and less effective interventions to be identified and reviewed.

It will also provide an opportunity to identify staff education and training needs ensuring an effective training strategy is implemented in line with the organisation's business objectives.

How will a children's service benefit from a clinical effectiveness strategy? Those of us working with children and their families are well aware of the legal and statutory framework which is central to our entire philosophy. This provides a sound basis from which to begin.

It may also be helpful to identify the pathways of care for those children with long term disabling conditions or chronic illness. The processes at each stage of the pathway can be evaluated and measured against national guidelines where they are available. For example there are national guidelines for the management of children with cystic fibrosis, diabetes and epilepsy. There is significant evidence of the value of Child Development Teams and a clear message from health authorities of the needs for close multi agency working on the management of children with continuing health care needs. The 1993 Code of Practice for children with special educational needs provides another process which can be examined to ensure health services are linking in appropriately.

There is a need to establish clear clinical guidelines because much of the clinical work which is undertaken, particularly in the area of disability, is not well researched. In the absence of research evidence consensus can be achieved through reference to expert opinion from nationally respected leaders in the field and through agreement at a local level in a clinical effectiveness forum. It is important that these guidelines are written down and where there is research evidence it is clearly referenced. The guidelines must be available to practitioners who need to understand that they are not protocols which must be followed but guidelines within which they have the freedom to practice. Evaluation through the audit process will ensure the guidelines are reviewed and if necessary amended.

Another aspect to consider in children's services is that parents on the whole are well informed about the nature of their child's condition and they will challenge professionals on the management of their child. This can be very threatening particularly for less experienced staff. Vociferous parents venting their anger and grief on the physiotherapist for the perceived lack of physical progress made by their child with cerebral palsy is a common experience. Physical progress, particularly the achievement of walking, being a more tangible and emotive aspect of a child's development, seems to conjure up far more dissatisfaction in

service provision than any other.

From personal experience, as a manager of therapy services, complaints fall broadly into two categories. For Occupational Therapy they are about the length of the waiting list reflecting the frustration of parents desperate to access a service for their child. For Physiotherapy they tend to be about the lack of hands on treatment by the physiotherapist.

There is an unrealistic view held by some parents of how much a physiotherapist can achieve which is based a fundamental lack of understanding of the role of the professional as a member of the wider multi-disciplinary team caring for that child.

Hands on treatment is becoming a luxury for those children identified to have high priority on our caseloads. Therefore it is important that we are able to base our decisions on prioritising both our caseloads and our time on clinical guidelines supported by sound research based evidence.

The broader, management focused, approach physiotherapists have been forced to adopt due to the size of their caseloads is not necessarily a less effective treatment intervention if appropriate skills are shared with other members of the team such as the parents and carers involved with a child. From our experience in Basingstoke we have found that a focus on those children who require multi-agency care planning, a written health needs summary and a costed package of care has enabled clear and realistic long term and short term goals to be identified which link the therapy treatment plan into the care plans of medical and nursing staff. The production of these summaries is in itself a highly skilled and time consuming process but it does enable an objective view to be taken of the needs of the child.

To summarise, further reference to Risk Management Standard Number 8 identifies another of the criteria for assessment which should provide some food for thought on where we may be in the future when computerised record keeping is established nationally.

**There is a unified record which all specialities use.**

JILL BROWNSON  
Grad.Dip. Phys.  
MCSP

All physiotherapists at some time during their careers face the dilemma of physiotherapy being a caring profession against the requirement, ever increasing, of the future of the profession depending upon accurate analysis of the effect of treatment intervention.

Professionally we know that our role within the multi-disciplinary team, providing for the needs of the child, means that we have to be accountable, effective, competent caring, compassionate, etc.

The factor that could be described as our greatest skill i.e. that we are a/the - handling profession - can backfire on us because we so often find it hard to be objective about our role in the care of the child.

And yet, we can see that if we become objective, measuring therapists then the very skills and attributes that we might abandon because they cannot be measured or proven are the treatment approaches that parents look for when they turn to the complementary and alternative therapies.

It's probably fair to say that the things that paediatric physiotherapists do best are observe, feel, touch, hold and analyse.

**Touch** and **hold** are our undeniable skills but only in the context of **observe, analyse** and **feel**. What we must never do is separate those qualities of our intervention because other disciplines or other services can readily take on the touch and hold but not with the same foundation of the core skills of physiotherapy. It might be sensible to list and look firstly at what we have available as evidence of paediatric physiotherapy effectiveness and then at the features of our role which seem not to be able to be measured which might come under the heading of 'health gain'. The argument that if it cannot be effectively measured then it is a role which should be handed to someone other than a physiotherapist must be diffused because the reason that we are in the best position to deliver this aspect of care comes back to the basic fact that we are the handling profession. It is our acquired **clinical judgement** which enables us to make decisions.

Eva Bower has represented our speciality most, by researching into the effectiveness of hands on physiotherapy treatment. She has been a great protagonist of the use of standardised tests to record our intervention and its effectiveness.

The Association of Paediatric Chartered Physiotherapists lists tests and assessment tools that are currently used to assess and record as a base line measure and then as a result of physiotherapy intervention.

We can use :

## STANDARDISED TESTS AND MEASURES

Gross Motor Function Measure (GMFM)  
Alberta Infant Motor Scale (AIMS)  
Oxford Central Recording of Motor Deficit (OCRMD)  
Motor Assessment of Infants (MAI)  
Paediatric Evaluation of Disability Inventory (PEDI)  
Functional Independence Measure for Children (Wee-FIM)  
Movement ABC  
Brunswicks-Ostereski Test of Motor Proficiency  
Motor Skills Inventory (MSI)  
Chailey Lying, Sitting and Standing Levels of Ability  
Physiological Cost Index of Gait (PCI)  
Dyspraxia Outcome Measures

APCP Journal - March 1997

However, we do need to remember and acknowledge that we have little evidence that using standardised tests and measures actually improves our effectiveness. To be used effectively we have to understand and analyse the information they are giving us.

And we need to remember that the use of tests which record functional gain will not be an appropriate measure of our effectiveness for a child with, for example, Muscular Dystrophy, where effective intervention will mean maintaining the best function at that time.

The accurate analysis of our treatment interventions help with service planning and enable the prediction of levels and intensity of care;

It has been suggested that measures will affect:

- Individual client decision making
- Research into effectiveness of treatment
- Programme evaluation
- Quality management
- Professional and financial accountability

Russell and Rosenbaum (1995)

How do we put into this practice of measurement the other things that are done to the child? To enable for example : ease of handling, compliance with the provision and use of equipment, improved quality of life.

# DELIVERING AN EFFECTIVE PHYSIOTHERAPY

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Eva Bower reminds us that one value of measurement is that :

'Physiotherapists who have not had the experience of observing a number of children with a particular problem over a substantial period of time may find it difficult to gauge what is a realistically achievable goal and which problems may encourage the development of a future deformity.'

Eva Bower 'Measurement'  
APCP Journal - Sept. 1997

We need to demonstrate the other aspects of our daily working lives that we as paediatric physiotherapists believe are essential components of our effectiveness. The aspects of our interventions which could come under the heading of Health Gains will be encompassed within our working lives.

Multi disciplinary liaison will provide all-round care following the child through infancy, nursery, education, the statementing process, respite care, the provision of appropriate equipment, orthotics, wheelchairs, Social Services adaptations.

What we need to demonstrate are these aspects of our daily working lives that we as paediatric physiotherapists believe are essential components of our effectiveness:

- advisory role - to carers whether this is parents or carers in a school environment the skills that we use to advise are based on the foundation of our training and experience - as highly skilled advisers we are delivering effective treatment interventions
- the imparting of confident handling skills to a carer is effective treatment
- the identification of a child's needs is effective intervention
- appropriate referral to other services is effective treatment
- the provision of appropriate equipment is effective treatment
- the support, underpinned by professional skills, provided to the child within the family and within society is effective intervention
- empowerment as a gradual process and to whatever extent the carers can cope with is effective treatment

Balance the fact that purchasers want a 'value for money service' children, their families and carers want 'the confidence that the child is receiving the best and most appropriate level of care and management of the condition by whatever means are necessary.

Sandra Holt undertook a study of parental attitudes regarding the Choice of treatment modalities, one finding was that 'parents want more physiotherapy'.

Perhaps what we really need to prove is that we have a quality service.

An effective service will also be a quality service - we can use the Standards for Paediatric Physiotherapy and the Guidelines for calculating Paediatric Physiotherapy caseloads which describe a quality service, because a quality service by definition should be an effective service.

A quality service will be :

**effective, efficient, and timely** in its delivery to the child, **accessible, equitable and acceptable** to both **consumers and purchasers** and **caring** to the staff and users.

APCP Publications 1995

Measurement may or may not be the key to providing an effective physiotherapy service.

'How do you measure it?' is a question which might easily roll from the tongue - without there being any substantial thought or reasoning behind it.

Those of us delivering a physiotherapy service have a very real need for research to evaluate aspects of our practice, and then we need to incorporate the useful things into our practice.

**GOALS NEED TO BE FORMULATED IN SUCH A WAY THAT THERE IS NO DOUBT AS TO THE EXTENT TO WHICH THEY HAVE BEEN ACHIEVED.**

Bower & McClellan 1994

In very many instances, however, the correct answer to the question 'How do you measure it?' might not be because we have a standardised measurement tool, but instead - because we have **standard** that we work to which is **benchmarked** against an example or model of excellence - or that we have a developed protocol which describes a model of care or the development of a **clinical guideline** which looks at a standard of care that can reasonably be expected to deliver a good level of care (neither the minimum nor the idealistic) for a particular aspect of physiotherapy intervention - that is to say a consensus of good practice.

