CHAIRMAN'S REPORT
THE SHAPE OF THINGS TO COME

Over the past few months there has been much going on in the world of paediatric audiology. The Newborn Hearing Screening Programme (NHSP) continues to be rolled out apace in England and Wales. Northern Ireland is well on the way to a national implementation and Scotland is set to begin the roll out in April 2005 beyond the 3 Health Boards currently delivering the service. Modernising audiology services is ongoing with the issuing of digital hearing aids to children now becoming fact rather than fiction in many areas.

Earlier diagnosis of permanent childhood hearing impairment is of course only the beginning and if Newborn Hearing Screening Programmes are to be a success it is essential that all the follow up services are also in place and of high quality. Paediatricians working within the audiology services must be proactive in ensuring that this is the case. The BACDA training group have been working hard on the production of competencies for the aetiological investigations in babies identified through the newborn hearing screen. BACDA also has representation on the NDCS working group which is developing parent friendly information regarding aetiological investigations.

There is currently much speculation about the future configuration of paediatric audiology services, the skill mix involved, shifting roles and responsibilities and the move towards more aspects of the paediatric audiology service being provided by non-medical audiologists than has previously been the case. As you are aware over the past few months there have been a number of different meetings and discussions taking place regarding the future of paediatric audiology.

Paediatric Audiology Workshop

In March this year a multidisciplinary meeting was held to take stock of the current situation and to consider options for the future. The meeting was chaired by Professor David Hall and sponsored by NHSU. All disciplines involved in paediatric audiology were represented. Roles, responsibilities, training, recruitment and retention issues were explored.The extending role of the non-medical audiologist (as this moves to an all graduate profession) was discussed. The falling number of paediatricians working in audiology, the varying sessional commitment, and the different levels of expertise and responsibility of paediatricians within paediatric audiology services were highlighted. The importance of the paediatrician within the audiology team was acknowledged, but their exact role not defined. This will undoubtedly alter over time and be influenced by the changing skills, knowledge, experience and attitudes of the other members of the audiology team. At the end of the day there were no solutions produced but some recommendations were highlighted for further consideration and action. Professor David Hall is compiling a report of the day which will be available in due course.

Royal College of Physicians working party in Audiological Medicine

Lesley Batchelor has been representing BACDA at these meetings which has been hearing evidence from parties involved in all aspects of audiology and vestibular medicine. The group is now at the stage of producing a report which will detail the role of the Audiological Physician, interactions with other professionals of all disciplines, how roles overlap and where they are unique. One of the main sections of the report will consider future training in light of Modernising Medical Careers.

Royal College of Paediatrics and Child Health working party on training for prospective Audiological Paediatricians

This working party has only recently been established. Lesley Batchelor and Sarita Fonseca are both members of this group. There is also representation from RCPCH education and training section, neurodisability speciality training group and BACCH.
This group will consider the training requirements for paediatricians working in audiology, taking into account Professor Hall's report from the Paediatric Audiology Workshop and the implications of Modernising Medical Careers.

I hope there will be consultation between the RCP and the RCPCH working parties as the future training for Audiological Physicians and Audiological Paediatricians must be linked and the possibility of development of a joint higher specialist training explored. It is of great benefit to future planning that Lesley Batchelor is a member of both groups.

BACDA – BAAP, The dawn of a new era

During the last 2 years there has been much talk about strengthening the relationship between BACDA and BAAP and the development of a Federation. As you are aware this development was given the support of the BACDA membership at the AGM. I am delighted to report that at the BAAP AGM in April the move was unanimously supported by the BAAP members present. After lengthy consideration it was decided that the name of the Federation would be "**The British Association of Audio-Vestibular Physicians and Paediatricians**"

The aims of BAAVPP are

- To present the unified voice in matters relating to medical issues in audiology
- To form the committee which can provide rapid response to issues of mutual high importance through fast track consultation
- To initiate and support the standards of clinical practice within the scope of both professional groups
- To combine educational activities of mutual interest to both professional groups
- To enhance the inter-professional support for individual members of the organisation

The committee will comprise of 3 officers from each organisation and will meet a minimum of twice a year. There will be reciprocal representation on the executive committee of each professional body.

