The Audiovestibular Medical Federation (AMF)

As you are all aware a BACDA / BAAP Federation Day was held in February this year. A report of the day compiled by Dr Susan Snashall is on page 16 of Audiens followed by the Power Point Presentations given.

Following some initial discussion the Federation, which was originally called The British Association of Audiovestibular Physicians and Paediatricians, was renamed the **Audiovestibular Medical Federation.** A small group was set up to consider a constitution for the Federation. Myself, Susan Rose and Lesley Batchelor representing BACDA met with Susan Snashall, Deirdre Lucas and Peter West from BAAP on 14th April 2005 and produced an initial draft. There will be full consultation with the members of both BAAP and BACDA before the AMF constitution is finalised.

In order to allow members to begin to consider the constitution I have included here the main body of the draft constitution.

Aims of the Audiovestibular Medical Federation

- To set and maintain competencies and standards in audiovestibular medicine and to advise the Royal Colleges upon these issues
- To demonstrate and maintain good practice by undertaking national audit projects
- To agree service models, standards and care pathways in collaboration with other professional and voluntary bodies, and with patients and their families
- To develop outcome measures in collaboration with other professional and voluntary bodies, and with patients and their families
- To provide advice regarding training in audiovestibular medicine to appropriate collegiate and statutory bodies
- To develop integrated working practices with related disciplines
- To foster mutual respect between professionals in order to promote multidisciplinary working for the benefit of patients and their families.
- To provide a unified, medical response to issues of mutual importance
- To enhance intra-professional support for individual members of the constituent bodies of the Federation

Officers of the Audiovestibular Medical Federation

- Officers will be the officers of the constituent organisations (Immediate Past Chairman, Chairman, Vice-Chairman, Treasurer and Honorary Secretary of BACDA and of BAAP)
- Officers are answerable to the constituent organisation in accordance with their constitutions
- Officers are empowered to take essential decisions without prior consultation with their constituent organisations provided approval is subsequently sought

Meetings

- Federation executive meetings will take place twice a year
- One Federation meeting to be incorporated into a BACDA Executive meeting
- One Federation meeting to be incorporated into a meeting of the BAAP officers
- In addition there will be mutual representation at the officers meetings of the constituent organisations
- Two officers of each constituent organisation are invited to attend the AGM of the other
- Ad hoc working groups will be established as required with members drawn from both constituent organisations as appropriate.

Finance

- The Federation will not charge subscriptions or have its own bank account or assets
- Constituent organisations will be responsible for the travel and accommodation expenses of their own members
- Constituent organisations will share equally the costs of room hire and other facilities where necessary
- Secretarial support to officers meetings will be provided and funded by the host organisation
- Other secretarial and additional costs incurred by the Federation and its working parties shall be shared equally by the constituent organisations but **must** be approved in advance by one of the Honorary Treasurers.
- The expenses of the Federation should be reviewed at least once a year by the Honorary Treasurers and presented to the AGMs of the constituent organisations

Academic Meetings

- Academic meetings will continue to be the responsibility of the individual constituent organisations
- Attendance at each others meetings is to be encouraged

Ann MacKinnon

Newborn Hearing Screening around the Country Part One

BACDA members have written about their experiences of the introduction of newborn hearing screening. These are written from experiences, whether informative or anecdotal. Contact the editor at irajlyons@btinternet.com

Implementation of Newborn Hearing Screening in Scotland Where are we now?

Background

In 2001 the Scottish Executive issued a Health Department Letter stating that, following the recommendations of the National Screening Committee, Universal Newborn Hearing Screening (UNHS) was to be implemented across Scotland with the rollout being completed by April 2005.

A National Implementation Group was established headed by the National Service Division (NSD) who has responsibility for all screening programmes in Scotland. Applications were requested from Health Boards to become "pathfinder sites". All costs for the implementation were to be met from within existing resources. There was not a huge flurry of applications!

Following further discussions it was agreed that some pump-priming money would be made available to cover initial set up costs, such as purchase of equipment, IT set up costs, and some initial staffing costs. All recurring costs were to be taken over by the Health Boards.

The Pathfinder Sites

Lothian and Tayside Health Boards successfully applied to become pathfinder sites. Following several months of planning they commenced screening in early 2003. Tayside use a 2 stage screen, otoacoustic emissions (OAEs) followed by automated auditory brainstem response (AABR) if required. Lothian use AABRs alone. In both boards there is a second protocol for babies who have been in the special care baby unit for more than 48 hours, which involves routinely screening with both OAEs and AABR.

Both Lothian and Tayside aim to screen as many babies as possible in hospital prior to discharge. Screening at outpatient clinics is offered for babies born in community midwife units, born at home, discharged home before the screen has been completed and for those babies transferring into the Health Board Area before the age of 6 months. In both areas coverage has been excellent with over 98.5% of babies being screened.

Prior to the establishment of the pathfinder sites Universal Newborn Hearing Screening was taking place in Highlands and Islands Health Board. The Remote and Rural Area Resources Initiative initially funded this UNHS programme. The project commenced in 2001 and the Health Board has now taken over the running costs. The pathfinder sites regularly report back to the National Implementation Group and the NSD and produced detailed reports following the completion of the first year of screening. There was an open invitation from the pathfinder sites to the other boards in Scotland to contact them and visit in order to discuss implementing the screen and follow up. Many, but not all, have taken this offer up.

The Rollout across Scotland

The rollout across Scotland has been slower than we would have hoped. There are a number of reasons for this.

- Financial Pressures on the Health Boards has meant that many areas have simply not been able to identify the funding for implementing UNHS
- Many Health Boards have delayed making detailed plans for implementing the screen as there had been an expectation that following the first year of the pathfinder sites the National Implementation Group would produce detailed national guidelines on the implementation of UNHS which boards would be able to follow. This written guidance has not been forthcoming and indeed Boards have been told that the Health Department will not dictate to them "how" they implement screen, just that they will.
- There has been until very recently uncertainties about IT support for UNHS. The Scottish Executive now has agreement from all 15 Health Boards that they will use eSP. Contract arrangements have only recently been finalised. Understandably some Health Board Areas are reluctant to move forward until eSP has been adapted for use across Scotland.
- Audiology Departments in Scotland have been under-resourced for many years. There has been a significant shortfall in staffing requirements and a lack of opportunities for many to develop the required skills to deal with young babies and their families. Over the past 2 years considerable efforts have been made to improve the situation and enable the delivery of high quality paediatric audiology services. Many departments

however are at an early stage in this development and some recognise that they currently would struggle to deliver appropriate diagnostic and early intervention for young babies. This quite rightly makes them cautious about embarking upon UNHS.

- Quality Improvement Scotland (QIS), the organisation responsible for setting and monitoring standards for many clinical services in the Scottish Health Service, convened a group in 2002 to write standards for all national maternal and newborn screening programmes, including newborn hearing screening. It was expected that draft standards would be produced and piloted within 18 months of the group originally meeting. Due to a variety of factors the process has taken considerably longer than expected, however they are now in final draft form and are expected to be launched in the autumn. Some Health Boards have been delaying implementing plans for UNHS as they wished to ensure that services they set up would be able to comply with the standards being set by QIS.

The Current Situation

By late 2004 no other Health Boards had commenced screening, although many had detailed plans for implementation. The Scottish Executive directed all Health Boards that they **must** implement UNHS by April 2005. A number of Boards stated they would be unable to meet this deadline. There were concerns that other Boards would be pressurised into commencing screening before they were properly prepared. Although the NSD have a responsibility for ensuring that screening takes place they are not responsible for ensuring the quality of the service.

Concerns were raised with the Scottish Executive about the advisability of forcing boards to implement the screening programme if they were not properly prepared for delivering the screen, ensuring high quality diagnostic services and ensuring co-ordinated well managed, multidisciplinary early support and intervention programmes. Boards must also have in place programmes for monitoring of babies "at risk" of progressive and late onset losses and also be able to provide prompt assessment of older children if there are concerns about their hearing.