An ideal measurement is one that 'is appropriately developed and validated to satisfy the purpose and population to be measured and is suitable for

use in the prevailing clinical situation'.

One of the aims of measurement might be to show whether a particular line of therapy can be shown to be helping a particular child and whether the outcome appears to be of greater benefit with one line of therapy rather than another.

Eva Bower undertook a study in 1992 which indicated that 'Children's progress towards certain goal was accelerated during a period of intensive physiotherapy'. She showed that some of these skills were maintained or improved upon even when the therapy became less frequent - if associated with daily function.

Physiotherapists working with children generally provide therapy not for its short term effects but for a presumed long term cumulative effect.

Eva's results allow her to hypothesise that intensive therapy delivered over a longer period of time might be associated with a cumulative benefit.

I believe that it is a collective responsibility for interested paediatric physiotherapists (who might otherwise be known as APCP) to work on behalf of the profession to provide standards, protocols and clinical guidelines - a consensus of good practice which encompasses clinical effectiveness; and that it is a moral responsibility for all physiotherapists working in paediatrics, whether or not they choose to become members of APCP to abide by and work to those standards, protocols and guidelines.

The future of physiotherapists working in paediatrics might be to become highly skilled advisers.

It might be considered that, in an ever changing Health Service environment, our professional skills can best be used by us becoming assessors, advisers and teachers. Empowerment is rather an emotive word; used by some it implies that all parents and carers whether in the home or at school can become the provider of therapeutic care. In that context it becomes easy to see that the role of the physiotherapists would then be assessor, adviser, and teacher.

But empowerment will be different for each and every family or set of carers, and may not necessarily be that they become the providers of therapeutic care. We and the purchasers of our services cannot abide by just one interpretation of this term;

- Empowerment for some people might be that they have the choice of where their child receives physiotherapy - in their own home or at a Children's Centre.

- Empowerment might be that they have an improved understanding of the options and choices available to them in the care of their child.
- Empowerment might be that they feel able to make choices that take them out of the mainstream health service provision, into alternative and complementary therapies with the knowledge that they can return again at some time in the future.
- Empowerment might even be that they feel confident to accept the advice and recommendations of a medical service which they might never have previously encountered and be able to explain treatment rationale to their families.

You can empower people with understanding, knowledge, choices and skills, and any of these could be 'measured' principally by recording against a standard, thus providing effective 'treatment'.

As specialist therapists we need to be able to identify all manner of health gains within the population we treat.

Health gain is not always interpreted as an achievable outcome and yet it may be just as much attributable to our involvement or intervention, as to those which we can measure with standardised tests which explain the need for a measured of standards, protocols and clinical guidelines.

We have to become confident that the use of a clinical benchmark will establish best possible practice and eliminate ineffective or unnecessary practice so that both the purchasers and the users of our services are assured of our effectiveness.

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## MAUREEN GRANT

Head of Physiotherapy Services,  
Edinburgh Sick Children's  
NHS Trust

## RATIONING OR PRIORITISING RESOURCES?

NHS funded resources are limited not least in the field of Physiotherapy for children with neuromotor disorders.

We are all familiar with the situation of restricted funding, heavy workloads, parental expectation and therapists frustrations. We should attempt to identify existing tools which are available in order to prioritise, manage and deliver the service effectively. This should result in objective assessment, planned delivery, control and a sense of ownership for parents agreed with the Physiotherapists as the expert adviser. There will never be enough resources but we must learn to maximise benefits and let go of anticipated nil outcomes.

We are faced with a dilemma - do we develop waiting lists, do we reduce frequency of treatments and reduce standards, do we prioritise by need or do we discharge children at the lower end of need?

Little proof is available that continuous Therapy over many years produces improved outcomes and we must develop outcome measures, ask ourselves what the expected outcome is and be realistic in selection of patients and allocation of time.

A suggested method of prioritisation was put to me by a medical colleague:



- A. Significant improvement - will they improve anyway?
- B. Steady and small improvement - intervention necessary?
- C. Gradual deterioration - what level of intervention will affect this?
- D. Continuous deterioration - despite intervention?

For good performance, efficient working and effective delivery of service therapists must feel in control of their individual caseloads and therapists should question whether there are alternative models of service delivery which will result in increased therapist efficiency demonstrated by improved caseload management and improved service as measured by the following:

- parent satisfaction
- physiotherapist satisfaction
- children's progress
- consultant satisfaction

Are there alternative models of assessment and service delivery which will result in improved caseload management and improved service?

We must be realistic:

- Assess for treatment needs
- Invest in treatment programmes which will have positive outcomes
- Set realistic and achievable goals
- Recognise the concept of family-centred care
- Empower parents and carers
- Recognise a duty of care to newly diagnosed children

Assessment of need and level of intervention must be objective. A proposed management model for this group of children is :

- Scoring and banding of new patients on referral in order to prioritise allocation times based on need
- Standards in place and monitored
- Assessment profile and scoring identifies intervention categories
- Development of "blocks and breaks". Involvement and education of parents and carers
- Treatment frequencies and pattern clearly stated and categorised by diagnosis and severity
- Regular review and adjustment of intervention categories based on goal achievement
- Increased involvement and education of carers

## Scoring new referrals:

	Criteria	Points
AGE	< 3 YEARS	3
	3 - 5 YEARS	2
	> 5 YEARS	1
DIAGNOSIS	Acute/newly diagnosed	3
	Potential for deterioration	2
	Minimal problems	1
REFERRAL REASON	Mobility Aids	3
	One off Assessment	2
	Re-referral	1
LENGTH OF TIME	For each 4/52 period	1

# DELIVERING AN EFFECTIVE PHYSIOTHERAPY

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Maximum 10 points, minimum 4 points but points for length of waiting time ensures that patients will not remain at the bottom of the list.

## Assessment Profile

Classification	Date:							
Potential for Deformity								
Potential for Deterioration								
Potential for Development								
Threat to Life								
Expectation of change								
Total points								

**Considerations when scoring :** (Each category scored out of 5, possible maximum score 25)

### 1. Potential for Deformity

At risk of contracture due to :

- increased tone
- decreased voluntary movement
- abnormal posture
- growth spurt

### 2. Potential for Development

- Acquisition of a new skill
- "Key" period of development e.g. learning to walk
- If a specific goal is likely to lead to improvement

### 3. Potential for deterioration

- Effect of non-intervention by Physiotherapy - short/long term
- Lack of other support services
- Poor carer compliance

### 4. Threat to Life

- Feeding Difficulties
- Respiratory problems

## 5. Expectation of change

- Surgery
- Serial Splinting
- Change of circumstances e.g. move to school, nursery, CC

### Example

1. Child referred with marked increased tone as new patient - 5
2. Potential for development through goal setting - 3
3. Potential for deterioration through lack of intervention for increased tone - 5
4. Threat to life a small risk but chest Physiotherapy should be taught as a precaution - 2
5. Expectation of change high e.g. splinting - 5

Child is reviewed at regular intervals and intervention adjusted accordingly.

Classification	Date 1/10/94	Date 1/04/95	Date 1/10/95						
Potential for Deterioration	5	2							
Potential for Deformity	5	2							
Potential for Development	3	4							
Threat to Life	2	1							
Expectation of change	5	3							
Total points	20	12							

## Intervention Categories

Intervention	Maintenance	Review
I1 = 1 x week	M1 = 1 x month	R1 = 1 x year
I2 = 2 x week	M2 = Fortnightly	R2 = 1 x 6 months
I3 = 3 x week		R3 = 1 x 3 months
I4 = 4 x week		R4 = 1 x 6 weekly
I5 = Daily		R5 = One-off treatment

## "Blocks and Breaks"

Children with a neuromotor disorder could be treated in blocks of treatment with a break between each set of treatment blocks. Determination of the length of blocks of treatment and the frequency of treatment within them is determined by therapist and parents. During the 'break' from formal treatment the child will have a management plan in place to prevent deterioration and maintain or continue to improve on gains made.

This model of service delivery will apply to children who require intensive therapy, i.e. require to be seen at least weekly. It is acknowledged that occasionally children who may be seen on a monthly review basis only may also occasionally require increased frequency at certain times eg. during a growth spurt, during acquisition of a new skill, if deterioration is anticipated to occur, a change in therapy management requiring new teaching to parents/carers/teachers.

A 'break' will only be instituted once an ongoing management programme has been established and parents/carers are competent and confident and continuing the programme.