Although it is early days there has already been considerable consultation and joint working between BACDA and BAAP. There is real commitment on both sides to ensure that BAAVPP succeeds. I personally feel that the formation of BAAVPP is the first evolutionary step towards a full amalgamation of BACDA and BAAP. If such an amalgamation was to take place we would need to ensure that the new body formed catered for the widely varying needs of the membership. I am aware that this concept may not be to everyone's liking and I would be interested to have feedback from the wider membership about this.

Shaping the future

The future for Paediatric Audiology Services, and those working within them, remains unclear. However the topic is very much on the agenda of both the colleges and various government bodies at the current time. Make it your business to find out what is going on nationally and within your local service.

BACDA, BAAP and BAAVPP have representation on many different working groups and committees which are in a position to influence the delivery of future services.
The Executive Committee are keen to do its best to represent the views of the wider membership in all its discussions and deliberations. If you have any issues that you wish the committee to consider don't wait to be asked! Make your voice heard. Contact any member of the Executive Committee.

We look forward to hearing from you

Ann J MacKinnon

BACDA AND BAAP FEDERATE

The British Association of Audio-Vestibular Physicians and Paediatricians (BAA-VPP)

Audiological Medicine became a speciality in 1976 and the British Association of Audiological Physicians was formed soon afterwards. The main concern at that time was training standards and to establish a Training programme for Senior Registrars to become Consultant Physicians in the specialty of Audiological Medicine. This was supervised at the Royal College of Physicians under the auspices of the Joint Committee for Higher Medical Training (JCHMT) Specialty Advisory Subcommittee (SAC) that first was part of the Neurology SAC and then became an independent SAC. The training included the MSc in Audiological medicine and a 4 year period as Senior registrar in one hospital with secondments elsewhere as required. This later changed to a 5 year rotation with the introduction of Calman and Specialist Registrars.

Meanwhile most Paediatric Audiology was conducted in Community clinics by a variety of paediatricians with different levels of seniority and training. Training programmes within paediatrics under the auspices of the Royal College of Paediatrics and Child Health are only now being considered, and the gap was filled by the establishment of the British Association of Community Doctors in Audiology (BACDA). The MSc in Audiological Medicine was considered highly desirable and many Community paediatricians undertaking Audiology clinics have this qualification. BACDA was formed in the 1980's to ensure common standards of Paediatric Audiology in the Community environment, as illustrated by the BACDA Curriculum for training in Community Paediatric Audiology. At that time there was considerable debate about whether BAAP should simply incorporate the community doctors, but as these paediatricians outnumbered the Audiological Physicians by 10:1 and had different training needs this proposal was rejected.

As Community paediatricians were awarded consultant status in the 1990's all those Consultant Community Paediatricians practicing primarily within Audiology were eligble to join BAAP and have enriched the Association.

Manpower planning for doctors working at all levels of Audiological and Vestibular Medicine has been of concern since the inception of BAAP and the annual review of training places is one of the duties of the Honorary Secretary. The Department of Health Medical Manpower committees (there have been several generations of these) were unable to take Community Paediatric Audiology into consideration other than to replace those consultants already members of BAAP. Manpower planning now involves all health care professionals and the total workforce delivering the service is considered by bodies such as Manpower Audiology Workforce Education and Training (MAWFET).

Having discussed the possibility of federating BACDA and BAAP for several years a sense of urgency was imposed by the Department of Health at the 2002 BSA conference when they advised those present that they could not negotiate with so many organisations. The Scientists, Technicians and Therapists joined to form the British Academy of Audiology this year and will eventually incorporate the private hearing aid dispensers. It became imperative that BACDA and BAAP should speak with one voice. A joint committee was set up in 2003, and terms of reference drawn up. In 2004 both BACDA ad BAAP accepted the draft terms of reference and voted for federation. The federation was formally accepted and instituted at the fourth annual joint BACDA/BAAP conference in York in April 2004 and the name British Association of Audio-Vestibular Physicians and Paediatricians (BAA-VPP) was adopted by common consent of those present.