In response to these concerns the Scottish Executive established a small task force who were charged with providing support to Boards who were having difficulty implementing the screening programme. One of the group's first jobs was to persuade the Scottish Executive that a more realistic timescale for implementation was required. It was suggested that all Health Boards as a minimum should have a detailed business plan in place for April which details the timescales for implementation. Implementation should be completed by the end of 2005.

In order to provide the intense support that some Health Boards require a case was made to the Scottish Executive that an appropriate person should be seconded to the group in order to ensure that protected time was available to undertake this important task. Dr Jackie Grigor was appointed in the late spring. She has spent the first few months in post visiting individual Health Boards to review with them their progress in planning and implementing UNHS. If there are perceived difficulties she is able to advise or put them in touch with an appropriate person or agency. Jackie is in a position to establish if there are any common areas of difficulty or areas of good practice that can be shared.

The Future

Implementation of UNHS in Scotland has been problematic. The lack of clear national guidance and ring-fenced money has meant that not all Health Boards have prioritised the implementation.

The Scottish Executive and National Services Division do now seem to be facing the challenges of implementation and realise that they must provide more co-ordinated and targeted support to the Health Boards in need. There is a huge amount of enthusiasm and determination at ground level to make UNHS in Scotland a success and I look forward to reporting on the successful implementation of newborn hearing screening across the whole of Scotland by this time next year.

Ann MacKinnon
August 2005

Experience of a Fourth Wave Team Leader

NHSP has eventually come to East Lancashire. In 1987 when I took up post as CCP in Audiology developing newborn hearing screening was in the business plan from day 1. An application to be a phase 1 site was not successful and there was much disappointment. Now 7 years later and 5 business plans later NHSP has arrived. I am pleased and relieved that I waited to become a fourth wave site. Although not always an easy journey it does appear to have been easier than earlier sites.

Why?

- Team leaders are given the opportunity to attend a one day meeting which clearly sets out the route to be taken and target dates for implementation
- Training for both local co-ordinators and screeners is clearly defined
- There is clear information available about the number of WTE professionals per 1000 births making planning much easier
- Clear guidelines on the responsibility of the PCT's
- Experiences from earlier sites available and shared
- The IT available now makes the patient's journey easy to follow with eSP and the Audiology based systems which can track babies so easily

This all seems easy but there have still been many challenges for me as Team Leader as follows:

Trust freeze on recruitment meant that although central funding was available that the senior managers still 'sat on' the vacancy review form submitted for the local co-ordinator. (LC)

The delay above resulted in critical dates for interview and appointment of the co-ordinator if the training date given by NHSP was feasible. We were very fortunate that we had the perfect candidate at interview. The training for LC, Northgate, Echoport and Algo3i was all booked for September. After appointment the co-ordinator was going to be on holiday for 3 out of the 4 dates and there were no more dates before our training date in November. She obviously felt the challenge was exciting and cancelled one week of her holiday.

27/08/04 LC on board – now to the screeners. More vacancy review delays. One day of interviews and we had appointed 9 screeners (5 on one site and 4 on the second smaller site). One screener gave back word and a further half day of interviewing only 2 weeks before the training date was needed.

Wednesday 24th November start date – 3 days of local induction were arranged with visits to both sites – postnatal, maternity, NICU and children' outpatients. Meetings with midwifes, teachers of the deaf, health visitor and parents of deaf children. An overview of ongoing testing for children and 'first day baby checks'.

Monday 29th November and MRC trainers on site. Two theory days with lots of coffee, nice biscuits and lunches to set the team spirit (allowance from MRC).

Pre-testing of babies during the training period was carried out by the Chief Audiologist and myself. Week 2 has ongoing training on the wards and a one day Northgate training in eSP. Although our screeners all had some experience of computers and the internet it was obvious that some were more familiar than others but after the day's training and the first week all the screeners were happy with the IT system. We made a positive decision to go 'live' with eSP the first day after training and do not regret this. The eSP system is very user friendly and the patient journey can be followed very easily. This combined with the use of Practice Navigator for Audiology referrals makes it easy to trace babies. Thank-you to all the early sites that contributed to the development of the eSP system. Of course the NN4B link to eSP cannot be overestimated.

6 months into the programme and what do we think?

- The local co-ordinator is the most important person in making the programme run
- We have an excellent team of screeners working very hard and have achieved over 96% coverage in the first 3 months completed (January to March)
- The IT systems make it easy to track babies but there is still a lot of administration
- There is an important role for the team leader in ensuring that the audiology results are entered and that babies are followed up
- We have had one mum very concerned and upset at the timing of the test because she had a NCR in all three tests and both ears. She has subsequently had a full assessment with CR in ABR and OAE at follow-up. However this has been a learning situation for all the screeners.
- We have identified one profoundly deaf baby although she would have been a high risk baby as her sister has a cochlear implant
- What has been very helpful is that a number of our mum of children with hearing loss and wearing hearing aids have had babies and they have felt very reassured by the screen.

Annabel Dodds
CCP in Audiology
East Lancashire Hospitals NHS Trust

Being a Phase 1 Site

It seems a long time ago that we embarked on newborn hearing screening in Manchester. The government announcement on the implementation of screening was in June 2000 and the intention was that the pilot sites would begin to come on line the following year. Well things always take longer than expected and we were not fully up and running in Manchester until October 2002.

Manchester is a complex, multi-cultural, inner city area with well-documented high levels of socio-economic deprivation and low birth weights. The average annual birth rate is around 10,000 babies, but only about 60% reside in Manchester. There are three maternity units across the city and the regional neonatal unit is based at St. Mary's Hospital. The hospital model for the screening was chosen because geographically it would be very difficult to get the coverage required in the community and attendance at clinics generally is poor.

A local Implementation team was established very early on in the planning stages and it worked extremely effectively as a multi-agency group. Representatives from Children's Services, the 4 audiology departments, the 3 maternity units, Education and IT attended regular meetings and through joint working developed service specifications, protocols, procedures and other necessary documentation.

Doreen Roberts had thought of everything when she costed the service; she included money for interpreters, money for the midwifery department as a contribution to the time midwives might spend talking to parents about the screen when the screeners are not around, plenty of clerical support, which helped make the implementation less problematic. We had long discussions about what sort of person we wanted for the coordinator and decided that we needed someone who had experience in managing staff and would be able to work their way through the complexities of screening on three sites. We were very lucky to recruit Gill Atty who had previously been a senior school nurse in Manchester and we had no regrets about choosing someone who had no experience of audiology.

The programme commenced in April 2002, following the recruitment and training of 10 part time screeners. Three left very early on and we realised that we had underestimated the number of screeners required to achieve the required coverage; 7 more screeners were recruited in August 2002, making a total of 14 screeners (8.4 WTE). Manchester went 'live' in mid October 2002, when the second intake of screeners was fully trained and operational.

Screeners are based on the post-natal wards in 3 hospitals, North Manchester General, St. Mary's and Wythenshawe Hospital. Manchester babies who miss their screen during their stay in hospital or who have incomplete screens are followed-up by two community screeners who run regular outpatient clinics around the city. Home births and movements-in are also offered the screen as an outpatient.

Accommodation was a problem in two of the hospitals; at one the screeners shared an examination room with the midwives and in another the equipment was stored in a linen cupboard and the screeners did their data inputting and much of the screening in the patients' dayroom. In due course, inevitably, the laptop was stolen!

The amount of paperwork generated by the programme was substantial and a well organised administration system was absolutely essential to ensure that information about out of Manchester babies (40% of all babies born in Manchester hospitals) who needed follow up reached the appropriate audiology department. In the first year there was contact with 15 different audiology departments around the North West and beyond. Manchester was allocated HiTrack as their database but unfortunately there was a delay in getting it fully operational until July 2002. This meant data could not be put on the system for a number of months causing a backlog and any data requested had to be collated manually – very time consuming! HiTrack was not ideal as a database but things are much better now that we are on eSP.