During the 'break' from intensive physiotherapy the following will occur:

- parents will be encouraged to incorporate the physiotherapy programme into their daily routines. This will require close collaboration between parents and therapists when determining programmes.
- parents will anticipate and accept that they are a major part of their child's management and will become more involved in therapy input.
- parents will be given a break themselves from formal appointments with the reassurance that there will not be any detrimental effects to the physical well being of their child.
- parents will learn to monitor the progress of their child more confidently

## Agree a standard

Recommended frequency in treatment blocks		AGE		
		0 - 3 yrs	3 - 5 yrs	School
Hemiplegia		I1/R4	I1 or M2/R3	R4-I1 when requ'd
Diplegia	Mild	I1/M1	I1/R4	R4-I1 when requ'd
	Moderate	I1/M1	I1/M1	I1/R4
	Severe	I1/M1	I1/M1	I1/M1
Quadriplegia		I1/M1	I1/M1	I1/R4

## Standards relating to this model of service delivery

An example relating to types of CP:

Children with quadriplegic CP will receive regular blocks of at least weekly treatment for eight weeks with a break from treatment not exceeding 4 weeks. (This will also give us a standard for review times for each of the differing types of CP)

An example relating to new referrals:

All new referrals will be seen within 3 weeks of receipt of the referral. If the child falls into the category of requiring treatment an initial eight week block of treatment will be initiated within 2 weeks of assessment.

An example relating to management during 'breaks' from treatment:

By the end of a block of treatment each child will have a physiotherapy home programme, parents will have been taught the home programme throughout the duration of intensive input.

Home programmes will be reviewed at the commencement of each new block of treatment and modified as required by the end of the block of treatment.

In conjunction with this model Managers should calculate staff time available for these case-loads and will be able to quantify the shortfall for their Purchasers with objective statements demonstrating the reduction in standards.

Paediatric Physiotherapists must learn to say "No" and to say "Goodbye" (but not for ever).

(APCP 1994)

## Acknowledgements :

Community Physiotherapy staff, Edinburgh Sick Children's NHS Trust, Nuala Gibson and Joyce Williams who all contributed directly or indirectly to this paper.

## References:

APCP Fact Sheet - Calculating Caseloads. 1994



**FIONA CORKHILL**  
National Committee member

The National Committee met in October 1997 at the James Gracie Centre in Birmingham for another 'workshop weekend'. These weekends have become a traditional feature of 'committee life' over the years and they occur every two or three years. The purpose of the weekend is to give the Committee time to discuss and consider a current Professional issue in some depth in order to provide a consensus opinion on the professional guidance which members expect to receive from the National Committee. Previous weekends have focused on issues such as Standards of Practice and Caseloads in Paediatrics and have resulted in publications for members. This time the Committee chose Clinical Effectiveness as their topic, knowing it was currently high on the agenda both nationally and for the CSP who were developing their Clinical Effectiveness Strategy. The National Committee felt very strongly that before they could be giving guidance to members on Clinical Effectiveness they needed to acquire a level of understanding of a topic which we were all finding very confusing. Hence the focus on this issue of the Journal and the pull out supplement.

The Committee were very keen to have the workshop facilitated by colleagues who had practical experience in clinical guideline writing. Through her involvement with the Yorkshire guidelines project Teleri Robinson recommended Sue Jessop, Physiotherapy Manager from Pinderfields NHS Trust in Wakefield, to facilitate the workshop and Gill Robinson, Senior Lecturer in Physiotherapy at the School of Human and Health Sciences at the University of Huddersfield to run a session on critical appraisal skills. We are extremely grateful to Sue and Gill for their support and enthusiasm which resulted in such a successful weekend.

Sue Jessop gave us the historical background to the topic which has been driven by the contracting process and the need for the provision of healthcare within available resources with measurable health gain. She also introduced many of the key words which are now associated with Clinical Effectiveness putting them into context with those factors we are familiar with and which influence our ability to provide efficient, effective services; e.g. caseloads, resources, training, and communication, to name just a few.

Hearing about the background to the process used by the Yorkshire project for the development of Clinical Guidelines enabled us to link it with terminology such as evidence based practice, outcome measures and benchmarking.

Gill Robinson gave us an inspirational lecture on the skills required to critically evaluate published research. It is so easy to skim through an article avoiding the methodology which looks far too confusing, jumping to the summary and reaching a conclusion about a study which assumes there were no flaws in the methodology and it is a valid and reliable

piece of research. For those of us who qualified in the dim and distant past it gave us a valuable insight into the need to understand the research process. Gill recommended a book - Research for Physiotherapists by Caroline Hicks - which provides a description of the different types of tests researchers use for various research designs.

So it was against this background that the Committee spent the Sunday morning brainstorming how we would feed back to the membership the very valuable knowledge gained over the weekend and how we, as a professional body, could perhaps become a focal point for the review and dissemination of paediatric guidelines. An action plan was devised to ensure you, the members, would gain something from the weekend and that we, as a committee, would use the Journal both to inform members and to request information on any work on guidelines currently being undertaken at a local level. We know from the volume of correspondence received by our Secretary Mary Goy that the Clinical Effectiveness agenda is reaching members at a local level. If the experience of the Committee is anything to go by having the opportunity to focus on the topic and put it into context from a professional point of view was invaluable and we all left feeling exhausted but far more comfortable with the topic that when we arrived. Incidentally it wasn't all work and like all Committee get togethers there was also valuable time for new members to get to know each other and for longer standing committee members to reflect on memories from previous workshop weekends.



### **Guidelines for Clinical Guidelines working party**

(left to right) Teleri Robinson, Terry Pountney, Carrie Jackson,  
Eileen Kinley

## GILL ROBINSON

M.C.S.P., Dip.T.P., Cert.Ed.  
Senior Lecturer  
Division of Physiotherapy  
University of Huddersfield

### Introduction

The need for physiotherapists to embrace evidence based practice has never been greater. The demands stem from the continued development of the profession, and the financial environment in which they are required to deliver first class health care.

This need may only be satisfied if the profession has a body of evidence that supports it, and the professionals who work within it have the skills required to address that evidence. It is essential that all who read, and therefore consume research, do so with a critical eye, making judgements about its worth and relevance. Even reputable journals publish poor research sometimes.

An all graduate profession has gone some way towards satisfying these requirements. Today's graduates emerge from a background that enables them to be consumers or practitioners of research. Other members of the profession have acquired the background whilst undertaking higher degrees. However, it is still a fact that a large number of physiotherapists have not had this opportunity, and in consequence regard research as a mystery. It is therefore, not surprising that they find the prospect of being critical of someone else's research somewhat daunting.

This paper is aimed at those physiotherapists with no formal background in research theory, and will hopefully remove some of the mystique surrounding the most daunting elements.

### What do we mean by critical appraisal?

Critical appraisal is concerned with making judgements on the reliability and validity of research in order to establish its worth and purpose.

This type of statement makes critical appraisal sound as though the person undertaking the task must have an in depth knowledge of the research process. Whilst this is true, in the sense that this reader may approach the task with a great deal of confidence, it is also true that the reader who lacks this in depth knowledge can often apply a common sense approach to the task and succeed in appraising appropriately. The problem is that the reader with no previous training in the research process has a perception of research and researchers, that has a tendency to place it out of reach to themselves. The author has seen many physiotherapists blanch at the mere suggestion that they already have some of the knowledge and many of the required skills to be critical of published research.

The important outcome of critical appraisal is the answer to the question:

*Is the reader sufficiently convinced of its worth, to apply the outcomes of the research to practice?*

## **The Process of Critical Appraisal**

A methodical approach is the key to undertaking successful critical appraisal. This should present no difficulties to the physiotherapist who applies a methodical approach consistently within their working day.

The inexperienced reader should look at each section of the report in turn.

### **Sections to be considered**

#### **Title**

This should clearly represent the contents and give the reader an idea of what the paper is about.

#### **Abstract**

This should clearly set out the aims, method, results and conclusions.

#### **Introduction**

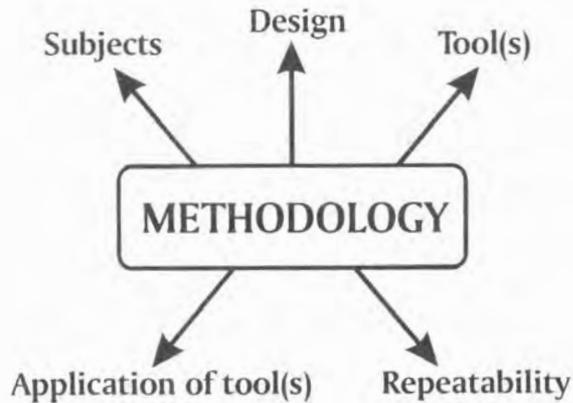
This should address existing relevant theory in order to establish the background from which the research question is developed. It is important for the reader to make a judgement of the extent to which the researcher has addressed this appropriately. Have they convinced you that the question they wish to answer is :

- Worth asking?
- Based on sound theory

#### **Methodology**

This is where things get a little more difficult for the reader with no formal background, but, if approached in a sound logical manner, it is surprising how much of the mystique will disappear.

The methodology presents the reader with information about how the research was performed. A well-written methodology should enable another researcher to replicate the study should they wish.



**Fig. 1 Common elements of a methodology**

The common elements of a methodology are illustrated in **Fig.1**, and are addressed below.

### **Design**

In general terms there are three types of research design; these are *survey, experiment and correlation*.

A survey is commonly used to define population characteristics and is essentially descriptive. An experiment is used to manipulate one or more variables (independent) and measure the effect on another variable (dependent). A correlation design is used to investigate associations, or relationships between variables.

The reader should judge if the design is appropriate to the aims. Is the aim of the research to describe, measure cause and effect, or is the intention to look for associations?

In practice it is quite common to find that a piece of research utilises more than one method. An example of this would be the researcher who uses a survey to measure a characteristic of a variable that is essentially part of an experiment.

### **Subjects:**

The subjects are the individuals upon which the research has been performed.