The role of the new body will be to speak with one voice to the Department of Health on manpower and policy issues, to consider training developments to prepare future consultants for both community and hospital based audio-vestibular medicine, and to provide common postgraduate educational activities. The executive meetings of each of the constituent organisations are attended by at least 2 officers of the other, and BACDA officers are present at meetings with the National postgraduate dean for Audio-vestibular Medicine, Professor Gallen from Leicester. Conferences and study days are held jointly. At some meetings such as MAWFET the interests of each organisation are represented by an officer of one or the other, at others such as the National Committee for Professional in Audiology (NCPA), both organisations currently send representatives. As the new Association evolves there will be more common representation.

Dr. Susan Snashall
Chair BAAP

Home Visiting to Test Children's Hearing During Sleep: an audit over one year of forty-four children

Keith Stewart, Associate Specialist, East Kent Children's Hearing Service

Introduction

The "difficult to test" child is ever present. Often colleagues are keen to know the hearing ability of a child and objective testing without sedation is unlikely to be successful. Plans for speech and language and occupational therapies, for nursery placement and family support through Portage, may depend on the paediatric audiologist floundering singly or with a partner to obtain any threshold results. Even the experienced and child-charmer, child-calmer tester of hearing will struggle from time to time to engage a child in behavioural techniques of testing hearing. Parents become concerned that a baby fails to "startle" or respond to sounds. In areas without an "at risk" hearing screening programme, children will be referred to paediatric audiology for any of the risk factors generally considered to be a possible cause of hearing loss, with the expectation that, by some magic, audiometry will be completed.

Objective testing under sedation or general anaesthesia will give limited information about hearing ability at a large cost, both financial and in parental, child (and professional) emotional stress. A couple of adverse reactions to sedation prompted the author to consider the alternative: to test a child objectively during its natural sleep. Many babies in the first few weeks of life have otoacoustic emissions (OAEs) and auditory brainstem responses (ABR) carried out when they are naturally asleep, in out-patient clinics or audiology rooms. The natural extrapolation to older children in their own beds seemed logical.

Forty-four children were included in this report – parents were offered a planned home visit either after the author read the referral, or had been unsuccessful in obtaining satisfactory audiometric results with the child in the clinic. One child with a bilateral sensorineural hearing loss was discovered.

Method:

Tools:

- Echocheck OAE Screener (Otodynamics)
- Portable tympanometer (QT1, Amplivox)
- Otoscope (battery powered)
- Kent A- Z, 2003 (Geographers' A-Z Map Company Ltd)

This study ran from 1st April 2003 to 31st March 2004.

Children over 14, and up to 24, weeks (corrected age) and any whom the referral letter indicated had severe behavioural problems were selected out and the parent(s) were telephoned by the author to offer a home visit to carry out the hearing test. Time of usual sleep was ascertained and a firm arrangement made for the visit. Parents were also asked for rough directions as some of the newer roads were not included in the 2003 version of the A-Z of Kent.

Any child whose letter of referral failed to indicate a possibly "difficult to test" child was sent a clinic appointment (for the closest to home of ten venues) with the appropriate urgency judged from the letter. Any child whom the author was unable to beguile into age appropriate hearing testing and in whom the window of opportunity for successful testing was closing was offered, through his/her parent(s), a similar home visit arrangement to the 14-24 weekers, above.

Most visits took place in the evening between 18.30 and 23.00 hrs., on a weekday. Few children were awake at the time of the home visit and most parents had made an effort to try to have the child asleep for the allotted hour.