The equipment that we had initially was a nightmare despite apparently having been used successfully in America. The main problem was with the OAE equipment: frequent faults being reported by the screeners requiring urgent site visits by the local coordinator with replacement units. Gill Atty's hair was getting greyer by the day! Problems we had with the AABR equipment practically stopped overnight once the probe was changed for muffins and it became apparent that the fault lay with the probe design rather than the unit itself. We now use a combined OAE and ABR machine which is much more reliable and our referral rate has dropped significantly.

So, did we feel like guinea pigs? Well certainly the problems with the database and the screening equipment have resulted in new approaches by the national team which successive sites will have benefited from. We had a lot of support from our regional coordinator who was able to feed back tips from other sites. We are identifying the hearing impaired babies in the numbers expected, although we have a higher proportion of severe to profound losses, and a high proportion of these have other risk factors.

Gill Painter

"Life on the Ocean Wave"

"Life on the ocean wave" – a phrase that conjures up images of thrilling and exciting times, but imagine for one moment quite literally feeling that you are on the high seas every waking minute of your life, believe me then it becomes a living hell.

This all started for me four years ago. It was Friday 13th 2001 (maybe I should have taken that as an omen). Myself and five other family members spent a long weekend aboard a luxury pleasure boat in Palma Spain. It was a lovely break; we would wake up each day to blue skies and crystal clear calm waters. After breakfast we would set sail to discover yet another perfect place to drop anchor and go for a swim, often returning at full throttle crashing over the waves, it was exhilarating, idyllic. Only one thing marred it, once back on dry land I continued to feel "all at sea" - the sink in the marina wash rooms would float up to meet me, in a restaurant the table would bob and weave about. I asked the others in my party if they were experiencing the same feelings – they looked at me as if I was mad.

Back home after a week the feelings hadn't subsided, I felt like I was constantly walking on a trampoline or cushions. I decided to visit my GP. He said that I hadn't found my "land-legs" yet and prescribed some anti-motion sickness tablets. They didn't work, nor did any of the others that he went on to prescribe. The sensation of being on a rough sea was constant, no let up, even when lying down in bed. Everyday tasks that we take for granted became so difficult, using a computer, ironing, vacuuming etc. all increased the level of motion I felt.

My GP decided to send me for an MRI scan, by now I was frantic, believing that I had a brain tumour (what else could be affecting my vision?) Thankfully it came back negative, but still no clue as to what was wrong with me. Then came a series of visits to an ENT consultant, numerous hearing and visual tests and still no positive findings. By now it was Christmas, the consultant apologised saying that although he firmly believed there was something wrong with me, he just didn't know what, especially not having any positive test results to work from. I remember leaving the hospital in floods of tears, was it all in my mind, was I going mad or having a break-down.

By the end of January 2002 I was suicidal, no quality of life left. My GP, relieved that I had something he could actually treat put me on anti-depressants. The rocking and swaying sensation was far worse than it had been on the boat, I felt constantly nauseous. Also I had developed tinnitus in both ears (never even had so much as an ear ache before this, was never travel sick) I couldn't believe this was it, no concrete diagnosis, just labelled under the vast umbrella of a "balance disorder." I started to surf the internet for clues/answers. My GP was unimpressed, told me to lay off it as I was becoming obsessive.

In February 2002 just over six long months after that fateful boat trip I got a reply to an email I had sent to the American Vestibular Disorders Association (VEDA) explaining my symptoms and how they came about. They said from my description it pointed to an illness called Mal de Debarquement Syndrome, French for quite literally "disembarking sickness" (MdDS for short). They told me where to find further information (www.nhffoundations.net/mdds). Now I had to set about being medically and professionally diagnosed. Eventually I came across the National Hospital of Neurology and Neurosurgery in London who had actually seen cases of MdDS before. I had my first appointment with them in September 2002.

Now over four years later there is no improvement, if anything I am worse, other problems have appeared, all linked and tied up in the mystery and misery of MdDS. Back then I naively thought there would be a miracle cure, some tablet I could take to make it all go away. There isn't. In June of last year I decided to seek a second opinion, I went to the Leicester Balance Centre. Their approach and treatment is in contrast to the Neuro hospital. Who is right, what is affective, who knows? There is little research on it probably due to the medical profession's ignorance on the condition. I carry on; what choice have I got?

To help turn something with such a huge negative impact in ones life into a positive I try to raise awareness. Probably because of my determined "doggedness" I am one of the few lucky ones who has actually been diagnosed. As there is no miracle cure, raising awareness is crucial in helping suffers know that it "isn't all in their head". For me it just helps to feel that I am doing something positive by "spreading the word" and raising it's profile. At the beginning of this year I set up a UK web-site (www.mdds.org.uk) During the past two years I have had a couple of articles about MdDS printed in local newspapers and women's magazines, and a couple of TV slots, including a recent appearance on the "This Morning" Show with Dr. Chris Steele. So far (sadly) I have had quite a lot of feedback, ranging from wanting to know more about the condition to one lady who appears to have had it, undiagnosed, for seven years! Surely this shouldn't happen in today's medically enlightened world? One audiologist in Cambridge told me they see at least one patient a month with MdDS, which makes me question just how "rare" it is. Travel is available to everyone these days, we are all aware of the risks of DVT and flying, why isn't this the same for MdDS?

It's a horrible, cruel illness, as the guy at Leicester says everyone understands and can relate to pain, but given an "invisible" illness where only you can feel and see what is going on, produces a lack of sympathy and understanding (to the outside world you look "normal") - it's a bitter blow and makes coping with it all the more difficult. Hopefully one day enough people will be correctly diagnosed then research and trials can begin in earnest. This is my ultimate goal.

Jane Houghton

BACDA/BAAP Federation Strategy Day

16th February 2005
St. George's Hospital, London

OUTCOMES

Report prepared by Susan Snashall Chairman British Association of Audiological Physicians (BAAP) and meeting organiser, together with Ann Mackinnon, Chairman of British Association of Community Doctors in Audiology (BACDA) DRAFT 23.2.05

Attendees

BACDA
Ken Abban
Lesley Batchelor
Mary O'Sullivan
Sarita Fonseca
Alison Hooper
Jeanne Jackson
Ann Mackinnon
Dipanker Mukherjee
Wanda Neary
Gillian Painter
Susan Rose
Tim Williamson
Jackie Grigor
Florence McDonagh

BAAP
Ansar Ahmmed
Basil Al-Shihabi
Katherine Harrop-Griffiths
John Irwin
Jay Jayarajan
Deirdre Lucas
Linda Luxon
Breege Macardle
Rudrapathy Palaniappan
Robin Yeoh
Peter West
Ewa Raglan
Susan Snashall
Roshini Alles
Iynga Vanniasegaram

Specialist Registrars
Ian Colvin
Louise Murdin
Victor Ose-lah
Elwina Timehin
Charlotte Agrup
Wendy Albuquerque

Change facilitator for World café discussions
Ian Hall

Keynote addresses
1. Children's Services, Lesley Batchelor (Past BACDA Chair)
2. Adult Neuro-otology, Linda Luxon (UCL ICH MSc)
3. Training issues, John Irwin (RCP SAC Chair)
4. Quality and Excellence, Breege Macardle (SAC Hon Sec)
5. Vision and Aims, Ann Mackinnon (BACDA Chair)

Federation of BACDA and BAAP

This is a Federation of two Associations representing doctors whose practice is in audio-vestibular medicine. Full membership of BAAP comprises consultants whose practice is primarily in Audio-vestibular Medicine, with Associate Membership for trainees within the specialty and Non-Consultant Career Grades whose practice is primarily in audio-vestibular medicine. Membership of BACDA comprises all doctors who practice in paediatric audio-vestibular medicine whether or not it forms the majority of their job plan (constitutions attached).

Training in the specialty is the responsibility of the Specialist Advisory Committee (SAC) for Audiological Medicine at the Royal College of Physicians (RCP).

Other doctors whose practice is related to audio-vestibular medicine are ENT surgeons whose practice is either Paediatric or otology; developmental paediatricians and those specialising in neuro-disability, geneticists, and geriatricians specialising in falls. These doctors belong to other medical groups.

Aim of the Strategy Day

The day was organised by the Chairmen of BACDA and BAAP to provide an opportunity for the membership of both organisations to express their views on the future direction that should be taken by the existing Federation of BACDA and BAAP which was formed with the agreement of both organisations in April 2004.