Aspects to consider in this section are :

- What is the population?
- What is the sample?
- How was the sample selected?

The population is the whole group of individuals which the researcher is interested in, and should be clearly defined. This makes it possible for the reader to judge the appropriateness of the sample selection and subsequent inferences.

The sample is that portion of the population, which has been chosen to represent that population.

There are many ways to obtain a sample, but the important concept here is the representativeness of the sample. What steps has the researcher taken to ensure that the sample mirrors the population in as many respects as possible? The ideal sampling method is that which ensures that any member of the defined population has an equal chance of being a part of the sample, as any other member, and is generated randomly from the whole population. In practice this is rarely achieved or even attempted. Constraints in terms of financial and other resources force the researcher to adopt a procedure that is manageable. This often creates problems with respect to the inferences that can be drawn from the outcomes and to whom they can be applied. It is the reader who must decide if the subjects represent the identified population.

Another important point to consider with respect to the subjects, is concerned with research that divides the subjects into groups in order to test for association or differences. In this instance it is important that the groups are comparable in terms of other factors which could affect the outcome of the study, i.e. extraneous or confounding variables. Examples of this may be equal distribution of factors such as age, experience, or equivalent activity. A good rule of thumb is that groups should have as similar characteristics as possible.

### **Tool(s) and their application**

The tool(s) is the means by which the researcher has measured the variable(s) under investigation. The plural option in the previous sentence indicates that one piece of research may use more than one tool, and is not uncommon.

In order to be critical of tools and their application it is worth identifying two critical concepts: reliability and validity.

- Reliability is concerned with trustworthiness, predictability and dependability.
- Validity is concerned with truthfulness and the foundation on which something is based.

The reader of the research must consider if the tool selected for the purpose is in fact capable of measuring what it is supposed to measure. In other words, are the tools appropriate for the task?

In many cases this question is readily answered, because the tool that has been selected is widely accepted as an appropriate means of measurement. A simple example of this would be the measurement of muscle strength. In this case the research would be valid if the tool selected was an isokinetic dynamometer. If, on the other hand, the research claims that muscle strength was measured using a De Lorme boot, you would rightly question the ability that this tool has to generate appropriate data, and the validity of the tool must be questioned.

Some variables, for example, pain and "feeling of well being", can be less easily defined and measured. In this case the researcher must satisfy the reader that the tool selected is capable of fulfilling the requirements. They would normally refer to previous work which has tested the selected tool against other measures and reached a reasoned decision as to its validity.

Further problems arise with the measurement of such things as attitudes and opinions. Questionnaires or interviews often generate data for variables such as these. The reader must consider such things as; how was the questionnaire, or interview, delivered to the subjects and was the content of them appropriate and unbiased?

When this has been established, the reader should then consider if the tool(s) have been accurately and consistently used. Ask yourself the questions:

- Is there any possibility that the results could be unreliable because of inaccurate or inconsistent application of the tool(s)?
- If more than one person is taking measurements, are they all doing the same thing in the same way?
- Is the data an accurate reliable representation of the variable being studied?

## Repeatability

It is difficult to judge the value of a study if the information supplied is insufficient to enable that study to be carried out by someone else.

## Results and Analysis

This section should present the reader with information about the variables which have been studied, and perform appropriate statistical analysis if the outcomes of the study are to be generalised to the identified population.

This is often the point where the reader with no background in statistical analysis either switches off and allows the information to flow right over their head, or skips the section altogether and moves straight on to the discussion. This is a pity, because it is surprising how easily some of the concepts can be grasped. As indicated in Fig. 2 the results and analysis section can be considered under two major headings, descriptive and inferential.

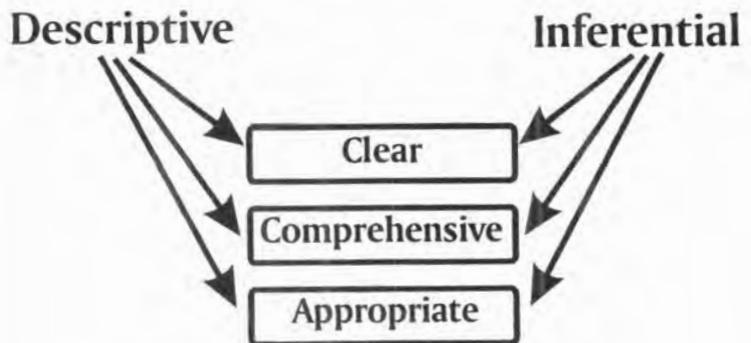


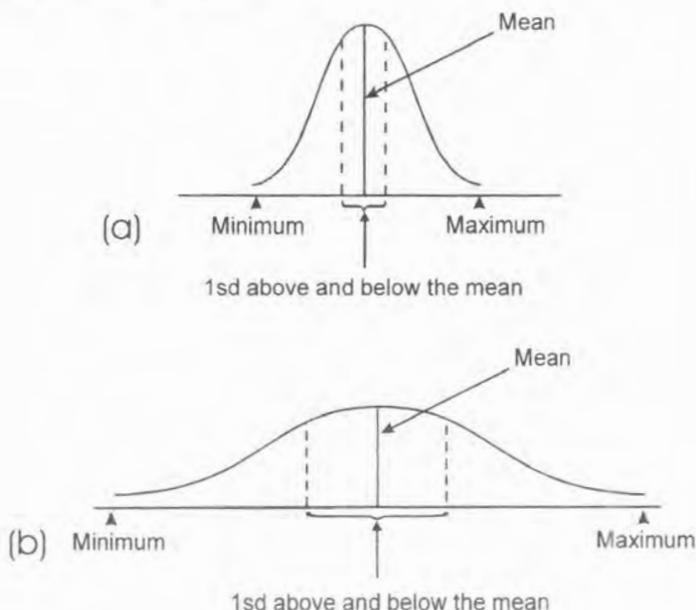
Fig.2 Analysis of results

## Descriptive analysis

It is important for the reader to gain some understanding of the variable(s) that have been measured. So what are the important elements of this understanding?

The reader needs to know how the measurements are distributed. What is the average measurement? What is the lowest value? What is the highest value? Are the values clustered closely together, or are they widely dispersed?

Consider the two distributions illustrated in **Fig. 3**. The average, or mean value, is the same for each distribution. If there was no visual representation and this was the only statistic that you had, you may assume that the distributions were the same. As you can see though in **Fig. 3**, this would be an incorrect assumption to make. The only way you can reach the correct assumption about the distribution of data is if you also know how widely spread about the mean the reported data is. The standard deviation (sd) tells you this.



**Fig.3 An illustration of a compact (a) and a diverse (b) distribution where the mean of (a) is equal to the mean of (b)**

Distribution (a) is compact and may be considered to be clustered around the mean. In this case the standard deviation is relatively small. Distribution (b), on the other hand, is less compact indicating that the data is more widely spread. The standard deviation for this distribution is relatively large.

If the researcher has failed to fully describe the variable(s), it is very difficult for the reader to make decisions as to the validity and reliability of the outcomes.

### **Inferential Analysis**

The researcher, to establish the significance of their results, performs this sort of analysis. It is unlikely to be performed if the research seeks to

be purely descriptive, but should be performed if the researcher is seeking to establish that some real difference exists. It is also performed if the design is trying to establish the strength of association, or relationship between variables.

The basis of inferential analysis is the concept of significance. Consider the concept of experimental design. In this sort of research the aim is to prove or disprove that some intervention has an effect on an identified outcome, e.g. physiotherapy intervention has a positive effect on the functional activity of patients who suffer from cystic fibrosis. In this scenario the researcher would have measured the functional activity of some cystic fibrosis patients who were receiving physiotherapy intervention and some that were not. It may be, that from an examination of the descriptive analysis of the results, there appears to be a difference in the functional scores for the two groups, but there is still the possibility that these results are not as significant as the researcher supposes. The researcher must then quantify the degree of difference between the scores. This is done by the application of an inferential statistical test.

### **Selection of a statistical test**

The selection of an appropriate test can depend on many things such as; the distribution of the data, the level of measurement, the sampling, etc. How then is the reader with no knowledge of these things to pass judgement on this type of analysis? The answer is that they should at least consider the nature of the measurement data. Data generated by measurement is classified under the following headings :

- Nominal
- Ordinal
- Interval
- Ratio

**Nominal** data is that which identifies categories, e.g. male/female, geographical region, black/white etc.

**Ordinal** data is that which allows us to place things in ranks; e.g. degree of satisfaction, level of functional activity etc.

**Interval** data is that which is highly informative, in the sense that it tells us exactly the distance between the points on the data scale, e.g. BP, torque, temperature, etc.

**Ratio** data is an extension of interval data, with the additional characteristic of having an absolute zero, and in practice can be considered in exactly the same way as interval data.

Some statistical tests are more appropriate for some kinds of data than others. The reader of research should know the level of the data being analysed in order to judge the appropriateness of the test applied. The appropriateness can then be ascertained by consulting an appropriate text, which often presents this information in tabular or flow chart format.

### **Interpretation of the inferential statistics**

The reporting of statistical results usually generates those mysterious things called significance levels and 'p values'.

What are they and what do they mean?