On the basis that a positive result with the Echocheck OAE screener was the most important outcome of the exercise, this test was first carried out on whichever ear was most accessible. The other ear was then tested. A first "inconclusive" result was always repeated. If the child passed on both sides, no further testing was carried out. A "refer" on either (or both sides) led to otoscopy and tympanometry. The results were explained to the parent(s), who was/were invariably in the room where the child was tested, and the result written in the Parent-held Child Health Record (Red) Book. Arrangements for any subsequent follow-up were agreed. A letter about the home visit was always sent to the referrer and circulated to include the Health Visitor (HV), G.P. and C.C.P. and, if the parents so wished, a copy was sent to them, too. In the case of children under seven months old, the HV was asked to carry out a routine Distraction Test (HVDT) at seven to nine months of age, as the OAE screen was not the accepted tool of the child heath screening in East Kent at the time.

Results:

Forty-four children received home visits in order to test their hearing whilst in natural sleep. Twenty were pre-planned after reading the referral letter. Twenty-four were arranged after unsuccessful attempts to obtain results in a clinic setting. Two woke during the test and testing was not completed. A few awoke and then went back to sleep and testing was completed. One who gave no obvious signs of waking removed the Echocheck OAE Screeners' ear-tip from his ears

on several occasions before testing was abandoned. The ages of the children thus tested ranged from one to fifty-nine months, though all but five were under two years old *fig. 1*.

Referrals were, mostly, received from Health Visitors (25) and paediatricians, both from acute and community services (14) *fig.2*. The main reasons for the referral were: a family history of deafness (8); parental concern (6); being referred after a second HVDT (7); developmental delay (11) *fig. 3*.

One child with a syndrome, family history was discovered, after referrals on both sides, to have a moderate to severe, bilateral, sensorineural hearing loss. Twenty children produced satisfactory otoacoustic emissions to pass the screen in both ears. Six had bilateral otitis media with effusion (OME) and ten had unilateral OME. It was impossible to test three (see above) *fig.4.* Five of those with bilateral OME and the three that could not be tested were subsequently tested with normal hearing and one with OME also had the sensorineural loss. Of the three who were impossible to test, one, the oldest in the study, was tested under general anaesthetic. He required this for another investigation and brainstem testing was carried out at this opportunity.

Discussion:

Testing children at risk of hearing loss is best carried using ABR. The Echocheck screener was used in this study because there was no alternative. The three most common causes for referral were family history, parental concern and after the second HVDT. These accounted for half of the referrals. None of these children had associated conditions that demanded brainstem testing. This was, essentially a screening exercise. The four children who had bacterial meningitis, the three with pre-auricular skin tags and the two premature children should have been tested with ABR. One mother, during the study period refused the offer of a home visit: her child was not included in the study. The children were "self-selected" for this study: it is the result of expediency that these children were offered a home visit. There is no control group, no prospective element and little chance of comparing similar cases. It is an eclectic group. This is a descriptive piece of study.

It is interesting that of sixteen children with otitis media with effusion, ten had it in only one ear: a ratio of 3:5, bilateral to unilateral effusion. This figure is contrary to a ratio of 8:1 children who have bilateral to unilateral OME (and are of a similar age group) being tested successfully in the author's clinics (unpublished annual audit data). The possibility is raised that children with unilateral "glue ear" are more likely to be difficult to test using behavioural techniques.

There would certainly be a cost saving for home visiting over hospital admissions and/or repeated returns to the clinic for the child. A colleague (Alkass, W. personal communication, 2003) calculated that each return visit to a clinic costs a paediatric audiology service £75. The cost of a child admitted as a day-case for sedation is approximately £85. If general anaesthesia, theatre time etc is added the cost more than doubles at £175 (East Kent Hospitals' Trust Finance Department, personal communication, 2004). The emotional stress to child and parent(s) is considerable. The cost of carrying out home visits (were they funded, which they were not in this study) would be approximately £80, allowing for an average round trip of 60 miles. The parental appreciation of the service provided by the study has been universal, both expressed to the author and fed back by Health Visitors. The children have been too young to express an opinion, even if they realised what had happened.

Why would a community paediatric audiology doctor want to provide a home visiting service to screen children's hearing? The author spent 28 years as a general practitioner before he moved to full-time paediatric audiology five years ago. Calls to homes in the evenings and at night were always part of his working life. It seemed a sensible solution compared with a fraught second and/or subsequent session in a clinic, trying to get results, or to sending a child off to the scary experience of admission to hospital with all that entails. The satisfaction for the author has been to provide a well-received service and to be able to report results to colleagues and parents that both can believe in.