The membership had already expressed their opinion that BACDA and BAAP should not merge and this was endorsed at the Strategy Day.

Overall outcome of the Strategy day

The day was organised on a World Café model to discuss 5 topics, the background of which were presented as keynote addresses. The members then broke into groups to discuss these issues with respect to the role of the Federation. After feedback on these discussions those present made suggestions regarding the role and responsibility of the individual doctor and of the Federation.
Federation actions should be:

- **Standard and competency setting** for individual doctors to be discussed by BACDA development group and BAAP standards group
- **Standard setting for services**, in collaboration with other bodies (BAA, RNID, NDCS, NHSP, BATOD etc.), and incorporating their standards.
- **Monitoring performance** of individual doctors
- **Benchmarking services** in collaboration with other bodies
- **Provide models** of services to RCP President on 22.3.05

- **Training advisory role** to the Royal Colleges (RCP, RCPCH, RCS, and RCGP) with respect to Modernising Medical Careers
- Develop HST in collaboration with BAA
- Develop tasters in A-V medicine locally
- **Name and register the federation** to include the word "Federation"
- **Finances** of federation to be discussed by the officers and put to a vote of the membership
- **Membership of BACDA and BAAP** to be asked for views upon whether tasks should be allocated to the Federation and whether they are willing to serve on Federation committees.
- **BACDA/BAAP annual meeting** to be discussed by the executives of both organisations
- **Constitution committee** for Federation to be set up
- **Subcommittees** to be set up as required to complete topic actions

College actions should be:
- Define core curriculum
- Selection criteria to HST defined by June 2005

Care pathways were already being defined by other organisations such as the Royal College of Physicians working party and the Royal College of Paediatrics and Child Health. The distinction between doctor as team leader versus clinical lead was debated as was the need for the doctor to personally undertake audio-vestibular assessment but these issues remain to be resolved, possibly as future tasks for the Federation.

Next steps
1 Circulate this report to all members of BACDA and BAAP for comment
2 Discuss report at next BAAP executive meeting in March
3 Present report and comments received to BAAP AGM in April and BACDA exec in May for decisions on further action.

Reports of Table top discussions

1. Table Topic Adult Neuro-otology

Service Model

Regional Centre:
Tertiary in teaching hospital attached to university
More than 2 specialist consultants in A-V Medicine
Large multidisciplinary team with surgical otologist
Specialised staff and equipment
Specialist services including adolescent care
Research
Teaching at all levels
Peer support
Hub and spoke to secondary centres

DGH Secondary:
A-V physician and ENT otologist with relevant CCST
ENT otologist does less A-V med than physician
Multidisciplinary team driven
Balance and falls clinics doctor driven/lead
Doctors respond to concern/red flags at this level

Primary care:
GPs and GPSIs retain medical responsibility
Audiologists and GPs using protocols with red flags

Conditions:
Balance always needs a medical diagnosis at any level
Hearing disorders and tinnitus managed by audiologists with protocols for referral and robust red flag systems.
Medical responsibility remaining with GP.

Role of the doctor:
DIAGNOSIS
New referrals to balance clinics
Response to red flags

Training:
Basic specialist training: AP medical; ENT surgical
Higher specialist training to CCT
CPD to special interest and work in tertiary centre

FEDERATION/RCP (SAC) ACTION
- **HST to discuss MMC common training with ENT.** AP may have more training in neuro-otology to release surgeons for surgical training/experience.
- **HST to discuss with BAA for collaborative training** for protocols, standards, care pathways, competencies and working with other professionals

2. Table Topic Standards and Quality

1. Personal: Competencies related to job plan and responsibilities
2. Service: Care pathways, service models, competency setting for different levels of service: primary, second tier, secondary and tertiary.

Standards and competencies set by….
1. Personal:
GMC
Federation of BACDA and BAAP
Academic units
Input from other professional bodies
Input from patient groups
Trust input on desired competencies

2. Service:
2 (a) Local
Federation BACDA and BAAP
BAA, CSALT, BATOD, psychologists etc.
NDCS, RNID, Meniere's Society etc.
Purchasers

Trust

2 (b) National:

Federation BACDA and BAAP
Academic Units
BAA, CSALT, BATOD, psychologists etc.
NDCS, RNID, Meniere's Society etc.
DoH
Planning care pathways for each level of service, Primary, second tier, secondary and tertiary
Incorporate all standards of all bodies by links at highest levels between organisations

Standards imparted by:

1. Personal: membership of professional body and GMC with knowledge of the recommended practice and competencies of those organisations. CPD to develop competencies gained during training as shown by CCST. Job planning.
2. Service: Federation to convince standard setting bodies of need for medical input. Federation to lobby PCTs, SHAs, and Scottish Regional Health Boards regarding need to specify standards of care when purchasing/ commissioning.

Standards monitored by:

1. Personal: Appraisal (eventually 360 degree multidisciplinary) using competencies for scenarios, equivalent of post training RITA process, peer review, notes review, patient surveys, medical audit (local and national- Federation).
2. Service: Benchmarking, inspection visits by experts and as part of national initiatives such as MCHAS, MHAS and NHSP, input from patient organisations and patient surveys and national service surveys using standardised questionnaires, local and national clinical audit and governance.

FEDERATION ACTION

- Set personal standards
- **Link** with other bodies to set service standards
- Link with other bodies to list appropriate service at each level
- **Lobby** (with other bodies) DoH, purchasers and commissioners
- Design standardised client questionnaires
- **Agree** methods of peer review

3. Table Topic Training

3a Curriculum

Should develop skills that complement non-medical practitioners in the field such as diagnosis.
Needs to provide building blocks in topics that can be used in a variety of specialties and levels of training.
HST limited to 3 years may have to separate adult and paediatric practice

3b. Recruitment

BST F2:

- Provide tasters in audio-vestibular medicine (both adult and paediatric)
- Must do SHO in paediatrics to be able to do HST in Paediatric A-V medicine
- Offer A-V medicine modules in F2 for geriatrics, rehabilitation, paediatrics, community child health and neurology etc.
- Use BST for building blocks towards HST

HST:

- Combine paediatric and adult training for common building blocks (neurology, genetics, ophthalmology, ENT if not already obtained at F2
- Adult arm of HST to include 3 months paediatrics especially for adolescents and adult learning disability
- Paediatric arm of training modules to be determined by National Service Framework and must include neuro-vestibular medicine
- MSc course to provide underpinning knowledge
- Research (MSc, MPhil, PhD) only for Academics and those planning to progress to academic centres

3c **FEDERATION ACTION**

- **Advisory role to Royal Colleges** (RCP, RCPCH, RCS, RCPGP)
- Need name of federation to be registered (where?)

4. Table Topic Children's Services

Should all professionals working in a paediatric team have specific paediatric training? If yes, could have a significant impact of the training of audiological physicians working with children
Training issues for paediatricians working in audiology teams
Why/When should a doctor be involved in the assessment of children?

What do doctors bring to the team?

- Early and ongoing assessment, diagnosis and medical management
  - Medical responsibility (does not equal team leader)
  - Holistic approach to the child and family
  - Ability to undertake comprehensive medical assessment
  - Can synthesise information from different disciplines
  - Have the ability to interpret audiology assessments taking into account past history, co-existing pathology or emerging pathology
  - Co-ordination of aetiological investigations
  - Complex needs children
  - Who has ultimate 'clinical' responsibility?
- Provision of second opinions
- Medico-legal issues
- Addressing complaints

What can doctors let go of?