They are quantifiable factors, which represent the degree of similarity or difference between at least two sets of data. Inferential analysis within an experiment seeks to quantify the difference and reports this as a 'p value'. The nearer the reported value is to 0.00, the more difference is being identified between the variables. Unless the data is completely different it is highly unlikely that the 'p value' will be as small as 0.00. It is therefore necessary to establish how small the 'p value' should be for the results to be accepted as an indication of *significant* difference between the measurements. The most common level of significance in physiotherapy research is that the 'p value' should be equal to, or less than 0.05. This means that if the generated 'p value' satisfies this requirement, the results can be accepted as significant and a real difference, (or relationship, in the case of a correlation design) exists. The case has been proven with a 95% degree of certainty. It also follows that there is still a 5% chance that the outcome is wrong. If the researcher wanted to be more certain of the significance of the results, they would apply a significance level of 0.01. This would establish a 99% degree of certainty and only a 1% chance of being wrong.

If this is the case you may well ask why all researchers do not use the 0.01 level. The answer would be that, although there is a chance of being wrong there is actually a greater chance of you failing to identify a significance that really does exist. In view of this, the 0.01 level of significance is only normally applied in such things as drug trials, where the outcome has to be right.

A good piece of research presents the results clearly and concisely.

### **Discussion and Conclusion**

Judgement of the value of research should also consider the quality of the discussion and conclusion. It is here that the researcher explains their results with reference to previous studies and places their study in

context. It is often closely related to the introduction.

The researcher should make reference to any difficulties encountered and identify how these difficulties may have impacted on the results by undertaking critical reflection of their study. Interpretation of results must be supported by sound evidence. The reader should consider this evidence and decide if the researcher is justified in coming to that conclusion.

### Summary

This paper set out to address the subject of critical appraisal for the inexperienced reader. In doing this it has identified the process of critical appraisal, and attempted an explanation of some elements that the inexperienced reader commonly finds difficult.

If this paper has achieved its objective, those of you with no prior knowledge of research will feel more confident as you address the issues of critical appraisal in order to inform evidence based practice.

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*In the last issue of the Journal a mistake was made in the title of the video reviewed and we also omitted to include the price and where to obtain it. I am therefore including the review again with the amendments.*

### NORMAL MOVEMENT IN THE FIRST YEAR OF LIFE

**Helen Stevens MCSP**

Produced for The Royal Hampshire Hospital, Winchester by The Video Unit of the Teaching Support and Media Services at the University of Southampton.

**Cost: £35 (including VAT and postage)**

**Order from: TSMS, Mail Point 800, Southampton General Hospital, Tremona Road, Southampton, SO16 6YD. Phone 01703 796560 Fax 01703 796376**

The purpose of this video was to show some of the components of movement required to achieve the milestones of normal sensory motor movement during the first year of life.

The baby is assessed at one month and thereafter at monthly intervals until one year of age. Each assessment examines the baby's activity in prone, supine, pulled to sitting, sitting etc. demonstrating the importance of weight shift, the development of righting and balance reactions, gross motor and fine manipulative skills to play, social interaction and attention.

Assessments are very detailed highlighting initially diminishing reflexes and asymmetry, then through symmetry, mid line orientation, development of proprioception, head and trunk control through rotation, lateral weight shift, righting reactions of head on body right through to independent balance in standing and walking.

This video is the most detailed I have ever seen of its kind, particularly as it has continuity with the same baby from start to finish. Each step of the way emphasises how each new motor skill acquired facilitated better fine motor skills and the acquisition of more sophisticated play and social interaction.

In retrospect I would like to have seen the same baby examined soon after birth and then at one month. Nevertheless, this video would be an invaluable asset to a paediatric library as a clear and concise teaching aid for staff and students and as an excellent reminder of what the 'norm' is.

**Barbara Bowen MCSP**

## ARTICLES IN OTHER PUBLICATIONS

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### **NAPOT - New Style Glossy Newsletter**

Articles include:-

#### **SUMMER 1997**

What is the Internet?

DCD Groupwork

SIT with Autistic Children

Semantic Pragmatic Disorder

#### **AUTUMN 1997**

Microcomputers

Do OT's and GP's need each other?

Aromatherapy, Massage and OT

Play is a Child's Work

Water Activities - Purposeful Therapy

### **ARTICLES IN OTHER JOURNALS**

#### **Archives of Physical Medicine and Rehabilitation 1997, vol 78, no 7, July**

Prosthesis satisfaction outcome measurement in paediatric limb deficiency.

S D Pruitt, J W Varni, M Seis, Y Setoguchi. 745-754.

#### **Complementary Therapies in Medicine 1997, vol 5, no 3, September**

Immunomodulatory actions of *Viscum album* (Iscador) in children with recurrent respiratory disease as a result of the Chernobyl Nuclear Accident.

V P Chernyshov, LI Omelchenko, P. Heusse et al. 141-146.

#### **Developmental Medicine and Child Neurology 1997, vol 39**

##### **no 8, August**

Computer tomograph and single-photon emission computed tomography as diagnostic tools in acquired brain injury among children and adolescents.

I M Emanuelsen, L. Von Wendt, J Bijure et al. 502-508.

Intrapartum fetal asphyxia and the occurrence of minor deficits in 4-to-8 year old children. M Handley-Derry, J A Low, S O Burke et al. 508-514.

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P Steinbok, A Reiner, J R W Kestle. 515-520.

Disability due to restrictions in childhood epilepsy. H A Carpay, J Vermeulen, H Stroink et al. 521-526.

##### **no 9, September**

Attention deficits and spectrum problems in children exposed to alcohol during gestation: A follow up study.

M Aronson, B Hagbery, C Gillberg. 583-587.

Effects of intraventricular haemorrhage and hydrocephalus on the long term neurobehavioural development of preterm very-low-birth weight infants.

J M Fletcher, S H Landry, T P Bohan et al. 596-606.

Respiration patterns during feeding in Rett syndrome.

R E Morton, R Bonas, J Minford et al. 607-613.

##### **no 10, October**

A comparison of intensive neurodevelopmental therapy plus casting and a regular occupational therapy program for children with cerebral palsy.

M Law, D Russell, N Pollock et al. 664-670.

Oxygen cost, walking speed and perceived exertion in children with cerebral palsy when walking with anterior and posterior walkers.

E Matteson, C Andersson. 671-676.

## ARTICLES IN OTHER PUBLICATIONS

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Boys with Asperger's disorder, exceptional verbal intelligence, ticks and clumsiness.

R Nass, R Gutman. 691-695.

Visual agnosia with bilateral temporo-occipital brain lesions in a child with autistic disorder: A case study.

L Mottron, S Mineau, J C Decarie et al. 699-705.

### **British Journal of Sports Medicine**

**1997, VOL 31, NO 3, September**

Somatotype in high performance female netball players may influence player position and the incidence of lower limb and back injuries.

D M Hopper 197-199.

## ARTICLE SUMMARY

### **Developmental Medicine and Child Neurology** **1997, 39:214-223**

#### **Development and Reliability of a System to Classify Gross Motor Function in Children with Cerebral Palsy**

Robert Palisano, Peter Rosenbaum, Stephen Walter, Dianne Russell, Ellen Wood, Barbara Galuppi

"To address the need for a standardised system to classify the gross motor function of children with cerebral palsy, the authors developed a 5 level classification system analogous to the staging and grading systems used in medicine. Nominal group process and Delphi survey consensus among 48 experts (physical therapists, occupational therapists and developmental paediatricians with expertise in cerebral palsy) was achieved. Interrater reliability was 0.55 for children less than 2 years of age and 0.75 for children 2 to 12 years of age, the classification system has application for clinical practice, research, teaching, and administration." Appendix B of this paper gives details of the classification system and how to use it. It is based on self initiated movement with particular emphasis on sitting (truncal control) and walking. Distinctions between levels of motor function are

based on functional limitations, the need for assistive technology including mobility devices (such as walkers, crutches and canes) and wheeled mobility, and to a much lesser extent quality of movement. Emphasis is on the child's usual performance in home, school and community settings. The title for each level represents the highest level of mobility that a child will achieve between 6 - 12 years of age. For each level separate descriptions are provided for children in several age bands: before 2nd birthday, from 2 to 4th, 4 to 6th and 6 to 12 years.

Broad descriptors are as follows:

**Level I:** walks without restrictions; limitations in more advanced gross motor skills.

**Level II:** walks with out assistive devices; limitations walking outdoors and in the community.

**Level III:** walks with assistive mobility devices; limitations walking outdoors and in the community.

**Level IV:** self-mobility with limitations, children are transported or use power mobility outdoors and in the community.

**Level V:** self-mobility is severely limited even with the use of assistive technology.

Carol Hurran



### PROFILE : SUE WHITBY PRO

I have always liked talking to people and organising things! It seemed like a good idea to agree to be the Regional Rep. for East Anglia, as I was enthusiastic about APCP and wanted to share this with everyone. I have now progressed through National Committee and have recently become your Public Relations Officer (PRO), so now all sorts of people ring me up and ask me to discuss things with them, and hopefully I can help them. I liaise between the CSP and various other organisations hopefully giving APCP's view. I also am the overseas members' representative.

I first worked with children when I was about 14, at Birmingham Children's Hospital as a volunteer. I grew up in Hall Green in south Birmingham and trained at the Queen Elizabeth Hospital School of Physiotherapy, also in Birmingham. I qualified in 1966 and left for 'the seaside'! I worked in Exeter at the orthopaedic hospital. After that I decided to be a bit more adventurous and went to work for the RAF in an Air Force hospital in Germany. I thoroughly enjoyed myself, and as a real bonus, I met Mike, who has been my wonderful husband for 25 years. On my return from Germany I worked in Cheltenham and in Gloucester. After that back 'home' for a bit! I worked at East Birmingham Hospital Child Care and Assessment Centre in 1971, which was one of the first 'CDCs'.