Conclusions:

The study was "family friendly", but at a cost to the spare time of the author. "Forty-four visits made" averages about one a week, allowing time off for annual and study leave. In one respect it is encouraging that only one child per week was perceived not able to be tested in a clinic setting (out of an average 70 children seen each week). The requirement will reduce: May 2004 saw the Newborn Hearing Screening Programme starting in East Kent. The big questions, that will be left unanswered, are: "Will the author continue the service on a voluntary basis?" And: "Will the NHS fund this locally?"

Fig. 1

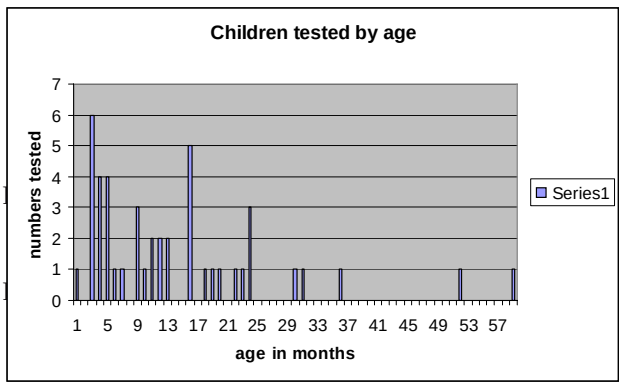


Fig. 2

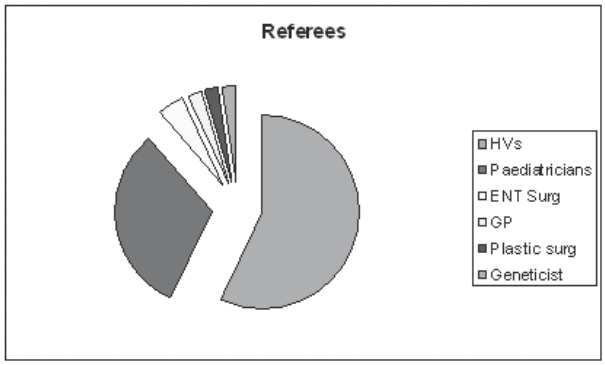


Fig. 4

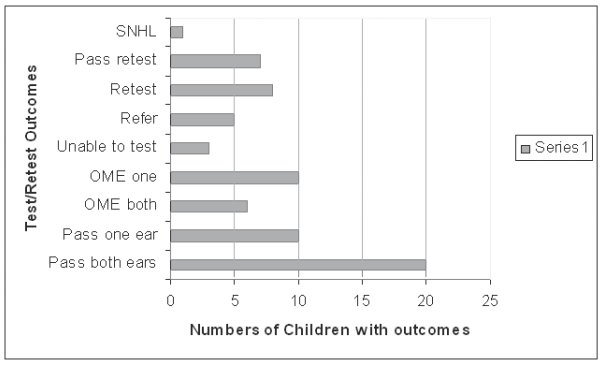
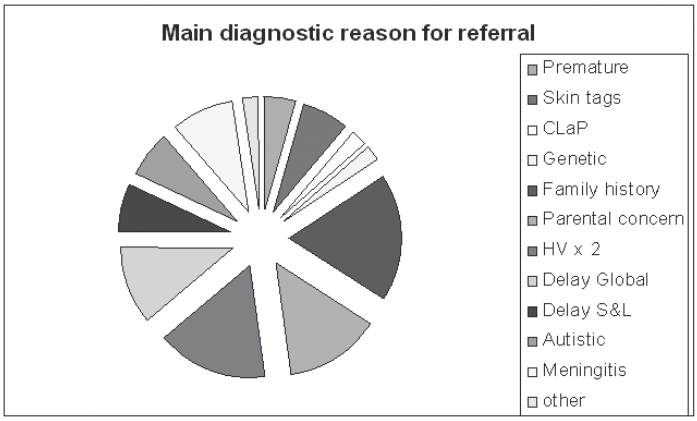


Fig. 3



British Academy of Audiology
Of, by, & for Audiologists

The British Academy of Audiology (BAA) is the new professional body representing audiologists in the UK. It came into being in April 2004 and has been formed by the amalgamation of the British Association of Audiologists (BAAT), the British Association of Audiological Scientists (BAAS) and the British Society of Hearing Therapists (BSHT). It is run by audiologists for audiologists.