- ?Uncomplicated glue ear
- ?Stable sensorineural hearing loss (5 yearly reviews with doctor, or reviews at key points in child life, e.g. transition stages)
- Routine testing – this should be undertaken by audiologists, they (doctors) may however have a continuing role in the audiological assessment of the difficult to test child or the child with complex difficulties
- Acknowledgement that most professional disciplines working with deaf children are stretched
- Changes to services must be sustainable

While doctors need not be the 'Team Leader' they must be integral members of the Paediatric Audiology Team

There is a need to develop, implement and audit national protocols and standards in conjunction with BAA and other agencies including education and social services

- Protocols/ referral pathways/care pathways must include red flags for referral to or review by a doctor
- Clinical governance and risk management must underpin all national standards
- Implications for training

FEDERATION ACTIONS

- Advisory role to the colleges re future training of both paediatricians working in audiology and of audiological physicians
- Liaison with BAA and other appropriate agencies in order to set standards and develop referral guidelines and care pathways
- Lobby appropriate bodies to ensure that all personnel working with children have appropriate paediatric training and experience

5. Table Topic Vision and Aims

a) For the Service

- Patients want
  - continuity / consistency across sites
  - continuity / consistency across the age range
  - continuity / consistency across professionals
  - a clinic where their condition is valued and understood
  - accessibility to health, education, social and other services
  - increased patient involvement
  - personalised care plans, with co-ordinated management
- Need for improved transitional arrangements between children and adult services
- Different models of service delivery need explored
- Hub and spoke
- Centres of excellence
- Managed clinical networks
- Make appropriate use of technology
- Electronic patient Records
- Telemedicine
- Significant resourcing and commissioning implications
- Services for adults with learning disabilities
- Training implications for all staff working in the service, should be competency based
- In order to continue to provide appropriate paediatric input into audiology services there must be a reversal of the depletion of audiology training for paediatricians

b) For BAAP, BACDA and the Federation

- Over 50% of current BAAP members expected to have retired by 2015
- 40% of current BACDA membership expected to be retired by 2015
- May not all be replaced by doctors
- Currently BAAP and BACDA members often fulfil different roles in their service
- BACDA and BAAP members have different requirements and support needs at the current time
- BACDA an outdated name for the organisation, name change to be proposed
- **Given the current uncertainties, particularly related to training issues both organisations should maintain their separate identities under an umbrella organisation, the Federation**
- ? Need for name change of BAAVPP to include 'Federation' in the title as this seems to be the common way we refer to BAAVPP
- Training issues both pre and post CCST
- Need for more joint / complimentary training for audiological physicians and paediatricians

FEDERATION ACTIONS

- Set up a small joint working party to draw up a draft constitution to present to the membership of both organisations. Details will need to include -
  - Name of the federation
  - Aims and objectives
  - Membership details
  - Committee structure and management
  - Finance plans
- Consideration to further subgroups dealing with
  - Training
  - Competencies
  - Standard setting
  - Mapping of services / directory of services
- Promote and raise the profile of the Federation among other professional groups
- Standard setting in consultation with other professional groups

The BACDA / BAAP Federation Strategy Day

The following articles are reproduced from presentations given at the BACDA / BAAP Federation Strategy Day

1 Vision
Aims
Membership
Constitution

2 The History

- 2000/2001
  - many changes beginning to take place in audiology
  - need for closer collaboration between BAAP and BACDA
- 2002
  - discussions between executive committees about how to strengthen links between the organisations
- 2003
  - wider membership informed of proposals to strengthen links.
  - Supported by the members of both organisations
- July 2003
  - 3 Office bearers from each organisation met to consider
    - **Aims of the Federation**
    - **Structure and Functioning**
    - **Name**
- 2004
  - Proposals for the Federation ratified at both AGMs
  - British Association of Audio-Vestibular Physicians and Paediatricians

3 Aims of BAA-VPP

- 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

4 Current Situation

- Reciprocal representation at executive committee meetings
- Close liaison between the Chairs
- Whenever possible represent each others interests at meetings (e.g. MAWFET)
- However we have not met as a federation committee or moved forward a constitution etc.

5 The Future??????

- Has the formation of the Federation been beneficial?
- How do we strengthen the Federation?
  – Should we?
- How should the Federation relate to the Royal Colleges?
- Should we go beyond the Federation and merge?
- Adults vs Paediatrics vs Lifelong
- **Many uncertainties**
  – Manpower issues
  – Modernising medical careers and effects on higher specialist training programme
  – Training for paediatricians
  – Developing role of the audiologist / audiological scientist

6 Today

- Opportunity to discuss and explore the different possibilities
- There are NO predetermined plans
- Need to consider not only the current situation but the services of the future
- How can BAAP and BACDA work effectively together to ensure high quality audio-vestibular services for the children and adults of the future?

7 Aims of today

- **To discuss and explore options for working together**

If possible

- **To develop proposals to take back to the wider membership**

Paediatric Audiology Services of the Future

1. The role of the doctor
- The patient is the first concern
- Assessment of the patient's condition
- History
- Clinical examination
- Investigation
- Interpretation of investigations
- Diagnosis
- Treatment and management
- Referral onwards if indicated
- Effective team working to provide an integrated care package

2. What is a paediatrician?

Paediatricians
- Have a detailed knowledge and understanding of diseases in children
- Are skilled at looking at specific health issues
- Develop expertise in practical procedures, specifically related to good clinical care
- Work in multidisciplinary teams
- Have strong communication and interpersonal skills
- Share expertise effectively
- Work with colleagues to ensure continuity of care in all aspects of the treatment and care of children
- Are committed to a policy of advocacy
- Have a particular compassion and respect for children and their families
- Are skilled in the management of emotionally complex family situations
- Show patience and sensitivity in their communications with children and their families
- Are aware religious and cultural beliefs that parents might have about their children
- Ensure that they are up to date in their practice and endeavour to promote evidence based medicine wherever possible
- Are committed to the highest standards of care and professional behaviour

3. Central to the work of a paediatrician
All decisions should be made in the best interests of the child or young person in their care

4. What is paediatrics?
- Knowledge of the normal child
- Effects of ante and perinatal events
- Acute and chronic disease/disorder management/ sequelae
- Prevention of ill health
- Effect on family
- Impact on adult life

5. Paediatric Audiological Medicine
- Congenital/pre-lingual hearing loss
- Progressive/sudden hearing loss
- Fluctuating hearing loss (inc OME)
- NOHL
- Children with complex medical problems
  - Autism
  - Difficult to test (?why)
  - Hearing loss not in isolation
  - Teamwork
- Children with speech and language disorders
- Tinnitus
- Cochlear Implant assessment
- Speech and language assessment
- CAPD
- AN

6. Paediatric neurovestibular assessment
- Deaf children in aetiological investigations
- Dizzy children
- Migraineurs
- Post head injury/cerebral insult

7. Tertiary services
- Concerned/dissatisfied parents
- Uncertain professionals
- Seeking fresh approach/expert opinion
- Wanting the answer

8. Interdisciplinary team
- Observations/assessments for full profile of child and family
- Active participation to inform parents and other relevant professionals
- Integrated care plan (family plan)
- Advice/interventions – overlapping and complementary

9. Contribution of doctor to team working
- Making a medical diagnosis
- Initiating appropriate investigations +/or interdisciplinary assessment
- Informing patient and team about condition

10. Impact of 'Modernised' services MCHAS, NHSP
- NHSP: large number of evidences based guidelines. www.nhsp.info
- MCHAS: 6 Evidence based guidelines www.mchas.manchester.ac.uk
- Audiologist led identification/intervention
- Emphasis on interdisciplinary team for management of babies
  - Health
  - Education
  - Social care
- Public health aspects
- DH working party – still no clear pathway

11. Paediatric Audiology 'back at the front'
- Taken from remarks in keynote address by John Bamford (BSA 2004) in BSA News
- 1957 Ewing (Ed) 'The Deaf School Child'
  - Data driven evidence base for key areas
  - Leading role for UK, not maintained
    - Under developed academic base
    - Lack of quality leadership. 'Myth' services led by doctors are better?
    - Centres of excellence keep their skills to themselves
    - Previous (limited) post graduate training (Manchester)
      - Skills based
      - Not critical or evaluative
    - Services provided by non-graduate or those whose primary specialism not audiology

12. Poor Practice (Bamford 2004)
- Click and Fit on infant hearing aid fittings
- Not using REMs for fitting and verification
- Not using VRA and insert VRA
- Refusing to use DSP aids
- Service lead refusing to attend MCHAS training
- Using only one model DSP aids
- No CHSWG
- No joint MCHAS training with education