In 1972 we got married. Whilst Mike was in the RAF we moved around a fair bit so I worked in all sorts of settings, gaining valuable experience, including the Rheumatism Clinic in the woods at Woodhall Spa and Papworth Hospital. In 1978 Stephen our first son was born and I had a few months off work. However, when the only paediatric physio. in Huntingdon got a research grant for a year to investigate clumsiness in children, I was 'volunteered' just to keep things going! I worked with 3-to-8 year olds and was hooked on paediatrics. I have mostly worked with children since then.

## APCP MATTERS

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We had a couple of years in Norfolk, where I worked at the Jenny Lind Children's Unit at Norfolk and Norwich Hospital. After that we moved back to the Huntingdon area, where we decided to stay. Our second son Keith arrived in 1982 to complete our family and I had a few months off work. However, 'they' found me again and I went back to work, to a very part time job. I have gradually built up my hours and I now get paid to work 25 hours a week!

I work for Hinchingsbrooke Healthcare NHS Trust, which is a combined Acute and Community trust. We have an Integrated Children's Service, which offers seamless care for all the children of the old county of Huntingdon and beyond. Nearly all the children have their therapy in a community setting. I have worked in a variety of situations, particularly in mainstream schools. Until last Summer I spent a lot of time with teenagers in a St. Neots comprehensive school, where the number of pupils who are physically disabled, using wheelchairs went up and up. I learnt a lot about Muscular Dystrophy and many other conditions and spent lots of time teaching other people! My head mistress at school always wanted me to be a teacher, so maybe she was right. I am now deputy superintendent paediatric physio. and work more in the North of our area. One of my particular tasks is to organise staff training and CPD. I have tried to combine this with APCP courses and study days lately, and hope we can do this more, especially where numbers of paediatric staff are low.

Mike and I have a busy life and for relaxation particularly enjoy going out and about in our classic sports cars. We belong to the Sporting Cars Motor Club - who drive for fun and at the same time raise money for children's charities.

I am a fairly recent convert to keeping fit and love swimming, working-out in the Gym and going to gentler fitness classes. I don't expect to stop rushing about just yet, although I have got lots of ideas for the house and garden.

P.S. If you attend the APCP AGM this March, please vote for me.

### INTRODUCTION TO PAEDIATRIC PHYSIOTHERAPY - SEPTEMBER 1997

The following students attended the Introduction to Paediatric Physiotherapy course and successfully completed their case studies

Victoria Alexander  
Penny Allen  
Catherine Ashton  
Joanne Ashman  
Sarah Baxter  
Lisa Beskeen  
Alison Butler  
Helen Clough  
Joanne Coxhill

Sarah Cockburn  
Tara Davidson  
Lynda Evans  
Lindsay Garrett  
Sue Harrison  
Victoria Kent  
Rachael King  
Debra Lambert  
Cathrine Maguire

Deborah Martin  
Pamela Moss  
Lorna Plura  
Melony Scholes  
Larissa Scott  
Donna Smith  
Nicole Van Dootingh  
Jane Whiby  
Melanie Phipps

## APCP MATTERS

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### SUMMARY OF ISSUES DISCUSSED AT THE APCP NATIONAL COMMITTEE MEETING HELD AT THE CHARTERED SOCIETY OF PHYSIOTHERAPY ON 16 JANUARY 1998

1. "Physiotherapy in Paediatrics." Leaflets currently being revised - first draft approved by Executive Committee.
2. Introductory Paediatric Course. Twenty-seven participants completed case studies and have been awarded their certificate.
3. ARC. The APCP are entitled to send four representatives to this year's conference in Llandudno. Lin Wakley, Sue Whitby, Sue Leech and Liz Hardy hope to attend.
4. 'Endorsing Clinical Guidelines - The Role of the Society.' Copies of this paper were circulated. The CSP has a commitment to put in place a process for the endorsement of clinical guidelines. Volunteers will be required to act as Reviewers and Panel Members to assist in the guideline endorsement process.
5. The Treasurer reported that she had received copies of their accounts from all the Regional Treasurers. All details are now with the auditors.
6. The Membership Secretary noted that to date the Association has 919 members though subscriptions are still coming in. At the end of 1997 there were 1302 members.
7. Publications. A new, revised edition of the Dyspraxia Handbook is now being sold.
8. The PRO is seeking suitable photographs for promotional material which members/trusts need for display purposes. Written permission must be obtained from parents/children.
9. The Research Officer reported that the APCP research register now contained 19 names. It was noted that the CSP's list of researchers in paediatrics contains 13 names and there is no overlap.
10. The CIG Liaison Officer reported on the recent CIG Liaison Committee meeting. Current topics being considered are: Standards, Guidelines, Public Relations and CPD.
11. APCP Journal. The editor has recently changed the format of the list of regional representatives' names and addresses and also reverted back to the former way of presenting courses. Feedback is requested.
12. The Post Registration Officer reported that the work continues on a fact sheet on manual handling. It is anticipated that an Information Pack on Outcome Measures will be available at the APCP National Conference.
13. 1999 Conference. The Committee discussed this issue at length and agreed that the APCP would, in 1999, be part of the National CSP Conference. London Region is to consider organising the clinical content of the lectures and workshops for which dedicated time has been allocated.
14. 2000 APCP Conference. It was decided that this would be organised by the National APCP Committee. After 2000 the organisation will revert to the rotational system through the regions.
15. It was noted that over 40 people have expressed an interest in being involved in the development of clinical guidelines - an outcome from the questionnaires distributed in the December 1997 Journal.
16. Next Meeting. The next meeting of the APCP National Committee will be held on Thursday 26 March 1998, at the Chamberlain Hotel, Birmingham.

**This is only a short summary of the National Committee Meeting. Copies of the Full Minutes are available from your Regional Representative on request.**

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# APCP PUBLICATIONS

BOOK/TITLE	QUANTITY PRICE LIST
<b>SERIAL SPLINTING IN HEMIPLEGIC "CEREBRAL PALSY"</b> <i>by Margaret Jones (2nd Edition)</i>	£3.50
<b>THE CHILDREN ACT 1989</b> <i>'A Synopsis for Paediatric Physiotherapists'</i>	£2.50
<b>PAEDIATRIC PHYSIOTHERAPY</b> <i>Guidelines for Good Practice</i>	£2.50
<b>DYSPRAXIA - A HANDBOOK FOR THERAPISTS</b> <i>by Michele Lee and Jenny French</i>	£5.50
<b>GUIDELINES FOR CALCULATING PAEDIATRIC PHYSIOTHERAPY CASELOADS - FACTSHEET</b>	£1.00
<b>BABY MASSAGE - AN INTRODUCTION FOR PARENTS - FACTSHEET</b>	£2.50
<b>STANDARDS OF PRACTICE - PAEDIATRIC PHYSIOTHERAPY</b>	£2.50
<b>STATUTORY ASSESSMENT OF CHILDREN WITH SPECIAL EDUCATIONAL NEEDS</b>	£4.00

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Post & Packing	Single copies	£0.50
	2 - 5 copies	£1.00
	6-10 copies	£2.50
	Over 10 copies	Charged according to weight.

Terms: Strictly cash with order

Cheques and postal orders should be made out to "A.P.C.P. Publications" and included with order.  
International Money orders accepted.

**SEND ORDERS WITH PAYMENT TO:**

**Carol F. Foster, A.P.C.P. Publications**  
**Birmingham Childrens Hospital Physiotherapy Department, Ladywood Middleway,**  
**Ladywood, Birmingham, B16 8ET**

Please supply Name and Address for delivery.

## THE ROLE OF THE RESEARCH OFFICER

The CSP's information leaflet defines the role as follows:

- to direct enquirers to appropriate sources of information e.g. local libraries, CSP Information Centre, NHS Centre for Reviews and Dissemination
- To facilitate networks for research issues  
i.e. establish a list of key researchers; liaise with the CSP; advise on where to register research e.g. on CSP or SIG databases
- Promote research within the SIG
- Act as a point of contact
- Answer enquiries from a variety of sources

### **NOT the role of the Research Officer**

- supply details about all articles relevant to enquirer's area of research
- carry out literature searches
- to be an expert in all areas of paediatric physiotherapy

### **How to assist the Research officer to assist you**

- Offer to review research articles in a paediatric journal that interests you e.g. medical, nursing, other PAM's etc.
- send reviews or abstracts to the research officer for inclusion in an APCP database
- register your research on the APCP list and so help other researchers

**The Education Department at the CSP issues a quarterly Research Bulletin. If you would like to receive copies, please contact the CSP on 0171 306 6601 or FAX 0171 306 6611**



## Snorkelling Club

*for People who have a Physical Disability*



**WHY** Because snorkelling is fun and we would like to share it. Also . . . snorkelling is good for improved stamina and mobility . . . or just relaxing. It can be competitive or non-competitive. But best of all, it's good for feeling the rush of water go by you or just drifting aimlessly along. Plus that dreaded word which everybody lacks from time to time . . . it's good for 'motivation'.

**WHO** Anyone over the age of 8 who has a physical disability, quite likes water who would like to have a go at snorkelling and possibly learn SCUBA diving as well. (A medical from a Doctor is usually required, forms supplied by the Club).