Members of the three existing groups voted overwhelmingly in January 2004 to amalgamate and form BAA. This was the culmination of many years work that has seen the professions grow closer together as the speciality of Audiology within the National Health Service (NHS) has changed beyond recognition. The origins of the amalgamation can be traced back to work with the then Chief Scientific Officer Peter Greenaway who hosted and supported the initial meetings in 1998 - for which we owe him a debt of gratitude. The Audiology Professions Group was formed of the chair and vice chair of each of the three groups and worked on the goal of a BSc (Hons) Audiology as the minimum qualification, a new career structure and a united profession. Over the next few years the faces changed but the three groups continued to remain wedded to the goal. Eventually the Audiology Professions Group became the shadow BAA Board and the new post amalgamation Board held it's first, two day meeting in April.

It should be noted that the shadow BAA Board contained representatives from the British Society of Hearing Aid Audiologists (BSHAA) who have worked very closely with us. We will continue to have dialogue on a possible future further amalgamation and unified profession and training structure. We would like to express our thanks to BHSAA and indeed to all the professionals who have contributed over the years, with special mention of the Shadow BAA Board.

BAA will build upon the successful work of the three organisations but it will be different. Audiology within the NHS has grown up as a profession in recent years and BAA must be a mature organisation in representing and supporting it. BAA will continue the work, begun in its shadow form in accreditation of the BSc and construction of the modular MSc. We must oversee the formation of the new skills escalator and implementation of Agenda for Change. BAA must look after audiologists.

Representing 2000 audiologists will be a new experience but it is worth elaborating on what I mean by different. We have constructed the Board differently to any of the previous organisation in that there will be a liaison Board member sitting on each of the working committees (such as Professional Development). The committees will be independently chaired spreading the existing talents of audiologists who have taken an active role thus far. The three groups have equal representation on the Board for the first period of work. Our grateful thanks to the American Academy of Audiology who have allowed us to quiz them at length over the last for years and for their unceasing support. We do not intend to be a British copy of the American Academy but it has been of immense value to examine a mature organisation.

Vision

- BAA will be the united powerful voice for the Audiology Profession throughout the UK.
- BAA will offer protection, encouragement, inspiration and guidance to its members and be the driving force to develop the profession.
- BAA will raise the profile of Audiology as an autonomous profession and develop and promote excellence in services for our patients.

BAA recognises that Assistants, Associate Practitioners and Student Audiologists are an integral part of the current and future service. We will help to define the role of every level of practitioner in the service and also represent them. There will be facility for membership for all categories of roles within BAA and special arrangements to ensure representation.

BAA acknowledges that legislation and models of service delivery are different in England, Scotland, Wales and Northern Ireland. It is particularly important that BAA are active in representing professionals in all the countries and providing coordination where appropriate. We recognise this and it will be an area of special responsibility of the Vice President.

We look forward to having productive working relationships with consumer representative organisations and audiology medical practitioner organisations. We foresee a need for the profession to uphold the high quality levels of service that are being achieved through modernisation. In representing the grown up profession it will be essential for us to turn round the professional body from being three disparate bodies, often only reactive, to become one coordinated voice, efficient where there is the need to be reactive but essentially a proactive organisation at the heart of all matters relating to audiology.

Jonathan Parsons MSc
President, British Academy of Audiology
Consultant Clinical Scientist (Audiology)
Mid Devon Primary Care Trust
(Located with the Royal Devon & Exeter Hospital)
01392 402225
Jonathan.Parsons@MidDevon-PCT.nhs.uk

Address for correspondence:
P O Box 346, Peterborough RM, PE6 7EG