13. What is a Competent Audiologist (Bamford 2004)
- Has a thorough grasp of audiological techniques and their evidence base
- Understands evidence-based health care
- Understands the concept of clinical effectiveness
- Keeps abreast of current research
- Reads audiological journals
- Understands how teams work
- Undergoes reflective practice
- Is sure enough of their ground to advocate for and defend standards and guidelines

14. Training Routes for Graduate Audiologists
- 4 year BSc includes clinical competency training
- Suitable first degree + 1 year diploma +competency training and assessment (CtP)
- Suitable first degree + 1 year MSc +competency training and assessment (CAC)
- All deliver to band 5 of the new career escalator
  - Will be competent to work in a team
  - But will need more training to move to a higher band/ lead a team

15. The workforce

200 paediatric audiologists (not specified whether medical or non-medical) needed as a result of MCHAS/NHSP

16. See diagram 1

17. The wider context: ESP and NSF

www.esp.org.uk
- The children's NSF is closely aligned to the wider Change for Children programme
- Change for Children– Every Child Matters
  - Be healthy
  - Be safe
  - Enjoy and achieve
  - Make a positive contribution
  - Achieve economic well being

18. Children's NSF – Standard 8
- Disabled children and young people and those with complex needs
  - Able to access all mainstream children's services
  - Receive child-centred multi-agency coordinated services
  - Early identification through clinical diagnosis
  - Access to high quality, evidence-based care delivered by staff who have the right skills for diagnosis, assessment, treatment and on-going care
  - Multi-agency transition planning

19. Options for future? (Bamford 2004)
- MCHAS & NHSP training cascade continues. Stop gap
- MSc without rigorous competency training is insufficient
- Longer term – BSc/MSc/Dip
- Development of accessible advanced CPD
  - Role of BAA/BSA?
- Some kind of rating scheme for services??
- Suitable training and registration for audiologists working in paediatrc audiology
- ?not a different specialism with audiology as 'add on'
- Some routine testing of older children by other specialities (Hall 2004)

20. Hall
- Managed network model of care
  - Maintain local access whilst developing a critical mass of expertise
  - SHA areas?
- Audiology services to remain multi-disciplinary
- Role of community paediatrician??
- "much of what is currently provided will be done by the graduate audiologist"
- Community paediatricians should be familiar with the issues around hearing loss
- Some community paediatricians will extend their interests to provide paediatric consulting and liaison service to paediatric audiology teams and networks
- S & LTs – extend the training to be able to undertake initial hearing assessment for children with concerns re: speech and language.

21. Post graduate medical education of the future

See diagram 2

22. The audiological paediatrician of the future (local)
See diagram 3

23. The audiological paediatrician of the future (tertiary)
See diagram 4

24. Barriers at the moment

- No Special Interest Group for Paed. Aud. in RCPCH
  - BACDA has been invited to next Speciality Board
  - BACDA making moves to apply for Special Interest status
- No HST in Paediatric Audiology
  - RCPCH Ed and Training Dept. is working on Level 2 Competencies (core HST)
  - Green light for Level 2 competencies
- No SAC in Paed Aud
  - RCPCH making every effort to ensure rep at next SAC Aud Med
  - ? Future Joint SAC????
- Confusion re: Neurodisability: FORGET IT!!

25. Paed HST of the future

- Potential for laddering across from Paed HST to Adult
- Or run parallel and come together at the end?
- Which entry qualification
- Should there be an exit qualification – if so which??

26. The future service

- Clinical networks
  - Geographical
  - Probably smaller than StHA
- 1 Aud Phys and 1 Aud Paed per 1 million
- Local districts have Paed with Special Interest
- People shouldn't work in isolation
  - Peer support
  - Audit
  - Quality standards

Diagram 1. Proposed Education and Training Skills Escalator for the Audiology Profession.

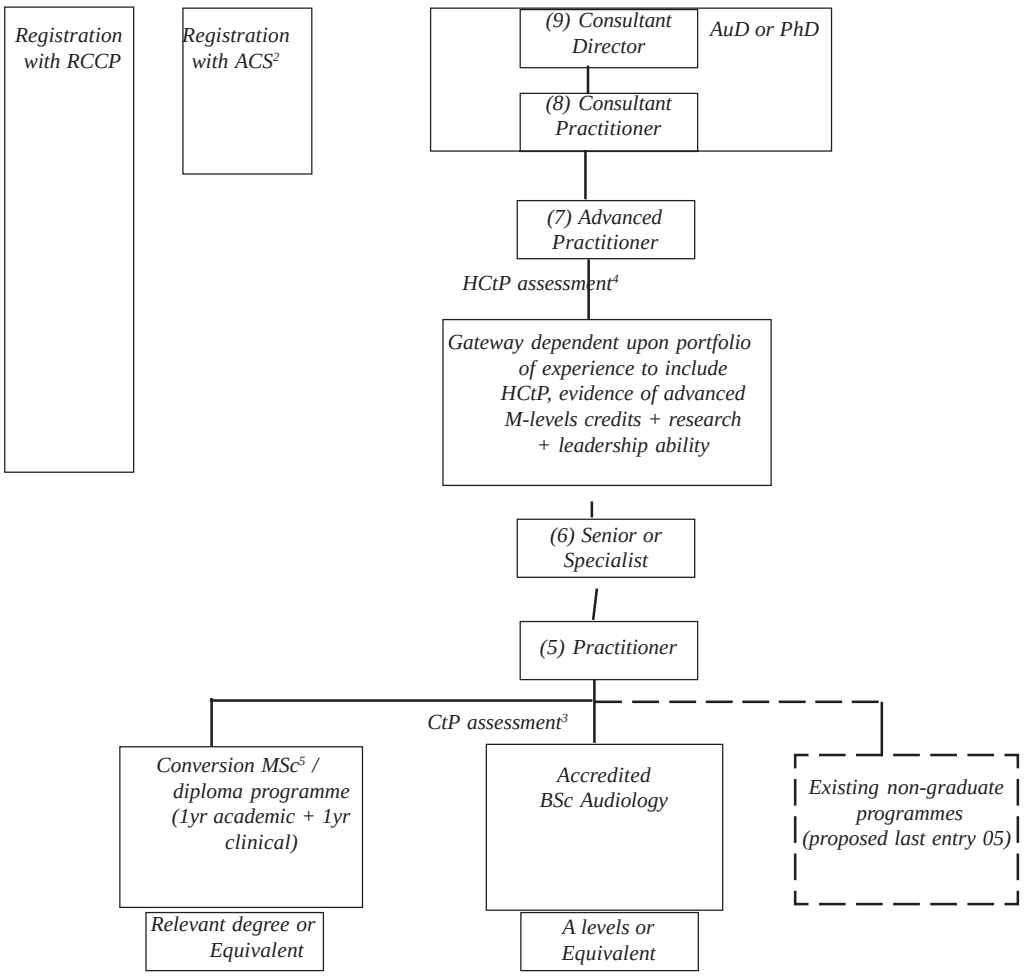


Diagram 2. Post Graduate Medical Education of the Future

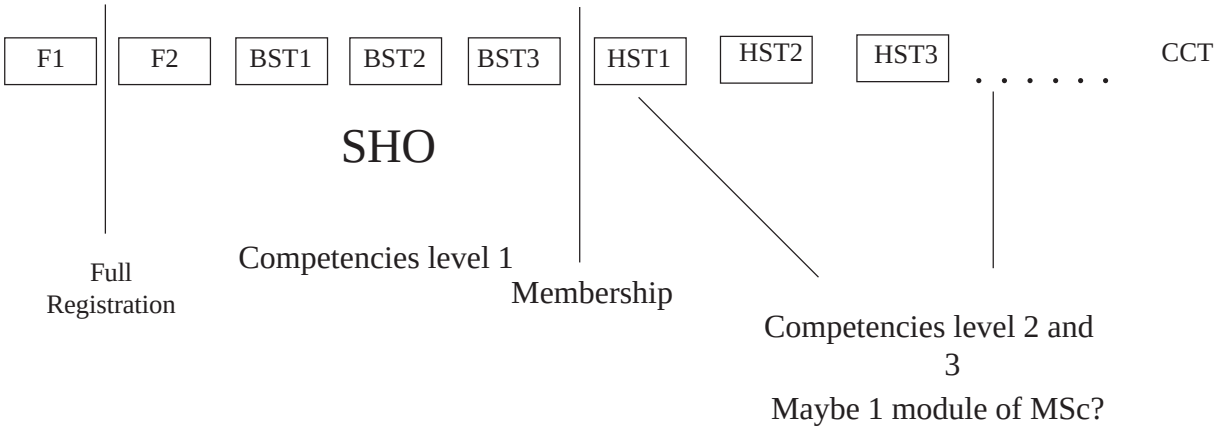


Diagram 3.
The audiological paediatrician of the future (local)