**HOW** Telephone, write, fax or Email us. For our part, we are qualified Instructors supported by qualified divers and snorkellers. All our students are always different, they come from different walks of life, have different abilities and different attitudes. Each person will learn in a different way and at a different speed and we look forward to helping each person move further forward to their potential. We will do our best to be open minded to each person's special requirements with regard to training, if you will help us to help you!

**WHEN** Tuesday evenings between 9.00 and 10.00 pm.

**WHERE** Tadcaster Swimming Pool which is completely wheelchair friendly.

**WHAT** What are our long term aims? Mainly to have fun. However, in reality, the sky's the limit, so to speak. Would you like to snorkel or maybe SCUBA dive with the grey Atlantic seals around the Farne Islands off the Northumberland coast? Would you like to dive in the Red Sea? Is this just a dream or could this be a reality? We aim for our club members to be able to exactly these things. The sky's the limit? I don't think so!

To 'have a go'



Ring 01904 744424 and ask for Ann  
Fax 01904 744724  
Write Ann Easterbrook  
10 Vicars Close  
Copmanthorpe  
York YO2 3TP  
or Email: [ann@diving-serv.co.uk](mailto:ann@diving-serv.co.uk)

### What are ADJUSTABILISERS ?

ADJUSTABILISERS are adjustable stabilisers specially designed to help children learn to ride bicycles as easily as possible.

### What makes ADJUSTABILISERS UNIQUE ?

The adjustabiliser wheels can be adjusted by gradual stages closer and closer to the bicycle rear wheel (see drawing showing back view of a bicycle fitted with adjustabilisers). The confidence of the rider in his or her own improving balance increases in easy stages.

*There is no longer the sudden change from full to no stabiliser wheel support which is necessary when ordinary stabilisers are removed.*

### How well do ADJUSTABILISERS work ?

ADJUSTABILISERS work so well that, with their help, even handicapped children with a poor sense of balance have been able to learn to ride bicycles.

### How ADJUSTABILISERS save parents time and effort

Parents usually have to spend considerable time and effort running along helping their child learn to balance when ordinary stabilisers are suddenly removed from the bicycle. Normally little or none of this is required after balance improvement from using ADJUSTABILISERS.

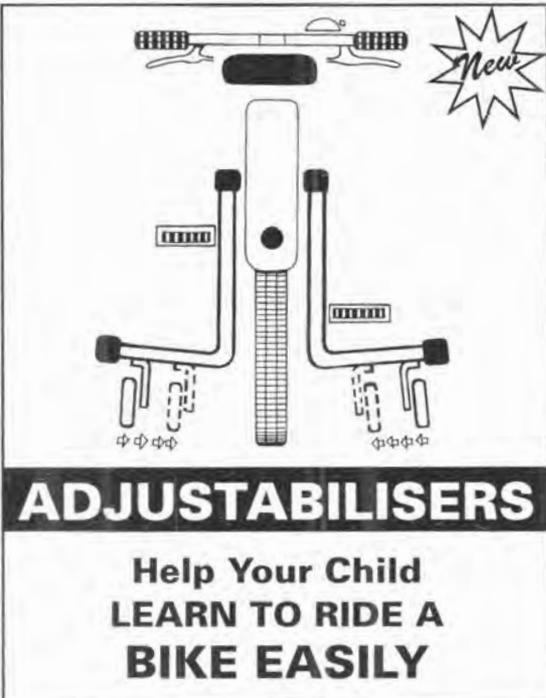
### ADJUSTABILISERS fit nearly any 12" to 20" bicycle including most geared models

This is because they clamp to any convenient space on the tubes at the rear of the bicycle frame.

### ADJUSTABILISERS - other benefits

- reduces riders and parents anxiety while learning to ride a bicycle

60 Gwel Eryri, Llandegfan, Menai Bridge, Gwynedd, Wales, LL59 5RD, U.K.



**ADJUSTABILISERS**

**Help Your Child  
LEARN TO RIDE A  
BIKE EASILY**

- easily fitted to most bicycles
- easy sideways wheel adjustment
- durable, strong, well-designed and high quality
- wheel height above ground level continuously adjustable to suit rider/practice area exactly
- large ordinary screwdriver only tool needed for setting up and adjustments
- suitable for almost all bicycles with wheels from 12" to 20" diameter and for riders up to 10 stone in weight
- free accurate setting up aids supplied

### ADJUSTABILISERS - the Future

Will ADJUSTABILISERS eventually become the way most children learn to ride bicycles? It seems not only possible but completely logical.

*The Voice  
of Working Parents*

PARENTS AT WORK offers:

- A helpline, bringing you practical information on childcare options and ways of balancing work and home. 0171 628 3578.

- Support, through our membership network of local groups.

- Promotion, of your needs to policy makers.

45 Beech Street, London EC2Y 8AD.  
Admin., Media, Publications Tel: 0171 628 3565

Information • Support • Families • Employers  
**PARENTS AT WORK**

### What we do

#### HELP CHILDREN

Our first concern. Informed parents will be able to make wiser decisions about childcare provision. We assist parents to make the best choices available, so that children do not suffer because of parents' employment commitments.

#### HELP FAMILIES

By giving practical, unbiased, information and support to working parents, which benefits the entire family.

#### OFFER SUPPORT

By helping parents to share support and experience on coping successfully with the demands of child-rearing and employment.

#### BUILD A NETWORK

We encourage the setting-up of local and workplace support groups and offer help in establishing them.

#### SUGGEST GUIDELINES

We encourage good practice between members and childcare workers.

#### PROVIDE INFORMATION

In our own specialist area to our members, employers, the media and other interested organisations.

#### CAMPAIGN

We work with other agencies, organizations and businesses concerned about children and their parents, and campaign for improvements in childcare, tax and employment rights to help working parents.

#### WORK WITH EMPLOYERS

To improve conditions for working parents to the benefit of both sides. Employers are increasingly aware of the need to understand the particular problems of working parents and to assist them.

### Join us!

PARENTS AT WORK is a national charity committed to the welfare of children of working parents.

We believe that children are our most valuable resource. Society has a responsibility to ensure that their developmental needs are met through the provision of affordable, good quality childcare and education.

The central role played by parents in bringing up their children should be more highly valued and parents should be enabled to make positive choices about how they balance work and home.

PARENTS AT WORK helps parents match the needs of their children with their responsibilities in the workplace.

## REGIONAL REPRESENTATIVES

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### **EAST ANGLIA**

Mrs S Howell  
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#### **OVERSEAS**

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PRO  
3 Manor Way  
Hail Weston  
Huntingdon PE19 4LG

## REGIONAL REPRESENTATIVES

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### EAST ANGLIA

Thank you to all our members in E.A. Region for Region for supporting the study days held in 1997 so well. Every one was a success. Please contact me if you have any ideas for future topics or a venue to offer.

By the time you read this we will have organised some of this year's study days, we will keep you posted. Also we are hoping to be involved with the C.S.P.'s Regional conference to be held at the University of East Anglia. More details in next newsletter.

I hope as many of you as possible will be going to the APCP Annual Conference to be held in Birmingham and I look forward to seeing you there.

STELLA HOWELL

### NORTH WEST

A quiet start to the New Year with 6 new members but nearly 60 failing to renew their membership subs. - Please remind your colleagues. I will be sending out a reminder to lapsed colleagues!

Our A.G.M. on 28th February is being supported by S. Reed and company; and by Langer Bio-Mechanics. I hope to see many of you there.

Plans are well in hand for the Feeding Day in April in Liverpool and we are in communication with the Royal National Orthopaedic Hospital in Middlesex re the proposed Erbs Palsy Day in Spring '99.

This journal issue will bring you up to date on A.P.C.P.'s work with clinical guidelines. Please contact me if you wish to join me in forming a small working group to further this initiative. (Thank you to the 3 people who have approached me already.)

WATCH THIS SPACE

SUE LEECH

### SCOTLAND

Following the December Journal's report on the National Committee working weekend on the writing of Clinical Guidelines several Scottish members have contacted me and expressed interest in joining working groups. They are eagerly awaiting this journal!

The Scottish Branch are running a Halliwick Course to be held in Edinburgh. Part A is in on the weekend of 25th and 26th April and will be held in November but the exact weekend has not been finalised.

Our A.G.M. will be on Friday 27th February 1998 and the study topics will be orthotics and seating.

CHRISTINE SHAW

### SOUTH WEST

Many thanks to all the members around the region who responded to our plea for interested parties to take forward clinical guidelines. Hopefully I will be able to contact you with more information following this edition of the journal and the National Committee meeting at the end of the month.

I hope to see some of you on March 14, at our AGM and study day, entitled 'Loss, Grief and Bereavement'. If you get your journal and read this in time and would like to come, give me a ring - there may still be places left!

We are going ahead with a repeat course on Gait Analysis, dates yet to be confirmed but it will be over a weekend in either April or May and the venue will be Southampton Hospital - contact me for further details. Note: Bargain price of £60 for members, £75 for non-members. This is an excellent course and superb value for money!!

I have news of a course for assistants - OT, PT, Special Needs Assistants, etc.

'Functional Anatomy and Effective Exercise'

Date: Tuesday 9 and Wednesday 10 June 1998

Cost: £70

For further details please contact: Sue Bearne, Woodlands School, Physiotherapy Department, Bodmin Road, Whitleigh, Plymouth, PL5 4DZ. Tel: 01752 785416.

I hope to meet up with some of you at Conference. If you are there make yourself known to me, it's really nice to put faces to the names I only see on labels for journals!

Best wishes JULIA GRAHAM

## REGIONAL REPRESENTATIVES

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### TRENT

Happy new year to all TRENT members. Thank you to everyone who attended our one day course on Dyspraxia with Michelle Lee in October. It was very successful.

After our course in Rotherham in February on 'Analysis of Gait' we will be organising our AGM. All details will be sent directly to members. Please make an effort to attend as we need to elect new members on to the committee.

Last year our membership rose to 82. This year so far we are only up to 55 so please remember to renew your subscription and encourage colleagues to join.

SUE PARGETER

### NORTH EAST

We had an excellent study day in November 1997 on 'Paediatric Respiratory Physiotherapy' - Liz Hardy. This was well attended and I would like to thank Liz for her stimulating presentation and hard work on the day.

By the time you receive your March journal, we will have had our next study day on 'BOT TOX', at Wakefield along with our AGM.

The study day 'Paediatric Sports Injuries' - Julie Sparrow, will be held on Friday the 8th May 1998 at the White Hart NHS Training Centre, Harrogate.

So far, I have only received written interest from four members regarding the possibility of forming a working party in the North East Region to look at developing clinical guidelines. Please do read your journal about this subject and perhaps then you will be more inclined to contact me!!!

If any member would like to see a full copy of any National Committee Meeting, then I am happy to oblige once I have received a written request.

I look forward to seeing many of you at our National Conference in Birmingham at the end of March.

MARY HARRISON

### LONDON

We had an excellent turn out to our last study day in December 1997 on the dilemma of when to use DAFO's, fixed and hinged AFO's and the day produced a lot of useful discussion.

Our next study evening and A.G.M. will be held on Thursday, 19 March, 1998 at St. Mary's Hospital, Paddington, and the topic will be "Limb Lengthening". Please try and support your local branch and come along.

Thank you to all those members who have already rejoined A.P.C.P. for this year, and welcome to our new members. Please do not forget to contact me if there is anything you wish me to take forward to the National Committee as your representative.

I hope to see you on 19 March at our A.G.M.

DIANE COGGINS

# APCP REGIONAL STUDY DAYS

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## AUTOGENIC DRAINAGE

**April 3 and 4**

**Pembury Hospital, Tunbridge Wells, Kent TN2 4QJ**

This two day course includes theory and practical tuition with children who have CF. The course tutor is Christine Atkinson from the Royal Hull Hospital. The cost is £80 for the two days, including lunch. There are only twenty five places available.

Apply: Sheila Minet, 01892 3535 Ext 3254 or in writing to the Physiotherapy Department, Pembury Hospital, Tunbridge Wells, Kent TN2 4QJ

## PAEDIATRIC RHEUMATOLOGY THERAPY COURSE

**April 8th - 10th 1998**

Three day course for Occupational Therapists and Physiotherapists, covering all aspects of treatment of Juvenile Chronic Arthritis and allied conditions. Places limited to 20.

Tutors: The staff of the Childhood Arthritis Unit, Birmingham Children's Hospital.

Course Fee: £290 - residential, £190 day delegates.  
fully inclusive of all meals, course notes, and accommodation (if resident).

Course Venue: The University of Birmingham Conference Park, Edgbaston, Birmingham.

Applications/course details from:

Mrs. Ann Parkin, MCSP

The Childhood Arthritis Unit, The Children's Hospital, Steelhouse Lane, Birmingham B4 6NH  
0121 454 4851, Ext 6824

## South West

## MUSCLE DISORDERS

**Friday, 24th April 1998**

Child Development Centre, Scott Hospital, Beacons Park Road, Plymouth PL2 2PQ.

Tel: 01752 550741 x 3403

Main Lecturer: Dr Jardin, Consultant Paediatric Neurologist who is setting up a new muscle disorder team in Bristol.

Fee: Members £30.00, Non Members £35.00,  
Students £20.00

For application forms and programme contact:  
Justine Reed.

Please send S.A.E. Closing date: 24th March 1998

## COURSES

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North West

### **FEEDING DIFFICULTIES IN CHILDREN WITH NEUROLOGICAL DISORDERS**

**Thursday, 30th April 1998**

Education Centre,  
Royal Liverpool Children's NHS Trust - Alder Hey,  
Eaton Road, Liverpool L12 2AP

Speakers include

Dr L Rosenbloom - Neurological Aspects  
Dr M Dalzell - Gastrointestinal aspect and use of PEGS  
Prof. H Carty - Radiological Investigations  
Siobhan McMahon - Speech Therapy  
Claire Ewan - Nutritional Aspects  
Pat Caldicutt - Gastrostomy Care  
A Multi-disciplinary Study Day

Fee: £40.00 - including lunch

For further details and application forms contact:

Gill Holmes, Senior I Physiotherapist, Child  
Development Centre, Royal Liverpool Children's  
Hospital NHS Trust - Alder Hey, Eaton Road, Liverpool  
L12 2AP. Tel: 0151 228 4811 x 2660.

### **NEUROMUSCULAR DISORDERS IN CHILDREN: CURRENT CONCEPTS IN MANAGEMENT**

**Date: May 11 - 13, 1998**

Venue: Wolfson Conference Centre, Hammersmith Hospital, London  
W12.

This 3 day course is aimed at all therapists working with children who  
have neuromuscular disease, and wish to update their current knowledge  
and practice.

The course will be split into three areas of management of children with  
varying disorders:

Day 1: The ambulant child.

Day 2: The child ambulant in orthoses.

Day 3: The non-ambulant child.

Topics will include: Genetics, orthopaedic management, seating and  
respiratory care. Speakers will be leading experts in these fields.

Cost: £175 for 3 days to include lunch and refreshments.

£75 for individual days.

Departmental tickets for all 3 days will be available.

For further information or application forms contact Denise Watson or  
Marion Main on 0181-383-3072.

## COURSES

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### THE INFLUENCE OF GRAVITY IN NEUROLOGICAL IMPAIRMENT

**Date: 21st May 1998** (to be confirmed)

Time: 9.00am - 4.00pm

Venue: Kettering, Northants.

This introduction to the Hare approach will cover the concept, analysis and measurement of levels of ability and the influence of gravity and the base of support on postural competence and basic trunk function.

Using lectures and small group workshops it will explore the concepts and their application to the treatment and management of adults and children with neurological impairment.

Cost: £40 To include pre-course package, course material and refreshments. (£35 HAFPA members)

Speakers: Caroline Griffiths and Pauline Pope

Participants should wear suitable clothing for practical workshops.

For further information, programme and application forms please send a stamped addressed envelope to:

Linda Whitaker, 21, Hague Bar, New Mills, High Peak SK22 3AT

Daytime telephone no: 0161 368 4242

### MANAGEMENT OF NEONATES

**25-26 June 1998**

The Royal London Hospital, Whitechapel, London E1 1BB

The purpose of this course is to provide an opportunity to consider the management of neonates on an NICU and their early follow-up post-discharge.

Topics to be covered will include :

Day 1 - Common neonatal conditions requiring surgery, management of the neonate (non respiratory) in the NICU, neonatal outcomes, neonatal developmental follow-up.

Day 2 - Handling and positioning in the ICU, Newborn Individualised Developmental Care and Assessment Programme (NIDCAP), and multi-disciplinary management in the early follow up period.

Cost: £70 or £40 per day.

For further details and application forms contact :

David Thomson/Helen Miles, Children's Physiotherapy Service,  
Mile End Hospital, Bancroft Road, London E1 4DG.

Tel. 0171 - 377 - 7874 Fax. 0171 - 377 - 7808

## COURSES

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**A FURTHER COURSE  
ON GAIT ANALYSIS  
IN CEREBRAL PALSY-  
HOW TO DO IT  
AND WHEN**

**Date: 6 - 8 July, 1998**

For further information contact

Erica Wilkinson

Institute of Orthopaedics

The Robert Jones & Agnes Hunt Orthopaedic & District Hospital NHS  
Trust, Oswestry, SY10 7AG.

Tel: 01691 404570. Fax: 01691 404071.

## Notes for Contributors

The Editorial Board welcomes research material; referenced articles and evaluations of physiotherapy practice; informal articles.

Manuscripts should be sent to Lin Wakley, 2 Ash Bank, Pipers Ash, Chester, Cheshire, CH4 7EH, U.K.

Copy to be submitted should be typed on one side of the paper, double spaced and with ample margins. All pages should be numbered consecutively.

**Manuscripts** should provide the title of the article and the author(s) name(s) and full postal address for correspondence.

**References** should be given in the Harvard System.

In text Author(s) name and initials followed by the date of publication. Use a,b, to indicate more than one publication in the same year. Where there are 3 or more authors use first name followed by et al.

For books Laszlo, J. & Bairstow, P. (1985) *Perpetual Motor Behaviour* (Rinehart and Winston)

For chapters

within books Morley, T.R. (1992) Spinal deformity in the physically handicapped child, in : G.T. McCarthy (Ed). *Physical Disability in Childhood* (Churchill Livingstone)

For articles Scott O.M., Hyde S.A., Goddard C.M., Dubowitz V., (1981a) Prevention of deformity in Duchenne muscular dystrophy. *Physiotherapy* 67(6), 177-80.

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