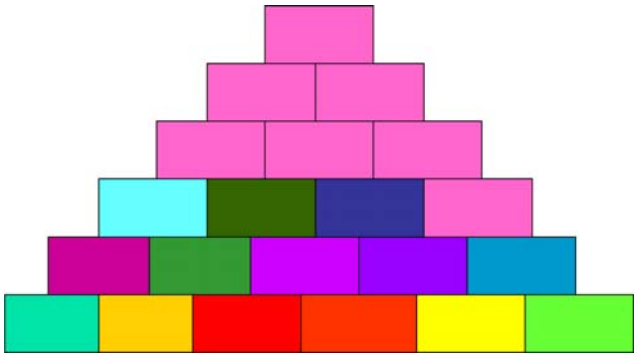
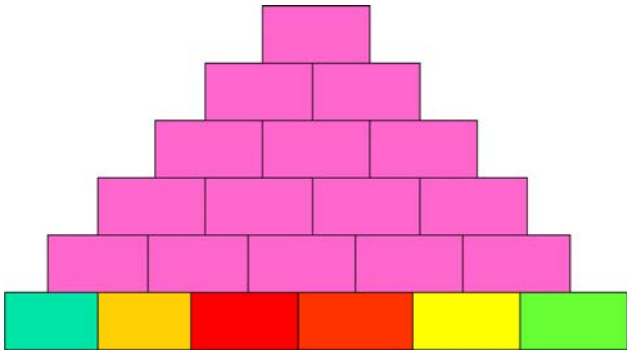


Diagram 4.
The audiological paediatrician of the future (tertiary)



Modernising Medical Careers - Audiological Medicine

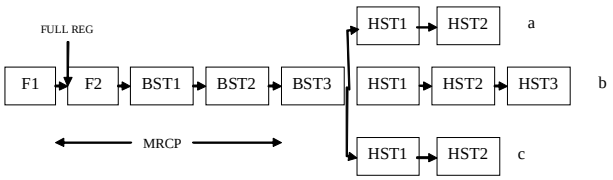
1. WHY MMC?

- Shortage of consultants
- Long time to train new ones
- Some of what doctors do can be done by others
- Medical student curriculum designed to promote life long learning skills

2. CONSEQUENCES

- Shorter time from graduation to consultant
- Possibly newly appointed consultants will not have the full range of skills that they do now
- Appraisal and CPD designed to overcome this

3.



Notes

a) Paediatric audiological medicine training route
b) Academic training route
c) Adult audiological medicine training route.

BST should be focussed on training relevant to the speciality – eg a)paediatrics, paediatric neurology, paediatric otology etc
b) neurology, otology, geriatrics. This could be included in the F2 year

BST3 is basic sciences relevant to the speciality - ideally training would include an MSc in Audiological Medicine.

Option of post CCT Fellowship in subspecialty after HST

4. SOME QUESTIONS

Separate adult and paediatric route?
Possible entry requirements
Dual certification
Can we train Adult and paediatric A-V Physicians?
Research to be done by all or only those in academic posts
MSc for all or modular diploma?
Do we need a new SAC in paediatric A-V medicine

Maintaining a quality multidisciplinary service and developing excellence: guidelines, standards. Audit and governance – ***and having a life!***

Dr Breege Mac Ardle

1. Aims

- Review the clinical governance checklist
- Insert some ideas on maintaining standards/excellence
- Identify some of the constraints relevant to doctors
- Wish list

2. Governance

"A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."

G Scally and L J Donaldson, 'Clinical governance and the drive for quality improvement in the new NHS in England' BMJ (4 July 1998): 61-65

3. Quality multidisciplinary service - checklist

- What do my patients need?
- Am I up to date with my practice?
- How well am I doing?
- Do I work as part of a team?
- How well is my organisation doing?

4. What do my patients need?

GMC

- make the care of your patient your first concern;
- treat every patient politely and considerately;
- respect patients' dignity and privacy;
- listen to patients and respect their views;
- give patients information in a way they can understand;
- respect the rights of patients to be fully involved in decisions about their care;
- be honest and trustworthy;
- respect and protect confidential information;
- make sure that your personal beliefs do not prejudice your patients' care;
- act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise;
- avoid abusing your position as a doctor;

5. Am I up to date with my practice?

- Are you a member of your National speciality group(s) association?
- Does your CPD include a good mix of BAAP/ BACDA/Neurotology/ENT and other relevant national/international meetings?
- Do you participate in local/regional national audit programmes?
- Have you devised multidisciplinary evidence based practice care pathways for your patients? And audit them?
- Do you have regular case discussions about clinical cases?
- Do you refer cases to other colleagues in the same or other specialities?

6. Am I up to date with my practice?

- Standards

- GMC guidelines on Duties of a Doctor
- Royal College directives
- BAAP/BACDA policies/documents
- NDCS standards
- NHS standards
- NHS waiting time targets
- ? Read journals or attend a journal club
- Is your CPD up to date?

7. How well am I doing?

- keep your professional knowledge and skills up to date;
- recognise the limits of your professional competence;
- be honest and trustworthy" (GMC duties of a doctor)

Stay sane and have a life!

8. How well am I doing?

Managing your work

Good medical care in an environment of -

- caseload / resource shortfall/audit/national association outcomes
- outcomes of complaints/external reviews
- problems arising from governance issues
- routine standards of care/critical incidents

9. How well am I doing?

Standards

Personal style :

- Open in ideas
- Flexible/Adaptable to change
- How to seek help – Quality maps
- Networks of support
- Stress management / time management
- Employ burn out avoiding behaviours

10. How well am I doing?

Audit

- Do you use any national guidelines in your clinical practice?
- Have you devised evidence based practice care pathways for your patients?
- Present to groups - within trust, regionally or nationally
- Is loop ever completed?
- Trust support for audit?
- Do you do audit ?

11.How well am I doing?

- Relationships with patients
- Good practice/ Nice letters/chocolates
- concerns about your relationships with patients
- 360 degree surveys/ peer reviews
- Complaints

12. Stay sane and have a life!

- Agree realistic job plans
- Enjoy your job – despite the constraints
- Stay in touch with colleagues
- Go to meetings, discuss cases, remain involved in BAAP/BACDA discussions
- Book leave even if you don't know how you will spend the time
- Anticipate and prepare lectures/talks
- Don't take work home
- Find people who are "good" for you
- Create "people" breaks this includes family and friends
- Laugh more often 5/500
- Relax regularly
- Financial planning
- Eat, exercise, and take time to eat lunch and go to the toilet!

13. Do I work as part of a team?

"*work with colleagues in the ways that best serve patients' interests*" (GMC duties of a doctor)

- Are you a team player?
- Does your team meet regularly ?
- Has your team agreed clearly defined roles and responsibilities?
- Does your team meet regularly to discuss quality issues?
- Does your team meet to devise "patient journeys"/ clinical care pathways
- Is your team "open" enough to learn from experience?
- Does your team perform multidisciplinary audit?
- Does your team involve user input?
- Do you and your team feel supported by trust management?

14. Working relationships with colleagues

- Don't just assume that a group of people can become a team.
  - A set of team rules can help improve the use and management of time.
  - *Remember*, time spent getting to know one another is never wasted
- know where to seek help if problems

15. Traditional preferences and behaviours encouraged in today's health service

16. Constraints for doctors

- Trained to make urgent decisions, independently on objective and complex information
- Working in teams
- Burning out

17. Incentives

- Team working
- Teaching and training
- Research , Audit
- Local and National contribution
- Job satisfaction
- New job/Imminent retirement

18. Incentives for doctors

- Monetary – Clinical excellence awards –
- Favour doctors who are more extraverts/intuitive thinkers /judgers and thinking types
- Does not favour – sensing/feeling/perceiving/introvert types

19. How well is my organisation doing?

- Does it support clinicians and MDT teams
- Does it provide meaningful appraisal
- Are job plan discussions and allocated PA's based on clinician's true working pattern
- Are staffing issues addressed appropriately
- Are complaints well managed
- Are staff conflict issues well managed

20. Wish list

- Realistic specimen job plans supported by RCP/ RCPCH/BAAP/BACDA for consultants who are - single handed, DGH/Community based,/tertiary centres/ academic posts
- More nationally agreed evidence based guidelines
- Better quality appraisal process in the NHS

21. Clinical Governance Checklist

- What do my patients need?
- Am I up to date with my practice?
- How well am I doing?
- Do I work as part of a team?
- How well is my organisation doing?

"Here is Edward Bear, coming downstairs now, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think of it"

A.A. Milne 1926
Illustration E.H.Shepard 192614

The Future of Adult Neuro-otology or
Adult Audiovestibular Services of the Future.

Linda M. Luxon

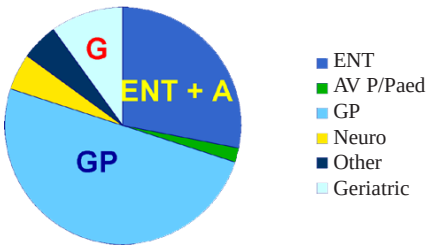
1. "A rose by any other name…."
- Audiological Medicine
- Audiovestibular Medicine
- ABC medicine
- Medical Audiology
- Medical Otology
- Neuro-otology
- Otoneurology
- Medical ENT

2. Audiological Medicine or Audiovestibular Medicine
- Paediatric audiology
- (Auditory electrophysiology)
- Adult auditory rehabilitation
- Adult neuro-otology

3. Adult Neuro-otology
- Adult diagnostic audiology including APD
  - Diagnosis
  - Investigation
    - site of lesion
    - aetiological
  - Rehabilitation
- Vestibular medicine, peripheral and central
  - Diagnosis
  - Investigation
    - site of lesion
    - aetiological
  - Rehabilitation

4. Adult Neuro-otology
- Adult diagnostic audiology including APD
  - Diagnosis
  - Investigation
    - site of lesion
    - aetiological
  - Management + Rehabilitation
- Vestibular medicine, peripheral and central
  - Diagnosis
  - Investigation
    - site of lesion
    - aetiological
  - Management + Rehabilitation

5. ?Adult Vestibular Presentations



6. Models of Service
- ENT does all
- ENT + **Audiologists** span content
- ENT + Neurologists cover work
- Neurologists + Audiologists do work

7. NHS Plan Objectives

1 Working Differently

– EWTD

From 2004 the European Working Time Directive (EWTD) health and safety legislation extends to apply to doctors in training. It is both a challenge and an opportunity for the modernisation of the NHS.

– New ways of working

The New Ways of Working team implements many of the initiatives designed to improve working patterns in the NHS. Agenda for Change, Changing Workforce Programme, Consultant Contract and Incentives Implementation, Protocol-Based Care, recruitment and retention, and solutions to the European Working Time Directive are some of these strategies.

2 Investment

8. Proposed Changes
- Medical support workers
- Extended nursing and other healthcare practitioner roles
- **Developing medical assessment facilities**
- Alternative night cover arrangements
- EWTD modelling and service redesign
- Mental health services
- Consultant role and working patterns

9. Hospital at Night

The Hospital at Night project aims to redefine how medical cover is provided in hospitals during the out-of-hours period. The project requires a move from cover requirements defined by professional demarcation and grade, to cover defined by competency.

10. DoH Initiatives
- Action on ENT
- Agenda for Change
- Modernising Medical Careers
- EWTD

11. Action on ENT
- Access for patients
- **Novel initiatives**
- Alternative provision
- Promotion of primary/community care
- Cost efficiency
- Evidence
- **Patient power**

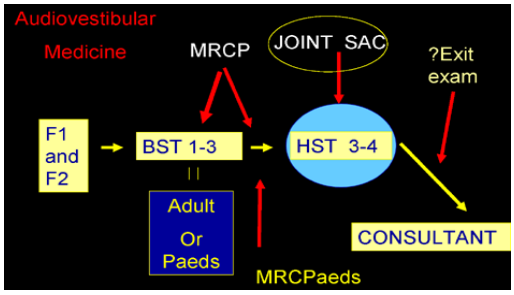
12. Agenda for Change
- New ways of working
- Role redesign
- Protocol based care
- Patient centred care

13. Other Drivers
- BAA – careers escalator
- RCP – working party
- RCPCH- community paediatrics
- ENT – medical otology
- Federation

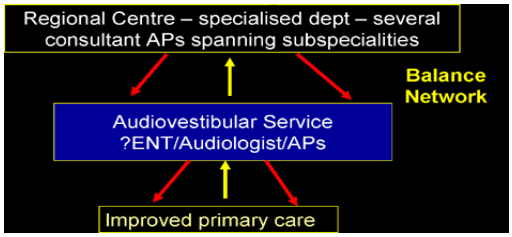
14. Competencies
- BAA
- BACDA
- SAC of RCP
- RCPCH

15. Options for Specialty
- Stay in RCP as independent specialty
- Align with ENT….EU model
- Align with Neurosciences (approp. model for medical/ surgical parallel disciplines)
- Divide into paediatric (RCPCH) and adult disciplines (RCP) with separate training
- Become super-specialty add-on i.e.
  - ENT + neuro-otology or
  - Neurology + neuro-otology
  - Peadiatrics + paediatric audiology

16. RCP / RCPCH



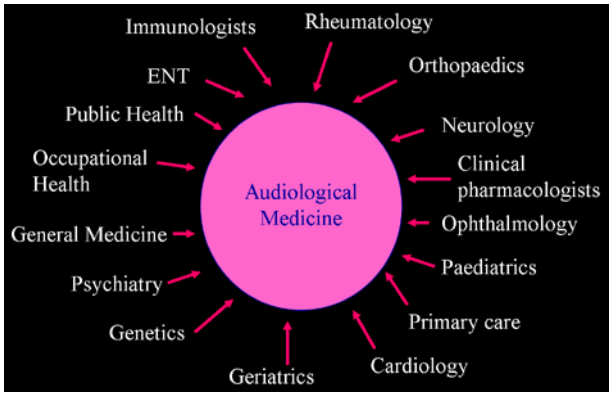
17. Adult A-V Services of the Future



18. Proactive

19. The Future

20.



21. Training Needs
- Audiological Paediatrians
- Audiological Physicians
- Super- specialist interests
- Academic medicine
- Integration of service needs across disciplines

22. Non - medical Colleagues
- Audiologists
- Hearing aid dispensers
- Teachers of the deaf
- Speech and language therapists
- Pharmacologists

23. Drivers of Health Provision
- COSTS
  - Economy of scale
  - Multi-tasking
- Patient expectations
- Clinical governance
- EU unification

24. EU Unification
- Speciality Register
- Training
- Work Patterns
- Research Collaborations
- Professional Bodies
- Publications

25. Costs
- Mergers
- Multitasking
- Change of emphasis to primary care
- Tertiary care: outpatient v. inpatient
- Technical/scientist led services
- Move away from specialist training

26. Future
- reassess our workload and work patterns
- work in multidisciplinary teams
- concentrate (+ define) doctors' unique contribution
- define competencies in all areas of our work
- be united and proactive
- concentrate on the patients' needs
- in our specific areas of expertise demonstrate excellence